Request For Information Submission:

CRFI 0511 HHR1500000002
Managed Care or Managed Care Alternative for Vulnerable Youth Populations

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

ORIGINAL

Community Health Solutions of West Virginia

Submitted by:

Community Health Solutions of America, Inc.
d/b/a Community Health Solutions of West Virginia

Community Health Solutions of West Virginia

February 23, 2015

WV State Purchasing Division, WV Department of Health and Human Resources
Robert Kilpatrick, Senior Buyer
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

RE: **Managed Care or Managed Care Alternative for Vulnerable Youth Populations (RFI)**
CRFI 0511 HHR1500000002

Mr. Kilpatrick,

Community Health Solutions of West Virginia (CHS-WV) is pleased to have the opportunity to respond to the State of West Virginia Managed Care or Managed Care Alternative for Vulnerable Youth Populations RFI.

If you require any additional information or clarification as you review CHS-WV response, please contact me via phone or email as listed below:

Joel Hall
(727) 212-3673– Mobile
jhall@CHSamerica.com

Best regards,

Joel Hall
Chief Revenue Officer
Community Health Solutions of West Virginia

Community Health Solutions of West Virginia

Submitter Name	RFI End Date	RFI Number
Community Health Solutions of America, Inc. d/b/a Community Health Solutions of West Virginia	February 20, 2015	CRFI 0511 HHR1500000002 MANAGED CARE OR MANAGED CARE ALTERNATIVE FOR VULNERABLE YOUTH POPULATIONS

Request Summary

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

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

The Department sees opportunities in bringing this population into a managed care or managed care-like environment through:

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

Introduction

Community Health Solutions of America, Inc. (CHS) is pleased to provide a response to the West Virginia State Purchasing Division in support of WV Department of Health and Human Resources. CHS was founded in 2003 with a commitment to serve pediatric and adult populations in need to improve health outcomes while reducing medical costs. CHS has developed an integrated Care Coordination delivery system specifically designed to focus on improved physical and behavioral health outcomes. The backbone of our approach consists of industry best practices and software technology, such as Consensus, which was specifically developed to deliver Care Coordination. Consensus is a comprehensive tightly integrated Care Coordination software package that supports Case management, Disease Management and behavioral health care needs. Community Health Solutions program is designed to facilitate care through a patient-centric, collaborative process of assessment, planning, facilitation, and advocacy. CHS's Care Management Program (CMP) serves as a means for achieving member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation.

Below are CHS' responses to CRFI 0511 HHR1500000002 - Managed Care or Managed Care Alternative for Vulnerable Youth Populations:

1.1 Improved Access to Care

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

RESPONSE: 1.1

CHS is experienced in developing similar networks in both South Carolina and Louisiana, servicing almost 350,000 Medicaid Members including a Medically Complex Children's Waiver Program.

CHS's plan for developing and maintaining a Medicaid provider network that meets the needs of the child and their caregiver addresses:

- The anticipated enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of the population;
- The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted services; The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides physical access for enrollees with disabilities.

- The number and location of enrollees assigned to out-of-state living arrangements.

1.1.1 Describe the approach(es) to establishing a statewide provider network that is comprehensive and contains providers who can provide a multi-disciplinary and comprehensive service array, either through their own practice or through collaboration with other providers; is accessible to children and their caregivers; incorporates evidence-based best practices and interventions; provides for continuous communication with stakeholders; and has capacity in rural areas and across specialty lines of health services.

RESPONSE: 1.1.1

Essential or Primary Care Providers (PCP)
In order to develop a comprehensive network of Primary Care Providers in both urban and rural areas and to facilitate access to specialty care services, CHS engages in approved marketing activities with:

- Hospital systems
- IPAs and PHOs
- Rural hospitals
- Federally Qualified Health Clinics (FQHCs)
- Rural Health Clinics (RHCs)
- County Health Departments
- School-based Health Clinics (SBHCs)
- Community Mental Health Centers
- Nurse Practitioners
- Physician Extenders

Female enrollees are provided with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's PCP if the PCP is not a woman's health specialist.

A PCP Network should satisfy the following access and availability requirements:

- Routine, preventive care appointments available within five weeks from the date of request for such care
- Urgent care appointments not deemed emergency medical conditions triaged and provided service within 24 hours of notification, if deemed necessary
- Appointments for member problems or complaints not deemed serious available within three weeks from the date of request for such care
- Initial prenatal appointments for women self-identifying as pregnant within five business days of date of request

- PCP office locations within 30 miles or 30 minutes travel time from the member's residence in urban areas (those areas not designated as "rural counties")
- PCP office locations within 60 miles or 60 minutes travel time from the member's residence in rural areas (those areas designated as "rural counties" and approved by CMS).
- Maximum in-office wait-times of one hour for scheduled appointments.

Hospitals, Specialists and Ancillary Providers
CHS suggests an open network for hospitals, specialists and ancillary providers meaning that all West Virginia Medicaid participating providers will be considered in network.

A Specialist Network should satisfy the following access and availability requirements:

- Two specialty providers of each provider type listed below who have locations of service within 60 miles of each member's residence; or
- A combination of two specialty providers for each type listed below in any one of the following combinations:
  - One of each type of specialty provider with a service location in each county, and
  - One of each type of specialty provider with a service location in a contiguous county, or
  - One of each type of specialty provider with a service location within 60 miles from the member's residence zip code

A minimum of two specialists of each type identified below within the access standards described above:

- Physician Specialties
  - Cardiologists
  - Orthopedic Surgeons
  - Physiatrists
  - Psychiatrists
  - Urologists
  - Nephrologists
  - Ophthalmologists
  - Dentists
  - Orthodontists
- Ancillary Providers
  - Durable Medical Equipment Providers
  - Home Health Providers
  - Transportation Providers
  - Skilled Nursing Facilities

The provider network should also include:

- Two durable medical equipment providers

- Two home health providers
- Providers who have training, expertise and experience in providing smoking cessation services.
- In urban areas as defined by OMPP and CMS, should include at least one behavioral health provider within 30 minutes or 30 miles;
- In rural areas as defined by OMPP and CMS, should include one behavioral health provider within 45 minutes or 45 miles of members.

