





- Working with the West Virginia Board of Medicine to determine newly licensed practitioners
- Assessing member requests
- Adding new providers to existing group contracts
- Reviewing out-of-network claim payments
- Reviewing quarterly network adequacy reports.

**4.8.4 The specific provider and facility types within the network per West Virginia county;**

	Allergy	Audiology	Cardiology	Dermatology	General Surgery	Gastroenterology	Neurology	Occupational Therapy	Oncology	OB/GYN	Ophthalmology	Orthopedics	Orthopedic Surgery	Otolaryngology	Pediatric PCP	Physical Therapy
Barbour	2		6					1								2
Berkeley	2	3	22	4	10	3	3		2	14	3	4	4		14	2
Boone	0		1	1	1	1				12	2	2	2	1	9	1
Braxton	0				3					1		1	1		2	1
Brooke	0	1	2			1				1					3	4
Cabell	3	10	24	4	23	11	16	3	13	37	15	24	24	5	39	3
Calhoun	0									1		2	2		1	
Clay	0															
Doddridge	0														1	
Fayette	0		1		3	1	1			1	1			1	4	2
Gilmer	0															
Grant	1		2		1					1	5	2	2	1	1	
Greenbrier	4	1	3	1	4	2	3	1	2	3	1	5	5		7	3
Hampshire	0		15	2	2	1				2		1	1		1	1
Hancock	2	2	3	2	7	5	1		10	11	5	3	3	2	10	2
Hardy	0			1						1					2	
Harrison	2	3	9	5	7	5	5	4	2	8	11	6	6	3	23	8
Jackson	5		7		2					1	3	3	3	1	3	2
Jefferson	1		2	1	7				3	3	1	5	5		7	5
Kanawha	6	4	30	9	35	12	12	4	17	44	26	22	22	9	46	14
Lewis	1		2		2		6	2	2	2	2	6	6	1	2	2
Lincoln	0									1					2	
Logan	4		6	2	3	1	2		2	3	5	3	3	1	3	3
Marion	1	5	7	1	5	1	1	2		11	1	6	6	3	17	5
Marshall	0	3	6		4	4			1	6	9	3	3	1	2	4
Mason	4	1	1		2		3		1	3	6	3	3	1	10	1
McDowell	0				1					4					2	1
Mercer	3	2	7	3	4	1	3		1	7	3	5	5	1	4	1
Mineral	0		8	1	3			1		1		4	4		1	1
Mingo	0			1							1				1	
Monongalia	5	10	33	15	26	18	28	10	20	41	33	30	30	21	58	10
Monroe	0														1	1



Morgan	0		12	1	2	1				1		2	2		1	1
Nicholas	2	2	1		4		3			6	2	3	3		13	3
Ohio	1	1	16	9	7	6	6	4	4	17	13	5	5	2	17	4
Pendleton	0			1				1							1	
Pleasants	0														1	1
Pocahontas	0															2
Preston	1		4		4		8					4	4	1	2	5
Putnam	2	3	9	2	3	4	10	2	4	25	1	8	8		33	4
Raleigh	10	4	9	4	10	8	5	1	9	13	13	12	12	2	12	6
Randolph	2		14	1	4	1			1	8	1	2	2		4	3
Ritchie	0															2
Roane	0		1		1		1			1		3	3			
Summers	0		1		1				1			1	1		1	1
Taylor	0		6				5								1	1
Tucker	0				1											4
Tyler	0		1									3	3			
Upshur	0	1	5		4	1	9			4	8	4	4		6	3
Wayne	0									4					1	2
Webster	0		1							1					2	
Wetzel	2	4	1	2	2				3	2		6	6		1	2
Wirt	0		8					1							1	
Wood	4	4	8	2	5	1	5	1	3	10	9	4	4	2	12	6
Wyoming	0				1		1								1	2

	PCP	Pulmonology	Anesthesiology	Chiropractor	Dialysis	DME	Endocrinology	Hematology	Home Health	Nephrology	Neurosurgery	Orthotics/Prosthetics	Pathology	Plastic Surgery	Podiatry
Barbour	15			1					1				1		1
Berkeley	62	3	6	4	2	4	4	2	4	9	5	1	4	2	7
Boone	52	1	3	2	1	1	1		1	3			1		
Braxton	11			1	1					1			1		1
Brooke	19			3		3			2				1		1
Cabell	158	9	9	20	3	5	9		3	12	10	5	2	6	10
Calhoun	12												1		
Clay	8														
Doddridge	9								1						
Fayette	46			3	2	2			1	3			2		5
Gilmer	9														
Grant	19					2			1				1		
Greenbrier	52	1		3	1	4	1	1	1	2	1		1	1	1
Hampshire	18	2				1					2		1		1
Hancock	46	2	7	3		1	2	1	1	5				3	4
Hardy	20			1	1					1					

Harrison	64	2	5	13	2	9	4	3	3	3	6	4	1	1	7
Jackson	36			2	1	1			2	3			1	1	2
Jefferson	31		1	3	1	2	1			4			1	1	4
Kanawha	209	5	49	27	3	17	12	1	6	14	7	3	7	11	11
Lewis	31	1		1	1	1			1	2			1	1	2
Lincoln	38	1													
Logan	45	1	6	3	1	3			3	2	1	1	2		1
Marion	37	1	1	8	1	3		1		3					4
Marshall	27	2	1	2		1		2	1				1		2
Mason	23	4	6	1	1	2		1	1	3			1		1
McDowell	24				1					1			1		
Mercer	48				2	5	2	1	4	2		1	1		6
Mineral	18	2	1	1	1	1				1			1		
Mingo	35					2				1					2
Monongalia	159	10	28	13	2	4	4	5	3	16	15	5	4	7	8
Monroe	9			2		1									
Morgan	9	1				1					2		1		1
Nicholas	28	6		1	1	2	2		1	4		1		1	1
Ohio	53		5	2	1	4	3		2	4	8	1	1	5	4
Pendleton	8														
Pleasants	9			1		1									
Pocahontas	17	1											1		
Preston	41	2		2	1	2			1	2			1		2
Putnam	60	2	15	6	1	3	2	1	1	2	3		1		5
Raleigh	88	2	3	8	3	10		2	5	2		3	6	1	8
Randolph	38	1	2	4	1	1			1	3		1	1		2
Ritchie	9			2					1						
Roane	19	6	2	1		2			1	1	1		1		1
Summers	10					1							1		
Taylor	17	1			1				1	1			1		
Tucker	9														1
Tyler	5												1		1
Upshur	31	1	3	2	1		1	1	1	2			1		3
Wayne	29			1		1									
Webster	16									1			1		
Wetzel	15			1	1				1	3			1		3
Wirt	10														
Wood	71	3	2	22	2	7	3		3	2	2	3	1	1	5
Wyoming	16			1	1	2									5
		Radiology	Thoracic Surgery	Urology	Oral Surgery	Psychology	Psychiatry	LICSW	Hospital	Outpatient SUD					

		Barbour	1				3	3		1	
		Berkeley	1	4	4		13	12	13	1	
		Boone	1				2	2	1	1	
		Braxton	1				1	1	16	1	
		Brooke	1	1					1	1	
		Cabell	2	2	7	1	44	21	17	2	2
		Calhoun	1							1	
		Clay					1				
		Doddridge									
		Fayette	2		2		2	2	18	2	
		Gilmer									
		Grant	1		1					1	
		Greenbrier	6		3		7	3	14	1	
		Hampshire	1				1			1	
		Hancock		1	5		1	2	3		
		Hardy							3		
		Harrison	1	2	2	1	15	9	24		
		Jackson	3		1	1	3		2	1	
		Jefferson	1		1		10	8	6	1	
		Kanawha	6	6	11	8	52	28	20	5	3
		Lewis	1		2		3	1	11	1	
		Lincoln						1	1		
		Logan	1		1		6	1	2	1	1
		Marion	1	1	3		7	5	11		
		Marshall	1	2	1			2	5	1	
		Mason	1		1		2			1	1
		McDowell	1				1	1	1	1	1
		Mercer	1		1		9	6	3		1
		Mineral	1				2		1	1	
		Mingo			1		4	1	2		
		Monongalia	15	18	11	8	42	32	55	2	1
		Monroe					4		1		
		Morgan	1					1	1	1	
		Nicholas			1		3				
		Ohio	1	8	2	1	6	2	18	1	
		Pendleton					1				
		Pleasants									
		Pocahontas	1				5	3		1	
		Preston	1		2		1		1	1	
		Putnam	1		4		10	8	3	1	
		Raleigh	2	1	4		11	8	11	1	
		Randolph	1	2	2		6	1	3		
		Ritchie					3				
		Roane	1		1		2	1	2	1	
		Summers	1				2	1	2	1	
		Taylor	1					1	1		

