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Request for Information (RFI)
CRFI 0511 HHR 1500000002

Managed Care or Managed Care Alternative for Vulnerable Youth Populations

Original

The Health Plan
52160 National Road, East
St. Clairsville, Ohio 43950
1.800.624.6961

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 (ACE). 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.

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.

RESPONSE:

The Health Plan (THP) continually reviews our network of providers in order to assure that all categories of members have choice and availability. A concentrated effort has been made in preparation for the needs of the impending expansion, SSI and vulnerable youth populations in regards to contracting with specific specialties, subspecialties and services. Network recruitment includes assuring the criteria of The Health Plan's excellent classification in credentialing through the National Commission of Quality Assurance (NCQA) is maintained, as well as cooperation from our providers in The Health Plan's healthy initiatives and HEDIS® reporting programs. This approach to networking includes agreements with Federally Qualified Health Centers (FCHC) and Rural Health Associated providers.

The Health Plan will establish contractual relationships and form partnerships with the various children's organizations such as Children's Home Society and Children's Alliance within the state. Should there be a provider who is identified as currently providing services to a youth in this category, the plan will make every effort to enter into a contractual agreement as long as the provider meets all aspects of The Health Plan's Credentialing/Recredentialing Policies and Procedures and is willing to become a participating provider of the plan. If the practitioner/provider is unwilling to enter into a contractual agreement with The Health Plan and the member is established with the practitioner/provider we will make every effort to allow the beneficiary to continue their care with the practitioner/provider by entering into a single case agreement with the practitioner/provider to provide continuity of care for the beneficiary until such time as the plan is able to provide the needed services within its established provider network.

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.

RESPONSE:

Upon notice of a deficiency in either/or time or distance requirement, identified providers located in West Virginia or boarding communities will be contacted in an effort to secure a contract, provided they meet The Health Plan credentialing process. Providers located outside of The Health Plan's service area will be contacted in an attempt to reach an agreement to accept West Virginia Medicaid reimbursement rates. WV DHHR claims data, commercial networks and

database searches will be utilized to identify potential solutions to deficiencies. The Health Plan has a longstanding reputation for working closely with key providers in the state. Through those relationships we are able to work with the major health systems to identify needs and provide support to the recruitments of needed providers in the state.

1.1.3 Describe the approach(es) to providing 24-hour access to a provider or service in emergency situations.

RESPONSE:

The Health Plan requires this provision contractually with its providers. In the event that a network based provider is not available, The Health Plan policy allows a member to access the nearest provider or facility and The Health Plan contacts provider to arrange payment. The Health Plan's 24-hour nurse information line is available to assist members with access to service.

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.

RESPONSE:

The Health Plan's customer service coordinators will immediately contact provider services upon identifying any issue in regards to inappropriate wait times. The Health Plan addresses this provision contractually and includes specifications in our electronic provider procedural manual. In the event that a violation occurs, provider services contacts the office and addresses. In the event the practice continues after counseling, the situation would be presented to The Health Plan Quality Assurance and Quality Improvement Committee (QIC) for immediate review and action.

In addition to the above, our quality improvement department routinely monitors access to care, wait time, etc. Any variances are reviewed by the Quality Improvement Committee and corrective actions are taken when necessary to ensure providers meet required access standards.

Providers are monitored through a variety of mechanisms including member complaints and surveys. Possible physician interventions may include provider education, requests for corrective action and review by the QIC. The QIC has the authority to recommend corrective action ranging from a telephonic meeting with a Health Plan medical director, all the way up to termination of the provider. QIC recommendations are reviewed by Executive Management for final disposition.

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.

RESPONSE:

In the event enrollment would exceed projection, providers would have the ability to adjust their member thresholds to allow for additional capacity as long as they remained in compliance with DHHR program standards. The Health Plan would also work directly with local facilities and key providers to recruit the needed providers to meet the needs of the communities.

1.1.6 Describe the approach(es) to offering/providing crisis response to children and their caregivers.

RESPONSE:

Crisis response to children and their caregivers will be provided by the following approaches:

- Ensure early intervention for children experiencing crisis
- Care manager registered nurses develop care plans including short and long term goals upon health care assessment
- Care manager registered nurses help obtain and schedule evaluations for emotional and physical trauma as well as other medical and dental care needs
- Coordination with child services agencies
- Utilize community resources
- 24x7 nurse line

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.

RESPONSE:

The Health Plan utilizes an integrated team approach on the development of the care plan. The team consists of, but is not limited to, care and case managers, disease managers, medical directors, dental director, pharmacist, behavioral health professional, social workers, patients, physicians in collaboration with primary caregivers, social services support system (including the child welfare providers), educators or relevant parties who understand and utilize community resources as well as all internal resources to assist members. Care and case managers reach out to non-participating providers when necessary to develop a transition plan for continuity of care. The Health Plan also has an established network of relationships with social service providers and community resources to help meet the various socio-economic needs.

The Health Plan uses a tracking system called HEART Case Tracker to coordinate the member's care across all spectrums. HEART Case Tracker includes all documentation and assessments regarding each member's care and also gives the representative reminders for follow-up contacts with the member or any providers. Outreach representatives also make numerous phone contacts with members for various reasons. Outreach representatives will coordinate with the member's educational system to be sure he/she is following the guidelines of that system. Representatives also have the ability to intervene with noncompliant children and their primary caregivers.

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).

RESPONSE:

The Health Plan monitors members to verify they are receiving the proper treatment of care services from their primary care physician (PCP) and or specialists; if a member is found to be missing preventative services or if services are not being coordinated between provider types, The Health Plan contacts the PCP, specialist, and the member or his/her primary caregiver. The member's care will be monitored through the following methods: claims data will be reviewed,

HEDIS measure monitoring, heath risk assessments and care/case manager contact with member and the specialist and PCP. Additionally, any type of ad-hoc reporting can be initiated at any time with results received the same day or the next day to be reviewed to ensure access to services.

The Health Plan will be conducting a series of regional as well as local provider workshops addressing all aspects of The Health Plan's operations policies and procedures. In addition, The Health Plan will provide direct mailing to primary and specialty providers informing them of vulnerable children enrollment. Ongoing education will be offered through The Health Plan's ProviderFocus newsletter, provider procedural manual, and annual provider seminars (The Health Plan's provider procedural manual includes information on the coordination of care between a specialist and PCP). Additional education will be provided through the collaboration of our government programs, medical department and the provider relations staff.

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.

RESPONSE:

The IFSP will be used as a source of relevant clinical information. The care team gathers member information as part of the care management process. The IFSP will be developed by the integrated team in the medical department upon the initial assessment of the member and will be updated on a regular basis thereafter. The IFSP is integrated into the systems utilized by The Health Plan to ensure access to information at all levels of care and service. As transitions in care occur, the system triggers staff to address the transitions and the impact on the established plan of care. When indicated, the plan is updated to reflect changes in status.

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.

