Health Benefit Plan Network Access and Adequacy §114 CSR 100		
§114-100-4 Network Access Plan Standards		
4.8		**An access plan shall describe, contain or address the following:**
	4.8.1	**The health carrrier's network, including how the use of telemedicine or telehealth or other technology maybe used to meet network access standards, if applicable;**
		In March 2020, The Health Plan (THP) began contracting with telemedicine/ telehealth providers to deliver needed care to members and excludes those telemedicine/ telehealth providers from network adequacy reporting. THP contracted with Teladoc to offer primary care, behavioral health and dermatology telemedicine services. THP also contracted with West Virginia University Medicine (WVUM) to offer virtual outpatient appointments through their telemedicine platform, MyWVUChart. In addition, through a contractual relationship with Charleston Area Medical Center (CAMC), THP members received expanded access to specialty care through CAMC's "24/7 Care" telemedicine application. Through these telemedicine/ telehealth options, THP increased member access for getting needed care, even though those access points are not reported in network adequacy reports.
	4.8.2	**The factors used by the heatlh carrier to build its network, including a description of the criteria used to select providers;**
		To build its provider network, The Health Plan (THP) used the following criteria for primary care, specialty care and behavioral health practitioners: • Completed credentialing application and supporting documents • Signed and dated provider agreement • Verified active medical license(s) • Verified Drug Enforcement Administration (DEA) registration, as applicable • Verified Professional liability insurance • Verified admitting privileges at a participating hospital • Verified clean National Practitioners Data Bank report • Verified Board-certification or board eligibility, or documentation of appropriate training for practicing specialty • Signed and dated provider agreement • Completed office site survey for primary care physicians (PCP), Obstetrical / Gynecological specialty care, and DME providers • Sufficient information concerning any malpractice actions. • Verified active National Provider Identifier (NPI)

		To protect members, THP does not allow providers to routinely provide medical care until the above criteria are verified and the provider is approved as a participating provider.
	4.8.3	**Establishing that the health carrier's network has an adequate number of providers and facilities within a reasonable distance of covered persons;**
		The Health Plan (THP) contracted with a number of providers to maintain adequate access in accordance with the Network Standards for Commercial enrollees as outlined in 114-100-3 (3.1) • THP developed, maintains and monitors a network of appropriate, credentialed providers, supported by written agreements, that is sufficient to provide adequate access to covered services (including preventative, primary care, specialty services) and to meet the needs of the population served. In establishing and maintaining the network, THP considers the following: o Anticipated enrollment o Numbers and types (in terms of training, experience, and specialization) of providers needed o Geographic location of providers and members, considering time and distance in accordance with standards set forth by the WV Department of Insurance • THP contracted with a mix of primary care providers, pediatric, OB/GYN and Specialists to ensure the member needs are met. • THP maintains an adequate panel of available PCPs so that the ratio of PCPs to enrollees meets or exceeds the required ratios of: o one (1) PCP for every five hundred (500) adult enrollee who is accepting new patients o one (1) PCP for every two hundred fifty (250) pediatric enrollees under age nineteen (19) who is accepting new patients o One (1) OB/GYN for every 1,000 enrollees o One (1) specialist for every 2,000 enrollees • THP considers family practice, general practice, internal medicine, geriatrics, pediatrics, and obstetrics/gynecologist or certified nurse midwife as primary care providers (PCPs). • THP considers the time and distance standards of the Commercial contracts in every county. For time and travel standards, THP counts all provider locations within the county or within the travel time from the county border against the member's home address. Also considered within the standards are basic hospital services, tertiary hospital services. Tertiary hospital services include acute care services to pediatric patients in medical and surgical units, obstetric services and neonatal intensive care unit. • THP network adequacy is monitored on a regular basis by: o Working with participating PCP's to determine current referral patterns (making sure the specialists to whom they refer are in-network)

- 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			
	4.8.5	**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;**									
		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: • GeoAccess type of software to analyze geographic distribution of primary care and specialty care providers and members • Member complaints regarding provider network adequacy • US Census data to assess members' linguistic, racial, and ethnic needs. • Provider's ethnicity and languages spoken other than English While a geographic analysis of THP's Commercial PPO 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.									

