State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
BMS70640	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:
ROBERTA WAGNER
304-558-0067

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
ROOM 251
350 CAPITOL STREET
CHARLESTON, WV
25301-3709 304-558-1737

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
11/14/2006				

BID OPENING DATE: 01/03/2007 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT NO	ITEM NUMBER	UNIT PRICE	AMOUNT

**********REQUEST FOR PROPOSAL**********
THE WEST VIRGINIA DIVISION OF PURCHASING IS SOLICITING BIDS TO OBTAIN THE SERVICES OF A QUALIFIED VENDOR TO PROVIDE HEALTH BENEFIT MANAGEMENT / ENROLLMENT BROKERING SERVICES TO THE MEDICAID MANAGED CARE PROGRAM.

****

PLEASE NOTE THAT A MANDATORY PRE-BID CONFERENCE SHALL BE CONDUCTED ON DECEMBER 7, 2006 AT 1:30 PM. SAID CONFERENCE WILL BE HELD AT 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301. ALL INTERESTED BIDDERS ARE REQUIRED TO BE PRESENT AT THIS MEETING. FAILURE TO ATTEND THE MANDATORY PRE-BID CONFERENCE SHALL AUTOMATICALLY RESULT IN DISQUALIFICATION. NO ONE CAN REPRESENT MORE THAN ONE VENDOR.

****

SCHEDULE OF EVENTS:

RELEASE OF THE RFP:	NOVEMBER 17, 2006
MANDATORY PREBID CONFERENCE:	DECEMBER 07, 2006
VENDOR'S WRITTEN QUESTIONS SUBMISSION DEADLINE:	
(CLOSE OF BUSINESS)	DECEMBER 12, 2006
ADDENDUM ISSUED:	DECEMBER 15, 2006
BID OPENING DATE:	JANUARY 03, 2007

PLEASE NOTE THE FOLLOWING ATTACHMENTS:
1) AFFIDAVIT (1 PAGE)
2) WV-96 AGREEMENT ADDENDUM (1 PAGE)
3) BMS70640 SPECIFICATIONS (45 PAGES)
4) DEBARMENT AND SUSPENSION CERT. (1 PAGE)

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
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WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

GENERAL TERMS & CONDITIONS
REQUEST FOR QUOTATION (RFQ) AND REQUEST FOR PROPOSAL (RFP)

1. Awards will be made in the best interest of the State of West Virginia.

2. The State may accept or reject in part, or in whole, any bid.

3. All quotations are governed by the ***West Virginia Code*** and the ***Legislative Rules*** of the Purchasing Division.

4. Prior to any award, the apparent successful vendor must be properly registered with the Purchasing Division and have paid the required $125.00 registration fee.

5. All services performed or goods delivered under State Purchase Orders/Contracts are to be continued for the term of the Purchase Order/Contract, contingent upon funds being appropriated by the Legislature or otherwise being made available. In the event funds are not appropriated or otherwise available for these services or goods, this Purchase Order/Contract becomes void and of no effect after June 30.

6. Payment may only be made after the delivery and acceptance of goods or services.

7. Interest may be paid for late payment in accordance with the ***West Virginia Code***.

8. Vendor preference will be granted upon written request in accordance with the ***West Virginia Code***.

9. The State of West Virginia is exempt from federal and state taxes and will not pay or reimburse such taxes.

10. The Director of Purchasing may cancel any Purchase Order/Contract upon 30 days written notice to the seller.

11. The laws of the State of West Virginia and the ***Legislative Rules*** of the Purchasing Division shall govern all rights and duties under the Contract, including without limitation the validity of this Purchase Order/Contract.

12. Any reference to automatic renewal is hereby deleted. The Contract may be renewed only upon mutual written agreement of the parties.

13. **BANKRUPTCY:** In the event the vendor/contractor files for bankruptcy protection, this contract is automatically null and void, and is terminated without further order.

14. **HIPAA Business Associate Addendum -** The West Viginia State Government HIPAA Business Associate Addendum (BAA), approved by the Attorney General, and available online at the Purchasing Division's web site **(http://www.state.wv.us/admin/purchase/vrc/hipaa.htm)** is hereby made part of the agreement. Provided that, the Agency meets the definition of a Covered Entity (45 CFR §160.103) and will be disclosing Protected Health Information (45 CFR §160.103) to the vendor.

INSTRUCTIONS TO BIDDERS

1. Use the quotation forms provided by the Purchasing Division.

2. **SPECIFICATIONS:** Items offered must be in compliance with the specifications. Any deviation from the specifications must be clearly indicated by the bidder. Alternates offered by the bidder as **EQUAL** to the specifications must be clearly defined. A bidder offering an alternate should attach complete specifications and literature to the bid. The Purchasing Division may waive minor deviations to specifications.

3. Complete all sections of the quotation form.

4. Unit prices shall prevail in cases of discrepancy.

5. All quotations are considered F.O.B. destination unless alternate shipping terms are clearly identified in the quotation.

6. **BID SUBMISSION:** All quotations must be delivered by the bidder to the office listed below prior to the date and time of the bid opening. Failure of the bidder to deliver the quotations on time will result in bid disqualifications.

SIGNED BID TO:

Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
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0001	1	YR		948-74		

RFP TO PROVIDE ENROLLMENT/BROKERING SERVICES

EXHIBIT 3

LIFE OF CONTRACT: THIS CONTRACT BECOMES EFFECTIVE ON ..... AND EXTENDS FOR A PERIOD OF ONE (1) YEAR OR UNTIL SUCH "REASONABLE TIME" THEREAFTER AS IS NECESSARY TO OBTAIN A NEW CONTRACT OR RENEW THE ORIGINAL CONTRACT. THE "REASONABLE TIME" PERIOD SHALL NOT EXCEED TWELVE (12) MONTHS. DURING THIS "REASONABLE TIME" THE VENDOR MAY TERMINATE THIS CONTRACT FOR ANY REASON UPON GIVING THE DIRECTOR OF PURCHASING 30 DAYS WRITTEN NOTICE.

UNLESS SPECIFIC PROVISIONS ARE STIPULATED ELSEWHERE IN THIS CONTRACT DOCUMENT, THE TERMS, CONDITIONS AND PRICING SET HEREIN ARE FIRM FOR THE LIFE OF THE CONTRACT.

RENEWAL: THIS CONTRACT MAY BE RENEWED UPON THE MUTUAL WRITTEN CONSENT OF THE SPENDING UNIT AND VENDOR, SUBMITTED TO THE DIRECTOR OF PURCHASING THIRTY (30) DAYS PRIOR TO THE EXPIRATION DATE. SUCH RENEWAL SHALL BE IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT AND SHALL BE LIMITED TO FOUR (4) ONE (1) YEAR PERIODS.

CANCELLATION: THE DIRECTOR OF PURCHASING RESERVES THE RIGHT TO CANCEL THIS CONTRACT IMMEDIATELY UPON WRITTEN NOTICE TO THE VENDOR IF THE COMMODITIES AND/OR SERVICES SUPPLIED ARE OF AN INFERIOR QUALITY OR DO NOT CONFORM TO THE SPECIFICATIONS OF THE BID AND CONTRACT HEREIN.

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

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OPEN MARKET CLAUSE: THE DIRECTOR OF PURCHASING MAY AUTHORIZE A SPENDING UNIT TO PURCHASE ON THE OPEN MARKET, WITHOUT THE FILING OF A REQUISITION OR COST ESTIMATE, ITEMS SPECIFIED ON THIS CONTRACT FOR IMMEDIATE DELIVERY IN EMERGENCIES DUE TO UNFORESEEN CAUSES (INCLUDING BUT NOT LIMITED TO DELAYS IN TRANSPORTATION OR AN UNANTICIPATED INCREASE IN THE VOLUME OF WORK.)

QUANTITIES: QUANTITIES LISTED IN THE REQUISITION ARE APPROXIMATIONS ONLY, BASED ON ESTIMATES SUPPLIED BY THE STATE SPENDING UNIT. IT IS UNDERSTOOD AND AGREED THAT THE CONTRACT SHALL COVER THE QUANTITIES ACTUALLY ORDERED FOR DELIVERY DURING THE TERM OF THE CONTRACT, WHETHER MORE OR LESS THAN THE QUANTITIES SHOWN.

ORDERING PROCEDURE: SPENDING UNIT(S) SHALL ISSUE A WRITTEN STATE CONTRACT ORDER (FORM NUMBER WV-39) TO THE VENDOR FOR COMMODITIES COVERED BY THIS CONTRACT. THE ORIGINAL COPY OF THE WV-39 SHALL BE MAILED TO THE VENDOR AS AUTHORIZATION FOR SHIPMENT, A SECOND COPY MAILED TO THE PURCHASING DIVISION, AND A THIRD COPY RETAINED BY THE SPENDING UNIT.

BANKRUPTCY: IN THE EVENT THE VENDOR/CONTRACTOR FILES FOR BANKRUPTCY PROTECTION, THIS CONTRACT IS AUTOMATICALLY NULL AND VOID, AND IS TERMINATED WITHOUT FURTHER ORDER.

THE TERMS AND CONDITIONS CONTAINED IN THIS CONTRACT SHALL SUPERSEDE ANY AND ALL SUBSEQUENT TERMS AND CONDITIONS WHICH MAY APPEAR ON ANY ATTACHED PRINTED DOCUMENTS SUCH AS PRICE LISTS, ORDER FORMS, SALES AGREEMENTS OR MAINTENANCE AGREEMENTS, INCLUDING ANY ELECTRONIC MEDIUM SUCH AS CD-ROM.

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WRITTEN QUESTIONS SHALL BE ACCEPTED THROUGH CLOSE OF BUSINESS ON DECEMBER 12, 2006. QUESTIONS MAY BE SENT VIA USPS, FAX, COURIER OR EMAIL. IN ORDER TO ASSURE NO VENDOR RECEIVES AN UNFAIR ADVANTAGE, NO SUBSTANTIVE QUESTIONS WILL BE ANSWERED ORALLY. IF POSSIBLE, E-MAIL QUESTIONS ARE PREFERRED. ADDRESS INQUIRIES TO:

ROBERTA WAGNER, SENIOR BUYER
PURCHASING DIVISION
2019 WASHINGTON STREET, EAST
P.O. BOX 50130
CHARLESTON, WV 25305-0130
FAX: (304) 558-4115
E-MAIL: RWAGNER@WVADMIN.GOV

VENDOR PREFERENCE CERTIFICATE

CERTIFICATION AND APPLICATION* IS HEREBY MADE FOR PREFERENCE IN ACCORDANCE WITH WEST VIRGINIA CODE, 5A-3-37 (DOES NOT APPLY TO CONSTRUCTION CONTRACTS).