		Tucker				3	2	3														
		Tyler							1													
		Upshur	1		1	2	8	8	1													
		Wayne				2	2	3														
		Webster	1			2			1													
		Wetzel	1	1				1	1													
		Wirt				2																
		Wood	1	3	5	18	9	5	1	1												
		Wyoming				3	1															
	<b>4.8.5</b>	<b>The health carrier’s documented, quantifiable and measurable process for monitoring and assuring the sufficiency of the network in order to meet the health care needs of covered persons on an ongoing basis;</b>																				
		<p>To document members' reasonable access to a sufficient number of in-network primary care and specialty care physicians within reasonable travel time and distance standards, THP conducts an annual review using the following data sources and software tools:</p> <ul style="list-style-type: none"> <li>• GeoAccess type of software to analyze geographic distribution of primary care and specialty care providers and members</li> <li>• Member complaints regarding provider network adequacy</li> <li>• US Census data to assess members' linguistic, racial, and ethnic needs.</li> <li>• Provider's ethnicity and languages spoken other than English</li> </ul> <p>While a geographic analysis of THP's Commercial HMO provider network and membership showed gaps in certain specialties and within certain counties THP met all time/distance network standards. Additionally, the minimum ratio standards were all met.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4" style="text-align: center;"><b>Commercial Measurement Results and Comparison to Performance Goal by Practitioner Type</b></th> </tr> <tr> <th style="width: 30%;"><b>Practitioner Type</b></th> <th style="width: 20%;"><b>Standard</b></th> <th style="width: 30%;"><b>Results</b></th> <th style="width: 20%;"><b>Goal Met? (Yes/No)</b></th> </tr> </thead> <tbody> <tr> <td>Primary Care Practitioners (PCP): Family and general practitioners</td> <td>90% of members have at least 2 PCP's within 30 Minutes or 25 miles  At least 2 PCP's to 500 members</td> <td>100% of access standards met</td> <td>Yes  Yes</td> </tr> </tbody> </table>									<b>Commercial Measurement Results and Comparison to Performance Goal by Practitioner Type</b>				<b>Practitioner Type</b>	<b>Standard</b>	<b>Results</b>	<b>Goal Met? (Yes/No)</b>	Primary Care Practitioners (PCP): Family and general practitioners	90% of members have at least 2 PCP's within 30 Minutes or 25 miles  At least 2 PCP's to 500 members	100% of access standards met	Yes  Yes
<b>Commercial Measurement Results and Comparison to Performance Goal by Practitioner Type</b>																						
<b>Practitioner Type</b>	<b>Standard</b>	<b>Results</b>	<b>Goal Met? (Yes/No)</b>																			
Primary Care Practitioners (PCP): Family and general practitioners	90% of members have at least 2 PCP's within 30 Minutes or 25 miles  At least 2 PCP's to 500 members	100% of access standards met	Yes  Yes																			

		<p>Primary Care Practitioners: Pediatrics</p> <p>90% of members under age 18 have at least 2 Pediatricians within 30 minutes or 25 miles</p> <p>At least 2 pediatricians to 250 members under age 18</p>	<p>100% of access standards met</p>	<p>Yes</p> <p>Yes</p>
		<p>High volume specialty: Obstetrics and Gynecology</p> <p>90% of members have at least 2 OB/GYN's within 30 Minutes or 25 miles.</p> <p>At least 2 OB/GYN's to 1,000 members</p>	<p>96.4% of access standards met. There are eight (8) rural counties in WV where there are no OB/GYN providers available to recruit.</p>	<p>Yes</p> <p>Yes</p>
		<p>High impact specialties: Oncology</p> <p>90% of members have at least 2 Oncologists within 30 Minutes or 25 miles</p> <p>At least 2 Oncologists to 2,000 members</p>	<p>97.7% of access standards met. There are sixteen (16) rural counties within WV where there are no Oncologists available to recruit</p>	<p>Yes</p> <p>Yes</p>



		<p>High volume specialty: Cardiology</p> <p>90% of members have at least 2 Cardiologists within 30 Minutes or 25 miles</p> <p>At least 2 Cardiologists to 2,000 members</p>	<p>99.0% of access standards met</p>	<p>Yes</p> <p>Yes</p>
		<p>High volume specialty: Chiropractic</p> <p>90% of members have at least 2 Chiropractors within 30 Minutes or 25 miles</p> <p>At least 2 Chiropractors to 2,000 members</p>	<p>99.9% of access standards met</p>	<p>Yes</p> <p>Yes</p>
		<p>High impact specialty: Dermatology</p> <p>90% of members have at least 2 Dermatologists within 30 Minutes or 25 miles</p> <p>At least 2 Dermatologists to 2,000 members</p>	<p>94.3% of access standards met. There are twenty-one (21) rural counties in WV with no Dermatologist available to recruit.</p>	<p>Yes</p> <p>Yes</p>
		<p>Behavioral Health Practitioners: Counselor/Therapists</p> <p>90% of members in each line of business have at least 1 BH practitioner within 45 miles</p>	<p>100% of access standards met</p>	<p>Yes</p>
<p>THP enhances its provider network and member access by:</p>				

		<ul style="list-style-type: none"> <li>• Educating members about telemedicine availability</li> <li>• Recruiting practitioners who speak a language to meet linguistic needs.</li> <li>• Recruiting practitioners with similar cultural and ethnic background as members</li> <li>• Recruiting non-participating providers identified by utilization on Commercial claims activity reports.</li> </ul> <p>Recruiting newly licensed providers identified by the WV Medical Board in order to contract with those practitioners just beginning their medical careers in West Virginia.</p>
	<p><b>4.8.6</b></p>	<p><b>The carrier's process to assure that a covered person is able to obtain a covered benefit, at the in-network benefit level, from a non-participating provider should the carrier's network prove to not be sufficient;</b></p>
		<p><b>This section explains the benefit levels for each product. How to obtain an out-of-network service is outlined in more detail in 4.8.7d</b></p> <p><b>Commercial HMO Plans</b>  Commercial health maintenance organization (HMO) plans are plans that are fully insured by a Health Insuring Corporation (HIC). Employer groups contract with The Health Plan to provide a health insurance benefit plan and pay a monthly premium to cover eligible employees. The Health Plan assumes the responsibility for providing the benefit package, administering all aspects of the plan and the risk for paying for all covered services. These plans require a member to choose a primary care physician (PCP), and although The Health Plan has eliminated the need for the PCP to call in a referral for specialty physician services, the member must be referred by their PCP and follow precertification guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admissions. Members do not have out-of-network benefits unless authorized by the plan.  HMO benefit plans generally have copays for:</p> <ul style="list-style-type: none"> <li>• Primary and specialty care physician office visits</li> <li>• Emergency room services</li> <li>• Urgent care</li> <li>• Outpatient mental health</li> <li>• Physical, occupational, and speech therapy</li> <li>• Durable medical equipment</li> <li>• Prescription drugs</li> </ul> <p>Members may have a deductible and co-insurance associated with their benefit plan, as well as cost sharing for laboratory and X-rays, not associated with preventive services, depending on the plan.</p> <p><b>Commercial POS Plans</b>  Commercial point-of-service (POS) plans are fully insured by a Health Insuring Corporation (HIC). Employer groups, with a minimum size of two employees, contract with The Health Plan to provide a health insurance</p>