RESPONSE:

The member is assigned a care manager who is responsible for identifying and organizing the interdisciplinary care team. The team consists of, but is not limited to care and case managers, disease managers, medical directors, dental director, pharmacist, behavioral health professionals, social workers, patients physicians in collaboration with primary care givers, social services support system (including the child welfare providers), educators or relevant parties who understand and utilize community resources as well as all internal resources to assist members. The team develops the care plan with updates to the care plan as problems are identified or resolved. This plan of care is inclusive of the member/caregiver and providers. Once the care plan is in place, it is shared by mail and/or telephonically with the PCP and member/caregiver as well as other members of the interdisciplinary team. The care plan is systematically tracked and monitored through our HEART Case Tracker system to ensure continued monitoring and compliance with the established plan of care.

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.

RESPONSE:

Case mix is established based on care needs, medical history, psychosocial history and other clinical information received during the health care assessment. The levels of management assigned are low, moderate and intensive. Case ratios encompass all levels of management. Current ratios are 75 members to 1 case manager plus the care team members identified to care for the member based on his needs assessment.

1.1.12 Describe the process for establishing relationships with community organizations and engage them in providing non-covered services to members.

RESPONSE:

The medical department social workers maintain an updated resource directory through web links and written materials. The social workers are experienced with available community resources in the state and make referrals for necessary services. A complete list of resources is

maintained electronically in the HEART Case Tracker system and is available throughout the organization as a resource for assisting members

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.

RESPONSE:

The member is assigned a care manager, who is responsible for identifying and organizing the interdisciplinary care team. The team consists of, but is not limited to, care and case managers, disease managers, medical directors, dental director, pharmacist, behavioral health professionals, social workers, patients physicians in collaboration with primary care givers, social services support system, educators or relevant parties who understand and utilize community resources as well as all internal resources to assist members. The team develops the care plan with updates to the care plan as problems are identified or resolved. This plan of care is inclusive of the member/caregiver and providers. Once the care plan is in place, it is shared by mail and/or telephonically with the PCP and member/caregiver as well as other members of the interdisciplinary team. The care plan is systematically tracked and monitored through our HEART Case Tracker system to ensure continued monitoring and compliance with the established plan of care.

1.1.14 Describe how a vendor would evaluate and report member progress in meeting goals identified in the ISP.

RESPONSE:

The care plan is updated as member needs are identified/resolved. These changes are communicated to the health care providers by mailing Care Plan Reports with the individualized care plan entries. The reports are processed through HEART Case Tracker system which is a Health Plan developed software tool which allows for tracking of all patient management considerations in one integrated tool. As the Plan is updated, updates are provided to relevant parties including member or caregiver, PCP, etc.

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.

RESPONSE:

The Plan of care is maintained in HEART Case Tracker. HEART Case Tracker is a Health Plan developed software tool which allows for tracking of all patient management considerations into one tool. HEART Case Tracker eliminates silos of information and allows for integration of all various facets of information utilized in the care/case management processes including work flow, care coordination, authorization, transition in care, documentation and timeliness of contacts, communications, clinical assessments and care plan development. Referrals/pre-authorizations, hospital reviews and claims information are available in HEART Case Tracker from the claims system.

The Health Plan has nurses who are certified case managers and one will be assigned to each member to manage the plan of care with the other members of the care team. Other members assigned to the team will be determined based on the individual member's needs assessment. A plan of care will be developed tor the individual member by the care team assigned to the case with the case manager coordinating the team. In addition, to the certified case managers the team could include nurses who have behavioral health (BH) expertise, nurses who are certified diabetes educators (CDE) in disease management who can work with children with diabetes, a nurse board-certified in pediatric nursing as a consultant, pharmacists, social workers, dieticians, medical directors, and physician consultants (BH and dental).

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?

RESPONSE:

As soon as The Health Plan is notified that the member is on the plan, outreach representatives will begin the process of contacting the foster parent(s) and the providers to assure that this standard is met. All participating providers will be educated by The Health Plan to clearly understand their responsibilities in this manner. This will be a priority for the outreach

representative and electronic reminders will be utilized for follow-up to be sure it was completed within the 72 hours. The Health Plan systems provide reporting and tracking of EPSDT services, allowing the plan to identify gaps in care and services. When identified, members and their providers are contacted to address the identified gaps in care.

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

RESPONSE:

A key component of care or case management is optimum and efficient use of benefits through knowledge and understanding of available benefits. The care managers work with providers to obtain care and services for members. Part of this process involved an understanding of services available to the member through a variety of resources. Care managers and social workers who would work with this population are able to collaborate to ensure state plan services such as home health and personal care are integrated into the overall plan of care for the member.

1.1.17.2 Nursing Facility

RESPONSE:

The Health Plan's Medical Department has established relationships with participating facilities, as well as non-participating facilities. The care manager will work directly with the facility to ensure the facility is able and willing to comply with the plan of care. Where possible, the facility representatives will be included in care planning meetings.

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

RESPONSE:

Social workers in the Medical Department are knowledgeable on available home and community based services and waiver services. The care managers refer members via HEART Case Tracker to the social worker when service needs are identified. These entities and their services would be incorporated into the care planning process.

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.

RESPONSE:

Customer service representatives and outreach representatives will receive initial training regarding the foster children program prior to going live. The training will include how to assist members and their caretakers in various manners such as their benefits, the referral process, handling crisis calls. It is important to understand that the child may have entered the foster system as a result of abuse or neglect or through juvenile delinquency proceedings. Representatives will also be trained in cultural sensitivity and HIPAA privacy laws. Representatives will educate members and caretakers regarding community resources and The Health Plan care, case, and disease management services that are available. Members can contact

a pharmacy technician or a nurse 24/7 for assistance. Representatives can help with referrals to the "Birth to Three" Program. The importance of immunizations, vision, behavioral health, and dental services will be explained to caregivers and how to access those services. Representatives can explain that there is federal funding for education related transportation costs. Representatives will coordinate with the DHHR caseworker to be sure a Life Skills Assessment is completed on foster children age 14 and older. Should the caregiver receive a letter that the continued Medicaid coverage will be terminated, The Health Plan can inform the caregiver of their right to a fair hearing. Foster/adoptive parents may be reimbursed for transportation costs for visits with the biological family or visits with the potential adoptive family. They can also receive child care services while they work. Respite care is another benefit for the caregiver. A child may also be eligible for other benefits such as Social Security, Veteran's, Railroad Retirement, etc. and The Health Plan can help explain these benefits so an application can be filed. The Health Plan will educate caregivers that an annual clothing allowance is available for children ages 4 to 18 or age 21, if the child remains in school. The Health Plan will remind caregivers that they should have a picture of the child ages 2 through 15 and participate in the SAFEKIDS PIX ID card program. The Health Plan will educate about a free annual credit report available for foster children ages 16 and older. The Health Plan will educate caregivers that a Case Review will be done to assess progress of the foster care involvement, and the courts require a quarterly status review until there's a permanency plan. Foster care is generally only until the child's 18th birthday unless they agree to continue to receive foster care services. The biological parents could move out of county or out of state.

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.