Behavioral Health Providers include the following:

- Community mental health centers
- Outpatient mental health clinics
- Psychologists
- Certified psychologists
- Health services providers in psychology
- Certified social workers
- Certified clinical social workers
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses under IC 25-23-1-1(b) (3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center

1.1.2 Describe the approach(es) to addressing deficiencies in the Essential Provider and Specialty Provider networks in relation to travel times and distances that may be experienced by a member.

RESPONSE: 1.1.2

CHS monitors network adequacy and identifies gaps in our network through geocoding. If gaps are identified, additional network members are recruited. CHS collaborates with state resources if any substantial gaps in network coverage are identified.

Additionally, member complaints of wait times or accessibility are addressed with providers through the CHS Quality management process.

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

RESPONSE: 1.1.3

Emergency services, as defined by prudent lay-person laws, are available and accessible 24 hours per day through emergency departments. Contracted providers must employ an answering service during and after business hours to

assist members needing services and direct them to the most appropriate setting of care.

1.1.4 Describe the approach(es) to measuring and regularly verifying network compliance standards, and actions that will be taken if notified of inappropriate wait times before a member is seen by a provider.

RESPONSE: 1.1.4

Effective PCP contracting and management is important to improving healthcare costs and utilization. The CHS approach is to monitor and manage the PCP network. PCPs are therefore expected to conform to the following standards for appointment availability:

- Emergency care – immediately upon presentation or notification
- Urgent care – within 24 hours of presentation or notification
- Routine sick care – within 3 days of presentation or notification
- Routine well care – within six (6) weeks of presentation or notification (15 days if pregnant)

PCPs conform to the following standards for office wait times:

- Walk-ins – within two hours or schedule an appointment within the standards of appointment availability listed above.
- Scheduled appointment – within 1 hour
- Life-threatening emergency – must be managed immediately

Education is given to providers with inappropriate wait time, followed by corrective action to improve member access. In case of persistent network geographic need or high rate of closed panels, we will attempt to recruit more PCP's to meet our accessibility standards.

Complaints about failure to adhere to provider requirements of participation in the program are investigated by the CHS Quality Management department. On an on-going basis, through implementation of our Quality Management Program and Provider Performance Dashboards, our Quality Management department identifies providers who exhibit aberrant prescriptive, referral, or service provision behaviors. The complaint source receives acknowledgment of complaint receipt and is advised of the corrective action to be taken and/or resolution. If verbal/telephonic outreach is not successful, then the complainant may be notified in writing, within a timeframe that is appropriate for the complexity of the complaint.

We use annual CAHPS Survey responses to assess and improve member access to PCP and their wait time.

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

RESPONSE: 1.1.5

CHS ensures access to all necessary and appropriate levels of care. As an initial matter, the acuity of program membership plays an important role in staffing levels. The acuity of any new membership is analyzed thoroughly and appropriate staffing levels are determined. We recruit and redeploy staff according to the needs of membership.

CHS works to expand the network of providers if higher than expected enrollment occurs. In addition, we utilize temporary clinical and provider network development staff, as needed, to accommodate any initial or subsequent spike in projected membership.

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

RESPONSE: 1.1.6

Enrolled children and their families have access to the services of a 24 hour nurse line. Nurse line services include help with general health, benefits, and symptom management questions and concerns. CHS partners with mental/behavioral health providers to assist members with crisis care as needed. CHS mental health network provides behavioral health services including, but not limited to, inpatient care, outpatient services including counselling, and telephone triage.

Improved Coordination of Care

1.1.7 Describe the coordination across systems, including the educational system, and continuity of care between health care, child welfare providers, behavioral health providers and care managers with an integrated care plan for all children.

RESPONSE: 1.1.7

CHS care model is based on accurate identification and stratification of members. Members are prioritized by risk and resource utilization, actual and potential. CHS care management team assesses members in order to develop a comprehensive and integrated (behavioral and physical health) care plan (called the Interdisciplinary Care Plan) that meets their unique personal needs. This plan is developed with input from relevant care providers and members/caregivers to maximize buy-in, adherence, and produce the best possible outcomes. CHS care teams hold periodic Interdisciplinary Care Team (IDCT) conferences to develop,

discuss, approve, and monitor care plans. The assigned child Care Manager communicates with members by phone, fax, mail, secured email, and face to face visits. Moreover, he/she establishes and maintains open lines of communication among all care team members including PCP's, subspecialists, behavioral health providers, and child welfare staff. Each and every information exchange among the interdisciplinary care providers is carried out under strict HIPAA guidelines.

Continuity of care activities ensures that the appropriate individuals, including school liaisons, are kept informed of the member's treatment regimen, goals, needs, and progress. Continuity of care activities facilitate member's and care provider's interactions so that they are timely and effective. CHS continuously monitors care delivered to its members, to identify and overcome care and service barriers.

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

RESPONSE: 1.1.8

The Care Manager (CM) facilitates interdisciplinary care team (IDCT) conferences at regular intervals, as well as, encourages and facilitates discussion between PCP and caregiver between conferences. The care manager faxes or electronically delivers individual service plans (ISP) or individual family service plans (IFSP) to relevant providers.

CHS care managers and staff are trained to develop and share care plans among all providers, members and/or caregivers. Training modules include Motivational Interviewing, Case Assessments, Closing of Gaps in Care, and Communication Skills. Inclusiveness of all parties in team conferences and care planning activities increases the likelihood of adherence to care plans (see response to 1.1.7 for more detail).

1.1.9 Describe the procedures and protocols for using the individualized family service plan (IFSP) information in the development of the member ISP (individualized service plan) and to authorize services.

RESPONSE: 1.1.9

The CM discusses the IFSP with the family and the social worker and assists the IDCT in integrating elements of the IFSP into the ISP. Services requiring prior authorization are forwarded to the CHS utilization management team. CHS adheres to the State covered benefits and covered services reimbursable to

providers, while facilitating member access to non-covered or exhausted benefits as much as possible from community or local resources.

1.1.10 Describe procedures and protocols for developing and including an interdisciplinary team in the assessment and care planning process, and how this information will be transferred to the primary care provider.

RESPONSE: 1.1.10

The IDCT includes, but is not limited to, the member and/or the responsible party, the PCP, any specialists involved in the member's care, the state social worker, school resources, therapists and CHS care teams consisting of RNs, LCSWs and Resource Navigators. The IDCT meets no less than quarterly to develop and update the ISP. Progress towards established goals, barriers to goal achievement, and gaps in care are identified and interventions to close gaps are discussed with the team. The case manager coordinates ICDT efforts and facilitates effective communication between diverse members of the ICDT. The conference takes place with the PCP, as well as the caregiver and/or member. A copy of the ISP is provided to the PCP via fax or electronic method. Physician feedback and participation is vital to successful case management activities.