A. APPLICATION IS MADE FOR 2.5% PREFERENCE FOR THE REASON CHECKED:

( ) BIDDER IS AN INDIVIDUAL RESIDENT VENDOR AND HAS RESIDED CONTINUOUSLY IN WEST VIRGINIA FOR FOUR (4) YEARS IMMEDIATELY PRECEDING THE DATE OF THIS CERTIFICATION; OR

( ) BIDDER IS A PARTNERSHIP, ASSOCIATION OR CORPORATION RESIDENT VENDOR AND HAS MAINTAINED ITS HEADQUARTERS OR PRINCIPAL PLACE OF BUSINESS CONTINUOUSLY IN WEST VIRGINIA FOR FOUR (4) YEARS IMMEDIATELY PRECEDING THE DATE OF THIS CERTIFICATION; OR 80% OF THE OWNERSHI

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INTEREST OF BIDDER IS HELD BY ANOTHER INDIVIDUAL, PARTNERSHIP, ASSOCIATION OR CORPORATION RESIDENT VENDOR WHO HAS MAINTAINED ITS HEADQUARTERS OR PRINCIPAL PLACE OF BUSINESS CONTINUOUSLY IN WEST VIRGINIA FOR FOUR (4) YEARS IMMEDIATELY PRECEDING THE DATE OF THIS CERTIFICATION; OR

( ) BIDDER IS A CORPORATION NONRESIDENT VENDOR WHICH HAS AN AFFILIATE OR SUBSIDIARY WHICH EMPLOYS A MINIMUM OF ONE HUNDRED STATE RESIDENTS AND WHICH HAS MAINTAINED ITS HEAQUARTERS OR PRINCIPAL PLACE OF BUSINESS WITHIN WEST VIRGINIA CONTINUOUSLY FOR THE FOUR (4) YEARS IMMEDIATELY PRECEDING THE DATE OF THIS CERTIFICATION.

B. APPLICATION IS MADE FOR 2.5% PREFERENCE FOR THE REASON CHECKED:

( ) BIDDER IS A RESIDENT VENDOR WHO CERTIFIES THAT, DURING THE LIFE OF THE CONTRACT, ON AVERAGE AT LEAST 75% OF THE EMPLOYEES WORKING ON THE PROJECT BEING BID ARE RESIDENTS OF WEST VIRGINIA WHO HAVE RESIDED IN THE STATE CONTINUOUSLY FOR THE TWO YEARS IMMEDIATELY PRECEDING SUBMISSION OF THIS BID;
OR
( ) BIDDER IS A NONRESIDENT VENDOR EMPLOYING A MINIMUM OF ONE HUNDRED STATE RESIDENTS OR IS A NONRESIDENT VENDOR WITH AN AFFILIATE OR SUBSIDIARY WHICH MAINTAINS ITS HEADQUARTERS OR PRINCIPAL PLACE OF BUSINESS WITHIN WEST VIRGINIA EMPLOYING A MINIMUM OF ONE HUNDRED STATE RESIDENTS WHO CERTIFIES THAT, DURING THE LIFE OF THE CONTRACT, ON AVERAGE AT LEAST 75% OF THE EMPLOYEES OR BIDDERS' AFFILIATE'S OR SUBSIDIARY'S EMPLOYEES ARE RESIDENTS OF WEST VIRGINIA WHO HAVE RESIDED IN THE STATE CONTINUOUSLY FOR THE TWO YEARS IMMEDIATELY PRECEDING SUBMISSION OF THIS BID.

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BIDDER UNDERSTANDS IF THE SECRETARY OF TAX & REVENUE DETERMINES THAT A BIDDER RECEIVING PREFERENCE HAS FAILED TO CONTINUE TO MEET THE REQUIREMENTS FOR SUCH PREFERENCE, THE SECRETARY MAY ORDER THE DIRECTOR OF PURCHASING TO: (A) RESCIND THE CONTRACT OR PURCHASE ORDER ISSUED; OR (B) ASSESS A PENALTY AGAINST SUCH BIDDER IN AN AMOUNT NOT TO EXCEED 5% OF THE BID AMOUNT AND THAT SUCH PENALTY WILL BE PAID TO THE CONTRACTING AGENCY OR DEDUCTED FROM ANY UNPAID BALANCE ON THE CONTRACT OR PURCHASE ORDER.

BY SUBMISSION OF THIS CERTIFICATE, BIDDER AGREES TO DISCLOSE ANY REASONABLY REQUESTED INFORMATION TO THE PURCHASING DIVISION AND AUTHORIZES THE DEPARTMENT OF TAX AND REVENUE TO DISCLOSE TO THE DIRECTOR OF PURCHASING APPROPRIATE INFORMATION VERIFYING THAT BIDDER HAS PAID THE REQUIRED BUSINESS TAXES, PROVIDED THAT SUCH INFORMATION DOES NOT CONTAIN THE AMOUNTS OF TAXES PAID NOR ANY OTHER INFORMATION DEEMED BY THE TAX COMMISSIONER TO BE CONFIDENTIAL.

UNDER PENALTY OF LAW FOR FALSE SWEARING (WEST VIRGINIA CODE 61-5-3), BIDDER HEREBY CERTIFIES THAT THIS CERTIFICATE IS TRUE AND ACCURATE IN ALL RESPECTS; AND THAT IF A CONTRACT IS ISSUED TO BIDDER AND IF ANYTHING CONTAINED WITHIN THIS CERTIFICATE CHANGES DURING THE TERM OF THE CONTRACT, BIDDER WILL NOTIFY THE PURCHASING DIVISION IN WRITING IMMEDIATELY.

BIDDER: ----------

DATE: ----------

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SIGNED: ----------

TITLE: ----------

* CHECK ANY COMBINATION OF PREFERENCE CONSIDERATION(S) IN EITHER "A" OR "B", OR BOTH "A" AND "B" WHICH YOU ARE ENTITLED TO RECEIVE. YOU MAY REQUEST UP TO THE MAXIMUM 5% PREFERENCE FOR BOTH "A" AND "B".
(REV. 12/00)

NOTICE

A SIGNED BID MUST BE SUBMITTED TO:

DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
BUILDING 15
2019 WASHINGTON STREET, EAST
CHARLESTON, WV 25305-0130

******* PLEASE NOTE THAT SEVEN (7) CONVENIENCE COPIES WOULD BE APPRECIATED.

THE BID SHOULD CONTAIN THIS INFORMATION ON THE FACE OF THE ENVELOPE OR THE BID MAY NOT BE CONSIDERED:

SEALED BID

BUYER: FILE 22

RFQ. NO.: BMS70640

BID OPENING DATE: JANUARY 3, 2007

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BID OPENING TIME: 1:30 PM

PLEASE PROVIDE A FAX NUMBER IN CASE IT IS NECESSARY TO CONTACT YOU REGARDING YOUR BID:

CONTACT PERSON (PLEASE PRINT CLEARLY):

****** THIS IS THE END OF RFQ BMS70640 ****** TOTAL:

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REQUEST FOR PROPOSAL

Department of Health and Human Resources
Bureau for Medical Services
BMS70640

PART 1 GENERAL INFORMATION/TERMS AND CONDITIONS

1.1 **Purpose:**
The Acquisition and Contract Administration Section of the Purchasing Division State@ on behalf of the Department of Health and Human Resources, Bureau for Medical Services (BMS), Agency@ is soliciting proposals to engage the services of a qualified vendor to provide Health Benefit management/enrollment brokering services for the Medicaid Managed Care program.

1.2 **Project:**
The mission or purpose of the project is to provide enrollment brokering services which will educate eligible members about their managed care options and assist eligible members in enrolling into managed health care plans.

1.3 **RFP Format:**
This RFP has four parts. "Part 1" contains general information/terms and conditions, "Part 2" describes the background and working environment of the project, "Part 3" is a statement of the specifications for the services requested pursuant to this RFP, contractual requirements, and special terms/conditions and "Part 4" explains the required format of the Bidder's response to the RFP, the evaluation criteria the State will use in evaluating the proposals received, and how the evaluation will be conducted.

1.4 **Inquiries:**
Additional information inquiries regarding specifications of this RFP must be submitted in writing to the State Buyer with the exception of questions regarding proposal submission which may be oral. The deadline for written inquiries is identified in the Schedule of Events, Section 1.16. All inquiries of specification clarification must be addressed to:

Roberta Wagner, Senior Buyer
Purchasing Division
2019 Washington Street, East
P.O. Box 50130
Charleston, WV 25305-0130
Fax: (304) 558-4115
E-mail: rwagner@wvadmin.gov

Absolutely NO contact shall be made by the vendor with any member of the evaluation committee. Violation may result in rejection of the bid. The State Buyer named above is the sole contact for any and all inquiries after this RFP has been released.

1.5 **Vendor Registration:**
Vendors participating in this process should complete and file a ***Vendor Registration and Disclosure Statement*** (Form WV-1) and remit the registration fee. Vendor is not required to be a registered vendor in order to submit a proposal, but the **successful bidder must** register and pay the fee prior to the award of an actual purchase order/contract.

1.6 **Oral Statements and Commitments:**
Vendor must clearly understand that any verbal representations made or assumed to be made during any oral discussions held between Vendor's representatives and any State personnel is **not** binding. Only the information issued in writing and added to the Request for Proposal specifications file by an official written addendum are binding.

1.7 **Economy of Preparation:**
Proposals should be prepared simply and economically, providing a straightforward, concise description of Vendor's abilities to satisfy the requirements of the RFP. Emphasis should be placed on completeness and clarity of content.

1.8 **Labeling of RFP Sections:**
The sections within this RFP contain instructions governing how the Vendor's proposal is to be arranged, submitted and to identify the material to be included therein.

1.8.1 Mandatory Requirements.
The mandatory sections included in Parts 3 and 4 require a response, and they describe the minimum requirements requested in this RFP. Any specification or statement containing the word "must", "shall, or "will" are mandatory. The vendor is required to meet the mandatory specifications in order to be eligible for consideration and to continue in the evaluation process. A simple "yes" or "no" response to these sections is not adequate. Failure to meet mandatory items shall result in disqualification of the vendor's proposal and the evaluation process terminated for that vendor. Decisions regarding compliance with the intent of any mandatory specification shall be at the sole discretion of the State.

1.8.2 Contract Terms and Conditions:
This Request for Proposals contains all the contractual terms and conditions under which the State of West Virginia will enter into a contract.