RESPONSE:

When the DHHR worker sends the letter to foster parents regarding court hearings and multidisciplinary treatment team (MDT) meetings, The Health Plan should be copied so that we can help coordinate with the foster parents. The Health Plan can help foster parents understand

their rights in any child abuse and neglect court hearings. The Health Plan can coordinate with other agencies to be sure the intent of the Adoption and Safe Families Act (ASFA) is met so that caregivers know about their rights to be heard in court hearings. The Sanders Field Liaison will notify The Health Plan. The Health Plan will contact the caregiver to select a provider and The Health Plan will contact the provider so he/she can complete the EPSDT exam within the 72 hours of placement. The Health Plan can make the appointment for the member. The Health Plan will follow up on any referrals that the provider deemed necessary. The Health Plan can coordinate non-emergency transportation through the assigned transportation vendor for the child and caregiver and work with the local Children's Alliance for additional coordination of care.

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.

RESPONSE:

Outreach representatives will have the responsibility of ensuring that these children receive all EPSDT services. Based on the EPSDT periodicity schedule, reminders will be sent to the children as well as to the providers. Outreach representatives will also follow-up on children who were non-compliant, no-shows, or missed their screenings. Early and regular assessment by the members PCP is key to ensuring access to needed services. Outreach representatives will work with caregivers to ensure a PCP relationship is promptly established and care needs are promptly addressed.

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.

RESPONSE:

Various Health Plan representatives will receive training and technical assistance prior to the go live date. Additionally, they will also receive ongoing training annually and more frequently as necessary. The Health Plan representatives will then be able to explain policies and procedures to new enrollees and their parents/caregivers. The Health Plan representatives will utilize detailed scripts when contacting members to ensure all appropriate areas are discussed. Health Plan providers will receive training prior to the go live date as well as ongoing training annually and more frequently as needed. Any new provider receives the training when he/she becomes effective. The same is true for any other interested parties. Examples of the training are: effective telephone training for this population, knowledge of community resources, and an effective outreach program for new enrollees, handling crisis calls, the importance of keeping a life book for the child, presenting both ID cards to all providers, etc.

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?

RESPONSE:

The Health Plan will be conducting a series of regional as well as local provider workshops addressing all aspects of The Health Plan's operations policies and procedures. In addition, The Health Plan will provide direct mailing to primary and specialty providers informing them of "Vulnerable Children" enrollment. Ongoing education will be offered through The Health Plan's Provider Focus newsletter, provider procedural manual with sections specific to the handling of this population, and annual provider seminars. (The Health Plan's provider procedural manual includes information on HIPAA compliance). Additional education will be provided through the collaboration of our government programs, Medical Department and the provider relations staff.

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?

RESPONSE:

The Health Plan will be conducting a series of regional as well as local provider workshops addressing all aspects of The Health Plan's (THP) operations policies and procedures. In addition, THP will provide direct mailing to primary and specialty providers informing them of "Vulnerable Children" enrollment. Ongoing education will be offered through THP's Provider Focus newsletter, provider procedural manual, and annual provider seminars (In addition to standard procedures, specific subject matter will be addressed towards the new populations and the differences between program standards). Additional education will be provided through the collaboration of our government programs, Medical Department and the provider relations staff.

Health Plan's training topics will include but not be limited to:

- Program Overview
- Service Area / Implementation Dates
- Member Eligibility
- Benefits / Covered Services
- Member Identification (ID Cards, Rosters, etc.)
- PCP responsibilities and patient assignment and selection
- Expanded role of secondary specialty providers (ex. pulmonology, nephrology, etc.)
- Review of in-network and tertiary providers
- Health Plan Medical Management Program
- Referral process
- Pre-authorization requirements
- Health Plan claims processing
- Appeal processes
- Health Plan outreach efforts and member support services
- Websites (provider and member)
- Care plan development and monitoring process
- Provision and tracking of EPSDT services
- Coordination with child welfare entities

- Referral process
- Pre-authorization requirements
- Health Plan claims processing
- Appeal processes
- Health Plan outreach efforts and member support services
- Websites (provider and member)

1.1.26 Provide a brief description of provider training programs. Please distinguish between training programs for PCP, 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

RESPONSE:

All newly enrolled providers with The Health Plan are visited by a provider representative and are provided with general training No less than annually, The Health Plan will be conducting a series of regional, as well as local, provider workshops addressing all aspects of The Health Plan's operations policies and procedures. Trainings may also be conducted through web modules In addition, THP will provide direct mailing to primary and specialty providers informing them of "Vulnerable Children" enrollment. Ongoing education will be offered through THP's Provider Focus newsletter, provider procedural manual, and annual provider seminars. Additional education will be provided through the collaboration of our government programs, Medical Department and the provider relations staff. These sessions are graded through survey and results reported to Executive Management Team for review.

Health Plan's training topics will include but not be limited to:

- Program Overview

- Service Area / Implementation Dates
- Member Eligibility
- Benefits / Covered Services
- Member Identification (ID Cards, Rosters, etc.)
- PCP responsibilities and patient assignment and selection
- Expanded role of secondary specialty providers (ex. pulmonology, nephrology, etc.)
- Review of in-network and tertiary providers
- Health Plan Medical Management and Disease Management Programs
- Referral process
- Pre-authorization requirements
- Health Plan claims processing
- Appeal processes
- Health Plan outreach efforts and member support services
- Websites (provider and member)

1.1.27 Provide a description of member education materials and a vendor might use them to inform and educate members.

RESPONSE:

The Health Plan has educational materials that can be printed in alternate formats if needed. These materials consist of the Member Handbook and other materials based on specific diagnoses of the member. Additional topics could include self-esteem, safety, smoking cessation, preventive guidelines, good dental care, ancestry, stay in school, and HIV/AIDS testing.

Members are also educated telephonically through the Health and Wellness Promotion Outreach Department. A follow-up letter recapping the outreach call, along with any requested educational materials, are sent to the member.

Members may request additional information on a variety of topics either by calling The Quality Improvement Department or by obtaining information directly through the web. Educational materials may include:

- Asthma Management

- Diabetes Care
- Prenatal Care
- Preventive Services
- Management of Congestive Heart Failure
- Management of COPD
- Stress Management
- Medication Safety
- Blood Pressure Control
- Maintaining a Healthy Weight
- Nutrition

Members can also log onto The Health Plan website and take a variety of interactive quizzes covering topics such as:

- Breast Cancer
- Cervical Cancer
- Colorectal Cancer
- Immunization Schedules (adult and child)
- Blood Alcohol Estimation
- Body Fat Estimator
- Body Mass Index Calculator
- Calorie Burn Rate Calculator
- Daily Energy Expenditure
- Due Date Calculator
- Ideal Weight Calculator
- Lose One Pound
- Cost of Smoking Calculator
- Target Heart Rate Calculator
- Waist to Hip Ratio

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.

RESPONSE:

The member advocate will assist caregivers in tracking appointments or testing by using the "create a reminder" application in HEART Case Tracker. The member advocate can set up daily reminders to call caregivers if needed. The member advocate can also use calendars to log appointments or testing and mail to caregivers.

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.

