West Virginia
Family Health

02/23/15 09:32:22
WV Purchasing Division

February 20, 2015

Bid Clerk
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

RE: Request for Information: CRFI 0511 HHR1500000002
Subject: Managed Care or Managed Care Alternative Vulnerable Youths
Proc Folder 70828 Comm Code: 84131602
Date of Issue: 01/28/2015 Due Date: 02/25/15 13:30:00
Buyer/Bid Contact: Robert Kilpatrick 304-558-0067 robert.p.kilpatrick@wv.gov

Dear Mr. Kilpatrick,

Please find attached the submission for West Virginia Family Health Plan, Inc. related to the above referenced CRFI related to Managed Care or Managed Care Alternative Vulnerable Youths. Per your request, I have enclosed one (1) hard copy original copy of the submission, and two (2) additional hard copies of the entire RFI response.

Should you require additional information, the contact for this initiative and submission is:

Jason Landers, Executive Director
West Virginia Family Health Plan, Inc.
614 Market Street
Parkersburg, West Virginia 26102
Jason.landers@highmark.com
304-424-7738 or 304-424-7660

Thank you for the opportunity to submit a response to this request for information. I appreciate the opportunity to continue to submit responses for this initiative when subsequent solicitation documents are requested.

Sincerely,

Jason Landers
Executive Director, West Virginia Family Health Plan, Inc.

ORIGINAL SUBMISSION

REQUEST FOR INFORMATION (RFI): CRFI 0511 HHR1500000002 MANAGED CARE OR MANAGED CARE ALTERNATIVE FOR VULNERABLE YOUTH POPULATIONS

SECTION 1 STATEMENT OF NEED

1.1 The WV State Purchasing Division, on behalf of the WV Department of Health and Human Resources (the "Agency"), is seeking information (only) to assist in their preparing specifications for a prospective solicitation to aid in their goal of supporting the safety, permanency, and well-being of vulnerable youth populations. For purposes of this request, vulnerable youth populations are defined as:

- Foster care children as defined under 45 CFR 1355.20
- Former foster care children under the age of 26 as defined by the Affordable Care Act
- Post-adoption children with subsidized care

Currently, there are approximately 4,000 foster care children in West Virginia, and approximately 11,000 total children meeting the definition of vulnerable populations as defined above. The Department sees opportunities in bringing this population into a managed care or managed care-like environment through:

- Improved access to care
- Improved coordination of services in physical and behavioral health
- Communications and training
- Enhanced quality and seamless continuity of care
- Improved oral health

This population of children and youth, many with physical, oral, and behavioral health needs, may lack access to regular primary care, dental care or behavioral health care needs. Due to the common circumstances that surround a child's need for out of home placement, many children have been exposed to Adverse Childhood Experiences (ACEs). This results in early toxic stress and trauma and the need for Primary Care Providers and Care Coordination that have knowledge of this complex and vulnerable population. This RFI is drafted with the intent of a continuation of services being provided up until the age of 26.

No contract will be awarded from this Request for Information (RFI). The Agency will not reimburse costs to any firm for their responses to this RFI. After reviewing the responses, the Agency may request a meeting or teleconference with any responding firms to gain further insight into their capabilities. Firms are discouraged from including marketing information that does not relate to the services described in the RFI. The Agency requesting information in the form of answers and/or proposed solutions from qualified vendors on the initiatives listed below. Respondents are not required to address all questions listed as information provided is for **evaluation purposes only**.

Responses to the RFI should be justified by industry best practices and include sufficient detail, such as the recommended approach, expected deliverables, communication efforts, and timelines by phase if appropriate. Vendors should provide cited references to information that is being presented, as applicable. Information included in responses to the RFI may be used by the Agency to develop specific Requests for Proposal. Please note that the RFI is not all-inclusive and vendors are welcome to provide additional narrative on solutions that may not be tied to specific questions outlined below.

Please find the responses for West Virginia Family Health (WVFH) related to the CRFI0511 HHR1500000002 Request for Information. For purposes of the responses to this RFI, services provided by WVFH will include activities and services that will be provided through its sub-delegates which include Highmark WV (BCBS), Gateway Healthplan, Argus Pharmacy, Davis Vision, Scion Dental and Beacon Health Strategies.

Improved Access to Care

It is essential for this targeted group of children to include preventive care, diagnosis and treatment across all domains, including: medical, dental, vision, behavioral/mental health, and pharmacy services. Service provision must be individualized to the needs of the child, and their caregivers, and consistent with the goals of the West Virginia child welfare system.

1.1.1 Describe the approach(es) to establishing a statewide provider network that is comprehensive and contains providers who can provide a multi-disciplinary and comprehensive service array, either through their own practice or through collaboration with other providers; is accessible to children and their caregivers; incorporates evidence-based best practices and interventions; provides for continuous communication with stakeholders; and has capacity in rural areas and across specialty lines of health services. WVFH utilizes robust medical, pharmacy, dental and behavioral health networks in 53 of 55 WV counties. The medical network was contracted and credentialed for Medicaid from the existing commercial PPO network of Highmark WV giving WVFH the ability to achieve state-wide accessibility to high-quality facilities and providers. The network includes 47 WV hospital facilities, a robust number of primary care and specialty physicians, therapists and other provider types. Specifically, the current network is comprised of 27 Acute Care facilities and 20 Critical Access facilities located throughout the state, offering an array of primary and tertiary care services. In addition to the hospital facilities, WVFH has four Health South rehabilitation locations in the network. WVFH works in a partnership effort with the facilities to encourage and promote services that are required for members with complex needs. Examples of partnership efforts include but are not limited to Quality Programs that seek to enhance the level of care provided to all patients including the complex case needs of the "vulnerable"/foster population as well as the TANF and SSI members. Through a well-coordinated Quality Program the partnership between WVFH, facilities and physicians seeks to ensure the member receives the appropriate care and the community contacts needed for follow-up, transportation, and home care. WVFH anticipates that the population will require specialty providers and hospitals to address pediatric, maternity, and complex acute and chronic medical needs. To meet demand for this population, WVFH's current network includes the following providers:

- 31 Federally Qualified Health Centers
- 37 Certified nurse midwives
- 169 Pediatricians
- 104 School Based Clinics
- 787 Primary Care Physicians (combination IM, GP, FP)
- 163 Certified Pediatric or Family Nurse Practitioners

To further meet the demand for this population, WVFH's facility services include 24-hour emergency and trauma care, rehabilitation, diagnostic radiology, cardiology services, intensive care and general surgery. To further assure access to the full range of providers for members with complex needs, the 22 owner/partner FQHCs have well-established relationships with community outreach service providers that will intervene and assist with the unique, complex needs of the "vulnerable"/foster population as well as the TANF and SSI populations. Argus (the Pharmacy Benefit Manager) has an established national network of over 65,000 contracted pharmacies, thereby providing an extensive pharmacy network both in WV and nationwide. The dental network is under the oversight of Scion Dental; the vision network is under the oversight of Davis Vision; and the behavioral health network is under the oversight of Beacon Health Strategies. For WV, the network meets or exceeds access standards for the Medicaid population in every county.

1.1.2 Describe the approach(es) to addressing deficiencies in the Essential Provider and Specialty Provider networks in relation to travel times and distances that may be experienced by a member. WVFH currently has established standards to ensure that the contracted and credentialed provider network has sufficient numbers and types of hospitals, primary care practitioners, specialty care providers, as well as dental and vision providers for the populations to be served. These standards align with National Committee for Quality Assurance (NCQA) requirements and Article III, Section 2.1 of the Mountain Health Trust (MHT) contract. Using Geo-Access reporting, based on Bureau of Medical Services (BMS)/CMS access regulations and requirement guidelines and identified member needs, a process has been established for evaluating network adequacy. The Geo-Access reports are used to effectively monitor and evaluate ongoing access to services allowing WVFH to identify and fill any network gaps for specialties or facilities specifically required by BMS. Geo-Access mapping and analysis identifies gaps in geographic dispersal of providers, drive time analysis to assess service access and matching of consumers to the nearest providers. The required specialties, hospitals and clinics are well represented in the existing network which includes 80+ specialties. The network PCPs will be monitored against these standards semiannually in March and September and the network specialists will be monitored against these standards semiannually in June and December using Geo-Access analysis. The network's ability to meet the cultural, ethnic, racial and linguistic needs of members will also be monitored on an annual basis in August. Results will be reported to the WVFH's Internal Quality Improvement/Utilization Management (QI/UM) committee for review and discussion, and also shared with WVFH's Provider Contracting Department for consideration in their recruitment plan. WVFH's Provider Contracting Team will take the following into consideration when finalizing their recruitment plan:

- Actual Medicaid enrollment, summary prepared by The Lewin Group for BMS, number (density ratios) utilizing the WV DHHR information and guidelines
- Actual utilization of services based on WVFH specific high volume claims/referral data and "frequently used specialists" as determined by BMS
- Geographic distribution via Geo-Access utilizing the Provider Network Standards
- Resources related to BMS, MHT and MHC Provider Network Ratio Worksheet for PCPs and OB/GYNs
- Open practices, handicapped accessibility, member complaints/CAHPS® results (as appropriate/when available) related to practitioner/provider availability and accessibility
- Cultural, ethnic, racial, and linguistic needs of its members/ability of network to meet the needs.

In addition, the partnership with the 22 FQHCs and 2 primary care clinics, as well as the Primary Care Association support (as shareholders of WVFH), provides a stable foundation of clinics needed to ensure member access for Medicaid beneficiaries with special health care and psychosocial needs. The significant primary care presence in WVFH's ownership is a driving force behind the participation and buy-in of WV providers of all specialties.

1.1.3 Describe the approach(es) to providing 24 hours access to a provider or service in emergency situations. WVFH is committed to assuring that members with special needs have access to care. Frequent and routine reporting and monitoring will be conducted to identify and address access barriers for WVFH members, and data for TANF and "vulnerable" members will be separately assessed for PCP access issues. WVFH has established standards and mechanisms to ensure access to services that align with NCQA standards and guidelines and Article III, Section 2.1 of the MHT contract. Using valid methodology, WVFH will collect the following data on an annual basis to measure performance against the standard related to emergency care immediately administered by PCPs and Medical Specialist which requires "regular and routine care appointments within 2-7 days with the PCP and Medical Specialist". On occasion, specialists may be approved to serve as a PCP upon the request of a member with complex needs; however the specialist must agree to meet the requirements of performing PCP care. PCP's are contractually obligated to agree to:

- Manage all aspects of member's health needs, including routine care (cough/cold and minor injuries)
- Be on call 24/7 to manage the member's care
- Coordinate all preventive health care

WVFH places great emphasis on educating and monitoring its PCPs on availability and appointment standards. Ongoing monitoring will allow for the timely engagement of non-compliant PCPs and affords an opportunity to bring them into compliance through re-education or implementation of a corrective action plan, if necessary. The internal multidisciplinary workgroup will review results of the monitoring activities to determine opportunities for improvement and identify potential interventions that recognize barriers as well as apply traditional or innovative strategies to boost network compliance. WVFH's PCP Agreements include the responsibility of practitioners to assure availability for PCP services on a 24 hours per day, seven 7 days per week, basis. Furthermore, all practitioners, upon execution of the Provider Agreements, agreed to adhere to MHT program appointment standards, as outlined in the Provider Policy and Procedure Manual. PCPs will be educated on the coverage and appointment scheduling standards during each initial orientation and reminded again during re-orientations and annual goal visits. WVFH uses a variety of methods, described below, to monitor and assure provider compliance with accessibility standards:

- Environmental assessments and medical record reviews - Provider relations representatives will be engaged to monitor compliance with the accessibility standards during environmental assessment visits with PCPs through review of the appointment book and discussion on accessibility standards, non-compliance issues, or steering patients to the ER when services could be provided in the office setting. Additionally, WVFH's QI staff will audit accessibility and missed appointment standards during Medical Records Reviews.
- Member complaints - Ongoing monitoring of PCP availability will be handled through member complaints. The provider relations department will receive all member complaints related to accessibility and will identify individual office accessibility issues on an ongoing basis as well as follow-up with each individual office not meeting the accessibility standards as identified by complaints.
- Annual appointment and after-hours survey studies - The survey will be used to determine if practitioners are available to WVFH enrollees at all times and to evaluate the accessibility of the PCP and high volume specialty care providers to members.
- CAHPS® Member Satisfaction Survey - The internal CAHPS® Workgroup will monitor member's perception of practitioner accessibility by reviewing the results of survey responses related to member's perception of PCP accessibility. Members will be surveyed on their satisfaction with getting "emergent, urgent and routine" care as needed.

1.1.4 Describe the approach(es) to measuring and regularly verifying network compliance standards, and actions that will be taken if notified of inappropriate wait times before a member is seen by a provider. Frequent, routine reporting and monitoring will be conducted against established standards to ensure access to services that align with NCQA standards and guidelines and Article III, Section 2.1 of the MHT contract. WVFH will measure performance against the standard related to regular and routine care appointments within 2-7 days for PCPs and Medical Specialists as required by the provider contract. WVFH is committed to supporting its primary care and specialty care practitioners in managing their patients with medically or socially complex needs. Provider education on the availability of these services will be emphasized in provider newsletter articles and during orientations and targeted visits, when deemed necessary.

1.1.5 Describe the approach(es) that would be taken to accommodate actual member enrollment if total exceeds projected enrollment, if this scenario presents an issue. Through Geo-Access analysis, WVFH will continue to monitor the network and outreach as required to ensure an adequate number of providers to service the members. Annually, WVFH will monitor the percentage of PCP practices open to potential members and maintain a

network that has at least 80% of its primary care panels open to new or existing members. WVFH will also monitor the average members per PCP to ensure adequate availability. If the members per PCP exceeds 2,000, the Provider Relations and Network Development Departments will work to transfer members to another PCP with a panel that does not exceed 2,000 members and will work to develop a corrective action plan to recruit additional PCPs in the county where the members per PCP standard is not being met. Exceptions to the limit will be considered on a case-by-case basis with physician and BMS consent.