		Commercial Measurement Results and Comparison to Performance Goal by Practitioner Type

Practitioner Type	Standard	Results	Goal Met? (Yes/No)
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
Primary Care Practitioners: Pediatrics	90% of members under age 18 have at least 2 Pediatricians within 30 minutes or 25 miles At least 2 pediatricians to 250 members under age 18	100% of access standards met	Yes Yes
High volume specialty: Obstetrics and Gynecology	90% of members have at least 2 OB/GYN's within 30 Minutes or 25 miles. At least 2 OB/GYN's to 1,000 members	96.4% of access standards met. There are eight (8) rural counties in WV where there are no OB/GYN providers available to recruit.	Yes Yes

		High impact specialties: Oncology	90% of members have at least 2 Oncologists within 30 Minutes or 25 miles At least 2 Oncologists to 2,000 members	97.7% of access standards met. There are sixteen (16) rural counties within WV where there are no Oncologists available to recruit	Yes Yes	
		High volume specialty: Cardiology	90% of members have at least 2 Cardiologists within 30 Minutes or 25 miles At least 2 Cardiologists to 2,000 members	99.0% of access standards met	Yes Yes	
		High volume specialty: Chiropractic	90% of members have at least 2 Chiropractors within 30 Minutes or 25 miles At least 2 Chiropractors to 2,000 members	99.9% of access standards met	Yes Yes	

		High impact specialty: Dermatology	90% of members have at least 2 Dermatologists within 30 Minutes or 25 miles At least 2 Dermatologists to 2,000 members	94.3% of access standards met. There are twenty-one (21) rural counties in WV with no Dermatologist available to recruit.	Yes Yes
		Behavioral Health Practitioners: Counselor/Therapists	90% of members in each line of business have at least 1 BH practitioner within 45 miles	100% of access standards met	Yes
		THP enhances its provider network and member access by: • Educating members about telemedicine availability • Recruiting practitioners who speak a language to meet linguistic needs. • Recruiting practitioners with similar cultural and ethnic background as members • Recruiting non-participating providers identified by utilization on Commercial claims activity reports. • 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.			
	4.8.6	**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;**			
		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 **Commercial Preferred Provider Organization (PPO) Plans** Commercial preferred provider organization (PPO) plans are fully insured by a Health Insuring Corporation (HIC). Employers contract with The Health Plan to provide a health insurance benefit plan and pre-pay a monthly premium to cover eligible employees. Members who are covered under			

		the PPO plan generally are not required to select a primary care physician (PCP) or obtain a referral for specialty physician services. All prior authorization guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admission apply. By utilizing The Health Plan in-plan or tertiary network, members receive a higher level of benefits. Members who utilize out-of-network providers or fail to preauthorize a service will have increased out-of-pocket expenses for deductibles, copays, and co-insurance amounts. PPO benefit plans generally have copays for: • Primary and specialty care physician office visits • Emergency room services • Urgent care • Outpatient mental health benefits • Physical, occupational, and speech therapy • Durable medical equipment • BioTech drugs Additionally, members are responsible for deductibles and co-insurance amounts associated with their benefit plan.
	4.8.7	**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:**
	4.8.7a	**The provision of a comprehensive listing of the health carrier's network of participating providers and facilities to covered persons and primary care providers;**
		The Health Plan (THP) provides a comprehensive listing of participating providers and hospitals at www.healthplan.org under "Find Providers". Members can also call Customer Service at 1-800-624-6961or email at information@healthplan.org. Member letters are distributed at enrollment to provide this information to members.
	4.8.7b	**Timely referrals for access to specialty care;**
		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. 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.

<table>
<tr><td></td><td></td><td>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.
<table>
<tr><th></th><th>Member Selects PCP</th><th>Referrals required for Specialty Care</th></tr>
<tr><td>Fully Insured PPO</td><td>NO</td><td>NO, Member may self-refer to any network specialist to receive in-network benefits.</td></tr>
<tr><td></td><td>Member has Open Access to Secondary Care Provider (OB/GYN, Endocrinology, Oncology</td><td>Member has Out of Network Benefits</td></tr>
<tr><td>Fully Insured PPO</td><td>Yes, for in-network secondary care physician when selected.</td><td>YES</td></tr>
</table>
</td></tr>
<tr><td></td><td>4.8.7c</td><td>Expedition of the referral process when indicated by the covered person's medical condition; and</td></tr>
<tr><td></td><td></td><td>The Health Plan (THP) strives to expedite medical necessity reviews and determinations according to the following standards:
• Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or</td></tr>
</table>