RESPONSE:

With our systemized data, The Health Plan would be able to electronically share the pertinent data elements in a manner to allow the WV Bureau for Public Health to incorporate pertinent information into their system files. It will be important to ensure that the care records of these 'children' are managed in a manner that ensures portability of the information so that future caregivers, etc. have access to the current and accurate information regarding the needs of the foster child. Because our systems are self-developed and we have a highly skilled staff of programmers and analysts, we are able to conform to required formats and technology for exchanged of medical information as permitted by law.

Enhanced Quality and Seamless Continuity of Care

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.

RESPONSE:

Assessing the level of care needs is a component of care/case management. The care managers begin with a health care assessment which covers medical/surgical history, psychosocial, activities of daily living (ADL), etc. From this assessment the care manager assigns a level of

management and creates a care plan. Everyone involved in the care treatment plan including the member can have an impact into the changes in the plan. The care plan is not a static document, it is revised by the care manager as the needs of the member change.

1.1.31 Describe how a vendor would handle multiple placements/removals in a way that is as seamless as possible for the child?

RESPONSE:

There are a number of options for placement and removals are performed for certain circumstances. The care manager will work with the member, caregiver or placement coordinators to ensure transitions are handled in a coordinated manner to reduce fragmented care. Although the placement changes, The Health Plan can provide a smooth transition for the child by continuing to coordinate the necessary services to meet the medical, social and emotional needs of the child and maintain the established standard of care. The care team would collaborate with the new placement and address the impact of the change in the plan of care.

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?

RESPONSE:

The Health Plan also provides assistance to members in obtaining medical care and services when benefits are not available in state, are exhausted or if a contract with a practitioner is discontinued. When coverage of health care services extends past the primary network region, the case/care manager assists the member in exploring alternative care options. Resources may be community sponsored, locally funded, or state funded. The case/care manager works with the member, a significant other, and the PCP to assist in transitioning the member to appropriate levels of care and offers suggestions for alternate resources. The social worker also may assist with locating resources as needed.

The case/care manager becomes involved, upon identification, to assist in the transition of care to another practitioner when a member's residence changes whether from county to county or state to state.

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

RESPONSE

The Health Plan is exploring the variety of payment mechanisms with a number of providers located throughout West Virginia. We recently entered into a PCMH program with one of our major providers of Medicaid services and we look to expand with similar relationships throughout the state. We also have incentive programs in place with providers to ensure and support the delivery of necessary and preventive health care services in a timely and appropriate manner. Along with these relationships we are sharing data and information with our providers in order to continually evaluate the effectiveness of our care delivery systems and work with the providers to improve those systems of care. Prior to program inception, The Health Plan will have a program established that rewards adherence with the proper utilization of services and proper level of health care services. The Health Plan recently invested in a medical data analytics program (CAVE) that will enable staff to effectively monitor and apply incentives based on the before mentioned criteria.

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.

RESPONSE:

The Health Plan's Medical Department registered nurses are available after hours, weekends and holidays to assist members to obtain care and services, wellness, prevention, the utilization management process or authorization of care. We think this is an important component to ensure our members have access to individuals who understand their plan and their individual needs and the best resources.

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

RESPONSE:

The care managers will work with the non-participating provider to develop a transition of care plan for the member to continue an ongoing course of treatment. The member's care plan is discussed and transition plan goals are identified. Pre-authorizations are entered for the ongoing care. Appropriate participating providers are provided to the primary care physician to assist with the care transition. Timeframes for transition are based on evaluation of the type of care being provided such as ongoing acute care or stable chronic or non-acute care with the primary goal being ensuring the members current and ongoing care needs are appropriately met.

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.

RESPONSE:

The Health Plan's medical directors assist the care managers and the PCP to evaluate the type of care being received by the member, diagnosis and type of specialist or sub specialist appropriate to render care for the member's individual care needs.

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.

RESPONSE:

When a member comes on the plan, an outreach representative contacts the parent/guardian to complete a health risk assessment and go over benefits and services available. This assessment is completed within 90 days of coming on the plan; however those with high clinical needs would be completed immediately. Based on the health risk assessment, any identified healthcare needs are referred to care, case, or disease managers for follow up. This electronic notification is done in real time. Any needs identified are also shared with the appropriate providers. There will also be triggers built into the health risk assessment (HRA) for referrals to the behavioral health services as required based on criteria. If a member is established with a non-par provider, nurses will assist with transition plans for continuity of care as well as obtaining pertinent clinical records from the various providers as needed to establish a clear record of care needs. Providing quick and efficient follow through on the various needs of the foster child, is paramount to ensuring their care needs are addressed promptly through the appropriate resources.

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.

RESPONSE:

New member outreach is conducted in governmental programs at The Health Plan. It is the first contact with the member. The call is educational and provides an initial screening so members with immediate needs, or complex diagnoses are referred to the care managers. If outreach

reveals immediate care needs, care manager is immediately contacted by outreach staff and works directly with member to address care needs.

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.

RESPONSE:

The Health Plan has a detailed process in place to track complaints, questions, and appeals. The process tracks all records and has established timeframes for handling each item. Our internal process includes a two- step process and both the informal (Second Reviews) and formal (Grievances) steps are available to our members to resolve and respond to all requests for appeals at no cost to the Enrollee or the Provider. We will dispose of each appeal and grievance, and provide notice, as expeditiously as the enrollee's health condition requires with state-established time frames. Enrollee's appeal rights are distributed upon enrollment, annually in the Member's Newsletter, on the website, and changes are re-distributed at least 30 days prior to change. Changes are also updated on our website immediately for enrollee's access.

We have created an Appeals Committee to review adverse determinations for our membership consistent with the related member handbooks and appeal/adverse appeal determination requirements. Our Appeals Committee is comprised of the following staff:

- Medical Director
- Director of Medical Management (or designated nurse manager)
- Director of Government Operations (or designated manager)
- Director of Pharmacy Program
- Optional representation from Quality Improvement and Behavioral Health Departments shall be assigned as relevant and necessary for review of specific cases.

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

RESPONSE:

The Health Plan has had a dual eligible special needs plan in West Virginia since January 1, 2014. The staff have been educated on dual-eligible and a D-SNP Unit is part of the Medical Department. There is a fully integrated process in place that ensures the needs of this population are addressed and incorporates the benefits of both Medicare and Medicaid to provide the most effective care plan for the member.

1.1.41 Describe how a vendor would evaluate for quality assurance and improve performance based on that review.

RESPONSE:

The Health Plan monitors key indicators of quality including: access and availability of care and services, guideline compliance, HEDIS, member satisfaction, quality of care concerns/member complaints and continuity and coordination of care.

ACCESS TO CARE

Access to Care Standards are monitored continuously through the Nurse on Call Program, through GeoAccess reports, annually through member satisfaction surveys, Telephonic review of physician offices after-hours, and review of appointment availability as needed during onsite visits, PCP changes, and member complaint analysis.

Annual data is compiled and analyzed for compliance. Physicians found to be out of compliance with the standards are required to submit a Corrective Action Plan (CAP). In regions or areas that are identified with gaps, provider relations staff will provide a network evaluation and determine how to best address gaps. Solutions may include enhanced reimbursement terms to recruit needed providers, telemedicine solutions for areas without needed specialists and access programs with regional providers to promote access. Data results are presented to the Quality Improvement Committee for additional recommendations, if needed.

