UNICARE®

February 24, 2015

Robert P. Kilpatrick
Senior Buyer
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

RE: UniCare Health Plan of West Virginia's Response to RFI #CRFI 0511 HHR1500000002

Dear Mr. Kilpatrick:

UniCare Health Plan of West Virginia, Inc., (UniCare) is pleased to submit the enclosed response to the West Virginia Request for Information (RFI): Managed Care or Managed Care Alternative for Vulnerable Youth Populations.

In accordance to the RFI, we are submitting three hard copies of our response, with one marked original.

Thank you for the opportunity to provide a response. We are eager to partner with the West Virginia Department of Health and Human Resources (DHHR) to address existing challenges in caring for youth involved in the child welfare system, as well as to offer innovative preventive solutions to caring for and supporting youth and families who may be at-risk for child welfare involvement.

If you have any questions or would like to discuss our response, please feel free to contact me via phone at (888) 611-9958 or by email at mitch.collins@anthem.com.

Sincerely,

Mitch Collins
Plan President
UniCare Health Plan of West Virginia, Inc.

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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)

[X]	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.

UniCare Health Plan of West Virginia, Inc.
Company


Authorized Signature

February 24, 2015
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

SECTION 1: STATEMENT OF NEED

1.1 Holistic Care for Children, Youth, and Young Adults Involved in the Child Welfare System in West Virginia

Executive Summary

UniCare Health Plan of West Virginia, Inc., (UniCare) is pleased to submit the following response to the West Virginia Request for Information (RFI): Managed Care or Managed Care Alternative for Vulnerable Youth Populations. We are eager to partner with the West Virginia Department of Health and Human Resources (DHHR) to address existing challenges in caring for youth involved in the child welfare system, as well as to offer innovative preventive solutions to caring for and supporting youth and families who may be at-risk for child welfare involvement.

UniCare is the largest Medicaid MCO in West Virginia serving nearly 90,000 children and families who receive their healthcare through our Mountain Health Trust program. Since 2003, UniCare has developed strong relationships with families, communities, Providers, State agencies, and other stakeholders that enhance our knowledge and understanding of the strengths and needs of the populations we serve, as well as the challenges they may experience in achieving their personal goals and wellness.

Our parent organization, Anthem, Inc., (Anthem) and our affiliate health plans currently serve nearly 40,000 youth in child welfare systems in 10 states: Florida, Georgia, Kansas, Kentucky, Louisiana, Maryland, New Jersey, Virginia, Washington, and Wisconsin. Our health plan affiliate in Georgia is a single, statewide MCO dedicated to overseeing the holistic care of 24,000 youth involved in child welfare that includes foster care, adoption assistance, and juvenile justice. In addition, Anthem and our affiliates have 23 years' experience providing service management and coordination for state-sponsored health programs that span 19 states and more than five million enrollees.

In responding to the questions in this RFI, we thoughtfully present perspective, guidance, and solutions for the State to consider while designing a Member- and family-centric program. In addition, we also put forth strategic policy recommendations we believe will support positive, long-lasting transformation that meets the healthcare and social support needs of vulnerable youth in West Virginia while promoting their safety, well-being, and permanency. Table 1.1-1 describes our policy recommendations for the State that are described throughout this response.

Table 1.1-1 UniCare's Strategic Policy Recommendations for Serving West Virginian Youth Involved in Child Welfare

Policy Recommendation	Rationale
Transition to a Managed Care approach	Reduces fragmentation, increases utilization of covered and non-covered services and supports, improves outcomes and quality, and reduces cost
Support a single, statewide MCO design through utilizing an existing Medicaid MCO	Provides program accountability and streamlined processes and procedures that reduce fragmentation and administrative burden and provides continuity of care through transitions into the Medicaid MCO program
Offer a full-range of physical, behavioral health, oral health, and social services and supports	Supports collaboration and coordination through an integrated care plan that is strengths-based and individualized to the Member's needs
Support family-strengthening education and interventions, services, and supports	Supports the prevention of abuse, neglect, and unnecessary removal from the home
Establish a cohesive, responsive crisis system	Provides twenty-four hours a day, seven days a week (24/7) support during high stress times to prevent removals from the family home, divert hospitalizations, and avoid placement disruption
Utilize best practices specific to caring for youth in child welfare systems	Informs the design of key program components that drive positive interactions and relationships with families such as care coordination, predictive modeling, risk stratification, information sharing, and transition processes
Facilitate collaboration between State agencies and system partners	Improves the understanding of system partner roles and responsibilities, reduces duplication of services, expands the availability of resources, and reduces fragmentation
Develop systems for overseeing and monitoring the use of psychotropic medications	Provides for strict oversight of the use of psychotropic medications for children and offers alternative treatments and services, as appropriate
Provide Medicaid coverage for young adults involved in child welfare up to the age of 26	Supports transition to the adult system with medical benefits intact, promotes continuity of care, and results in improved Member and community health and well-being
Reduce the use of in-state and out-of-state residential and inpatient services	Results in the investment in and development of home- and community-based alternatives across the State to increase permanency and allow children to remain in their homes, communities, and schools
Provide statewide, initial, and on-going trauma-informed training and education programs	Promotes knowledge and understanding of the impact of adverse childhood experiences on the child's development and improves meaningful service delivery that supports safety, well-being, and permanency
Establish realistic funding	Supports program development and maturation over a reasonable period of time
Align incentives across systems and Providers	Improves accountability for delivering high-quality, integrated care and services

UniCare's experience in West Virginia, combined with that of Anthem and our affiliate health plans across the country, supports our position that simply adjusting a standard managed care program does not address the life challenges often faced by children, youth, and young adults who experience abuse, neglect, and trauma and are removed from their families and home. The program should be tailored to specific challenges, including but not limited to the involvement of multiple systems that have varying roles, regulatory requirements, objectives, and processes; limited alternatives for placement, particularly for youth with complex needs and young adults; high turnover rates of State caseworkers; and availability and accessibility of specialized care that are tailored to the needs of the children, youth, and young adults and reflective of the social, cultural, and economic factors of West Virginia communities.

UniCare has a long-standing philosophy that care should be delivered through an integrated approach that is as unique and individualized as the Members and families themselves. We recommend DHHR select an existing Medicaid MCO that demonstrates knowledge of the West Virginia landscape and expertise in delivering holistic care through an integrated, person-centered approach that meets Members' biopsychosocial strengths, goals, preferences, and needs; supports Member safety, well-being, and permanency; promotes improved health and life outcomes; supports administrative and cost efficiency; and achieves the short- and long-term goals and objectives of the State.

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.

Meeting the needs of youth involved in child welfare begins with knowing and understanding the experiences they may face prior to and following removal, as well as the services and supports necessary to promote their safety, well-being, permanency, and ultimate independence. In fact, researchers estimate that a majority of children in foster care exhibit emotional and/or behavioral problems, either from their experiences before entering foster care or from the foster care experience itself.[1] We recognize these youth have some similar health needs as other children in government-sponsored programs, yet they are often at higher risk for conditions associated with trauma such as neglect, physical and sexual abuse, separation, loss, and grief. This trauma can lead to physical, behavioral, and/or social issues and is often exacerbated by frequent placement changes, educational transitions, and difficulties navigating fragmented systems of care.

Knowledge of a state's healthcare landscape, understanding the unique and diverse needs of the population, established Provider relationships, and proven network development strategies are essential to quickly identifying, contracting, and credentialing specialty Providers who have the requisite experience necessary for caring for Members in or transitioning from child welfare. Because UniCare understands the challenges DHHR is experiencing engaging specialty Providers such as child psychiatrists and Providers with trauma-informed certification, we recommend the State require an MCO to demonstrate experience in understanding what types of Providers are needed and the strategies necessary to build a network that:

- Offers specialized care for conditions such as depression, anxiety, aggression, eating disorders, self-stimulation, and failure to thrive
- Utilizes a trauma-informed approach to screening, assessing, and working with vulnerable youth
- Participates in care planning that is integrated, individualized, strengths-based, and holistic
- Coordinates care with the Member, caregiver, State caseworker, Service Manager, and other involved parties such as the Guardian ad Litem (GAL) and Court Appointed Special Advocate (CASA)
- Responds to urgent and crisis events to divert hospitalizations and placement disruption
- Oversees safe and appropriate physical and behavioral health medication management
- Shares information with team members in a timely, accurate, and complete manner
- Completes referrals, authorization requests, and required documentation

[1] *The Future of Children: A Collaboration of The Woodrow Wilson School of Public and International Affairs at Princeton University and The Brookings Institution.* © 2015 The Trustees of Princeton University.

Efforts to build an adequate statewide Provider network will require established relationships with local Providers and communities. These relationships will provide opportunities for identifying and engaging specialized Providers; partnering with existing Providers and community organizations to expand capacity, service offerings, and training capabilities; and soliciting guidance from those organizations that already serve these Members.

1.1.1 Establishing a Statewide Provider Network

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

Establishing a statewide Provider network that is comprehensive and accessible requires collaboration and partnership with the State, local Providers, community-based organizations, and other stakeholders involved in the child welfare system of care. In other states, our affiliate plans have partnered with governmental entities, community mental health centers (CMHCs), federally qualified health centers (FQHCs), rural health centers (RHCs), family support organizations, crisis receiving units, and hospitals to develop specialized and expanded services for children and youth in need. This requires a return on investment-based approach that evaluates the mix of services available in both the physical and behavioral health delivery systems for Members and creates new value propositions for Providers to expand services where additional capacity is needed.

Our affiliate health plans redirect funds to the most effective services such as holistic assessment, in-home supports, and crisis stabilization, reinvesting existing dollars in services that improve delivery, efficiency, and effectiveness of care. The following are a few examples of the types of efforts we recommend:

- Working with existing Providers to develop specialized programs and supporting expansion of those programs to other states
- Developing Provider skill sets such as funding Provider training and certification in areas such as the Child and Adolescent Needs and Strengths (CANS) assessment and Trauma-informed Care (TIC) certification
- Increasing the availability of independent assessors through training and certification in trauma, additional reimbursement, and clinical consultation support
- Working with local Providers and organizations to enhance the crisis system to support diversion or transition from higher levels of care
- Training and incorporating peer and family supports into the care model that help normalize what is happening to them, encourage voice and choice, set realistic expectations, and prepare for crisis situations

1.1.2 Approach to Addressing Provider Network Deficiencies

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.