1.1.6 Describe the approach(es) to offering/providing crisis response to children and their caregivers. To assure members are stabilized without any provider delay due to concerns over reimbursement, WVFH has in place procedures to reimburse providers and facilities for crisis stabilization services. Emergency room services will be reimbursed for both participating and non-participating providers without a referral from the PCP or UM authorization for treatment in a medical emergency to stabilize the patient.

Improved Coordination of Care

1.1.7 Describe the coordination across systems, including the educational system, and continuity of care between health care, child welfare providers, behavioral health providers and care managers with an integrated care plan for all children. WVFH would anticipate and welcome the need to coordinate across many systems for the integration and effective care of the "vulnerable children". WVFH will dedicate case managers who specialize in working with the caregivers/parents, the educational system, child welfare providers and the full range of health care providers to ensure optimal results for the members. Since optimal integration occurs at the provider level, the PCP and specialists will be coordinated (as discussed in our earlier responses), as well as through pharmacy management. Routine EPDST, dental and vision recommendations will be made to ensure service is provided to the members, and WVFH will ensure integration of the physical health and behavioral health of the member by coordinated care management of the two care teams. In behavioral health, there is a full range of provider types (individual practitioners, CMHCs, LBHCs, etc.) serving the members, and therefore there can be wide variation in capabilities and skill sets within individual provider settings. WVFH sees integration as an ongoing and long term quality improvement process with the goal of promoting communication and collaboration between medical and behavioral health providers for the maximum quality outcome for the member. True service integration can begin with the development of medical health homes within the FQHCs and other medical settings, as well as the development of health homes for individuals who prefer to receive their integrated care within a primary behavioral health facility. WVFH can provide technical support to FQHCs, Comprehensive Mental Health Centers and LBHCs in the development of both medical homes and health homes. WVFH will assist CMHCs/LBHCs in recruiting for medical personnel to staff health homes and provide technical assistance in developing and optimizing health home resources. WVFH will also apply our extensive data analytic capabilities to a combined medical, pharmacy and behavioral health claims database to identify members who are experiencing gaps either in medical or behavioral health care and proactively alert providers of these member/patient needs.

1.1.8 Describe how a vendor would provide training to ensure a plan of care that is jointly developed and shared among the primary care provider and/or specialist serving as a principal coordinating physician, and the child and caregiver(s). Member services representatives and care management staff will receive training on the newly carved-in benefits and expansion population including detailed review of newly carved-in benefits, applicable authorization criteria, overview of demographics of the expansion population, and training on how to access online reference tools specific to the newly carved-in members. Case managers will work directly with the caregivers/parents to ensure the plan is well communicated and agreed upon by all parties under the direction of the members various providers.

PCPs/specialists may need training on including behavioral health assessment and screening into their practices as a matter of routine. They may also need to be educated on the availability of social services and other community-based agencies, and the appropriate use of psychotropic drugs. Case managers and provider relations teams can connect with FQHCs/PCPs to provide this education, which occurs onsite during regularly scheduled site visits and specially scheduled training visits or webinar training. Members' PCPs/specialists will be supplied with behavioral health screening tool options designed specifically for the primary care setting, such as the PHQ-9 depression screener and the CAGE, for substance use conditions. WVFH will provide training on the tools, as well as documentation and billing for behavioral health screening, and post this information to the website for 24/7/365 PCP or specialist access. WVFH will offer physician decision support lines for PCPs/specialists to discuss behavioral health issues with psychiatrists, such as psychopharmacology, treatment alternatives and when to refer for a psychiatric assessment. However, WVFH recognizes members must give their consent for providers to coordinate care, requiring a Release of Information and BH/PCP communication form.

1.1.9 Describe the procedures and protocols for using the individualized family service plan (IFSP) information in the development of the member ISP (individualized service plan) and to authorize services. Individualized family service plans and member individualized service plans are written by each Case Manager, in coordination with the members PCP, who works with a member. With a focus on proactively outreaching members, the focus will be on members with chronic or catastrophic conditions or for vulnerable children. Case managers will coordinate care and educate members on their care needs. They will look at potential barriers to care and whether the members or caregivers/parents are ensuring adherence to treatment plans. Their efforts will also include coordinating community resources needed by the members and families. They will ensure there is collaboration with and among the providers to optimize patient outcomes. The goal will be to achieve and maintain an optimal level of health and prevent complications and co-morbidities. The process will also include case manager's review of pharmacy utilization, along with conducting medication reconciliations and assisting members with adherence strategies with medications. Case managers will use pharmacists to consult on a case-by-case basis, if needed. There are a number of pre-identified diagnoses/situations that are used to determine case management interventions including, but are not limited to, oncology, behavioral health, hypertension, HIV/AIDS, CVA/TIA and/or complex psychosocial situations. Frequent case reviews are held for discussion of complicated cases and are supplemented through the consideration of the member's pharmacy profile.

The information contained within the IFSP is consistent with the holistic model of assessment and support to which WVFH subscribes. Please refer to the response in question 1.1.56.1 for additional information regarding WVFH's model of PCM® and the BEEMSS℠ assessment. WVFH would anticipate and welcome the need to coordinate across many systems for the integration and effective care of the "vulnerable children". An assigned Case Manager would outreach, with consent, to a member's Supports Coordinator to collaborate to meet the child's needs and to link the family unit to the appropriate community resources while enhancing the capacity of the family system to meet the special needs of the child. The assigned Case Manager would request a copy of the IFSP. This would provide valuable information to the Case Manager regarding the member's PCP, specialists, well child visits history as well as immunizations, diagnosis, inpatient stays, medications, adaptive skills, cognitive function and overall risk factors. The IFSP also provides critical information such as any special needs of the member, and strengths, challenges and barriers of the family unit. In turn, the Case Manager would share with the Supports Coordinator relevant information provided to the Case Manager during the completion of the BEEMSS℠ assessment. The relationship between the Case Manager and the Supports Coordinator would be integrated to best support the member while reducing duplication of efforts and services.

The Case Manager would cross reference claims for medication, providers, and DME against those listed in the IFSP. This would help with medication reconciliation, and to ensure the most current providers listed in WVFH's systems are the same as those engaged with the Birth to Three Program and the Service Coordinator.

WVFH will provide the same level and types of services as those currently available through the Children with Special Health Care Needs program (CSHCN) program including access to multidisciplinary care. When children with special needs are away from home, for example in substitute care, transitional care, adoptive care or medical foster care, WVFH's Case Managers will assist agency staff and/or temporary caregivers with care coordination to ensure those children receive timely EPSDT services and do not experience any delay in having other healthcare needs addressed.

The Case Manager, in conjunction with the member/guardian, develops a person-centered Plan of Care (POC). The POC, which is comprised of problems, goals and interventions, considers appropriate options for the member related to his or her medical, behavioral health, and psychosocial case-specific needs. While the member is under active case management, the POC would be updated at least quarterly and as needed with changes to the member's status or goals. The CM would maintain ongoing contact with the Supports Coordinator so both parties are abreast of any changes or obstacles in meeting the member or family's needs.

When WVFH receives an order from a provider for equipment or services, the IFSP would be used, if needed, to help support the medical necessity of the request. If the requested DME or services were beyond the scope of the covered services of the Medical Assistance Program and perceived as direct barriers to a member's ability to access needed medical care or adhere to treatment regimens, the assigned Case Manager would seek out resources to support the member. All staff has access to on-line resources including the internet and a robust community repository application developed by WVFH to locate a myriad of community resources. The community repository was developed by WVFH specifically to assist staff in locating community resources most frequently accessed by Medical Assistance populations, including Medical Assistance recipients residing in every county in West Virginia. The repository is continuously updated and resources are validated annually. In addition to working with the assigned Supports Coordinator and the Birth to Three Program, some of the other community resources the Case Manager would use would include: Woman, Infants and Children (WIC), Supplemental Security Income (SSI), West Virginia Children's Health Insurance Program (WVCHIP), Medicaid, InROADS, Children with Disabilities Community Service Program (CDCSP), Children with Special Health Care Needs program (CSHCN), Non-Emergency Medical Transport (NEMT), Parent Educator Resource Center (PERC), West Virginia Parent Training and Information (WVPTI), Title XIX Waiver, Family Support Program, Child Care Resource & Referral, West Virginia Early Childhood Training Connections and Resources (WVECTCR), and the Office of Maternal, Child and Family Health (OMCFH).

1.1.10 Describe procedures and protocols for developing and including an interdisciplinary team in the assessment and care planning process, and how this information will be transferred to the primary care provider.
There will be the development of a comprehensive, holistic treatment plan that is based on the health assessment, with input from the member, provider, or specialist. Interaction with PCPs/specialists and the behavioral health providers is the critical to ensure the coordination of care. When members are serviced by the WVFH case managers, they will lead on coordinating the overall care with the PCP/specialist which is truly a "best practice" initiative to ensure optimal care to the member as there should be far more benefit to the member when there is an integration of the primary medical and the behavioral healthcare. Increased effective communication and collaboration between behavioral health providers and PCP/specialist medical providers will help to improve the service provided to the member, the quality of the care, reduce medication errors, and decrease healthcare costs. In addition, through a consolidation of medical documentation between the medical and behavioral health providers,

the member should gain a level of comfort that their providers are working as a team to improve their overall health and well-being, and there should be an improvement in patient outcomes. WVFH's behavioral care management team uses DSTHS CareConnect software to document and report care management activities, including the administration of care plans. These care plans can be shared with the PCP/specialists with the consent of the member or caregivers/parents which requires a Release of Information and BH/PCP communication form.

WVFH has a comprehensive care coordination program that emphasizes patient education, self-management, supportive counseling, and practitioner education and support necessary to assist members who have experienced a critical event or diagnosis and require extensive resource coordination and assistance navigating the healthcare system. As part of this process, Case Managers review pharmacy utilization, conduct medication reconciliations, and assist members with adherence strategies with medications. Members eligible for complex case management are identified through multiple methods including, but not limited to claims, utilization management processes, discharge planners and pharmacy data. Monthly case reviews are held for discussion of complicated cases. A pharmacist attends these meetings and provides input on the member's pharmacy profile.

1.1.11 Provide a description of the appropriate case mix and staffing ratio of service coordinators to members and the target ratio of service coordinators to members for each service coordination level. Medical care management staff will be hired according to enrollment projections. Caseloads should not exceed a maximum of 100 cases for all case types, except complex case or behavioral health management which should not exceed a maximum of 50 cases (with a maximum ratio of 1:60). WVFH will use the following metrics to monitor utilization management staff capacity: Staff to member ratio: RN 1:10,000, PCT 1:18,000 to service the providers on the WVFH benefits and processes.

1.1.12 Describe the process for establishing relationships with community organizations and engage them in providing non-covered services to members. WVFH will assure that members with complex medical and/or psychosocial issues are offered appropriate care management programs that encompass integration of all provider inputs which is well-established and comprehensive to address members who have special health care needs using a proactive, holistic approach. Referrals will occur for members identified for community or local services through physician referrals, community agencies referral, member self-referral or other internal departments such as the pharmacy, member services, quality improvement, and complaints/grievances. WVFH will provide assistance in accessing medically necessary services and assistance in identifying and accessing community services as well as a point-of-contact for the member that can assist with health-related services, and to coordinate care needs. Case managers will also provide appropriate information to the member/caregiver/parent concerning specific health conditions and the types of services that may be available and how to access the services which will include a process to facilitate, maintain and coordinate communication among service providers. The goal will be to provide all care and services in a cost effective way without compromising quality. This may also require WVFH to address health care disparities for members with unique cultural and ethnic needs. WVFH will explore new methods for engaging "hard-to-reach" populations including the use of incentives with select subsets of the population, as appropriate, and partnerships with community-based organizations to increase member education and awareness.

WVFH is committed to ongoing staff training and professional development to assure that culturally competent and relevant care management and coordination of services is provided to members. Ongoing training and refresher training about motivational interviewing and member engagement strategies will also remain a priority. WVFH has dedicated staffs which conduct outreach to members and providers for the purpose of promoting preventive health services, improving member access to preventive health services and providing preventive health

education to targeted populations. Staff will assist members with scheduling appointments, locating community resources, including transportation, as well as appointment reminders. WVFH has in place a Special Needs Care Management Unit (SNCMU) whose goal is to intervene in medically or socially complex cases that may benefit from increased coordination of services to optimize health and prevent disease. The SNCMU will provide support to eligible members and the practitioners who manage their care. Additionally, WVFH will educate practitioners on the services of the SNCMU which include serving as a liaison with various healthcare practitioners, community social service agencies, advocacy groups and other agencies with which the population may interface. Members refusing care management services are mailed member educational materials, and/or provided community resource referrals, as appropriate, and provided with the care management department 800 number for future reference.

For Children with Special Health Care Needs, WVFH is developing network relationships with existing primary care and specialty providers to coordinate care for children with special needs. This program is designed to help families and the community care for children with special health problems. This will be incorporated into the care model aimed at improving overall member health. WVFH is targeting specific providers adept at providing care for children with special health care needs and those that provide clinics for evaluation and medicines, transportation, and doctor visits.

1.1.13 Describe the process for creating an ISP, including parties to be consulted, information to be incorporated, and how the member will be involved in the process. The primary focus of WVFH's care management program is to proactively outreach to members with chronic or catastrophic conditions or for vulnerable children to coordinate care, educate members, address potential barriers to care and adherence to treatment plans, coordinate community resources, and collaborate with providers to optimize patient outcomes, in an effort to maintain an optimal level of health and prevent complications and co-morbidities. As part of this process, case managers may review pharmacy utilization, conduct medication reconciliations, and assist members with adherence strategies with medications. Pharmacists are consulted by case managers on a case-by-case basis, if needed. Diagnoses/situations managed through the programs may include, but are not limited to, oncology, behavioral health, hypertension, HIV/AIDS, CVA/TIA and/or complex psychosocial situations. Monthly case reviews are held for discussion of complicated cases and are supplemented through the consideration of the member's pharmacy profile.

