

Managed Care Expanding Once Again in West Virginia

The West Virginia Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) recently awarded contracts to five managed care organizations (MCOs) to provide services to West Virginia Medicaid members. In addition to the current MCOs (Coventry Cares, The Health Plan, UniCare and West Virginia Family Health), CareSource will begin to accept West Virginia Medicaid members. CareSource is located in Dayton, Ohio, and currently provides services to Medicaid members in Ohio and Kentucky. The contract and rates with the five MCOs will be reviewed annually and submitted to the Centers for Medicare and Medicaid Services (CMS) for approval.

Before CareSource can begin enrolling Medicaid members, they must submit a Mountain Health Trust Application, which must be approved by BMS; undergo a desk and onsite review as well as a review by CMS; and undergo system testing with the state's Medicaid Management Information System (MMIS) and the managed care enrollment broker. A defined start date is not yet available since it is dependent on the plans meeting the criteria listed above. CareSource has been reaching out to West Virginia medical providers to build their networks for the past several months.

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APS Healthcare is Now KEPRO; Continues to Serve as Utilization Management Contractor

In May 2015, APS Healthcare was acquired by KEPRO, a leading quality improvement and care management organization. The combination has enhanced KEPRO's ability to provide comprehensive and high quality service through an integrated approach and customized solutions. In May 2016, the West Virginia Department of Health and Human Resources (DHHR) awarded the utilization management (UM) contract to KEPRO.

KEPRO offers innovative and outcomes-focused solutions to control the utilization of health care resources and optimize quality of care for public and commercial clients. Tailored programs maximize members' quality of life, and realize greater cost savings for members and clients.



"This change really emphasizes our dedication to providing additional value to meet our customers' and their members' specific needs," stated KEPRO President and Chief Executive Officer (CEO) Joseph A. Dougher. "KEPRO continuously delivers on our promise of providing intelligent value and our new website and its functionality does just that."

KEPRO provides administrative, clinical and consultative services to West Virginia DHHR's Bureau for Medical Services, Bureau for Children and Families, and the Bureau for Behavioral Health and Health Facilities. Since 2000, KEPRO has been helping the state serve more than 500,000 members and 30,000 providers to ensure citizens are getting the right care, at the right time and in the right setting.

APS is currently in the process of rebranding itself as KEPRO. As part of the rebranding initiative, KEPRO unveiled the new website, <http://wvaso.kepro.com>, that includes enhanced usability and

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Managed Care Expanding Once Again in West Virginia *(Continued from page 1)*

There have been some additional changes to the State Fiscal Year (SFY) 2017 (July 1, 2016 to June 30, 2017) contract with the MCOs including the following:

- Hepatitis C drugs will now be covered under the fee-for-service (FFS) program for all Medicaid members. Providers will need to submit bills for these drugs to Molina for payment.
- Personal care services will be rolled into the managed care benefit package effective January 1, 2017. The MCOs are in the process of contacting personal care providers to determine network contracting details.
- BMS also plans to move the Supplemental Security Income (SSI) population into managed care by January 2017. This excludes members who are waiver participants and those who are dually eligible for Medicaid and Medicare. BMS is currently working with the enrollment broker MAXIMUS to develop a timeline to begin sending out materials to SSI Medicaid members. All eligible members will have to select a plan by mid-December or they will be auto-assigned to an MCO using the same auto-assignment logic currently in place. MAXIMUS is also planning to conduct town hall-type meetings across the state to assist this population in understanding all of their choices.