While UniCare currently has contracts with many service Providers available to serve children, youth, and young adults in West Virginia, we recognize there are numerous specialty Providers that currently provide services directly to youth involved in child welfare through other fee-for-service arrangements. We also believe that offering a full range of behavioral health services is essential to the success of the program. As a result, we recommend that network development activities include the sharing of existing Provider information between the State and the MCO to identify all physical and behavioral health

contracted Providers; Providers with specialized training, certification, linguistic capabilities, and cultural competencies; and Providers who may be interested in expanding their expertise or practice.

We recommend the State require other types of approaches to addressing Provider network deficiencies in relation to travel times and distances such as the following:

- Working with local community-based programs such as School-based Health Centers (SBHCs), CMHCs, FQHCs, and RHCs to develop opportunities for improving access and availability of services
- Establishing and improving relationships with child welfare-focused organizations such as State agencies, child placement agencies, GALs, and CASAs
- Engaging local child welfare stakeholders, advocates, Provider associations, and community-based resources to identify potential Providers for network participation
- Developing and supporting substance abuse-focused programs for young adults and biological parents and families
- Supporting Patient-centered Medical Home (PCMH) and Health Home transformation by helping Providers more effectively use their clinical expertise to increase practice capacity with existing resources and by providing incentives
- Working with local psychiatrists, Primary Care Providers (PCPs), and other Providers that currently have or are interested in having Telemedicine/Telehealth capabilities for improved access in rural areas or areas with limited Providers
- Identifying and contracting Providers who are not enrolled as a West Virginia Medicaid Provider and out-of-network Providers to encourage enrollment in Medicaid as needed and participation in our network

1.1.3 Approach to Providing 24-hour Access in Emergency Situations

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

The majority of emergency situations that arise for children and families in the child welfare system are behavioral health-related; frequently occur at night and weekends; and often result in emergency room visits, hospitalizations, and placement disruption. We believe offering rapid specialized crisis interventions and supports that Members and caregivers can access on a 24/7 basis minimizes crisis events; promotes Member safety and well-being; helps Members realize resiliency, recovery, and independence; and preserves placements. We find that the following types of proactive and early interventions are the primary solutions to preventing emergent situations:

- Behavioral health screening in the primary care setting and physical health screening in the behavioral health setting
- Assignment of Service Managers with expertise in the Member's primary needs
- Individualized care and crisis planning with the Member, caregiver, and other care team Members
- After-hours and same-day or next-day appointment availability from PCPs and specialty Providers
- Transition planning from higher levels of care
- Provider access to psychiatric consultation

In the event of a crisis situation, we recommend a holistic approach that offers 24/7 access to needed resources and/or services such as a dedicated Service Manager; a licensed, behavioral health professional through a dedicated behavioral health hotline; mobile crisis teams; current and pertinent Member information such as the crisis plan and prescribed medications; and short-term, specialized services such as extended observation and respite.

1.1.4 Approach to Measuring and Verifying Compliance Standards

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.

Developing and maintaining an adequate network requires collaboration between the entities and organizations that understand both the service delivery challenges and gaps that may already exist in the State, as well as the services and supports needed to support the youth involved in child welfare. This can be a tall order for an MCO that does not have the requisite experience in the State or child welfare.

We recommend the State work closely with the MCO to develop the checks and balances that promote compliance with the necessary Provider network standards. The MCO should be responsible for on-going verification of network compliance standards through processes such as generating and analyzing meaningful GeoAccess® reports; reviewing Member and Provider satisfaction surveys, Member grievances and appeals, and Member Services reports; and conducting activities that identify appointment wait times and after-hours availability. The MCO should establish contractual requirements for Provider compliance and have policies and procedures in place to address any issues, including but not limited to training, technical assistance, and corrective action as needed. In addition, we recommend that the State partner with MCO to train the providers collaboratively through regional forums that bring Providers together and solicit solutions, feedback, and recommendations.

1.1.5 Approach to Accommodating Member Enrollment

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.

Fluctuations in expected Member enrollment are common in managed care and should not impact an MCO's ability to serve its Members. A competent MCO should provide an established infrastructure with proven and scalable systems and processes capable of transitioning Members in a seamless, timely manner and maintaining the on-going delivery of individualized, quality care. UniCare recognizes the benefits and magnitude of not only integrating physical, behavioral, and oral healthcare into one statewide program for Members, but we also believe the delivery of meaningful preventive services and supports, education, and training results in healthier families and fewer removals by the State.

We know that a robust Provider network is key to accomplishing this and can be achieved in a number of ways. Our recommendations include offering training, supports, and incentives to Providers who have the capacity and ability to expand their delivery of services; focusing efforts on information sharing and care coordination to assure the provision of the most appropriate service and prevent duplication; supporting the transition of youth who are aging into the adult Medicaid system; and developing alternative treatment options to out-of-home placement.

1.1.6 Approach to Providing Crisis Response

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

UniCare understands that the current crisis system in West Virginia is fragmented and crisis services are provided in a variety of ways by a variety of organizations such as the Administrative Service Organization (ASO), child placement agencies, adoption agencies, and licensed behavioral health centers (LBHCs). We believe that every youth, family member, and caregiver involved in the child welfare system responds to information and situations in different ways. As a result, we recommend an approach to crisis situations that begins with proactive and integrated screening, assessment, and crisis planning that is supplemented with de-escalation and stress management training for Members and caregivers and the availability of credentialed physical and behavioral health staff who are trained to deliver crisis intervention and stabilization services that are available on a 24/7 basis and are coordinated with existing service Providers and caregivers.

This can be achieved through a combination of resources such as a dedicated behavioral health hotline, nurse helpline, mobile crisis teams, clinical consultation, and community-based services such as short-term stabilization, extended observation, and respite. We suggest that efforts following crisis situations be immediate, address the event that precipitated the crisis, and focus on reducing the risk of subsequent emergencies.

Improved Coordination of Care

1.1.7 Coordination of Care across Systems

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 Service Managers with an integrated care plan for all children.

Because of the significant number of system partners responsible for the safety, well-being, and permanency of youth involved in child welfare, we believe coordination and collaboration are essential to the delivery of quality care that is meaningful, clinically appropriate, and non-duplicative. According to the American Academy of Pediatrics, healthcare management and coordination require skilled health expertise and are key components to improving health outcomes for youth involved in child welfare. Research also shows that youth in foster care use more behavioral health services and have significantly greater mental health expenditures than children who qualify for Medicaid through Temporary Assistance for Needy Families (TANF), are more likely to be overrepresented in restrictive services such as residential and group care, and more frequently receive concurrent prescriptions for psychotropic medications[2].

These results, combined with our experience, support our position that integrating behavioral health services into the program is essential to implementing a person-centered approach that is based on the following:

- Integrated, holistic Member screening and needs assessment
- Individualized and integrated care planning
- Collaborative Care Coordination with Providers, including community-based service and support Providers
- Partnership with State agencies involved in the care, safety, and well-being of the child such as DHHR, CPS, HealthCheck, and the Department of Education

[2] Centers for Health Care Strategies. *Examining Children's Behavioral Health Services Utilization and Expenditures*, Faces of Medicaid, December 2013.

UniCare suggests a program that utilizes a highly skilled and trained combination of bachelor's-level nurses, behavioral health management technicians, master's-level nurses, and behavioral health clinicians with integrated care management experience to oversee the provision of care to Members involved in the child welfare system. We also support the seamless continuation of care for Members transitioning to managed care with their current Providers and at the same level until the appropriate level of assessment is conducted to determine the appropriateness of the Member's care. The Member's multidisciplinary care team (MCT) should determine any changes in care.

1.1.8 Providing Care Plan Training

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).

Provider training should support the joint development and mutual sharing of care plans that are carefully balanced with the safety, privacy, and wishes of the Member. This can only be achieved through robust training; coordinated and effective Member, caregiver, and Provider engagement; collaboration and communication with care team members; and on-going sharing of information that may impact the Member's care. We recommend a care planning model that:

- Is Member-centered and based on transparency
- Incorporates all information pertinent to the Member's success, including community-based services and supports, as well as crisis, permanency, and transition planning
- Promotes reciprocal sharing of pertinent and timely information in a secure manner
- Provides 24/7 access to the Member's information for Providers and other care team members as appropriate

We believe this can only be achieved through initial and on-going educational and training opportunities that are tailored for the audience of Members, caregivers, Providers, community members, stakeholders, and MCO staff and are offered through a variety of user friendly, conveniently located training modalities.

1.1.9 Using the Individualized Family Service Plan Information

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.

Many youth involved in the child welfare system may not have received the evaluation, assessment, and services critical to early identification, intervention, and on-going care for Members with special health care needs prior to entering into the system. We believe that the sooner specialized needs for any Member are identified, the more likely he or she can be supported in reaching developmental and learning potential. Given the importance of early identification, intervention, and transition planning, we recommend the State only consider MCOs that have demonstrated experience in coordinating with Early Childhood Intervention programs; utilizing and incorporating the individualized family service plan (IFSP) in care planning and service delivery; and including early intervention Providers in the care planning process.

We suggest the State, Department of Education, and MCO work closely together to develop joint training and referral, assessment, and IFSP processes designed to:

- Promote early identification and intervention
- Maximize Member development and learning
- Assure inclusion of the IFSP in the Member's care plan

- Facilitate requests for authorization if needed
- Provide support to caregivers and families
- Support rapid and enhanced coordination of services

MCOs should also demonstrate knowledge of and experience in assisting Members and caregivers in transition activities from early intervention to school-based services, including the development of the Member's Individual Education Plan (IEP) as requested and identifying resources for any gaps in services.

1.1.10 Developing and Including the Multidisciplinary Care Team

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.

Youth involved in the child welfare system may have multiple needs that can best be served by a variety of professionals with specialized expertise who collaborate and cooperate with one another to reach the desired outcomes for the Members they serve. We support an MCT approach that incorporates involvement from MCO physicians and clinicians with expertise that is aligned with the Member's primary condition; engages the PCP and other Providers; utilizes best practices for integration; performs routine and emergent clinical rounds; maintains systems that support timely information sharing; and provides clinical consultation for Providers serving Members with complex conditions. A qualified MCO should have established policies and procedures for these types of practices to facilitate solution-oriented discussions and feedback; promote the integration of community resources and natural supports in the Member's assessment and care planning processes; and assure the Member is provided a full array of services that address his or her needs and support individual recovery goals.

