Response to

Request for Information (RFI): CRFI 0511 HHR1500000002

Managed Care or Managed Care Alternatives for Vulnerable Youth Populations

Presented to

The West Virginia Purchasing Division, on behalf of the West Virginia Department of Health and Human Resources

February 25, 2015

Improved access to care

CoventryCares of West Virginia (CCWV), an Aetna Better Health[1] plan, is experienced in administering programs for foster care children, foster care youth, and other vulnerable youth populations.

We want our members, including vulnerable youth, to receive the right care where and when they need it. Our goal is to expand access to needed, integrated health care services through an emphasis on primary care, behavioral health, and oral health services. We focus on individualized, preventive, and wellness care services that address the whole person.

To develop a continuum of care that is developmentally appropriate, addresses the unique health and psychosocial concerns of youth in placement or transitioning from custody, produces improved health outcomes, ties to health promotion and support of self-management, and is cost effective, we recommend programming that includes the following critical elements:

- Improved access to care
- Coordination of services
- Enhanced quality and seamless continuity of care
- Communication and training
- Improved oral health

We know from experience that our young members often have special and complex needs, including exposure to Adverse Childhood Experiences (ACE), that require competent and extensive coordination of care with the full continuum of providers, including specialists; psychiatric services, including trauma-informed care; and oral health providers, which research has demonstrated are vital to overall health. Our focus on care coordination, member and provider service, and quality outcomes promotes the highest level of health possible for our members.

We recommend a care coordination model, such as our Integrated Care Management (ICM) program, to be the basis of any managed care program for vulnerable youth. Our ICM program is the foundation for serving our members and providing the critical elements listed above. ICM uses a whole-person approach to address the medical, non-medical, behavioral, and social needs of members. With clinicians who have a wide variety of expertise and who are trained to assess the full biopsychosocial profile of each member, our interdisciplinary ICM team is a resource for both members and providers to help coordinate and promote access to care.

[1] In delivering services proposed in this RFI, CCWV will leverage the resources and experience of its affiliate, Aetna Medicaid Administrators LLC, which is also wholly owned by Aetna Health Holdings, LLC, and which will provide or arrange for the provision of a broad array of services under an administrative services agreement with CCWV. To simplify the presentation and add clarity to our proposal, we will refer to CCWV simply as CCWV and to Aetna Medicaid Administrators as Aetna Medicaid. For functions generally performed through the combined efforts of CCWV's affiliated entities that support Medicaid programs, we will also refer to the combination as Aetna Medicaid.

1.1.1 Establishing a statewide provider network

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.

CCWV has a local presence as a trusted collaborator in the delivery of high quality, cost-effective, and integrated managed care services in West Virginia. When in-state services are not available, Aetna Better Health affiliates maintain a comprehensive network of providers in surrounding states that is prepared to meet the treatment needs of West Virginia's vulnerable youth. This network includes the full continuum of services required by this population, ranging from prevention and primary care to residential treatment such as Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT). We recommend collaborating with the state to develop clinically appropriate and safe alternatives to residential treatment to reduce utilization of this level of care. For youth who require more restrictive settings on a short-term basis, we recommend initiating discussions with providers who may be interested in building residential programming for children and adolescents.

Aetna Medicaid has more than 28 years of national experience in building comprehensive, multi-disciplinary, and integrated Medicaid provider networks for diverse populations. We are experienced in working with state governments, local provider networks, and provider associations to expand treatment resources to meet the unique needs of child, adolescent, and young adult populations—including the diverse needs they bring to treatment and diverse geographic locations in which services are needed.

When we analyze the need for services, we consider:

1. Anticipated enrollment
2. Sub-populations to be served
3. Anticipated diverse make-up and attendant needs of each sub-population
4. Expected utilization of services
5. Numbers and types of providers needed to meet the holistic needs of the population

For example, as a starting point for calculations and assumptions, we recommend using actual West Virginia experience of treating vulnerable youth populations to analyze past utilization of services, severity of need, and other information. This data, along with input gathered from meetings held with provider associations and oversight committees, can yield assumptions about how many members each PCP, specialist, and other ancillary provider can serve.

Our experience serving foster care recipients in other states, strengthened by the information we have obtained in discussions with local community advocates and providers, has helped us to understand what the vulnerable youth population, their families, and caregivers need from their providers. For example:

- **Children currently in foster care** generally need comprehensive evaluations and assessments to determine what gaps may have occurred in their care and what services they need to address any presenting issues. These services may include preventive care, such as immunizations; mental health screenings to evaluate for trauma; and dental exams, treatment, and possible restorative care.

- **Former foster children**, especially transitional age youth who have aged out of the system, require health care appropriate to their developmental stage. We have found that young adults in this category (18 to 26 years old) often need primary preventive care, screening, and education regarding healthy sexuality, sexually transmitted infections, and substance use.
- **Post-adoption children with subsidized care** require comprehensive continuity of care plans to address ongoing behavioral and physical health needs, possible developmental, intellectual and physical disabilities, and supportive services for families. These children may be receiving home- and community-based services, which need to be authorized and monitored on a regular basis. Care from specialists is critical for this group, too.

Vulnerable youth population in West Virginia will require a comprehensive continuum of care, including the services of:

- Pediatricians
- Pediatric specialists
  - Endocrinologist
  - Gastroenterologist
  - Cardiologist
  - Pulmonologist
  - Neurologist
  - Urologist
- Pediatric general surgeon, pediatric ophthalmologist and optometrist, pediatric thoracic surgeon, pediatric neurosurgeon, pediatric gastroenterological surgeon
- Orthopedists
- Dermatologists
- Psychiatrists
- Licensed Professional Counselors
- Licensed Clinical Social Workers
- Home health for private duty nursing and skilled nursing, both Registered Nurses and Licensed Vocational Nurses
- DME providers for wheelchairs, orthotics, prosthetics, and vent supplies and ostomy supplies
- Psychologists
- Neuropsychologists
- Oncologists
- Obstetrician
- Gynecologists.

Technology that Medicaid managed care companies can bring—particularly Electronic Health Records, telehealth, and telemedicine—can be very helpful to facilitate the delivery of services to these recipients. We recommend working with local community clinics, university resources, and the federally qualified health centers, to explore the infrastructure capabilities to initiate these options.

1.1.2 Addressing provider network deficiencies

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.

We believe network adequacy is in the eye of the beholder: the member. If a member cannot access a provider, specialist, or pharmacy, then the network is insufficient, regardless of whether the network technically meets a definition of adequate.

We recommend that the health plan work closely with DHHR and stakeholders to map and study the existing provider network, find deficiencies, and identify new provider services to achieve adequacy now and in the future. This Provider/Stakeholder Committee should include a Youth Community Liaison.

The committee should rely on frequent GeoAccess reports to monitor how the provider network compares to the relevant requirements. We recommend analyzing tertiary services within travel distance and after-hours accessibility requirements using a variety of tools, including:

- Weekly analysis of appointment availability, appointment wait times, and after-hours surveys for the first 180 days of operations and then quarterly
- Weekly analysis of member inquiries, member satisfaction results, and out-of-network utilization for the first 180 days of operations and then quarterly

CCWV's comprehensive review evaluates all provider types, including PCPs, specialists, behavioral health providers, hospitals, ancillary providers, pharmacies, telehealth and community-based service providers. Our Clinical and Administrative Advisory Committees review our consolidated reports. We also present a summary of our findings to Quality Management Oversight Committee (QMOC) for review and feedback. The QMOC is an interdisciplinary committee that includes participating providers and handles our Quality Program.

When we identify a need for additional service providers, we add new providers who have met credentialing for and joined an FQHC or other group. We contact providers who have not joined our network but are registered with the state; providers who had previously closed their panels; and providers who had previously declined to join the network. We recruit providers who are new to the area by maintaining an extensive and accessible network of professional organizations, soliciting referrals from existing providers or community-based stakeholders, identifying providers who offer specialized services, and seeking recommendations from other providers.

Incentivizing providers is a proven method to increase networks and access to care. We recommend developing a value-based purchasing model like the one we use in other markets, and identifying other incentives that would attract quality providers to the entire system of care.

1.1.3 Providing 24-hour provider access in emergencies

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

CCWV gives members access to the physical and behavioral health care they need, when they need it. Our members receive the same level of assistance from us at 1:00 a.m. as they receive at 1:00 p.m. This level of accessibility is particularly critical for vulnerable youth and their caregivers, as we see every day in similar markets. Our response to question 1.1.6 provides more detail on our approach to behavioral health crisis response.

We recommend contractually requiring all provider practices to be available and accessible 24/7. We further recommend establishing a provider after-hours program to incentivize providers for West Virginia, where participating providers who see members after regular office hours would receive additional reimbursement for after-hours care. This offers members quick access to a provider instead of rushing to an Emergency Department. Through this program, the provider would have to be the member's PCP of record. In addition, we recommend requiring behavioral health to offer after-hours availability, whether through emergency contact numbers or through a facility crisis center if the provider is associated with a provider group or agency.

Recurring compliance monitoring should use a variety of methods, including site visits to provider offices, availability surveys sent to members, annual provider surveys, and evaluation of emergency department data. If a service provider office is unavailable after-hours, members should be able to link

to an on-call, after-hours Service Coordinator trained to respond to the unique needs of this specific population. The Service Coordinator would arrange for immediate care if medically necessary. If immediate care is not necessary, the Service Coordinator would continue to attempt to reach the provider that same day and ask the provider to contact the member immediately to schedule an appointment. The Service Coordinator should also contact Provider Services staff to request assistance in contacting the provider and getting the appointment scheduled. If attempts to resolve the issue are not successful on the day in question, the member should have an opportunity to select a different PCP.

1.1.4 Supporting network compliance

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.

Measuring and verifying network compliance

We recommend using Quarterly GeoAccess reports to evaluate the provider network. Other monitoring tools should include:

- An annual appointment and availability access survey
- Review of provider-to-member ratio and capacity review
- Provider Panel Study
- Secret shopper surveys
- Quarterly grievances and appeals trend and analysis reviews

Taking action if inappropriate wait times occur

When we receive inbound Member Services calls that reveal a challenge to getting a timely appointment, we flag the call for follow-up by a Provider Services Representative to follow up with the provider, as well as the member's Service Coordinator to help the member secure the appointment or find another provider if necessary.

When we identify that a provider fails to meet appointment availability or after-hours coverage requirements, our Quality Management and Provider Services departments determine the appropriate actions, which may include:

- **For providers with no previous deficiencies** – Mailing a re-education letter to remind the provider about our contractual requirements for appointment availability and what constitutes appropriate wait times for members.
- **For providers with prior complaints or deficiencies** – Through Provider Services, conducting tailored, face-to-face re-education to meet the needs of that particular provider.
- **For providers who fail to comply or refuse to discuss the deficiency** – Requiring the provider to submit a Corrective Action Plan (CAP) within 30 days which details improvement milestones within an appropriate timeframe; then following up with the provider to check CAP progress and report status to the appropriate Service Area's Clinical and Administrative Advisory Committee. Once the provider successfully completes the CAP, a Provider Services Representative conducts a follow-up audit to verify continued compliance with standards. A summary of actions is presented to the QMOC.
- **If non-compliance continues** – Through the Service Area's Clinical and Administrative Advisory Committee, restricting new member assignments to the provider's panel or terminating the provider contract.

1.1.5 Accommodating exceeded projected enrollment

Describe the approach(es) that would be taken to accommodate actual member enrollment if total exceeds projected enrollment, if this scenario presents an issue.

CCWV and our affiliate plans regularly measure network adequacy, report results, take action, and conduct follow-ups to prevent and address potential network gaps. However, several factors may cause unexpected growth exceeding expectations, including sudden reduction in the availability of providers and changes in health care reform. We bring long-term presence and experience serving vulnerable populations, and our national support and resources enable us to immediately respond to an influx of members resulting from eligibility increases, program modifications, and changes to state or federal legislation. In these instances, we take immediate action to see that members have uninterrupted access to quality care concurrently with implementation of our long-term solutions.