1.8.3 Informational Sections:
All information specifications do not require a response from the vendor. They are intended to aid the vendor in structuring an effective proposal capable of meeting the needs of the issuing agency.

1.9 **Proposal Format and Submission:**
1.9.1 Vendors must complete a response to all mandatory specifications in order to be considered. Each proposal should be formatted as per the outline in Part 4 of this RFP. No other arrangement or distribution of the proposal information may be made by the bidder. Failure on the part of the bidder to respond to specific requirements detailed in the RFP may be basis for disqualification of the proposal. The State reserves the right to waive any informality in the proposal format and minor irregularities.

1.9.2 State law requires that the original technical and cost proposal be submitted to the Purchasing Division. All proposals must be submitted to the Purchasing Division **prior** to the date and time stipulated in the RFP as the opening date. All bids will be date and time stamped to verify official time and date of receipt.

1.9.3 Vendors mailing proposals should allow sufficient time for mail delivery to ensure timely arrival. In accordance with State Code 5A-3-11, the Purchasing Division cannot waive or excuse late receipt of a proposal which is delayed and late for any reason. Any proposal received after the bid opening date and time will be immediately disqualified in accordance with State law and the administrative rules and regulations.

Submit: One original technical and cost plus seven (7) convenience copies to:

Purchasing Division
2019 Washington Street, East
P.O. Box 50130
Charleston, WV 25305-0130

The outside of the envelope or package(s) should be clearly marked:

Buyer: RW-22
RFP#: BMS70640
Opening Date: January 3, 2007
Opening Time: 1:30 P. M.

1.9.4. **Best Value Purchasing Standard Format**
All Requests for Proposals should follow the standard format defined by the Purchasing Division. This format addresses required areas and enables the agency to modify the background and scope of work to meet its needs.

1.9.4.1 Evaluation Criteria: All evaluation criteria must be clearly defined in the specifications section and based on a 100 point total score Based on a 100 point total, cost shall represent a minimum of 30 of the 100 total points in the criteria.

1.9.4.2 Proposal Format and Content: Proposals shall be requested and received in two distinct parts: Technical and Cost. The cost portion shall be sealed in a separate envelope and will not be opened initially.

1.9.4.3 Technical Bid Opening: The Purchasing Division will open only the technical proposals on the date and time specified in the Request for Proposal. The Purchasing Division representative will read aloud the names of those who responded to the solicitation. The Purchasing Division Buyer will confirm that the original packages contain a separately sealed cost proposal prior to providing the courtesy copies to the agency to begin the evaluation process.

1.9.4.4 Technical Evaluation: The pre-selected, approved evaluation committee will review the technical proposals, deduct appropriate points for deficiencies and make a final written consensus recommendation to the Purchasing Division Buyer. If the Buyer

approves the committee's recommendation, the technical evaluation will be forwarded to an internal review committee within the Purchasing Division.

1.9.4.5 Cost Bid Opening: Upon approval of the technical evaluation from the internal review committee, the Purchasing Division shall schedule a time and date to publicly open and read aloud the cost proposals. The agency and the vendors shall be notified of this date.

1.9.4.6 Cost Evaluation and Resident Vendor Preference: The evaluation committee will review the cost proposals, assign appropriate points and make a final consensus recommendation to the Purchasing Division. In accordance with West Virginia State Code §5A-3-37, the Purchasing Division will make the determination of the Resident Vendor Preference, if applicable. Resident Vendor Preference provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the West Virginia State Code. A certificate of application is used to request this preference. Generally, a West Virginia vendor may be eligible for two 2.5% preferences in the evaluation process

1.9.4.7 Contract Approval and Award: After the cost proposals have been opened, the evaluation committee completes its review and prepares the final evaluation making its recommendation for contract award based on the highest scoring vendor. The final evaluation is submitted to the Purchasing Division buyer. Once approved by the buyer, the final evaluation must be reviewed and approved by the Purchasing Division internal review committee. The contract is prepared and signed in the Purchasing Division, forwarded to the Attorney General's Office for approval as to form, encumbered and mailed to the appropriate parties.

1.10 **Rejection of Proposals:**
The State shall select the best value solution according to the evaluation criteria. However, the State reserves the right to accept or reject any or all proposals, in part or in whole at its discretion. The State reserves the right to withdraw this RFP at any time and for any reason. Submission of, or receipt by the State of proposals confers no rights upon the bidder nor obligates the State in any manner

A contract based on this RFP and the Vendor's proposal, may or may not be awarded. Any contract resulting in an award from this RFP is not valid until properly approved and executed by the Purchasing Division and approved as to form by the Attorney General.

1.11 **Incurring Costs:**
The State and any of its employees or officers shall not be held liable for any expenses incurred by any bidder responding to this RFP for expenses to prepare, deliver the proposal, or to attend any mandatory prebid meeting or oral presentations.

1.12 **Addenda:**
If it becomes necessary to revise any part of this RFP, an official written addendum will be issued by the State to all bidders of record.

1.13 **Independent Price Determination:**
A proposal will not be considered for award if the price in the proposal was not arrived at independently without collusion, consultation, communication, or agreement as to any matter relating to prices with any competitor unless the proposal is submitted as a joint venture.

1.14 **Price Quotations:**
The price(s) quoted in the bidder's proposal will not be subject to any increase and will be considered firm for the life of the contract unless specific provisions have been provided for adjustment in the original contract.

1.15 **Public Record:**
1.15.1 Submissions are Public Record.
All documents submitted to the State Purchasing Division related to purchase orders/contracts are considered public records. All bids, proposals, or offers submitted by bidders shall become public information and are available for inspection during normal official business hours in the Purchasing Division Records and Distribution center after the award is complete and documents have been microfilmed.

1.15.2 Written Release of Information.
All public information may be released with or without a Freedom of Information request, however, only a written request will be acted upon with duplications fees paid in advance. Duplication fees shall apply to all requests for copies of any document. Currently the fees are $0.50/page, or a minimum of $10.00 per request which ever is greater.

1.15.3 Risk of Disclosure.
The only exemptions to disclosure of information are listed in West Virginia Code §29B-1-4. Primarily, only trade secrets as submitted by a bidder are the only exemption to public disclosure. The submission of any information to the State by a vendor puts the risk of disclosure on the vendor. The State will make a reasonable effort not to disclose information that is within the guidelines of §29B-1-4 and is properly labeled "proprietary information not for public disclosure". The State does not guarantee non-disclosure of any information to the public.

1.16 **Schedule of Events:**

Release of the RFP	11/17/2006
Vendor's Written Questions Submission Deadline	12/12/2006
Mandatory Prebid Conference	12/07/2006
Addendum Issued/ Response to Questions	12/15/2006
Bid Opening Date	1/03/2007

1.17 **Mandatory Prebid Conference:**
A mandatory prebid conference shall be conducted on the date specified above at 1:30 p.m. Said conference will be held at 350 Capitol Street, Room 251, Charleston, WV 25301. All interested bidders are required to be present at this meeting. Failure to attend the mandatory prebid conference shall automatically result in disqualification. No one person can represent more than one vendor.

1.18 **Affidavit:**
West Virginia State Code §5A-3-10a requires that all bidders submit an affidavit regarding any debt owed to the State. The affidavit must be signed and submitted prior to award. It is preferred that the affidavit be submitted with the proposal.

1.19 **General Terms and Conditions:**
By signing and submitting their proposal, the successful Vendor agrees to be bound by all the terms contained in this RFP.

1.19.1 Conflict of Interest:
Vendor affirms that it, its officers or members or employees presently have no interest and shall not acquire any interest, direct or indirect which would conflict or compromise in any manner or degree with the performance or its services hereunder. The Vendor further covenants that in the performance of the contract, the Vendor shall periodically inquire of its officers, members and employees concerning such interests. Any such interests discovered shall be promptly presented in detail to the Agency.

1.19.2 Prohibition Against Gratuities:
Vendor warrants that it has not employed any company or person other than a bona fide employee working solely for the vendor or a company regularly employed as its marketing agent to solicit or secure the contract and that it has not paid or agreed to pay any company or person any fee, commission, percentage, brokerage fee, gifts or any other consideration contingent upon or resulting from the award of the contract.

For breach or violation of this warranty, the State shall have the right to annul this contract without liability at its discretion, and/or to pursue any other remedies available under this contract or by law.

1.19.3 Certifications Related to Lobbying:
Vendor certifies that no federal appropriated funds have been paid or will be paid, by or on behalf of the company or an employee thereof, to any person for purposes of influencing or attempting to influence an officer or employee of any Federal entity, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement.

If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee or any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the Vendor shall complete and submit a disclosure form to report the lobbying.

Vendor agrees that this language of certification shall be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients

shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this contract was made and entered into.

1.19.4 Vendor Relationship:
The relationship of the Vendor to the State shall be that of an independent contractor and no principal-agent relationship or employer-employee relationship is contemplated or created by the parties to this contract. The Vendor as an independent contractor is solely liable for the acts and omissions of its employees and agents.

Vendor shall be responsible for selecting, supervising and compensating any and all individuals employed pursuant to the terms of this RFP and resulting contract. Neither the Vendor nor any employees or contractors of the vendor shall be deemed to be employees of the State for any purposes whatsoever.

Vendor shall be exclusively responsible for payment of employees and contractors for all wages and salaries, taxes, withholding payments, penalties, fees, fringe benefits, professional liability insurance premiums, contributions to insurance and pension or other deferred compensation plans, including but not limited to Workers' Compensation and Social Security obligations, and licensing fees, etc. and the filing of all necessary documents, forms and returns pertinent to all of the foregoing.

Vendor shall hold harmless the State, and shall provide the State and Agency with a defense against any and all claims including but not limited to the foregoing payments, withholdings, contributions, taxes, social security taxes and employer income tax returns.

The Vendor shall not assign, convey, transfer or delegate any of its responsibilities and obligations under this contract to any person, corporation, partnership, association or entity without expressed written consent of the Agency.

1.19.5 Indemnification:
The Vendor agrees to indemnify, defend and hold harmless the State and the Agency, their officers, and employees from and against: (1) Any claims or losses for services rendered by any subcontractor, person or firm performing or supplying services, materials or supplies in connection with the performance of the contract; (2) Any claims or losses resulting to any person or entity injured or damaged by the Vendor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use or disposition of any data used under the contract in a manner not authorized by the contract, or by Federal or State statutes or regulations; (3) Any failure of the Vendor, its officers, employees or subcontractors to observe State and Federal laws, including but not limited to labor and wage laws.