The SFY 2017 performance measures for the MCOs based on the National Committee for Quality Assurance (NCQA) are:

Performance Measure	Targeted Benchmark	Data Collection Method
Well-child visits in the 3 rd , 4 th , 5 th , and 6 th years of life	National Medicaid average from 2016 NCQA Quality Compass	Health effectiveness data and information set (HEDIS)
Adolescent well-care visits	National Medicaid Average from 2016 NCQA Quality Compass	HEDIS
Initiation and engagement of alcohol and other drug dependence treatment – initiation	National Medicaid Average from 2016 NCQA Quality Compass	HEDIS
Follow-up after hospitalization for mental illness (follow-up visit within seven days of discharge)	National Medicaid Average from 2016 NCQA Quality Compass	HEDIS
prenatal and postpartum care – postpartum care	National Medicaid Average from 2016 NCQA Quality Compass	HEDIS
Annual monitoring for patients on persistent medications – total	National Medicaid Average from 2016 NCQA Quality Compass	HEDIS
Medical assistance with smoking and tobacco use cessation (MSC) – advising smokers to quit	National Medicaid Average from 2016 NCQA Quality Compass	HEDIS
Childhood immunization status	National Medicaid Average from 2016 NCQA Quality Compass	HEDIS
Comprehensive diabetes care	National Medicaid Average from 2016 NCQA Quality Compass	HEDIS
Nutrition counseling for children/ adolescents	National Medicaid Average from 2016 NCQA Quality Compass	HEDIS

APS Healthcare is Now KEPRO; Continues to Serve as Utilization Management Contractor *(Continued from page 1)*

content. The website provides quick and easy access to essential information and programs to assist members and providers in getting the resources they need. The site is enhanced with richer online content that is easy to navigate. The website will be updated on a regular basis to ensure that content is always current and accurate.

To learn more about the services and solutions KEPRO offers, visit www.kepro.com. You can also get health tips, information about the organization or learn about exciting job opportunities by following KEPRO on [Twitter](#), [Facebook](#) or [LinkedIn](#).

Provider Revalidation Information Must be Submitted by September 24, 2016

As a requirement of the Patient Protection and Affordable Care Act, Medicaid agencies must revalidate the enrollment of all providers by September 24, 2016. West Virginia Medicaid has established an application submission deadline of August 31, 2016, to enhance the chance that providers will meet the federal revalidation deadline of September 24, 2016. While there is no guarantee that an application submitted by August 31 will complete the revalidation process by the September 24 deadline, it provides the best possible chance of continued enrollment.

If a revalidation application has not completed the approval process by September 24, 2016, the provider will not be reimbursed by West Virginia Medicaid for dates of service on and after September 25, 2016. To avoid possible disruption in claims payment for dates of services on and after September 25, 2016, providers should submit a revalidation application to Molina's Provider Enrollment Unit as soon as possible.

Providers who have received the following communications from the Molina Provider Enrollment Unit should act quickly to ensure they have completed the process by the deadline:

- **Revalidation Not Started** – Molina records indicate an electronic application has not been entered nor a paper application submitted. Pay-holds were placed on claims billed under your West Virginia Medicaid Provider ID on August 1, 2016. If revalidation is not completed during the pay-hold period, your enrollment with Medicaid will be terminated. Claims submitted with dates of service after placement of the initial pay-hold will be voided.
- **Additional Information Required** – Molina records indicate a submitted application may still need additional information. If you have not already done so, please contact Molina's Provider Enrollment Unit at 1-888-483-0793 to determine the supporting documentation needed to complete your revalidation application. This action needs to occur before September 1, 2016, to avoid being placed on pay-hold. If you fail to contact Molina by this date, claims billed under your West Virginia Medicaid Provider ID number will be placed in a pay-hold status. If the additional information required is not submitted during the pay-hold period, your enrollment with Medicaid will be terminated. Claims submitted with dates of service after placement of the initial pay-hold will be voided.
- **In Process with Molina** – Molina records indicate that a submitted application is currently being worked by Molina's Provider Enrollment Unit. If additional information is required, you will be contacted. No action is required at this time. If you are currently working with Molina on your active revalidation case, you will not be included in the pay-hold process.