Through the experience of our affiliates, we have learned how to implement immediate actions to avoid care disruptions for our members.

We use frequent GeoAccess reporting to monitor provider accessibility. It we identify the need to fortify our provider network due to a membership increase, we recruit new PCPs, behavioral health providers, and needed specialists; contact PCPs and encourage open panels with opportunity for improved value-based purchasing; and set up out-of-network authorizations and letters of agreement, if needed, until providers join the network.

Our approach to developing strategies to prevent any network deficiencies in West Virginia is to work closely with DHHR and stakeholders. We advise forming a work group to thoroughly map the existing network, with particular attention to out-of-state services. We also propose an inviting the local universities and teaching centers—a potential source of resources and services that could combine with the managed care network to cover any deficiencies.

Our affiliate health plan in Kentucky faced a daunting challenge two years ago: taking on 68,000 members from a retreating managed care organization between 11:59 p.m. on July 5 and midnight on July 6. Our Kentucky health plan was able to coordinate the needs of their new membership by loading enrollment, sending ID cards, answering member and provider calls, conducting reviews, and issuing prior authorizations in record time.

By the end of the initial transition period, the Kentucky health plan:

- **Made 1,100 case management outreach contacts**
- **Identified 83 high-risk obstetrics members**
- **Initiated a full medical review for members with organ transplants**
- **Managed 50 behavioral health transitions of care and transition of care for all members impacted by pharmacy prior authorization requirements**
- **Withstood a 50% surge in fax and call volumes during the first few days**

The work group might focus on expanding residency programs; consulting with local health departments and community providers to expand providers and locations; and working with the community behavioral health centers, disability advocate groups, and community-based providers to identify service needs that are not being met.

It is essential to make sure that any managed care provider network build consider existing programs and funding streams so as not to duplicate services or put those funding streams and grants in jeopardy. Once the network is expanded and established, we recommend continuing monitoring activities to verify continued network adequacy.

1.1.6 Providing crisis response for children and caregivers

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

Timely and effective response to behavioral health emergencies is a top priority. This is particularly true for vulnerable youth, their families, and caretakers. These youth frequently have histories that include trauma and abuse that require behavioral health treatment in varying intensities. Adolescents and transitional age youth in this population may also be struggling with mental health or substance use issues, prescription drug abuse, homelessness, unplanned pregnancies, sexually transmitted diseases, and other challenges. Any of these can initiate a behavioral health emergency that requires compassionate, competent, and timely response.

To provide the appropriate level of response, we recommend that the plan:

- Provide a toll-free Behavioral Health Hotline available 24/7 for members
- At first assessment, identify members at the highest risk for behavioral health emergencies and develop a Behavioral Health Crisis Prevention and Crisis Intervention Plan for those found to be at highest risk
- Seek participation from the member; the member's legally authorized representative, appropriate behavioral health providers, and community groups when developing the Behavioral Health Crisis Prevention Plan
- Develop a strategy for effectively responding to behavioral health emergencies and preventing them from reoccurring
- Effectively communicate strategies to Member Services and service coordination and provide additional training to address the member's needs if appropriate

Our affiliate plans use a comprehensive process to respond to behavioral health crises if members or their guardians call for service. However, we recommend that the state explore various options to make contacting crisis services more attractive and convenient for youth in transition and other adolescents. This population communicates primarily through text and social media. Rather than calling 911, a crisis line, or member services, they are more likely to post a "status" concerning their emergency. We would like to consult with the state to share our recommendations for mobile technology that can facilitate appropriate emergency services for these youth in a way that responds to their needs and also engages them in the treatment process.

For children and adolescents who require treatment services, we recommend working with the State and local providers to establish a wide range of crisis intervention services. As warranted by circumstances, population needs, and available resources in the community, this may yield additional services for members:

- **Residential crisis respite** – Stabilization for children in a behavioral health crisis, which can help up to 80% of children avoid hospitalization
- **Transition services** – Behavioral health clinician support to help transition the member from inpatient care and back to their PCP
- **Family partners** – Peer specialist support for families, helping to reduce stressors for parents and caregivers by offering parallel group services

Improved coordination of care

1.1.7 Coordinating across systems

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.

Aetna Medicaid has established a fully integrated approach to care coordination, both at the health plan and the service provision levels. This approach addresses the issues that vulnerable populations bring, especially those experienced by children who are in foster care, transitioning out of foster care, and otherwise involved with the child welfare system. Vulnerable youth and children in foster care require a vigilant, complex approach that involves all the agencies that may be involved, along with all care providers, ranging from the child placement agencies to medical specialists and hospitals.

Coordination of care takes on a heightened sense of urgency and attention because these multiple entities affect the functioning of the child. Our Care Managers would likely be sharing information regularly with DHHR case managers, foster families, and sometimes, members of the judicial system. Care Management takes on added significance because the decisions we make directly impact where and how services are provided and while also having the potential to impact placement decision-making and case and permanency planning for children and families. Implementing a collaborative care model will reduce redundancies and increase awareness of all treatment providers.

We are aware of the trends in best practices for treatment and care coordination for the vulnerable youth population, such as the collaborative care model, and propose holding joint meetings with DHHR to evaluate these best practices for implementation in West Virginia. Critical to approaching coordination of care for children in custody is working with those agencies that are responsible for their welfare: child protective services, child welfare, child placement agencies and, by extension, foster families. There are often multiple providers involved with each child to address their physical and behavioral health needs. This becomes even more complicated in the case of children who are placed in residential treatment facilities outside of the state. Because Aetna Medicaid is a national company, we have opportunity to meet with these residential facilities and facilitate coordination of care for any West Virginia child placed in their care.

For children who are still attending school, it is critical to involve educational personnel such as classroom staff and counselors who may be seeing the child while they are in school. These children may have Individual Education Plans (IEPs), which must be factored into any assessment or care planning process.

Because there are multiple organizations, agencies, and providers involved, it is critical to identify a common Individual Service Plan (ISP) to pull together all the disparate needs and goals. We offer a collaborative program for members, families, custodial parties, state and local agencies, and physical and behavioral health providers, whether in-state or located out of state. Our approach uses a core principle of managing resources and providing a fully integrated system and continuum of care. We

recommend the health plan also manage the behavioral health benefit, which makes maintaining continuity of care much more efficient and cost effective. However, regardless of whether we manage the behavioral health benefit, CCWV always works with members in a whole-person approach, including these services within the scope of each ISP to keep a focus on integrated care.

1.1.8 Providing training to support the plan of care

Describe how a vendor would provide training to ensure a plan of care that is jointly developed and shared between the primary care provider and/or specialist serving as a principal coordinating physician and the child and caregiver(s).

During ISP development, our Case Managers educate our members on the importance of sharing relevant medical and clinical information with involved providers. We explain how to authorize appropriate information exchange so participants on the member's care team receive ISP information and updates, and learn about any changes in the member's condition. We include members, their families, custodians, and legal representatives in the care planning process, any follow-up meetings, and ISP review. We can also train providers on our ISP care planning and ISP development process and included in all steps to complete these tasks.

1.1.9 Using ISFP information

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.

To the extent possible, and with authorization from the member or the member's authorized representative, ISPs should take all other relevant service planning documents into account. An essential input should be the Individualized Family Service Plan (IFSP) because this document drives the setting in which the child will be placed, what treatment is initially recommended, and who will be involved in ongoing services. In addition, the ISP should include all school-based information, plans, and service plans created outside of CCWV; plans from agencies providing services under the auspices of various waivers operational in West Virginia; Medicare MCOs (for dual eligible members); and others as applicable.

Our recommendation is to develop and include a standardized process for providing IFSPs and information to the health plan as soon as possible after a child is placed in foster care or other out-of-home placement. Because is not unusual for service providers and other agencies to question whether they should be providing this information to the health plan, a standardized process and requirement by the state would eliminate these questions. Aetna Medicaid and CCWV would be pleased to work with the state and other state-contracted vendors to develop these protocols.

1.1.10 Developing an interdisciplinary team for care planning

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.

CCWV routinely convenes Interdisciplinary Care Teams (ICTs) to address the diverse needs of members. These teams consist of primary care providers, specialists, behavioral health providers, representatives from child serving agencies, and others who are service or responsible for the child, We also believe it is very important to include the family, guardians, caretakers, and the member if they are of an age to understand the process.

In our model, the ICT convenes as early as possible in the care process and participates in the assessment and care planning from the beginning. Not all providers may have been identified at the point of assessment, but we contact those who are involved with the child and invite them to be a part of the process.

Our ICTs meet regularly, depending upon the needs of the member and any changes with the member's health status. We also recommend exploring using telehealth/telemedicine to provide members and others with face-to-face options for participating in regular ICT meetings. Our members, their parents, and other representatives provide the most important information about our clinical and non-clinical programs, services, and processes. Their vital, firsthand input helps us identify best practices, make improvements to our existing processes, improve the accessibility and availability of services, and enhance the member's overall quality of care.

1.1.11 Determining case mixes, staffing ratios, and target ratios

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.

We recommend using a case mix and caseloads that are of reasonable complexity and sufficiently small to reflect the intensity of tasks required to assist vulnerable youth members. Service coordinators need dedicated time to perform the tasks associated with this role, including building relationships with members, their families, caretakers, custodians, and others; conducting assessments, arranging and coordinating services, and advocating for member needs.

Table 1.1.11: Our Service Coordinator caseload ratios optimize services for every member

	Level 1	Level 2	Level 3
Minimum requirement	Four face-to-face meetings and twelve telephonic contacts annually	Two face-to-face meetings and six telephonic contacts annually	One face-to-face meeting and three telephonic contacts annually
Maximum ratio	One Service Coordinator for every 40 members	One Service Coordinator for every 60 members	One Service Coordinator for every 170 members

For example, Service Coordinator Supervisors oversee 10-12 Service Coordinators and monitor caseloads daily. When we approach the caseload maximum thresholds, our leadership team would conduct a staffing review. Based on the results of this review, we would submit a requisition to hire additional Service Coordinators or reallocate resources, without exceeding the maximum ratios, in a way that would enable us to provide members the services they need.

1.1.12 Working with community organizations

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

By partnering with community-based organizations and other resources that serve vulnerable youth and their families, we will develop strategies to increase access to non-covered services. We propose to collaborate with agencies, such as the West Virginia Three Branch Institute, the Commission to Study Residential Placement of Children, the West Virginia Court Improvement Program, and the Education

of Children in Out of Home Care Advisory Committee, as well as many community agencies in rural areas. In addition, we propose to build relationships with a variety of community provider organizations. Our discussions with these groups will reveal population needs for non-covered services and opportunities for partnerships to address those needs.

We recommend convening collaborative relationships with all key stakeholders through a Community Advisory Council before initiating the program to ensure that all participants understand the many and diverse funding streams and reporting requirements that are involved with care for these youth. This understanding and resulting collaboration will maximize the effectiveness of the funding across the systems. For example, until the capitated managed care program includes behavioral health services, these services are currently funded by block grants, general revenue funds, and shared Medicaid match—not through the managed Medicaid funding.

1.1.13 Creating an ISP

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.

We thoroughly assess members and use assessment data to create and regularly update a comprehensive, person-centered ISP for each member. For children in custody of child welfare, we work closely with child placement agencies, state children's service agencies, and other organizations to gain access to any assessments and evaluations the member may have completed before enrolling with us. It is not unusual to find disparities between assessments, so we take the initiative to convene staffing meetings to discuss how to best come to agreement on the ultimate treatment needs of the child. The resulting ISPs articulate assessment findings, short- and long-term goals, service needs, and member preferences. Because ISPs must give a comprehensive view of each member's condition, needs, strengths, and weaknesses, we work with all individuals and entities that can contribute information so we can paint a complete picture from everyone involved in improving each child's life.