1.1.11 Determining the Case Mix and Staffing Ratios for Service Coordinators

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.

An experienced MCO should demonstrate proven ratio development processes and policies that are founded on the belief that youth and families deserve the level of interaction necessary to support their individualized needs. We believe this can only be achieved through sound predictive modeling and risk stratification practices that 1) are based on knowledge of trauma and experience with similar populations, 2) drive the initial triage, 3) identify common characteristics and needs, and 4) determine the level of service coordination based on the Member's condition. Attention should then be focused on monitoring and adjusting the level of service coordination based on the Member's individualized strengths, needs, and progress. The MCO should also have processes and procedures for assessing and responding to the effectiveness of its model and as frequently as necessary to meet enrollment fluctuations, variations in the needs of Members and caregivers, changes in State and federal requirements, and the evolution of best practices in serving youth and families involved in child welfare.

1.1.12 Establishing Relationships with Community Organizations

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

Connections to and involvement with community organizations are cornerstones for promoting Member safety and permanency and improving the overall well-being of youth involved in child welfare. Qualified MCOs should demonstrate experience and success in developing quality non-covered services and supports by collaborating with:

- Youth, families, and caregivers
- Providers such as primary care, behavioral health (including substance abuse), hospital, home health, and home- and community-based
- State partners such as DHHR, CPS, and HealthCheck
- Local and national thought leaders and advocacy groups such as the Casey Family Programs, Foster Family Treatment Association, Alliance for Children and Families, and Family Resource Network
- Agencies such as education, juvenile and adult justice, court, and law enforcement

This can only be accomplished through initial and on-going engagement efforts and statewide training on the trauma and challenges these youth experience and how to access available services and supports.

1.1.13 Creating the Individualized Service Plan

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.

We share the State's position that, along with the assessment process, the development and use of the individualized serviced plan (ISP) are extremely important processes for the Member and caregiver. Together, these processes should support the Member's voice and choice in his or her own healthcare; deliver a holistic view of the Member's strengths, needs, preferences, and short- and long-term goals; provide the care team with guidance and direction on the services and supports needed; and incorporate peer, natural, and community-based supports. We suggest enhancing this process to include integration of the crisis plan, IFSP, permanency plan, IEP, and other information relevant to the Member's safety and well-being.

1.1.14 Evaluating and Reporting Member Progress

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

The level of service management and coordination should be based on the strengths, needs, and preferences of the Member; meet the complexity of the Member's condition; and be adjusted based on the Member's on-going needs, progress, and assessment. The ISP should be an evolving document that is regularly reviewed, evaluated, and updated based on the Member's level of progress. Table 1.1.14-1 illustrates an example of recommended ISP monitoring processes.

Table 1.1.14-1. Example of Continuous Delivery and Monitoring of ISP Interventions

Service Management Responsibilities to Deliver and Monitor Member Interventions in the ISP
Maintain communication and collaboration with the care team that includes the Member, caregiver, CPS caseworker, Providers, and other involved parties to monitor the Member's health status, safety, well-being, and progress toward meeting goals established in the ISP
Maintain communication and collaboration, as appropriate, with the Member's care team
Participate in integrated case rounds for Members with unmet needs; case rounds serve as a consultative, multidisciplinary forum of professionals, including a clinical pharmacist, select Medical Directors, behavioral health experts, Service Managers, and other clinical staff
Monitor the evolution of the ISP and the Member's progress in relation to relevant clinical practice guidelines and make adjustments as necessary
Update and revise the ISP as indicated based on changes in the Member's health status and progress in meeting ISP goals and assess to identify barriers to meeting goals or complying with the plan

1.1.15 Tracking the Provision of Service Coordination

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.

Effective service coordination is a cornerstone to assuring the provision of quality, non-duplicative services and supports to youth whose needs are met through a number of systems that are often fragmented and have varying priorities. To accomplish accurate and timely tracking of service coordination activities, the MCO must provide a conduit for capturing and sharing information derived from assessments, the ISP and crisis plan, clinical notes, Provider credentials and encounters, and other data sources. Secure, user-friendly technology should be leveraged to provide readily accessible information to Service Managers, care team members, and MCO staff such as medical management and clinical supervisors. Service Managers should also facilitate verbal and hard copy information sharing with and amongst care team Members with appropriate consent. Service coordination activities should be regularly monitored and reviewed to verify that Members receive the care identified on the ISP and to support staffing level adjustments as needed.

1.1.16 Meeting EPSDT Standards

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?

At-risk youth often enter the child welfare system with fragmented physical and behavioral health records such as incomplete immunization, dental, and medication records. To maximize success in reaching all Members, including those hard to reach, a multipronged approach should be utilized to assure compliance with necessary Early and Periodic Screening, Diagnosis and Treatment (EPSDT) testing. The approach should empower Members; include collaboration with the HealthCheck Liaison; involve families and caregivers; support Providers; leverage community resources and government programs; and facilitate effective partnerships and productive collaboration.

Should an MCO network Provider provide these services, the Provider should be notified of the Member's child welfare involvement upon referral so that, if needed, an appointment can be scheduled within the required 72-hour time frame and the Members' historical information can be immediately accessible through a secure forum. If a contracted HealthCheck Provider provides these services, the Service Manager should facilitate the transfer of information between the Providers. Service Managers should also work closely with DHHR staff and the caregiver as appropriate to obtain as much information as possible so the Provider can make the most informed and appropriate physical care decisions.

It is the responsibility of the MCO to educate Members, DHHR staff, Providers, caregivers, and other participants involved in the care of the Member about the importance of preventive healthcare services, including oral care. Focus should be on making sure that Members receive these services in an effective and timely manner. Policies and procedures for EPSDT and other preventive healthcare services should be based on and comply with federal and State requirements and relevant recommendations of national organizations such as the American Academy of Pediatrics (AAP), Advisory Committee of Immunization Practices (ACIP), Centers for Disease Control and Prevention (CDC), and the U.S. Preventive Health Task Force.

1.1.17 Coordinating Services with Other Entities

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

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

1.1.17.2 Nursing Facility

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

Non-capitated services such as home health, personal care, nursing care, and other services provided by Home and Community Based Services (HCBS) organizations are often the most important services youth receive during their involvement in child welfare. We believe the inclusion of these types of services into one managed care plan supports the design and implementation of a single, fully-integrated system of care. This approach also promotes the delivery of holistic, person-centered care through one unified care plan; streamlined processes for overseeing communication and training; and policies and procedures that result in accountability, consistency, administrative simplification, and cost efficiency.

Regardless of whether these types of key Providers and services are integrated into the program or not, as a practice they should be included as care team members and participate in care planning and service coordination processes. The MCO should have processes and policies for identifying, engaging, and collaborating with these Providers and community-based organizations, as well as monitoring, verifying, documenting, and recommending adjustments to the services and supports as appropriate.

Communications and Training

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

The wide range of individuals potentially in the life of a youth involved in the child welfare system presents a challenge to providing pertinent education and training in a meaningful way. Education and training audiences could include youth; young adults; caregivers such as kinship and foster families; State staff; primary, acute, dental, and behavioral health Providers; court personnel; juvenile justice staff; and first responders such as law enforcement. As a result, UniCare recommends a centralized education and training structure that can be continually monitored, reviewed, and tailored to the audience and topic. Comprehensive training should incorporate a consistent set of principles and values when working with these youth while modifying the content and modalities to address varying needs, obligations, and time and location constraints of the audience.

1.1.18 Outreach and Training for Youth, Young Adults, and Caregivers

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.

It is essential that the MCO demonstrate understanding of and the ability to provide education and training on the challenges older youth in child welfare experience. Youth who age out of child welfare are more likely to discontinue their participation in services; are prone to return to their family of origin; have higher rates of behavioral health needs; and are susceptible to elevated rates of homelessness, poor educational outcomes, low wages, unemployment, health issues, and incarceration. As a result, we recommend the State continue coverage for these Members to the age of 26.

In addition, to minimize the disruptive effects associated with being involved in and aging out of child welfare, the MCO should implement "aging-out" processes that engage the Member and the Member's natural support system, as well as encourage the Member's continued participation in services. Preparing young adults for transition to the adult system of care should be early, on-going, informative, and individualized to the Member's needs. Working with the DHHR caseworker and engaging with transition centers and community-based programs that support transition-age youth are also critical. For example, transition-age youth can receive continued healthcare coverage up to the age of 26, as well as supports through DHHR such as a transitional living allowance or aftercare room and board assistance to foster a transition to independence.

The MCO should work with State partners such as the child placement agencies and the Service Development and Delivery Workgroup to enhance existing processes. With the assistance of State partners, Members transitioning to the adult system should be engaged and encouraged to share their knowledge with those who can benefit from their experience—other youth involved in child welfare.

1.1.19 Assuring Compliance with Sanders Compliance Plan

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

To adequately support the required enrollment and participation in HealthCheck for all youth involved in the child welfare system, the MCO should demonstrate its experience in working with State partners to develop processes that align with the State's established procedures and requirements. This should include the development of collaborative processes, policies, and procedures for child welfare staff, caregivers, Providers, and MCO staff to assure Members are assessed for and receive needed preventive and primary health services in a timely manner. Accurate documentation and reciprocal sharing of information between the Member's Service Manager and HealthCheck are critical to assuring needs are met while preventing duplication of care, as well as compliance with the initial and on-going HealthCheck Periodicity Schedule.

1.1.20 Assuring Members Receive Full EPSDT Benefits

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.

Given the previous challenges with the EPSDT program in West Virginia, we believe tracking and accurate documentation of Member participation in EPSDT services are key to assuring youth in child welfare receive the full-range of EPSDT benefits in the recommended time frame. The MCO should have policies and procedures for consistently capturing and monitoring historical, screening, assessment, and service delivery information on the Member's ISP, as well as in the Member's electronic health record. The MCO should also be responsible for educating Members, caregivers, Providers, and other potential care team Members on the importance of EPSDT services and adhering to the Periodicity Schedule, as well as mailing appointment scheduling reminders. Collaboration, communication, and sharing of information between HealthCheck physicians and MCO contracted Providers should be facilitated and supported by the Service Manager as well. The caregiver should be supported in scheduling appointments, addressing any barriers to the Member's participation, and providing reminders of scheduled appointments.