Additionally, WVFH has five comprehensive, population-based, diagnoses-driven Lifestyle Management Programs that address the needs of both children and adults with chronic health care conditions. All of the programs emphasize member education and self-management as well as provider support and education. The approach to planning, evaluating and improving these programs is health screen and encounter data driven, and includes process, outcome and financial indicators. Stratification of members with a targeted condition is based on utilization management thresholds including inpatient admissions, emergency room visits, pharmacy utilization and overall costs. Based on these thresholds, members are then targeted for telephonic care management. All other members identified with that diagnosis receive diagnosis-specific education and a telephone number to contact a case manager if they have questions.

1.1.14 Describe how a vendor would evaluate and report member progress in meeting goals identified in the ISP. Completion of care plans is monitored via a weekly report provided to care management managers. Case managers will develop a care plan for every member enrolled into a care management program. The care plan will include one or more problems, planned interventions, and short and long-term goals. Case managers are required to enter an outcome for each goal that indicates whether the goal was completed or not.

1.1.15 Describe a plan for tracking service coordination provided to members, including numbers and types of contact, timeliness of contacts, and qualifications of individuals making the contact. The "Goal Outcome" is a reportable field within CareConnect that will be used to monitor individual goal outcomes on a regular or ad hoc basis. Case managers are also required to close each case with an overall Case Outcome that indicates whether the care plan was completed, regardless of the outcome of the goals. WVFH tracks the completion of care plans via its DSTHS CareConnect software. Reports are generated weekly and sent to care management managers accordingly to review actual against the planned treatment goals. Supervisors do routine audits to ensure treatment plan goals have addressed the member's needs and issues and to determine that appropriate progress is being made for the member to achieve optimal outcomes.

Additionally, for behavioral health, the information management system includes a clinical management module that serves as a comprehensive data warehouse and analytical reporting layer incorporating authorization, medical, behavioral and pharmacy data. This information helps to inform care planning and documents the treatment plan and any changes to it. Through this information management system, FLEXCARE360, behavioral health case managers can check a member's progress against their treatment goals. Supervisors do routine audits to ensure that treatment plan goals have been addressed and progress is being made relative to the behavioral health needs of the member.

1.1.16 How would a vendor meet standards for American Academy of Pediatrics (AAP) for Early & Periodic Screening, Diagnosis and Treatment (EPSDT) testing within 72 hours of placement? WVFH has a program in place that is based upon the federally mandated EPSDT program for children under the age of 21 years. Through the EPSDT program, children are eligible to receive regular medical, dental, vision, and hearing screens to assure that they receive all medically necessary services. PCPs are required to assure that all children under the age of 21 have timely access to EPSDT services, and are responsible for assuring continued coordination of care for all members due to receive EPSDT services. In addition, PCPs are to arrange for medically necessary follow-up care after a screen or an encounter. WVFH has well-established procedures, materials, monitoring tools and reports that are used to ensure compliance with EPSDT program requirements. All families or households of pediatric members will be encouraged to establish a medical home by choosing a PCP and getting regular, timely check-ups, and to establish a dental home by choosing a dentist and keeping dental appointments. A WVFH outreach representatives will conduct telephonic outreach to members and will send educational mailings to all targeted members, regardless of the member's geographic location within the WVFH service area, as well as target members for telephonic outreach based on appropriate age/claims criteria. Staff may offer members the following types of assistance, if requested: help scheduling an appointment via a conference call with the provider office; a reminder call prior to the appointment, and linkage to transportation resources. WVFH reimburses for all billed EPSDT claims for visits where the EPSDT services were provided to the member, thereby eliminating any possible financial disincentives for the PCP to not perform this level of care on a frequent basis. This should help ensure the members have complete medical examinations with each appropriate PCP visit.

As new members are enrolled in WVFH, the initial outreach will be made to ensure the health risk assessment is prepared to determine the member's compliance with their age-appropriate EPSDT requirements. The focus of pediatric and adolescent telephonic outreach and education will be as follows:

a. Children who are due, or overdue, for immunizations or EPSDT well-child visits
b. Adolescents who are due, or overdue, for immunizations or EPSDT well-child visits
c. Children due/overdue for a blood lead level screening or who have lead levels of 10 mg/dL or greater
d. Children or adolescents who chronically do not keep PCP visits
e. Members between ages 2-18 months will be targeted for age-specific immunization reminders via automated telephone calls.

Caregivers/parents of pediatric or adolescent members who are already being followed by a case manager in a care or lifestyle management program will also receive information on age appropriate screenings and immunizations. Physicians and other providers can request assistance from staff to telephonically follow-up with members who need additional education or further explanation about issues such as the importance of keeping scheduled appointments and obtaining referrals for specialty care. Practitioners can fax a Member Outreach Fax Form for the following reasons:

a. Education regarding compliance with recommended testing, such as blood lead level testing
b. Scheduling assistance for EPSDT screenings
c. Education about the potential implications of chronically "no-showing" for preventive appointments

Care Gap software application allows any staff person who is speaking with a household or provider to immediately see a flashing button on the computer screen that serves as an alert that one or more members in that household is in need of some type of testing or screening, including EPSDT services. Once the Care Gap is discussed with someone in the household, the flashing button is deactivated. If a claim is not received within 30 days for the various screenings, the flashing button is reactivated when claims data is refreshed. The Care Gap will be discussed during subsequent calls to or from the household, until the gap is closed. This provides a proactive, holistic approach to interacting with members.

WVFH will also engage in outreach campaigns with physicians since many PCPs may not have systems in place to track patients that are due for preventive services. WVFH will send a quarterly PCP Dashboard Report to all physicians in the WVFH network. This report details several key screenings, tests and/or visits that the PCP's panel membership is missing. This helps give the physician a quick snapshot regarding what discussions they may want to have and/or recommendations they will want to make with WVFH members. This report also points out all new members to the practice within the past three months. WVFH will provide physicians with resources related to the EPSDT Program and services which include the following:

a. Provider Manual which outlines provider responsibilities related to EPSDT services
b. WVFH website which includes the EPSDT Periodicity schedule
c. Newsletters with articles pertaining to improving vaccination rates, Member Outreach Program, etc.

1.1.17 Describe the service coordination process for members who also receive non-capitated services through the following programs:

1.1.17.1 Medicaid state plan services such as but not limited to Health Home and Personal Care

1.1.17.2 Nursing Facility

1.1.17.3 Home and Community Based Services (HCBS) Waiver Services (IDD, TBI, ADW)

During provider orientations, annual provider workshops, goal visits, and targeted visits, WVFH will educate PCP/specialists on coordinating physical health services and ensuring that the PCP/specialist coordinates services that will continue to be provided on a fee-for-service basis. The objective of all educational sessions will be to ensure that WVFH network practitioners thoroughly understand the MHT Medicaid program, WVFH policies and procedures, and standards of care. WVFH's staff can assist members/families with referrals for routine services or specialized treatment resources. Member services can be contacted to provide assistance with setting up an appointment. When WVFH recommends or arranges an appointment, we place follow-up calls to the member to determine whether the member was able to see the provider and is satisfied. If the member was not able to connect with the provider or is dissatisfied, we arrange an alternative appointment. WVFH also monitors provider accessibility and responsiveness through member complaints and our annual member satisfaction survey. Personal Care Agencies must have a process in place to identify providers that do not show up for appointments (i.e.

telephone verification system to "punch-in" from the member's home). Agencies will have a process in place for sending another provider if one does not show up for an appointment, usually by having a pool of back-up providers on stand-by.

Case managers coordinate with the treating physician, home health, durable medical equipment provider and community agencies, as indicated, to ensure member has timely access to care and services. For behavioral health services, no reduction in community based services should occur under a MCO carve-in and its care management processes. Because WVFHs intend to implement more extensive care management oversight, there should be additional levels of outreach and proactive identification of members resulting in a decrease in inpatient hospitalizations or reduced hospital length of stays. In addition, WVFH will allow even more extensive services without authorizations, and the grievance and appeals process will likely result in less intervention and fewer opportunities for denied services to occur that would result in a member or provider grievance or appeal.

Communications and Training

In addition to providing initial training, ongoing training for advocates, providers, and other stakeholders will be necessary.

1.1.18 Describe how a vendor would provide outreach and training in an ongoing manner to youth and young adults and their respective caretakers who are eligible for services. WVFH will employ member education and outreach techniques, specific to youth (children) and young adults. The combination of mail, telephonic, and Interactive Voice Response (IVR) outreach intervention has demonstrated success in improving screening rates for several quality metrics including: well-child visits, EPSDT compliance, dental appointments, lead screening in children, appropriate treatment for children with upper respiratory infections, cholesterol management for patients with cardiovascular disease, LDL-C screens, and management of hypertension in diabetics.

WVFH has processes and procedures in place to identify members and their caregivers/parents with or without special needs and to perform a comprehensive assessment and to conduct a health risk assessment. The use of validated assessment tools help to construct person-centered care plans that are developed with the member and shared with the members, caregivers/parents and their families, PCPs and specialists, which helps members to get the services they need and helps providers to stay on track with treatment that achieves the member's goals. The Case Manager helps the member with any obstacles to following the care plan. Working collaboratively, Case Managers ensure members receive high quality education, supportive counseling and timely care coordination. Consultation between the Case Manager and behavioral health providers occurs whenever increased coordination and collaboration is required, with the permission of the member.

For its members, WVFH will develop and disseminate general and disease-specific education that is designed specifically for the target audience and considers gender, race, and disease-state. All member materials are written at a sixth (6th) grade reading level. In addition, WVFH's approach to lifestyle management will include a specific registry and specific identification and stratification criteria. Once the members are stratified into one of five levels, the following interventions will be provided:

a. Population-based interventions will be directed toward all members and /or PCPs and include newsletter articles for members regarding various disease conditions (asthma, cardiac disease, diabetes, hypertension, etc.) and self-care tips (healthy eating, weight control, hygiene, smoking, etc.), as well as telephonic pre-queue messaging that addresses healthy diet, exercise, smoking, and reminders for various testing and screenings. The WVFH website also contains health tips, searchable health topics, and information for a healthier lifestyle.

b. Members in the lifestyle management registry will receive educational mailers addressing issues such as the importance of medication adherence, screenings, and PCP follow-up. Members who are new to the registry will receive a welcome letter with instructions on how to contact us for additional information or assistance.
c. Telephonic Case Managers will work with members to provide disease-specific education, health coaching, care coordination and referrals for their health condition(s) as well as any co-morbid conditions. Either medical or behavioral health Case Managers will also collaborate with the pharmacy department to address members who have gaps in medication fills, lock-in, non-PDL medications, or other pharmacy-related issues/concerns.

WVFH will outreach to the member or to the caregivers/parents, as appropriate, to discuss preventive health or condition-specific topics based on health risk assessment or claim data data-mining results. Interventions include:
a. Quarterly outreach reports, specifically focused on well-child visits and young adult preventive screenings/tests will be generated for members that are due, or overdue, for an EPSDT screen based on age and claims criteria or are due, or overdue, for an adult preventive health screen or test.
b. Outreach Representatives will contact members to provide education on the importance of obtaining timely preventive care, to assist the members in scheduling appointments, and to coordinate medical assistance transportation. Reminder calls for future appointments are also available, upon request.
c. WVFH designed, implemented and is successfully using a software application, called Care Gap, that allows Outreach Representatives to immediately see a flashing red button on their computer screen that serves as an alert that a member is in need of testing, screening, or health education. A lack of encounter data for one of these health requirements activates this alert. When interacting with members, the clinical and member services staff will see Care Gap alerts on the member profile and take the opportunity to discuss preventive health or condition-specific testing, screening, or health education.
d. IVR campaigns and age-appropriate text messaging will also be used by WVFH to educate members and provide specific disease and preventive health information and /or self-care tips.

1.1.19 Describe how a vendor would coordinate with other state agencies, health organizations, and community providers, as necessary, to ensure compliance with Section II.D (goal) of Sanders Compliance Plan, thus curtailing the likelihood of a party to petition the Court to reopen Sanders et al v. Lewis, as allowed in Section IX (Dispute Resolutions, Modifications, and Case Termination) of the Sanders Compliance Plan. WVFH will work closely with Foster Care Liaisons, the Sanders Field Liaison, as well as any and all other applicable state agencies, health organizations and community providers in order to make sure that eligible children in out-of-home placement receive the necessary EPSDT consistent with federal and state law and the Sanders Compliance Plan. WVFH will coordinate with the aforementioned entities in order to inform all Medicaid-eligible children and their caretakers of the availability of EPSDT services. WVFH will provide informational materials and forms, run reports, provide the contact information of its EPSDT providers and meet with state and local agencies and organizations, as necessary. In addition, WVFH will take steps to ensure that its providers are delivering quality EPSDT care to children in out-of-home placement in accordance with applicable laws and regulations.

1.1.20 Describe how a vendor would ensure that all children in temporary or permanent legal custody who are in out-of-home placement receive the full benefits of the EPSDT program. Outreach Representatives conduct telephonic outreach to members and their caregivers/parents and send educational mailings to all targeted members based on appropriate age/claims criteria. Pediatric and adolescent members will be sent educational mailings with the goal of educating and encouraging members and their caregivers/parents to ensure the member has access to timely preventive health services. These types of mailings will include:
a. A Member Handbook, which includes information defining EPSDT services and how to obtain these services, will be mailed upon enrollment.

b. A Preventive Health letter identifying screenings that are due or overdue will be mailed to members that are unable to be reached telephonically by the outreach representatives
c. Birthday cards will be mailed in each member's birthday month, to remind them to get regular checkups.
d. "It's Time for a Check-up" letter will be mailed quarterly to all members under the age of 21 who have been identified as being due for an EPSDT screening in the past 12 months

Children (all members under the age of 21) will be automatically enrolled in the EPSDT program which entitles members to all medically necessary services, including well-child care, immunizations, screenings, expanded and wrap-around services, regardless of whether the service is included on the Medicaid State Plan. WVFH will discuss with the caregivers/parents of pediatric members the need to establish a medical home by choosing a PCP and getting regular and timely checkups. Children with chronic conditions such as asthma and diabetes will be included in the aforementioned lifestyle management registry and their households will receive age-appropriate mailings that include:
a. Preventive health telephonic outreach by a dedicated team of Outreach Representatives
b. Targeted mailings and outreach for children ages birth to 15 months of age
c. Targeted mailings and outreach for children in the second, third, fourth, fifth and sixth years of life
d. Targeted mailings and outreach for children ages 7 to 21 years old

Materials developed to target young children will be directed to the caregivers/parents of those children and address issues such as EPSDT services, lead screening, safety, and child care. Materials developed to target adolescents will be directed to the adolescent and address issues relevant to that population such as safety, tobacco, sexuality, EPSDT services, and behavioral health. Member materials developed to target young adults will address preventive health screenings, management of chronic conditions, and general health education such as nutrition, exercise, and smoking cessation. All educational materials will be evidenced-based and reviewed and updated annually.