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Provider Revalidation *(Continued from page 3)*

To recap, here are the steps you need to take to initiate revalidation or submit additional information:

- Contact Molina Provider Enrollment at 1-888-483-0793 or 304-348-3360 (Charleston area) Monday through Friday, 7:00 a.m. to 5:00 p.m. Enter your National Provider Identifier (NPI) and select option #4.
- Please refer to correspondence sent by Molina using your listed case number. You may revalidate electronically via the Provider Enrollment Application Portal (PEAP) at www.wvmmis.com. Review the Provider Enrollment Checklist in the Provider Enrollment Process section for a list of all documentation needed to complete the revalidation process.
- Access the PEAP link to begin the revalidation process.
- If you have already submitted through the PEAP and have been contacted to provide Molina with additional supporting documentation, please complete that process as soon as possible.

National Correct Coding Initiative (NCCI) Third Quarter 2016 Edits

Medicaid National Correct Coding Initiative (NCCI) edits are updated quarterly by the Centers for Medicare and Medicaid Services (CMS) and implemented in Molina's claims processing system. Updated NCCI edits apply to practitioner, outpatient hospital, durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claims. The new third quarter 2016 NCCI edits are effective for dates of service July 1, 2016 and after. The CMS Medicaid NCCI edits are found at www.medicaid.gov/.

The third quarter 2016 NCCI update includes both Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUEs). One of the new PTP edits pairs a variety of preventive medicine services CPT codes with CPT Code 99173 (visual acuity screening). For example, PTP column one CPT code 99382 (preventive visit, new, age one to four years) is paired with column two CPT Code 99173. As such, Code 99173 is not eligible for separate reimbursement.

The third quarter 2016 update also includes MUEs for allergy testing and allergen immunotherapy CPT codes. For example, CPT Code 95004 (percutaneous allergy skin tests) now has an MUE of 80. And an MUE of 10 has been established for CPT Code 95145 (antigen therapy services - single stinging insect venom). The MUE for Code 95145 is consistent with Medicaid Policy 519.3, Antigen and Allergy Services, on the maximum number of billable doses per multi-dose vial. This policy is found at www.dhhr.wv.gov/bms/.

If you have questions or concerns regarding claim line denials based on the NCCI edits, please contact the Molina Provider Relations Unit at 1-888-483-0793, which can refer unresolved inquiries to a certified coder on staff.

Pharmacy Update

In accordance with the recently released 2016 Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain, the Bureau for Medical Services (BMS) will be implementing a new morphine equivalency edit in early September. Chronic users of opioids, who have received greater than 50 average MME (Morphine milligram equivalent) per day during a 90 day window, will trigger a prior-authorization case review. Providers will be contacted during the prior-authorization process. More details will be forthcoming and will be posted to the Pharmacy News section of the BMS website.

To keep up with all of the latest news from the Pharmacy Unit, visit the Pharmacy News section of the BMS website at www.dhhr.wv.gov/bms/.

Dental Services Update

The Bureau for Medical Services (BMS) updated Chapter 505-Dental Services with an effective date of June 1, 2016. Two new dental codes D9986 (missed appointment) and D9887 (cancelled appointment) were added and apply to both fee-for-service and managed care Medicaid members. The fee for both codes is \$0.

KEPRO has updated and rebranded their dental forms and website. The Organization Manager and Provider Portal Direct Data Entry (direct data entry) websites have changed. For the next several months, you will be redirected to the new URLs. The new site URL for Organization Manager functions is <https://c3wv.kepro.com>. The new site URL for requesting prior authorizations is <https://providerportal@kepro.com>. You will find the new URLs on the authorization website as well. Please save the new site addresses in your bookmarks or favorites. Additionally, the system will no longer reference APS Healthcare. For example, instead of APS Member ID you will see Member ID. You will also notice the new KEPRO logo throughout the system and on all letters and forms.

All XXX@apshealthcare.com email addresses will be replaced with XXX@kepro.com addresses. Emails sent to the old addresses will be redirected to the new addresses for a short period of time. Please be sure to update KEPRO staff email addresses in your contacts lists, as the redirection is only temporary.