1.1.21 Training and Technical Assistance to Members, Parents, Caregivers, and Providers

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.

The event of a child entering the child welfare system is traumatic for the Member and can often be overwhelming for all involved depending on the needs of the Member. Education, training, and technical assistance should be the first step in preparing those involved in the Member's safety and well-being to understand how to access and deliver the quality, meaningful care these Members need and deserve. This includes training topics and modalities that are tailored to the learning needs of the audience. The following are examples of common training scenarios an MCO should be able to offer:

- A new Member may receive information about available services during a one-on-one interaction with his or her dedicated Service Manager
- A Member's biological parent may receive information on how to contact the MCO for treatment options through the DHHR caseworker
- A caregiver may receive information through the Member handbook and the MCOs Member portal
- A Provider may attend a webinar focused on how to engage and interact a Member with trauma-related experiences
- A Child Advocate may attend community-based training facilitated by and located at a local Provider

We suggest the State only consider MCOs that can demonstrate the "who, what, where, when, why, and how" of the training and technical assistance they can offer for this program.

1.1.22 Training for Staff and Contracted Providers

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?

As described above, those involved in the Member's safety, well-being, and care must receive the training and technical assistance necessary to engage Members in a safe and engaging manner. Youth involved in child welfare must be engaged with an understanding of the strengths and perseverance that are common amongst these children. This can only be achieved through a comprehensive training program that promotes understanding of the challenges a Member may experience prior to and after entering the child welfare system. Essential Providers necessary to the holistic care of these Members, including hospitals and pharmacies, must demonstrate an understanding of the Member's needs that, while they may be similar to the needs as other Members in Medicaid programs, they also come with experiences that are unique to their situation. A qualified MCO should have demonstrated experience in balancing HIPAA requirements with the primary goals of information sharing, privacy, and assuring the safety of the Member.

1.1.23 Promoting Understanding of Managed Care and the Population

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?

Managed care can often be misunderstood or viewed as interfering with a Member's existing Providers, services, or benefits, when in reality it can provide advanced clinical expertise, availability of an array of integrated services, and cost-savings to the State. Together with the State, the MCO should be responsible for educating and training all Providers on the role of managed care; benefits available to Members, families, and caregivers, including value-added benefits; benefits of trauma-informed care; importance of care coordination; and value of community-based supports and resources. Recognizing time constraints, Providers should have 24/7 access to education and training offered in a variety of modalities, clinical consultation, and support from Service Managers.

1.1.24 Educating Members about the Program and Available Benefits

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?

MCOs should be ready to support the State agency in its eligibility and enrollment processes and functions.

Every Member, caregiver, or DHHR caseworker as appropriate should receive a New Member Welcome Packet that includes information on Member eligibility, benefits, available services and supports, rights and responsibilities, available Providers (including Specialty Providers), how to access services, and when and how to ask for help. Members should be assured that they will have voice and choice in their own care planning and healthcare decisions. Educational opportunities could include welcome calls to Members and caregivers, as well as mailings and telephone and face-to-face reminders for appointments following ER visits, hospitalizations, and placement changes.

1.1.25 Outline of Proposed Provider Manual

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

UniCare recommends that the State require the MCO to maintain a robust Provider manual that affords Providers access to complete, accurate, and current information. To support an integrated model of care, the Provider manual should include the following types of behavioral health and physical health information:

- Access to training on the needs of foster care children (for example, trauma-informed care)
- Reference and resource information (key phone numbers, websites, and community resources)
- Evidence-based practices and practice guidelines
- Member eligibility and enrollment
- Covered physical and behavioral health services and enhanced benefits
- Precertification and utilization management processes
- Member management support — care management, disease management, care coordination
- Billing and claims administration
- Member and Provider rights and responsibilities
- Complaint and appeal processes
- Quality management systems

The MCO should make the Provider manual available during the contracting process, when updates are made, and on their website.

1.1.26 Provider Training Program Description

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

We believe that trauma- and system-informed training is the cornerstone to understanding the needs of youth involved in child welfare and delivering holistic care that is meaningful, integrated, and individualized and results in positive outcomes. This does not mean business as usual for the MCO—it means a qualified MCO should demonstrate experience developing and delivering statewide training programs for similar populations; understanding of existing system strengths and challenges; commitment to delivering quality care that is integrated and well-coordinated; and significant resource dedication to training individuals who are involved in the safety, well-being, and permanency for youth involved in child welfare. Target audiences should include youth, families, caregivers, MCO employees, State agencies, DHHR caseworkers, Providers, court personnel, attorneys, court-appointed special advocates, child advocates, and other stakeholders.

We believe an MCO should demonstrate its ability to and experience in developing and delivering a comprehensive child welfare training program that is:

- Inclusive of current and pertinent information that is tailored to the needs and learning styles of the audience
- Delivered through a tiered approach that takes into account initial, on-going, ad hoc, and annual training needs
- Provided by individuals with requisite subject matter expertise such as a Child Psychiatrist training PCPs on best-practice prescribing for youth diagnosed with ADHD or a family support organization providing education to youth and caregivers on self-care techniques
- Offered frequently in community-based forums and through a variety of modalities that are conducive to attendance and participation
- Monitored and adjusted as necessary based on participant feedback to assure relevancy

1.1.27 Member Education Materials

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

UniCare knows that supporting health literacy involves more than just reviewing written and web-based materials for readability. Our experience participating in the care of Members involved in child welfare systems in six states supports that Members and their caregivers must have the ability to read materials, understand the content, and be able to take action on what they read. The American Academy of Pediatrics identifies multiple barriers to healthcare in the child welfare system. These include:

- Multiple and complex healthcare needs requiring medical knowledge and familiarity with health care systems that most case workers and foster parents do not have
- A highly mobile and transient nature of the population which complicates care coordination and transfer of medical information
- Complexity of the child welfare system with shared responsibility for the child among foster parents, birth parents, caseworkers, courts, and others, which presents opportunities for miscommunication, conflict, and abrogation of responsibility

UniCare recommends a comprehensive and thoroughly vetted health education strategy that will focus on minimizing barriers that Members, caregivers, and placements encounter to make appropriate use of healthcare and become engaged in the maintenance of the Member's health. The strategy also assures keeping DHHR staff, GALs, judges, attorneys' ad litem, and other interested parties informed about UniCare processes to coordinate respective roles in the support of services for Members and promote effective communication.

To ensure that all of the populations we serve receive the appropriate type and amount of information, our efforts range from providing Member and caregiver education that builds health literacy (the ability to comprehend and apply information to address issues) and empowers caregivers and Members to fully participate in decisions around healthcare to offering personal solutions for targeted outreach and education for individual Members. The needs of children in foster care are frequently similar to those of children with special healthcare needs. Our care management, disease management, and children with special healthcare needs programs reflect an intensive approach to boosting self-care skills. Developed specifically to meet the needs of Medicaid, CHIP, and waiver program participants, our programs will be adapted to meet the specific needs of our Members, including incorporating a trauma-informed care model for education and communication. The Member handbook will provide information to help

caregivers understand their role in treatment planning and care decisions for the Member and providing consent for services.

1.1.28 Supporting Caregivers with Appointment Adherence

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.

Given the priority of services and supports for the Member, the role and needs of the caregiver can often go unnoticed or unmet. Offering and delivering extended caregiver DHHR caseworker support can often mean the difference between placement preservation and placement disruption. Caregivers are tasked with multiple responsibilities, including the day-to-day management of the Member's schedule that can include appointments with multiple Providers. Dedicated Service Managers can provide support to caregivers through 24/7 availability, scheduling and attending appointments, arranging transportation, and conducting appointment reminder calls as needed. The MCO should also offer education on topics such as behavior management, managing medications, stress reduction, and navigating the healthcare system through community-based and web-based forums.

1.1.29 Coordinating with the Bureau for Public Health

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.

Public health departments, along with other State partners, fill critical gaps in access to care. Successful collaboration with these departments and programs improves the MCO's ability to identify, prevent, and address healthcare issues such as lack of health literacy, poor birth outcomes, and lack of access to preventive care. We recommend that the State create forums for all agencies and organizations involved in the care of children in foster care to collaborate and share information in order to develop a seamless system of care.

The MCO should demonstrate experience, willingness, and ability in working with public health departments to identify and address issues that impact common service delivery systems, for example:

- Leveraging existing programs rather than duplicating efforts
- Connecting Members to programs and agencies that support and/or provide interventions for Members with specialized healthcare needs
- Sharing data that is timely and accurate
- Identifying opportunities for program improvement

The MCO should also offer strategies for working with public health departments that demonstrate knowledge of potential solutions to address local issues.

Enhanced Quality and Seamless Continuity of Care

1.1.30 Developing Services Range

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.

The best approach to developing a continuum of care that meets the unique needs of youth in child welfare is for a single statewide MCO to manage the full range of benefits and services for children and their families. This will reduce fragmentation and promote member and family access to the services they need when they need them through a single point of entry. Additionally, requiring a single MCO to be responsible for all services and supports enhances accountability for access to care and improved health outcomes.

UniCare recommends that the State seek an MCO partner with demonstrated ability in enhancing the system of care and delivering better health outcomes. The MCO should be experienced in building partnerships with local stakeholders and agencies and demonstrate its approach to collaborating with Members, families, caregivers, State partners, Providers, and other stakeholders. In our experience, these individuals are knowledgeable of the community's needs, as well as Providers who are willing and able to meet those needs. Therefore, the MCO should be able to describe its approach to maintaining frequent contact with and gathering on-going information from these stakeholders, as well as to demonstrate how they have used this information to develop innovative approaches and expand the use of clinical best practices.

1.1.31 Handling Multiple Placements/Removals

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

Permanency is critical for children and youth involved in child welfare to realize improved health, wellness, and stability. To achieve this goal, we recommend the State require the MCO to develop programs to prevent placement disruption. The MCO should demonstrate a multifaceted approach to collaborating with State agencies, Providers, families, and caregivers through activities such as:

- Developing 24/7 Provider, natural, and MCO supports for crisis situations to prevent placement disruption
- Implementing programs for aftercare coordination and support
- Developing relationships and facilitating communication between Providers, caregivers, and system partners
- Providing training and support to families, caregivers, and system partners regarding proactive interventions
- Implementing reciprocal data-sharing processes
- Supporting Members and caregivers throughout transition to and from the system
- Working with the Member and caregiver to develop a person-centered plan that addresses their unique needs

To further prevent multiple placements and removals, we recommend that the State's program include coverage of HCBS. In our experience, creating better linkages to community-based services and supports prevents crisis situations that may result in children entering foster care or experiencing multiple

placements. Additionally, we recommend that the program focus on and invest in strategies that promote reunification, as appropriate.