1.19.6 Contract Provisions:
After the successful Vendor is selected, a formal contract document will be executed between the State and the Vendor. In addition, the RFP and the Vendor's response will be included as part of the contract by reference. The order of precedence is the contract, the RFP and the Vendor's proposal in response to the RFP.

1.19.7 Governing Law:
This contract shall be governed by the laws of the State of West Virginia. The Vendor further agrees to comply with the Civil Rights Act of 1964 and all other applicable laws (Federal, State or Local Government) regulations.

1.19.8 Compliance with Laws and Regulations:
The vendor shall procure all necessary permits and licenses to comply with all applicable laws, Federal, State or municipal, along with all regulations, and ordinances of any regulating body.

The Vendor shall pay any applicable sales, use, or personal property taxes arising out of this contract and the transactions contemplated thereby. Any other taxes levied upon this contract, the transaction, or the equipment, or services delivered pursuant here to shall be borne by the contractor. It is clearly understood that the State of West Virginia is exempt from any taxes regarding performance of the scope of work of this contract.

1.19.9 Subcontracts/Joint Ventures:
The Vendor is solely responsible for all work performed under the contract and shall assume prime contractor responsibility for all services offered and products to be delivered under the terms of this contract. The State will consider the Vendor to be the sole point of contact with regard to all contractual matters. The Vendor may, with the prior written consent of the State, enter into written subcontracts for performance of work under this contract; however, the vendor is totally responsible for payment of all subcontractors.

1.19.10 Term of Contract & Renewals:
This contract will be effective (date set upon award) and shall extend for the period of one (1) year, at which time the contract may, upon mutual consent, be renewed. Such renewals are for a period of up to one (1) year, with a maximum of four (4) one year renewals, or until such reasonable time thereafter as is necessary to obtain a new contract. The "reasonable time" period shall not exceed twelve (12) months. During the "reasonable time" period the vendor may terminate the contract for any reason upon giving the Agency ninety (90) days written notice. Notice by Vendor of intent to terminate will not relieve Vendor of the obligation to continue to provide services pursuant to the terms of the contract.

Any change in Federal or State law, or court actions which constitute binding precedent in West Virginia, and which significantly alters the Vendor's required activities or any change in the availability of funds, shall be viewed as binding and shall warrant good faith renegotiation of the compensation paid to the Vendor by the Agency and of such other provisions of the contract that are affected. If such renegotiation proves unsuccessful, the contract may be terminated by the State upon written notice to the Vendor at least thirty (30) days prior to termination of this contract.

1.19.11 Non-Appropriation of Funds:
If the Agency is not allotted funds in any succeeding fiscal year for the continued use of the service covered by this contract by the West Virginia Legislature, the Agency may terminate the contract at the end of the affected current fiscal period without further charge or penalty. The Agency shall give the vendor written notice of such non-

allocation of funds as soon as possible after the Agency receives notice. No penalty shall accrue to the Agency in the event this provision is exercised.

1.19.12 Contract Termination:
The State may terminate any contract resulting from this RFP immediately at any time the Vendor fails to carry out its responsibilities or to make substantial progress under the terms of this RFP and resulting contract. The State shall provide the Vendor with advance notice of performance conditions which are endangering the contract's continuation. If after such notice the Vendor fails to remedy the conditions contained in the notice, within the time period contained in the notice, the State shall issue the Vendor an order to cease and desist any and all work immediately. The State shall be obligated only for services rendered and accepted prior to the date of the notice of termination.

The contract may also be terminated upon mutual agreement of the parties with thirty (30) days prior notice.

1.19.13 Changes:
If changes to the original contract become necessary, a formal contract change order will be negotiated by the State, the Agency and the Vendor, to address changes to the terms and conditions, costs of work included under the contract. An approved contract change order is defined as one approved by the Purchasing Division and approved as to form by the West Virginia Attorney General's Office, encumbered and placed in the U.S. Mail prior to the effective date of such amendment. An approved contract change order is required whenever the change affects the payment provision and/or the scope of the work. Such changes may be necessitated by new and amended Federal and State regulations and requirements.

As soon as possible after receipt of a written change request from the Agency, but in no event more than thirty (30) days thereafter, the Vendor shall determine if there is an impact on price with the change requested and provide the Agency a written statement to identifying any price impact on the contract or to state that there is no impact. In the event that price will be impacted by the change, the Vendor shall, provide a description of the price increase or decrease involved in implementing the requested change

NO CHANGE SHALL BE IMPLEMENTED BY THE VENDOR UNTIL SUCH TIME AS THE VENDOR RECEIVES AN APPROVED WRITTEN CHANGE ORDER.

1.19.14 Invoices, Progress Payments, & Retainage:
The Vendor shall submit invoices, in arrears, to the Agency at the address on the face of the purchase order labeled "Invoice To" pursuant to the terms of the contract. Progress payments may be made at the option of the Agency on the basis of percentage of work completed if so defined in the final contract. Any provision for progress payments must also include language for a minimum 10% retainage until the final deliverable is accepted.

If progress payments are permitted, Vendor is required to identify points in the work plan at which compensation would be appropriate. Progress reports must be submitted to Agency with the invoice detailing progress completed or any deliverables identified.

Payment will be made only upon approval of acceptable progress or deliverables as documented in the Vendor's report. Invoices may not be submitted more than once monthly and State law forbids payment of invoices prior to receipt of services.

1.19.15 Record Retention (Access & Confidentiality):
Vendor shall comply with all applicable Federal and State of West Virginia rules and regulations, and requirements governing the maintenance of documentation to verify any cost of services or commodities rendered under this contract by Vendor. The Vendor shall maintain such records a minimum of five (5) years and make available all records to Agency personnel at Vendor's location during normal business hours upon written request by Agency within 10 days after receipt of the request.

Vendor shall have access to private and confidential data maintained by Agency to the extent required for Vendor to carry out the duties and responsibilities defined in this contract. Vendor agrees to maintain confidentiality and security of the data made available and shall indemnify and hold harmless the State and Agency against any and all claims brought by any party attributed to actions of breech of confidentiality by the Vendor, subcontractors, or individuals permitted access by Vendor.

PART 2 OPERATING ENVIRONMENT

2.1 Location:

Agency is located at 350 Capitol Street, Room 251, Charleston, WV 25301.

2.2 Background:

The State of West Virginia is committed to offering Medicaid eligibles a choice of managed health care programs. This managed care initiative, developed by the Department of Health and Human Resources, Bureau for Medical Services, seeks to achieve the following objectives:

2.2.1 Improve the health status of Medicaid members through improved access and coordination of care.

2.2.2 Reduce Medicaid expenditures from current spending for the unmanaged, fee-for-service program and improve the budget predictability of Medicaid expenditures.

2.2.3 Foster the growth of organized delivery systems in West Virginia based on principles of quality, efficiency, accessibility, competition, and accountability.

The program will enroll Temporary Aid to Needy Families (TANF), Aid to Families with Dependent Children (AFDC)-related, and the Supplemental Security Income (SSI) populations. The TANF population began receiving health care services under the program on September 1, 1996 The Adult SSI population will begin receiving health care services through Managed care programs in 2006. The Medically Needy and Medicare/Medicaid dual eligible populations will be excluded, as will Medicaid-eligibles residing in nursing facilities.

PART 3 PROCUREMENT SPECIFICATIONS

The mandatory sections included in Part 3 and 4 require a response, and they describe the minimum requirements requested in this RFP. Any specification or statement containing the word "must", "shall, or "will" are mandatory. The vendor is required to meet the mandatory specifications in order to be eligible for consideration and to continue in the evaluation process. A simple "yes" or "no" response to these sections is not adequate.

3.1 General Requirements:

3.1.1 Provide Enrollment Broker Services

3.1.2 Educate eligible members about managed care options

3.2 Scope of Work:

3.2.1 Assist eligibles in enrolling into managed care

3.2.2 Educate providers

3.2.3 Planning, set-up & enrollment functions

3.2.3.1 Develop a plan

The Enrollment Broker or Health Benefits Manager (HBM) must develop a strategic, organized plan to inform interested parties of the Department's managed health care system, Mountain Health Trust (MHT) to include the primary care case management system, the Physician Assured Access System (PAAS), and to assist the Department in enrolling eligibles into the managed care organizations/primary care case management system. There are three major objectives which must be incorporated into the plan and must be the overriding focus of the Health Benefits Manager (HBM). The first is to objectively inform the population regarding the choices available and the eligibles rights and responsibilities regarding both the enrollment process and the ensuing enrollment. The second is to process the forms and the calls necessary to perform the actual enrollment function. The third function is to act as educator of the Medicaid Redesign and to process the information that will drive benefit package assignment. See Appendix A for the first phase of the Redesign. Other populations will be added yearly.

Ongoing enrollment into a Health Maintenance Organization (HMO) or PAAS is occurring in all 55 counties, the differing county arrangements shown in the Appendix B. The county enrollment options can change at any time.

Mandatory enrollment for TANF and TANF-related groups began on September 11, 1996. The eligible adult SSI population will be enrolled on a mandatory basis at some point. Enrollment for the eligible adult SSI group will be phased-in. The Medically Needy and Medicare/Medicaid dual eligible populations will be excluded from the program, as will Medicaid-eligibles residing in nursing facilities.

Appendix B provides a detailed chart of the current enrollment. The HBM will be responsible for educating, assisting in enrolling eligibles, and processing information that will drive benefit package assignment in all 55 counties.

3.2.3.2. The HBM must determine staffing needs based on the current enrollment. The HBM must analyze demographic information supplied by the State to accurately predict costs and operational considerations.

3.2.3.3. The HBM must describe a process for assisting the State with enrollment in each of the current counties. The process must clearly address the unique enrollment needs of each county.

3.2.3.4. The HBM is responsible for supplying and distributing any pamphlets and other mailing material, in addition to DHHR approved materials supplied by the HMOs/PAAS, and Medicaid Redesign.

3.2.3.5. Outreach activities, including Medicaid Redesign, must continue in each county and an intense outreach activity at least 45 days prior to any change of choice or process in that county.

3.2.3.6. The HBM must describe a process for receiving member agreements and processing the information to determine the benefit package in which the member should be assigned.

3.2.3.7. The HBM will act as a resource for answering member/provider questions about enrollment and Medicaid Redesign.

After the Department's initial review of the outreach, education and enrollment schedule, any adjustments to the schedule must be approved by the Department

DELIVERABLE: DRAFT ENROLLMENT PLAN AND OPERATIONAL PROCEDURES FOR DEPARTMENT REVIEW; REVISE AS NEEDED FOLLOWING REVIEW WITH THE DEPARTMENT.