As with access to essential services, ensuring that the network meets adequacy standards ensures that access is provided to affordable care. In addition to the traditional care delivery mechanisms, The Health Plan also contracts with local community resources that help to provide better access

to needed services in a convenient, affordable and quality setting. Examples include local health department, FQHC, FHC, urgent care centers and clinics and other community based providers of care. Because many of the regions of our service area are rural in nature, traditional provider practices are often not sufficient to meet all of the service needs of our populations.

Practitioner accessibility is measured against Health Plan standards and corrective actions will be implemented as needed. Results of surveys are reported to the Quality Improvement Committee. The current standards for access to care are:

- Preventive Care - Established Health Plan members calling for Preventive/Well Child Care appointments should be scheduled within 30 days. These clinical preventive services include well child care examinations, physical examinations, and routine wellness appointments. The appointments can include screenings for hypertension, elevated cholesterol, high blood sugar, and cancer. In addition, immunizations and other procedures known to prevent or detect disease in its early stages are considered preventive care.
- Routine Non-Urgent, Symptomatic Care - Health Plan members calling for routine non-urgent, symptomatic care should be scheduled within 72 hours, as clinically indicated. These clinical services provide non-urgent care for symptomatic conditions and therefore differ from wellness care.
- Behavioral Health Standard: Routine Office Visit: within 10 working days
- Urgent Care – Health Plan members calling for urgent care should be scheduled within 24 hours. These members have a disabling symptom or condition that, if not treated, could result in a more intense level of treatment.
- Behavioral Health Standard: Urgent Care: within 48 hours
- Emergency Care – Health Plan members are to be seen immediately when emergent care is needed. There can be a dramatic increase in morbidity or mortality without this care, thereby necessitating immediate evaluation and treatment.
- Behavioral Health Standard: Emergency Care: immediately
- Non-Life Threatening Emergency - members are experiencing symptoms that, if not treated, could result in the member decompensating leading to a more intense level of treatment.
- Behavioral Health Standard: Non-Life Threatening Emergency: within 6 hours
- Prenatal Care Visit – An initial prenatal care visit should be scheduled within 14 days of the date on which the woman is found to be pregnant.

- After-Hours Care – Health Plan members are to be contacted by their primary care physician or a designated covering physician within one hour of a member leaving a message through an answering service or similar means for after-hours care, on weekends, and holidays.

PRACTITIONER AVAILABILITY

GeoAccess and network adequacy standards are monitored annually or more frequently if indicated. The availability standards are:

- At least 90 percent of all members must have access to a primary care physician within 10 miles of their residence.
- At least 90 percent of female members must have access to an obstetrician/gynecologist within 20 miles of their residence.
- At least 90 percent of D-SNP members with condition specific health care needs (i.e. diabetes, COPD) must have access to a specialist with expertise in that area within 30 miles of their residence.
- At least 90 percent of all members must have access to the following identified high volume specialists within 45 miles of their residence: orthopedist, ophthalmologist, oncologist, dermatologist, podiatrist, cardiologist, and behavioral health counselor therapist.
- At least 90 percent of all members must have access to a hospital within 45 miles of their residence.
- The overall Health Plan ratio of member to primary care physician is no greater than 300:1.
- The overall Health Plan ratio of members to obstetrician/gynecologist is no greater than 1000:1.
- The overall Health Plan ratio of members to high volume specialists is no greater than 2000:1.

GUIDELINES

The Health Plan develops clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical diagnoses. Clinical practice guidelines are based on clinical literature and expert consensus and are reviewed every two years at a minimum, or more often if changes occur. These guidelines allow The Health Plan to measure outcomes of care and to identify practitioner variations in diagnosis and treatment. Collaboration with providers in establishing best practices and defining effective performance

measures is essential. primary care and/or specialty care physicians review the guidelines for applicability to Plan membership. Once reviewed, guidelines are approved by the Medical Directors' Oversight Committee.

Current guidelines are maintained on the provider web site. Notification is sent to applicable participating providers whenever revisions occur. Paper copies can be mailed to the provider if requested or they can be accessed from the web site.

Current Health Plan Clinical Practice Guidelines include:

- Access to Care and Services Standards
- Diabetes Mellitus Management Guidelines
- Patient Records Standards
- Preventive Health Services Guidelines
- Chronic Heart Failure Management Guidelines
- Management of Depression
- Substance Abuse
- Management of Chronic Obstructive Pulmonary Disease
- Management of Asthma
- Management of Acute Low Back Pain
- Perinatal Guidelines
- Diagnosis, Evaluation, Treatment of ADHD

Compliance with the guidelines is monitored on an annual basis through use of medical record review and/or HEDIS results. Data is collected and analyzed to determine practitioner adherence to the adopted guidelines and to improve practitioners' performance. Results of the reviews are reported to the Quality Improvement Committee for recommendations and guidance, if needed.

HEDIS®

The Health Plan recognizes that preventive services are a key to wellness and encourages members and providers to adhere to the Preventive Service Guidelines that are distributed annually. HEDIS reports are generated each spring and provide information regarding the areas where progress has been made as well as the areas where additional or a change in interventions, are indicated. HEDIS results are compared to national and regional statistics available through Quality Compass with the ultimate goal to achieve results in the 90th percentile.

MEMBER SATISFACTION

Member satisfaction is monitored annually with a survey. NCQA* requires the survey be conducted by a certified vendor for our Commercial, Medicaid, and Medicare populations using an NCQA approved survey tool. The survey addresses member satisfaction with The Health Plan and providers. Results of the survey are reported to NCQA and The Health Plan. Analysis of the results is performed by The Health Plan staff and includes year-to-year comparisons of rates, barriers that may affect results, and areas of opportunities for improvement. The analysis is taken to the Focus Group Committee for prioritizing what areas will be addressed and the interventions necessary to impact the rates. The Continuous Quality Improvement and Quality Improvement Committees may recommend areas for corrective action to improve member satisfaction. Development and implementation of the corrective action is supervised by the appropriate department within The Health Plan and overseen by Executive Management. Follow-up evaluation determines the success of the corrective action.

QUALITY OF CARE CONCERNS/MEMBER COMPLAINTS

Potential quality of care concerns are generated from The Health Plan Medical Department or Utilization Review Department. Quality of care concerns and complaints are investigated by the Quality Improvement Department nurses, utilizing a variety of methodologies such as:

- Administrative/claims review
- Medical record review
- Correspondence to providers and/or facilities
- Medical director review
- Quality Improvement Committee review

Cases that result in a true quality of care concern are presented to the Quality Improvement Committee for recommendations and/or corrective action.

CONTINUITY AND COORDINATION OF CARE

Continuity and coordination of care are attributes of medical care that influence overall quality and are vital to patient safety. Continuity can be defined as the lack of interruption in needed care, while coordination is a process by which medical personnel involved in the member's care communicate with each other. When communication is performed consistently and effectively, members are afforded effective and safe care.

The Health Plan considers the PCP to be the primary figure for coordination of all member health care needs.