We incorporate all relevant information that affects member health care, including services the member is currently receiving, services the member is not receiving but may be beneficial, the plan for integrating and providing those services, the goals of services and treatments, the family's priorities, and the roles and responsibilities of each member of the team. To the extent possible, and with authorization from the member or their representative, the ISP accounts for school-based information, plans, and service plans created outside of our health plan, including IEPs and IFSPs, if available.

Members and their representatives are active participants in developing the ISP and in identifying others who will have input. When establishing member-centered goals, we help the family, foster family, guardian, or legal representative identify which skills they want to learn to help improve their child's participation in activities of daily living.

Members can have access to their complete ISP through our mobile app. Members can use the mobile app to easily share ISP information with providers and others. This promotes a greater degree of accuracy and continuity between providers and caregivers and empowers members and their representatives with greater control over their own care.

Providers can access their assigned member's ISP through the mobile app and through our provider portal. Providers may also update ISPs through the portal and upload any other pertinent information that should be included in the member's Aetna Electronic Medical Record.

1.1.14 Evaluating and reporting member progress

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

Member progress toward ISP goals is vital information and should documented in the member record regularly. Based on the needs of the member and at least annually, the ICT reviews the ISP. This review includes objective and subjective estimations of how the member is progressing in his or her achievement of health care goals and whether these are related to physical or behavioral health. Goals may also be psychosocial in nature, such as those related to attaining employment or housing. We would note all progress in the member's CCWV Electronic Medical Record and revise the member's goals as necessary. In addition, if warranted, we would compare the member's progress against the baseline evaluation through rescreening and reassessment to obtain post-scores. Any significant change to a member's condition or status requires an update to the ISP. These changes would often also trigger an ICT meeting to discuss these changes and the need for modifications to care and services.

In addition, CCWV would the member's ISP with changes to clinical and biopsychosocial information, as well as changes to community-based service needs, with options for medically necessary covered and non-covered services. We share this information with the member, PCP, and anyone with member-approved access through our portal. The ISP incorporates updates from the member's school IEP (if the member or representative permits it), including socialization; need for adaptive aids; health- and behavioral-related issues affecting school attendance; and any other barriers preventing the member from achieving his or her highest potential in the school and home. The ISP includes transitional information related to moving from one level of care to another, such as from inpatient to home or home to group home.

1.1.15 Tracking service coordination

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.

Currently, CCWV uses two primary methods to document contacts with individuals. When our staff contacts a member, we document the contact in the member's electronic record. Our system maintains this record as long as required; making it available to review for care planning, service authorization, and other services.

When contracted providers, such as in-home care staff, work with member, we apply electronic record verification methodology. Care workers can use an internet connection or a smart phone to document their location and the service provided. Care workers can also use landline telephones to check in and out when providing services.

All staff qualifications, whether employed by CCWV or part of a contractor's staff, would be verified before these individuals can have direct contact with members.

1.1.16 Meeting standards for timely EPSDT testing

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?

In West Virginia, we would consider offering an additional financial incentive, perhaps through use of a code modifier, to ensure completion of these screenings within 72 hours of placement. We currently cover an EPSDT visit in addition to a sick visit, sports physical, or a visit for another purpose or procedure on the same day. EPSDT screening completion would also be included as a Pay-for-Quality provider quality measure.

1.1.17 Coordinating services for members who receive non-capitated services

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

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

1.1.17.2 Nursing Facility

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

Aetna Medicaid focuses significant resources and effort on effectively coordinating care for members, including the coordination of carved-out services provided by contracted entities. Aetna Medicaid has experience serving waiver populations since 1986, when we began managing care for senior and disabled members of Arizona's groundbreaking Arizona Long-Term Care Services program.

This experience enables us to understand the services involved—including the continuum of home-based services, nursing home care, and targeted case management—and to identify barriers to optimal care. We can then develop improvement strategies through coordination of care for our members, regardless of whether we are responsible for its authorization and payment or not. The challenges that we have faced and the lessons that we have learned will be valuable in consulting with DHHR and stakeholders on how to develop effective communication and provider training strategies regarding access to non-capitated services for this vulnerable youth population.

Our collaboration efforts include developing a confidential reciprocal referral process, communication protocols, incorporating waiver services into the ISP, and regular sharing of information regarding members receiving waiver services so that care planning can accomplished.

We can coordinate with home-based service programs and providers who are new to managed care and its requirements. We will work closely with them, holding workshops and providing training. Our Provider Representatives would also be available to work individually with providers so that they feel comfortable interfacing with a managed care company and can submit clean claims. We anticipate that there may be challenges to overcome, including difficulty finding sufficient providers in rural areas or getting providers in urban areas to members' home in remote locations, and we are prepared to work with the State and providers to offer potential successful solutions to these challenges.

Through our experience in other states with managed Long-Term Services and Supports (LTSS) programs, we can coordinate with waiver, home-based, and other services in a meaningful way, effectively exchanging relevant information with members, providers, the health plan, and the State. This coordination improves the effectiveness of health care, enhances member safety, and increases

effectiveness of the person's overall goals and treatment while identifying risks and minimizing avoidable costs. For example, our mobile app, available to Aetna Medicaid members in our other markets, provides reminders regarding gaps in care, including those related to non-covered or non-capitated services. This promotes personal responsibility and increases the chances of a positive overall health outcome.

Aetna Medicaid has a standard mixed-services protocol that allocates financial and medical management responsibilities in the most commonly occurring circumstances where these situations occur. We propose to work with DHHR and the non-capitated program providers using a customized protocol that meets member needs and the needs of West Virginia. Customization may include developing reports and tracking mechanisms regarding shared members in a format that is usable, relevant, and compatible with both the providers' and our data management systems.

We also know that no protocol or process will anticipate all possible circumstances. When the agreed-upon mixed-services protocol does not correctly allocate financial and medical management responsibilities in a particular case, we will collaborate with the State to reach consensus.

Communications and training

1.1.18 Providing outreach and training to youth, and their caretakers

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.

Effective outreach to adolescents and transition age youth is critical to encouraging their participation in any type of health care services. In addition to the member material and outreach offered to members described in question 1.1.27, we offer orientation and training to members, their families, caretakers, and others involved with youths in the program. These programs are specifically designed for youth, using current terminology and messaging. We recommend collaborating with DHHR and stakeholders on how to best develop joint social media and Internet marketing and messaging approaches.

Peer Advisors

To make the training inviting and accessible to these young members, we propose a peer-to-peer program in which young people conduct the presentations and discussions as Peer Advisors. The Peer Advisors will be youth who may be enrolled in the health plan or who have had similar experiences with physical or behavioral health issues and are participating in care and progressing toward their health goals. Young members are more likely to respond to and hear messaging when given by someone to whom they can relate to. We will also explore the potential of having Peer Advisors maintain blogs where members can access day-to-day information, such as the availability of seasonal preventive care like flu vaccines.

CCWV also recommends developing a Youth Council, which will be staffed regularly by peer advisors and occasionally by operational and medical staff, such as the CCWV Chief Medical Officer. Most of the Youth Council would be members who represent the age range of the total population. We would ask this group to provide input regarding program development and feedback concerning the services they experience. This input will help us design the program and inform ongoing operations and customer service. In addition, the Youth Council would review all member materials before distribution. This review will help keep material relevant for our population.

1.1.19 Ensuring compliance with Sanders Compliance Plan

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.

CCWV will work with all other involved parties, agencies, and other organizations to ensure compliance with the Sanders Compliance Plan. This includes participating in all activities required by the Compliance Plan.

1.1.20 Ensuring EPSDT program benefits for children in legal custody

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.

As discussed in 1.1.16, we emphasize the facilitation of EPSDT services for our child and adolescent members. We combine health promotion and education activities and materials to improve the understanding of the EPSDT program by members and their families and caregivers. Our outreach activities and materials help members and their families and caregivers understand the value of this critical program, provide information on how to access EPSDT services, and assist members in using these services. This is especially important for those children placed in facilities out of state. We recommend regularly reaching out to facility staff to provide reminders about the required EPSDT services and monitors that they have been completed. Our EPSDT outreach and education strategies include:

- **General education and information** – The materials we develop and employ to support EPSDT compliance include the Member Handbook, member newsletters, surveys, on-hold messaging, health-related brochures, and website content. Our Member Handbook includes information on the EPSDT Program, child health guidelines, and tips to keep children and youth healthy. Our member newsletters include articles about the value of the EPSDT program.
- **Automated voice messaging** – We use an automated voice messaging system to remind members of upcoming well-child checkups and to follow up on missed appointments. We also use our Member Services toll-free line to educate callers during their brief on-hold waiting periods about various aspects of the EPSDT Program, and include EPSDT reminders on our website. All content presented in these various formats are included on our website for easy reference.
- **Population-specific information** – Our Outreach Coordinators send a variety of age-specific health materials to inform our members and their families and caregivers about our EPSDT Program. We mail an age-specific postcard to the homes of members who are due for a well-child visit.
- **Community collaboration** – We collaborate with community-based organizations and public agencies with similar goals. We share EPSDT information as well as information about our PCP network education at health fairs, group gatherings, and other community events. Our Quality Improvement, our Community Development teams, and representatives from local community organizations work together to identify specific topics to address.

1.1.21 Providing training and technical assistance to new enrollees and providers

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.

We use the following tools for new member orientation, which are available in hard copy and online:

- Welcome Packet
- New member welcome call

Welcome Packet

We send a Welcome Packet to all new members within five days of enrollment. The Welcome Packet includes a Member Handbook (which includes instructions on how to access the online version), a

welcome letter that includes the member's PCP contact information, a grievances and appeals flyer, and Notice of Privacy Practices. As described in 1.1.27, all of our materials are relevant to the population and presented in multimedia versions. We also suggest that the Youth Council we are introducing in our approach has the primary responsibility for the review of and input on these materials.

We recognize that some of the population will be difficult to reach. If a Welcome Packet is returned as undeliverable, we check the address we received from the State and resend the packet if we have an alternate address. If a member's information is outdated, we will make every attempt possible to locate the updated member information in our system. We generate a report for our Service Improvement Committee if a member does not receive a Welcome Packet within five days.

New member welcome calls and messages

Our new member welcome calls are important tools in the education of new members. Welcome calls provide an additional layer of outreach and communication by welcoming each new member to our plan, providing basic information, giving the member an opportunity to ask questions, and gathering data (such as language preferences and other demographic information not on the member record) that will allow us to serve better serve members. We also propose to explore texting options for the vulnerable youth population in West Virginia, especially adolescents and transition age youth. These sub-populations are more inclined to communicate by text and other social media means rather than taking phone calls.

Text messages are a viable method for sending messages that these youth will read and save. Text messages can also provide links to brief YouTube videos where members can watch information about their benefits on their smart phones.

Technical assistance

Aetna Medicaid uses a concierge model of support for our members. Our goal is to effectively and efficiently work with each member, their family, and other caretakers to resolve concerns and requests. Our Member Service Representatives (MSRs) act as concierges to facilitate access to services and resources by using a hands-on, personalized support process. Our MSRs use the skills from their training to give members individualized answers to their questions.

Provider training and assistance

The Provider Services Department is responsible for the field service and ongoing education and training of our provider community. Each Provider Services Representative has a thorough understanding of our operations and is well versed in each of our managed care programs and plans.

Our education program begins with the provider orientation process. Upon each provider's credentialing approval, we send a welcome letter. Within 30 days of the provider's effective date, a Provider Services Representative will contact the provider's office to schedule an orientation. In our new provider orientation, our local team meets face-to-face with providers and their staff to introduce requirements and processes for authorization requests and claims submissions. During our visit, we demonstrate online tools, such as how to submit, look up, and view the status of an authorization.