		• 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. Urgent Pre-Service Request Electronic: THP makes a decision within 48 hours if the request is for medical care or other service Non- Electronic: 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.
	4.8.7d	**Member access to services outside the network when necessary;**
		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 medical needs are not available within The Health Plan's network or cannot be safely provided in network due to complexity of care. 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. 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. "*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*".
	4.8.8	**The health carrier's process for enabling covered persons to change primary care providers (PCP), if applicable;**
		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 myplan.healthplan.org to change their PCP. The selected PCP must be available and accepting new patients.
	4.8.9	**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.**
		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. 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. 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. 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 applicable state and federal laws and regulations. The Health Plan will use InterQual or other nationally recognized criteria in the review process. The Health Plan Utilization Management Department will serve as a resource to the Practitioners/Providers and will endeavor to assist in discharge planning and in the coordination and continuity of care for The Health Plan Members. Hospital shall use reasonable efforts to discharge a Member within 24 hours of notice from The Health Plan to Hospital that an acute level of care is no longer Medically Necessary; provided, however, All Practitioners/Providers will be informed of The Health Plan Utilization Management Program and its related rules, regulations, and procedures. Practitioners/Providers will cooperate with The Health Plan's Utilization Management Program, the terms of which have been provided to Practitioner/Provider prior to the Effective Date. The Health Plan shall give Practitioners/Providers thirty (30) days prior written notice of all changes to the Utilization Management Program which impact Practitioners/Providers unless mutual agreement to implement sooner, or Practitioner/Provider shall not be required to comply with any changes unless and until Practitioner/Provider receives such thirty (30) day notice. For notification requirements in regard to Material Amendments, see Amendments section of this Agreement. Prior authorization must be requested prior to the initiation of certain services including all elective hospital admissions and select outpatient surgery procedures per requirements established by Plan benefit design. The Health Plan may require certain clinical records and diagnostic aids relating to a member to be included with requests for prior authorization.

		The Health Plan will not reimburse Providers for services requiring an authorization, where Provider has failed to obtain a prior authorization before performing the service. Charges for services rejected because the Provider failed to initiate or receive prior authorization shall not be collected from the Member. The admitting Practitioner is responsible to obtain this preauthorization prior to the admission; however, The Health Plan will accept information from Hospital in instances when Hospital and Practitioner have a relationship whereby Hospital assists Practitioner in provision of such information to The Health Plan. The Health Plan shall approve or deny a request for preauthorization within two (2) business days of the request unless additional information is required to complete the review. Both Practitioner and Hospital are responsible to ensure appropriate authorizations have been obtained. Urgent and emergency admissions will be subject to concurrent and retrospective review. Appropriateness of admission and length of stay will be reviewed based on severity of illness and intensity of service. Hospital and/or Practitioner shall provide The Health Plan with sufficient medical information to carry out concurrent and retrospective review processes. Upon provision of such information, The Health Plan shall communicate directly with Hospital and/or Practitioner regarding issues with appropriateness determinations. "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. All out of plan and tertiary admissions and services, except in an emergency, must be preauthorized by The Health Plan Utilization Management Department. 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. 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. Emergency room utilization and pharmacy utilization will be reviewed retrospectively. 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. 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 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. 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. 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: (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 (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.
	4.8.10	**The health carrier's methods for accessing the health care needs of covered persons and their satisfaction with services;**
		The Health Plan's (THP's) methods to assess members' health care needs and satisfaction with services includes the following: • Responding to THP's annual member satisfaction survey • Emailing feedback and suggestions to information@healthplan.org To recommend changes in policies and procedures, members may contact THP's Customer Service Department at 1-800-624-6961.
	4.8.11	**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;**
		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. 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 PPO. 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. 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. 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. • The Health Plan Provider Network conducts an analysis to determine any unmet needs to our members through use of the following data: o Member complaints o Member surveys o Member enrollment data o Network practitioner languages and ethnic background • A quantitative and qualitative analysis is performed against the results of member complaints, member surveys, member enrollment data and practitioner language and ethnic background to determine any unmet needs of our members. • US Census data is analyzed for member linguistic, racial, and ethnic needs. • Customer Service and Marketing language translation requests along with any other available member enrollment data are used to meet the language needs of members. • Member complaints at a minimum are used to analyze member cultural needs. • The data is analyzed annually to determine network adequacy. Adjustments to the practitioner network are made as necessary based on the analysis. • These adjustments may include any of the following: o Recruit, credential and contract with practitioners who speak a language to meet linguistic needs. o Recruit, credential and contract with practitioners with similar cultural and ethnic background as identified in analysis. o Cultural competency training for practitioners based on racial/ethnic composition of member population. • The analysis will be reported to The Health Plan's Continuous Quality Improvement Committee. • Additionally, Complex Case Navigation includes the following assessment documentation:

		○ Initial assessment of member's health status including current disease states. ○ Documentation of clinical history, including medications, past medical and surgical histories. ○ Initial assessment of activities of daily living, instrumental activities of daily living, and functional status. ○ Initial assessment of mental health status, including cognitive functions; PHQ-2, PHQ-9 if indicated. ○ Evaluation of cultural and linguistic needs, preferences, or limitations ○ Evaluation of caregiver resources and involvement ○ Evaluation of available benefits within organization, community resources, providers, and durable medical equipment ○ Assessment of life planning activities including living wills, advance directives or medical power of attorney ○ Information is available to send if needed ○ Evaluation of visual and hearing needs, preferences or limitations ○ Initial assessment of psychosocial issues, and social determinants
	4.8.12	**The health carrier's method of information covered persons of the plan's covered services and features, including but not limited to;**
	4.8.12a	**The plan's grievance and appeal procedures;**
		The Health Plan (THP) informs members of their grievance and appeal rights through the following documents: • Member Handbook (Evidence of Coverage), which is sent to all new members and includes a section on Appeals and Complaints. • Explanation of Benefits which is sent upon claims adjudication lists information on how to file an appeal Denial letter, which is sent as appropriate, includes information on how to file an appeal 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. THP's Policy is to provide a thorough and consistent process for addressing a member's formal grievance, complaint and appeal process. 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: A. Record receipt of the formal appeal in grievance log in Heart.

		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.) C. Scan completed grievance form, and any attachments, into the document repository by member ID number. D. Gather all pertinent information pertaining to the case file. E. Review information with the appropriate department to determine accuracy of the informal appeal. F. Issue a case file number. G. Send the case file to the Grievance Committee for review prior to the meeting. H. Schedule meeting to discuss case including the member, if they requested to appear in person or communicate with the Grievance Committee telephonically. 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. **Formal Appeal** 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. 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. 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. 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. 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.

		If the Grievance Committee reverses its original decision, the referral/claim is updated, and the member is notified of the decision in writing. **Time Frames for the Grievance Committee's Decision on Appeal** **Urgent Care* Appeals**: 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. **Pre-service Appeals**: Within a reasonable period of time appropriate to the medical circumstances, not later than 10 days after receipt of the appeal. **Post-service Appeals**: Within a reasonable period of time, not later than 30 days after receipt of the appeal. • 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. 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. **Contents of Written Decisions of Denials on Appeal:** 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. 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. 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.

		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. 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. 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. 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. 8. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. 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." 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 https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/internal-claims-and-appeals). 10. A statement of the member's right to sue under ERISA Section 502(a), if relevant. **Providing Notices in Culturally and Linguistically Appropriate Manner** Notices of denials on appeal shall be provided in a culturally and linguistically appropriate manner by providing: 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; 2. Relevant notices in any applicable non–English language upon request; and

		3. A statement clearly indicating how to access the language services provided, which is prominently displayed in any applicable non–English language. 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
	4.8.12b	**Its process for choosing and changing providers;**
		The Health Plan informs members of the process for choosing and changing Primary Care Physicians in the member handbook. 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. 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. Members of The Health Plan may change physicians once per calendar month if so desired (depending upon the availability of the chosen physician).
	4.8.12c	**Its process for updating its provider directories for each of its network plans;**
		The Health Plan (THP) informs members of the process to update its provider directories at www.healthplan.org 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."
	4.8.12d	**A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and**
		The Health Plan (THP) offers the following health care services: • Ambulance/Emergency Transportation • Autism Spectrum Disorder • Behavioral Health Services • Chronic Pain Rehabilitation • Clinical Trials • Dental Services • Diabetic Equipment, Education, and Supplies • Diagnostic Services • Emergency Services

		• Habilitative Outpatient Services • Home Care Services • Home Infusion Therapy • Hospice Services • Inpatient Hospital, Physician, and Surgical Services • Maternity Services • Medical Supplies, Durable Medical Equipment (DME), and Appliances • Outpatient Services • Surgical Services • Reconstructive/Cosmetic Services • Mastectomy Notice • Sterilization • Temporomandibular or Craniomanibular Joint Disorder and Craniomandibular Jaw Disorder (TMD/CMD) • Therapy Services • Physical Medicine and Rehabilitation Services • Human Organ and Tissue Transplant Services • Gene Therapy • Prescription Drug Benefits Preventive Care Services are available to all covered Health Plan members, and include outpatient services and office services, screenings are covered as preventive care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition but instead benefits will be considered under the Diagnostic Services benefit. Preventive Care Services shall meet requirements as determined by Federal and State law. These services fall under four broad categories: 1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: o Breast cancer o Cervical cancer o Colorectal cancer o High blood pressure o Type 2 diabetes mellitus o Cholesterol o Child and adult obesity 2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