Although formal referrals are not usually required for services, members are expected to contact their primary care physician before receiving any health care outside of the primary care setting. The primary care physician is the coordinator of all medical care for the member and still needs to coordinate referrals to specialists. The primary care physician focuses on the health of the whole person rather than on a single organ system in the body. He/she emphasizes the importance of prevention and establishes a schedule for age-appropriate health screenings. When a suspected problem does exist, he/she can make the initial diagnosis, advise the patient on further treatment and make necessary referrals ensuring that the member is referred to the most appropriate specialist for his/her specific needs. The PCP is also responsible for coordinating a unified patient record and sharing important aspects of the member's care with the various specialists involved in the care. This helps eliminate duplication of care and avoids possible safety issues and over utilization.

It may be appropriate for some members to select a secondary care physician (SCP) to provide specialty care services with respect to his/her specialty, while the primary care physician will handle the general health care needs. The SCP and the PCP work together to coordinate the member's health care and meet their medical needs. These specialties include nephrologists, medical oncologists and obstetricians/gynecologists, and endocrinologists.

The Health Plan monitors continuity and coordination of care between PCP and specialists, PCP and behavioral health practitioners, emergency department (ED) encounters and inpatient stays at least annually. During 2012, this was accomplished during the PCP annual compliance with *Standards for Patient Records*. Enhancement to our electronic data collection tool allowed for member-specific encounter data to be identified. Correspondence back from the specialist, BH practitioner, ED and/or hospital was looked for in the PCP chart. Provider and facility education is provided. The results of these reviews are presented to the Quality Improvement Committee for discussion and interventions towards improvement.

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.

RESPONSE:

Some HEDIS measurement is targeted towards individuals without complex medical needs. As examples, routine immunization schedules may not be appropriate and the frequency of expected visits may be significantly greater. Additionally, many HEDIS measures require continuous enrollment in the plan and access to data over multiple years. Movement of children in and out of the foster care system may make these longer term measurements an inappropriate mechanism for monitoring the effectiveness of care delivery for this population.

There is a greater prevalence of reported dissatisfaction with care and problems with ease of using services among parents of CSHCN. The severity of the child's condition and inadequate family-centered care are frequently associated with dissatisfaction with care and problems with ease of using health care services. Accordingly, measures of satisfaction with the providers and care delivery may provide a mechanism to measure to the delivery aspects of care.

The Health Plan would work with Delmarva to determine if other more appropriate measurement criteria are available.

However, it will be critical that whatever measurement is used that it be standardized so that results can be compared.

1.1.43 Describe the approach for evaluating member satisfaction.

RESPONSE:

Member satisfaction is monitored annually with a formal survey conducted by NCQA certified vendors. More specific surveys, such as those assessing a member's experience with care/case management services, behavior health services, provider experience, etc. are also conducted throughout the year.

Member satisfaction is also measured by monitoring member complaints and concerns through our call/contact tracking and reporting system. Our internal quality team reviews reports and data on a regular basis to address any concerns noted as a result of complaint tracking.

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:

RESPONSE:

Network providers are required to participate in The Health Plan's quality improvement program and processes. They are regularly educated on the various components and monitored to ensure compliance. Issues of non-compliant or need for improvement are addressed directly with the provider. The Quality Improvement Department establish a detailed work plan each year which incorporates a number of projects aimed at measuring the quality of care provided by our contracting providers. These are further reviewed by a number of physician based committees and reviewers.

The Health Plan recently invested in a Medical Data Analytics program that will enable staff to effectively monitor and apply incentives based on the before mentioned criteria. This program in coordination with the proper incentive programs as well as input from The Health Plan's Quality Assurance Department will address each of the criteria below.

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

RESPONSE:

The Health Plan recently invested in a Medical Data Analytics program that will enable staff to effectively monitor and communicate results on a number of quality of care measures. Using this capability, THP medical directors will be able to share this data with providers at both a personal level as well as a network wide overview.

THP will be working with providers to establish an incentive based program for reimbursement that will capitalize on the quality measures identified as improving the level of care received by our members. Providers identified as consistently compliant with the measure mentioned previously as well as THP policies and procedures will be considered for THP "Gold Card" status which will alleviate the need for certain reviews and authorizations currently in place to insure THP members are receiving the appropriate level of services. Additionally, programs are

currently in development which provide rewards and incentives consistent with the PCMH model as described in section 1.1.33 of this RFI.

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

RESPONSE:

By utilizing our data analytics software, this will enable The Health Plan to share best practices and allow a more sophisticated reporting structure with our provider community. In addition, our medical directors will be able to share best practices to our panel of providers based upon data that comes available as part of the analytical process.

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

RESPONSE:

Providers are monitored through a variety of mechanisms including HEDIS reviews, Nurse Information Line, guideline reviews, member complaints and quality of care concerns (variances). If a physician is found to be demonstrating unacceptable performance in any of these areas there are multiple possibilities for interventions including provider education, requests for corrective action, peer review and review by the Quality Improvement Committee (QIC). The QIC has the authority to recommend corrective action ranging from a telephonic meeting with a Health Plan medical director all the way up to termination of the provider. QIC recommendations are reviewed by Executive Management for final disposition.

1.1.44.4 Strategies that could be adopted to simplify the administrative procedures

RESPONSE:

Web-based reporting of data analytics and availability of patient specific care needs are two ways we are able to simplify our strategies with regard to provider compliance. Providers are able to access their patient-specific information (based on HEDIS specifications) by logging into the secure provider web site. An interactive tool provides the most up-to-date information based on claims data. Additionally, providers are offered the opportunity to meet and review actionable reports to help them increase patient compliance. The Health and Wellness Promotion Call Center also provides follow up information to providers to keep them informed on education provided to their Health Plan patients. The call center is also able to work with the provider to help schedule members for appointments for needed care.

1.1.45 Describe the utilization management guidelines that would be employed and applied to authorize services.

RESPONSE:

The Health Plan ensures appropriate licensed health professionals supervise all review decisions. These include licensed registered nurses, behavioral health registered nurses and certified case managers. The Medical Directors review all cases where medical appropriateness is questioned and are solely responsible for making determinations based on the requested health care services. A Medical Director is available twenty-four hours a day. The Medical Director(s) communicates telephonically with primary care physicians, attending or consulting physicians and specialist review physicians in case reviews, as appropriate.

All cases which require clinical judgment outside the expertise of the UM staff are reviewed by licensed board certified specialty physicians. A list of board-certified physicians by specialty, is kept by the UM staff as a resource when needed.

The Transplant and New Technology Assessment Committee serves as the internal advisory committee that is responsible to provide the multi-disciplinary oversight and review of new and evolving technology for possible inclusion in the benefit structure. The committee also reviews individual requests for new procedures, devices, pharmaceuticals, behavioral health procedures or transplant by members or practitioners.