West Virginia CHIP Provider Enrollment Reminder

All West Virginia Children's Health Insurance Program (WV CHIP) providers must enroll with the WV CHIP program at Molina to be reimbursed for services, even if you have revalidated with Medicaid. The WV CHIP supplemental application is very short if you are already a West Virginia Medicaid.

To smooth the transition to the Molina system, WV CHIP allowed some providers to be provisionally enrolled; however, that will be ending in September 2016. Any providers who have not been enrolled through the Molina process will be terminated on September 24, 2016. Federal regulations require full WV CHIP enrollment by September 2016 to continue payments. Go to www.wvmmis.com to enroll.

Coding Corner

Unbundling is coding each component of a service separately when one comprehensive code that encompasses the entire procedure is available. Unbundling is considered a fraudulent billing practice by the Centers for Medicare and Medicaid Services (CMS) when a bundled code is available and could result in substantial penalties.

When unbundled services are identified on single claims submitted to West Virginia Medicaid, the charge of each individual component procedure code is denied and the comprehensive code is added to the claim and considered for payment. However, if unbundled services are submitted on separate claims, manual claim adjustments are required. In the past, when separately billed components of a comprehensive service were identified on separate claims, Medicaid has reversed and replaced the previously paid service, denied the unbundled services on each claim, and added the comprehensive procedure code for consideration.

Effective immediately, Medicaid will no longer add and consider the comprehensive code. Unbundled procedure codes will now be denied, and the health care provider must rebill with the correct code(s).

Behavioral Health: Ready for Changes

The West Virginia Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) behavioral health services team is led by Keith King and Cynthia Parsons. King is a Licensed Psychologist and Social Worker who specializes in child residential services. Parsons has a master's degree in Counseling and specializes in substance abuse disorders.

BMS behavioral health services encompasses many areas including:

- Behavioral health clinic services
- Behavioral health rehabilitation services
- Crisis services
- Child residential services
- Psychological and psychiatric services
- Supportive services
- Targeted case management services

In State Fiscal Year (SFY) 2016, behavioral health services were transitioned to managed care so that behavioral health services and physical health services are more integrated. While integration of behavioral and physical health continues to be a focus, this fiscal year, more changes are coming to behavioral health with King and Parsons leading the way.

The BMS team collaborates with the Bureau for Children and Families (BCF), the Bureau for Behavioral Health and Health Facilities (BBHFF) and the Bureau for Public Health (BPH) to provide the best possible service for Medicaid members and to make the system of care easier to manage.

Due to legislative and fiscal issues, child residential services is changing in SFY 2017. On September 1, 2016, payment for child residential services will be unbundled, and new processes will be implemented. BCF will pay for room, board and supervision of children residing in a facility. Also, children will only be allowed to spend six months in a residential facility. Providers will be offered incentives for a successful discharge back into the community. BMS will pay for therapy services through the fee-for-service (FFS) program.

“Under the new child residential system, the treatment the child receives can be monitored so that appropriate evidence-based therapy can be initiated, utilized and modified, if needed, to meet the child’s individual needs,” says King.

The decision to unbundle child residential services was based on studies involving children receiving treatment. Children who receive treatment within their own environment, who are integrated into their community and have positive support from family and friends have a higher level of success and a lower relapse rate.

“The overall goal is to treat the child with the best practices in a less restrictive environment, ultimately providing them safety and comfort,” says Parsons.

The behavioral health team welcomes the changes, regardless of any challenges they face, because they believe the outcome will help reduce the level of trauma a child receives when placed outside of their home environment. Also, it will help preserve the positive family and social system that supports the child’s physical and mental development.



Pictured left: Keith King and Cynthia Parsons

Quality Unit Launches Second Quality Improvement Project

West Virginia Medicaid's Quality Unit was required to implement a second Quality Improvement Project (QIP) under its Centers for Medicare and Medicaid Services (CMS) Adult Medicaid Quality grant. In 2013, West Virginia Medicaid selected the CMS Core Measure "Follow-Up after Hospitalization for Mental Illness" as the focus of the project.