1.1.22 Providing program training for staff and contracted providers

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?

Our education program begins with the provider orientation process. Within 30 days of the provider's effective date, a Provider Services Representative will contact providers—including private practices, hospitals, pharmacies, and specialists—to schedule orientations. In our new provider orientation, our local team meets face-to-face with providers and their staff to introduce the requirements and processes for authorization requests and claims submissions. During our visit, we demonstrate online tools such as how to submit, look up, and view the status of an authorization. Our new provider orientation also includes topics such as reviewing the Provider Manual and the tools and processes for billing.

One of the most important topics covered is the secure exchange of member information, including Protected Health Information, according to HIPAA requirements and information related to substance use disorders according to 42CFR Part 2 requirements. We train our Provider Service Representatives to provide training regarding the HIPAA requirements that are specific to the services that vulnerable youth are receiving. We also provide training regarding privacy and confidentiality for our provider portal and mobile app, describing the security features embedded in these programs that only allow authorized individuals to access the information contained. All access to this information must be previously approved either by the member or their legally authorized representative.

For current providers, we offer educational forums with in-depth training on rotating topics. Common topics in the provider forums include covered services and enrollment, provider claims disputes, and training to address the unique needs of the covered population. Providers and their staff can choose from multiple locations and different times of the day to attend educational forums.

Our Provider Services Representatives conduct follow-up office visits to reinforce training for providers and their staff, especially concerning confidentiality issues. We also discuss claim denials related to prior authorization requirements. For prior authorization issues, our staff conducts a conference call with the provider staff and a member of our Prior Authorization team to review specific examples in the system. To support our face-to-face training, we publish reference documents, such as the Provider Manual, bulletins, and quarterly newsletters.

1.1.23 Promoting provider awareness of program requirements

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?

Providers and their office staff must successfully complete specific training on this population. Training can take place in-office, in community-based meetings, and through online resources and focus on increasing the capacity of health care providers to provide quality health care for the West Virginia vulnerable youth population, including children in foster care and children in subsidized adoptions. All training materials will include any material designed by West Virginia child welfare experts and we will develop the training curriculum in collaboration with DHHR and key stakeholders.

CCWV recommends working with DHHR and stakeholders to design a proactive and interactive provider education approach. Our Provider Services Representatives will train providers about the

needs of vulnerable youth, including existing community-based services, health homes, service coordination, and telemedicine/telehealth, as well as access to care requirements during new provider orientation and routine office visits.

We would present information so that providers:

- Have a better understanding of health, wellness, and care issues concerning vulnerable youth
- Identify barriers to quality health care for these youth
- Identify common developmental disabilities and associated secondary conditions, including the results of trauma and adverse childhood experiences
- Can identify the four goals of *The Surgeon General's Call to Action to Improve the Health and Wellness of People with Disabilities* and recognize the four barriers to quality health care, as addressed in the Americans with Disabilities Act
- Enhance accurate assessment and delivery of quality care

In addition to the above, within 30 days of joining our network, our providers would complete an orientation that addresses the specific needs of the vulnerable youth population. This orientation, plus any additional as-needed training, would include:

- Reimbursement available for assessing children's behavioral health needs in their offices
- Education to PCPs addressing the non-traditional therapies available to providers
- Information regarding trauma-informed care and what opportunities exist to attend training and certification in the evidence-based treatments available for these challenges
- Information regarding the Waiver Programs
- How to use and collaborate with, the 24/7 Behavioral Health Crisis Line, Mobile Response Crisis Teams, and other available crisis lines
- The role of the Service Coordinator
- Assessment and treatment planning, psychiatric services, substance abuse services, medication management, inpatient services, outpatient therapy, intensive outpatient services and case management services
- The importance of promoting early intervention and health screening for identification of behavior health problems and patient education
- Using behavioral health screening tools

We would provide additional trainings to address new benefits and legislative changes regarding this population.

1.1.24 Providing program information to eligible members

How would a vendor inform eligible members to educate them about their ability to participate in this program and what benefits are available to them?

We want to explore opportunities to collaborate with DHHR and other key stakeholders to promote consistent messaging and optimize opportunities to improve frequency and reach. Mobile and online marketing and messaging will be essential, especially to reach the older youth in the proposed population.

Typically, as described in our response to question 1.1.21, we notify members of the availability of program benefits through the Member Handbook (available online); new member welcome calls, messages, and welcome packets; mailings; and direct communications, such as the member

newsletter. The Member Handbook explains program specifics for vulnerable youth and lists contact information for requesting care management services at any time.

We also inform members directly about the program when we identify the need for these services. For instance, when we receive referrals or the member comes to our attention through predictive modeling or a health risk assessment or questionnaire, we contact the member, describe the program, and invite the member to participate. Once the member is enrolled, Case Managers describe the program in detail during assessment and care planning activities. During this initial contact with the member, our Case Managers inform the member about the nature of the services, circumstances under which information will be disclosed to third parties (such as complying with HIPAA), the rationale for implementing care management services, how the services may benefit the member, and the availability of a complaint process.

1.1.25 Compiling the provider manual

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

In addition to face-to-face training, our Provider Manual gives instructions for a wide range of claims mechanisms and requirements, including:

- Timely claims submission requirements
- National provider identifier
- Acceptable forms
- Claim submission and billing requirements
- Coordination of benefits
- Third-party resources
- HEDIS quick reference guide
- Billing address
- Claims inquiries
- Claims resubmission and reconsideration
- Timely filing denials and override review criteria
- Claims reconsideration process vs. appeal of claim action process
- Provider appeals of claims actions
- Right to audit
- Trauma-informed care

Our Provider Manual encourages strong collaboration with our network of credentialed and contracted providers to administer and manage efficient, effective, and quality health care to members. It also provides all of the details providers need to successfully provide services to our members. The Provider Manual offers an in-depth, step-by-step overview of topics, including specific covered health services for which the provider is responsible, prior authorization and referral procedures, multilingual and TDD availability, and others.

To offer the most effective response and care possible, we include links to a variety of articles and training opportunities, including those through the Substance Abuse and Mental Health Services Administration, the U.S. Health Resources & Services Administration, and the Agency for Healthcare Research and Quality. These resources can inform all care provided to this population from primary care to specialty psychiatric interventions.

We also make available training opportunities regarding child welfare—a complex topic. Many providers do not have experience working with this population, so we either offer training or provide links through various sources, including in-person workshops and webinars. These training sessions include information on how the system works, which authorizations need to be in place for foster parents to make medical decisions for children, when the child's child welfare case worker must be involved, and he requirements for providers to appear at court hearings and staffings. All content provided by CCWV to West Virginia providers will be co-developed and approved by DHHR.

1.1.26 Providing training programs for providers

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

a. The types of programs that would be offered, including the modality of training

b. What topics would be covered (billing, complaints, appeals, telemedicine, etc.)

c. Strategy for training providers on requirements of contract an unique needs of population

d. How provider trainings would be evaluated

e. The frequency of provider trainings

For current providers, we offer educational forums with in-depth training on rotating topics. Table 1.1.26 lists the programs we offer, the format, and the frequency. In addition, please refer to our responses to questions 1.1.21, 1.1.22, and 1.1.23 for additional information on our provider training programs.

Our Provider Services Representatives conduct follow-up office visits to reinforce training for providers and their staff. We believe in meeting face-to-face with our providers regularly to build relationships and rapport. We also discuss claim denials related to prior authorization requirements. For prior authorization issues, our staff conducts a conference call with the provider staff and a member of our Prior Authorization team to review specific examples in the system. To support our face-to-face training, we publish reference documents, such as the Provider Manual, bulletins, and our quarterly newsletters.

Table 1.1.26: Training and education for specific program areas

Program area	Provider Manual	New provider orientation	Newsletter	Onsite education	Portal	One-on-one meetings
EPSDT	Online, on demand	Initial within 30 days	Monthly and as needed	Quarterly	Monthly and as needed	As needed
Lead	Online, on demand		Monthly and as needed	Quarterly	Monthly and as needed	As needed
Children with special health care needs	Online, on demand		Monthly and as needed	Quarterly	Monthly and as needed	As needed
Asthma	Online, on demand	Initial within 30 days	Monthly and as needed	Quarterly	Monthly and as needed	As needed
Prenatal care	Online, on demand	Initial within 30 days	Monthly and as needed	Quarterly	Monthly and as needed	As needed
Dental services	Online, on demand	Initial within 30 days	Monthly and as needed	Quarterly	Monthly and as needed	As needed

Program area	Provider Manual	New provider orientation	Newsletter	Onsite education	Portal	One-on-one meetings
Behavioral health	Online, on demand	Initial within 30 days	Monthly and as needed	Quarterly	Monthly and as needed	As needed
Reduction of inappropriate utilization of emergent services		Initial within 30 days	Monthly and as needed	Quarterly	Monthly and as needed	As needed
Reduction of racial and ethnic health care disparities to improve health status	Online, on demand	Initial within 30 days		Quarterly	Monthly and as needed	As needed

1.1.27 Informing and educating members through education materials

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

We propose a multimedia approach to our member, provider, and community communications program. Please see our responses to questions 1.1.20, 1.1.21, and 1.1.24 for additional detail regarding our member materials, their development, and how we use them.

We create and enhance member educational materials with the members' needs in mind, as well as our goal to improve health literacy. The programs and materials we provide do not discriminate against members based on their health history, health status, or need for health care services.

Our affiliate health plans have adopted the enhanced national standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care developed and promoted by the United States Department of Health and Human Services Office of Minority Health. We strive to meet all 15 standards and through our Cultural Competency Plan (CCP) that addresses each of the standards that support the "Principal Standard."

We also have our own standards for developing materials—standards that are consistent with and support the CLAS standards. Because our members' needs and cultural backgrounds are diverse, we tailor our words, the tone of our messages, and any graphic representations to meet their needs, preferences, and expectations. Additionally, for young members, we focus on delivering the message in ways to which they will relate, such as using text messaging, social media, and video messaging through resources such as YouTube.

CCWV creates all member presentations and materials using what we call "plain speak." This means we:

- Use active voice in our written communications, avoiding jargon and technical language when possible. We use clear word choices and express complete thoughts
- Use legible type in at least 10-point font size (with some exceptions, such as Member ID Cards and the Provider Directory); simple layouts; and appropriate white space
- Write in clear, easy-to-understand language, helping us simplify the complexities of the health care system, including our members' benefits and services
- Organize written materials using short sentences and paragraphs

- Write materials at or below a sixth-grade reading level, according to the Flesch-Kincaid Reading Ease scale
- Translate our written English materials into Spanish and all other identified, commonly used non-English languages, free of charge, according to Contract requirements. All letters receive certification with letters of attestation to verify their accuracy
- Provide materials on our website that are compliant with the Americans with Disabilities Act and Section 508 of the Rehabilitation Act of 1973, as amended 29 USC §794(d)

1.1.28 Reminding caregivers of upcoming appointments

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.

Aetna Medicaid's mobile application, currently in development, includes a function that reminds members of necessary screenings and tests by linking to gaps in care data. CCWV Service Coordinators would work with members and caregivers to coach them on how to use the calendar function on a smart phone and other ways to remember their appointments. Our proposed peer-to-peer program may also be helpful with appointment reminders. Peer Advisors can work with those who need the most help in remembering appointments by making a reminder call a day or two in advance.

We also expect providers to be proactive in reminding members about appointments and screenings. Using live phone calls, automated calls, automated text messaging, or email, providers should send reminders to members or caretakers for each appointment.

1.1.29 Coordinating with the WV Bureau for Public Health

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.