Review criteria is the result of multiple resources. It may have resulted from locally developed standards or nationally developed standards which have been modified and adopted by the Physician Advisory Committee (practitioners with professional knowledge or clinical expertise in the specific area of the criteria). Criteria is reviewed and updated as appropriate, at least annually

Review criteria is updated annually or as needed. Includes, but not limited to:

- Durable medical equipment manual
- Claims payment guidelines
- Practice guidelines
- Nationally recognized criteria for acute care and rehab admissions
- eMember Handbook/Benefits
- Nationally recognized clinical criteria for Home Health services
- Nationally recognized criteria for imaging/procedures
- National Medicare coverage guidelines issued by CMS
- Medical technology directory
- Infusion therapy manual/contracts
- Medical/Surgical DRG-GMLOS
- National Payer Guidelines
- Behavioral Health DRG-GMLOS

For services that have gone through the appeal process and remain denied, written notification is sent to the member and the case is sent to an Independent Reviewer.

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.

RESPONSE:

Outreach Representatives initially contact all new enrollees and complete an electronic HRA within 90 days; however, foster children must be contacted sooner in order to be in compliance

with the child receiving an initial EPSDT exam within 72 hours. For ongoing EPSDT services, members and providers are sent reminder notices based on the EPSDT periodicity schedule. The Health Plan has an electronic program built which shows EPSDT exams, immunizations, and member contacts beginning at birth or whenever the member came on the plan. The reminders are system generated based on this program. Providers return the reminder list back to THP and indicate if the member is non-compliant, missed the appointment, was a no-show, and other reasons. Based on that, Outreach Representatives contact the parent/guardian and stress how important these exams are. Based on the electronic HRA, members may be referred to care, case, or disease management or other THP resources as appropriate based on criteria. The Health Plan has access to the WV Immunization Registry and would be able to obtain records of any immunizations that the child had from any provider, including a health department. Based on this information, we could contact the provider. When the child is removed from his/her home, immunization records may easily be misplaced so accessing a central repository will allow continuity of care. It will also avoid over or under utilization of services. Providers want to be accurate in the services they are rendering to their patients. The Health Plan will monitor utilization for this population more closely than the TANF population as we consider their special needs are different than the TANF children.

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.

RESPONSE:

The Health Plan is poised to improve clinical outcomes because we employ a dedicated IN HOUSE Behavioral Health department that addresses both mental health and substance abuse admissions and visits and collaborates with medical and pharmacy care needs. In our department, our referral coordinators, utilization review nurse and case and care manager's work closely together to tie in the whole picture of the member. One growing area of treatment is substance abuse. Our utilization manager conducts concurrent reviews with the inpatient facility and reviews for appropriateness of treatment, making sure that the member is stepped down, or up, to the appropriate treatment level. The member is also followed after discharge from all programming by the care manager to ensure that the member is following up on an outpatient basis and also to assist in facilitating treatment. The care manager will continue to educate the member and be the member's contact person at The Health Plan. We also integrate our services

with other departments. Some of our initiatives with the pharmacy department address members new to anti-depressant therapy, children 6 years to 12 who are new to ADHD medication and members with prescriptions for Suboxone.

Through these initiatives, members receive calls from the case and care managers addressing such things as side effects, the need for follow-up appointments with prescribing physicians and give the member a chance for open dialogue. Educational materials are provided

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.

RESPONSE:

The Health Plan recognizes that there are instances where face-to-face visits are not possible. In these cases, Telemedicine and Telehealth visits are a perfect alternative. This is especially true in the case of child psychiatry. Many areas, especially rural areas, can utilize these services to provide care that would not be available otherwise. There are multiple instances where counseling, as well as medication management, can be conducted via video or telephonically. For example, a client who has physical or behavioral limitations may not be able to attend an appointment at a distant site but can come to an originating site, a client cannot be seen by the behavioral health provider in a timely manner in that provider's office, but can be seen via Telehealth /telemedicine from the originating site, or transportation may not be possible at all. The Health Plan will not only reimburse the provider fee, but also the facility originating fee when the client is seen at an alternate facility.

1.1.49 Please describe the process that would be undertaken to manage the pharmacy benefit under a proposed program.

RESPONSE:

The Health Plan participates in the pharmacy benefit management of the Bureau of Medical Services. As such Vulnerable Youth Services members would have access to all drugs on the WV Preferred Drug List (PDL). Additionally, The Health Plan offers coverage for a limited

number of over the counter medicines and first aid products. These include over the counter fever and cold products, ointments and creams for skin infections, rashes etc., and comfort items such as bandages. THP maintains a large nationwide network of 60,000 pharmacies with nearly all pharmacies in WV participating. Additionally, THP participates with the medical care teams with the pharmaceutical management of complex patients taking multiple medications. Assistance with medication review includes compliance, omission of therapy, and classic interventions on drug/drug, drug/disease and drug/food interactions. In-House Clinical pharmacists are available to interact with members and prescribers on drug conflicts when necessary.

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?

RESPONSE:

It is assumed this population will be under the formulary and coverage rules of the WV PDL. As such moving to managed care would not generally cause a disruption of a prescribed therapy as all managed care companies and the fee for service pharmacy vendor use the same PDL. In event the member has a non formulary brand name drug it would come under coverage review. To assure the member's therapy is not disrupted during the review period, an automatic 72 hour supply is offered at the point of sale pharmacy while the coverage review is completed. THP handles coverage reviews within 24 hours of receipt of the request for a non formulary brand drug. Determinations are communicated in writing to the member and prescriber. If time constraints warrant an outreach call this is attempted with the member, prescriber and if necessary the pharmacy. The WV Bureau of Medical Services creates all coverage review rules through the Drug Utilization Review Subcommittee of the WV BMS Pharmacy and Therapeutics Committee. THP follows these rules. Consideration is always made if the prescriber can provide evidence of potential risk that could occur if the patient is switched off a medication that has provided a desired response.

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?

RESPONSE:

THP uses two computer generated surveillance programs to affect drug utilization review. These programs are Concurrent Drug Review (CDR) and Rational Drug Therapy (RT). CDR reviews new and refill transmissions from the pharmacy to our member files to determine if a conflict exists. Conflicts can be drug interactions, duplication of therapy, age appropriateness, and non-compliance. If detected information is sent to the pharmacy for intervention by the pharmacist at the time of dispensing. The Health Plan also contracts with a consultant psychiatrist who is available to assist with questions on medication management issues relative to psychotropic drugs. We ensure other practitioners (specifically PCP) are aware of patients who have been prescribed such drugs to hopefully avoid any prescribing issues that may cause unnecessary interaction.

Rational Med is a safety tool that uses pharmacy claims and medical claims to discover conflicts with medications and medical conditions. This is retrospective tool that uses over 7000 rules to determine if a safety concern may exist with the member's prescription history and/or medical conditions. In today's practice of medicine there are often multiple prescribers for one patient. This creates gaps in member's medical and pharmacy history. This tool pulls all claims from all providers to discover conflicts which might occur when multiple prescribers are administering care to an individual member. An example of such a conflict could be a member taking an attention deficit medication from a behavioral health provider and has a cardiac condition being treated by a cardiologist. Drugs such as Adderall for attention deficit can worsen certain cardiac conditions. RT will discover this conflict and report it to the prescriber of the Adderall to alert the prescriber to possibly take action.

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?