1.1.11 Provide a description of the appropriate case mix and staffing ratio of service coordinators to members and the target ratio of service coordinators to members for each service coordination level.

RESPONSE: 1.1.11

CHS utilizes a strong interface between members of the care team. Case managers and resource navigators are assigned using a combination of geography, membership density, and acuity level. Call center, other administrative and utilization management staff are located in Florida.

Each Resource Navigator is assigned approximately 150 members with whom they interact on a regular basis, and for whom they advocate with providers and community-based organizations. By employing Resource Navigators who reside within the community, CHS achieves several goals: 1) facilitates regular face to face contact with members; 2) enhances ability to link members to existing resources within the community; 3) advocates for members with providers within the community.

RN and LCSW case managers manage approximately 40 to 60 members, based on acuity and need. These case managers focus exclusively on assessment, care planning, and face-to-face interactions with their assigned participants, family, and professional caregivers. Utilizing the strengths of the other team members,

including call center staff and resource navigators, CHS provides a highly effective, efficient model of care.

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

RESPONSE: 1.1.12

CHS develops linkages with available community organizations in order to enable members to receive assistance with non-covered services such as child care, post-secondary education, job skills, etc. Resource navigators, being local residents with local community knowledge and ties, will be able to assist members/caregivers to tap into these community resources. A community resource directory is electronically accessible to all care team members. CHS participates in community activities sponsored by relevant community agencies to establish local market credibility and visibility.

1.1.13 Describe the process for creating an ISP, including parties to be consulted, information to be incorporated, and how the member will be involved in the process.

RESPONSE: 1.1.13

Family and/or member involvement is paramount to the success of any ISP. The child/member is assessed by the nurse and /or LCSW. Member and family strengths are incorporated into any ISP. Member preferences, goals, and values are incorporated into any ISP. The IDCT discusses domains including psychosocial needs, safety, family, education, vocational, legal, financial, and housing. Family and individual goals are defined and strategies are developed to meet those goals.

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

RESPONSE: 1.1.14

During regular and monthly contact, together with quarterly conferences, the CM evaluates member/family progress toward goals. Information from specialist and other providers, including school Individualized Education Plan (IEP) is reviewed by the IDCT. The ISP is updated with new information, progress, and barriers to goal achievement. The child/member is re-assessed no less than annually. ISP goals are quantifiable, measurable, and achievable. These goals center around the member and his or her needs, strengths, and priorities.

1.1.15 Describe a plan for tracking service coordination provided to members, including numbers and types of contact, timeliness of contacts, and qualifications of individuals making the contact.

RESPONSE: 1.1.15

Upon entering services into our proprietary case management software application, the assigned CM contacts the Child Protective Services (CPS) worker and the caregiver/member. Contact occurs monthly via phone, through quarterly home visits, and at least quarterly in the team conferences. We use LCSW, RNs, and Care Navigators with an education background in either social work or nursing such as BSW, ASW, LPNs. CCM is strongly encouraged and preferred in LCSW and RN staff. CHS also has telephonic support from call center staff. Utilization management is staffed by RNs and LPNs with support from physicians. CHS has its own physician medical director input in all CM activities, care team conferences, and IDTP.

Our proprietary case management software application is configured to track activities including contacts, time, type of contact (UM, CM, etc.), staff member, timeliness and content of contacts with both members and providers.

1.1.16 How would a vendor meet standards for American Academy of Pediatrics (AAP) for Early & Periodic Screening, Diagnosis and Treatment (EPSDT) testing within 72 hours of placement?

RESPONSE: 1.1.16

Upon notice of placement into foster care, call center staff reaches out to the member's caregiver to:

- obtain PCP name and phone number or address (if known),
- introduce the member/caregiver to CHS Care Management support program,
- offer assistance in scheduling an appointment, arranges transportation (if needed), and to confirm that appointment with the member/caregiver.

The CM may intervene with a physician office if appointment availability is limited. The CM follows up with the member/caregiver to ensure the EPSDT visit has occurred. CHS coordinates with the Sanders Field Liaison to ensure initial HealthCheck visits occur timely.

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

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

RESPONSE: 1.1.17.1

Personal care services require a referral from the PCP and coordination with the case manager. Skilled home health requires prior authorization for nursing, physical, occupational, and speech therapies. CHS develops a Standard Operating Procedure (SOP) for members receiving personal or skilled care in the home. After confirming the services provided to members through these programs, CHS continues to supplement them with other needed services without redundancy or duplication. The case manager interacts regularly with physician office and home health providers to assure smooth transitions between differing levels of care.

1.1.17.2 Nursing Facility

RESPONSE: 1.1.17.2

Inpatient skilled nursing services for rehabilitation would be subject to prior authorization through utilization management. Members living in residential or custodial long term care receive case management and coordination of services. Like members receiving case management in the community, residents of long term care facilities have, at minimum, monthly contacts, quarterly ISP conferences, and periodic face-to-face visits. CHS is committed to maintaining the highest level of independence for members through routine assessments. Assessment of members in a long term care facility takes place no less than annually to evaluate, with a physician, the least restrictive, safest living placement for the individual. The case manager coordinates with the rest of the IDCT to facilitate smooth transitions to the least restrictive care setting the team agrees the member could safely and successfully manage.

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

RESPONSE: 1.1.17.3

CM team coordinates with waiver services team for transition to CHS support program. CM team coordinates services provided through the waiver with those provided by CHS support program. After confirming the services provided to members through these programs,

CHS continues to supplement them with other needed services without redundancy or duplication.

Communications and Training

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

1.1.18 Describe how a vendor would provide outreach and training in an ongoing manner to youth and young adults and their respective caretakers who are eligible for services.

RESPONSE: 1.1.18

Call center staff performs outreach calls to engage members in CM services. During the initial phone call, the call center staff discusses benefits of participation. Information about our program is mailed to all eligible members. The assigned case manager assesses member and family needs. The case manager facilitates communication between the PCP, member/caregiver, and other members of the IDCT, to develop and implement an ISP, coordinating necessary services and disease education as applicable or needed.