		<p>benefit plan and pay a monthly premium to cover eligible employees. POS plans are designed to allow members the freedom to choose between having their health care managed or arranged by their primary care physician (PCP) as an in-plan option or the member has the option to manage and arrange their care as an out-of-plan option. The plan provides the benefit package giving the employer the option to choose from a variety of deductibles and copay plans. These plans require a member to choose a PCP, obtain a referral for specialty physician services, and follow precertification guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admissions. Members have out-of-plan option benefits and may choose to access services outside The Health Plan network at an increase in their out-of-pocket expense for deductibles, copays, and coinsurance amounts.</p> <p>POS benefit plans generally have copays for:</p> <ul style="list-style-type: none"> <li>• Primary and specialty care physician office visits</li> <li>• Emergency room services</li> <li>• Urgent care</li> </ul> <p>Member Benefits also include:</p> <ul style="list-style-type: none"> <li>• Outpatient mental health</li> <li>• Physical, occupational, and speech therapy</li> <li>• Durable medical equipment</li> <li>• BioTech drugs</li> </ul> <p>Additionally, members are responsible for deductibles and co-insurance amounts associated with their plan benefit.</p>
	<b>4.8.7</b>	<b>The health carrier’s procedures for making, and authorizing referrals within and outside its network. The procedures should address the health carrier’s processes regarding:</b>
	<b>4.8.7a</b>	<b>The provision of a comprehensive listing of the health carrier’s network of participating providers and facilities to covered persons and primary care providers;</b>
		<p>The Health Plan (THP) provides a comprehensive listing of participating providers and hospitals at <a href="http://www.healthplan.org">www.healthplan.org</a> under “Find Providers”. Members can also call Customer Service at 1-800-624-6961 or email at <a href="mailto:information@healthplan.org">information@healthplan.org</a>. Member letters are distributed at enrollment to provide this information to members.</p>
	<b>4.8.7b</b>	<b>Timely referrals for access to specialty care;</b>
		<p>It is the policy of The Health Plan to facilitate ongoing specialist care and coordination of the benefit for appropriate members. This would apply when the primary care practitioner, in consultation with a specialist practitioner, identifies the need for specialty care for a condition that is life-threatening, degenerative, or disabling. The PCP is responsible for initiating a specialist referral if one is required and supplying appropriate member history to the specialist.</p>

A treatment plan is formulated by both physicians and the member. The plan of care is subject to review by the Clinical Services Department. Short-term specialist care (six months or less) is requested upon a specialist referral form if required by the enrollee's group or specialist physician. Ongoing care over an extended period of time is requested on a standing referral. This is typically seen with prior authorized episodes of care, tertiary care requirements or approved single case agreement provider referrals. The number of visits shall be based upon the treatment plan and shall be limited to a one-year period.

Additionally, some members may choose a Specialist as PCP. When the member's care cannot be delivered in the primary care setting due to complexity of care or a particular disease process, the member may choose to select an in-plan participating specialist as PCP. Examples of a specialist as PCP may include endocrinology, oncology, nephrology or cardiology. Members requesting/requiring management by a specialist should be enrolled in care management. With the listing of an in-plan specialist as PCP, the specialist practitioner is authorized to provide and refer for health care services in the manner of the primary care practitioner, providing the care is relevant to the expertise of the specialist. In order to assure appropriate coordination of care, the PCP or specialist granted a standing referral shall provide the primary care practitioner or treating practitioner with regular reports on the care provided to the member. For a specialist to continue to coordinate care, an in-plan PCP must remain actively listed with The Plan or the continuation of a standing referral, the primary care practitioner is required to request an extension of the standing referral every year and to provide updated reports and treatment plans to support medical appropriateness.

Specialist and standing referrals are subject to the Timeliness of UM Decisions and Notification Policy.

	<b>Member Selects PCP</b>	<b>Referrals required for Specialty Care</b>
<b>Fully Funded HMO</b>	YES	YES. PCP must coordinate all specialty care and document all referrals in the patient's chart. Prior authorization must be submitted to The Health Plan for any tertiary or out-of-network care.
<b>Fully Insured POS</b>	YES	YES. PCP must coordinate all specialty care and document all referrals in the patient's chart. Prior authorization must be submitted to The Health Plan for any tertiary or out-of-network care.

			<b>Member has Open Access to Secondary Care Provider (OB/GYN, Endocrinology, Oncology)</b>	<b>Member has Out of Network Benefits</b>
		<b>Fully Funded HMO</b>	Yes, for in-network secondary care physician when selected.	NO
		<b>Fully Insured POS</b>	Yes, for in-network secondary care physician when selected.	YES
	<b>4.8.7c</b>	<b>Expedition of the referral process when indicated by the covered person's medical condition; and</b>		
		<p>The Health Plan (THP) strives to expedite medical necessity reviews and determinations according to the following standards:</p> <ul style="list-style-type: none"> <li>• Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or</li> <li>• In the opinion of a health care practitioner with knowledge of the patient's medical condition would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.</li> </ul> <p>Urgent Pre-Service Request</p> <p><u>Electronic</u>: THP makes a decision within 48 hours if the request is for medical care or other service</p> <p><u>Non- Electronic</u>: THP makes a decision within 72 hours with or without all of the required information. If submitted without sufficient information for review, THP will notify the member/members representative within 24 hours that specific information is needed to review the request.</p>		
	<b>4.8.7d</b>	<b>Member access to services outside the network when necessary;</b>		
		<p>Out-of-network care is defined as care outside of The Health plan's contracted network of in-plan (primary, secondary or tertiary) providers and facilities. Out-of-network care requires prior authorization. Prior authorization requests for out-of-network care should be submitted from a participating in-network primary, secondary or tertiary care provider following medical evaluation. Consideration of the member's medical needs and determination if their needs can be met with an in-network provider or facility is reviewed by a medical director. Out-of-network care is approved only when services or providers required to meet a member's</p>		

		<p>medical needs are not available within The Health Plan's network or cannot be safely provided in network due to complexity of care.</p> <p>THP and providers agree through contractual language that in-network providers will refer to participating providers when available. Failure to refer to an in-network provider or obtain an authorization for an HMO member will result in non-payment to the out-of-network provider. Authorizations may be obtained by participating providers by contacting THP's utilization management department.</p> <p>Single case agreements are negotiated for members when THP does not have a qualified provider to provide medically necessary services within the defined time and distance standards. THP and the provider will come to an agreement on medically necessary services and codes. THP and the provider will mutually agree to payment methodology. All single case agreements require signature and have language that prohibits the provider from balance billing, i.e. <i>"As a condition of this agreement, [Provider Name] may not bill or balance bill the member for any covered service except for any applicable copays, coinsurance or deductibles"</i>.</p>
	<b>4.8.8</b>	<b>The health carrier's process for enabling covered persons to change primary care providers (PCP), if applicable;</b>
		The Health Plan's (THP's) process for enabling members to change their primary care physician (PCP) is described in the member handbook, which informs members to call THP or to request the change through THP's member portal at <a href="http://myplan.healthplan.org">myplan.healthplan.org</a> to change their PCP. The selected PCP must be available and accepting new patients.
	<b>4.8.9</b>	<b>The health carrier's quality assurance standards, which must be adequate to identify, evaluate and remedy problems relating to access, continuity, and quality of care.</b>
		<p>The Health Plan (THP) established a Utilization Management Program to review and evaluate the medical appropriateness and efficiency of all services delivered to The Health Plan Members.</p> <p>The Health Plan Utilization Management Department will evaluate and monitor the utilization of all services delivered to The Health Plan Members in order to create a health care strategy that addresses escalating costs while maximizing the quality of care.</p> <p>The Health Plan Utilization Management Department will review and monitor the preauthorization process by collaborating with Practitioners/Providers, Members, and their families and employers to streamline the medical regimen, minimize unnecessary medical and service problems, and promote care in the least restrictive setting.</p> <p>The Health Plan Utilization Management Program will consist of reviews from prospective, concurrent, and retrospective methods developed by The Health Plan Utilization Management Department in conformity with</p>