After analyzing three years of data (2012-2014) for all fee-for-service (FFS) Medicaid members, the Quality Unit proposed the project to several behavioral health facilities. The Behavioral Health Pavilion of the Virginias at Princeton Community Hospital accepted the opportunity to partner with Medicaid to implement the pilot program designed to increase the follow-up rate after a hospitalization for mental illness. All Medicaid members, both FFS and managed care participants, discharged from The Pavilion between June 20, 2016 and November 31, 2016, will be included.

Members will receive educational materials that focus on the importance of keeping their follow-up appointments after being discharged from the hospital. At the time of discharge from The Pavilion, hospital discharge staff will review educational materials with the member emphasizing the importance of keeping follow-up appointments. The materials include: contact information for MTM (West Virginia Medicaid's non-emergency medical transportation broker), a notepad, a fact sheet of important information regarding the follow-up appointment and additional information. The Pavilion may provide additional information as well. In December 2016, the Quality Unit will analyze outcome data to determine if the QIP increased the follow-up rate after hospitalization for mental illness.

Six-month MMIS Implementation Update

On January 19, 2016, Molina implemented the new Medicaid Management Information System (MMIS) for West Virginia Medicaid and WV CHIP members and providers. This new system was under development and testing for the past three years and includes many updates and new features. The MMIS applies only to West Virginia Medicaid and WV CHIP fee-for-service (FFS) members and their providers. It does not impact members enrolled in the Medicaid managed care program or the claims that providers submit to the managed care organizations. The new system offers new functionality for members and providers, including enhancements to Molina's web-based provider portal.

With an implementation of this size, the need for some follow-up work is expected. Over the past six months MMIS and Molina staff have worked on fine-tuning the areas of coding, the provider enrollment application and claim submission. We want to thank the provider community for working with us on this collaborative effort and creating a successful implementation.

2016 Fall Provider Workshops

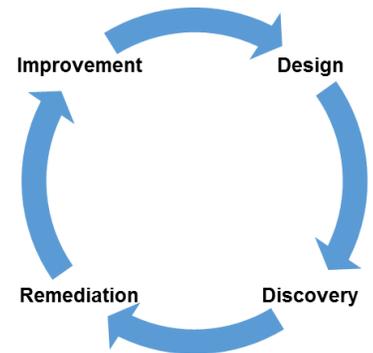
The schedule for the 2016 Fall Provider Workshops is now available except for the Elkins site. As soon as registration information is available it will be posted on the BMS website at www.dhhr.wv.gov/bms/ and the Molina website and provider portal at www.wvmmis.com.

October 11, 2016: Charleston at Beni Kedem
October 13, 2016: Huntington at St. Mary's Conference Center
October 14, 2016: Beckley at Tamarack
October 17, 2016: Martinsburg at the Holiday Inn
October 18, 2016: Wheeling at Oglebay Resort
October 19, 2016: Morgantown at the Waterfront Hotel
October 20, 2016: Parkersburg at the Vienna Conference Center

Quality Measures: Medicaid Waiver Programs

Home and community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community. The West Virginia Bureau for Medical Services (BMS) is approved through the Centers for Medicare & Medicaid Services (CMS) to offer home and community-based services through three separate waiver programs: Aged and Disabled Waiver (ADW), Intellectual/Developmental Disability Waiver (I/DDW) and Traumatic Brain Injury Waiver (TBIW).

Last year, all three waivers were renewed for five years by CMS. As a condition of that approval, West Virginia Medicaid had to plan for and prove that services satisfied multiple quality measures. By following the continuous quality improvement cycle, CMS illustrates that states must design quality measures, discover compliance/non-compliance, remediate non-compliance and, ultimately, evidence quality improvement.