1.1.19 Describe how a vendor would coordinate with other state agencies, health organizations, and community providers, as necessary, to ensure compliance with Section II.D (goal) of Sanders Compliance Plan, thus curtailing the likelihood of a party to petition the Court to reopen Sanders et al v. Lewis, as allowed in Section IX (Dispute Resolutions, Modifications, and Case Termination) of the Sanders Compliance Plan.

RESPONSE: 1.1.19

Community Health Solutions' approach to case management is an interdisciplinary, integrated, and holistic model that emphasizes a participant-centric system of care. Our case management and utilization management programs are accredited by URAC. Through a collaborative process that involves participants, family members/caregivers, providers, and CHS's dedicated Case Management (CM) Team, our Case Management program promotes preventive services; educates participants; provides early risk identification and assessments; and plans, implements, coordinates, monitors and evaluates the individual ongoing care needs of the participant. CHS embraces a holistic integrated approach to improving care by considering clinical, psychosocial, and socioeconomic aspects of the individual. Our case management initiatives encompass a whole-person approach to co-morbid, chronic, and acute conditions

as well as preventive health care needs. CHS works collaboratively and fully with providers and other caregivers to ensure that all participants' needs are addressed.

A key team member in the interdisciplinary approach is the Sanders Field Liaison who coordinates and schedules the child's initial HealthCheck visit within 72 hours of placement. The CHS team coordinates with the HealthCheck provider, foster parents, and social worker to facilitate the child's appointment and assists with any referrals or follow-up required.

1.1.20 Describe how a vendor would ensure that all children in temporary or permanent legal custody who are in out-of-home placement receive the full benefits of the EPSDT program.

RESPONSE: 1.1.20

The assigned CM and resource navigator work with caregivers and providers to schedule well child and EPSDT visits and referrals at appropriate intervals. The CM reviews the EPSDT schedule and compliance during quarterly conferences to ensure the member remains on schedule. Resource navigators perform audit for completion documentation related to routine well visits and EPSDT screening schedules and results. Screens requiring further intervention are discussed with the PCP, and the CM or resource navigator facilitates appropriate referrals.

1.1.21 Describe how training and technical assistance would be provided on an ongoing basis to new enrollees and their parents and caregivers, as well as new providers and other interested parties.

RESPONSE: 1.1.21

CHS works collaboratively and fully with providers and other caregivers to ensure that all members' needs are addressed.

Case Managers provide members with evidence-based educational programs and assist them in developing self-management skills.

CHS has training and education specific to the needs of members. CHS matches members with Limited English Proficiency (LEP) to Case Managers who are fluent in the preferred language of the member or who utilize an on-demand Language Line. CHS also assists participants with LEP in locating providers and services that have experience serving diverse cultures and populations.

CHS ensures that interpreter services are provided in an appropriate manner to members with LEP or those who have a hearing impairment. Case Managers confirm the member's primary language or if they have a hearing impairment,

during the initial phone call, and will document language preference in their record accordingly. The CM determines if the member's providers can accommodate their language preference or hearing impairment. If not, the CM facilitates a transfer to a provider who is able to do so. If the member prefers not to be transferred or if there is not a provider in their geographic area that can accommodate the communication/language needs, we work with the existing providers to ensure that interpretation and communication services are made available;

- All of CHS's marketing materials, printed publications, website, and education materials include a statement advising participants that these materials will be made available to them in their primary language, as well as Braille and audio tapes, upon request, including instructions on how to request such service;
- CHS, upon request, provides alternative forms of communication for persons with visual, hearing, speech, physical or developmental disabilities at no expense to the participant to include, but not be limited to:
  - Materials in Braille;
  - Audio tapes;
  - Materials translated in various languages;
  - Materials at lower than a sixth-grade reading level; and
  - Translator services.
- CHS's process for handling calls from participants with LEP or with a hearing impairment includes a Spanish option, Language Line option, and our TTY Text Phone. All callers are advised that their call is recorded and may be monitored for quality control purposes; and
- All CM Team members are trained in the operation of the TTY Text telephone and are able to assist callers with hearing impairment.

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

RESPONSE: 1.1.22

After the initial recruitment and enrollment activities are conducted, network responsibilities are transitioned to CHS and ongoing provider engagement and support activities are carried out by regionally-based Provider Service Representatives (PSRs) employed by CHS. PSRs meet face-to-face with each clinic or PCP office and begin to develop the infrastructure and protocols necessary for coordinated care. Initial on-site trainings may be supplemented with webinars, as needed, to ensure complete engagement of providers and their staff. PSRs make quarterly visits to each participating provider and additional visits upon request, such as when there is a change in the practice staff and additional

training is sought. In addition to providing information about the program, CHS PSRs also provide information and support about Medicaid and other issues such as HIPAA-compliant communications. By performing a vital function of trouble-shooting problems and connecting practices to resources, CHS is able to build trust within the provider practices and engage them in effective quality improvement.

CHS distributes provider handbooks, sends fax blasts and calls to provide information about our program, including benefits, requirements, rights of providers and members and HIPAA compliant exchange of information. During quarterly visits and program education seminars CHS reviews compliance with HIPAA communication guidelines. CHS is available to answer questions through our call center.

1.1.23 How would a vendor ensure that providers are aware of the requirements of this managed care or managed care-like program for foster, former foster and adoption support children, and how the needs of this population may differ from those in the traditional Temporary Assistance for Needy Families (TANF) MCO population?

RESPONSE: 1.1.23

CHS distributes provider handbooks, sends fax blasts, and calls to provide information about our program, including benefits, requirements, rights of providers and members, and foster program participants' risks and specialized needs. Additionally, CHS communicates via provider bulletins and monthly newsletters to update providers on program changes and member trends. Provider Service representatives communicate with providers regularly to ensure they have up-to-date accurate information. CHS is available to answer questions through our call center.

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

RESPONSE: 1.1.24

CHS follows state marketing guidelines when interacting with eligible members. CHS employs grass roots efforts to educate potential members about the program. Such efforts include attending community health fairs and providing program literature in physician offices when permitted. Members receive program education via handbooks, newsletters, periodic mailings, and auto-calls encouraging members to call back with any questions.

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

RESPONSE: 1.1.25

Provider manuals outline CHS services, program policies and procedures, as well as how to access CHS services. The manual outlines provider rights and responsibilities, member rights and responsibilities, claims information, contracting information, complaint processes, payment information, and general services that may require prior authorization as well as those requiring referral.