	<p>Upon provision of such information, The Health Plan shall communicate directly with Hospital and/or Practitioner regarding issues with appropriateness determinations.</p> <p>"Sufficient medical information" shall mean the clinical information necessary to support the appropriateness and level of services provided to a Covered Individual based upon InterQual or other national criteria. Notwithstanding the foregoing, utilization management decisions for Covered Services received on the weekend or holidays shall be made, in the case of a weekend, on the Monday immediately following the weekend or, in the case of a holiday, the weekday immediately following the holiday.</p> <p>All out of plan and tertiary admissions and services, except in an emergency, must be preauthorized by The Health Plan Utilization Management Department.</p> <p>Ancillary services provided by a The Health Plan facility, such as cardiac and pulmonary rehabilitation, skilled and rehabilitation placement, and durable medical equipment issued by the physical therapy department, require pre-authorization.</p> <p>Concurrent and retrospective review of all ambulatory claims will include services rendered in the Practitioner's office and services provided in provider facilities ordered by the Practitioner.</p> <p>Emergency room utilization and pharmacy utilization will be reviewed retrospectively.</p> <p>The Health Plan utilizes participating Practitioners to participate as members of the Medical Advisory Committee. The Committee's function consists of reviewing and correcting over-utilization and under-utilization of health care services. Practitioners/Providers are required to comply with corrective actions as directed by The Health Plan and/or the Medical Advisory Committee.</p> <p>If Practitioner provides a Covered Service to a Member after first having obtained an authorization for coverage from The Health Plan for the Covered Services, The Health Plan will not retrospectively deny payment for the Covered Services after they are rendered unless one of the following occurs: (i) the medical record discloses that the information provided prior to the authorization varies materially from the information in the medical record; (ii) fraud or violation of a federal or state law, rule or regulation; (iii) the Member's eligibility for coverage has been retroactively terminated; (iv) the services provided are no longer Covered Services because the benefit or plan limit has been exhausted; (v) the services provided were not the services authorized for coverage by The Health Plan; (vi) The Health Plan is not the primary insurer for the services at issue; (vii) the services at issue were not performed within the timeframe authorized for coverage by The Health Plan; or (viii) the services authorized for coverage by The Health Plan were never performed by Practitioner. Nothing in this Agreement shall prevent The Health Plan from approving or denying coverage as part of</p>
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		<p>the concurrent utilization review process so long as The Health Plan's performance of the concurrent utilization review process is consistent with applicable federal or state laws, rules and regulations and the terms and conditions of this Agreement.</p> <p>In cases in which the Practitioner determines that Emergency Services are required for a Member, notwithstanding the foregoing, Practitioner shall provide such services as are necessary to evaluate and, if necessary, stabilize the condition of the Member without prior approval from The Health Plan as required by state and federal law including, but not limited to, EMTALA. The Health Plan or the applicable payor shall pay all reasonably necessary costs associated with the Emergency Services for screening and stabilization in accordance with Attachment C; provided that when processing a claim for Emergency Services, The Health Plan shall consider both the presenting symptoms and the services provided. If a Member is admitted as an inpatient, Practitioner shall notify The Health Plan of the Emergency Services delivered on the next business day unless the Member's medical condition prevents the Member from providing such information and shall provide, in a timely manner, clinical information relevant to the circumstances of the admission diagnosis and treatment plan. In the event a Member is unable to provide such information as defined in this section, then Practitioner shall provide such notification to The Health Plan within twenty-four (24) hours of the Member becoming physically able to provide the information to the Practitioner.</p> <p>Except in the case of provision of Emergency Services, prior to: (i) admitting Members as inpatients; (ii) performing outpatient surgeries that are Covered Services for Members; and (iii) performing those procedures set forth in Attachment A hereto, Practitioner shall:</p> <ul style="list-style-type: none"> <li>(a) Contact The Health Plan or its designee directly, by phone or electronically for the purpose of authorizing the performance of Covered Services and confirming the Member's eligibility to receive Covered Services; and</li> <li>(b) verify the identity of the Member by: (i) requiring the Member to produce his or her Identification Card and another form of identification with a photo whenever possible; or (ii) if no membership card has yet been issued, two (2) forms of identification, at least one of which shall be a photo identification whenever possible. If Member is a minor, his or her parent's identification will be acceptable if Member's eligibility is verified with The Health Plan as set forth in this section.</li> </ul>
	<p><b>4.8.10</b></p>	<p><b>The health carrier's methods for accessing the health care needs of covered persons and their satisfaction with services;</b></p>
		<p>The Health Plan's (THP's) methods to assess members' health care needs and satisfaction with services includes the following:</p> <ul style="list-style-type: none"> <li>• Responding to THP's annual member satisfaction survey</li> <li>• Emailing feedback and suggestions to <a href="mailto:information@healthplan.org">information@healthplan.org</a></li> </ul>

	<p>To recommend changes in policies and procedures, members may contact THP's Customer Service Department at 1-800-624-6961.</p>
<p><b>4.8.11</b></p>	<p><b>The health carrier's efforts to address the needs of covered persons, including, but not limited to, children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of ECPs in its network;</b></p>
	<p>The Health Plan (THP) strives to maintain adequate availability of primary care, behavioral healthcare, specialty care practitioners and ECP's, i.e. FQHC's, Family Planning, RHC's, etc., to members, giving consideration to geographic location, linguistic and/or cultural needs and preferences of our member population. THP members can search online and paper directories by a provider's linguistic capabilities to ensure there is not a communication barrier to care.</p> <p>THP is contracted with all hospitals in West Virginia and credentials all individual providers working in an FQHC or RHC to render services to Commercial HMO. THP's current West Virginia provider network is able to address the majority of complex medical, physical, and mental disabilities that THP members face. The adult population, when needed, has access to large academic institutions including, but not limited to, University of Pittsburgh Medical Center (UPMC) and The Ohio State Medical Centers. The children of the state have access to Nationwide Children's Hospital and Children's Hospital of Pittsburgh, to name a few world-renowned children's facilities.</p> <p>As part of the contracting and onboarding process, THP extends cultural competency training and an attestation to the provider. Training documents are provided for the provider and office staff to complete, or they provider's office can schedule an educational visit with a THP Practice Management Consultant for onsite training and education.</p> <p>The Health Plan maintains sufficient numbers and types of primary care, behavioral healthcare and specialty care practitioners in its network through the analyses of member cultural, ethnic, racial and linguistic needs and adjusts the availability of its practitioners within the network as needed.</p> <ul style="list-style-type: none"> <li>• The Health Plan Provider Network conducts an analysis to determine any unmet needs to our members through use of the following data:             <ul style="list-style-type: none"> <li>○ Member complaints</li> <li>○ Member surveys</li> <li>○ Member enrollment data</li> <li>○ Network practitioner languages and ethnic background</li> </ul> </li> <li>• A quantitative and qualitative analysis is performed against the results of member complaints, member surveys, member enrollment</li> </ul>