3.2.4: Set up an office in the State of West Virginia.

The HBM must operate from an office in Charleston, West Virginia for ease and efficiency to fulfill the requirements of the contract.

3.2.4.1 The HBM must maintain an office in the Charleston area, so that regular business can be conducted with the Department.

3.2.4.2 Administration of telephone support (as described in 3.2.16) must be conducted from its Charleston area office.

3.2.4.3 The HBM must furnish and supply its office at its own expense. The HBM must provide telephones, toll-free numbers, fax, paper supplies, postage machines, furniture, etc., for its work force. The HBM must supply computer linkage to both State systems, Medicaid Management Information System (MMIS) and Recipient Automated Payment and Information Data System (RAPIDS).

3.2.4.4 The HBM must also provide additional, highly mobile benefits managers to travel to all counties educating consumers, providers, agencies, and organizations. The field benefit managers will have high visibility within the communities in which they perform their outreach and educational activities.

DELIVERABLE: ESTABLISH OFFICE IN CHARLESTON, WEST VIRGINIA.

3.2.5 The HBM must enroll eligibles into an approved Medicaid managed care plan or into a PAAS approved primary care physician (PCP), according to county requirements and to the enrollment goals of the Department. All enrollment tasks detailed in this section apply to both new enrollments and changes in plans/primary care physicians (PCPs).

3.2.5.1 The HBM must develop enrollment forms that comply with the requirements of 42 CFR §438 Subparts A-J. The enrollment form must ask potential enrollees to indicate:

3.2.5.1.1 His or her choice of Managed Care Organization (MCO) or Primary Care Case Management (PCCM).

3.2.5.1.2 The name of his or her existing provider(s) (42 CFR §438.50).

3.2.5.1.3 His or her race, ethnicity, and primary language spoken (42 CFR §438.204).

3.2.5.1.4 Whether he or she has a special health care need (42 CFR §438.208).

The form should specify that information on race, ethnicity, primary language, and health status is not required for eligibility or enrollment. This information must be transmitted to the MCO or PCCM at the time of enrollment.

3.2.5.2 The HBM must process enrollment forms as they are returned to the HBM's office.

3.2.5.3 The HBM will be responsible for opening the mail, sorting the enrollment forms into those that can be processed, those that need to be outreached, those that need researched in State systems, those that cannot be processed due to illegibility, damaged in the mail, etc. Any mail that is sent to the HBM that is intended for the Department must be sent to the Department the same day the HBM receives the mis-sent mail.

3.2.5.4 The HBM must notify the Department, on a case by case basis, of any discrepancies found on the enrollment form such as name spelling, date of birth, number of family members in the home, returned mail which indicates the Medicaid eligible has moved, etc., for resolution.

3.2.5.5 The HBM must develop a process whereby HMOs, PAAS, local DHHR offices and HBM are linked in the immediate enrollment of newborns.

3.2.5.6 The HBM must process all complete enrollment forms within 24 hours of receipt. Care must be taken by the HBM to process all enrollment forms prior to monthly cutoff dates to avoid a month's postponement in enrollment

3.2.5.7 Enrollment forms received from eligibles that cannot be processed due to

incomplete information, must either be returned to the member the same day received with the missing information highlighted and a postage paid return envelope, or the member may be telephoned within 24-hours, so the missing information can be obtained immediately. Once the missing information is obtained, the enrollment form should be processed within the same guidelines set forth in 3.2.5.6.

3.2 5.8 Enrollment forms that cannot be processed due to illegibility, being damaged in the mail, etc., must be returned to the member with a postage paid envelope, if the member can be identified, the same day it was received with a letter which includes a new enrollment form and explanation that a new enrollment form must be completed and returned to the HBM.

3.2.5.9 The HBM must describe a process for following-up on returned mail to include MHT/PAAS mail returned to the local DHHR offices, with the goal of eventually delivering the intended enrollment material to the member.

3.2.5.10 Enrollment forms must be processed by the HBM by the cutoff date to effect the member's enrollment or change in enrollment for the following month. HMO/PCCM enrollments are effective from the first day of the month to the last day of the month. The cutoff date falls within the third week of the month. The HBM will be provided with an annual schedule.

3.2.5.11 At the Department's request, the HBM must forward either copies of the enrollment forms, or a computer printout of all enrollments processed, to each participating plan of that plan's enrollment on a monthly basis.

3.2 5.12 The HBM must submit monthly reports on enrollment activity. The monthly report must include, but is not limited to, the number of enrollment forms and enrollment phone calls received per day, and of those, the number processed, the number of contacts made, the number of forms returned and the reason returned. Enrollment reports must be generated for each county, for each plan by county, and totaled by county and by plan for the State.

3.2.5.13 The HBM must work with the Department to reconcile the monthly list of enrollees for each plan if discrepancies are noted. Extensive research may be required. Requests for research are received from a variety of sources. HBM must monitor Unisys reports and alert DHHR to discrepancies.

3.2.5.14 The HBM must work with the Department to develop the algorithm that will be used to assign members who did not make a selection to a managed care plan or to the primary care case management system The algorithm must assign members based on their current PCP affiliation and their geographic access to providers.

DELIVERABLE: DEVELOP AN ENROLLMENT PROCESS USING THE STATE'S CURRENT SYSTEM AND MANAGE ENROLLMENT PROCESSING PROCEDURES

3.2.6: Develop culturally sensitive written and visual materials.

This task requires a series of activities that include developing written and visual materials for use in outreach and education efforts. The end purpose of these efforts is the enrollment of an informed Medicaid population into managed care plans. Materials include enrollment forms, notices, letters, pamphlets, presentations, videos, and other information.

3.2.7 Develop expertise in managed care philosophy and delivery system in West Virginia.

3.2.7.1 The HBM must become familiar with the organization and goals of the Department as they relate to managed care and member enrollment. This may be accomplished through a series of meetings with the Department, as well as through reading written materials supplied to the HBM by the Department. Overview of Medicaid eligibles and Department policies and procedures will be provided to the HBM by the Department.

3.2.7.2 The HBM must meet with each Medicaid managed care plan and the primary care case management(PCCM) system to obtain detailed information about each individual operation. These meetings must take place within 30 days after the contract has been awarded to the HBM The HBM must identify a liaison at each site to foster ongoing communication between the HBM and each plan and the PCCM.

3.2 7.3 Similarly, the HBM must become familiar with the specific providers in each county that make up the network of contracted providers within the managed care plan/PCCM. A knowledge of the location of each managed care plan's site(s), network of practitioners, hospitals, clinics, etc., will be necessary to assist members in selection In addition, the HBM will need a knowledge of Medicaid covered benefits that plans/PCCM are responsible to furnish to Medicaid members. The plans/PCCM will be expected to supply the HBM with current information about their organizations on an ongoing basis. It is important that the HBM establish a relationship with each plan/PCCM administration for the purpose of keeping each other up to date on changes in policies or procedures. The HBM may be asked by the Department to review managed care/PCCM member materials and other written information and to assist in the approval of marketing materials and proposed marketing/outreach efforts. Any review of marketing materials should ensure that they comply with the requirements of 42 CFR §438 Subpart C.

3.2.7.4 The HBM will be supplied with materials previously approved by the Bureau, by the plans, the PCCM and for Medicaid Redesign. The materials will be mailed to Medicaid members to help them in their choice, and to notify them that their benefits may change if the member agreement is not executed. Examples of materials are member handbooks, question and answer sheets, network provider listings, any Department-approved advertisement developed, and letters related to the Medicaid Redesign.

3.2.7.5 The HBM must be alert to possible discrepancies between approved materials and actual practices as may be reported by members. Any discrepancies discovered should be documented and forwarded to the Department for disposition.

3.2.7.6 The HBM must remain impartial when helping Medicaid members enroll into the managed care plan or primary care provider of their choice. While they will not be allowed to recommend one plan or one primary care provider (PCP) over another to the Medicaid member, they will be expected to work with the member in determining access features including locations, and hours that the member is seeking.

DELIVERABLE: A DESCRIPTION OF THE PROCESS TO BE USED TO BECOME FAMILIAR WITH AND TO CONTINUE TO BE INFORMED ABOUT THE WEST VIRGINIA MEDICAID PROGRAM, THE CONTRACTED MANAGED CARE PLANS, AND MAILING AND PROCESSING INFORMATION RELATED TO MEDICAID REDESIGN.

3.2.8: Develop written materials to educate Medicaid members, advocates, providers, community agencies and Department caseworkers about any changes in Medicaid delivery systems.

The HBM's educational materials and presentations must clearly inform members about the programs and choices to be made in their area. At a minimum, the HBM must cover the following elements:

3.2.8.1 The HMO/PCCM availability in that county and how to appropriately access health care services.

3.2.8.2 The role of the primary care provider in HMO/PCCM.

3.2.8.3 The HMO/PCCM arrangement in each county, which providers participate and what optional services each provides.

3.2.8.4 The policies and procedures for enrollment, disenrollment, exemption and grievances.

3.2.8.5 Ways to access family planning services.

3.2.8.6 Ways to access emergency transportation services.

3.2.8.7 Ways to access Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

3.2.8.8 Ways to access carved-out services.

3.2.8.9 After the HBM gains knowledge about the State's health care delivery systems and about individual HMOs and the PCCM, the HBM must develop written materials to educate the Medicaid member about the changes in the health care delivery system and the enrollment choices to be made.

3.2.8.10 The HBM must develop enrollment materials that comply with the requirements of 42 CFR §438.10(e). The materials must be geared to the sixth grade reading level. These materials must include: general information about

the basic features of managed care and the benefits to members of their participation in either an MCO or PCCM; instruct members of their rights and responsibilities as listed in 42 CFR§438.100, and assist members in their selection of an appropriate plan/provider. The materials must indicate which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; and MCO and PCCM responsibilities for coordination of enrollee care. The materials must notify members that they must select a plan or provider within 45 days or the State will assign them to one. The materials should also note that oral translation services are available free of charge for persons who do not understand the English materials. The materials must also contain information specific to each MCO or PCCM program operating in the potential enrollee's service area (county). A summary of the following information is sufficient, but HBM must provide more detailed information upon request: benefits covered, service area, and names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients (includes at a minimum information on primary care physicians, specialists, and hospitals). The materials must include information on benefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For the Mountain Health Trust (MHT) capitation MCO program, this includes behavioral health services, dental services for members under 21-years of age, non-emergency transportation, and prescription drugs.