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

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

RESPONSE: 1.1.26

The relationship between CHS and our providers is a very important one in making our program a success in the community. Our goal is to make every effort to adequately orient providers to the program requirements and CHS specific policies and procedures in accordance with DHH requirements. Our provider training includes one-on-one office visits and periodic group training sessions, as well as web-based options. Topics vary, depending on the need of the Providers and include billing and claims, complaint management, appeals, the utilization of telemedicine and the unique needs of a diverse population. Attendees have the opportunity to complete an evaluation upon completion of a session. This feedback is utilized to incorporate new ideas and continually improve course offerings. Providers are oriented and then offered training upon request. Self-paced or web based training is available at any time. Other topics may be required periodically (i.e. annually) to meet regulatory or contractual requirements.

Core content of the orientation and training program is similar among the provider disciplines, PCP's, specialists and behavioral health providers with an emphasis on care coordination across the continuum of care to optimize the outcome of the member. Additionally, the programs are then customized to focus on issues specific to the provider audience. For example, specialists, while aware of well-visits, are generally not called upon to do the well-visit on a consistent basis, but

instead are most effectively utilized for specific treatment regimens. Therefore EPSDT and well visits are a focus topic for PCP's, while the topics for behavioral health providers would revolve about the coordination of care for behavioral health diagnoses and the holistic approach to managing the condition (i.e. ADHD).

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

RESPONSE: 1.1.27

Member engagement and activation is paramount to impacting healthy lifestyle and member/responsible party self-advocacy. Health literacy improves engagement and improves member outcomes.

CHS uses Krame member education materials. Krame is written and reviewed annually to meet up to date standards of care and evidence-based practice. Krame materials are written with members in mind and are peer-reviewed for accuracy and readability.

CHS focuses on the following areas of need:

- Mental/behavioral health
- Substance abuse
- Asthma
- Diabetes
- Heart disease
- Obesity

The CM will provide the material and review with the member in an on-going program combining reading, discussion, question and answer, and motivational interviewing to elicit positive lifestyle choices and change.

1.1.28 Describe how a vendor would work with caregivers to help them track appointments or tests that enrollees are scheduled for and may miss without further reminders or assistance.

RESPONSE: 1.1.28

Case managers and Resource Navigators work together to improve member/responsible party self-advocacy and compliance with appointments and treatment plans. CHS uses a variety of interventions including, but not limited to, text reminders, email, phone calls, print calendars and assistance with transportation. The resource navigator or case manager may call the member/responsible party after a scheduled appointment time to confirm

attendance. The case manager may work with the provider office to schedule appointments at times more convenient for the member/responsible party.

1.1.29 Describe how a vendor would coordinate with the WV Bureau for Public Health and services that are provided by that bureau to improve care, including how a vendor would propose to interface with the State's technology system.

RESPONSE: 1.1.29

CHS would obtain registration to utilize an authorized electronic exchange of health care data with the West Virginia's Health Information Exchange. With this authority, Consensus, our Care Coordination Software platform, will transmit HL7 CDA Coordination Care Plans created, modified and maintained by the care coordination team. Utilizing this state of the art electronic communication capability, the care coordination team can access the latest provider encounter data for optimal coordination of care. Similarly, providers and care givers for the patient will be able to access up to date care coordination information.

In cases where Health Information Exchange transmission is not available, systematic file exchange is accomplished via automated secure file transfer with the WV Bureau for Public Health's systems. Eligibility and enrollment files, institutional, professional and pharmacy claims data, state immunization registry data, quality measure results data may all be securely transmitted via automated file transfers from the WV Bureau for Public Health's systems to Consensus.

Enhanced Quality and Seamless Continuity of Care

1.1.30 Describe the approach a vendor would take in developing services that range in intensity and restrictiveness (in terms of community integration) based on member situations, or an alternative approach to best meet the needs of members with varying levels of needed care.

RESPONSE: 1.1.30

CHS advocates for the least restrictive living environment safe for the individual. At least annually and more often as needed, the CM works with the IDCT and social worker to evaluate member needs and the safest, least restrictive way to meet those needs. The CM works with the IDCT to transition members safely and seamlessly between differing levels of care to best suit the needs of the member. CHS will work with "Take Me Home West Virginia" to provide funding to allow members to live successfully in the safest, least restrictive environment.

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

RESPONSE: 1.1.31

The CM stays in close contact with the CPS social worker and contacts the current/new placement caregiver regarding member needs. The CM assists in coordinating the IDCT to ensure upcoming appointments are kept and services continue with the same providers as able. When providers change, the CM provides a care synopsis to new providers to avoid or reduce repetitive/ redundant services and other gaps in care and service.

1.1.32 How would a vendor handle out-of-state placements, and how would a vendor make recommendations for how best to help develop in-state services to bring youth back to West Virginia and as alternatives to sending youth out of state?

RESPONSE: 1.1.32

CHS and CMs develop solid working relationships with out of state agencies and maintain close communications with in-state agencies. The CM will collaborate with CPS to bring a child back to West Virginia safely, by developing relationships with organizations and community groups within the state capable of providing same or similar level of care.

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

a. Identified opportunities for cost savings

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

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

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

RESPONSE: 1.1.33 (a-d)

CHS' provider friendly model supports incentivizing providers to increase quality, improve access to care, and ultimately decrease costs. CHS has

historically incentivized providers in several ways. Where appropriate, CHS has supported sharing a designated portion of its PMPM payments with providers in order to incentivize certain practice behaviors that result in better population management and associated cost savings (e.g. implementation of an EMR system, providing after-hours access to care, etc.). In addition, CHS has incentivized providers by paying them a proration of the shared savings realized in a particular program. Also, when financial incentives have been offered to CHS for satisfying specific Quality Metrics, or "money measures," CHS has successfully designed unique incentive opportunities to encourage provider participation.

In this instance, CHS has identified many opportunities for providers to impact cost savings. These include, but are not limited to:

- ED utilization reduction
- ED redirection and triage
- Avoidable admissions
- Hospitalization management and reducing length of stay
- Appropriate management of short stays (less than 48 hours)
- Use of and redirection to ambulatory surgery centers
- Appropriate discharge planning
- Readmission prevention
- Observation conversions
- Increase use of generics and biosimilars (as they become available)
- Identification of efficient providers and redirecting members to their practices.