One of the most important activities we undertake in a new program is to work closely with the state and the individual agencies that are responsible for the population being served. In West Virginia, we would meet as often as necessary with the Bureau for Public Health, DHHR, the Bureau for Children and Families, and other agencies to evaluate the current system of care for vulnerable youth. This evaluation would include a needs assessment of what gaps in care exist for the population and each sub-population and then collaborate to identify ways to fill those gaps in care. We will also work together to find ways to improve any current service sets that may not be meeting the needs of youth entirely. We seek input from state agencies, provider associations, and advocacy groups to identify providers that need to be added to the network and those who are doing the best job and need to be retained. The West Virginia Office of Project and Data Management will be key in identifying areas for improvement, whether in the provider network or in service systems.

Interfaces between existing technology systems can be difficult for a variety of reasons. We take the time and provide the resources necessary to ensure a secure, effective exchange of data between systems. The DHHR information technology staff will be important contacts as we work together to identify appropriate communication points between the our systems and SACWIS, the FACTS Report Distribution function, FACTS Reporting, Analysis, Information, and Lookup System, and other systems. We will also look to work with the CFSR composite measures, as they will provide baseline data for quality activities.

Enhanced quality and seamless continuity of care

1.1.30 Developing services for varying levels of care

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.

As discussed throughout this response, one of our first and most important tasks will be to evaluate the needs of the overall population of vulnerable youth included in the proposed program and those of each sub-population to build a provider network that will meet those needs. This is critical due to the diverse nature of each sub-population and the challenges they bring to health care. The issues most important for a 3-year-old are very different than those for a 19-year-old. We would work collaboratively with DHHR, other state agencies, providers and provider associations, advocacy groups, and the youth themselves to identify treatment needs and any gaps in care that may exist.

Once we understand the needs of the youth in the program, we can begin to develop a continuum of services to address those needs. For example, we know that because there are few opportunities for psychiatric residential treatment services within West Virginia, children who require this intensive level of care most often are placed out of state. Our process will seek to understand:

1. Do all of the children in residential care truly require that level of care?
2. For those children who do need that service, how can the resource be built in state?

It may be possible to safely and effectively treat some children who are currently in residential care by offering evidence-based alternatives, such as:

- An intensive partial hospital program combined with therapeutic foster home services
- Intensive in-home and community-based family therapy such as Multi-Systemic Therapy or Functional Family Therapy

Our goal, particularly with children, adolescents, and young adults, is to provide services that are appropriate, safe, effective, and take place in the least restrictive setting possible. That goal will form the underlying foundation of our approach to developing a range of services to meet the varying needs of the vulnerable youth population.

1.1.31 Handling multiple placements and removals

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

Continuity of care is paramount as we develop ISPs for vulnerable youth. To maintain this continuity, we would approach multiple admissions, placements, and discharges by stabilizing as many of the controllable factors as possible for the child, family, and caretakers. We would do this by assigning a

CCWV Service Coordinator or Care Manager who would follow the member throughout their treatment, regardless of what level of care they may be receiving. We would also work to maintain the same outpatient treatment providers, such as PCPs, behavioral health providers, and other specialists. This provides continuity for the member so they know that no matter where they may be placed, their doctors, counselors, and other treatment providers remain the same. Members also know they can check in with their Service Coordinator or Care Manager whenever they need to.

A critical aspect of continuity is monitoring prescription medication. It is not unusual for vulnerable youth who are placed in a variety of settings and being assessed by many professionals to be prescribed multiple medications. We focus on tracking those medications, including information on each prescription in the member's Electronic Medical Record, so that the ICT and others involved in the member's care will know the status of each medication and what each is intended to treat.

Ultimately, the goal of this activity is to make the child as comfortable as possible during these placement transitions by eliminating some of the stress that comes with them.

1.1.32 Handling out-of-state placements

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?

We want to see children placed as close to their home communities as possible so they can maintain connections with local providers and other community resources. We understand this may not be possible in every case, so we would work with child placement agencies and child welfare to complete assessments, evaluations, and ISP reviews regularly while a child is placed out of state. These assessments and reviews will help to determine when a child might be able to return to the community.

As we discuss in our response to question 1.1.30, we want to understand why a child is placed out of state and whether there is a way to bring the child back. Our experience and relationships with West Virginia's border state providers will be valuable. Preferably, we would like to be involved in the process before the out-of-state placement so that, if safely possible, we could arrange an alternative to keep the child in West Virginia. By evaluating which services exist and services that may need to be developed to address the needs of children who require a more intense level of care, we can collaboratively and creatively develop ISPs that will address service needs in a more local model.

1.1.33 Facilitating alternative payment structures

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 saving

Aetna Medicaid is committed to developing and expanding innovative payment and incentive models designed to improve quality, reduce costs, transform care delivery, and move beyond the traditional fee-for-service model. We base our approach on a comprehensive value-based purchasing strategy of

highly collaborative relationships with the provider community to maximize their participation in our three core programs:

- **Pay-for-Performance (P4P)** – Rewards providers if they demonstrate core competencies to provide quality care, enhance access and improve health outcomes
- **Pay-for-Quality (P4Q)** – Rewards providers for achieving better performance on a broad spectrum of HEDIS measures and utilization metrics for their CCWV member panel
- **Patient-Centered Medical Home (PCMH)** – Compensates providers for increasing the level of care coordination for our members

These programs support effective approaches to care delivery and care coordination, continually improving the quality of care and health outcomes. Our multi-level approach enables providers at any panel size to participate in the program that best matches their practice capability and transformation goals. Because practice transformation and movement to new payment and delivery models can be a time-intensive process, we have established an entry-level program that allows providers with even a single active member to participate. Depending on the program and the practice's capacity, a provider may participate in more than one program at a time. Providers can step up to more advanced payment models, including shared-savings and risk-sharing models.

We would build upon our existing collaborative relationships with West Virginia providers to provide resources, actionable information, and other support as they evolve and transform their clinical practices. CCWV has had a successful P4Q agreement with a provider group in the Charleston area for the past 10 years, providing us significant experience with this type of model. We also maintain a capitation arrangement with a facility in the same region.

1.1.34 Offering a member or nurse hotline

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.

Our answers below are based an optimal model with Behavioral Health services fully integrated into the Medicaid program.

A dedicated, toll-free Behavioral Health Services Hotline 24/7, 365 days a year would be fundamental to connecting members to appropriate care. We would handle crisis, urgent, and routine requests from members and remain on every call as long as necessary to address all questions.

We recommend initiating a forum to evaluate the current nurse hotlines available in West Virginia and develop a joint approach to ultimately make the resource easily accessible to members, families, and caretakers.

We would plan staffing for the hotline based on enrollment projections. In our affiliate plans where behavioral health is carved in, hotline staffs understand the recovery and resiliency principles and approaches of our integrated service model. Our behavioral health professionals would be credentialed, experienced, and trained to serve our vulnerable youth members. Hotline staff would have expertise working within the full scope of behavioral health practice, including crisis situations, children and adolescents with multiple diagnoses, co-occurring mental health and substance use issues, individuals with physical disabilities and Intellectual and Developmental Disabilities (I/DD), and other behavioral health situations that may present during crisis calls.

Our hotline call routing provides timely, accurate response to member inquiries. Members use one telephone number to access all services. When they call the toll-free hotline, our system will route them appropriately. Our Avaya telephone management system would support seamless transfer of calls within the behavioral health hotline team or between the hotline and our other departments.

We use a concierge model of support for our members. This model's goals are to effectively and efficiently work with each member to resolve concerns and requests. Member Service Representatives act as concierges to facilitate access to services and resources, using a hands-on, personalized support process.

During normal business hours, we would route calls related to behavioral health crisis situations, screening, and triage to our local health plan staff. A licensed behavioral health clinician would always available during business hours. After-hours and on weekends, behavioral health crisis and routine calls would be automatically routed to our national Call Center to prevent delay. An on-call, locally based clinical Service Coordinator would also be available to coordinate local resources for members.

The system would also support conference calling when behavioral health hotline staff need to consult with the Medical Director or others regarding complex clinical situations. Hotline staff would also warm transfer to, or conference call with, local crisis teams for intervention or mobile response.

1.1.35 Ensuring continuity of prior authorized service for transferring members

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

Our Transition of Medical Services policy supports facilitation of continuity of care for medically necessary covered services. Members who are receiving medically necessary covered services on the day before enrollment in our health plan would continue to receive those services from us without any form of prior approval and without regard to where such services are being provided by network providers or those who are not in our network until one of the following:

- The lesser of 90 calendar days
- The member has transferred, without disruption in care, to a participating provider

Members receiving case management would continue to receive services for at least 30 calendar days after the member's enrollment and will not have services reduced until we complete an assessment.

Communicating with both new and existing members during the transition period is critical for maintaining plan membership, as well as helping members understand what they need to do and how the change affects them. Our goal is to help our members and their caretakers feel confident that we will preserve continuity of care and existing relationships while implementing program changes that will directly benefit them.

1.1.36 Determining appropriateness of changes in provider

Describe how a vendor would evaluate and make certain that changes in provider are appropriate for the member's unique healthcare needs.

Our goal is to see that each member is assigned a provider who is experienced in the health care issues of vulnerable youth and challenges with which each individual is struggling with. When a member or a caregiver asks to change a PCP, we work with them to facilitate that change, locating a provider with the expertise required for appropriate care. However, we also ask why the change is requested. The answer to this question helps us determine which provider will be more suitable for the member. Additionally, we can follow up with the former provider to address any issues that need to be changed or improved.

When members or caretakers request a specialist or a behavioral health provider, we want to verify that the new provider is both qualified and suitable to treat the member. For example, if the member requests a female behavioral health therapist who is experienced in trauma-informed care, we will seek out this type of provider from our database and make referrals accordingly. We also hope to assign providers to members who are located within close geographic proximity to help mitigate transportation issues.

1.1.37 Assuring continuity of care for members with high physical or behavioral health needs

Describe how a vendor would identify and track new members with high physical or behavioral health needs to assure continuity of care.

Aetna Medicaid's proprietary, industry-leading Consolidated Outreach and Risk Evaluation (CORE) predictive modeling technology—tailored specifically for the Medicaid population—maintains data and produces reports regarding members who need case management and treatment interventions. CORE requires at least six months of claims data. It also produces reports on risk scoring and rankings to promote optimal integrated health care delivery. CORE makes it easier to proactively identify the right members for the right interventions. The typical predictive model used in the industry has a positive predictive capability of about 55%, meaning that CORE results are more predictive in multiple dimensions:

- The Emergency Department model has a positive predictive value of 72.1%, meaning that 72.1% of the time, the predicted Emergency Department utilization occurs in the next 12 months.
- Our inpatient modeling is outstanding, with a positive predictive value of 95.4%.

CCWV currently uses CORE with expanded functionality planned for July 2015. An alternative is to use self-report data and traditional surveillance methods, such as referrals, PCPs, and behavioral health providers.

1.1.38 Identifying members with immediate service needs

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.

Aetna Medicaid is experienced at implementing new programs and reaching out to members who have immediate needs for care. This activity is a key part of our implementation plan. We want to be sure that members are receiving the treatment they need and that continuity of care is maintained. In cases where there is a need for service and the member has not been receiving it, we work quickly to get treatment in place.

When implementing a new program or health plan, we use the CORE predictive modeling technology, described in 1.1.37, and applies its data analysis to the most recent claims data that can be provided by the State. This helps identify members with the highest risk of using the Emergency Department and inpatient services. CORE also identifies members with the highest need of immediate intervention, based on their past utilization and diagnostic categories.

Once these members are identified, they can be prioritized for immediate outreach by our Service Coordination, Case Management, or Care Management staff. Our team would attempt phone calls and identify members who are hard to locate so we can deploy individuals in the field to find them. After initial contact, we would perform face-to-face assessments in cases where members need to be seen by a clinical staff person to evaluate the member's level of care need and the status of current services.

1.1.39 Reviewing member complaints, questions, and appeals

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.