1.1.21 **Describe how training and technical assistance would be provided on an ongoing basis to new enrollees and their parents and caregivers, as well as new providers and other interested parties.** New WVFH members will be contacted, welcomed to the plan, and receive important new member. WVFH will outreach to all newly enrolled members with a "vulnerable youth" category to conduct a health risk assessment and determine any needs related to care coordination, including transitioning from a non-network provider to an in-network provider.

Using a combination of the website and approved marketing items/new member materials, WVFH would reach out to newly eligible enrollees after accepting WVFH. These materials will be prepared and mailed within 5-7 business days from receipt of the enrollment files from BMS. WVFH would anticipate a need to ensure the new member package clearly has information related to:

- ID cards with information related to how to access services as well as a Member Handbook
- Available benefits matrix and member service contact information
- Instructions on PCP selection
- General health information, possibly focused on age, gender and other related factors
- Website access instructions, information, and site address

Education materials will be designed and made available to new enrollees based on the primary health related issues prevalent in the WV area, and would include materials on smoking cessation, smokeless tobacco, weight management, nutritional articles, etc. These items will be mailed to enrollee home addresses via newsletters and published on the WVFH website for general review.

WVFH understands the importance of facilitating a smooth transition for members as they change managed care services. A critical need in transition is ensuring that all aspects of the managed care organization's care plan are communicated to the new entity. In order to ensure that this process occurs, WVFH will reach out to APS or another MCO for transition planning for members in inpatient and other higher levels of care on the day of transition. We anticipate that APS or other MCO will communicate to each patient in care management that a transition is occurring. After the member is notified of the change, the WVFH medical and behavioral health Case Managers will reach out to members through phone calls, letter, and home visits, if indicated to engage the member in the new care management process. The Case Manager will also work with APS to ensure continuity with the APS-developed treatment plan, if appropriate.

For the new enrollees, PCPs may need training on the availability of social services and other community-based agencies. Case Managers and provider relations teams connect with FQHCs/PCPs to provide this education, which occur onsite during regularly scheduled site visits and specially scheduled training visits, as well as through webinar trainings. Education will be provided to the provider network upon entry into the network and on an ongoing basis, as well as during goal and targeted visits, hospital orientations, individual and group practitioner orientations presented by the Provider Relations Department. Provider education and training work plans include the training curricula, schedule and/or frequency of programs, as well as a brief description for each training module. The Provider Relations Representative will visit and orient all new hospitals within 30 days of becoming contracted. Representatives from registration, billing, admissions, and utilization management will be invited to attend. At the time of the orientation, the Provider Relations Representative will supply a copy of the QI Manual and review pertinent information from Provider Policy and Procedure Manual. The Provider Relations Representative will provide EPSDT training, review appropriate referrals for mental health, drug and alcohol and substance abuse, sensitivity training on cultural diversity, care management/disease management programs for the special needs population, authorization and referral guidelines including the process for requesting standing referrals, among other WVFH administrative processes. The Provider Relations Representative will deliver all necessary forms, manuals and reference materials to assist the hospital and providers in successfully treating WVFH members. New practices to WVFH will receive an orientation within 30 days of becoming a credentialed participating provider. If a new practitioner joins an existing practice, all new practitioners joining an existing practice will be offered an orientation within 30 days of becoming credentialed and approved. Annually, the Director of Provider Relations will review the need to conduct group practitioner orientations for existing counties, as a part of ongoing training and education. There will be provider target visits and goal visits scheduled, and annually each Provider Relations Representative will schedule one goal visit with each PCP, OB/GYN and high-volume specialty practices as a part of ongoing training.

1.1.22 How would a vendor ensure that staff and contracted providers, including hospitals, pharmacies, and specialty-care providers receive training on this program, including what is and is not allowable exchange of information in a HIPAA compliant organization, in order to preserve and support continuity of care?

Training will be provided to the staff and contracted providers, including hospitals, pharmacies, and specialty-care providers through several different messaging models to ensure the training reaches the providers, office staff, and others capable of impacting the member's care. The messaging will be communicated during:

a. Provider workshop sessions and training webinars
b. Onsite office site visits
c. The distribution of provider newsletters and flyers
d. Provider Manual and related updates
e. Benefit change communication messages
f. Other written and oral communications

WVFH will identify members with special needs and to perform a comprehensive assessment and a health risk assessment. WVFH will use the assessment tools to construct person-centered care plans and will share this information with the member's PCP/specialist as deemed necessary to care for the patient and ensure members have access to the identified health care. This helps providers with treatment and tracks the member's success in achieving identified health goals. The Case Manager assists the member in overcoming obstacles or challenges to following the care plan, thereby modifying the plan as needed. Case Managers also work collaboratively to ensure members receive quality education, supportive counseling and timely care coordination as needed to optimize success. The care plan will be shared with the member, caregivers/parents and the family as prescribed by HIPPA guidelines and with appropriate member authorizations. Additionally, consultation between the Case Manager and behavioral health providers occurs whenever increased coordination and collaboration is required, with the permission of the member. This would include information related to hospitalizations, pharmacy medication management, and other treatment plans which the member is actively participating in. Members must give their consent for providers to coordinate a member's care, requiring the Release of Information (ROI) and BH/PCP Communication forms.

1.1.23 How would a vendor ensure that providers are aware of the requirements of this managed care or managed care-like program for foster, former foster and adoption support children, and how the needs of this population may differ from those in the traditional Temporary Assistance for Needy Families (TANF) MCO population? WVFH has significant experience and expertise in care coordination for medically fragile or vulnerable children which includes the children in foster, former foster or adoption situations. WVFH will leverage this experience in assigning a Case Manager to each of these children. The Case Manager will be responsible for ensuring that the child's services are received in a timely and efficient manner. Outreach will be made to the child's PCP/specialists to discuss special circumstances and needs of the children and to close any care gaps. The Case Manager will serve as a health advocate for the vulnerable children and work diligently with practitioners, care givers and other ancillary providers to ensure that the child's needs are met. WVFH will provide the same level and types of services as those currently available through the CSHCN program (whose needs are more like the vulnerable child than the TANF child) including access to multidisciplinary care. When children with special needs are away from home, for example in substitute care, transitional care, adoptive care or medical foster care, the Case Manager will assist agency staff and/or temporary caregivers with care coordination to ensure that those children receive timely EPSDT services and do not experience any delay in having other healthcare needs addressed. WVFH will employ member/provider education and outreach techniques, specific to adults versus children. The combination of mail, telephonic, and IVR outreach intervention has demonstrated success in improving screening rates for several quality metrics in the current membership. Messaging around program requirements will be communicated:

a. At provider workshop sessions and training webinars
b. During onsite office site visits
c. With the distribution of provider newsletters and flyers
d. Via integration in the Provider Manual and related updates
e. As benefit changes are announced by the State
f. Through value add and quality initiatives around this dedicated population
g. Review of HEDIS and other quality measures, as well as through chart review and outreach
h. After a focus issue is identified as a Quality Improvement initiative for WVFH
i. Through other written and oral communications focused on this population

1.1.24 How would a vendor inform eligible members to educate them about their ability to participate in this program and what benefits are available to them? Member services representatives and care management staff will receive training on the newly carved-in benefits and expansion population including detailed review of newly

carved-in benefits, applicable authorization criteria, overview of demographics of the expansion population, and training on how to access online reference tools specific to the newly carved-in members. After identification of the "vulnerable child or youth" (either by the enrollment brokers' identification of members, care management health risk assessments, or provider referrals), assigned clinical staff will be responsible for conducting member outreach. Outreach will be coordinated with existing providers, including FQHCs/PCPs, wherever possible. WVFH will use the following tools to conduct outreach and attempt to engage referred members in our high-risk case management program:

a. Coordinate with PCP/specialist to notify member about the program and educate them about the benefits
b. Develop and distribute mailings as well as conduct outreach phone calls
c. Provide in-person outreach during acute inpatient stays
d. Identify effective mechanisms, frequency, and member outreach strategies
e. Prepare a PCP Dashboard Report on a quarterly basis that details several key screenings, tests and/or visits that the PCP's panel membership is missing. This gives a quick snapshot regarding what discussions PCPs may want to have and/or recommendations they will want to make related to WVFH members and identifies new members to the practice within the past three months.
f. EPSDT Reports will be prepared monthly to identify members under age 21 that have not had a well-child visit in the past year. Care management will telephonically outreach to those members within thirty (30) days.
g. Care Gap software allows any staff person who is speaking with a household or provider to see a flashing button on the computer screen that serves as an alert indicating members in the household that are in need of some type of testing, screening or primary care services. Staff will discuss the care gap(s) with the member during that call and assist with scheduling an appointment and arranging transportation, if needed.
h. Periodically, ad hoc reporting will be prepared by staff targeting certain groups of members based on age, ethnicity, geography, or other factors for outreach campaigns that include primary care services. Staff will identify, via claims data, members in those groups who have not had primary care services and engage these members telephonically, via mailed materials or automated voice recording.
i. Newsletters and outreach materials will be prepared to focus on benefit changes as well as reminders of all ongoing benefits and services that are available to the WVFH members.

1.1.25 Outline the proposed content to be included in a provider manual for both physical and behavioral health.

At the present time, the provider manual for all WVFH providers addresses the physical health requirements that are applicable to servicing of WVFH members. In addition, a full behavioral health provider manual has been developed for the providers that would service the behavioral health needs of WVFH members. These documents are available for review upon request.

1.1.26 Provide a brief description of provider training programs. Please distinguish between training programs for PCPs, acute care providers, behavioral health and community-based services providers. The description should include:

a. The types of programs that would be offered, including the modality of training
b. What topics would be covered (billing, complaints, appeals, telemedicine, etc.)
c. Strategy for training providers on requirements of contract an unique needs of population
d. How provider trainings would be evaluated
e. The frequency of provider trainings

WVFH will educate the provider network on enhancements in place to assist with caring for members, including those with complex needs. Education and orientation will be provided by the Provider Relations Department on an ongoing basis, during goal and targeted visits, hospital orientations, individual and group practitioner orientations. The objective of all visits and orientations will be to ensure network practitioners and hospitals understand the MHT Medicaid program, WVFH policies and procedures, and standards of care. Provider

education and training work plan, outlined below, includes the training curricula, schedule and/or frequency of programs, as well as a brief description for each training module. An index of each training module is also included which indicates if the training will be targeted towards new providers or be part of the ongoing training for existing providers.

WVFH is keenly aware that, to provide exceptional access and quality of healthcare to its members, it is essential that network providers and their staff have a solid understanding of the member's needs, WVFH contract requirements and other protocols, as well as applicable contract standards and Federal and/or State regulations. Each participating primary care practice, specialty care practice and hospital will be assigned a Provider Relations Representative, who is responsible for ongoing education in their assigned Service Region. As a follow-up to the initial orientation session, the assigned Provider Relations Representative (PR Rep) will regularly contact each provider and their staff to assure that they fully understand the responsibilities outlined in the Provider Agreements and Manual. Several types of orientation and visit opportunities have been created to complete outreach to providers.

Practitioners (individual orientations) – The PR Rep will call, send an e-mail or letter offering an orientation to all new physicians within 30 days of becoming credentialed and approved. At the time of the orientation, the PR Rep will provide a copy of the QI Manual and review WVFH Provider Policy and Procedure Manuals with the practitioner and/or office staff, in detail, at this on-site orientation. The PR Rep will provide EPSDT training, review appropriate referrals for mental health, drug and alcohol and substance abuse, sensitivity training on cultural diversity, care management/disease management programs for the SSI/Special Needs population, and authorization as well as referral guidelines, including the process for requesting standing referrals, among other WVFH administrative processes. The PR Rep will deliver all necessary forms and reference materials to assist the provider in successfully treating WVFH members. PR Reps provide introductory training to providers and their office staff.

Practitioners (group orientations) – Based on attendance records of previous group orientations, looking at the number of policy changes since the last orientation, and considering input from PR Reps, there will be recommendations for orientation content. The Orientation Planning Committee will organize and plan all group orientation timelines and content. All group orientations will reference the current WVFH Provider Policy and Procedure Manual, QI Manual, and continuity of care requirements. At the time of the orientation, providers will be asked to register and a packet of information will be given to each enrollee at the time of their registration outlining the presentation for the orientation and will serve as a source of the relevant policies and procedures to the provider. The following WVFH provider supplies will be made available to attendees: referral forms, reference materials, QI Manuals and the WVFH Provider Policy and Procedure Manual, as needed.