CHS proposes monitoring providers for at least the following 6 quality metrics during year one of the West Virginia programs (these are subject to change depending on the program's actual population):

1) Providers will be required to utilize an Electronic Health Record (EHR) system.
2) Providers will be required to participate (along with CHS' Interdisciplinary Care Team) in the development of a care coordination Care Plan, which shall be reviewed and updated every 6 months.
3) Annual PCP wellness visits will be required.
4) After discharge visits will be required within 10 days of any hospital discharge.
5) Members who have an active diagnosis of Asthma will need to be prescribed appropriate asthma medication.
6) Members who have an active diagnosis of ADHD will need to be prescribed appropriate ADHD medication.

CHS would initially encourage the behaviors for quality metrics 1 and 2 by potentially paying practices a portion of its PMPM. This is designed to help offset any cost incurred by the provider.

Metrics 2 through 6 would be part of a shared savings plan, wherein providers meeting certain thresholds will be incentive eligible. Only those who demonstrate improvement will be rewarded.

In addition, CHS can offer "access" rewards for PCP practices which successfully reduce their ED visit rates while maintaining or increasing their office visit rates for CHS patient panel.

1.1.34 Describe the need for a member and/or nurse hotline, and if deemed appropriate, the functionality of such an option, including hours of operation, staffing, and training needed.

RESPONSE: 1.1.34

CHS contracts with URAC accredited outside vendors to provide nurse line 24 hours a day. This is available to members with benefits questions as well as symptom management. The advice line may assist members with treatment questions, ED questions and medication questions. CHS contracts with a mental/behavioral health provider for crisis intervention. During the day CHS call center will warm transfer to 24 hour nurse line or mental health service. The automated after hours telephone system offers the nurse line as a choice and connects members directly with the nurse line.

1.1.35 Describe the process for ensuring continuity of prior authorized services when a member transfers from a fee-for-service program to a managed care type of program, including how a vendor might authorize the member's out-of-network providers to complete an existing treatment

RESPONSE: 1.1.35

CHS recognizes the importance of continuity in maintaining or attaining highest practical level of function. CHS honors authorized treatment plans for at least 30 days after transfer to our program. Treatment plans extending longer than 30 days (except for pregnancy and terminal illness) will be evaluated on a case by case basis. Our utilization department will work to negotiate payment with any out of network provider or work to enroll a qualified provider into our network.

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

RESPONSE: 1.1.36

CHS recognizes that appropriate providers improve member outcomes. CHS evaluates a provider specialty, experience and history through a credentialing process. CHS expects providers to have experience with the foster population and be able to serve this population effectively, efficiently and with professionalism. CHS incorporates member/responsible party preferences into assisting with changes. Also, unique health needs including cultural and linguistic background will be considered for changes of providers.

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

RESPONSE: 1.1.37

CHS uses Johns Hopkins Adjusted Clinical Groups Predictive Model (ACG-PM) to identify members at high risk. The ACG model uses disease burden information, cost information and utilization information through claims data mining to score members who would benefit most from case management. CHS also uses other indicators of risk including frequent ED use, high cost members, diagnosis with targeted conditions and mental/behavioral health issues. Once identified, new members with high physical or behavioral health needs are flagged within our proprietary tracking system for prioritization for outreach.

1.1.38 Describe how a vendor would develop a plan to identify and reach out to members with the most immediate service needs leading up to and immediately following implementation of a program.

RESPONSE: 1.1.38

CHS uses Johns Hopkins Adjusted Clinical Groups Predictive Model (ACG-PM) to identify members at high risk. The ACG model uses disease burden information, cost information and utilization information through claims data mining to score members who would benefit most from case management. CHS also uses other indicators of risk including frequent ED use, high cost members, diagnosis with targeted conditions and mental/behavioral health issues.

Upon identification, CHS call center staff reaches out to members/responsible parties identified as high risk. The call center staff performs health risk screens with the member/responsible party to further identify highest immediate needs and connect the member/responsible party with a case manager. Health risk

specific segment of care) and, instead, working on behalf of the child across systems of care, support for the child and family is increased. This greatly increases program effectiveness and reduces system inefficiency and family stress.

- Administrative Simplification--By reducing the time that physicians and other care professionals spend on redundant and time-consuming paper processes for this population and implementing innovative communication approaches with providers, valued health professionals and physicians can increase their productivity delivering vitally needed health services across the state. Community Health Solutions' case management teams partner with providers to ensure effective communication and cooperation; this results in care plans that better reflect the needs of participants and avoid service gaps, duplication, and unproductive effort.

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

RESPONSE: 1.1.45

McKesson's InterQual® Criteria is a nationally accepted criteria set for utilization review. Over time, based on the needs of our members, CHS develops medical policies in consultation with and under direction from Medical Directors to better and more specifically address needs of the specific population served. Services requiring prior authorization and not qualifying under Interqual criteria are referred to secondary medical review.

1.1.46 Describe the process for initially and periodically screening and assessing members' needs for services and the functional assessment instruments to be used in the evaluation process, including coordinating the requirements for EPSDT.

RESPONSE: 1.1.46

The assigned CM completes an assessment upon entrance to the program and re-evaluates with the IDCT no less than quarterly, and as needed, based on changing clinical or mental/behavioral member needs. The case manager or resource navigator works with the PCP and the member/responsible party make sure EPSDT screenings and interventions remain on schedule.

1.1.47 Identify the areas believed to be the greatest opportunities for clinical quality improvement in behavioral health, and how a vendor would work to improve clinical behavioral health outcomes.

RESPONSE: 1.1.47

CHS recognizes lack of access to qualified mental health providers and medication over- or under-use can contribute to poor outcomes. By creating and facilitating access to mental/behavioral health providers, CHS case management can improve member outcomes. Outpatient follow/up within 7 days after discharge from a mental health facility, appropriate utilization, and adherence to antipsychotics are examples of clinical quality interventions which are monitored to assess and improve quality of behavioral health care.