Members or others legally able to act on a member's behalf may file a grievance or appeal—together or separately—by calling our Member Services Department or by writing to Member Services or other health plan staff. If a member chooses to have another person act on his or her behalf, the member must submit written notification to us designating an alternate person as his or her representative. We never take punitive action against a provider for acting on member's behalf in requesting an expedited resolution or appeal.

Our goal is to resolve grievances as quickly as possible following federal and any applicable state and local regulations. We always notify the member or their representative of the resolution in writing. We document all relevant and required information in our grievances and appeals application. The system stores information throughout the process from that obtained upon initial filing of the grievance or appeal all the way through review, including comments, decisions, and communications. We review the grievances and appeals system regularly and make adjustments as needed to meet the mandated turnaround times while maintaining the confidentiality and security of our members' Protected Health Information. We also use our system to manage and provide support for all members' requests for State Fair Hearings.

1.1.40 Coordinating care for dual-eligible members

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

We make every effort to identify situations where members have other commercial health, property and casualty, workers compensation, or Medicare insurance coverage. When we discover that a member has other coverage, we document it in our business application system.

We administer Medicaid and Medicare benefits through integrated processes that improve coordination of and access to affordable care. Our bio-psycho-social approach will seamlessly coordinate all aspects of a member's care including preventive, physical health, behavioral health, social, and LTSS, regardless of payer. Our ICM model's capabilities in successfully managing dual-eligible members have been selected by other states through the award of four recent contracts for State/CMS duals demonstration programs in Illinois, Michigan, New York, and Ohio. We benefit from the insight gained through serving dual-eligible members through a large Special Needs Plan operated by the State of Arizona's Medicaid program.

Medicare is the primary insurer for dual-eligible members and covers medically necessary acute care services, including physician, hospital, hospice, durable medical equipment, SNF, and home health services, with exhaustible limits and some exclusionary criteria. Medicaid cost-drivers for dual-eligible members include long-term care for custodial nursing facility care, HCBS, transportation, dental, vision, and cost sharing for wrap-around services for Medicare benefits that have been exhausted. MIPPA drug coverage through SHIP provides pharmaceutical reimbursements.

With this segmentation of reimbursement responsibility for benefits among payers, providers have an important role in the seamless and holistic presentation and delivery of the dual-eligible member's health care services. Along with frontline provider's interactions with members, plans providing either Medicaid or Medicare coverage must address key challenges for dual-eligible members, using comprehensive coordination and collaboration to protect the dual-eligible member from any interruption in services. Instead, health plans must provide support to make certain that care transitions and linkages are successful and seamless.

- **Member strategy** – We believe the key to making benefits seamless for the member starts with our Case Manager training processes. The member's assigned Case Manager is extensively trained on the member benefit packages and coordination of care for our dual-eligible members. Our Case Managers (Care Coordinators) are a single point of contact for dual-eligible members. The member's Case Manager and the member's personalized Care Coordination Team (CCT) assist the member in the development of a person-centered plan of care and identification of attainable goals.
- **Provider strategy** – Dual-eligible members use services across all systems of care. Our priority is to develop and maintain a comprehensive provider network that includes the specialized clinical expertise necessary to manage the unique needs of our members. Physical, behavioral, LTSS, and social and community providers are integrated within our systems.
- **Community strategy** – Each dual-eligible member may have multiple providers involved in his or her care, particularly in cases in which the member is using home- and community-based services. Our community strategy supports ongoing communication with our key partners providing services; in many cases, we can arrange for no-cost services for these members, leveraging available community resources. Such resources include faith-based organizations and others that receive grants or county funding to support needs within a service area. We

leverage all funding sources for our members and use state-developed infrastructure where appropriate to reduce cost to the State.

1.1.41 Evaluating and improving performance

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

The Aetna Medicaid Quality Assessment and Performance Improvement (QAPI) program includes an annual work plan that reflects a coordinated strategy to implement the QAPI program, including planning, decision making, intervention, and assessment of results. Work plans are always specific to the program we are administering and will specify planned quality management and performance improvement activities, timeframes for reporting progress and completion, designated staff positions and/or department responsibilities, and the resources required to complete the work plan within anticipated timeframes. The QAPI program description includes a description of the organization, responsibilities, and training of the staff that are assigned to the QAPI program and referenced in the work plan.

We would use the annual QAPI work plan as an action plan to document the status and changes in activities throughout the year. We would review the QAPI work plan at least quarterly, revise it if necessary, and submit it for approval to the appropriate committees.

We would evaluate the overall effectiveness of the QAPI program and work plan annually. The annual evaluation, documented in the annual work plan, assesses the year's completed and ongoing activities. It provides analyses of results of quality management and performance improvement initiatives (including barriers to care) and report progress made in our efforts to influence safe and effective clinical practices across the network. The identification of data trends will allow us to grasp opportunities for improvement and to modify the coming year's clinical programs as necessary.

Upon completion of the annual QAPI evaluation, we would develop specific quality management and performance improvement goals for the coming year. The goals would be based on opportunities for improvement identified in the evaluation as well as those articulated by the State regulators or other key stakeholders, including members, member advocates, and providers. We would then incorporate these goals and recommended changes into the subsequent year's program and work plan.

1.1.42 Measuring quality for children and adolescents with special healthcare needs

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.

We recognize the challenges inherent in applying traditional HEDIS measures to West Virginia's vulnerable youth population. Although HEDIS does help us verify that these members are receiving the necessary preventive services, we need additional measures to assess a broader range of health care needs and provider types.

Specific challenges in using traditional measures to assess quality of care for children with special health care needs include:

- Capturing the complexity of all member needs, because not all needs are measured and recorded by using HEDIS and other standard clinical indicators alone
- Addressing widely different expected outcomes among children with the same primary condition
- Applying more behavioral health-focused measures than provided by traditional HEDIS to address the high prevalence of behavioral health conditions
- Qualifying for the study population with enough members to produce valid results because of wide variation in conditions and comorbidities among these children
- Measuring family involvement in shared decision-making; traditional satisfaction surveys lack questions to collect the required information
- Capturing access issues unique to or more prevalent for the vulnerable youth population, such as transportation obstacles and sexually transmitted diseases
- Identifying valid measures to monitor LTSS services

Through our ongoing quality monitoring process and input from the member and provider advisory committees, we propose to continue to assess and identify appropriate measures to monitor clinical quality for the unique needs of West Virginia members, such as:

- CHILD CAHPS® item set for Children with Special Health Care Needs
- Member satisfaction with Service Coordination
- Quality of LTSS services; for example, evidence of consistency in providing services following the authorized plan of care, gaps in HCBS, member quality of life, member and provider complaints, and percentage of member retention, appropriateness of physical therapy and occupational therapy services
- Transportation complaints
- Home health assessment of needed preventive services including well-child visits, immunizations, asthma action plans, and home safety measures
- Caregiver stress

Aetna Medicaid is evaluating ongoing efforts within various nationally recognized organizations and standards bodies, such as the National Quality Forum, to identify and apply additional measures that will be relevant, useful, and statistically valid for LTSS and other services for children with special health care needs.

We would use both HEDIS and other clinical indicators, together with measures listed above, to effectively gauge and measure quality for West Virginia vulnerable youth. This combined set of measures will give us a more detailed picture of a member's needs and provide better and more comprehensive member-tailored services.

1.1.43 Evaluating member satisfaction

Describe the approach for evaluating member satisfaction.

Based on national experience, we recommend several methods to obtain member and provider feedback:

- Member and provider satisfaction surveys
- Member Advisory Council
- QM/UM Committee, which includes representatives from the provider community
- Feedback from providers during Provider Services visits and provider training opportunities

- Feedback from members when Case Managers meet with members, caretakers, and others in their circle of support
- Grievances and appeals, monitored through their respective quality committees
- Regularly scheduled provider meetings in the community

1.1.44 Working with network providers to ensure accountability and quality improvement

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

Our QAPI program would be guided by a committee structure that includes input from providers; CCWV staff; various stakeholders, including member advocates and state representatives; and our Board of Directors. This committee structure would be responsible for reviewing quality information and data, approving quality initiatives and any changes to the program, and reviewing the results of performance improvement activities. These committees would also have a role in recommending and monitoring provider corrective actions, when necessary.

We recommend having a broad range of physical health, behavioral health, and specialty providers as members of the following committees:

- Quality Management/Utilization Management Committee
- Aetna Credentialing and Performance Committee
- Aetna Practitioner Appeals Committee
- Pharmacy and Therapeutics Committee

1.1.44.1 Rewarding providers for continued excellence or improvement

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

We recommend offering incentives to providers that offer high quality services to our members. We describe our approach to these incentives in our response to question 1.1.33.

1.1.44.2 Sharing best practices with providers

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

We work collaboratively with the provider community to identify practices that are promising or have been identified as evidence-based practices. Through provider newsletters, provider forums, webinars and other means, we share information regarding these practices, thereby "cross-pollinating" the entire network. Some of this activity also takes place when CCWV Provider Services Representatives meet with providers and facilities by facilitating monthly "lunch and learn" activities and distributing information to providers and their staff.

As providers seek additional training in best practice methods, we identify opportunities to offer training sessions, some of which lead to certifications. If possible, we offer continuing education credit for training. This is a great benefit to providers who must maintain a minimum level of continuing education for ongoing licensure/certification.

1.1.44.3 Taking action against poorly performing providers

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

We provide educational opportunities for providers to increase their knowledge of innovative programs and services, while reinforcing their efforts to meet requirements. When necessary, we institute corrective action plans to assist providers in making changes so that they can meet the requirements and provide the best service possible to members. Corrective action plans are provider-specific and approved by our Chief Medical Officer.

As appropriate, CCWV would apply sanctions to providers up to and including contract termination. If a provider has demonstrated an offense that must be reported, our Compliance Officer, in conjunction with the Quality Director and Chief Medical Officer would review the situation and report to the appropriate authorities.

1.1.44.4 Simplifying administrative procedures

Strategies that could be adopted to simplify the administrative procedures

Aetna Medicaid has worked with providers and state agencies in our other markets to simplify the procedures required to authorize and submit claims for services. CCWV will work with DHHR and other relevant West Virginia agencies to identify procedures that need streamlining and develop solutions to adjust them.

1.1.45 Applying UM guidelines to authorize services

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

For physical health, CCWV uses InterQual, a nationally recognized source of clinical decision-making criteria.

As the primary decision support for most behavioral health diagnoses and conditions, the Level of Care Utilization System (LOCUS) are the clinical guidelines for making decisions regarding medical necessity for behavioral health and substance abuse. The American Association of Community Psychiatrists developed LOCUS for adults. We will also use the Child and Adolescent Service Intensity Instrument (CASII), which were developed by the Work Group on Systems of Care of the American Academy of Child and Adolescent Psychiatry. It incorporates developmental, family, and community systems of care perspectives. Developmental status determines the cut-off between LOCUS and CASII. Finally, we use ASAM patient placement criteria for decisions regarding treatment for substance use disorders.

We also use Clinical Policy Bulletins (CPBs) developed by Aetna Medicaid. Aetna develops these CPBs using peer-reviewed medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of health care providers, and evidence-based guidelines from nationally recognized professional health care organizations and public health agencies. Aetna Medicaid reviews CPBs annually or more frequently as they receive relevant new medical literature, guidelines, regulatory actions, or other relevant new information warrants more frequent review. During each CPB update, Aetna conducts a comprehensive search of the peer-reviewed published medical literature to determine if there is a change in the experimental and investigational status or medical necessity of the relevant medical technologies for which the CPB

applies. Both new and revised CPB drafts undergo a comprehensive review process that includes review by Aetna's Clinical Policy Council and external practicing clinicians and approval by Aetna's CMO or his or her designee. Aetna's Clinical Policy Council includes Aetna pharmacists and medical directors from the Medical Policy & Operations unit, National Accounts Department, Behavioral Health Department, Clinical Pharmacy Department, and Health Care Delivery.