Practitioner Goal Visits - Each PR Rep will schedule one goal visit per year with participating practices in the area of Primary Care, OB/GYN, and High Volume Specialists. Practices that are not High Volume specialty providers will receive a letter offering a re-orientation. The agenda will include:

a. Review of Referrals/Standing Referrals and Authorization Guidelines
b. Coordination of Care, including Behavioral Health
c. Review of guidelines for Encounter submissions and inclusion of all charted ICD-9 codes on claims
d. Review of Accessibility Standards
e. Discussion of Healthcare Disparities/Cultural Sensitivity policies
f. Review of EPSDT Billing Guide and Periodicity Schedule/Dental referrals
g. Review of Care management/Disease Management Programs for SSI/Complex Needs beneficiaries

Practitioner Targeted Visits - Additional targeted visits will be performed on an as needed basis. Some of the reasons for additional targeted visits may include low EPSDT rates, encounter data submission, or provider profiling, etc.

Hospital (Initial Orientation) - PR Rep will visit and orient all new hospitals within 30 days of becoming contracted. Representatives from registration, billing, admissions, and utilization management will be invited to attend. At the time of the orientation, the PR Rep will supply a copy of the QI Manual and review pertinent information from WVFH's Provider Policy and Procedure Manual. The PR Rep will provide EPSDT training, review appropriate referrals for mental health, drug and alcohol and substance abuse, sensitivity training on cultural diversity, care management/disease management programs for the SSI/Special Needs population, authorization and referral guidelines including the process for requesting standing referrals, among other WVFH administrative processes. The PR Rep will deliver all necessary forms, manuals and reference materials to assist the hospital in successfully treating WVFH Medicaid members.

Hospital (Re-orientations) - PR Rep will offer a reorientation to all participating hospitals once a year. A letter or email will be sent to either the CFO or the PR Rep's direct hospital contact. The hospital billing, ER, admissions, and UM departments should all be invited to attend the reorientation. At the time of the reorientation, providers are asked to register; a WVFH packet of information will be given, at the time of registration, to each enrollee that outlines the presentation. Relevant policies and procedures will also be provided. At the time of the presentation, the following WVFH provider supplies will be made available to attendees: WVFH At-A-Glance reference guide and the WVFH Provider Policy and Procedure Manual.

1.1.27 Provide a description of member education materials and *how* a vendor might use them to inform and educate members. WVFH will work closely with the Chief Medical Officer, PCPs/Specialists, behavioral health providers, pharmacy operations, care management staff, local FQHCs, clinics, and community organizations to assure that member materials are developed with the members' special needs in mind. Care management staff will utilize Healthwise® for evidence-based clinical guidelines to conduct assessments and manage cases, which provides up-to-date clinical information to aid in member education, care planning and follow-up. In addition, the use of Healthwise® for the Care Management staff promotes consistent education and management of members with special health care needs. WVFH is committed to assuring that its members, including those with special health care needs, communication barriers, physical challenges, lower literacy, and those who are non-English speaking, have access to member materials that are designed with those special needs in mind. All member materials are written at a sixth (6th) grade reading level and use plain language in accordance with BMS requirements. Topics include:

- General education for disease
- Injury prevention
- Wellness education
- Nutritional education
- Prenatal care/newborn care
- Stress management
- Weight management
- Tobacco cessation
- Member Handbook
- Other beneficial programs

1.1.28 Describe how a vendor would work with caregivers to help them track appointments or tests that enrollees are scheduled for and may miss without further reminders or assistance. Providers can request assistance from WVFH staff to telephonically follow-up with members who need further explanation on the importance of keeping scheduled appointments and obtaining referrals for specialty care. Practitioners can fax a Member Outreach Fax Form for the following reasons:

a. Education regarding compliance with recommended testing, such as blood lead level testing
b. Scheduling assistance for EPSDT screenings
c. Education about the potential implications of chronically "no-showing" for preventive appointments

In addition to the provider requests for outreach, WVFH will outreach to the member or caregivers/parents to discuss preventive health needs. Interventions include quarterly outreach reports, specifically focused on well-child visits and adult preventive screenings/tests will be generated to members that are due, or overdue, for an EPSDT screen based on age and claims criteria or are due, or overdue, for an adult preventive health screen or test as well a reminder calls for future appointments are also available, upon request.

1.1.29 Describe how a vendor would coordinate with the WV Bureau for Public Health and services that are provided by that bureau to improve care, including how a vendor would propose to interface with the State's technology system. WVFH would work to coordinate with the state agencies and services to allow for interface in State technology systems as proposed by the State upon award of the program contract.

1.1.30 Describe the approach a vendor would take in developing services that range in intensity and restrictiveness (in terms of community integration) based on member situations, or an alternative approach to best meet the needs of members with varying levels of needed care. WVFH has policies and procedures in place to grant a member a standing referral to a specialist if the member has special health care needs that require very complex, highly specialized health care services expected to last six (6) months or more, and by virtue of the complexity, it would be difficult for a primary care physician (PCP) to manage. Specialist providers must collaborate with the member's PCP to coordinate other needed services or care. Members who have a special healthcare need and desire a standing referral will be referred to the Case Manager. The Case Manager will collect all necessary information, including the treatment plan from the provider, and route the request to a Medical Director for review. Approvals are generally granted for six (6) months and up to one (1) year depending on the member's anticipated length of treatment. Specialists may admit patients for inpatient care, choose the hospital of admission, and keep the patient hospitalized. All WVFH members will be required to obtain a valid referral from their PCP, prior to receiving specialty services, except for the services that can be accessed by a self-referral. The only exception to this is for Neonatologists who may issue a referral to other participating hospitals and/or specialists for babies discharged from the NICU who require services before seeing their PCP. The admitting physician will be required to obtain inpatient authorizations. If additional specialty care or diagnostic testing not authorized on the original referral is needed, the specialist will need to contact the member's PCP to obtain another WVFH referral unless the procedures are being performed on the same date of service and in the same office as indicated on the original referral.

In an effort to assure a consistent level of quality, WVFH will contract with many participating hospitals and laboratory facilities for outpatient laboratory services. WVFH providers will be required to have all of the member's outpatient laboratory work completed through the appropriate contracted lab. At the time of the initial orientation, the PCPs will be required to select a designated laboratory based on office location and the lab used most frequently. WVFH will require participating practitioners to utilize the member's specific designated laboratory, based on their PCP's selection, for any and all studies required for WVFH members. The designated laboratory will be listed on the member's ID Card. If the member's designated lab is not used, the ordering specialist will be required to contact the member's PCP to request a referral to the non-designated lab.

WVFH understands that access to community resources and social services is critical to its members and is an essential component of the care delivery model for its members. Members can call Member Services to obtain information about community resources and social services agencies. The staff has access to the Community Repository utilizing on-line resources developed by WVFH to locate a myriad of community resources. The community repository was developed to specifically to assist staff in locating community resources most frequently required by our members. The repository is constantly updated and currently contains over 3,500 agencies. Members will be made aware of available community resources and social services using a variety of

methods including a member newsletter, the WVFH website, Case Managers and member services representatives. Some examples of community resources include support for domestic violence, WIC, and tobacco cessation. Members assigned to a Case Manager will receive a comprehensive and holistic assessment to identify all barriers to care including medical and non-medical. Case Managers work collaboratively with the member and/or responsible caregivers/parents to determine the appropriate community resources to meet the member's needs. The Care Management interventions could include referrals to the following agencies/organizations: Meals on Wheels, Lions Club, Special Kids Network, Make-A-Wish Foundation, Support groups, neighborhood centers, food banks, WIC, shelters, housing, American Cancer Society, Energy Assistance Program and religious organizations.

1.1.31 **Describe how a vendor would handle multiple placements/removals in a way that is as seamless as possible for the child?** When children with special needs are moved between placements or away from home, for example in substitute care, transitional care, adoptive care or medical foster care, the Case Managers will assist agency staff and/or temporary caregivers with care coordination to ensure that those children receive timely services and do not experience any delay in having other healthcare needs addressed through outreach and tracking. Based on information provided by the State or information received from families or caregivers, the member will be tracked and outreach continued by the assigned Case Manager. The new caregiver will be encouraged to continue established relationships with the member's assigned PCP or specialists, as well as any behavioral health providers. Also, written communication and verbal outreach will be tracked if either indicates a change in guardianship with the records updated and new contact information obtained.

1.1.32 **How would a vendor handle out-of-state placements, and how would a vendor make recommendations for how best to help develop in-state services to bring youth back to West Virginia and as alternatives to sending youth out of state?** WVFH will assist members or their caregivers/parents with finding and selecting an appropriate in-state (in-network or out-of-network) provider that meets the access and availability standards required by BMS. To assure continuity of care, an authorization can be provided to the out-of-network (in-state) provider until an appropriate in-network (in-state) provider is located and able to begin services. WVFH will facilitate the secure transfer of clinical files, including care plans, to the newly selected in-network provider with appropriate member consent.

Regardless of whether services are medical, dental, or behavioral health, WVFH has an established process for handling referrals for out-of-network care. Members and providers will be informed about how to request out-of-network care. WVFH will allow members, on a case-by-case basis, to receive their ongoing course of treatment from an out-of-network (and potentially an out-of-state) provider if the member is unable to safely transition to an available and accessible in-state provider. Elective out of network provider services, and emergency inpatient admissions at out of network facilities, will require authorization from WVFH, but authorizations will not be withheld to continue the services, reduce, delay or interrupt the receipt of the services, prior to the concurrent review. Out-of-network authorizations will be reviewed, on a monthly basis by the Provider Contracting Department to identify and address network gaps. WVFH's network development activities almost never leave a permanent gap in any given provider network. In those cases where there is not an in-network provider who can meet the member's needs, WVFH will attempt to arrange for telepsychiatry services with the provider for that member under the direction of the PCP, specialist or the behavioral health practitioners.

1.1.33 **Propose a plan for alternative payment structures (e.g. provider incentives, overcoming limitations of diagnosis-driven eligibility) to increase quality and efficiency through collaboration and innovation to improve access to comprehensive health care. The plan should include:**

a. Identified opportunities for cost savings

b. Reductions in inappropriate utilization of services, including inappropriate admissions and readmissions

c. Mechanics by which incentive payments to providers to improve quality of care would be made

d. Quality metrics that would be required for provider incentives and shared savings

WVFH has a policy in place for ensuring there are no financial incentives utilized that could encourage barriers to care or service. The following draft language will be included in the annual provider newsletter: "UM decisions are based only on the appropriateness of care and services and existence of coverage. Practitioners or other individuals are not specifically rewarded for issuing denials of coverage or service. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. WVFH monitors for both over and underutilization of care to prevent inappropriate decision-making, identify causes and corrective action, and to indicate inadequate coordination of care or inappropriate use of services. WVFH is particularly concerned about underutilization and monitors utilization activities to assure members receive all appropriate and necessary care.

Alternative payment structures could include PMPM care management capitation arrangements with WVFH oversight, as well as the Chief Medical Officer's oversight and review, as deemed appropriate by WVFH's internal care management team. These payment structures would be dependent on successfully achieving high quality standards across quality measures deemed appropriate for the specialty types.
PCP or specialist incentives could be implemented to encourage quality and access to health care. For example, providers would be scored on their ability to meet standards on selected quality measures. Based on success across a population of patients, quality provider incentives could be offered for the following services:

a. Health Assessment (Initial upon assignment or selection of the PCP or Specialist serving as the PCP)
b. EPSDT (with emphasis on EPSDT within 72 hours of placement)
c. Dental referrals by PCP (when they result in a scheduled appointment with a dentist)
d. Completion of the PRSA for the pregnant members within the first thirteen weeks of pregnancy.
e. Medical management for members (specifically identified by WVFH) who are not taking their medications as prescribed resulting in sub-optimal dosing, sub-therapeutic dosing, polypharmacy, quality alerts (i.e., pregnant women on psychotropic medications, children on multiple anti-psychotics), and outlier prescribing patterns. Through analyses of an integrated data file (combined prescription, medical, and psychiatric claims), WVFH can identify claims-based, medication-related problems based upon available evidence and established best practices.
f. Appropriate follow up on inpatient (medical or behavioral) admissions, including incentives if no re-admission within 60 days of discharge.
g. Reduction in emergency room utilization for members (specifically identified by WVFH) who have been frequent-utilizers in the past, i.e. no additional "inappropriate" ED encounters for 120 days.
h. Wellness initiatives performed during routine office visits, i.e. smoking cessation counseling, weight or BMI counseling, substance abuse referrals to behavioral health providers by PCPs, etc.

WVFH believes there is a high opportunity for cost savings available for this population by consolidating of all aspects of the member's health management in a managed care arrangement through consolidating medical, physical and behavioral, along with pharmacy and dental services into one organization. In addition, additional savings could be available by incorporating long-term care and personal care services for this group as well.

1.1.34 Describe the need for a member and/or nurse hotline, and if deemed appropriate, the functionality of such an option, including hours of operation, staffing, and training needed. If the member has a health care concern, WVFH offers a 24/7/365 Nurse Helpline (phone number appears on the back of the member's WVFH ID card) to assist members with understanding the nature of their issue, answer health care questions, and help member make good health care decisions. Health Dialog is staffed with registered nurses who make sure members get the medical care needed in the most appropriate setting. They will assess the callers information and either refer the caller to the assigned PCP (number appears on the member's WVFH ID card) or an alternate provider/urgent care center or emergency room (if member is too far away to see their assigned PCP). If the call is an emergency, members will be told to call 911. The Nurse Helpline is not meant to replace the medical advice of

the PCP. Members are reminded that they can reach the PCP 24 hours a day at the number on the WVFH ID card. After normal business hours, leave your name and phone number with the PCP's answering service. The WVFH Member Handbook also gives directions and contact information for the Nurse Helpline.