		<p>data and practitioner language and ethnic background to determine any unmet needs of our members.</p> <ul style="list-style-type: none"> <li>• US Census data is analyzed for member linguistic, racial, and ethnic needs.</li> <li>• Customer Service and Marketing language translation requests along with any other available member enrollment data are used to meet the language needs of members.</li> <li>• Member complaints at a minimum are used to analyze member cultural needs.</li> <li>• The data is analyzed annually to determine network adequacy. Adjustments to the practitioner network are made as necessary based on the analysis.</li> <li>• These adjustments may include any of the following:             <ul style="list-style-type: none"> <li>○ Recruit, credential and contract with practitioners who speak a language to meet linguistic needs.</li> <li>○ Recruit, credential and contract with practitioners with similar cultural and ethnic background as identified in analysis.</li> <li>○ Cultural competency training for practitioners based on racial/ethnic composition of member population.</li> </ul> </li> <li>• The analysis will be reported to The Health Plan's Continuous Quality Improvement Committee.</li> <li>• Additionally, Complex Case Navigation includes the following assessment documentation:             <ul style="list-style-type: none"> <li>○ Initial assessment of member's health status including current disease states.</li> <li>○ Documentation of clinical history, including medications, past medical and surgical histories.</li> <li>○ Initial assessment of activities of daily living, instrumental activities of daily living, and functional status.</li> <li>○ Initial assessment of mental health status, including cognitive functions; PHQ-2, PHQ-9 if indicated.</li> <li>○ Evaluation of cultural and linguistic needs, preferences, or limitations</li> <li>○ Evaluation of caregiver resources and involvement</li> <li>○ Evaluation of available benefits within organization, community resources, providers, and durable medical equipment</li> <li>○ Assessment of life planning activities including living wills, advance directives or medical power of attorney</li> <li>○ Information is available to send if needed</li> <li>○ Evaluation of visual and hearing needs, preferences or limitations</li> <li>○ Initial assessment of psychosocial issues, and social determinants</li> </ul> </li> </ul>
	<b>4.8.12</b>	<b>The health carrier's method of information covered persons of the plan's covered services and features, including but not limited to;</b>
	<b>4.8.12a</b>	<b>The plan's grievance and appeal procedures;</b>

	<p>The Health Plan (THP) informs members of their grievance and appeal rights through the following documents:</p> <ul style="list-style-type: none"> <li>• Member Handbook (Evidence of Coverage), which is sent to all new members and includes a section on Appeals and Complaints.</li> <li>• Explanation of Benefits which is sent upon claims adjudication lists information on how to file an appeal</li> </ul> <p>Denial letter, which is sent as appropriate, includes information on how to file an appeal</p> <p>To ensure a thorough, appropriate and timely resolution for a member's formal appeal and to the extent required by the Department of Labor's Group Health and Disability Plans Benefit Claims Procedure Regulations (29 CFR 2560.503-1), as amended by the Patient Protection and Affordable Care Act (29 CFR 2590.715-2719) ("DOL Claims Procedure Regulations") or as, and to the extent required by, applicable state law.</p> <p>THP's Policy is to provide a thorough and consistent process for addressing a member's formal grievance, complaint and appeal process.</p> <p>In order for a member to file a formal appeal, the member or their authorized representative must first have requested an informal appeal and received an adverse determination and must complete The Health Plan's grievance form no later than 180 days after receipt of the adverse benefit determination. Upon receipt of the completed grievance form, the Appeal Coordinator will do the following:</p> <ol style="list-style-type: none"> <li>A. Record receipt of the formal appeal in grievance log in Heart.</li> <li>B. Send a letter within three (3) working days to the member acknowledging receipt of their grievance (WV Code Rule 114-96-5.8 et. Seq.)</li> <li>C. Scan completed grievance form, and any attachments, into the document repository by member ID number.</li> <li>D. Gather all pertinent information pertaining to the case file.</li> <li>E. Review information with the appropriate department to determine accuracy of the informal appeal.</li> <li>F. Issue a case file number.</li> <li>G. Send the case file to the Grievance Committee for review prior to the meeting.</li> <li>H. Schedule meeting to discuss case including the member, if they requested to appear in person or communicate with the Grievance Committee telephonically.</li> </ol> <p>The Grievance Committee reviews the formal appeal, renders a final determination and notifies the member, pursuant to the procedures and within the applicable time frame stated below.</p> <p><b>Formal Appeal</b></p> <p>A member is required to be provided continued coverage pending the outcome of an appeal, meaning a member's benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advanced review.</p>
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	<p>Upon request and free of charge, a member shall be provided access to and copies of documents, records, and other information relevant to the member's appeal.</p> <p>Before an appeal is denied based on new or additional rationale or evidence, the member must be provided with such rationale or evidence free of charge. If necessary, the period for deciding an appeal will be tolled to give the member a reasonable opportunity to respond to such rationale or evidence prior to issuance of the formal appeal.</p> <p>The Grievance Committee shall not give any deference to the underlying decision. The Grievance Committee's review shall be based on the full record of the claim and take into account all comments, documents, records, and other information submitted by the member relating to the claim, without regard to whether it was submitted or considered in the underlying decision.</p> <p>In deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment – including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate – the Grievance Committee shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The individual consulted may not be anyone, or the subordinate of anyone, who was consulted in the underlying decision.</p> <p>If the Grievance Committee reverses its original decision, the referral/claim is updated, and the member is notified of the decision in writing.</p> <p><b>Time Frames for the Grievance Committee's Decision on Appeal</b></p> <p><b>Urgent Care* Appeals:</b> As soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the appeal. A determination by the member's attending provider that a claim is urgent shall be given deference by the Grievance Committee. If a delay in decision-making has the potential to seriously jeopardize the member's life or health, the member or authorized person, provider/practitioner may ask for the formal review to be expedited and will be notified of the decision as expeditiously as the medical condition requires, but no later than 48 hours after the request is made. Electronic or written confirmation of the decision for expedited appeals will be sent within three calendar days of providing notification of the decision, if the initial decision was not in writing.</p> <p><b>Pre-service Appeals:</b> Within a reasonable period of time appropriate to the medical circumstances, not later than 10 days after receipt of the appeal.</p> <p><b>Post-service Appeals:</b> Within a reasonable period of time, not later than 30 days after receipt of the appeal.</p> <ul style="list-style-type: none"> <li>• For appeals involving urgent care claims, either oral and/or written requests will be accepted, and all necessary action will be taken to assist in expediting the review process, including communicating with the member by telephone, facsimile, or other available similarly expeditious method.</li> </ul>
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	<p>If a member fails to submit information necessary for the Grievance Committee to decide an appeal, the time frame shall be tolled from the date on which the notification of the need for additional information is sent to the member until the date on which the member responds to such request.</p> <p><b>Contents of Written Decisions of Denials on Appeal:</b></p> <ol style="list-style-type: none"> <li>1. Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.</li> <li>2. The specific reason for the denial, including the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim, in easily understood language and in the prevalent language spoken by the enrollee, or in an alternate format for special needs of the visually impaired or those with limited reading proficiency. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.</li> <li>3. Notification that the member can obtain, upon request and free of charge, reasonable access to and copies of all documents relevant to the member's appeal.</li> <li>4. A reference to the benefit provision, guideline, protocol, or other similar criterion, if any, on which the appeal decision was based and notification that the member, upon request and free of charge, can obtain a copy of such benefit provision, guideline, protocol, or other similar criterion.</li> <li>5. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, notification that the member, upon request and free of charge, can obtain an explanation of the scientific or clinical judgment for the adverse benefit determination, applying the terms of the plan to the member's medical circumstances.</li> <li>6. A list of titles and qualifications of individuals participating in the appeal review. Participant names are provided upon member request. The identification of medical or vocational experts whose advice was obtained in connection with the member's adverse benefit determination, if any, even if such advice was not relied upon in making the benefit determination.</li> <li>7. A description of available external review processes, including information regarding how to initiate an external review. See External Independent Reviews, CO-40 policy for external review notice requirements.</li> <li>8. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation.</li> </ol>
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		<p>One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."</p> <p>9. Statement regarding the availability of (and contact information for) any applicable office of health insurance consumer assistance or ombudsman to assist with internal claims and appeals and external review procedures (see "Consumer Assistance Programs" on the DOL website at <a href="https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/internal-claims-and-appeals">https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/internal-claims-and-appeals</a>).</p> <p>10. A statement of the member's right to sue under ERISA Section 502(a), if relevant.</p> <p><b>Providing Notices in Culturally and Linguistically Appropriate Manner</b>          Notices of denials on appeal shall be provided in a culturally and linguistically appropriate manner by providing:</p> <ol style="list-style-type: none"> <li>1. Oral language services (such as a telephone customer assistance hotline) that includes answering questions and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;</li> <li>2. Relevant notices in any applicable non-English language upon request; and</li> <li>3. A statement clearly indicating how to access the language services provided, which is prominently displayed in any applicable non-English language.</li> </ol> <p>A non-English language is considered an "applicable non-English language" only if ten percent or more of the population residing in the county to which the notice is sent is literate in the same non-English language, as reflected in applicable federal guidance issued for this purpose</p>
	<b>4.8.12b</b>	<b>Its process for choosing and changing providers;</b>
		<p>The Health Plan informs members of the process for choosing and changing Primary Care Physicians in the member handbook.</p> <p>Each member must have a PCP to coordinate care and make any necessary referrals. Members can see any primary care practitioner within the benefit plan that is available and accepting new patients.</p> <p>If no PCP is provided upon initial enrollment, all members are added in the enrollment system without a PCP. Once the enrollment is completed, the system auto assigns a based on the member's age (pediatrician or general practitioner) and residency.</p> <p>Members of The Health Plan may change physicians once per calendar month if so desired (depending upon the availability of the chosen physician).</p>
	<b>4.8.12c</b>	<b>Its process for updating its provider directories for each of its network plans;</b>