1.1.32 Handling Out-of-state Placements

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?

We believe that youth who are removed from the home should be kept close to home (safety permitting) to maintain connection to their communities, natural supports, and schools. In West Virginia, over seven percent of West Virginia children involved in child welfare are in out-of-state placements for a variety of reasons such as a lack of appropriate specialized in-state services and a shortage of therapeutic placements. UniCare supports the State's efforts to transition these children back to their local communities and is pleased to offer our recommendations for developing community-based services that will allow children to remain in West Virginia.

To promote local, community-based treatment, we recommend that the State and the MCO work collaboratively across systems and providers to develop an in-state network. The State and MCO should also work to transition youth back to their communities using evidence-based strategies such as wraparound services and community-based programs that support Members with specialized needs. The MCO should also collaborate with Providers and system partners to leverage available community resources and natural supports that provide on-going assistance to the child and family.

Rather than relying on institutional services that would require sustained removal from the community, the State and MCO should develop and promote family-centered, home-based programs, including therapeutic counseling coupled with other focused services such as training on social skills, coping, and anger management. For example, the State should collaborate with the MCO to develop peer and family support programs to train caregivers to manage children with behavioral health needs in the home. These programs can also provide support during times of high stress, reducing the likelihood that situations will escalate to a crisis.

The MCO should educate Providers on trauma-informed care and evidence-based community service models. Providers should receiving training on clinical practices and operational support to successfully implement innovative programs that support children, youth, and caregivers. Additionally, the MCO should work with Providers to develop new lines of business and expand their current service offerings.

We also recommend that the MCO implement a comprehensive, responsive crisis system that supports caregivers during emergent situations and is equipped to meet the unique needs of children involved in child welfare. By providing children, youth, and families with the support they need, out-of-state placements can be avoided. Crisis supports are also critical to successfully transitioning Members to their communities and homes, further avoiding placement disruption, removals, and out-of-state placements.

1.1.33 Providing Alternative Payment Structures

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***

Systems that deliver services and supports to children and caregivers should be designed to achieve the goals of increased permanency, safety, and well-being. In support of these goals, UniCare recommends that the State collaborate with the MCO to develop alternative payment strategies that reward Providers for providing services that holistically address the child's and family's needs.

Payment structures should reward Providers for engaging Members in appropriate behavioral health and physical health services, thus promoting integration and Member access to appropriate services and reducing inappropriate service utilization. For example, the State should consider payment strategies that encourage providers to closely monitor psychotropic medications for children and provide community-based services that reduce placement disruptions. Incentives should be aligned across providers, enabling the State and the MCO to hold the entire system accountable for meeting the goals of increased permanency, safety, and well-being.

We also encourage the State to consider a broad range of measures that assess health outcomes, as well as quality of life and family indicators. Nationally, we see a trend toward the use of measures such as national core indicators and measures published the by the Casey Family Foundation. These measures should be incorporated into value-based purchasing strategies such as shared savings and Provider incentives.

1.1.34 Implementing the Member and Nurse Hotlines

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.

Youth involved in the child welfare system are more likely to have significant physical and behavioral health concerns that can affect their ability to become healthy adults. This puts them at risk for poor health outcomes and increased utilization of inpatient and facility-based services. Additionally, caregivers do not always have a complete picture of the medical services the child is currently receiving, increasing the likelihood of emergency department use to address behaviors and/or symptoms.

A 24/7 hotline is a valuable tool to support children, youth, and caregivers. Providing Members and caregivers access to triage and information on available medical and behavioral health services and the appropriate setting to meet their needs reduces the likelihood of admissions to higher levels of care and improves permanency as families learn how to manage the child's needs.

We recommend that MCO hotline staff have the expertise to triage and resolve caller issues. Staffing should be determined by call statistics such as call volume and average length of call. Routine reports should be available for hotline supervisors to make adjustments as needed.

Hotline calls should be answered live by staff who have the experience, knowledge, and training necessary to assist callers on a spectrum of needs such as the following:

- Crisis situations, including screening, assessing, de-escalation, stabilization, and emergency dispatch as needed
- Prescription needs
- Member benefits, including covered and non-covered services
- Concerns and complaints
- Referrals to specialty Providers
- Identification of and referral to community-based resources
- Identification (ID) card replacement requests

The goal is to make services readily available to caregivers or social workers involved in the transition from home to foster placement, making sure that all children in the child welfare system have regular preventive healthcare and appropriate medical follow-up care. Hotline staff should have access to medical records and other data as questions arise, and they will be an on-going resource of reliable information about emergent concerns, non-emergent issues like compliance with EPSDT, and access issues such as helping locate a PCP in the Member's new setting.

1.1.35 Assuring Continuity of Prior Authorized Services

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.

Engaging Members early on through the identification, assessment, and care plan development processes promotes better health outcomes. Therefore, the MCO should have an established, effective process in place for supporting seamless transition of Members with pre-existing care plans. UniCare recommends that the MCO's process for transitioning new Members includes:

- Informing new Members and caregivers of program benefits
- Evaluating Members as soon as possible to determine their medical, functional, and behavioral health status
- Prioritizing outreach and assessment according to the Member's risk levels
- Identifying the appropriate level of care coordination, stratification, and engagement
- Obtaining and incorporating existing care plans and other information, such as previously completed assessments, into our clinical system

Systems should be in place for incorporating prior authorization information into the Member's care plan and for authorizing those services during the transition to promote continuity of care. Members should receive an initial assessment to determine their needs and inform the development of a new care plan. On an on-going basis, the MCO should monitor the Member's progress and coordinate services across Providers and system partners. Additionally, data should be transferred electronically and available to all individuals involved in the Member's care.

As part of transition planning, the clinical team should identify Members receiving services from out-of-network Providers and work to implement a contract. The MCO should also have processes in place to transition the Member to a participating Provider or enter into a single-case agreement if it is in the best interest of the Member.

1.1.36 Meeting the Member's Unique Healthcare Needs

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.

The MCO should develop processes to evaluate the appropriateness of the services each Member receives in meeting their unique healthcare needs. Through these proactive processes, Members can be connected with the right Provider up front, and on-going service delivery should be monitored to verify continued appropriateness.

Members should receive an initial assessment upon enrollment, as well as on-going assessments to verify that their needs continue to be met and that identified goals and services are appropriate. Due to the changing needs of children and youth in child welfare systems, on-going assessment is particularly important. The MCO should work closely with the WV Comprehensive Assessment and Planning System (CAPS) to include information and not duplicate processes. After the initial assessment, on-going assessment should occur upon changes in placement, service Provider, or Member status or at the caregiver's request, at a minimum. This information is the basis for the MCO's work with the Member, Providers, and caregivers to develop a comprehensive service plan.

The MCO should continuously support effective service delivery through on-going data analysis and reporting to identify gaps in care, utilization trends that indicate an unmet need, and the need for Member outreach. This information should be used to continuously evaluate that Member's needs are being met and to address identified issues. If the Member is not progressing toward his or her treatment goals and the clinical team determines a change in Provider is appropriate, the MCO should have processes in place to work with the Member, caregivers, and Providers to seamlessly transition the Member to an alternative Provider. The MCO should be able to describe its protocols for identifying an appropriate provider, sharing Member information, supporting the Member and caregiver throughout the transition, and following up to verify the new Provider is meeting the Member's needs.

1.1.37 Identifying and Tracking Members with High Needs

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

It is imperative to evaluate a new Member's need for services as soon as possible to identify any emergent or urgent needs to connect the Member to necessary behavioral or physical health services. Therefore, UniCare recommends that the State require the MCO have processes in place for collecting and using CAPS information to identify new Members with high physical or behavioral health needs.

The MCO should use CAPS, as well as information from other Provider assessments and evaluations, psychotropic medication use, co-morbidities, in-patient hospitalizations, facility placements, and emergency department utilization to assign a risk level based on the Member's needs. The MCO should then have systems to provide Members with the level of support they need.

On an on-going basis, the MCO should have the capability to identify gaps in services or utilization trends that indicate the Member may need additional support and engagement. These Members should have access to intensive outreach, which may include linkages to community resources, case management, and/or telephonic or face-to-face support.

1.1.38 Identifying and Reaching Out to Members with Immediate Needs

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.

Implementation of new programs and the successful transition of new Members should be core competencies for an MCO dedicated to serving Members involved with child welfare. In our experience, the use of data provided by the State to identify those Members with the highest needs is integral to the implementation process. This information should be readily available to the MCO prior to Contract implementation. Based on their analysis of this data, MCOs should work with Providers to give Members the supports they need to minimize any disruption in care and connect Members to appropriate services.

During implementation, the MCO should have processes in place to establish a relationship with Members and verify that their needs continue to be met. Members and families should have ready access to assistance in navigating the healthcare system or resolving issues. Throughout the transition, there should be multiple opportunities for Members, families, advocates, and stakeholders to provide meaningful experience and input and to receive information on progress and any systems changes. Following implementation of the program, MCO staff should follow up with Members identified as having immediate and high needs to continue to engage them in services.

1.1.39 Receiving and Addressing Member Complaints, Questions, and Appeals

1.1.39 Describe the process a vendor would follow to review Member complaints, questions, and appeals. The process should start from the receipt of a request and describe each phase of the review including notification of disposition.

The Member complaint, inquiry, and appeal processes are key for protecting the rights and health of Members and for improving program operations and management. The MCO should demonstrate that its Member complaint and appeal processes comply with federal and State standards and are simple and user-friendly. The MCO's processes for resolving complaints, questions, and appeals should afford Members, caregivers, and advocates the opportunity to provide the MCO with their concerns and/or dissatisfactions in a non-threatening manner.

All MCO helpline employees should be trained on the MCO's inquiry, complaint, and appeal process. MCO processes for handling Member complaints, questions, and appeals should include reviewing the specifics, analyzing records and other information, interviewing persons involved, as appropriate, and resolving the issue as expeditiously as possible and within required time frames.

All MCO employees should have access to the tools necessary to resolve nearly all Member inquiries that do not involve dissatisfaction or a potential quality-of-care concern during the initial call.