3.2.8.11 The HBM, in concert with the Department, must decide the type of written materials to be developed. The list should include, but is not limited to:

3.2.8.11.1 a general informational pamphlet that can be used in any of the enrolled counties.

3.2.8.11.2 specific pamphlets that describe in detail the choices available to members depending on their place of residence.

3.2.8.11.3 enrollment forms that will be completed by the members.

3.2.8.11.4 posters and brochures that advertise the changes in delivery systems and promoting preventive care.

3.2.8.12 The HBM must provide any special services necessary to accommodate the Medicaid members. Special services include, but are not limited to,

3.2.8.12.1 Teletypewriter (TTY) line.

3.2.8.12.2 translation service.

3.2.8.12.4 audio tape for the blind/literacy challenged.

3.2.8.12.5 fact sheet in different languages.

The Department must approve all written materials while they are in draft form and may recommend changes in whole or part. The Department should be consulted on all materials as they are being developed. Each pamphlet, letter, etc., should be accompanied by a concise memo which indicates the document's expected use, the

audience it is targeted to reach, the reason it needed to be written, and the quantity that will be distributed. Each revision should follow the same procedures. Each draft document and revision should include the printing specifications for the document such as size, quality, basic weight of paper, color of paper, color of ink(s), layout, and quantity.

After final Department approval, the contractor will be responsible for printing all written materials, maintaining a sufficient stock of materials and distributing materials as needed at the contractor's expense. The HBM must use current and complete mailing lists that will be provided by the Department.

3.2.8.13 The HBM must establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the state ("prevalent" defined as a language that is the language of more than 5 percent of state residents). If the Department and the HBM determine that a language other than English is prevalent, the HBM must make available all written information in each prevalent non-English language.

3.2.8.14 The HBM must develop a letter for members notifying them that their benefit package may change upon redetermination. All communications regarding Medicaid Redesign must be approved by BMS.

DELIVERABLE: DEVELOP WRITTEN MATERIALS THAT WILL INFORM MEMBERS, PROVIDERS, COMMUNITY ADVOCATES, DEPARTMENT FIELD STAFF AND OTHER INTERESTED PARTIES ABOUT MOUNTAIN HEALTH TRUST (MHT) AND MEDICAID REDESIGN.

3.2.9 Prepare visual materials for use in outreach and educational efforts.

The goal of the presentations will be to explain the philosophy of managed health care through either system of care (HMO/PCCM), instruct members on how to access needed services, tell the members about their responsibilities in a managed care/primary care case management system, assist the members in an appropriate selection, and assist the members in understanding Medicaid Redesign.

3.2.9.1 Visual material explaining each system of care and the arrangements offered in each county will expedite the education effort. The HBM must develop standard presentations using a number of different mediums to assist presenters in their explanations. The materials should be audience-appropriate, e.g., members, DHHR caseworkers, advocates, providers, and other interested parties.

The HBM must update visual materials as needed at least annually. Production, reproduction, updating and distribution of the video will be at the HBM's expense. All visual materials must have Department approval before production and distribution. The Department reserves the right to edit all or part of the visual material before distribution.

DELIVERABLE: DEVELOP VISUAL MATERIAL TO ASSIST IN EDUCATING MEMBERS AND OTHER INTERESTED PARTIES IN THE COMMUNITY ABOUT THE MEDICAID MANAGED CARE/PRIMARY CARE CASE MANAGEMENT SYSTEMS, MEDICAID REDESIGN, AND ENROLLMENT PROCEDURES.

3.2.10: Schedule educational presentations to inform Department offices, eligibility offices, Medicaid members, and the community of the Department's HMO/PAAS delivery system and Medicaid Redesign for Medicaid members.

The Department wants the contractor to take a proactive role in reaching out to members to assure that each member has the information needed to make both an informed choice of plan and an awareness of what is expected after the enrollment has taken place with Medicaid Redesign. Since many members cannot or will not read written materials or attend an informational session, creative means must be developed to achieve effective outreach. One key to accomplishing these goals is outreach to all those in the community who interact with members, be they Department employees or interested parties in the community who come into contact with members. The HBM is required to coordinate with community agencies and organizations in order to provide information and education to members on managed care/primary care case management.

3.2.10.1 All Department of Health and Human Resources central and local offices must be informed of any changes in Mountain Health Trust and Medicaid Redesign progress and changes. The HBM must participate in all new employee training as well as training current staff at each local and central office. Updated presentations may be necessary as county choices change or as enrollment increases. See Appendix C for a list of regional and county offices.

3.2.10.2 General informational meetings must be scheduled throughout enrolled and expansion counties in West Virginia. The HBM will respond to requests for meetings but should also be proactive in working with community agencies to generate interest in the MHT/PAAS initiatives and in hosting a gathering for interested members of the community. The HBM must keep a log of requests for presentations, and schedule them on an as needed/requested basis (including evening and weekend presentations). Medicaid members will be the primary audience for these meetings but other targeted groups such as child and family agencies, county offices, community based agencies/service groups will likely request presentations.

3.2.10.3 HBM will participate in state-wide annual provider workshops, providing written material as well as a presentation for each session.

3.2.10.4 HBM will seek out and establish partnerships with other agencies/organizations who interact with Medicaid members/low-income families to better reach the hard-to-reach.

3.2.10.5 Since not all members will respond to the written materials or attend an informational presentation, the HBM must describe the methods it intends to

employ to reach out to those members who, because of housing circumstance, day care, transportation difficulties, cultural differences, or other circumstance, are unwilling or unable to access information through the local eligibility office or community hosted information program. The methods must describe the additional outreach services the HBM will use to reach both the TANF and SSI populations.

3.2.10.6 The HBM will perform outreach functions, make presentations the HMO/PCCM arrangements available in that area, conduct one-on-one interviews either in person or on the telephone, and act as a resource on managed care and Medicaid Redesign for the local staff and others in the community.

3.2.10.7 The HBM will pursue opportunities to develop workshops for conferences, set up display tables at conferences, seminars, legislative events, health fairs and community events.

3.2.10.8 The HBM's presenters must request audiences to comment on and evaluate the presentation by requesting they complete evaluation forms. Presentation materials and content should be adjusted if evaluations indicate a revision is necessary.

DELIVERABLE: PREPARE AND PRESENT COUNTY-APPROPRIATE HEALTH DELIVERY SYSTEM INFORMATION IN ALL COUNTIES OF THE STATE.

3.2.11: Education regarding carve-out services.

The HBM will be responsible for educating members at the time of their MCO enrollment on how to access services that are carved-out of the managed care program and left in the fee-for-service (FFS) system. These services will include behavioral health services, dental services for members under 21-years of age, and non-emergency transportation. Prescription drugs will be phased into the MHT program in 2006

3.2.12: Develop understanding of the carve-out services and the services in the various benefit packages available through the Medicaid Redesign.

The HBM must become familiar with the fee-for-service (FFS) system, particularly those benefits in the Medicaid benefit package that are not part of the capitated managed care program. The HBM must also understand and communicate the differences in benefit packages as it relates to the Medicaid Redesign. The HBM needs to develop an understanding of these services and ways to access them under the program.

DELIVERABLE: GAIN IN-DEPTH UNDERSTANDING OF SERVICES CARVED-OUT OF THE CAPITATED BENEFIT PACKAGE AND BE ABLE TO EXPLAIN THE LINK BETWEEN THE MCO AND FFS PROGRAMS.

3.2.13: Educate new enrollees regarding carve-out services.

3.2.14: Educate new eligibles regarding Medicaid Redesign and benefit packages available and the process for getting an enhanced package.

The HBM will be responsible for educating new enrollees on how to access carve-out services under the fee-for-service (FFS) program. The HBM should inform potential enrollees at the point of enrollment about these services and how to access them.

DELIVERABLE: ASSIST NEW MEMBERS IN UNDERSTANDING HOW TO ACCESS CARVE-OUT SERVICES IN THE DEPARTMENT'S FEE-FOR-SERVICE (FFS) PROGRAM. ASSIST NEW AND EXISTING ELIGIBLES ABOUT THE BENEFIT PACKAGES AVAILABLE AND THE PROCESS FOR GETTING ENHANCED PACKAGES.

3.2.15 Creation and operation of a telephone unit.

The HBM will provide a telephone unit whose responsibilities will be to complete forms to enroll members into the managed care plan/primary care provider of their choice; answer managed care/PCCM questions asked by Medicaid members, providers and the general community; settle complaints when possible, provide information on covered services, complete research as requested by State, and answer questions regarding Medicaid Redesign.

3.2.16 Develop and implement administrative policies and procedures for telephone operators.

This task includes the development of operational procedures, manuals, forms and reports necessary for smooth operation of the telephone responsibilities of the HBM.

3.2.16.1 The HBM must establish a State toll-free line. The HBM must develop operational policies and forms for the telephone staff. This includes designing the enrollment forms, enrollment materials and enrollment process. Hours of operation will be (at least) from 8 a.m. to 6 p.m., Monday through Friday, excluding State holidays. A voice mailbox must be on-line after hours with a call-back for the next working day.

3.2.16.2 The telephone staff will be responsible for the following types of telephone calls:

- 3.2.16.2.1 enrolling members into the managed care plan of the member's choice.
- 3.2.16.2.2 enrolling members into the primary care provider of the member's choice.
- 3.2.16.2.3 enrolling newborns into the mother's county-appropriate choice of plan/PCCM.
- 3.2.16.2.4 assisting members in transferring from one plan to another.
- 3.2 16.2.5 assisting members in transferring from a plan to a PCCM.
- 3.2.16.2.6 assisting members in transferring from PCCM to a plan.

3.2.16.2.7 assisting members in transferring from one primary care provider to another; in accordance with criteria established by the Department.

3.2.16.2.8 assisting members with the process of Medicaid Redesign

3.2.16.3 The telephone staff will be responsible for responding to the following types of telephone calls:

3.2.16.3.1 processing exemption requests using Department developed criteria.

3.2.16.3.2 assessing any unique health care needs to ensure appropriate enrollment.

3.2.16.3.3 identifying and, if possible, maintaining existing member/provider relationships.

3.2.16.3.4 explaining the options available to individuals depending upon their place of residence.

3.2.16 3.5 explaining the health benefit coverage.

3.2.16.3.6 giving specific information about each option such as whether or not new members are being accepted, available sites, the network of providers including physicians, hospitals, home health agencies.

3.2.16.3.7 documenting reason for change and including change information in monthly reports to Department.

3.2.16.3.8 informing clients that EPSDT services are covered services and making appropriate referrals.