1.1.35 Describe the process for ensuring continuity of prior authorized services when a member transfers from a fee-for-service program to a managed care type of program, including how a vendor might authorize the member's out-of-network providers to complete an existing treatment. WVFH understands the importance of facilitating a smooth transition for members as they move from fee-for-service (or another managed care organization). A critical need in transition is ensuring that all aspects of the prior care plans are communicated to the WVFH. In order to ensure that this process occurs, WVFH will reach out for transition planning to either APS for behavioral health services, MCO for member transfers, or FFS on member transfers wherever possible for existing care plan information. This will allow the Case Manager to evaluate issues with in-network vs out-of-network providers. In addition, all members who are deemed to be inpatient and at extremely high levels of care will have care management outreach to their assigned PCP, specialist or behavioral health providers. Also, outreach will be made early to the member or their caregivers/parents to ensure continuity and continuance of care early in the transfer. Well before the transition date, WVFH will engage wherever possible to develop a process to ensure the appropriate communication for prior authorization is incorporated into our planning for the care of upcoming members. WVFH anticipates that FFS (for medical/physical health) or APS (for behavioral health) will communicate to each patient in care management that a transition is occurring related to behavioral health services. After the member is notified of the change, the WVFH Case Manager will reach out to members through phone calls or letter, if indicated to engage the member in the new care management process. WVFH has an established policy that allows a member to continue an existing relationship with an in-network or out-of-network provider, or with a provider who leaves WVFH's network, under the following circumstances:

a. When there is continuity of care issues
b. When a participating provider cannot provide the service
c. When a participating provider is not accessible or available

1.1.36 Describe how a vendor would evaluate and make certain that changes in provider are appropriate for the member's unique healthcare needs. If a member is currently in an active course of treatment with an out-of-network provider, WVFH will request clinical information including necessity for an out-of-network provider. When a member is receiving an active course of treatment for chronic or acute medical conditions, WVFH will allow continued treatment for the illness. Female members who are pregnant will be automatically approved for continued treatment through the post-partum period after delivery. If a member under 21 years of age transfers from FFS or another managed care plan, WVFH will approve out-of-network services based on the quantity, length, and scope of services specified by the originating program upon confirmation of an existing authorization. Additionally, WVFH will perform a concurrent review of services with an existing authorization, on a case-by-case basis, to determine the potential for transition to an in-network provider. The case will be reviewed by, but not limited to, the PCP, the non-participating provider and/or WVFH's Medical Director. WVFH will not withhold the authorization to continue the services, reduce, delay or interrupt the receipt of the services, prior to the concurrent review.

WVFH will also approve an out-of-network authorization either if a participating provider is not able to provide a covered service, or if there is not a participating provider who is accessible or available to the member. This determination will be based on the access and availability standards outlined in the managed care organization agreement (30 minutes to PCP and frequent-use specialists, 45 minutes to basic hospital services, and 60 minutes to tertiary services). Exceptions to the standards may be made based on the accessibility to the community-at-large.

1.1.37 Describe how a vendor would identify and track new members with high physical or behavioral health needs to assure continuity of care. Health risk assessments will be performed on children entering WVFH previously identify as a "vulnerable child" with special physical or behavioral health needs. Conditions/criteria considered when determining if a member possesses special health care needs are as follows: members at an increased risk for having a chronic physical, developmental or behavioral condition and those who also require health and related services of a type or amount beyond that required generally. Examples of conditions that are considered to deem a member as having a special health care need include: diabetes, COPD, cardiac disease, asthma, pregnancy, HIV, serious trauma, physical/mental disability, active cancer, uncontrolled hypertension, or developmental delay. In addition, any member that has a serious or complicated physical and/or psychosocial issue and would benefit from care management will be contacted by a Case Manager. Upon the enrollment brokers' identification of members with behavioral health needs, assigned behavioral health clinical staff will be responsible for conducting member outreach. Outreach will be coordinated with existing providers, including PCPs, specialists or behavioral health providers, wherever possible. WVFH will use the following tools to conduct outreach and attempt to engage referred members in our high-risk case management program:

1. Coordinate with the PCP and other providers to notify members about the program and educate them about its benefits
2. Develop and distribute mailings as well as conduct outreach phone calls
3. Provide in-person outreach during acute inpatient acute or psychiatric stays, as needed

1.1.38 Describe how a vendor would develop a plan to identify and reach out to members with the most immediate service needs leading up to and immediately following implementation of a program. Health risk assessments performed on children entering WVFH will be scored and ranked to determine those with the greatest need for immediate service and coordination of care from the group identified as a "vulnerable child" with special physical or behavioral health needs. These members are at an increased risk for chronic physical, developmental or behavioral condition (i.e. addiction, diabetes, asthma, HIV, active cancer, physical/mental disability, behavioral risks, or developmental delay).

1.1.39 Describe the process a vendor would follow to review member complaints, questions, and appeals. The process should start from the receipt of a request and describe each phase of the review including notification of disposition. WVFH is committed to assuring that members with special needs have access to care. Member complaints, questions, grievances or appeals regarding access barriers will be referred to the Provider Relations Department for investigation and follow-up where staff will assess the basis of the complaint, outreach to the provider, re-educate if necessary, or make appropriate referrals to the Provider Contracting Department for network recruitment. On a quarterly basis, complaint and grievance data will be compiled, reviewed and analyzed for trends. The trends will be reviewed and compared to availability and accessibility information. This data will then be brought the internal QI/Delegation Oversight Subcommittee for review and discussion, with further action being taken, as needed. Finally, the complaint and grievance data regarding access barriers will be reviewed, on an annual basis, for further analysis to identify baselines, network gaps, and member satisfaction.

Member Services personnel are trained to meet the special needs of these members, which includes assisting with complaints, questions, grievances or appeals to members with physical and developmental disabilities. The Member Aide program has specially trained Member Aides to assist members, as needed, with complaints and grievances through the entire process, if requested. Additionally, members will also be referred to Care Management for further assistance with any care coordination needs, if requested. WVFH maintains a dual evaluation system whereby a Member Aide's performance is evaluated by an Appeals Coordinator working on the

case. The completed form is sent to the Member Aide's Supervisor for discussion during monthly coaching sessions.

Both BMS and the WVFH Director of operations will receive both quarterly and annual reports of grievances or appeals filed analyzing issues for categories that include: disabled access, communication barriers, sensory impairments, cultural competency and other complaints and grievances. BMS will receive and monitor reports regarding resolution outcomes of all grievances and appeals, within 45 days of the close of the quarter and within six months of the close of the year to ensure effective resolution by WVFH.

One of the focuses of the QI Program will be to ensure clinical and service quality for health plan members including health care disparities, access and availability studies, complaint, grievances, appeals and reconsideration analysis. Other tools that will be used to assess successful efforts related to grievance and appeals will be a review of CAHPS and Member Satisfaction Survey results. Often times, review of complaints and grievances can act as a proxy to evaluate the availability of appropriate pharmaceutical therapies for beneficiaries so WVFH will analyze complaints and grievances specific to pharmacy services and therapies and subsequently assess and perform outreach to extend their contracted pharmacy networks and/or formulary availability, if deemed necessary. WVFH will also educate practitioners on the services of the SNCMU which include facilitation of dispute resolution including informing members of the complaint, grievance, and appeal mechanism that is available to the member.

1.1.40 Describe the process for coordinating Medicaid and Medicare care for dual eligibles.

WVFH systematically identifies eligible members, including dual eligible or SSI members, who may benefit from Care Management, on a daily, weekly and monthly basis. Evidence-based clinical guidelines, assessments and algorithms are used to enhance the identification process. Mechanisms used to identify eligible members include, but are not limited to:

a. Medical and pharmacy claims
b. Utilization Management referrals
c. Member self- referrals
d. e. Weekly inpatient discharge reports
f. Provider or Medical Director referrals
g. Pharmacy department
h. External vendor referrals
i. Predictive Modeling software
j. Community agency referrals
k. Enrollment Broker file

WVFH recognizes providers, particularly PCPs, as primarily responsible and accountable for coordinating care for WVFH members, however Case Managers will be intimately involved in coordinating care for this group of members. A provider's contract could be terminated if the provider fails to provide coordination activities, after re-education and/or corrective action. WVFH will follow a tiered approach of education and sanctioning prior to implementing termination procedures.

1.1.41 Describe how a vendor would evaluate for quality assurance and improve performance based on that review. WVFH recognizes it has a responsible, as well as a mission and passion, for ensuring quality of care for the Medicaid population and has processes in place for the ongoing monitoring of activities to ensure the quality of care provided to its members. Processes include the evaluation and documentation of all findings, conclusions, recommendations and corrective actions that have occurred as a result of QI activities as monitored via an established work plan that will be updated at least quarterly. Annually this information will be compiled to develop the QI/UM Program Evaluation. The findings and recommendations from this evaluation will be used to determine the effectiveness of the QI Program or to identify needed modifications (within MHT program requirements). The annual review includes input from internal stakeholders who are responsible for key QI activities, which results in a review and revision the WVFH QI Program Description and develop a QI Work Plan that supports program activities. The quality program will consider elements from the MHT program requirements,

NCQA Standards and Guidelines for Health Plans, and NCQA Multicultural Health Care Standards. The focus of the QI Program will be to ensure clinical and service quality for health plan members, practitioners and providers and to develop an established guide for monitoring quality activities. The QI Work Plan will specify activities to be conducted throughout the calendar year, as well as the responsibilities and timeframes for these activities. The activities will include HEDIS® measures, guideline studies, care management program outcomes, preventive health services, pharmacy programs, health care disparities, access and availability studies, complaint, grievance and reconsideration analysis, utilization of services, CAHPS Member Satisfaction Survey results, and provider satisfaction survey results. The QI Program and Work Plan will be enhanced to include specific activities as defined by the MHT State Contract and those identified by an applicable External Quality Review.

The review process will also be conducted, at least quarterly, to collect data and report a summary/status of QI activities, which will include actions taken on all clinical and service activities and progress of the QI Work Plan. Additionally, program effectiveness will be evaluated with a description of activities, outcomes, trending, goals, barriers, opportunities and interventions, as well as recommendations. In collaboration with related departments, the QI Department will identify quality opportunities within clinical and/or service areas. Periodic meetings will take place to review data and develop activities/studies for the year. WVFH will monitor practitioner and provider availability and utilization patterns at least semi-annually. The QI/UM Committee, Internal QI/Delegation Oversight Subcommittee and internal work groups will review all data and provide for input on performance, goals, barriers and opportunities. For every measure that does not meet an established goal, the committee will conduct a quantitative and qualitative barrier analysis. Internal workgroups will monitor these outcome results for opportunities for improvement by comparing results to NCQA's Quality Compass, state-wide plan performance rates, and internal goals. These considerations, in addition to performance trends, will be used to drive focus measures for the year and to prioritize measures for intervention.

1.1.42 **Describe the challenges associated with using traditional measures like Healthcare Effectiveness Data & Information Set (HEDIS) for children and adolescents with special healthcare needs and what other types of measures could be used to gauge and measure quality for this population. Frequency of data collection and analysis:** Historically, HEDIS results were monitored annually with analysis including identification of barriers and opportunities for improvement. This was a challenge due to the inability to quantify "misses", develop action plans collaboratively, implement mid-year improvement initiatives and impact ultimate performance outcomes for each measure. A new software program, CareAnalyzer, was implemented in 2013 that allows for off-cycle HEDIS reporting and targeting of interventions. CAHPS®, EQR, guideline studies, practitioner and provider accessibility, and encounter data results can be evaluated annually and compared to the previous year to identify opportunities for improvement. Collaborative efforts will focus on HEDIS measures, treatment guideline adherence or identification of at-risk members based on medical and behavioral health claims, along with pharmacy claims.

1.1.43 **Describe the approach for evaluating member satisfaction.** Each quarter, WVFH will mail to the head-of-household of its membership a member satisfaction survey (with a prepaid return envelope) to receive direct feedback from the members on specific topics related to member satisfaction. The results of these surveys is compiled, analyzed and presented to the internal QI team with recommendation on potential areas for improvement. In addition, the CAHPS® Member Satisfaction Survey will be used to solicit comments and to identify barriers. An open-ended question, "What can your health plan do to

better serve you?" is asked in the survey. Comments received will be used to identify areas of opportunities or misunderstanding and allow for implementation of corrective actions.

1.1.44 Describe how a vendor would actively work with network providers to ensure accountability and improvement in the quality of care provided, including:

1.1.44.1 How a vendor would reward providers who demonstrate continued excellence or significant performance improvement over time;

1.1.44.2 How a vendor would share best practice methods or programs with other providers

1.1.44.3 How a vendor would take action against providers who demonstrate unacceptable performance

1.1.44.4 Strategies that could be adopted to simplify the administrative procedures

WVFH will engage in outreach campaigns with physicians to allow for comparative data across the PCPs, i.e. how well does the PCP track patients who are due for preventive services, including dental screenings. WVFH will send a quarterly PCP Dashboard Report to all physicians in the WVFH network for evaluation of how well the PCP is performing on various quality measures. This report might detail key screenings, tests and/or visits that the PCP's panel membership is missing, including well-child visits. This helps give the physician a quick snapshot regarding performance related to WVFH members. WVFH might conduct focused clinical studies for its members related to healthcare disparities with interventions such as, outreach to GPE® (a provider pay-for-performance program) practices. In addition to dashboards, WVFH could conduct an AVR Campaign to attempt to implement change to impact improvement from baseline rates.

By using provider profiler during site visits to share data about WVFH's standards for appointment access and the provider's performance against the network average, WVFH could expect to elicit higher compliance and quality improvement. Using EPSDT reports which are run as a monthly report, PCPs could identify members under age 21 that have not had a well-child visit in the past year and appointments could be scheduled along with Case Managers using telephonic outreach to those members. WVFH could establish the medical record review (MRR) process to ensure consistent evaluation and documentation of medical care provided to members, including care provided by behavioral health providers. Medical record standards containing specific elements for each of the different practitioner and provider types are utilized to conduct the MRRs. To improve medical record documentation standards of care, critical elements could be added for each practitioner and provider type, although some elements cross all providers, i.e. continuity and coordination of care as demonstrated by PCP medical record containing outcomes of screenings and evaluations performed by any and all specialists including behavioral health. A QI Consultant (RN) could review the PCP medical records according to policy and if a critical element is not found in the record, the PCP office will fail the review. A written summary of performance, as compared to the MRR standards, could be provided at the conclusion of the review and the office could be advised that another review will occur in six to nine months following the implementation of opportunities for improvement. Discussion would also occur regarding the need for the PCP office to educate members on the importance of continuity of care, the need to communicate services provided by someone other than their PCP, and advising the members to sign a "Release of Information" form to allow that communication to occur, especially where behavioral health is concerned.