	<p>The Health Plan (THP) informs members of the process to update its provider directories at <a href="http://www.healthplan.org">www.healthplan.org</a> under Find Providers in the Data Source Document. In addition, the following statement appears on every online provider directory search result: "The Health Plan has made every effort to ensure that the list of providers displayed is up-to-date and accurate. Provider information is updated within 30 days of receipt, or within 30 days of effective date of the change. All updates to The Health Plan database appear on the website within 24 hours. A key limitation for many of these items is that the information may not be current if there are changes which were not reported to The Health Plan."</p>
<p><b>4.8.12d</b></p>	<p><b>A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and</b></p>
	<p>The Health Plan (THP) offers the following health care services:</p> <ul style="list-style-type: none"> <li>• Ambulance/Emergency Transportation</li> <li>• Autism Spectrum Disorder</li> <li>• Behavioral Health Services</li> <li>• Chronic Pain Rehabilitation</li> <li>• Clinical Trials</li> <li>• Dental Services</li> <li>• Diabetic Equipment, Education, and Supplies</li> <li>• Diagnostic Services</li> <li>• Emergency Services</li> <li>• Habilitative Outpatient Services</li> <li>• Home Care Services</li> <li>• Home Infusion Therapy</li> <li>• Hospice Services</li> <li>• Inpatient Hospital, Physician, and Surgical Services</li> <li>• Maternity Services</li> <li>• Medical Supplies, Durable Medical Equipment (DME), and Appliances</li> <li>• Outpatient Services</li> <li>• Surgical Services</li> <li>• Reconstructive/Cosmetic Services</li> <li>• Mastectomy Notice</li> <li>• Sterilization</li> <li>• Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder (TMD/CMD)</li> <li>• Therapy Services</li> <li>• Physical Medicine and Rehabilitation Services</li> <li>• Human Organ and Tissue Transplant Services</li> <li>• Gene Therapy</li> <li>• Prescription Drug Benefits</li> </ul> <p>Preventive Care Services are available to all covered Health Plan members, and include outpatient services and office services, screenings</p>





	4.8.12e	<p><b>Its procedures for covering and approving emergency, urgent and specialty care, if applicable;</b></p>
		<p>The Health Plan's (THP's) procedures to cover and approve emergency, urgent and specialty care are described in the Member Handbook (EOC – Evidence of Coverage) as follows:</p> <p><b>Emergency Services Procedures:</b></p> <ul style="list-style-type: none"> <li>• When practical, call your physician. He/she can direct you to the appropriate care and can assure proper follow-up to that care. Follow up care is not considered Emergency Care. When a phone call is not practical, go to the nearest emergency room or call 911 for assistance.</li> <li>• After treatment, contact your physician within 48 hours or as soon as reasonably possible. By informing your physician of the situation your care can be better coordinated. An emergency admission must be called in to us within 48 hours (or as soon as reasonably possible).</li> <li>• Only initial care for an emergency medical condition Out-of-Network is covered at the higher benefit level. Any follow-up care outside the Network will be covered at the lower benefit level. Follow up care is not considered Emergency Care.</li> </ul> <p><b>Urgent Care Procedures:</b></p> <ul style="list-style-type: none"> <li>• Covered services received from a Network urgent care facility will be provided at the higher benefit level and Out-of-Network services at the lower benefit level.</li> </ul> <p>The Health Plan is responsible to cover emergency medical conditions or urgently needed services:</p> <ul style="list-style-type: none"> <li>• Regardless of whether services are obtained within or outside The Health Plan's service area;</li> <li>• Regardless of whether there is pre-authorization for the services;</li> <li>• If the emergency situation is in accordance with a prudent layperson's definition of "emergency medical condition," regardless of the final medical diagnosis;</li> <li>• Whenever a practitioner of The Health Plan who has a written contract to furnish plan covered services to its members or other plan representative instructs a member to seek emergency services within or outside The Health Plan.</li> <li>• For ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health.</li> <li>• Which a plan provider or a Health Plan representative instructs an enrollee to seek emergency services within or outside the plan.</li> </ul>





		<p>15.6 The parties agree to cooperate with each other to resolve promptly any outstanding financial, administrative or patient care issues upon the termination of this Agreement. Physician agrees that it will not interfere with the relationship between The Health Plan and its Members and will promptly supply all records necessary for the settlement of outstanding medical bills to The Health Plan upon the termination of this Agreement. The provisions of this Section shall survive the termination of this Agreement.</p> <p>15.7 Nothing herein shall be construed as authorizing or permitting Physician to abandon any patient.</p> <p>15.8 Subject to this article, West Virginia Physicians shall provide sixty (60) days advance written notice to the West Virginia Insurance Commissioner (as required by West Virginia HMO law) before canceling this agreement for any reason. Nonpayment by The Health Plan for services rendered by the provider is not a valid reason to avoid such sixty (60) day notice.</p> <p>15.9 Physicians, including Specialists or specialty groups, shall provide sufficient written notice of termination to The Health Plan so that The Health Plan may notify affected Members prior to termination of this Agreement.”</p> <p>*Policy: Notification to members and governing entities regarding network changes of termination of a hospital facility and primary care provider. Ensuring The Health Plan members have continued access to care when a provider and/or hospital leaves the network.</p> <p>All members of The Health Plan (THP) are to be notified at least 30 calendar days prior to the effective termination date, or within 14 calendar days after receipt of the notification from the provider, when their primary care provider (PCP) leaves the network without cause as well as termination or closing of an in-network hospital, a formal letter will be sent to the member by the Provider Data Quality (PDQ) department.</p> <p>For PEIA members, when The Health Plan initiates a termination for cause with a primary care provider (PCP) or OB/GYN all members who have the terminated provider listed as their PCP or OB/GYN will receive formal written notice from the PDQ department within 10 days of the termination letter to the provider.</p>
	<p><b>4.8.14</b></p>	<p><b>The health carrier’s process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at their participating hospitals. The subdivision does not apply to limited scope vision plans or limited scope dental plans as defined in W.Va. Code §33-53-1</b></p>
		<p>The Health Plan’s (THP’s) process for monitoring access to physician specialists in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services includes a quarterly network adequacy review.</p>
<p><b>4.9</b></p>		<p><b>The Commissioner may develop forms to be completed by the health carrier regarding the information required by subsection 4.8 of this rule.</b></p>
<p><b>§114-100-5 Coordination and Continuity of Care</b></p>		