3.2.16.3.9 explaining Medicaid covered services and freedom of choice for access to family planning services.

3.2.16.3.10 referring members to the correct human service agency if calls are received that are outside the scope of MHT/PAAS.

3.2.16.3.11 "triaging" members' calls to service representatives and medical hotlines, where necessary.

3.2.16.3.12 resolving complaints and acting as troubleshooter and member "ombudsman" for enrollees in the program.

3.2.16.4 The HBM must assure the Department that the telephone lines are adequately staffed and telephone personnel are trained on all matters listed in 3.2.16.3 above.

3.2.16.5 The HBM must develop a Quality Assurance Plan to assure that all telephone functions meet the standards set forth below:

3.2.16.5.1 100% of telephone calls must be answered within four rings (a call pick-up system which places the call in queue may be used).

3.2.16.5.2 no more than two calls per operator should be in the queue at any time.

3.2.16.5 3 telephone calls should be of sufficient length to assure adequate information is imparted to the member.

3.2.16.5.4 the wait time in the queue should not be longer than five minutes.

3.2.16.5.5 the rate of abandoned/dropped calls does not exceed 10 percent.

3.2.16.6 The HBM must assure that telephone operators treat all callers with dignity and respect the callers' need for privacy.

3.2.16.7 The HBM must maintain logs that document the number and type of telephone calls received by the telephone unit. Logs must reflect the number and nature of enrollments, i.e. initial member enrollment and change requests (by case and member within case); exemption requests; number of referrals; number of information-only calls; number of inappropriate calls received and their general nature; calls resulting in information generated to the Department's TPL section. The report should note whether previously unknown resources were referred or if TPL resources were coded on the system which no longer are valid. Logs must be maintained daily and tallied on a monthly basis with a report sent to the Department. The Department must approve the format to be used and the HBM must work with the Department if revisions are deemed necessary by either the HBM or the Department.

3.2.16.8 At least one of the telephone lines must be equipped with TTY capability for the deaf.

3.2.16.9 Telephone staff must have access to oral translation services that can be used to answer questions and provide information to enrollees who do not understand English.

DELIVERABLE: PROCESSES AND PROCEDURES WHICH CONFORM WITH THE STANDARDS OF PROMPTNESS AND ASSURE TELEPHONE ACCESS FOR MEDICAID ELIGIBLES.

3.2.17: Telephone service reporting requirements.

Extensive reporting by the HBM of telephone activity will be required to assure that the HBM is fulfilling the promptness and quality standard requirements of the contract. The HBM must submit monthly reports obtained from the call accounting system to the Department which must include but are not limited to:

3.2.17.1 number of telephone calls answered per day/per week/per month by each operator; regarding Managed Care enrollment versus Medicaid Redesign.

3.2.17.2 total number of telephone calls received by all operators per day, per week, and per month.

3.2.17.3 number of calls in the queue at peak times.

3.2.17.4 wait time for calls in queue.

3.2.17.5 average length of call per operator per day.

3.2.17.6 number of calls abandoned per operator per day.

3.2.17.7 active time and inactive time for each operator's line.

DELIVERABLE: DEVELOP POLICIES AND PROCEDURES THAT ASSURE MEMBER ACCESS TO THE TOLL-FREE INFORMATION TELEPHONE NUMBER.

3.2.18 Member mailings

The HBM will be responsible for all member mailings for HMO/PCCM, and Medicaid Redesign, and must coordinate all member mailings with the Department. The cost of the materials, printing and postage for these mailings will be the responsibility of the HBM. The HBM will also be responsible for the cost of re-mailings of returned mail, other notices sent on an individual basis and any mailings not done through the system process. The HBM must advise the Department on the style and content of the mailings and notices. Note that the HBM's proposal must detail the HBM's assumptions in arriving at estimated mailing costs.

DELIVERABLE: EFFECTIVE AND EFFICIENT MAILING PROCESS.

3.2.19 Reporting, staffing and credentials, policies and procedures
The HBM will be expected to provide the Department with monthly reports of their activities, current staffing levels, and resumes of key staff. Policies and procedures or each responsibility of the HBM must be developed and updated as necessary.

3.2.20 Reporting

3.2.20.1 The HBM must furnish the Department with monthly reports of activities in the following areas:

3.2.20.1.1 number and type of member mailings done by the HBM, related to Managed Care enrollment versus Medicaid Redesign.

3.2.20.1.2 per mailing, the number of members mailed to, reason for mailing, date of mailing. (All member mailings must have prior approval of the Department).

3.2.20.1.3 telephone reports as detailed in 3.2.16.

3.2.20.1.4 the number of new enrollments, change of enrollment, reason for change.

3.2.20.1.5 problems reported by counties or providers.

3.2.20.1.6 number and types of questions asked.

3.2 20.1.7 complaints about the marketing methods or discrepancies in the enrollment materials.

3.2.20.1.8 complaints about the HBM and how they were resolved.

3.2.20.1.9 number of members placed in the various benefit packages by eligibility groups.

3.2.20.2 Monthly reports must not just be a compilation of numbers but must also include concise narrative to explain trends in enrollment, problems experienced in the month, recommendations to the Department for policy or procedural change and any comments the HBM may want to give. Reports should include charts and graphs to illustrate points.

3.2.20.3 The HBM must transmit all reports, drafts of written material, drafts of slides and other correspondence to the Department for approval.

DELIVERABLE: PROVIDE DETAILED PERIODIC REPORTS FOR THE DEPARTMENT'S REVIEW.

3.2.21: Employee staffing and credentialing

The HBM must assure the Department that the project is adequately staffed with experienced, knowledgeable personnel.

3.2.21.1 The HBM must employ and train staff necessary to complete the agreed upon tasks at the performance standard levels specified by the contract.

Staff must include the following, but is not limited to, staff listed below:

1) One (1) full time project manager who must possess managerial training and experience and have a health related and a systems background. A knowledge of West Virginia's managed care providers, primary care case management program, social services programs and geography is required.

2) Full time project supervisors who will supervise the following areas:

Telephone Staff
Data Coding Staff
Presenters/Information Specialists

Supervisors must possess supervision experience and knowledge of their assigned area. Supervision staffing must be adequate to assure proper direction and adequate oversight of employees.

3) Other staff as needed for the project. The proposal should display a staffing table by type of staff, a job description for each type of position and a time line for bringing each identified position into the project.

The ability of staff who interact with the public either in person or on the telephone is an important consideration. These staff persons must have the education, skills, and

experience to communicate effectively and should be sensitive to the cultural diversity of the client population. They should be able to learn new material quickly.

3.2.21.2 Resumes of all key management staff currently employed and proposed to complete the terms of this contract must be submitted with the HBM's proposal. If all key management staff are not currently employed, the HBM must submit qualifications, job descriptions and plans for recruiting proposed staff.

3.2.21.3 Any changes or addition in staff once the contract has begun must also be reported to the Department with resumes submitted to the Department.

DELIVERABLE: EMPLOY QUALIFIED, KNOWLEDGEABLE STAFF.

3.2.22: Development of policies and procedures.

The HBM must develop written policies and procedures in consultation with the Department for each of its functions.

DELIVERABLE: PROVIDE REPORTS PER THE ESTABLISHED SCHEDULE AND ENSURE ADEQUATE STAFFING, POLICIES AND PROCEDURES

3.2.23: Maintain direct communication with the department.

The HBM must maintain direct, ongoing communication with the Department regarding the HBM's activities and work closely with the Department to assure accomplishment of the enrollment goals and objectives. The Department intends to maintain close contact with the HBM to assist as needed and to provide contract oversight.

The Department will designate a staff person whose responsibility it is to oversee the HBM performance and to act as a liaison between the HBM and the Department and the HMOs/PCCM.

3.2.23.1 The HBM must forward any complaints concerning its staff to the Department with an explanation. Serious or repeated complaints about any staff person may result in contract sanction if not acted upon by the HBM.

DELIVERABLE: ENSURE THE HBM AND THE DEPARTMENT WORK CLOSELY TO ACCOMPLISH GOALS OF PROGRAM.

3.2.24: Systems development

The HBM must perform the following systems development tasks. The HBM's proposal must specify its plans for implementing these tasks.

3.2.24.1 Establish and maintain databases and systems to support the enrollment operation.

3.2.24.2 Work with the Department to learn the data entry screens within the Medicaid Management Information System (MMIS), which will allow members to be enrolled in a managed care plan or primary care provider; and develop linkage to RAPIDS, to facilitate research.

3.2.24.3 Work with the Department and the fiscal agent to identify any modifications needed.

3.2.24.4 Work with Department staff in refining the default algorithm, responding to county-specific algorithm needs, for the mandatory enrollment of Medicaid members who fail to make a choice and the voluntary enrollment system for clients who voluntarily choose their managed care plan or primary care provider.

3.2.24.5 Establish and maintain a database of new eligibles for notification to Medicaid members of the reduction of benefits and the Medicaid Redesign Program.

DELIVERABLE: WORK WITH THE DEPARTMENT TO DEVELOP AN INTERFACE SYSTEM WITH THE MMIS/RAPIDS SYSTEMS.

3.2.25 Acquire capital equipment and supplies.

This involves purchasing capital equipment including computer equipment that will be necessary to carry out the responsibilities of the contract.

3.2.25.1 The HBM must acquire computer equipment and necessary communication lines that are able to transmit/change information on-line with the Department's MMIS/RAPIDS systems at a transaction speed deemed acceptable to the Department. All computer equipment purchased by the HBM for purpose of fulfilling the needs of this contract will belong to the State of West Virginia when the term of the contract is ended. These items must be purchased/leased in consultation with Department staff and must be compatible with the Department's equipment.

DELIVERABLE: PURCHASE/LEASE CAPITAL EQUIPMENT AND SUPPLIES SO HBM FUNCTIONS CAN BE MANAGED TIMELY AND EFFICIENTLY

3.2.26 Collect third party liability information

The HBM is responsible for all activities relating to the collection of third party liability (TPL) information. The HBM will be responsible for querying about possible third party resources during contacts with members. The HBM need not report information that is identical to that on the TPL files, but will need to report to the Department any information which is at variance with the information on the TPL system. The HBM will verify information, noting such on the TPL form, and transmit copies of verification if provided by the member.

3.2.26.1 Before the HBM collects third party liability information, greater

knowledge of the topic will be necessary. The HBM must work with the Department and other sources to gain the needed knowledge and to learn the process for transmitting TPL information collected by the HBM.

3.2.26.2 The HBM must become familiar with the Department's current method of collecting third party information and displaying the information on the eligibility system.