		3. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. 4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following: o Sterilization procedures, along with patient education and counseling. o Women's contraceptives. The four contraceptive method categories are covered under the "Preventive Care" benefit. o Covered products include all FDA-approved 18 contraceptive methods available through the prescription drug benefit, including all OTC contraceptive barrier methods (diaphragm, female condom, spermicides, etc.), all hormonal methods (oral contraceptives, skin patch, injectable contraception and vaginal ring), and all contraceptive devices (Intrauterine systems and implants.) Emergency contraceptives (Plan B, Ella) are also covered through the prescription drug benefit. o Breastfeeding support, supplies and counseling (one breast pump per benefit period) o Gestational diabetes screening Other covered services include: • Routine hearing screens • Routing vision screenings
	4.8.12e	**Its procedures for covering and approving emergency, urgent and specialty care, if applicable;**
		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: **Emergency Services Procedures**: • 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. • 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). • 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. **Urgent Care Procedures:** • 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. The Health Plan is responsible to cover emergency medical conditions or urgently needed services: • Regardless of whether services are obtained within or outside The Health Plan's service area; • Regardless of whether there is pre-authorization for the services; • If the emergency situation is in accordance with a prudent layperson's definition of "emergency medical condition," regardless of the final medical diagnosis; • 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. • For ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health. • Which a plan provider or a Health Plan representative instructs an enrollee to seek emergency services within or outside the plan. **Specialty Care Procedures:** • Covered services received from a in Network specialist will be provided at the higher benefit level and Out-of-Network services at the lower benefit level. The Health Plan facilitates ongoing specialist care and coordination of the benefit for appropriate members: • 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. • 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.
	4.8.13	**The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons shall be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transitioned to other providers in a timely manner; and**
		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: "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. 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. 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. 15.7 Nothing herein shall be construed as authorizing or permitting Physician to abandon any patient. 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. 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." *****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. 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. 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.
	4.8.14	**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**
		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.
4.9		**The Commissioner may develop forms to be completed by the health carrier regarding the information required by subsection 4.8 of this rule.**
§114-100-5 Coordination and Continuity of Care		
5.1		**A health carrier shall address its process for ensuring the coordination and continuity of care for its covered persons in the access plan for each network offered by the carrier.**
5.2.		**The process for ensuring the coordination and continuity of care shall include, but is not limited to the following;**
	5.2.1	**The health carrier's documented process for ensuring the coordination and continuity of care for covered persons referred to specialty providers;**
		The Health Plan has a Continuity and Care Coordination Policy applicable to all members including those with special health care needs. To ensure that members of The Health Plan have the benefits of continuity and coordination of their health care and are empowered to become active, knowledgeable participants in the development and implementation of treatment plans to promote their own health. Through its performance of the nurse navigators' functions, The Health Plan's Medical Department/Behavioral Health Services strive to support and enhance the partnership of member and primary care practitioner, to ensure continuity and coordination of care, member understanding of and participation in their care. All practitioners/providers involved in a member's care must share clinical information with each other and the member in a timely fashion.

		The primary care practitioner (PCP) bears primary responsibility for coordinating the member's overall health care in a manner consistent with the member's own goals and preferences. Most referrals to specialty practitioners or other practitioners/providers must originate with the PCP. Treatment plans should specify an adequate number of direct access visits to specialty practitioners to accommodate implementation of the treatment plan. Members are afforded direct access to behavioral health practitioners/providers. The health care navigators produce a treatment or service plan meeting criteria for members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be: • approved in a timely manner if prior authorization is required. • In accordance with any applicable State quality assurance and utilization review standards; and • Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per §441.301(c)(3) Practitioners/providers must document member input in all treatment plans submitted for authorization; Medical Department/Behavioral Health Services nurse navigators will review treatment plans for such documentation before approving requested services. Practitioners/providers must document member input in all treatment plans submitted for authorization; Medical Department/Behavioral Health Services nurse navigators will review treatment plans for such documentation before approving requested services. 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. 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. 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. 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. 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. The Health Plan does not prohibit a health care professional from advising, advocating on behalf of a member. 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. 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. 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.
	5.2.2	**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;**
		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. The Clinical Service Program description is reviewed by the Executive Management Team and is evaluated annually. 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: • To promote and provide appropriate allocation of health and behavioral health care services to our members, • 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,

		• To identify members for social service referrals, complex case management, health care navigation and/or chronic disease navigation programs, • To assess Utilization Management Program performance by soliciting input from members and practitioners through surveys. • To develop interventions based on input received from members and practitioners to improve the quality of services to all customers, • To ensure confidentiality of personal health information' • 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, To educate practitioners on the scope of the Utilization Management Program and Medical Management Services.
	5.2.3	**The health carrier's documented process for ensuring appropriate discharge planning;**
		The Health Plan's (THP's) process for ensuring appropriate discharge planning includes the following: 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. 2. Unplanned care transitions are identified through inpatient navigation. The member's primary practitioner is faxed an updated care plan with any transition of care, following a transition of care assessment performed by a licensed navigator. 3. All notes pertaining to transitions are documented under a clinical overview note. 4. Care Settings include: o Home o Home Health o Acute Inpatient o Skilled Inpatient o Custodial Inpatient (long term care) o Rehabilitation Inpatient o Long term acute care (LTAC) o Ambulatory Care Settings The internal care team is the liaison for practitioners, members, providers, and caregivers, promoting appropriate and safe transitions. The internal care team communicates with the member or caregiver, telephonically, through care transitions, when possible, Discharge calls are made to members within 48 hours of notification of discharge. Any changes in health status or care needs are discussed at that time. A transition of care assessment is documented. The member receives a mailed transition of care plan, unless they reside in a long-term care facility. A request is sent