Notification of Disposition

MCO complaint and appeal processes should include systems to mail a written acknowledgment to the Member regarding his or her appeal request. The letter notifies the Member of the right to present evidence and allegations of fact or law in person, as well as in writing. It also notifies the Member of his or her right to examine the case both before and during the appeals process.

An appropriately licensed physician should review each appeal and render a final decision. The Medical Director or reviewing physician should not participate in the review if they have been involved in the initial determination or are subordinate to any person involved in the initial determination.

1.1.40 Coordinating Care for Dual-eligible Populations

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

UniCare envisions a fully integrated and seamless system of care that is coordinated across a care continuum for all Members regardless of their multiple sources of coverage. We recommend that the State require the MCO to offer Members who are dually eligible a coordinated, seamless approach to service delivery through a single point of access, a fully integrated care management program, and technology that supports coordination across benefits and Providers.

The MCO's Care Coordination solutions for dual-eligible Members should be person- and family-centered, seamless systems of care offering comprehensive care delivery and case management that link Members and caregivers to needed services. All Members should have access to a comprehensive continuum of care that helps achieve positive health outcomes, high consumer satisfaction, and overall cost effectiveness and savings. Our affiliate health plans have arranged and coordinated services for dual-eligible Members since 1998. We understand the complex challenges that dual-eligible Members face, and our approach streamlines services. Nationwide, UniCare and our affiliate health plans serve more than 685,000 Medicare Advantage Members and more than 124,000 dual-eligible Members. Nearly 34,000 of these Members are enrolled in our D-SNPs in nine states.

1.1.41 Evaluating Quality Assurance and Improving Performance

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

A managed care approach to delivering services for children and families involved in child welfare can provide a focus on quality of care while meeting the program's goals of increased permanency, safety, and improved well-being. An MCO with national experience can provide the expertise necessary to support the State in improving the overall service delivery system within the context of the current environment. To do this, the MCO should demonstrate its ability and willingness to collaborate with the State and system partners to develop systems and processes for continuously evaluating and addressing access to care and the quality of services.

The MCO should employ multiple evaluation and improvement methods, including but not limited to data-driven monitoring, programmatic reviews, performance measures, and satisfaction surveys. Appropriateness of care should be analyzed by comparing practice against evidence-based practices and professional practice standards. Overall quality should be assessed by measuring Member and caregiver outcomes on measures that indicate well-being such as quality of life and family indicators.

We encourage the State to work with the MCO to implement an outcomes-based system for measuring and improving quality. We recommend that the MCO and the State monitor data gathered in the first year of the program to establish a baseline minimum performance. At the end of the first year, the State should analyze outcomes data and work closely with the MCO to refine performance and improvement targets. The second year of the program should focus on improvement over the baseline period for these same quality metrics. In year three of the program, the MCO should be able to demonstrate sustained improvement.

To achieve sustained improvement, we recommend that the MCO have information management systems and data mining tools to identify opportunities for further improvement to care and services. These systems and tools should allow the MCO to track, trend, and analyze single-data sources over a period of time and conduct multifaceted analyses using several different data sources. The MCO should analyze this data to identify key populations that are drivers of low performance such as geographic area, age, language, ethnicity, and assigned Providers to determine areas of focus. The MCO should be able to

demonstrate experience developing clinical performance improvement projects specific to children involved in child welfare that result in improved Provider and network performance.

1.1.42 Addressing Challenges with Traditional HEDIS® Measures

1.1.42 Describe the challenges associated with using traditional measures like Healthcare Effectiveness Data & Information Set (HEDIS) for children and adolescents with special healthcare needs and what other types of measures could be used to gauge and measure quality for this population.

UniCare recommends that the State collaborate with the chosen MCO to develop quality metrics that are meaningful to the State and stakeholders to measure program performance, health outcomes, and Member well-being. The MCO should work collaboratively with the State to design and implement quality metrics for measuring and improving quality using the following types of principles:

- Quality metrics should include existing, widely-accepted, evidence-based, and peer-reviewed measures of quality such as HEDIS. While HEDIS has some limitations for measuring the quality of care delivered to children with special health care needs such as the lack of measures related to specialty and chronic care, it allows the State to use quality rankings as targets for improvement and allows for comparative analysis based on regional variations. Additionally, HEDIS measures are well known by the Provider community, allowing for ease in defining a starting point for a new program.
- Quality measures should reflect issues that are prevalent in the population. A measure may be desired, but if the prevalence of the issue is low in the population, the denominator for measuring will be small and will have the tendency toward large statistical variance that distorts true improvement vs. chance.

We encourage the State to implement an outcomes-based system for measuring quality for this population. We recommend that the MCO and the State monitor data gathered in the first year of the program to establish a baseline minimum performance. At the end of the first year, the State should analyze outcomes data and work closely with the MCO to refine performance and improvement targets. The second year of the program should focus on improvement over the baseline period for these same quality metrics.

UniCare also recommends the State require the MCO to routinely use data to improve Member outcomes. For example, the MCO should monitor and routinely report on HEDIS, HEDIS-like measures, and utilization data related to preventive services across all age categories. In this way, the MCO can begin proactively identifying and addressing potential systems issues and use this information to inform system enhancements.

1.1.43 Evaluating Member Satisfaction

1.1.43 Describe the approach for evaluating Member satisfaction.

Information from Members, families, and system partners is critical for the MCO to understand the strengths and opportunities to improve the service delivery system. Therefore, the MCO should be required to utilize multiple opportunities to provide input and feedback. These should include formal mechanisms such as committees, satisfaction surveys, and the complaint process, as well as informal mechanisms such as community forums and interactions with MCO staff.

UniCare encourages the State to require the MCO to use a nationally recognized NCQA-certified vendor to administer the most current version of the Consumer Assessment of Health Care Providers and Systems® survey (CAHPS) to gather data on satisfaction with access, availability, and quality of services. The MCO should also demonstrate how they use the results to identify opportunities for improvement and develop and implement quality improvement activities to address areas of concern.

1.1.44 Working with Providers to Promote Quality Care

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

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

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

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

1.1.44.4 Strategies that could be adopted to simplify the administrative procedures

In our experience, working with Providers to ensure accountability and quality of care requires a long-term commitment to allow the MCO to develop a relationship with the Providers and consistency in how performance is measured. Additionally, a single MCO that delivers one set of expectations allows the Provider to focus on delivering quality care instead of meeting multiple requirements and reduces administrative burden.

When developing this program, we encourage the State to contract with a single MCO to administer the program and extend the Contract term to allow sufficient time for quality systems to become effective. Additionally, we recommend the State commit to supporting the lifelong health of Members by expanding the age range for this program to age 26. This will allow Members to transition into adulthood with their medical benefits intact, resulting in improved Member and community well-being.

When implementing the program, the MCO should give Providers the tools, resources, and support necessary to effectively and efficiently serve Members. The MCO should have systems and processes in place to provide it with actionable information and to support the Provider in effectively using available data to enhance his or her performance. These tools should include Provider reporting, value-based contracting, opportunities for provider input, and best practices. The MCO should provide examples of how it has utilized these processes to reduce administrative burden, as well as its systems for taking corrective action when Providers do not meet standards.

1.1.45 Utilization Management Guidelines

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

Utilization management (UM) guidelines should reflect optimal evidence-based treatment protocols for youth in child welfare and be based on the following:

- Established physical and behavioral health guidelines adopted from nationally recognized, reputable organizations such as Interqual®, which establish standards for medical necessity and clinical-decision management
- Internally developed clinical practice guidelines (CPGs) based on applicable, valid, and reliable information from evidence-based practices (EBPs); nationally-recognized sources such as the American Academy of Child and Adolescent Psychiatry and the Substance Abuse and Mental Health Services Administration (SAMSHA); accepted and approved local practice; and local and national government sources such as the Centers for Medicaid and Medicare Services (CMS)

Recognizing the prevalent need for timely services among youth in the child welfare system, prior authorization and UM processes should never delay needed services or place additional administrative burden on our Providers or Service Managers.

1.1.46 Screening and Assessing Members' Needs

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.

Conducting timely, initial, and on-going physical and behavioral health screening and assessment activities with Members is key to identifying any new, unmet, undiagnosed, and emergent needs and connecting the youth with necessary services and supports to address those needs. Thorough assessments should be conducted for all new Members entering child welfare after obtaining the appropriate consent using a standardized assessment tool that covers all domains. This includes the Member's medical, behavioral, dental, vision, social, environmental, and functional status; identifies risks of adverse outcomes; and identifies names of current Providers, information on medication, durable medical equipment, or needed supplies.

To inform the assessment and the determination of the Member's initial risk levels, the MCO should be required to utilize results from screenings and assessments completed by other system partners, rather than subject the Member to repeated processes, to minimize duplication of efforts. We support the use of the Child and Adolescent Needs and Strengths (CANS) assessment and Adult Needs and Strengths Assessment (ANSA) tools and incorporation of the results into engagement, care-planning, and service-delivery processes. Given the frequency of changes for a youth involved in child welfare, a qualified MCO should have policies and procedures for conducting on-going screening and assessment triggered by situations such as placement changes, crisis events, ER visits, hospitalizations, care-team recommendations, and annual updates.

Prior to the implementation date, our Georgia affiliate's dedicated foster care program employees facilitated the completion of over 9,000 initial Member health service assessments. To assure all initial Member medical, dental, and trauma assessments were completed by the Member's PCP, staff worked closely with the Member's medical home/PCP to schedule timely appointments. Our affiliate MCO also developed a list of Transitional Healthcare Assessments Centers composed of primary care, behavioral health, and dental Providers to complete assessments within the compliance time frame, as needed.

1.1.47 Improving Behavioral Health Service Delivery and Outcomes

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.

We recommend the MCO continually assess the quality of behavioral healthcare provided to Members using Provider, Member, and stakeholder feedback and quantifiable data. Based on the experience of our affiliates serving Members involved in child welfare in other states, as well as our knowledge of the West Virginia landscape, we recommend collaboration between the State and the MCO to identify opportunities to enhance care for this population. Table 1.1.47-1 provides examples of clinical practice improvement opportunities for behavioral healthcare, as well as planned interventions and measurements for success.