With the renewal of each waiver program, BMS sought to streamline and standardize quality measures across all three waivers. This effort was initiated with the expectation of achieving administrative efficiencies and promoting a holistic waiver environment that includes learning opportunities across programs. The BMS waiver programs have the following quality assurances:

- Level of care: Participants must be evaluated/reevaluated on an annual basis to ensure they meet the level of care required in a facility.
- Service plan: Service plans must be adequate to meet participants' needs.
- Qualified providers: Those providing services must be qualified.
- Health and welfare: The state must assure participant health and welfare.
- Financial accountability: The state must demonstrate financial accountability of the waiver program.
- Administrative authority: The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver.

To date, West Virginia waiver programs are exceeding CMS's expectations of compliance. Applicants and program participants are being assessed within timelines at least 98% of the time. Providers are adequately trained and meet background check requirements at least 98% of the time. A review of files on-site shows people are receiving services as indicated on their plans, and their health and welfare is being monitored. Critical incidents and abuse/neglect/exploitation are being reported within timelines at least 98% of the time.

While the majority of the quality measurements meets expectations, BMS still recognizes and seeks opportunity for improvement. BMS meets with their contractors regularly to discuss and discover any areas that may require remediation or a quality improvement plan. Typically, technical assistance or training, modifying a form or further educating providers results in improvement. Each waiver program also engages a group of stakeholder volunteers to comprise a Quality Improvement Advisory Council. The councils' agendas always include a review and discussion of the quality measures and opportunity to advise BMS on ways to improve program quality. BMS is pleased with the outcomes so far and looks forward to continuing to provide quality waiver services for those who qualify for and need them.

West Virginia State Health System Innovation Plan

Over the past year and a half, the West Virginia Health Innovation Collaborative, a group of health care leaders in both the private and the public sector, used a State Innovation Model (SIM) grant from the Centers for Medicare & Medicaid Innovation (CMMI) to craft a framework for improving the health of West Virginians through a transformed health care delivery and payment system. The SIM is based on and aligned with the triple aim objectives of improved population health, improved experience of care and improved value through reductions in the overall cost of health care services. The model was submitted to CMMI for review and consideration of a model testing grant, if funding is available.

The five-year vision for the SIM is to modernize and transform West Virginia's health care delivery and payment system. The plan highlights the achievement of the following five drivers to assist the state in making this vision a reality.

Driver 1: Ensure all West Virginians are connected to a primary care provider and, where appropriate, have access to advance primary care delivery systems. Strategies to reach this goal include:

- Coordinate efforts to identify individuals without a primary care provider (PCP) and connect them with a PCP.
- Pursue Affordable Care Act Section 2703 regarding health homes or encourage health homes look-alikes by collaborating with the Medicaid managed care organizations (MCOs).
- Encourage reimbursement models that reward advanced primary care delivery systems.
- Launch a shadow transforming clinical practice initiative.
- Promote reimbursement models that facilitate the integration of community health workers with primary care programs and the use of related approaches to addressing psycho-social risks, patient engagement and self-care.

Driver 2: Accelerate population health management by implementing the Centers for Disease Control and Prevention's scaled intervention approach to improved population health. Strategies to reach this goal include:

- Focus on projects/programs to address super-utilizers (those individuals who use a disproportionate share of health care services).
- Link community-based health and social support resources to the health care delivery system.
- Build on successful community-wide health improvement programs and develop specific initiatives to address obesity.
- Promote the integration of behavioral health and primary care services.

Driver 3: Leverage data and information management capacity. Strategies include:

- Encourage providers to continue training staff in data management and analytics.
- Leverage the Medicaid data warehouse.
- Align quality measures across payers.
- Develop a standardized provider scorecard.
- Optimize a Health Information Exchange (HIE) to enable sharing of timely health information, including behavioral health information.

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West Virginia State Health System Innovation Plan *(Continued from page 9)*

Driver 4: Advance value-based reimbursement models, progressing based on risk readiness. Strategies include:

- Set a vision for a value-based system through the state's public payer contracts.
- Encourage payers to migrate toward value-based reimbursement.
- Establish regional self-organized health communities.