	<p>Services nurse navigators will review treatment plans for such documentation before approving requested services.</p> <p>Nurse navigators, when required, will educate members regarding their rights and responsibility to provide input to practitioners/providers as to their care preferences, and document such education appropriately.</p> <p>The health care navigators must implement mechanisms to comprehensively assess each member identified by the State, HRA, and clinical analytics as having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.</p> <p>Responsibilities of the health care navigator also include assessing member's conditions, identifying medical procedures to address and/or monitor the conditions, coordinating hospital admission/discharge planning and post-discharge care and continued services (e.g., rehabilitation), providing assistance to members in obtaining behavioral health and community services, and providing assistance in the coordination of behavioral health, physical health and all other services.</p> <p>Nurse navigators, will, where appropriate, advise members and practitioners/providers of available training in self-care, health promotion, etc. This advice should include information about non-covered community resources as well as The Health Plan coverage for such services as dietary consults, smoking cessation programs, certified diabetic education, home health nurse educators, wound or ostomy care teaching, home infusion services, etc. and are documented.</p> <p>Health care navigators develop treatment plans appropriate for those members determined to need a course of treatment or regular care monitoring, as established by federal requirements.</p> <p>The Health Plan does not prohibit a health care professional from advising, advocating on behalf of a member.</p> <p>Health care practitioners/providers should provide information about the findings, diagnoses and treatment options regardless of coverage, so the member has the opportunity to decide among all relevant treatment options.</p> <p>The member should be given information about the risks, benefits, and consequences of treatment or non-treatment and be provided a choice to refuse treatment and discuss their preferences about failure treatment decisions.</p> <p>Health care navigators will periodically review treatment plans with their members to ascertain progress and compliance. These reviews will be shared with the primary care practitioner, and updated plans requested where appropriate. This process and outcomes are documented.</p>
<p><b>5.2.2</b></p>	<p><b>The health carrier's documented process for ensuring the coordination and continuity of care for covered persons using ancillary services, including social services and other community resources;</b></p>

		<p>The Health Plan's (THP's) Clinical Service Program ensures the coordination and continuity of care for members, including behavioral health services, social services and other community resources while addressing the effectiveness and quality of the care. The delivery of health care services are monitored and evaluated to identify opportunities for improvement. The program provides for a systematic process to promote access to medically appropriate care in a timely, efficient manner across the network through care/complex case navigation, preauthorization/referrals, admission/concurrent review and disease management navigation and health promotion programs.</p> <p>The Clinical Service Program description is reviewed by the Executive Management Team and is evaluated annually.</p> <p>The primary goal of the Clinical Service Program is to measurably improve the care and services provided to our members in a way that is financially responsible and responsive to their individual health care needs. This goal is achieved by meeting the following objectives:</p> <ul style="list-style-type: none"> <li>• To promote and provide appropriate allocation of health and behavioral health care services to our members,</li> <li>• To perform utilization processes with minimal disruption to the delivery of care and services, including clinical information gathering, documentation review, and communication of utilization management decisions,</li> <li>• To identify members for social service referrals, complex case management, health care navigation and/or chronic disease navigation programs,</li> <li>• To assess Utilization Management Program performance by soliciting input from members and practitioners through surveys.</li> <li>• To develop interventions based on input received from members and practitioners to improve the quality of services to all customers,</li> <li>• To ensure confidentiality of personal health information'</li> <li>• To maximize the likelihood that THP members will receive the right care at the right time and at the right cost utilizing appropriate utilization and care management tools,</li> </ul> <p>To educate practitioners on the scope of the Utilization Management Program and Medical Management Services.</p>
	<p><b>5.2.3</b></p>	<p><b>The health carrier's documented process for ensuring appropriate discharge planning;</b></p>
		<p>The Health Plan's (THP's) process for ensuring appropriate discharge planning includes the following:</p> <ol style="list-style-type: none"> <li>1. Planned transitions are identified through prior authorizations for services requested through the UM/referral process. The prior-authorization nurse navigators notify the assigned nurse navigator, of the services requested, to promote ongoing care coordination for the member.</li> </ol>







	<p><b>other cessation of operations, as well as how policyholders impacted by such events will be transferred to other providers in a timely manner.</b></p>
	<p>The Health Plan (THP) describes continuity of care in the event of a provider contract termination in its contracts with providers. Below is an excerpt from the agreement:</p> <p>“Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination, including, but not limited to, Physician's duty not to bill Members for Covered Services.</p> <p>15.5 The termination of this Agreement shall not release Physician from any obligation to provide continuing treatment to a Member, if such treatment cannot reasonably be continued by another Participating Physician. The Health Plan shall pay for such treatment in accordance with Physician's customary billed charges, subject to each party's right to request that the Member be treated by another Participating Physician as soon as is medically practicable and appropriate. The parties shall cooperate with each other to transfer the care of Members who have been treated by Physician to another Participating Physician.</p> <p>15.6 The parties agree to cooperate with each other to resolve promptly any outstanding financial, administrative or patient care issues upon the termination of this Agreement. Physician agrees that it will not interfere with the relationship between The Health Plan and its Members and will promptly supply all records necessary for the settlement of outstanding medical bills to The Health Plan upon the termination of this Agreement. The provisions of this Section shall survive the termination of this Agreement.</p> <p>15.7 Nothing herein shall be construed as authorizing or permitting Physician to abandon any patient.</p> <p>15.8 Subject to this article, West Virginia Physicians shall provide sixty (60) days advance written notice to the West Virginia Insurance Commissioner (as required by West Virginia HMO law) before canceling this agreement for any reason. Nonpayment by The Health Plan for services rendered by the provider is not a valid reason to avoid such sixty (60) day notice.</p> <p>15.9 Physicians, including Specialists or specialty groups, shall provide sufficient written notice of termination to The Health Plan so that The Health Plan may notify affected Members prior to termination of this Agreement.”</p> <p>*Policy: Notification to members and governing entities regarding network changes of termination of a hospital facility and primary care provider. Ensuring The Health Plan members have continued access to care when a provider and/or hospital leaves the network.</p> <p>All members of The Health Plan (THP) are to be notified at least 30 calendar days prior to the effective termination date, or within 14 calendar days after receipt of the notification from the provider, when their primary care provider (PCP) leaves the network without cause as well as termination or closing of an in-network hospital, a formal letter will be sent to the member by the Provider Data Quality (PDQ) department.</p>





		<ul style="list-style-type: none"> <li>• For appeals involving urgent care claims, either oral and/or written requests will be accepted, and all necessary action will be taken to assist in expediting the review process, including communicating with the member by telephone, facsimile, or other available similarly expeditious method.</li> </ul> <p>If a member fails to submit information necessary for the Grievance Committee to decide an appeal, the time frame shall be tolled from the date on which the notification of the need for additional information is sent to the member until the date on which the member responds to such request.</p> <p><b>Contents of Written Decisions of Denials on Appeal:</b></p> <ul style="list-style-type: none"> <li>• Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.</li> <li>• The specific reason for the denial, including the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim, in easily understood language and in the prevalent language spoken by the enrollee, or in an alternate format for special needs of the visually impaired or those with limited reading proficiency. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.</li> <li>• Notification that the member can obtain, upon request and free of charge, reasonable access to and copies of all documents relevant to the member's appeal.</li> <li>• A reference to the benefit provision, guideline, protocol, or other similar criterion, if any, on which the appeal decision was based and notification that the member, upon request and free of charge, can obtain a copy of such benefit provision, guideline, protocol, or other similar criterion.</li> <li>• If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, notification that the member, upon request and free of charge, can obtain an explanation of the scientific or clinical judgment for the adverse benefit determination, applying the terms of the plan to the member's medical circumstances..</li> <li>• A list of titles and qualifications of individuals participating in the appeal review. Participant names are provided upon member request. The identification of medical or vocational experts whose advice was obtained in connection with the member's adverse benefit determination, if any, even if such advice was not relied upon in making the benefit determination.</li> </ul>
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	<b>6.1.1c</b>	<b>The health carrier's procedures for providing and approving emergency and non-emergency medical care;</b>
	<b>6.1.1d</b>	<p><b>The health carrier's process for choosing and changing network providers;</b></p> <p>All HMO and POS members must have a PCP listed upon enrollment. Each member must have a PCP who coordinates the member's care and makes any necessary referrals and is needed to pay claims. Members can see any primary care practitioner within the benefit plan. Employers enroll members by submitting a Health Plan (THP) enrollment form, submitting enrollments using the THP employer group enrollment portal or use a vendor that sends a file feed for enrollments.</p> <p>If no PCP is provided upon initial enrollment, all members are added in the enrollment system without a PCP (PCP is left blank). Once the enrollment is completed, the system auto assigns a PCP for all members that are added without a PCP the system auto selects a PCP based on the member's age (pediatrician or general practitioner) and residency. A report is sent to enrollment from Provider Relations to auto assign a PCP for these members.</p> <p>Members are informed in the member handbook of their right to designate any PCP who participates in The Health Plan network and who is available to accept them as a patient. The handbook also directs the member that they can change PCPs by contacting Customer, or by logging into the member portal at myplan.healthplan.org.</p> <p>The member's personal choice of a primary care physician (PCP) enables the member to participate in the management of his/her total health care needs, including the right to refuse care from a specific practitioner. Members of The Health Plan are encouraged to establish a relationship with their chosen PCP so that they can work together to maintain good health. Members of The Health Plan may change physicians once per calendar month if so desired (depending upon the availability of the chosen physician).</p>
	<b>6.1.1e</b>	<b>The health carrier's documented process to address the needs, including access and accessibility of services, of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities; and</b>
		<p>The Health Plan (THP) addresses the needs, including access and accessibility of services for members with limited English proficiency and literacy, and/or diverse cultural and ethnic backgrounds and/or with physical or mental disabilities through its Language Access and Non-Discrimination Plan which includes the following components:</p> <ol style="list-style-type: none"> <li>1. Provision of a non-discrimination notice and multi-language taglines to THP members in compliance with Section 1557 of the ACA.</li> </ol>