Table 1.1.47-1. Opportunities to Enhance Behavioral Healthcare for Youth involved in Foster Care

Supporting Information	Interventions and Measurement for Success
Opportunity 1: Development of Unique, Recovery-, and Resiliency-focused Care Management Strategies for Members with an SED diagnosis	
- The American Academy of Pediatrics (AAP) identified mental health issues are the largest unmet need for children and youth in child welfare. - The American Hospital Association stated in 2009 that mental health conditions were the fourth most common reason for child and youth hospitalizations.	**Interventions:** For Members diagnosed with SED or identified as a "super-utilizer" we assess and engage Care Coordination at the Intense Service Level, which provides frequent contact through follow-up calls and home visits from the assigned care manager who reviews and revises the care plan as needed, to build a set of services that better address the Member's specific needs and encourage the Member's enrollment in a Health Home. **Measurement for Success:** Increase in health home enrollment; improved placement preservation; and reduced use of crisis, residential, and inpatient services.
Opportunity 2: Preservation of Member Placement Through Increased Access to and Coordination of Services	
- According to 2011 data from the Adoption and Foster Care Analysis Reporting System (AFCARS), 61 percent of Indiana children and youth in child welfare for more than 24 months have three or more placements. - Each change in placement translates to moves that can disrupt access to healthcare, continuity of education, and overall stability.	**Interventions**: Care managers work with the Member, caregiver, guardian, PCP, and others to develop a crisis plan that is easily accessible and incorporates support from our Provider network, Comprehensive In-home Support Team, crisis response, and the Member's and caregiver's natural supports. **Measurement for Success:** Reduction in the rate of placement disruptions, hospitalizations, and approvals for extended hospital stays.
Opportunity 3: Enhance Psychotropic Medication Monitoring for Youth in Child Welfare	
Recent reports have highlighted how children in child welfare are prescribed psychotropic drugs at very high rates. According to data compiled by the Congressional Research Service, between 2008 and 2010, nearly one out of every four children in child welfare was using a psychotropic medication on any given day—more than four times the rate among all children.	**Interventions:** Care managers review daily reports to identify new or concerning utilization such as antipsychotic and antidepressant drugs and lack of informed consent and medical monitoring gaps. **Measurement for Success:** Reduction in prescribing for antipsychotics, more than one medication in the same classification, and medications for children under the age of 5, as well as an increase in informed consent documentation.

1.1.48 Using Telemedicine, Telehealth, and Telemonitoring

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.

Access to specialty and behavioral health services, particularly psychiatry services, represents a challenge throughout West Virginia. This challenge is further exacerbated in many rural areas where the nearest specialty Provider may be located hundreds of miles away with a lengthy wait list. Telemedicine uses advanced communication technologies and the Internet to deliver health-care services remotely. By using advanced bi-directional communication technologies, behavioral health professionals are able to widen their reach to Members in a cost-effective manner.

To improve access to behavioral health services, a comprehensive telemedicine strategy to improve access in rural and underserved areas should be deployed. Telemedicine strategies should include contracting with Providers such as FQHCs, CMHCs, and RHCs that are capable of providing telemedicine services to Members; forming relationships with Providers who are interested in pursuing telemedicine; and supporting the development of new telemedicine sites.

The telemedicine strategy should employ a "hub-and-spoke" network whereby a Provider, under contract, provides telemedicine services via telemedicine connectivity (hub). Members travel to a location established in their service area (spoke). The Member remotely connects to the hub Provider for diagnosis and treatment. This approach reduces Member's travel time and increases access to psychiatric services that would not normally be available at the spoke locations. Identifying and contracting with Providers with telemedicine capabilities, including the use of available televideo technology, will increase access to specialty behavioral health assessment and treatment Providers. The MCO should determine the exact number and locations of all telemedicine end points (spokes) and the number of rural Providers who will commit to working with our telemedicine contractors (hubs) and conduct Provider outreach to increase the availability of spokes in medically underserved areas. We also suggest actively recruiting rural Providers and forming relationships with Providers who practice in SBHCs to evaluate the possibility of establishing school-based telemedicine clinics for behavioral health.

1.1.49 Managing the Pharmacy Benefit

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

A study by the National Institute of Mental Health found that nearly half (47.9 percent) of youth in child welfare were determined to have clinically significant emotional or behavioral problems. Likewise, researchers at the Casey Family Programs estimate that between one-half and three-fourths of individuals entering child welfare exhibit behavioral or social competency problems that warrant mental health services.[3] Many psychotropic medications, particularly antipsychotics, impact a child's overall physical health, including rapid weight gain, increased risk for diabetes and heart disease, and adverse drug reactions. Additionally, many psychotropic medications do not have Food and Drug Administration (FDA)-approved labeling for use in children. Due to the side effects of these drugs it is critical to incorporate frequent and on-going monitoring of the need for these medications. It is our recommendation that MCO's focus on the reduction in prescribing for antipsychotics, for more than one medication in the same classification, and for medications for children under the age of five. In addition, there should be a focus on informed consent documentation.

[3] National Council on Disability, http://www.ncd.gov/newsroom/PolicyCorner/05062013.

Providing access to a variety of psychosocial services and supports in concert with psychotropic medications is critical. As a result, we suggest full integration of psychotropic medication management with medical care management programs to optimize quality of care and prevent over-prescribing, under-prescribing, and misuse of medications.

1.1.50 Continuity of Prescription Medication

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?

Continuity of care and access to medically necessary medications for Members should be a primary objective of a sound medication-therapy management program. Breakdown in drug therapy can lead to reduced medication adherence and increase the risk of medication-related adverse outcomes. To mitigate potential lapses in care, a transition process should include coverage for Members who are stabilized on drugs not included on the preferred drug list and cover non-preferred drugs for the Member as long as medically appropriate. The MCO should demonstrate effective transition policies and procedures for Providers responsible for completing prior authorizations and medication assessments to prevent interruption of medication access. Additionally, available authorization and claims data should be analyzed to identify previously authorized medications. Members who receive non-preferred drugs should continue that medication during the transition period and up to the length of the existing authorization. When the prior authorization from the previous plan expires, the MCO should work with the prescriber to initiate a prior authorization and determine medical necessity for the non-preferred drugs.

1.1.51 Assuring Appropriate Prescribing of Psychotropic Medications

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?

Effectively prescribed and managed medications assist children in addressing trauma or treating inherited or developed behavioral health conditions. When not appropriately managed, these medications can negatively impact a child's physical health and emotional well-being. We recommend the State and MCO work together to develop a Psychotropic Medication Utilization Review program that adheres to best practices for safe prescribing and provides effective medication therapy management that:

- Promotes Member safety through active monitoring and management of poly-pharmacy, prescriber patterns, and potential drug interactions accounting for the unique clinical considerations of youth in child welfare and other factors endemic to the population as detailed above
- Supports utilization of therapeutic interventions in conjunction with medications
- Manages drug utilization consistent with the State parameters and other best practice standards of practice
- Promotes cost-effective prescribing through collaboration, education, and information sharing
- Fosters compliance with State, federal, and contractual standards through established policies and procedures, continual monitoring, and collaboration and information sharing with DHHR
- Requires that pharmacies fill prescriptions for covered drugs ordered by any licensed Provider regardless of the Provider's network participation

We believe a phased-in approach to training, educating, supporting, and monitoring Providers will result in sustainable, meaningful change that improves the appropriate utilization of psychotropic drugs.

1.1.52 Assuring Provider Access to Member Information

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?

UniCare's vision of information sharing represents a single, comprehensive approach that supports the overall care and services of youth in child welfare. A complete view of the Member's current and historical information should be made available to care team members, including assessment results; service provision and participation; treating Providers; school-related documents such as IEPs and functional behavior assessment/intervention plans; and service plans such as the DHHR Permanency Plan, ISP, crisis plan, and IFSP. We believe that making it easy to access information and tools is better for the Member and increases Provider and care team use of those tools.

We recommend that Provider contracts require network Providers to share accurate and timely information, communicate directly with one another telephonically or electronically, and coordinate with one another as clinically appropriate and at a minimum of quarterly to assure quality, appropriate, and non-duplicative care. This two-way communication includes key information such as care plan updates, changes in medications, and hospitalizations. Provider coordination activities should be monitored and documented by Service Managers.

Finance

1.1.53 Methodology for Establishing Capitated Payments and Projected Cost

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.

UniCare and its affiliated health plans have worked closely with states across the country to establish capitation rates for Medicaid managed care programs. Our experience has provided us with insight into the best practices for this process, which are outlined in this response.

First and foremost, capitation rates have to be developed to be actuarially sound. For a new program such as this, the process followed by the actuary may include the following steps:

- Adjust existing historical fee-for-service data for any program differences such as:
  - State or federal mandates
  - State fee schedule adjustments
  - Benefit changes
  - Eligibility changes
  - Regional cost variations with the State
- Trend the data forward to the contractual rating period
- Consider adjustments for opportunities to reduce expected costs as the result of managed care (managed care savings)
- Include a reasonable administrative allowance
- Consider any applicable State premium taxes or fees
- Include a provision to account for the Federally Mandated Health Insurance Fee required by the Affordable Care Act, including the non-deductibility of this tax

The actuary should also consider the need to develop separate capitation rates depending on the age of the child. For example, some States have separate rates for children ages 0–5, 6–10, 11–17, and 18 or over. The actuary should also consider the level of Member need in order to vary rates by the disability status

of the child. Additionally, some states vary rates depending on eligibility status such as providing separate rates for children in Foster Care versus Adoptive Assistance.

Developing costs directly from historical fee-for-service data is the preferred methodology when the data is credible. Another approach is to use information from another state; however, this approach would require additional assumptions to account for eligibility, provider reimbursement levels and methodologies, benefit plans, state mandates, and other differences between the two state programs.

1.1.54 Calculating Costs for Program Administration

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?

Based on our experience in other states, the administrative load is typically reflected in the rates as a percentage of the total capitation rate. The administrative allowance should include reasonable allowances that consider:

- General overhead
- Claims payment
- Enrollment processing, member ID cards, and other communication
- Provider and Member call center
- Provider network development and maintenance
- Quality programs
- State and federal reporting requirements
- Premium and other taxes levied on the MCO (including the Health Insurer Fee included in the ACA)
- Profit and capital requirement

The billing period is typically monthly for both claims and administrative costs.

1.1.55 Case Scenarios

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.