Driver 5: Better address the unique needs of aging West Virginians by reducing spending on long-term care and strengthening the delivery care system to older adults. Strategies include:

- Emphasize lower-cost, better care settings.
- Establish geriatric medical homes.
- Identify and implement best practices to improve care transitions.
- Develop a consultative peer network for rural geriatricians using Project Extension for Community Health Outcomes (ECHO) (for more information visit: <http://echo.unm.edu/>).

These five drivers were developed with the following goals for improving health care by all involved parties.

- Decreasing obesity in the state by focusing on increased physical activity, better nutrition, and lowering Type 2 Diabetes, hypertension and cardiovascular disease rates.
- Decreasing the use of tobacco by focusing on education and cessation programs for adults, youths and pregnant women, lowering chronic obstructive pulmonary disease (COPD) and associated cancers, and lowering dependency on smokeless tobacco and other nicotine products.
- Integrating behavioral and physical health by increasing mental health provider availability, advancing and coordinating mental health in-home services, and decreasing prescription drug and illegal substance abuse, as well as decreasing neonatal abstinence syndrome.

More information regarding the SIM project and the West Virginia Health Innovation Collaborative can be found at www.wvhicollaborative.wv.gov/.

Billing of Service Location Identifier

West Virginia Medicaid will require the service location suffix to be included in field 32b on the Centers for Medicare and Medicaid Services (CMS) 1500 claim form effective for service dates on and after October 1, 2016. A three digit service location identifier was assigned to providers as part of the enrollment/revalidation process. The provider's primary location on the application is identified using suffix -001 with the suffix for additional service locations following sequentially.

Please enter the service location identifier on the CMS 1500 claim form as follows:

In field 32b, enter the provider NPI or API, followed by a dash, then the three digit suffix assigned to that service location, i.e., the service location identifier for the primary location for NPI/API 1234567890 will be the 10 digit number-three digit suffix, 1234567890-001. Do not enter any other value to field 32b. Each service location must be affiliated to your billing provider claim processing.

In early 2017, an edit for the service location identifier will be set to a warn disposition for at least three months before moving to a deny disposition. More information will be posted in the future on the Bureau for Medical Services and Molina websites.

Assuring Access to Care

The Centers for Medicare and Medicaid Services (CMS) posted the final rule for methods state Medicaid programs must use to assure access to covered Medicaid Services. The rule provides for a transparent data-driven process to document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered care and services.

Every three years, state Medicaid programs must review access to care for, at least, the following services:

- Primary care services including those provided by a physician, a Federally Qualified Health Center (FQHC), clinic or dentist.
- Physician specialist services, e.g., cardiology, urology, and radiology.
- Behavioral health services including mental health and substance use disorder.
- Pre- and post-natal obstetric services including labor and delivery.
- Home health services.

In addition, states must add services to the access monitoring review plan when rates are reduced or restructured. If the changes could result in diminished access, the state must monitor access to those services for at least three years after the effective date of change. If a state or CMS receives a significantly higher than usual volume of beneficiary, provider or other stakeholder complaints regarding access to a particular type of care for a geographic area, the state must add those services to review procedures.

The plan must include an access monitoring analysis describing data sources, methodologies, baselines, assumptions, trends, factors and thresholds. The plan must identify data elements that will address:

- extent to which beneficiary needs are fully met,
- availability of care through enrolled providers, and
- changes in beneficiary service utilization.

CMS will review the plan for completeness and to determine if the state has addressed all of the required elements in a reasonable manner. If CMS determines changes are necessary to the state's submission, they will work with the state to make such changes. No formal approval or disapproval letters will be issued.

The West Virginia Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) posted its proposed plan on July 14, 2016, for a 30 day public comment period. To review the plan go to www.dhhr.wv.gov/bms/. The plan must be submitted to CMS by October 1, 2016.