1.1.45 Describe the utilization management guidelines that would be employed and applied to authorize services. WVFH utilizes national, evidence-based criteria to guide utilization management decisions, supplemented by applicable regulatory and contractual requirements, which will include the MHT definition of medical necessity. When authorizing the delivery of healthcare services to plan members, For medical services, WVFH applies the McKesson® InterQual Criteria for authorization requests. The usage of McKesson's proprietary criteria may be modified by the QI/UM Committee based on the practice patterns of the practitioner community and characteristics of the local delivery system. In addition to use of McKesson® InterQual Criteria, WVFH has developed evidence-based guidelines that allow the nursing staff to approve medically necessary care. Medicare and Medicaid information, when available, along with published guidelines from national insurers, such as Blue Cross/Blue Shield, Aetna, Cigna, Humana, etc. is utilized in developing the approval guidelines. When services cannot be approved by using these guidelines, the cases are reviewed by a Medical Director for medical necessity determinations. For potentially experimental or investigational services, WVFH conducts a search of Hayes Inc. literature and requests input from specialty physicians, as needed. For pharmacy-related requests, criteria are developed by the Pharmacy & Therapeutics Subcommittee, which is reviewed by WVFH's QI/UM Committee. Reviews of out-of-network requests are conducted to determine if the services can be safely delivered by an available and accessible in-network provider. Out-of-network provider approvals may be given based on continuity of care, or the availability and accessibility of a participating provider.

All UM criteria and guidelines are reviewed at least annually by the multi-disciplinary physicians on WVFH's QI/UM Committee with input from an expert panel of physicians. The applicable QI/UM Committee or Subcommittee reviews and approves the application of criteria, which includes consideration of individual patient characteristics (e.g. age, co-morbidities, complications, progress of treatment, psychosocial situation and home environment, when applicable) and limitations of the local delivery system, including available coverage. Any updates to InterQual criteria published by McKesson®, including annual updates, are reviewed prior to use by the UM staff. Physicians on the QI/UM Committee may modify criteria based on the practice patterns of the physician community or characteristics of the local delivery system.

WVFH makes UM criteria and guidelines available upon telephonic or written request from members and participating or non-participating providers. Members are informed of how to request a copy of the criteria within each UM denial letter. Providers may also request criteria information from the UM Nurses during the authorization request process. The process to request UM criteria will be included in the WVFH Provider Manual. In addition, an online link for providers to access clinical criteria and guidelines from the WVFH website is currently in planning and development for implementation in 2015.

For behavioral health, authorization protocols are provided primarily through the use of the telephonic, web-based/electronic or paper document submission from providers. WVFH uses proprietary level-of-care (LOC) criteria and procedures to determine medical necessity as expeditiously as the case requires. WVFH uses a set number of initial encounters (IEs) for all in-network outpatient providers. Generally, outpatient therapists are allowed 8 - 12 visits without need for prior authorization or concurrent review. Our policies require that our behavioral health providers inform the member's PCP of any services rendered. In terms of crisis stabilization, WVFH does not require prior authorization for emergency room services or psychiatric facility services when a member presents with a mental health crisis at both participating and non-participating facilities. Once the crisis is stabilized and the member no longer

presents a risk to self or others, a treatment plan will be developed. This treatment plan can result in the member being admitted to an inpatient care facility or receiving outpatient care, such as an outpatient partial hospitalization. Concurrent inpatient care will be reviewed by WVFH as expeditiously as the member's health care condition requires, but no later than 24 hours after notification to WVFH. Outpatient care is reviewed on a pre-service authorization timeframe.

WVFH clinicians collect only the information necessary to certify the admission, treatment, length of stay or frequency or duration of services. WVFH does not routinely request copies of all medical records on patients reviewed. Additional medical records will only be requested when there is difficulty in making a decision. WVFH does not routinely require hospitals, physicians or other providers to numerically code diagnoses to be considered for authorization. Authorizations are based on the clinical information gathered during the review. All concurrent reviews are based on the severity, complexity of the member's condition. A clinical evaluation for medical necessity is conducted at each concurrent review to determine when the next review will be due. Concurrent reviews are not routinely conducted on a daily basis. Members have open access to "traditional" outpatient behavioral healthcare services and are not required to obtain referrals, unless contractually required for a service line, i.e. intense radiology procedures require authorization.

1.1.46 Describe the process for initially and periodically screening and assessing members' needs for services and the functional assessment instruments to be used in the evaluation process, including coordinating the requirements for EPSDT. WVFH has a program in place that is based upon the federally mandated EPSDT Program for children under the age of 21 years for regular medical, dental, vision, and hearing screens. PCPs are required to assure that all children have timely access to EPSDT services, including well-child care, immunizations, and screenings for lead toxicity, dental, vision, and hearing and are responsible for assuring continued coordination of care for all members and to arrange for medically necessary follow-up care after a screen or an encounter. To assure PCPs are well-educated on the importance of referring members beginning at age 3 to a dentist, WVFH will conduct EPSDT training during individual and group orientations, annual goal visits and targeted EPSDT visits. Special emphasis will be given to reviewing the components of a complete screen that includes a dental examination for members who are 3 years through age 20.

Outreach Representatives will conduct telephonic outreach to members and will send educational mailings to all targeted members based on appropriate age/claims criteria and will assist in scheduling an appointment via a conference call with the provider office. The focus of pediatric and adolescent telephonic outreach and education will be on children/adolescents who are due, or overdue, for immunizations or EPSDT well-child visits, blood lead level screening or who have blood lead levels of 10 mg/dL or greater as well as members who chronically do not keep PCP visits. Caregivers/parents of members who are being followed in a care or lifestyle management program will also receive information on age appropriate screenings and immunizations. Physicians and other providers can request assistance from WVFH's staff to follow-up with members who need to keep scheduled appointments and obtaining referrals for specialty care by faxing a Member Outreach Fax Form.

Care Gap software alerts allow any incoming calls to have outreach related to past due testing and appointments for any member of a household. Pediatric and adolescent members will be sent educational mailings with the goal of educating and encouraging members and their families to access timely preventive health services. Also several written member materials focus on EPSDT and how to

obtain these services, including Member Handbooks, Preventive Health Letter (identifying screenings that are due or overdue), birthday card reminders and "It's Time for a Check-up" Letter .

WVFH will also engage in outreach campaigns with physicians by preparing quarterly PCP Dashboard Report detailing screenings, tests and/or visits that the PCP's panel membership is missing. Additionally, the Provider Manual outlines provider responsibilities related to EPSDT services, the WVFH website includes the EPSDT Periodicity schedule and Provider Newsletter articles are focused on improving vaccination rates. The Environmental Assessment includes ensuring that the office is able to perform EPDST services for individuals under age 21 and that the waiting time to schedule an EPSDT screening for a new member assigned to the practice will be within 45 days of the effective date of enrollment.

WVFH is committed to informing and educating members and caregivers/parents about the EPSDT program and services. WVFH has procedures, systems, and reporting tools in place to identify and outreach to members that are due, or overdue, for EPSDT services, and to monitor compliance with EPSDT services.

1.1.47 Identify the areas believed to be the greatest opportunities for clinical quality improvement in behavioral health, and how a vendor would work to improve clinical behavioral health outcomes. WVFH's business model of PCM® fosters a holistic approach to member management. To that end, WVFH anticipates great coordination and collaboration will occur between medical and behavioral health providers. WVFH's collaboration starts at the member level and extends to development of systemic efforts to partner with all stakeholders involved in the member's care delivery. Telephonic outreach is conducted routinely and aids the member in securing needed services when barriers to care are present. Members have open access to "traditional" outpatient behavioral healthcare services and are not required to obtain referrals, unless contractually required for a service line, i.e. set number of initial encounters (IEs) for all outpatient visits. Our policies require behavioral providers inform the member's PCP of any services rendered. Case Managers are able to view all pharmacy utilization, both behavioral and physical health medications, to assist in the management of the member. Atypical or extensive utilization often serves as a driver for these ad-hoc, member-focused and collaborative efforts, specifically instances when behavioral health utilization is adversely impacted by physical health issues.

WVFH's behavioral health vendor provides additional management opportunities over pharmacy practices through its Psychotropic Drug Intervention Program (PDIP), which promotes evidence-based psychiatric medication use, the identification of inappropriate psychotropic medication use, and intervention strategies to achieve positive health outcomes. PDIP interventions include the identification of those members prescribed psychotropic drugs from all appropriate drug classes and from multiple prescribers and will inform all prescribers, including the member's PCP, to ensure proper coordination of pharmacologic care. PDIP also identifies issues with non-evidence-based use of medications and problems with member adherence to prescribed regimens, as well as potential fraud and abuse. PDIP clinicians, nurses, pharmacists and physicians reach out to PCPs, BH prescribers and members to assist them with addressing any barriers to optimal medication use. PDIP provides important data on members' medication use as well as providers' prescribing patterns. Specifically, PDIP captures data on members who are not taking their medications as prescribed and provides data on sub-optimal dosing, polypharmacy, and outlier prescribing patterns. Through analyses of an integrated data file (combined prescription, medical, and psychiatric claims), PDIP can identify claims-based, medication-related problems based upon available evidence and established best

practices. Medication-related problems that are identified include: polypharmacy, sub-therapeutic dosing, non-adherence, and quality alerts (i.e., pregnant women on psychotropic medications, children on multiple anti-psychotics).Pertinent pharmacy information is shared with the prescriber, be it a psychiatric or medical professional, and the PCP through several different methods. When a prescribing pattern places a member at high risk for an adverse event, the prescriber will be notified by phone and case consultation with a peer will be arranged. Less time-sensitive communication may be handles through letters and alerts.

1.1.48 Describe how a vendor would use telemedicine, telehealth, and telemonitoring services including opportunities to use video conferencing to improve quality or access to care. Telemedicine is defined as the exchange of medical information between sites via electronic communication for the purpose of transmitting clinical information for diagnostic, monitoring, and therapeutic purposes. The term "telehealth" is often used in conjunction with telemedicine and is intended to include a broader range of services using telecommunication technologies, video-conferencing and store and forward. It may be a covered benefit after the member has an initial face to face visit with the same specialist as the follow-up visit. During the specialist virtual visit, the member is connected to the specialist at an originating site such as their PCP's office or an outpatient facility. Telehealth services are available for services including assessments, evaluations, screenings, plan development, oversight, consultations, and counseling (identified by procedure code in the behavioral health provider manual). Services will be expanded as provider availability and site accesses increases. The distant site is the location where the specialist rendering the professional service is located. The originating site is the location of an eligible member at the time the service is being provided. WVFH recognizes the need and benefit of offering services in remote areas and is working on partnerships with telemedicine providers to increase access to services and potentially lower costs.

1.1.49 Please describe the process that would be undertaken to manage the pharmacy benefit under a proposed program. WVFH will ensure that beneficiaries have access to a suitable range of therapies through various network access options, including: retail network, compounding pharmacies, home infusion network, and specialty pharmacies. Care coordination, when necessary, occurs regardless of utilization of specialty medications. Any changes that negatively affect a member are communicated to the member, provider, and, if applicable, pharmacy provider. This includes any drug or pharmacy network changes. The communication to the member is done via letter, while a fax is sent to alert physicians and pharmacy providers. WVFH will direct members to specialty pharmacies through a variety of channels. Pharmacy claims must be submitted at point-of-sale with a valid prescriber NPI to uniquely identify the prescribing provider. Pharmacy claims data is incorporated within WVFH's Care Management system to support its Prospective Care Management (PCM®) business model which fosters a holistic approach to member management. WVFH has a detailed prior authorization policy for non-participating providers to assure quality and appropriateness of care for medical services and care coordination with the member's PCPs. Behavioral health and non-participating providers are not prohibited from prescribing medically necessary medications. Overall utilization management strategies engaged for pharmacy benefit management include several prescribing practices for behavioral health, non-participating, and participating providers.

Outreach and communication occurs with the prescribing provider and PCP to coordinate care and manage utilization as needed. Participating and non-participating providers must follow the same exceptions process to access non-PDL, non-formulary medications and utilization management limits as participating providers. Assessment of pharmacy utilization is a focus of WVFH given the extensive co-

morbid behavioral and physical health conditions prevalent within the members. Utilization of antipsychotics, antidepressants, stimulants and narcotic analgesics has historically been the top utilized medications within the behavioral health population. WVFH's pharmacy staff also routinely conducts outreach to providers to address concerns with medication prescribing practices, with providers and/or a Medical Director for review of services and medications and includes representation on the Pharmacy and Therapeutics (P&T) Subcommittee. An external specialty panel is also available for additional input on medication reviews taken to the P&T Subcommittee. All pharmacy claims are screened to assure the prescriber has a valid and unrestricted license to prescribe the medication. In addition to the prescriber verification process, all medications dispensed undergo concurrent drug utilization review to screen for duplicate therapy, drug-drug interactions, and appropriate dosing. WVFH has a procedure for pharmacy lock-in assignments which addresses handling lock-in assignment changes to be in compliance with the WV state lock-in requirements. WVFH recognizes that the Medicaid population has significant co-morbid physical health and behavioral health conditions and has a long history of proactively collaborating with providers to coordinate care and manage pharmacy utilization.

1.1.50 How would a vendor ensure that enrollees who are on a non-formulary brand name and/or other potentially costly medications do not have to change to a formulary or generic medication after enrollment? During a member's transition to WVFH, the member is offered a transitional benefit. Subsequent to enrollment, non-formulary brand name medications will be reviewed by the Medical Director, Pharmacy Director and Case Manager in conjunction with PCP, specialist or behavioral health providers will review the prescribed medications to determine medical necessity. Once this review is completed, the member and providers will be advised if a medication change is recommended. For those individuals in care management programs, the case manager will assist in taking the lead in assisting members with any transition and facilitates communication between providers, members and caregivers/parents. The goal of WVFH transition planning is to provide a seamless as possible transition that creates minimal member anxiety and confusion. WVFH is not responsible for the costs of investigational drugs or devices or the costs of non-healthcare services such as the costs of managing research or the costs of collecting data that is useful for the research project but not necessary for the enrollee's care.