UniCare recommends the State only consider selecting an MCO that has specialized solutions that address the individualized needs of Members and helps achieve the State's goals of improving health outcomes, facilitating the appropriate use of services, reducing duplicated or fragmented care, and achieving long-term sustainable savings, as well as delivering an established care management model that is tailored to the needs of this population. While we recognize that each individual has his or her own strengths and needs, we have learned that we need to achieve the following through our Care Coordination processes:

- Supporting Members during transitions between levels of care, placement changes, crisis events, and Provider changes
- Identifying the level of education and training needed for the Member, caregiver, and other members of the MDT
- Connecting youth to natural and social supports such as peer supports and community-based resources
- Connecting Members to HCBS to assist them in achieving their healthcare and quality of life goals
- Reducing administrative burden on Providers and State caseworkers by streamlining resources
- Engaging the right Providers with expertise and training that are aligned with the Member's conditions

The MCO should have the organizational structure and established processes, policies, and procedures to provide a full range of person-centered coordination interventions that support resiliency, recovery, and independence.

1.1.56.1 Care Management Approach

a 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.

UniCare believes that there is no one care management approach because every Member has his or her own needs that differ from other Members involved in the same program. The MCO should demonstrate its ability to tailor care management and coordination activities to the needs of the Member and caregiver. Tables 1.1.56-1 and 1.1.56-2 illustrate the care management activities we would conduct based on the information that has been provided in the scenarios to promote the safety, well-being, and permanency for the each child.

Table 1.1.56-1 Care Management Approach for Matt

Care Management Component	Purpose
Assignment of a licensed Registered Nurse as Matt's Service Manager	• Aligns the Service Manager's expertise with the Member's conditions for improved identification of needs and monitoring • Facilitates gathering and clinical review of pertinent historical and current medical information • Completes initial and on-going assessment with the caregiver for new, unmet, or undiagnosed conditions • Supports relationship building with the caregiver • Determines the most appropriate level of Member and caregiver contact
Completion of the assessment with the caregiver utilizing a standardized, trauma-informed assessment tool	• Identifies the biopsychosocial needs of the Member, including physical, behavioral, oral, and social needs • Identifies the caregiver's strengths, desires, and preferences
Multidisciplinary Care Team development and engagement	• Brings together Matt's natural support system and service Providers to support collaborative and coordinated care planning that focuses on his individual strengths and needs • Develops Matt's ISP that identifies, integrates, and monitors needed in-home services, supports, and resources at the appropriate frequency such as in-home occupational, physical, and speech therapies; DME; and developmental interventions on an on-going basis • Develops Matt's individualized crisis plan that identifies a plan and the medical resources for the caregiver should Matt have a breathing or seizure emergency
Caregiver training, education, and support	• Meets current and future caregiver needs • Supports informed responses to Matt's progress and challenges • Engages resources for caregiver stress-management and respite such as peer support, counseling, support group, and web-based activities • Supports placement permanency
Medication review and reconciliation	• Ensures appropriate prescribing of medications at the levels that meet Matt's physical and behavioral health needs • Reduces challenges associated with medications that are contraindicated or have significant side effects • Includes medical and psychiatric consultation as needed
On-going MCT communication	• Monitors Matt's stability and progress • Adjusts service needs based on his condition and progress • Assures the caregiver is receiving support at the level it is needed to prevent burnout and preserve the placement

Table 1.1.56-2 Care Management Approach for Ben

Care Management Component	Purpose
Assignment of a Service Manager who is licensed in behavioral health and certified in trauma-informed care	• Aligns the Service Manager's expertise with Ben's current and potential needs • Provides support for addressing Ben's trauma from his adverse childhood experiences such as neglect, removal from the home, loss, and grief • Conducts an integrated screening to quickly identify potential physical and behavioral health concerns • Completes a comprehensive assessment with Ben and Ben's uncle to identify Ben's physical, behavioral, and oral health needs; his social and natural support system; and the behaviors that Ben is experiencing in the classroom • Allows for on-going monitoring of potential behavioral needs
Multidisciplinary Care Team engagement and development	• Service Manager includes Ben and his uncle, PCP, DHHR caseworker, teacher, and other participants as chosen by Ben's uncle. • Develops a care plan that includes therapeutic intervention to address Ben's trauma and a referral to a psychiatrist for further evaluation of his ADHD symptomatology and identifies other needed services and supports • Incorporates a crisis plan, classroom behavior management plan, and adoption plan to support crisis diversion and long-term permanency for Ben
Engagement of a peer support for Ben	• Provides Ben interactions with someone who has had similar experiences as Ben • Supports Ben's self-management techniques, and navigation of the system
Participation in after-school programs	• Assists in Ben's development of a social network • Develops Ben's social skills, confidence, and self-management • Provides stress relief and physical activity
Caregiver support and training	• Tailored to the needs of Ben's uncle to preserve the placement and support long-term permanency

1.1.56.2 Educating and Engaging the Care Team

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?

For both Matt and Ben and all youth involved in child welfare, a Service Manager with the expertise that is most closely aligned with the Member's primary needs should be assigned to the Member. The Service Manager should remain with the Member through his care and time in the system as appropriate and be responsible for engaging all parties who are responsible for the Member's safety, well-being, and care, as well as any other individuals of the Member's choosing. While every care team will be individualized to the Member's needs, the team will always include the Member and caregiver and may include a combination of other participants such as the DHHR caseworker, PCP, specialty Providers, and other involved parties.

Based on the Service Manager's contact with the various participants, he or she will determine any training or educational needs and will either provide it directly in one-on-one sessions or identify other opportunities such as computer-, classroom-, or community-based training. Care team members should understand the role of the MCO and Service Manager, purpose of the care team, types of services and supports available to the Member and caregiver, and how to get help or further information when needed.

The Service Manager will continually assess education needs during each contact with the Member, caregiver, and care team members, as well as by following any changes in the Member's condition, placement, and goals.

1.1.56.3 Care Coordination Activities

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?

As described in 1.1.55.1, the dedicated Service Manager will be responsible for initial and on-going contact, engagement, communication, and coordination with the key people involved in the child's care. The primary responsibilities of the Service Manager include the following:

- Initial and on-going Member screening and assessment
- Care team development
- ISP and crisis plan development and on-going revisions as needed
- Identify, engage, verify, and monitor service initiation and provision by Providers that are aligned with the Member's needs and conditions
- Facilitate time and accurate information sharing
- Complete and verify Provider completion of documentation
- Member and caregiver support, education, and training as needed

1.1.56.4 Contacting the Member's Social Worker

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

We consider the role of the State caseworker to be the most demanding and often the least understood. We recognize there are many federal regulations and State requirements the caseworker must adhere to prior to and following the removal of youth from their homes. As a result, we collaborate with our State partners to develop policies and procedures for sharing pertinent information with the caseworker. While every situation is unique to the Member, Table 1.1.56-4 describes examples of when, how, and what is shared with a DHHR caseworker.

Table 1.1.56-4 Types of Information and Frequency of Information Sharing with the DHHR Caseworker

Situation	Modality	Frequency	Types of Information
Upon Member enrollment	• Telephonic	• Initial	• Service Manager role and contact information • Assessment date • Member benefits • Request additional Member history, documentation, and consent as needed
Member assessment	• Telephonic • Electronic	• Initial assessment • Annual assessment • Re-assessment as needed (placement or condition changes)	• Request participation • Assessment results • Potential interventions • Schedule MCT meeting if needed
MCT development and communication	• Telephonic • Electronic • In-person	• Initial MCT meeting • On-going MCT meetings	• Request participation • Contact information for participants • Role of participants
ISP and Crisis Plan development and update	• Telephonic • Electronic • In-person	• Initial • Ongoing as needed (goal achievement or changes, updates, revisions, etc.) • Annual	• Copy of ISP and Crisis Plan • Member strengths, needs, and preferences • Identified Providers • Provider contact information • Service initiation dates
Progress updates	• Electronic • Telephonic	• Routine — monthly • Urgent — immediately	• Member engagement • Provider feedback • Referrals • Medications
Crisis situations	• Telephonic	• Immediately	• Precipitating situation • Response • Additional services • Follow-up appointments

1.1.56.5 Tracking Areas of Concern

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

As in both Matt's and Ben's situations, a qualified MCO should be able to demonstrate established and scalable care management technology that can capture the multitude of information types and documents that often accompany youth involved in child welfare in a safe and secure environment. This includes the youth's historical information; screening and assessment results; the ISP, crisis plan, IFSP, and permanency plan; names and contact information for involved parties; historical and current services, supports, and medications; and progress notes. The Service Manager should be responsible for the on-going updating of information as needed and facilitating the timely and accurate exchange of information between appropriate parties to support the delivery of meaningful care and prevent duplication of services.

1.1.56.6 Coordinating Durable Medical Equipment Needs

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

While Ben does not appear to have Durable Medical Equipment (DME) needs at this time, Matt has significant needs for DME that meets his complex physical needs. The MCO should have established processes, policies, and procedures that minimize administrative burden on care team members and assure prompt delivery of needed supports. The Service Manager should be responsible for requesting and assuring the acquisition and delivery of DME to the Member's home or placement, as well as the on-going assessment, monitoring, and adjusting of equipment as needed.

1.1.56.7 Addressing Potential Cultural and Language Barriers

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

While the scenarios do not provide any information on cultural or language barriers, we believe they affect many youth and families involved in child welfare. In addition to physical and behavioral health issues, youth in child welfare face social and system-related adversities that can affect their health and well-being. They are more likely to come from families in extreme poverty, be permanently removed from the family, and experience frequent changes in foster homes, schools, and communities. Youth are not only removed from the only environment they have ever known, but they also may be separated from meaningful cultural and ethnic socialization important for healthy development. We believe this significantly affects the Member's safety, well-being, and sense of permanency and puts at risk their desire or ability to develop trusting relationships with others. We recommend a model of care that seeks to restore, to the extent possible, cultural and ethnic supports that nurture a healthier experience and instill a sense of self and belonging in the Member.

1.1.56.8 Working with the School System

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

It is our understanding that youth involved in child welfare change schools often due to behavioral concerns and placement disruptions. This often affects the Member's ability to develop trusting relationships, achieve learning potential, and adhere to recommended medication regimes. We recommend the State require potential MCO candidates to demonstrate experience in working with local school systems to develop joint, collaborative processes that support in-school accommodations for the Member as needed. This includes individuals involved with the Member while he or she attends school such as the teacher, school nurse, liaison, and SBHC staff.