	<ul style="list-style-type: none"> <li>• The provider directory</li> <li>• Denial notifications</li> <li>• Appeal and grievance notifications</li> </ul> <p>If the format requested is not feasible, alternate methods of providing the information will be explored in consultation with the member.</p> <p>Member Identification</p> <p>Members who have requested alternative forms or formats, such as large print documents, are flagged in the system. A "large print" (LgPrt) button is used to flag members who have requested large print. Reports are generated on a monthly basis to identify "large print" flagged members and the documents provided to the member for the month. Large print formatted documents are identified with an "L" in the naming convention.</p> <p>Guidelines for Communications for Visually Impaired Individuals</p> <p>Individuals with vision impairments may request communications in alternative formats or alternative means. Customer Service should speak to the member directly to determine a strategy of communication to best meet the member's needs. For members with vision impairments, THP would generally, at the request of the member:</p> <ul style="list-style-type: none"> <li>• Provide the member handbook, (EOC), summary of benefits, and ANOC (or comparable documents) in large print (18 pt. font);</li> <li>• Communicate, directly to the member, directory and/or formulary information by reading the information out loud or directing the member to the information on the THP website;</li> <li>• Provide the explanation of benefits (EOB) and other benefit-related communications (e.g., routine letters, referrals, coverage determinations, organization determinations, appeal notifications, denial notifications, etc.) in large print (18 pt. font); and</li> <li>• Communicate enrollment information out loud by explaining these forms to persons who are blind or visually impaired.</li> </ul> <p>Members who are visually impaired or blind may request documents in alternative formats such as audio or braille. Customer services should work with the Marketing Department to determine which formats can be made available in a reasonable period of time. The member should be consulted to determine which documents are needed in the alternative format. THP should provide the member with assistance by reading documents out loud and verbally explaining forms and documents to the member whenever possible. Language assistance services should also be available to discuss clinical issues such as utilization management.</p> <p>Guidelines for Communications for Hearing Impaired Individuals</p> <p>Individuals with hearing impairments may utilize TTY services through the state relay service number at 711.</p> <p>Guidelines for Individuals with Limited Reading Proficiency</p> <p>Member communications should be written in language that is easy to understand. Communications to members with limited reading proficiency should be written at a sixth grade reading level whenever feasible.</p>
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	<p>CSRs should be available to answer questions from members with limited reading proficiency in a manner understandable to the member.</p> <p>Guidelines for Communications for LEP Individuals</p> <p>All LEP individuals should be provided access to a qualified interpreter through the language assistance line free of charge. The language assistance line can be accessed by calling 1.800.276.2519. Directions on how to use the language line service can be found on the Intranet, under Resources &gt; Language Line.</p> <p>Individuals with LEP may request information in a non-English language. THP should take reasonable steps to provide access to the LEP individuals. Reasonable steps include:</p> <ul style="list-style-type: none"> <li>• Provide access to a qualified interpreter free of charge to communicate information to the member, including information provided in plan documents, EOBs and other member communications.</li> <li>• Review the member's needs for translated materials, if any. Customer Service should contact the Marketing Department to determine the availability of translated materials and reasonable alternatives.</li> <li>• Reasonable requests for translated materials should be honored.</li> </ul> <p>Guidelines for Availability of Web-Based Materials through Alternative Media</p> <p>The Health Plan will make available to members and prospective members, upon request, copies of the web-based materials, including but not limited to, physician and/or hospital directory information in print or relay this information over the telephone. Information that is printed will be available to the member free of charge. This function shall be managed through the Customer Service Department.</p> <p>Staff Training on the Language Access Plan</p> <p>The applicable THP staff should be educated on the contents of this Language Access Plan. Applicable departments include, but are not limited to, Customer Service, Marketing, Sales and Broker Relations.</p>
<p><b>6.1.1f</b></p>	<p><b>The health carrier's documented process to identify the potential needs of special populations.</b></p>
	<p>The Clinical Service Program ensures the provision of appropriate health care, including behavioral health services, to its members, while addressing the effectiveness and quality of the care. The program is driven by established policies and procedures. These policies and procedures are reviewed and revised yearly, more often if deemed necessary, then approved by Executive Management. Program leadership provides general direction and guidance towards policy execution. The delivery of health care services is monitored and evaluated to identify opportunities for improvement. The program provides for a systematic process to promote access to medically appropriate care in a timely, efficient manner across the network through care/complex case navigation,</p>







7.2		<b>Provider directories maintained by a health carrier shall meet all of the following requirements:</b>
	7.2.1	<b>A health carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions as described in W.Va. Code §33-53-4;</b>
		The Health Plan (THP) posts electronically a current and accurate provider directory with information and search functions as described in W. Va. Code §33-55-4 THP's online provider director is available at <a href="http://www.healthplan.org">www.healthplan.org</a> under "Find Providers".
	7.2.2	<b>When making the directory available electronically, the health carrier shall ensure that the general public is able to view all of the current providers for a network through a clearly identifiable link or tab without requiring an individual to create or access an account or requiring the entry of a policy or contact number;</b>
		The Health Plan's (THP's) electronic provider directory is available to the general public without requiring a user to create an account or to be a policy holder. THP's online provider directory is available at <a href="http://www.healthplan.org">www.healthplan.org</a> under "Find Providers".
	7.2.3	<b>The health carrier shall include a disclosure in the directory of the date of the most recent update for electronic directories, or the date of printing for printed directories. This disclosure shall state that the information in included in the directory is accurate, to the best of the carrier's knowledge, as of the date of updating/printing, and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website, or call the carrier's customer service telephone number to obtain current provider directory information.</b>
		The Health Plan (THP) includes a disclosure in the directory of the date of the most recent update. "The Health Plan has made every effort to ensure that the list of providers displayed is up-to-date and accurate. Provider information is updated within 30 days of receipt, or within 30 days of effective date of the change. All updates to The Health Plan database appear on the website within 24 hours. A key limitation for many of these items is that the information may not be current if there are changes which were not reported to The Health Plan."
	7.2.4	<b>A health carrier shall provide a print copy of the requested pertinent portion of the current provider directory to a covered person or a prospective covered person within five (5) business days of the request.</b>
		Members are notified in the member handbook that they can request a copy of a printed provider directory or portion thereof by calling THP's Customer Service department. 24 hours post call into THP's Customer Service a printed Directory is generated and mailed to the Commercial member.
	7.2.5	<b>A health carrier shall include, in both the electronic and print directory, the following general information for each of its provider networks:</b>