RESPONSE:

When a preauthorization for service is completed, a copy is sent to the PCP as well as the member and the behavioral health provider. The preauthorization lists the name of the provider of service, the referring provider and the PCP, making all providers aware of whom they should share information with. The Health Plan addresses Continuity and Coordination of care in the Provider manual and provides a form on the website for

provider use in sharing information, as well as a release of information form. We remind providers via the newsletter what information should be shared, such as Medication changes. Our pharmacy partner will also issue alerts to providers when there is a possibility of an adverse drug risk or coordination of care concern. Both the medical and the behavioral health provider will receive this alert.

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.

RESPONSE:

The capitation arrangement would be developed using standard actuarial pricing techniques. We would likely start with actual claim experience and make appropriate adjustments for provider fee schedule differences and expected utilization differences. Utilization adjustments would include reductions for the impact of managed care and increases for improved access to care.

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?

RESPONSE:

Admin will be calculated based on direct and indirect expenses related to the management of the program.

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:

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.

RESPONSE:

Case Scenario #1 (Matt)

The assessment strategy would include the care manager reviewing the information available and facilitating care. Does Matt have the oxygen he needs in the home? If not, why? Contact to discuss with physician.

Where was Matt evaluated for his developmental delays? Ask his physician on oxygen call. Contact provider of evaluations, inquire when evaluations will be complete and provided to Matt's physician. Continue to contact provider until evaluations are received by Matt's physician.

Contact physician when follow-up is scheduled at the hospital. Contact the member's caregiver to inquire if there are any issues to prevent Matt from keeping his follow-up appointment such as transportation. The care manager will work to resolve the issues, if any.

Case Scenario #2 (Ben)

The Care/Case Manger will contact the family/guardian and conduct a thorough assessment that is specific to the member condition, whether it is ADHD, PTSD or anxiety/depression; From this assessment, the Care/Case Manager will determine what goals need to be met and what interventions will be attempted. The family/guardian is an integral part of this process by supplying information and facilitating care in the home. Since the member does not have a cap on psychiatric services, as long as the member continues to meet criteria (InterQual), the member would receive services. There is no need for a referral or preauthorization for this member to be evaluated by a psychiatrist, psychologist or counselor. If psychological testing is necessary, this must be preauthorized. There is no need for a preauthorization for any services with the psychiatrist. If this member is receiving ADHD medication a review is sent to the BH Care Manager from the pharmacy department. The Case Manager will review what information is available and the member will be placed into our ADHD program. This program is geared to educate the parent/guardian regarding correct use of medication and the need for follow-up visits and regular lab work. Educational materials are sent to the family and follow-up calls are made on a regular basis. This ADHD program would be melded into any other services he is receiving from The Health Plan. If the member is diagnosed with other Behavioral Health conditions, such as PTSD, the care manager will continue to monitor and assist the family with educational materials, assistance in finding appropriate providers for services and follow-up calls to determine if the member is improving or if alternate levels of treatment would be needed. Copies

of all preauthorization's/referrals are sent to the PCP. The PCP is also informed of all admissions to facilities

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1.1.1.1 How would a vendor educate and engage the various parties responsible for the well-being of the child and about the ongoing care required?

RESPONSE:

Case Scenario #1 (Matt)

The Health Plan's Member Care Team led by the case manager will meet to coordinate Matt's health care and services. They may consult with the medical director on the composition of the team. The participants of the team are documented in HEART Case Tracker. The team's mission is whole person care and the participants vary based on the needs of the member. Also included on the team in addition to The Health Plan staff are the member as appropriate, the caregiver and the primary care physician. The case manager can add members to the team as the need is identified for specific services such as behavioral health, certified diabetes educator, pharmacist, social worker, etc. The Member Care Team sets the next meeting date prior to the end of the current meeting. The length of time between meetings is dictated by the member's acuity, health care needs or risk stratification.

Case Scenario #2 (Ben)

Case # 2 The Care or Case Manager would regularly contact the family/guardian and assess the member condition. An integral part of the care management is the education of the family/guardian regarding, for example, medications, handling of escalated situations, follow-up visits and types of providers that are available for services. The Care or Case Manager would also assist the family/guardian to obtain the necessary care, whether finding a provider or making appointments to see a provider. If the family/guardian cannot be reached by phone, letters and post cards are sent to the family/guardian requesting contact be made.

1.1.1.2 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?

RESPONSE:

Case Scenario 1 & 2

For both case scenarios the Care/Case Manager will contact the family when informed of the case. Contact is usually within 48 hours. The care/case manager will find out what services are needed and will assist as necessary. If the member is in need of an appointment and is unable to obtain a timely appointment, the care/case manager will call the provider office and request a timely appointment, explaining the need. If the member needs to find a provider, the care/case manager will assist the family/guardian by walking them through the web site under "Find a Provider" and how to select a provider or will send the family a listing of providers, including specialty and phone number. If the family/guardian is unable to make the calls for the appointment, the care/case manager will assist in doing that. As the care plan is established regularly scheduled follow up activities will be scheduled consistent with the care plan. The care plan will be evaluated in the following instances:

1. If there is noncompliance (these are monitored in our system)
2. Care need changes
3. Transitions in care (discharge from hospital, new placement, new care needs)

1.1.1.3 When would a vendor contact the child's social worker and what information would a vendor typically share?

RESPONSE:

For both case scenarios, the social worker would be contacted if there is a release of information signed allowing the Case/Care manager to share this information. In the case of a release being signed, the Case/Care manager could share any pertinent information that the release allows. This would probably entail any information regarding goals and interventions that are being undertaken in the Case and collaborating to assure that the Social worker and the Case Manager

are working toward the same goals. An ultimate goal would be to have social worker involved in the care planning process and part of the regular team meetings.

1.1.1.4 How would a vendor track the areas of concern related to the child's care in a typical system?

RESPONSE:

Case 1 & 2 Our HEART Case Tracker system houses the entire case log. All concerns, conversations, referrals and contacts are available for review in one location.

1.1.1.5 How would a vendor coordinate the specific Durable Medical Equipment (DME) needs of the member?

RESPONSE:

During the health care assessment, DME equipment currently in the home is discussed. Additional DME needs may be identified by the care manager. She will contact the physician to communicate the need and attempt to secure an order to obtain the needed equipment through a participating DME provider.

1.1.1.6 How would a vendor address potential cultural and language barriers?

RESPONSE:

When the care/case manager completes the assessment, cultural and language barriers are assessed so that these areas can be addressed from the start of the case. The care/case manager would direct care to providers who fit Ben's cultural/language barriers. If the necessary provider cannot be found in-network, The Health Plan will find the appropriate provider(s) and work with that provider regarding payment.

1.1.1.7 How would a vendor work with the school system to ensure appropriate accommodations are made?

RESPONSE:

Physical accommodations most probably will not be necessary for Ben. However, if there is need for a special companion or aide, the care/case manager can relay that information either through his social worker or, with permission of the family/guardian, to the proper school administration to be addressed in the IEP meetings. The care/case manager would encourage the family/guardian to share medication needs with the school administration.

Matt is 19 months old and therefore eligible for West Virginia's early intervention program called Birth to Three, for infants and toddlers with developmental delays. In some areas Easter Seal services are available for Matt.