		to pharmacy to reconcile medications. The assigned nurse navigator documents and coordinates: 1. Emergent hospital admissions received from network hospitals through the UM process 2. Prior authorized elective admissions, transfers to skilled, rehab, or LTAC facilities, and home health care Assistance within plan re-direction of services or single case agreements (if out of network is necessary), as appropriate
	5.2.4	**The health carrier's process for enabling covered persons to change primary care providers; and**
		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 myplan.healthplan.org to change their PCP. The selected PCP must be available and accepting new patients.
	5.2.5	**The health carrier's proposed plan and process for providing continuity of care in the event of contract termination between the carrier and any of its participating providers or in the event of the carrier's insolvency or other inability to continue operations. The proposed plan and process shall include an explanation of how covered persons will be notified in the case of a provider contract termination, the health carrier's insolvency, or of any other cessation of operations, as well as how policyholders impacted by such events will be transferred to other providers in a timely manner.**
		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: "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. 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. 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. 15.7 Nothing herein shall be construed as authorizing or permitting Physician to abandon any patient. 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. 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." *****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. 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. 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.
		§114-100-6 Network Access Plan Disclosures; Attestations
6.1		**In the access plan for each network plan offered, a health carrier shall explain its method for informing covered persons of the plan's services and features through disclosures to covered persons.**
	6.1.1	**Required disclosures include:**
	6.1.1a	**The health carrier's grievance and appeal procedures;**
		The Health Plan (THP) provides a thorough and consistent process for addressing a member's formal grievance and appeal process. To ensure a thorough, appropriate and timely resolution for a member's formal appeal as, 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. 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: • Record receipt of the formal appeal in grievance log in Heart. • 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.) • Scan completed grievance form, and any attachments, into the document repository by member ID number. • Gather all pertinent information pertaining to the case file. • Review information with the appropriate department to determine accuracy of the informal appeal. • Issue a case file number. • Send the case file to the Grievance Committee for review prior to the meeting. • Schedule meeting to discuss case including the member, if they requested to appear in person or communicate with the Grievance Committee telephonically. 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. **Formal Appeal** 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. 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. 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. 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. 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. If the Grievance Committee reverses its original decision, the referral/claim is updated, and the member is notified of the decision in writing. **Time Frames for the Grievance Committee's Decision on Appeal** **Urgent Care* Appeals**: 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. **Pre-service Appeals**: Within a reasonable period of time appropriate to the medical circumstances, not later than 10 days after receipt of the appeal. **Post-service Appeals**: Within a reasonable period of time, not later than 30 days after receipt of the appeal. • 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. 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. **Contents of Written Decisions of Denials on Appeal:** • 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. • 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. • 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. • 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. • 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.. • 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. • 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. • The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. 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." • 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 https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/internal-claims-and-appeals). • A statement of the member's right to sue under ERISA Section 502(a), if relevant. **Providing Notices in Culturally and Linguistically Appropriate Manner** Notices of denials on appeal shall be provided in a culturally and linguistically appropriate manner by providing: • 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; • Relevant notices in any applicable non–English language upon request; and • A statement clearly indicating how to access the language services provided, which is prominently displayed in any applicable non–English language. 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
	6.1.1b	**The extent to which specialty medical services including but not limited to physical therapy, occupational therapy and rehabilitation services, are available;**
		THP develops, maintains and monitors a network of appropriate, credentialed providers, supported by written agreements, that is sufficient to provide adequate access to covered services (including preventative, primary care, specialty services, physical therapy, occupational therapy and rehabilitation services) and to meet the needs of the population served. All specialties are monitored at least quarterly for network adequacy.
	6.1.1c	**The health carrier's procedures for providing and approving emergency and non-emergency medical care;**
	6.1.1d	**The health carrier's process for choosing and changing network providers;**
		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. 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).
	6.1.1e	**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**
		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: 1. Provision of a non-discrimination notice and multi-language taglines to THP members in compliance with Section 1557 of the ACA. 2. Guidelines for the provision of assistive services and alternative formats for LEP and members with disabilities. These guidelines address both commonly encountered and less common requests by THP members for alternative access and alternative formats. 3. A process to address member complaints involving allegations of discrimination and/or the inability to obtain communications in alternate formats. 4. Staff training and education on the provisions of the THP Language Access and Non-Discrimination Plan. In accordance with Section 1557 of the Affordable Care Act: 1. The home page of the THP website includes the non-discrimination notice, or a link to the notice, in a conspicuous location. Website tagline links should be written "in language." 2. The full notice, including at least 15 taglines representing the prevalent non-English languages in the state, should be incorporated into, or distributed with, the following annual and new member documents: a. Annual Notice of Change/Evidence of Coverage (ANOC/EOC): b. Provider and pharmacy directories; c. Formularies; d. Summary Plan Document (commercial and self-funded); e. Summary of Benefits and Coverage (commercial and self-funded); f. Annual and new health risk assessments (HRAs). 3. The notice should be posted in physical locations of THP where the plan interacts with the public. 4. All THP lines of business should provide notice in compliance with this policy and Section 1557 requirements. 5. Section 1557 required documents can be obtained from the Marketing Department. In addition, the following guidelines assist THP in taking reasonable steps to ensure that persons with LEP or persons with disabilities have an equal opportunity to participate in plan services, activities, programs and other benefits. Persons with disabilities include persons who are deaf, hard of hearing, or blind, or who have other sensory or manual impairments. THP must make reasonable accommodations, such as the provision of auxiliary aids, the provision of interpreters or the provision of information in alternative formats to remove or reduce, to the extent practicable, barriers