1.1.46 Screening and assessing needs for services

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.

CCWV is focused and committed to facilitating EPSDT services for members. Please see our responses to questions 1.1.16 and 1.1.20.

1.1.47 Improving clinical behavioral health outcomes

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.

Each sub-population of vulnerable youth brings unique issues based on their developmental status. School-age children may be struggling with the educational setting, where adolescents may have more difficulties with substance use, depression, sexuality, and anxiety. Transition-age youth have challenges based on emancipation issues, such as employment, continuing education, and housing, layered on relationship difficulties, and ongoing sexuality and substance use problems. And all of these groups may also be dealing with the after-effects of trauma and adverse childhood experiences, which lead to post-traumatic stress disorder and other trauma-induced issues.

To effectively address each of the diverse set of clinical presentations, we seek to build a network of providers who bring experience and training in treating the specific issues that a child, adolescent, or young adult may present. We would focus on using evidence-based treatment modalities that are well researched and recognized, such as cognitive-behavioral therapy, trauma-informed treatment, and motivational interviewing. As we identify providers who are trained in these methods and use them regularly, we will ask that they provide information regarding their certifications, training, and education so that we can refer members to them for specific concerns.

1.1.48 Using telemedicine, telehealth, and telemonitoring

Describe how a vendor would use telemedicine, telehealth, and telemonitoring services including opportunities to use video conferencing to improve quality or access to care.

Nationally, Aetna Medicaid has been offering telemedicine, telehealth, and telepsychiatry to our members and providers for years. This technology allows members to connect with providers from urban and rural areas. In addition, telehealth has increased access to specialists, particularly for our members who have transportation difficulties or who live outside of urban areas, which will be helpful in West Virginia.

We are seeing compelling evidence that telemedicine services improve health outcomes, reduce disease burden in communities, and promote the concurrent use of advanced specialty capabilities in coordination with a member's local PCP. With 80% of Emergency Department visits attributed to lack of

access to the right providers at the right time, we will offer telemedicine services to promote member access to provider services when possible.

As telemedicine services can be delivered in a variety of settings, including provider offices, health care institutions, member homes, and on mobile devices such as smart phones and tablets – we would work with closely with our Medical Director and Provider Services Representatives to identify need. Telemedicine can play an important role by offering West Virginia members and providers real-time access to the information and services they need to optimize health care. This capability is particularly important when access to specialty care is limited due to geographic, physical, or socioeconomic constraints. New advances in technology enable us to provide traditional primary care services and permit specialized diagnostic assessments and behavioral health services that are easy for members to use. We expect telemedicine to become an important part of our specialty and rural networks in West Virginia, extending our outreach to members.

We have identified potential resources for consideration in West Virginia to increase access to Child and Adolescent Psychiatry expertise:

- Massachusetts Child Psychiatry Access Project (MCPAP)[2]
- National Network of Child Psychiatry Access Programs (NNCPAP)[3]

1.1.49 Managing the pharmacy benefit

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

CCWV oversees the design and management of our pharmacy program as well as the activities of our pharmacy benefit manager (PBM). The management of the pharmacy benefit is an Aetna organization-wide endeavor, involving local staff from CCWV pharmacy management team, along with CCWV Quality Management, Provider Services, and Member Services Departments, as well as internal committees such as the Pharmacy and Therapeutics Committee. We are responsible for delegation oversight of the PBM contract.

Our contractual requirements and collaborative relationship with our PBM affords us the flexibility to request customization of PBM policies and procedures to meet the specific needs of any health plan we are contracted to administer. CCWV and our PBM have worked together to successfully customize processes, policies, and procedures as necessary to meet all contractual requirements for each of our Medicaid customers.

1.1.50 Maintaining medication regimens for new members

How would a vendor ensure that enrollees who are on a non-formulary brand name and/or other potentially costly medications do not have to change to a formulary or generic medication after enrollment?

During the initial screening and assessment process, we learn about the medications that each member is taking. At the time of program transition or immediately following enrollment, we do not require members to change any medication regimen, regardless of the plan's approved formulary. If a member was taking a non-formulary medication, we would contact the prescribing provider to evaluate

[2] Child Psychiatry Access Project - Baystate Health

[3] http://www.nncpap.org/index.html

any possible medication options that may meet the member's need and treat the condition just as well as the non-formulary drug.

If a satisfactory alternate medication is available, our Pharmacist will work with the prescribing provider to develop a plan to transition the member from the original medication to the alternate. If no alternate medication exists, our Pharmacist and Chief Medical Officer will consult with the prescriber to determine options, including whether a different type of medication would be efficacious.

1.1.51 Ensuring appropriate dosage of psychotropic medications

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 underutilization or misuse of medications?

Aetna Medicaid, in our service to vulnerable youth in other state Medicaid programs, continues to collaborate with PBMs and state agencies to monitor psychotropic medications. We have found that a lack of integrated services, primarily access to behavioral health professionals, often results in an over-reliance on psychotropic medications.

We would recommend a multi-pronged approach to monitoring quality improvement as it relates to psychotropics:

- **Giving all providers incentives to receive Trauma Informed Care training** – An effective approach to correctly identifying and appropriately responding to trauma can reduce reliance on psychotropic medication
- **Establishing a data-sharing agreement between Pharmacy Benefit Managers, MCOs and the State** – Improves monitoring of prescribing across the state
- **Requiring that children in foster care have consent forms for all psychotropic prescriptions** – Representing an appropriate clinical review has been completed and therapies approved
- **Adopting the following 2015 HEDIS metrics** – Specifically: Use of Multiple Concurrent Antipsychotics in Children and Adolescents; Metabolic Monitoring for Children and Adolescents on Antipsychotics; Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Even when appropriately prescribed, these drugs can have long-lasting and serious adverse effects. In Illinois, the state is requiring that all children on second-generation antipsychotics be screened for metabolic disease, such as diabetes. We recommend that DHHR consider a similar approach.

We would work closely with our PBM to regularly identify providers who prescribe antipsychotic medications for children outside of clinical guidelines. If a clinical review substantiates that a practice that does not meet guidelines, we would recommend a peer review and possible consultation by a Pharmacist or Behavioral Health Medical Director as an intervention.

These procedures help us monitor care for vulnerable youth and verify that our members are receiving appropriate medication dosages. When we identify providers who are prescribing outside of clinical guidelines and best practices, we offer education that specifically addresses these issues in an attempt to change the pattern. We also guide providers to available resources to help inform them about prescribing antipsychotic medications to children. These may include evidence-based, best-practice interventions to augment medication usage.

1.1.52 Ensuring access to updated medical records

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?

As described in 1.1.13, our provider portal would help PCPs and other providers access all information contained in the member's Electronic Medical Record. Data updates automatically when Service Coordinators, Case Managers and others input information. Providers can also upload information to the member's electronic record.

In addition to the Electronic Medical Record, our Service Coordinators would work personally with providers to share information and connect regarding each member's health status. As they gather information that is important to relay immediately to providers, each member's Service Coordinator would contact providers and pass it on. They would also inquire about any information that needs to be gathered by CCWV and updated in the Electronic Medical Record. Another venue for information sharing would be the regular meetings of the Interdisciplinary Care Team. Although the meetings may review information over the past three to six months, they offer an opportunity to share the latest updates to the providers.

Finance

1.1.53 Establishing capitated payments

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.

This process would involve:

1. Identifying the most recent fee-for-service claim experience for the targeted population
2. Adjusting for completion
3. Developing appropriate trend for utilization and unit cost
4. Determining and applying the managed care savings factor
5. Determining reasonable administrative costs
6. Finalize rates

Due to the large degree of differences across multiple state Foster Care programs, and the lack of experience with the West Virginia Foster Care program, it would not reliable to compare different programs.

1.1.54 Calculating administrative costs

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?

We recommend using both West Virginia Department of Insurance financial filings and financial statements of the servicing MCOs to develop an administrative load to the rate. We also recommend considering additional adjustments to include program changes such as start-up costs, and to meet additional program requirements.

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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.

1.1.56.1 Typical care management approaches

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.

Our overall approach for Matt is to seek stabilization in placement and to ensure that the most appropriate services are available. In addition, we want to arrange for a quick response to urgent or emergent situations to avoid delay in getting Matt into a higher level of care, if necessary. Our Service Coordinator would first request the results of the evaluations that have been completed. The Service Coordinator and a Medical Director with pediatric specialty would consult with Matt's provider to identify recommendations. The Service Coordinator would then contact all involved parties, engage them in a discussion regarding Matt's status, explain our approach to care management, and convene an ICT. The ICT would include Matt's social worker, the foster family, the provider, occupational therapists, in-home service providers, and any

As with Matt, our goal for Ben is to assist in stabilizing placement and to determine what the most effective health care services would be to treat any physical and behavioral health issues with which he is currently challenged. Our Service Coordinator would meet with Ben and his uncle in their home—or another location preferable to Ben's uncle—to explain available benefits and how the assessment and treatment process would work. The Service Coordinator can also address Ben's uncle's concerns about Ben's behavioral health issues, reassuring him that we will work with him to get those services in place. We would assess Ben, including his current treatment and prescription medication regimens, and discuss the next steps for his care. If Ben's uncle authorizes us to do so, the Service Coordinator would contact the school to

others who have been identified as necessary to care decisions. This group would take a collaborative care approach to determine next steps, including permanency, short- and long-term medical care goals, future educational considerations, and early intervention plans.

discuss the situation with the school counselor and Ben's teachers. In a collaborative care approach, we could convene an ICT that would include Ben, his uncle, all current providers, his social worker, and educational staff. This group would determine the need for further evaluations, a review of medications, and what the most appropriate school setting would be for Ben.

1.1.56.2 Member circles of support

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

Our Service Coordinator would convene the ICT as soon as possible after enrollment, providing information about the care management program and our care management process so that team members can be active participants. This group would address treatment issues, permanency, and future plans and goals.

Our Service Coordinator would convene the ICT as soon as possible after enrollment, providing information about the program and our care management process so that team members can be active participants. This group would address treatment issues, permanency, future plans and goals, and educational issues.

1.1.56.3 Care coordination

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?

Our Service Coordinator would initiate regular communications and meet with all involved parties as soon as possible after enrollment to convene an ICT. ICT members or others involved with Matt's care can contact us at any time. In addition, our mobile app can help Matt's circle of support access information, leave a message, or receive information from the Service Coordinator or others at CCWV.

Matt's Service Coordinator would work to facilitate appointments with assigned providers and would assist with obtaining transportation and other support services as necessary. If

As with Matt, Ben's Service Coordinator would meet with all parties, engage them in the process, and convene an ICT. The Service Coordinator would initiate and maintain regular communication throughout the transition process and on an ongoing basis. The Service Coordinator would also work to facilitate appointments, especially those to a mental health provider to evaluate the ADHD-like symptoms that Ben is experiencing.

However, it is not clear if Ben would be flagged by our CORE system and through other screening as a child needing an immediate

there were any issues with getting appointments, we would address these immediately with providers so that children with health care needs that require a high intensity of response, such as Matt, are seen quickly. If any provider could not accommodate Matt's appointment needs within a reasonable timeframe, we will seek alternate providers who are qualified to treat his medical conditions in a timely fashion.

Since Matt would be identified as a child with high intensity needs who needs assessment, an ISP, and treatment as soon as possible, he would be flagged at enrollment for immediate response by our Service Coordination team.

assessment. There is no evidence of a current diagnosis or previous Emergency Department or inpatient admissions that would signal a need for immediate response. If his record were not flagged, then we would contact Ben during the standard timeframe for screening and assessment purposes, determining through that process the urgency of his need.

1.1.56.4 Information sharing with social workers

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

In Matt's case, the Service Coordinator would be in regular contact with the social worker, sharing treatment progress and updating one another regarding the goals that the ICT developed for Matt.