1.1.51 How would a vendor ensure that children who are on psychotropic medications are receiving appropriate dosages at the right age and frequency to avoid over or under-utilization or misuse of medications? The Psychotropic Drug Intervention Program (PDIP) promotes evidence-based psychiatric medication use, the identification of inappropriate psychotropic medication use, and intervention strategies to achieve positive health outcomes. PDIP identifies members who have been prescribed psychotropic drugs from multiple prescribers to ensure proper coordination of pharmacologic care. PDIP looks for non-evidence-based use of medications and problems with member adherence to prescribed regimens. PDIP captures data on members who are not taking their medications as prescribed and provides data on sub-optimal dosing, polypharmacy, and outlier prescribing patterns. PDIP can identify claims-based, medication-related problems including polypharmacy, sub-therapeutic dosing, non-adherence, and quality alerts. PDIF can identify inappropriate use of medications or potential prescriber dispensing patterns, including potential fraud.

1.1.52 How would a vendor coordinate with the enrollee's PCP and behavioral health provider to ensure each provider has access to the most up-to-date medical records? WVFH will use the Medical Record Review (MRR) process established to ensure that PCPs maintain information shared by providers, including behavioral health providers, as to the outcomes of screenings and evaluations.

The Primary Care Services section of the contract specifically states it is a PCP responsibility: "If provider is a PCP, provider shall: maintain a current medical record for the Enrollee, including documentation of all services provided to the Enrollee by Provider, as well as any specialty or referral services." For behavioral health providers, the manual states a provider's treatment record must contain clear document that contains: "documentation of communication and coordination between behavioral health providers, primary care physicians, ancillary providers, and health care facilities". In addition, if a member transfers from one behavioral health provider to another, the transferring provider must communicate the reason(s) for the transfer along with the information (as specified for communication from behavioral health provider to PCP), to the receiving provider.

Finance

1.1.53 **Describe what methodology might be used for establishing capitated payments for these services or how they might be set up. If possible, provide a projected cost for serving a population similar to that described in the Statement of Need, above, or an existing cost to operate in another state or states with similar populations of eligible youth.** To establish capitated payments for the services required for this "vulnerable youth population", WVFH would request an actuarially sound retrospective review of claims data for the past two years (24 months) to establish the PMPM rate for like-kind members who have had claims processed under fee-for-service arrangements. All services anticipated to be carved-in to the managed care organization outlined in this RFI should be included in the rate calculation. Providing a cost projection without having access to actual utilization data for this population would not be prudent.

1.1.54 **Describe how a vendor might calculate admin costs for administration of such a program. What costs would factor into administration of such a program? What is a typical billing period for administrative and other costs?** If the capitated payment rate PMPM is set at the correct level for the population, then administrative costs for providing services to the "vulnerable youth population" would be anticipated to be approximately 85% MLR and 15% administration based on other Medicaid population. It would be anticipated that administrative costs would include management salaries, benefits, marketing/advertising, insurance, taxes, etc. The average billing period for administrative and other costs will likely be thirty to sixty days.

Case Scenarios

Given the following scenarios, please answer the associated questions that follow that relate to each case study.

1.1.55 **Case Scenario #1 (Matt)**

Matt is a 19 months old boy who was placed in foster care at birth from the hospital. Matt's parents' parental rights were terminated and he remains in foster care. Due to his medical needs, placing Matt has been a challenge. Matt has a brain anomaly, cortical dysplasia, epilepsy and developmental delays. Matt has medication to control his seizures, which have become more controlled. When Matt has a seizure, the flap in his throat tends to close and he usually needs repositioning to open the airway, but sometimes oxygen is needed so it must be continuously available. Matt has been evaluated for his developmental delays, vision problems, and speech therapy. Matt's provider has not received the results of these evaluations yet and follow-up with the hospital is needed.

1.1.56 Case Scenario #2 (Ben)

Ben is 8 years old and entered foster care after living in an unsafe environment for several years. He is legally free for adoption. He was placed with his uncle who wants to adopt him; however, he is concerned about his future behavioral health care needs and what long-term support options he will have given the exposure to trauma Ben has experienced.

Ben is currently on multiple psychiatric medications and his teachers complain of ADHD-like symptoms.

Case Scenario Questions:

WVFH is committed to protecting the confidentiality of member and provider information. In each of the scenario responses, a Case Manager would be assigned to the member. The Case Manager would request copies of guardianship and HIPAA authorization forms to be able to coordinate with all stakeholders including but not limited to, Child Protective Services (CPS), mental and behavioral health supports and providers, schools, social workers, foster caregivers/parents, external case managers and services coordinators. The answers below are written with the assumption all necessary releases were received and reviewed with authorization granted to share information without restriction.

1.1.56.1 What is a typical care management approach for each child, beginning with describing your assessment strategy? Please consider the placement setting and legal status in determining the proposed approach. WVFH places a strong emphasis on the proactive identification and assessment of not only the medical needs, but also the psychosocial needs of members due to the tremendous impact these issues have on a member's health status and overall well-being. Because of the commitment to addressing these concerns, WVFH's business model, *Prospective Care Management (PCM®),* emphasizes the importance of utilizing a holistic approach to care management and anticipation of member needs. This holistic approach includes a comprehensive assessment of a member's behavioral, economic, environmental, medical, social and spiritual (BEEMSS℠) strengths and needs. This enhanced model of care is culturally sensitive and identifies barriers for effective and timely care. This would be the foundation for the Case Manager's assessment of Matt and Ben's needs.

The assigned Case Manager would interface with stakeholders to complete the BEEMSS℠ assessment. The Case Manager would initiate calls to foster caregivers/parents, CPS, social workers and providers to gather information about Matt and Ben's health, medical needs, informal and formal supports, and care gaps, including the status of immunizations. The Case Manager would work with Matt and Ben's guardians, caregivers, and providers to develop a plan of care (POC) based on the BEEMSS℠ assessment. A person-centered approach would be used in developing the POC. Examples of elements included in the POC are prioritized goals, an effective plan for transitions between health care settings, a communication plan with the primary care physician (PCP) and other providers. For Matt, additional providers may include a neurologist, speech therapist, Birth to Three program staff, CPS, and his social worker(s). Some additional providers for Ben would include behavioral health providers, CPS and social worker(s).

1.1.56.2 How would a vendor educate and engage the various parties responsible for the well-being of the child and about the ongoing care required? The Case Manager would contact caregivers/parents by telephone to introduce them to the are management program. The BEEMSS℠ assessment, noted in responsee 1.1.56.1, would be completed. The foster family would be engaged to assess knowledge

deficits and strengths of the family unit. The Case Manager would use dynamic questioning and active listening skills to assess the caregivers' understanding of doctors' orders, medication administration, use of equipment, appropriate use of the emergency department, etc.

The Case Manager would work with the PCP and specialists to review treatment plans, medication regimen, equipment needs, and scheduling of follow up appointments. The Case Manager would provide appointment reminders and help ensure transportation is not a barrier to keeping appointments. Caregivers/parents would be engaged in ongoing telephonic Case Manager no less than quarterly, while there are active goals and unmet needs. The Case Manger would link to caregivers/parents to relevant resources and education material.

Matt: Interventions would include the Case Manager initiating calls to help ordering doctors' get reports on Matt's neurological testing, speech therapy evaluation and other pending reports. The Case Manager would speak with caregivers/parents to assess their understanding of Matt's needs. Specific questions would focus on caregivers' knowledge of repositioning Matt and assessing his need for supplemental oxygen during a seizure and comfort using DME such as a pulse oximeter. If there are knowledge deficits, the Case Manager would provide coaching and facilitate discussion between the caregiver and ordering doctors. The Case Manager would work with the PCP to coordinate a referral for home health for hands on training for the caregivers, if warranted.

Ben: The Case Manager would utilize and make referrals to resources such as The Safe at Home program. Although Ben is slightly below the target age for this program, they would be a great resource to locate doctors and behavioral health providers who are skilled in trauma assessments and working with children, exposed to similar unsafe home environments.

WVFH will seek out resources whenever identified needs are beyond the scope of the covered services of the Medical Assistance Program. All staff of WVFH has access to utilize on-line resources including the internet and a robust community repository application developed by WVFH to locate a myriad of community resources.

1.1.56.3 Describe the care coordination activities that might be initiated and timelines related to the child, including communication between key people involved in the child's care. How would a vendor ensure timely access to specialty providers that should be seen in addition to those already being seen, including mental health providers? The Case Manager will be responsible for ensuring Matt and Ben's services are received. Staff will serve as a health advocate for these vulnerable children and will work diligently with caregivers/parents and providers to ensure needs are met. Case management includes outreach to ensure members have an ongoing source of primary care appropriate to their needs. It includes opportunities to coordinate care with the most appropriate PCP and specialists include scheduling assistance, discharge planning, follow-up due to frequent low acuity emergency room visits, and ongoing care coordination. Staff will work to make sure the member has a PCP that meets his needs based on factors such as location and language or cultural preference. Quality and appropriateness of care for Matt and Ben would be measured through on-going telephonic care coordination with his guardian and caregivers, no less than quarterly as long as there are active goals. Case Managers would view claims history, authorizations, pharmacy claims and care gaps through an integrated documentation system. This is another avenue for an integrated approach to care management.

WVFH will provide the same level and types of services as those currently available through the Children with Special Health Care Needs (CSHCN) program including access to multidisciplinary care.

When children with special needs are in substitute care, transitional care, adoptive care or medical foster care, WVFH Case Managers will assist agency staff and/or temporary caregivers with care coordination to ensure the children receive EPSDT services and other healthcare needs addressed timely.

1.1.56.4 When would a vendor contact the child's social worker and what information would a vendor typically share? Provided necessary consents were received, as part of the initial assessment the Case Manager would contact Matt and Ben's social workers. In accordance with HIPAA guidelines, information shared would meet the minimum necessary standard. Ongoing collaboration with the social worker would be encouraged. This would be an opportunity for the Case Manager to gather information on cultural considerations for the members and caregivers. A medical and social history with relevant information would be requested. Other obstacles and points of discussion would include transportation needs to and from appointments, and barriers to meeting physical and psychosocial needs. The Case Manager would engage in a dialogue with the social worker about obstacles to placing Matt and how he could be linked to medical and psychosocial resources in order to facilitate a more consistent, stable, and appropriate home environment. For Ben, discussion would include how he could be linked to medical and psychosocial resources in order to help his uncle feel more prepared to meet Ben's long term needs.

1.1.56.5 How would a vendor track areas of concern related to the child's care in a typical system? WVFH has significant experience and expertise in care coordination for medically fragile children. WVFH will leverage this experience. Matt and Ben would each be assigned one dedicated Case Manager. Having one point of contact provides continuity to ensure the POC will remains current and applicable to the goals. Matt and Ben's providers and guardians would be encouraged to call the Case Manager directly if changes or concerns arise before the Case Manager is due to outreach.

The Case Manager, in conjunction with the caregiver/member/guardian, develops a person-centered Plan of Care (POC). The POC considers appropriate options for Matt or Ben related to their medical, behavioral health, psychosocial, and case-specific needs at each specific point in time. The POC is fluid, based on the member's ever changing needs. It is updated as changes occur with a goal to be updated at least quarterly.

WVFH's system of record for case management documentation enables staff to identify barriers to achieving goals, set a goal date and intervention dates. Caseloads would be sorted by review date to keep Case Managers on target with meeting needs in a timely and efficient manner.

1.1.56.6 How would a vendor coordinate the specific Durable Medical Equipment (DME) needs of the member? During the assessment, the Case Manager would gather a list of current DME and anticipated DME needs. The Case Manager has the ability to view claims to see previously requested DME and the status of pending requests. The Case Manager would provide education to the PCP about the process for requesting DME through the utilization management department (UM). If needed, the Case Manager would assist in finding par providers and coordinating to get an order for medically necessary equipment. Depending on the need and type of equipment, an evaluation by a specialist or therapist may be warranted. The Case Manager would facilitate this process, as well.

In Matt's case, it would be important to know he has a vendor for supplemental oxygen who covers a wide area to prevent switching vendors if he moves. His proximity to providers should be based upon his physical location and not the address of his guardian which is likely to be a centralized CPS address.

1.1.56.7 How would a vendor address potential cultural and language barriers? As part of the initial assessment, the Case Manager would ask stakeholders about cultural considerations and barriers for Matt and Ben, and their foster families. If the caregivers' primary language is not English, the Case Manager would use the established language line for an interpreter. WVFH's staff training program provides staff with training related to care management practices in accordance with regulatory requirements. One the training objectives is to develop an awareness of and sensitivity to racial, ethnic, cultural and socio-economic factors that characterize a member's background and influence the formation of the helping relationship and Case Manager outcomes. This objective is apparent throughout training models.

1.1.56.8 How would a vendor work with the school to ensure appropriate accommodations are made? The Case Manager would encourage Ben's uncle to actively participate in Ben's Individual Education Plan (IEP) meetings and to request participation of advocates such as the social worker and CPS case worker. The Case Manager would attend IEP meetings via conference call. A copy of IEP should be provided to Ben's PCP and behavioral health providers. The school indicated Ben has "ADHD-like" behaviors; it is unclear if he has a related diagnosis or if this is symptomatic of his trauma. The Case Manager would request related assessments and evaluations with results to be shared with external providers for an integrated and coordinated team approach in development of his POC. If trauma evaluations have not been completed, the Case Manager would facilitate getting referrals to appropriate providers for evaluation. Ben's uncle would be referred to the Parent Educator Resource Center (PERCs) for advocacy and support with the IEP process. The Case Manager would research available resources and make referrals for support such as those available through the Expanded School Mental Health program.