		that prevent effective communication between THP and a member with a disability or LEP. When utilized, THP should enlist the services of qualified interpreters or translators. The following materials are available, upon request and free of charge to members and potential members, in alternative formats: • The member handbook • The provider directory • Denial notifications • Appeal and grievance notifications If the format requested is not feasible, alternate methods of providing the information will be explored in consultation with the member. Member Identification 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. Guidelines for Communications for Visually Impaired Individuals 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: • Provide the member handbook, (EOC), summary of benefits, and ANOC (or comparable documents) in large print (18 pt. font); • 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; • 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 • Communicate enrollment information out loud by explaining these forms to persons who are blind or visually impaired. 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. Guidelines for Communications for Hearing Impaired Individuals

		Individuals with hearing impairments may utilize TTY services through the state relay service number at 711. Guidelines for Individuals with Limited Reading Proficiency 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. CSRs should be available to answer questions from members with limited reading proficiency in a manner understandable to the member. Guidelines for Communications for LEP Individuals 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 > Language Line. 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: • 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. • 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. • Reasonable requests for translated materials should be honored. Guidelines for Availability of Web-Based Materials through Alternative Media 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. Staff Training on the Language Access Plan 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.
	6.1.1f	**The health carrier's documented process to identify the potential needs of special populations.**
		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, preauthorization/referrals, admission/concurrent review and disease management navigation and health promotion programs. The Clinical Service Program description is reviewed by the Executive Management Team and is evaluated annually. 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: • To promote and provide appropriate allocation of health and behavioral health care services to our members, • 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, • To identify members for social service referrals, complex case management, health care navigation and/or chronic disease navigation programs, • To assess Utilization Management Program performance by soliciting input from members and practitioners through surveys. • To develop interventions based on input received from members and practitioners to improve the quality of services to all customers, • To ensure confidentiality of personal health information' • 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, To educate practitioners on the scope of the Utilization Management Program and Medical Management Services.
6.2.		**The following attestations shall be submitted with the access plan;**
	6.2.1	**Health carrier attests that each of its health benefits plans having a network plan will maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health, behavioral health and substance abuse care services, to assure that the services will be accessible without unreasonable delay. The attestation should include language stating that the health carrier's network is in compliance with the network adequacy standards set forth the section 3 of this rule.**
		Attestation will be uploaded to site
	6.2.2	**Health carrier attest that each of its health benefit plans having a provider network include in its provider network(s) a sufficient number and**

		geographic distribution of ECP's, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in their service areas.
		Attestation will be uploaded to site
	6.2.3	**If the health carrier does not immediately meet access plan standards, the carrier will include an attestation adequately addressing how it plans to meet the standards specified in sections 3 and 4 of this rule. Such changes shall be implemented and filed by the health carrier in accordance with the reasonable schedule established by the carrier and reviewed by the Commissioner.**
		See attached Network Files with GEO Maps For the geo mapping analysis, THP aligned its member population data with the West Virginia Commercial Network Adequacy Standards. The standards requested an analysis on specific provider types that would be applicable to only a certain population. For example, an analysis must be provided on pediatric or age-appropriate primary care providers. To ensure access is captured appropriately, THP segregated its membership data into adults and pediatrics to align the standard with the appropriate primary care specialty. THP considers its pediatric population to be those members who are age 18 and under. THP considers its pediatric population to be those members who are age 18 and under. Therefore, line 1,583 of the PPO Commercial Geo Excel file listed 103 members which represents the total number of pediatric members in our Commercial PPO product line. The Health Plan (THP) did not include the network adequacy analysis for pediatric dental or orthodontist standards in our access plan submission. THP does not offer dental or pediatric dental benefits with its group Commercial PPO product. Therefore, THP did not include an access analysis of these provider types in our plan submission.
		§114-100-7 Provider Directories
7.1		**Provider directories shall be maintained by a health carrier for each of its health benefit plans having a network plan. Sample screen shots of the carrier's electronic provider directory and a PDF sample of the carriers printed provider directory must both be filed in SERFF with the access plan filing.**
		Documents filed with SERFF: THP Commercial Provider Directory- printed THP Facility directory search- electronic THP Hospital directory search- electronic THP Provider directory search- electronic
7.2		**Provider directories maintained by a health carrier shall meet all of the following requirements:**