Although Ben's Service Coordinator will be in regular contact with the social worker, the information shared may be limited. Ben is old enough that he may be engaged in behavioral health therapy to help him deal with the effects of the trauma he saw and experienced. Because this type of treatment is heavily protected by confidentiality regulations, our Service Coordinator will only share what is approved and required by the legal relationship that the social worker has with Ben. Although therapy may be a service required by the state, there are certain aspects of it that are not shared with state representatives, including the social worker. However, our Service Coordinator would remain engaged with the social worker, sharing the information that is approved and required, and collaborating in Ben's best interest to see that he receives the best and most appropriate care possible, and that permanency is achieved as quickly as possible.

1.1.56.5 Information tracking

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

We would record all areas of concern in the member's Electronic Medical Record. Information would include covered services, non-covered services, carved-out services, and other ancillary services necessary to provide a system of holistic care for Matt. With appropriate security in place, portions of this record would be available to view by providers, Matt's foster parents, and others authorized by Matt's legally authorized representative. The system also provides alerts regarding gaps in care and reminders to schedule appointments and screenings, such as for vaccinations or well-child checks.

We recommend using the same system for Ben.

1.1.56.6 Durable medical equipment

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

All required services would be included in the ISP and coordinated by our Service Coordinator. The Service Coordinator would facilitate authorization of any required DME and verify with the foster parent that equipment has been delivered, is set up, and explained adequately. The Service Coordinator could also monitor use of the DME to determine if the equipment is in working order and is being used correctly. We recommend assisting the foster parent in contacting the DME company if there is a problem and help to get it corrected.

We recommend applying the same services and resources for Ben and his uncle.

CoventryCares of West Virginia
An Aetna Company

1.1.56.7 Cultural and language barriers

How would a vendor address potential cultural and language barriers?

Although Matt is quite young now and these issues may not impact him, we are sensitive to the needs of his current foster family home as well as his future placement and potential adoption. These families are crucial to Matt achieving positive health outcomes and their preferences must be taken into account during the ISP and health care service provision process.

We promote cultural competency throughout the organization and provider network to make quality health care services readily accessible to the diverse membership we serve. Members and their families would receive support and services that are consistent with their personal and cultural values, beliefs, and preferences. We develop ISP goals that are suited to each member and their circles of support while honoring their cultural practices and beliefs.

We address any specific cultural and language needs that might challenge a member's ability to access care or understand healthy practices that lead to optimum health outcomes. We ensure availability of a language interpreter and translated printed materials. Beyond this, we address cultural beliefs to help the Service Coordinator begin to understand how these values affect the family and the member's health, and find the best way to coordinate the care and services that will meet the member and family's cultural needs. Cultural competency is a part of all care management training and hiring.

Being older, Ben is more likely to be aware of any cultural and linguistic differences that impact his life—including health care, school, and all other life domains. The approach we describe for Matt is also applicable to Ben. The major difference is that Ben would be engaged in any interventions regarding the need to address cultural and language barriers.

1.1.56.8 School accommodations

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

In Matt's case, there is currently no need for accommodations by a school, as he is not enrolled yet. However, he is eligible for Early Intervention services under IDEA. As Matt grows up, the foster or adoptive parents may require assistance and advocacy to work with the educational system. The Service Coordinator would include school representatives in the ICT process so they can understand the full scope of Matt's needs. The group would work with the school to identify accommodations that will be necessary for Matt to attend school. The Service Coordinator can assist the foster or adoptive parents by coaching them on self-advocacy in the school staffing setting and is available to go with them to school meetings, if they would like.

Because Ben is already having problems at school, the Service Coordinator would engage the school system to participate in the ICT process so that any accommodations can be made for him. Results of complete evaluations that may clarify any diagnosis would help to guide decision-making on exactly the type of accommodations Ben may need. As with Matt, the Service Coordinator would be available to coach Ben's uncle regarding self-advocacy with the school and can attend school staffings with him, if he chooses.

SOLICITATION NUMBER: CRFI 0511 HHR1500000002
Addendum Number: 1

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[✓] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[ ] Other

Description of Modification to Solicitation:

Addendum #1 issued to respond to Technical Questions, per the attached.

The deadline for the submission of responses remains February 25, 2015, by 1:30pm.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ATTACHMENT A

RFI Page	RFI Section	RFI Question	Question Detail	Question	Answer
Page 1 Paragraph 1	Section 1 Statement of Need	1.1	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	*Do the children and youth currently enrolled in the program obtain their physical health benefits through one of the health plans, or are they enrolled in fee for service Medicaid?*	*Currently enrolled children and youth are in fee-for-service Medicaid.*
Page 2 Paragraph 2	Section 1 Statement of Need	1.1	Responses to the RFI should be justified by industry best practice and include sufficient detail, such as recommended approach, expected deliverables, communication efforts and timelines by phase if appropriate.	*This statement is requesting a level of detail normally outlined and included in a bidders RFP response hence including confidential and trade secret information. Based on this request of detail, can responses be marked as confidential and proprietary where reasonable and then protected from what will be posted, publicly distributed and/or included in public records request?*	*Responders may opt to include or exclude information as they see fit. However, submitted information will be used per the guidelines provided in the Instructions to Vendors Responding to a Request for Information, Section 8, Disclosure. Vendors wishing to have any part of their response to be exempted from public disclosure must follow the guidelines provided therein.*

Page 1 Paragraph 2	Section 1 Statement of Need	1.1	The Department sees opportunities in bringing this population into a managed care or a managed care-like environment...	*Would you please provide clarification as to the department's view on the difference in a "managed care" or "managed care-like" environment?*	*The department is reviewing all models available to assisting these populations including managed care, accountable care (ACO), health homes, etc. "Managed care-like" is used as a term to show that there are no limitations with proposed model types.*
Page 1 Response Submission	Instructions to Vendors Section 4	4.	Acceptable delivery methods include hand delivery, delivery by courier, or facsimile.	***Instructions, Section 4 Response Submission*** *outlines three methods (hand delivery, delivery by courier, or facsimile) of submission, however in RFI,* ***Section 2 Request for Information Submission and Results*** *states "one (1) hard copy original, clearly identified as such, and two (2) additional hard copies of the entire RFI response should be submitted to the address in the Instructions to Vendors Responding to a Request for Information.* *Based on these two slightly different directions, can you please clarify what is deemed as an acceptable method of "delivery by courier" (i.e. is FedEx or UPS acceptable) and as to whether or not facsimile is an acceptable method of delivery?*	***Delivering by UPS, FedEx, etc is an acceptable method of delivery. Facsimile is also an acceptable method of submitting (if submitting by facsimile, one complete fax is acceptable; no convenience copies would be necessary).***

NA	NA	NA	NA	*If the WV Department of Health and Human Resources decides to conduct a formal procurement process for managed care or a managed care alternative for vulnerable youth populations, based on input received through the RFI, please provide a potential timeline for both the procurement and implementation.*	*No decisions have been made regarding formal issuance of a procurement, thus a timeline cannot be provided. Information received from this request will help determine the State's next steps in this effort.*

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: HHR1500000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[✓]	Addendum No. 1	[ ]	Addendum No. 6
[ ]	Addendum No. 2	[ ]	Addendum No. 7
[ ]	Addendum No. 3	[ ]	Addendum No. 8
[ ]	Addendum No. 4	[ ]	Addendum No. 9
[ ]	Addendum No. 5	[ ]	Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Coventry Cares of West Virginia
Company

Authorized Signature

2/23/15
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

INSTRUCTIONS TO VENDORS RESPONDING TO A REQUEST FOR INFORMATION

1. REVIEW DOCUMENTS THOROUGHLY: The attached documents contain a solicitation for information only. Please read these instructions and all documents attached in their entirety.

2. VENDOR QUESTION DEADLINE: Vendors may submit questions relating to this Solicitation to the Purchasing Division. Questions must be submitted in writing. All questions must be submitted on or before the date listed below and to the address listed below in order to be considered. A written response will be published in a Solicitation addendum if a response is possible and appropriate. Non-written discussions, conversations, or questions and answers regarding this Solicitation are preliminary in nature and are non-binding. Submitted e-mails should have the solicitation number in the subject line.

   Question Submission Deadline: February 5, 2015, by 5:00pm EST

   Submit Questions to: Robert P Kilpatrick, Senior Buyer
   2019 Washington Street East
   Charleston, WV 25305
   Fax: (304)558-4115 (Vendors should not use this fax number for response submission)
   Email: Robert.p.kilpatrick@wv.gov

3. VERBAL COMMUNICATION: Any verbal communication between the Vendor and any State personnel is not binding.

4. RESPONSE SUBMISSION: All responses must be delivered to the Purchasing Division at the address listed below on or before the date and time of the bid opening. Any response received by the Purchasing Division staff is considered to be in the possession of the Purchasing Division and will not be returned for any reason. The Purchasing Division will not accept responses, modifications of responses, or any other documentation associated with the response be email. Acceptable delivery methods include hand delivery, delivery by courier, or facsimile. ELECTRONIC RESPONSES THROUGH WVOASIS ARE NOT BEING ACCEPTED FOR THIS SOLICITATION. The response delivery address is:

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

   FAX NUMBER FOR RESPONSES IS (304)558-3970

Responses should contain the following information on the face of the envelope or the response may be rejected by the Purchasing Division:

REQUEST FOR INFORMATION: CRFI 0511 HHR1500000002
BUYER: ROBERT P KILPATRICK, FILE 22
RESPONSE OPENING DATE: 2/25/2015
RESPONSE OPENING TIME: 1:30PM EST

5. RESPONSE OPENING: Responses submitted for this Solicitation will be opened at the location identified for RESPONSE SUBMISSION (above) on the date at time listed above. Delivery of a response after the opening date and time may result in the response being discarded. For purposes of this Solicitation, a response is considered delivered when the response is time stamped by the official Purchasing Division time clock.

6. ADDENDUM ACKNOWLEDGMENT: Changes or revisions to this Solicitation will be made by an official written addendum issued by the Purchasing Division. Vendor should acknowledge receipt of all addenda issued with this Solicitation by completing an Addendum Acknowledgment Form, a copy of which is included with each Addendum issued. Failure to acknowledge addenda may result in the response being discarded. The addendum acknowledgment should be submitted with the response.

7. COMMUNICATIONS LIMITATIONS: In accordance with West Virginia Code of State Rules §148-1-6.6, communication with the State of West Virginia or any of its employees regarding this Solicitation during the solicitation period, except through the Purchasing Division, is strictly prohibited without prior Purchasing Division approval. From the date the Request for Information is issued and the until after the Response Opening Date and Time, contact regarding this solicitation between Vendors responding to this solicitation and individuals employed by the State is restricted to the Buyer listed above as the contact for Vendor Questions.

8. DISCLOSURE: Vendor's response to this Solicitation is considered a public document and will be disclosed to the public in accordance with the laws, rules, and policies governing the West Virginia Purchasing Division. Those laws include, but are not limited to, the Freedom of Information Act found in West Virginia Code §§29B-1-1 et seq. and the competitive bidding laws found in West Virginia Code §§5A-3-1 et seq., 5-22-1 et seq., and 5G-1-1 et seq.

   If a Vendor considers any part of its response to be exempt from public disclosure, Vendor must so indicate by specifically identifying the exempt information, identifying the exemption that applies, providing a detailed justification for the exemption, segregating the exempt information from the general response information, and submitting the exempt information as part of its response but in a segregated and clearly identifiable format. Failure to comply with the foregoing requirements will result in public disclosure of the Vendor's response without further notice. A Vendor's act of marking all or nearly all of its response as exempt is not sufficient to avoid disclosure and WILL NOT BE HONORED. Vendor's act of marking a response or any part thereof as "confidential" or "proprietary" is not sufficient to avoid disclosure and WILL NOT BE