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

RESPONSE: 1.1.48

To coordinate the care of patients with chronic conditions and avoid their unnecessary admission to long-term institutional care, care delivery can be facilitated by telehealth technologies to increase access and overcome geographic and distance barriers. Telehealth involves the systematic care coordination and implementation of health informatics, home telehealth, and disease management technologies. It helps patients live independently at home. CHS applies strict criteria to determine patient eligibility for enrollment into the program. Internal assessment and evaluation helps CHS determine whether telehealth services are appropriate and cost-effective for its member. While studies (i.e. VHA) demonstrate that such technological approaches are effective in managing chronic care patients in both urban and rural settings, application to the unique foster care program of West Virginia may generate different results.

Members who are institutionalized will benefit from telehealth initiatives as part of the "Take Me Home West Virginia" program. Providing telehealth services will increase self-efficacy, independence, and ability to live at home rather than in an institutionalized setting.

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

RESPONSE: 1.1.49

CHS works with expert vendors to assist with managing pharmacy services. A comprehensive drug formulary will be developed in conjunction with the Medical leadership and pharmacy vendor to meet the medical and mental/behavioral health needs of members.

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

RESPONSE: 1.1.50

CHS works with the pharmacy vendor, Medical leadership and the primary care physicians to ensure medications are appropriate and effective. Non-formulary drugs may require prior authorization and periodic review for continued necessity and efficacy. Upon enrollment, members with current non-formulary or high-cost medications are identified, and their situations reviewed clinically to identify potential alternatives. The case manager, prescriber and the PCP are included in these clinical case reviews.

1.1.51 How would a vendor ensure that children who are on psychotropic medications are receiving appropriate dosages at the right age and frequency to avoid over or under-utilization or misuse of medications?

RESPONSE: 1.1.51

CM works with the prescribing provider, mental/behavioral health vendor and UM to ensure appropriate prescribing. The case manager facilitates communication to ensure necessity and efficacy. The case manager works with providers and member to target lowest effective dose of any given psychotropic drug.

1.1.52 How would a vendor coordinate with the enrollee's PCP and behavioral health provider to ensure each provider has access to the most up-to-date medical records?

RESPONSE: 1.1.52

One of the key technology success factors for effective and seamless coordination across the continuum of care is secure, HIPAA compliant exchange and integration of health data with the Patient's PCP, behavioral health providers, specialists, and extended interdisciplinary care team. Our Care Coordination system, Consensus, has been specifically designed to present the care team with a holistic, accurate, real time health record view of the patient. Equipped with this data, the care coordination team can best deliver informed and optimal care.

The form of communication will vary and must be diverse to engage with providers effectively. Our Care Management Software Platform, Consensus, delivers integrated functionality for multiple forms of communication with

providers and other caregivers including integrated telephonic communication, secure email, and integrated electronic faxing.

Our Care Coordination technology suite delivers an integrated secure web accessed Provider Portal. Through the Provider Portal, providers log in to securely access real time patient records such as, diagnoses, specialty appointment information including status of attendance, up-to- date care coordination care plans, medications with refill information, and all claims data including hospitalization and ED information. In addition, the Provider Portal has powerful artificial intelligence for Utilization Review automated prior authorization decisions.

To ensure engagement and close coordination with providers, several key dashboard and metrics reports are accessible via the secure web based provider portal for practice level monitoring. These include reporting on patient status of EPSDT visits, patients due for EPSDT visits within 60 days, Quality Measure Scorecard, reports on ED and inpatient admissions including LOS data and all-cause and same diagnoses readmissions.

In some cases, where electronic data exchange is not available from providers, Care coordinators may obtain limited and secure access to the Providers' EMR system, thereby gaining access to the most up to date health information for patients.

For providers who have implemented capabilities and are registered to exchange HL7 EMR data with West Virginia's Health Information Exchange, Consensus, the Care Coordination Software platform, will have the capability to transmit health care data in HL7 CDA format via the Health Information Exchange or via automated secure file transfer to the Provider EMR system.

Finance

1.1.53 Describe what methodology might be used for establishing capitated payments for these services or how they might be set up. If possible, provide a projected cost for serving a population similar to that described in the Statement of Need, above, or an existing cost to operate in another state or states with similar populations of eligible youth.

RESPONSE: 1.1.53

When managing moderate and high risk member populations, the healthcare system typically pays for activity rather than results. The sicker the population, the more revenue is generated for providers, particularly hospitals. Because increased activity results in greater revenue, encouraging change presents difficulty. In order to address this conundrum, CHS recommends the

implementation of a Primary Care Case Management (PCCM) model, which may be used as a glide path towards eventual risk-based capitation.

Specifically, the type of methodology proposed for managing this population is a fee-for-service PCCM shared savings model. In order to induce provider participation and quality outcomes, the providers in CHS's network will have the opportunity to generate revenue in two additional ways: 1) receiving of a portion of CHS' monthly care coordination "PMPM" payments for meeting certain measures (e.g. providing after-hours access, engaging in timely discharge planning, and/or utilizing an EMR system); and 2) sharing in the savings generated by the program.

CHS recommends utilizing a PCCM model for up to 36 months in order to improve quality outcomes and control costs prior to considering moving towards a capitated model. Based on CHS' past results, managing this population via a PCCM model will result in provider engagement and cost reduction.

Depending on a program's size, complexity, and opportunity to realize shared savings, CHS has been paid between $10.00 and $230.96 in PMPM fees. Based on the limited data available for the subject population, CHS estimates it would require between a $35.00 and $65.00 PMPM fee. A capped amount (as determined by the State) of the savings realized by the program would be split on a rolling year basis between the State and CHS, with the state retaining 50% and CHS retaining 50%. CHS's savings will be shared with its contracted providers who reach certain quality measures.

After the initial contract period, an extension of the PCCM program may be appropriate or the State can move towards capitation by supporting a capitated model with risk protection for up to an additional 18 months, prior to moving towards full capitation if desired. In essence, the PCCM model will "prime the pump" by engaging quality providers, improving outcomes, reducing costs, and laying the foundation for capitated risk.

1.1.54 Describe how a vendor might calculate admin costs for administration of such a program. What costs would factor into administration of such a program? What is a typical billing period for administrative and other costs?

RESPONSE: 1.1.54

Under the PCCM model, calculating administrative costs is a simple process. The care coordination "PMPM" fee, which should be billed and paid on a monthly basis based on membership, will include all costs related to CHS's administration of the program. These costs include, but are not limited to, the following:

- Care Management staff and related costs

- Member and Provider call center staff and related costs
- Provider Network management staff and related costs
- IT staff and related costs
- Consensus software implementation and management costs
- Quality and Compliance staff and related costs
- Support staff costs (Human Resources, Executive, Finance)
- Associated vendor costs (e.g. after-hours nurse line, HEDIS resources if needed, etc.)
- Program implementation costs

An unknown variable for determining program cost is staffing. The acuity and geography of the membership will determine the appropriate staffing ratios and location.