	7.2.1	**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;**
		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 THPs online provider directory is available at www.healthplan.org under "Find Providers".
	7.2.2	**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;**
		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 www.healthplan.org under "Find Providers".
	7.2.3	**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.**
		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	**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.**
		Members are notified in the member handbook that they can request a copy of a printed provider directory or portion therof 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	**A health carrier shall include, in both the electronic and print directory, the following general information for each of its provider networks:**
	7.2.5a	**A description of the criteria the health carrier has used to build its provider network;**

		The Health Plan's (THP's) participation guidelines provides a detailed description of the criteria used to build the provider network.
	7.2.5b	**A note that an authorization or referral may be required to access some providers;**
		The Health Plan's directory makes note that an authroization or referral may be required in the definitions of specific provider types.
	7.2.5c	**A description of the criteria the health carrier has used to tier providers; and**
		The Health Plan (THP) does not tier providers, thefore, 7.2.5c, d, d1, d2, and d3 are not applicable.
	7.2.5d	**A description of how the health carrier designates the different provider tiers or levels in the network and identifies (e.g. by name, symbols or grouping) which tier or level the following are placed in;**
	7.2.5d1	**Each specific provider;** N/A
	7.2.5d2	**Each specific hospital; and** N/A
	7.2.5d3	**Each specific other type of facility in the network;** N/A
	7.2.6	**A health carrier shall make it clear, in both its electronic and print directories, which provider directory applies to a particular health benefit plan, such as including the specific name of the health benefit plan as marketed and issued in West Virginia**
		See Attached
	7.2.7	**The health carrier shall include, in both its electronic and print directories, customer service contact information by electronic means such as email, text or social media and, telephone number and an electronic linkthat covered person or the general public may use to notify the carrier of inaccurate provider directory information.**
		See Attached
	7.2.8	**For the items of information required in a provider directory pursuant to W.Va. Code §33-53-4 pertaining to a health care professional, a hospital or facility other than a hospital, the health carrier shall make available, through the directory, the source of the information and any limitations; and**
		See Attached
	7.2.9	**A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link or information regarding available assistance for persons with limited English proficiency.**
		See Attached
7.3		**A health carrier shall update each electronic provider directory at least monthly. Current provider directories shall be made available to the Commissioner upon request.**
		The Health Plan (THP) updates its electronic provider directory daily. This daily update includes additions, deletions, and changes made the previous day. THP's electronic directory is publicly available at www.healthplan.org at "Find Providers".

7.4		**No less frequently than three times during each plan year, a health carrier shall audit at least fifty percent (50%) of the providers contained in its provider directories for accuracy and update that directory based upon its findings. Every provider in the directory must be audited at least once during each plan year.**
		2022 Provider Directory Audit Methodology: The Health Plan (THPs) performs a directory audit once per calendar quarter. To ensure provider data integrity, THP audits sample size sample size based member utilization as demonstrated through claims data. THP's provider servicing team outreaches to the provider's office to perform directory verification. Any changes to provider directory data are requested in writing before THP's internal system is updated. **PDS & Compliance Auditing:** THP's Provider Operations team has partnered with THP's internal compliance team for additional directory auditing purposes. THP produces a monthly report that identifies all directory data changes for the previous month. The compliance team then uses a random number generator tool to select a random sample of directory changes. THP's Compliance Program Auditor then reviews the report verse the data in THP's provider directory and internal system to validate compliance. The results of the audit are then sent to the Director of Provider Information Management for review and retention purposes.
7.5		**Audits shall be conducted such that all entries in a provider directory will be audited at least once every eighteen (18) months. Documentation of the process and findings of all audits and the information required by the rule shall be retained for no less than thirty-six (36) months and shall be made available to the Commissioner upon request.**
		The Health Plan (THP) conducts provider data audits to assure that all entries in the provider directory will be audited at least once every eighteen (18) months. THP retains process documentation and finding for ten (10) years and will make those documents available to the Commissioner upon request.