West Virginia CARES Celebrates One Year Anniversary

On August 1, 2015, the West Virginia Clearance for Access Registry and Employment Screening (WV CARES) began processing background checks for current and potential Medicaid nursing home employees in West Virginia. Since that time, WV CARES has expanded its services to include Medicaid home health agencies and waiver programs. It is anticipated that all Medicaid long-term care facilities will be using the WV CARES system to screen potential applicants by fall 2016.

Since its inception, WV CARES has provided monthly monitoring of approximately 49,000 long-term care employees and provided employment fitness determinations for approximately 23,000 potential and current employees. With the addition of the federal background check, WV CARES has found 20 individuals seeking employment in West Virginia who were being sought by police on various charges. Six of these individuals were taken into custody by the West Virginia State Police for extradition.

West Virginia Medicaid is currently working with WV CARES to implement the federal required fingerprint based criminal background check for specific providers.

Contact

Molina Medicaid Solutions
Provider Relations
888-483-0793
304-348-3360

wvmmis@molinahealthcare.com (email)

EDI help desk
888-483-0793, prompt 6
304-348-3360

Provider Enrollment
888-483-0793, prompt 4
304-348-3365

Molina PR Pharmacy help desk
888-483-0801
304-348-3360

Member Services
888-483-0797
304-348-3365

Monday-Friday, 8:00 a.m. to 5:00 p.m.

Molina Provider Fax
304-348-3380

Molina Automated Voice Response System (AVRS) Prompt Tree

Please make sure that you are utilizing the appropriate prompts when making your selection(s) on the AVRS system to ensure that you will be connected to the appropriate department for your inquiry. Once you have entered in your provider number, the following prompts will be announced:

1. Accounts Payable Information
2. Eligibility Information
3. Claim Status Information
4. Provider Enrollment Department
5. Hysterectomy Sterilization Review
6. EDI Help Desk/Electronic Submission Inquiries
7. LTC Department
8. EHR Incentive
9. BHHF

Claim Form Mailing Addresses:

Please mail your claims to the appropriate Post Office Box as indicated below. PO Boxes are at Charleston, WV 25337.

PO Box 3765 NCPDF UCP Pharmacy

PO Box 3766 UB-92

PO Box 3767 CMS-1500

PO Box 3766 ADA-2002

Hysterectomy, Sterilization and Pregnancy

Termination Forms

PO Box 2254

Charleston, WV 25328-2254

Provider Enrollment & EDI Help Desk

PO Box 625

Charleston, WV 25337-0625

FAX: 304-348-3380

Molina Mailing Addresses:

Provider Relations & Member Services

PO Box 2002

Charleston, WV 25327-002

FAX: 304-348-3380

Provider Enrollment & EDI Help Desk

PO Box 625

Charleston, WV 25337-0625

FAX: 304-348-3380

MCO Contacts:

Coventry Health Care of WV
888-348-2922

The Health Plan
888-613-8385

Unicare
800-782-0095

WV Family Health
855-412-8002

Vendor Contacts:

KEPRO
304-3439663

MAXIMUS
800-449-8466

Please send provider enrollment applications and provider enrollment changes to:

Molina Medicaid Solutions PO Box 625, Charleston, WV 25337

Claims and Application Information

To expedite timely claims processing, please make sure claims are sent to the correct mailing address as indicated below:

- Facilities and Institutional Providers who bill on a UB04 Claims form: PO Box 3766, Charleston, WV 25337
- Medical Professionals billing on a CMS Claims form: PO Box 3767, Charleston, WV 25337
- Dental Professionals billing on ADA 2006 Claims form: PO Box 3768, Charleston, WV 25337
- Pharmacy Claim form NCPDP UCF:

Suggestions for Web Portal Improvements

We are looking for ways to improve the Provider Web Portal. If you have any suggestions on how we can improve the portal to make it more user friendly, please contact our EDI helpdesk at: edihelpdesk@molinahealthcare.com.