Case Scenarios

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

1.1.55 Case Scenario #1 (Matt)
Matt is a 19 months old boy who was placed in foster care at birth from the hospital. Matt's parents' parental rights were terminated and he remains in foster care. Due to his medical needs, placing Matt has been a challenge. Matt has a brain anomaly, cortical dysplasia, epilepsy and developmental delays. Matt has medication to control his seizures, which have become more controlled. When Matt has a seizure, the flap in his throat tends to close and he usually needs repositioning to open the airway, but sometimes oxygen is needed so it must be continuously available. Matt has been evaluated for his developmental delays, vision problems, and speech therapy. Matt's provider has not received the results of these evaluations yet and follow-up with the hospital is needed.

1.1.56 Case Scenario #2 (Ben)
Ben is 8 years old and entered foster care after living in an unsafe environment for several years. He is legally free for adoption. He was placed with his uncle who wants to adopt him; however, he is concerned about his future behavioral health care needs and what long-term support options he will have given the exposure to trauma Ben has experienced
Ben is currently on multiple psychiatric medications and his teachers complain of ADHD-like symptoms.

Case Scenario Questions:

1.1.56.1 What is a typical care management approach for each child, beginning with describing your assessment strategy? Please consider the placement setting and legal status in determining the proposed approach.

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

1.1.56.3 Describe the care coordination activities that might be initiated and timelines related to the child, including communication between key people involved in the child's care. How would a vendor ensure timely access to specialty providers that should be seen in addition to those already being seen, including mental health providers?

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

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

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

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

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

RESPONSE: 1.1.55

A RN Case manager would be assigned to Matt. The nurse would meet with the CPS Social Worker and the foster parent assessing current services in place and gaps in care and service. The CM and social worker may review the ISFP. The nurse would meet with the PCP regarding gaps in service and care. The Case Manager would discuss the need for home health visits to the foster family to ensure the family understands how and when to manage Matt's medical needs. The CM nurse would contact the hospital to obtain records of his evaluations for developmental delays, vision problems and speech therapy. The CM nurse encourages referrals from the PCP for appropriate therapies based on the hospital evaluations.(1) The CM nurse would have an interdisciplinary care team (IDCT) conference arranged for when Matt and his foster parent can be present to review current services, medications, oxygen therapy and need for additional services related to Matt's evaluation results.(2) A resource navigator would assist with coordination of in-home and outpatient services Matt needs.(3) At this meeting a comprehensive, individualized care plan would be developed by the team. The case manager would assist the PCP to notify and submit appropriate information for utilization management and assist with prior authorization needs.(4) The CM nurse would work with an LCSW, resource navigator, and CPS to coordinate care and smooth transitions for changes in foster homes. The resource navigator would assist the PCP office in maintaining EPSDT schedules. The CM and IDCT would meet no less than quarterly, and contact with the foster parent would occur no less

than monthly. A home visit to the foster parent home would occur no less than quarterly.[5] CPS social worker would be contacted no less than quarterly after a home visit and as needed.[6]

(1) 1.1.56.1 What is a typical care management approach for each child, beginning with describing your assessment strategy? Please consider the placement setting and legal status in determining the proposed approach.
(2) 1.1.56.2 How would a vendor educate and engage the various parties responsible for the well-being of the child and about the ongoing care required?
(3) 1.1.56.6 How would a vendor coordinate the specific Durable Medical Equipment (DME) needs of the member?
(4) 1.1.56.3 Describe the care coordination activities that might be initiated and timelines related to the child, including communication between key people involved in the child's care. How would a vendor ensure timely access to specialty providers that should be seen in addition to those already being seen, including mental health providers?
(5) 1.1.56.5 How would a vendor track the areas of concern related to the child's care in a typical system?
(6) 1.1.56.4 When would a vendor contact the child's social worker and what information would a vendor typically share?

RESPONSE: 1.1.56

Ben would be assigned an LCSW Case Manager. The Case Manager would meet with the CPS social worker and Ben's uncle regarding current services in place and gaps in care and service. The ISFP is reviewed at that time. The nurse would meet with the PCP regarding any gaps in care and service. The case manager would discuss the potential need for referrals to mental/behavioral health providers for medication management and counselling.[1] The case manager would arrange a meeting with school officials to discuss an Individualized Education Plan (IEP) and barriers to Ben's educational success.[2] A resource navigator would assist in arranging an IDCT conference for when Ben and his uncle are available. A resource navigator would assist in coordinating the communication between the school, the PCP, the mental/behavioral health provider and Ben's uncle.[3] During the IDCT conference a comprehensive, individualized care plan would be developed by the team.[4] The care plan incorporates IEP and ISFP information. A registered Nurse (RN) would assist Ben's uncle in learning about any medications Ben is prescribed as well as any physical, medical issues. Learning materials are provided in a format that meets Ben and Ben's uncle's needs for reading and language comprehension.[5] A resource navigator may assist PCP office in maintain EPSDT schedules. The CM and the IDCT would meet no less than quarterly and contact with Ben's uncle would occur no less than monthly. A home visit to Ben's uncle would occur no less than quarterly.[6] CPS social worker would be contacted no less than quarterly after a home visit and as needed.[7]

(1) 1.1.56.1 What is a typical care management approach for each child, beginning with describing your assessment strategy? Please consider the placement setting and legal status in determining the proposed approach.
(2) 1.1.56.8 How would a vendor work with the school system to ensure appropriate accommodations are made?
(3) 1.1.56.3 Describe the care coordination activities that might be initiated and timelines related to the child, including communication between key people involved in the child's care. How would a vendor ensure timely access to specialty providers that should be seen in addition to those already being seen, including mental health providers?
(4) 1.1.56.2 How would a vendor educate and engage the various parties responsible for the well-being of the child and about the ongoing care required?
(5) 1.1.56.7 How would a vendor address potential cultural and language barriers?
(6) 1.1.56.5 How would a vendor track the areas of concern related to the child's care in a typical system?
(7) 1.1.56.4 When would a vendor contact the child's social worker and what information would a vendor typically share?