3.2.26.3 The HBM must include an inquiry about potential third party resources at the time of enrollment and enrollment change, whether written or verbal.

3.2.26.4 While collecting the information, the HBM must check the third party information currently on the eligibility system, question the member (If information isgained on TPL through either a face-to-face or telephone interview) about discrepancies in the information and transmit any information not on record to the Department's TPL unit.

3.2.26.5 Collect information regarding availability of COBRA if client recently employed. Collect information regarding availability of group insurance if employed but not already enrolled.

3.2.26.6 Become knowledge about the Health Insurance Premium Program (HIPP); be able to explain availability to members.

DELIVERABLE: DEVELOP A SYSTEMATIC PROCESS FOR COLLECTING THIRD PARTY LIABILITY INFORMATION FROM MEMBERS AND TRANSMITTING THAT INFORMATION TO THE DEPARTMENT.

Optional Services: (3.2.27 and 3.2.28)
The following additional services may be requested at a future time during the contract period. The response shall detail the process the HBM will utilize to accomplish the goals of the Bureau. Individual pricing of these services will also be submitted separately from the services previously outlined.

3.2.27 As Healthy Rewards are developed for the Medicaid Redesign, the Bureau will require the HBM to track the utilization of services by the members to warrant rewards and enhanced benefit packages.

3.2.27.1 The HBM will track the utilization of services as they relate to to the member agreement and the plan of care submitted by the PCP.

3.2.27.2 The HBM will track member utilization as it relates to referrals by the PCP for compliance with the member agreement.

3.2.27 3 The HBM will develop systems to provide information about each member who signs the member agreement related to utilization of services.

3.2.27.4 Prior to the member's redetermination date for eligibility, the HBM will provide the data necessary for BMS to determine the appropriate benefit package in accordance with the member agreement.

DELIVERABLE: THE HBM WILL ACCEPT THE MEMBER AGREEMENT FROM THE PCP. INFORMATION ABOUT THE UTILIZATION OF SERVICES WILL BE PROVIDED TO BMS PRIOR TO THE ELIGIBILITY REDETERMINATION DATES. THE DATA MUST BE RELATED TO THE MEMBER AGREEMENT AND PCP CARE PLAN.

3.2.28 The HBM will print eligibility cards for Medicaid Redesign members that indicate the benefit package that the member has chosen

3.2.28.1 The HBM will develop and maintain systems to print and provide appropriate to each member the card identifying the benefit package chosen by the member.

3.2.28.2 Cards will be printed in different colors that indicate the benefit package; i.e. red for basic plan, gold for enhanced, and green for traditional plan.

3.2.28.3 Cards will be mailed to each member upon eligibilty redetermination and when changes occur related to the member agreement or change in eligibility category.

DELIVERABLE: ALL MEMBERS ELIGIBLE FOR THE MEDICAID REDESIGN WILL BE PROVIDED WITH COLORED CARDS INDICATING THE BENEFIT PLAN THAT THE MEMBER HAS, BUT MAY ALSO PROVIDE, BUT IS NOT LIMITED TO, MEMBER'S ELIGIBILITY, PCP, AND TPL INFORMATION.

3.3 Special Terms and Conditions:

3.3.1 Bid and Performance Bonds: Not required.

3.3.2 Insurance Requirements:
The Vendor, as an independent contractor, is solely liable for the acts and omissions of its employees and agents. Proof of insurance shall be provided by the Vendor at the time the contract is awarded. The Vendor shall maintain and furnish proof of coverage of liability insurance for loss, damage, or injury (including death) of third parties arising from acts and omissions on the part of the Vendor, its agents and employees in the following amounts:

a) For bodily injury (including death): Minimum of $500,000.00 per person, $1,000,000.00 per occurrence.
b) For property damage and professional liability: Minimum $1,000,000.00 per occurrence.

3.3.3 License Requirements:

Provide certification that it is registered with the Secretary of State's Office to do business in West Virginia; provide evidence it is in good standing with the State Bureau of Employment Programs as to Unemployment Compensation coverage and Worker's Compensation coverage or exempt from such coverage.

3.3.4 Litigation Bond: Non-applicable to this proposal.

3.3.5 "No Debt Affidavit":
West Virginia State Code §5A-3-10a-(3)(d) requires that all vendors submit an affidavit of debt which certifies that there are no outstanding obligations or debts owing the State of West Virginia. The Debt Affidavit is attached to this request for proposal which should be completed, signed and returned with the vendor's proposal. If bidding a joint proposal, a Debt Affidavit must be completed for both vendors.

3.3.6 HIPAA Business Associate Addendum
The West Virginia State Government HIPAA Business Associate Addendum (BAA), approved by the Attorney General, and available online at the Purchasing Division's web site (http://www.state.wv.us/admin/purchase/vrc/hipaa.htm) is hereby made part of the agreement. Provided that, the Agency meets the definition of a Covered Entity (45 CFR§160.103) and will be disclosing Protected Health Information (45 CFR §160.103) to the vendor.

3.3.7 Agreement Addendum: Form WV-96:
Any contract resulting from an award from this RFP and a vendor's proposal must include, but is not limited to, in its terms and conditions all mandatory sections contained herein. Failure of the successful vendor to sign an Agreement Addendum (Form WV-96) as part of the contract may result in the disqualification. Agreement Addendum is available online at http://www.state.wv.us/admin/purchase/vrc/wv96.pdf

3.3.8 Debarment and Suspension:
Vendor will not be considered in proposal process if debarred or suspended. Vendor must certify that they are not debarred or suspended. Successful vendor must certify that no entity, agency or person associated with the vendor is debarred or suspended.

--- End of Part 3 ---

PART 4 PROPOSAL FORMAT

The mandatory sections included in Part 4 require a response, and they describe the minimum requirements requested in this RFP. Any specification or statement containing the word "must", "shall, or "will" are mandatory. The vendor is required to meet the mandatory specifications in order to be eligible for consideration and to continue in the evaluation process. A simple "yes" or "no" response to these sections is not adequate.

4.1 Vendor's Proposal Format:
The proposal must be formatted in the same order, providing the information listed below:

Title page - Shall state the RFP Subject and number, the name of the Vendor, Vendor's business address, telephone number, name of authorized contact person to speak on behalf of the Vendor, dated and signed.

Table of Contents - Clearly identify the material by section and page number.

Section I - Understanding of the Project Objectives and Time-line

Vendors will discuss their understanding of the overall project (Please identify your response in the order of the requirements for Parts 3.1 and 3.2 thru 3.2.28.3); list current projects with which they are now engaged; and, list their workload scheduled. Vendors shall provide a time line showing how they will be able to commence providing services upon award of the contract and continue to provide those services. A statement that the firm will meet the desired deadlines should be included.

Section II - Vendor Experience

Vendors must provide credible, detailed evidence of their related experience and capabilities in providing the required services. Vendors must provide details of: the background of the company/organization; the size and location of the company/ organization; and, the experience and capabilities of the company/ organization which qualify and enable them to provide the service. At least three (3) vendor references from work within last five (5) years, should be included, along with a detailed description of the work performed for each reference.

Section III - Qualifications of Project Staff

Vendors must provide resumes of qualified staff to be assigned to the project and a staff organizational chart. If proposed staff are not employed by the Vendor, the Vendor must provide a signed letter of intent from the individual indicating that they will accept employment if the Vendor is awarded the contract. Vendors must identify key personnel assigned to the project. The Department of Health and Human Resources reserves the right to reject any staff proposed or later assigned to the project and require the successful vendor to remove them from the project. Whenever possible, the successful vendor will notify the Department two (2) weeks prior to replacing any key staff.

Section IV - Project Work Plan

Vendors must provide a proposed work plan discussing its provision of administrative support services for the Medicaid Managed Care program. The work plan must demonstrate a clear grasp of the overall project and services to be provided, with specific action steps that will guarantee the successful provision/completion of services. This work plan must detail how the vendor will perform/complete the services required in Part 3.2 of this RFP.

Section V - Cost Proposal

The cost proposal, with the bidder's name, title, date and signature, must be in a separately sealed envelope and be included with the technical proposal or attached there to and shall contain:

a) The total amount proposed, including a not to exceed= figure. The total not to exceed@ cost is to contain all direct and indirect costs including travel and out of pocket expenses.

b) The factors involved in calculating that amount, including any hourly rates of staff, together with a breakdown of all costs and estimated hours of work associated with the staffing affiliated with the proposal.

c) The Vendor will provide an all-inclusive hourly rate for the pricing of additional services that the Department may purchase. The all-inclusive hourly rate will include all direct and indirect costs, to include travel and out-of-pocket costs. The Vendor may propose an annual inflation increase to the hourly rate, not to exceed the Consumer Price Index (CPI).

d) Vendor is to submit costs on the cost proposal sheet labeled Attachment #1, as laid out in RFP Part 4.5.

4.2 Evaluation Process:

4.2.1 Method of Evaluation:
The proposals will be evaluated by a committee of three (3) or more individuals in accordance with the criteria stated. The Vendor who meets all the mandatory specifications, attains the final highest point score of all vendors (possible one-hundred 100 points maximum) shall be awarded the contract. The selection of the successful vendor will be made by a consensus of the evaluation committee.

4.3 Evaluation Criteria:
The following are the evaluation factors and maximum points possible for technical point scores:

I. Understanding of the Project Objectives & Time-line (Part 3, Part 4, Section I)	20 Points Possible
II. Vendor Experience (Scope of work, Part 4, Section II)	30 Points Possible
III. Qualifications of Project Staff (Section 3.1, Part 4, Section III)	15 Points Possible
IV. Project Work Plan (Scope of work, Part 4, Section IV)	5 Points Possible
V. Cost Proposal (Part 4, Section V)	30 Points Possible
Total	100 Points Possible

Each cost proposal cost will be evaluated by use of the following formula for all vendors who attained the Minimum acceptable score only:

$$\frac{\text{Lowest price of all proposals}}{\text{Price of Proposal being evaluated}} \times 30 = \text{Price Score}$$

4.4 Minimum Acceptable Score:
Vendors must score a minimum of 70% of the total technical points. The minimum qualifying score would be 70% of 70 points or a technical score of 49 points or greater to be eligible for further consideration and to continue in the evaluation process. All vendors not attaining the minimum acceptable score (MAS) shall be disqualified and removed from further consideration.

The State will select the successful vendor's proposal based on best value purchasing which is not necessarily the low bidder. Cost is considered but is not the sole determining factor for award The State does reserves the right to accept or reject any or all of the proposals, in whole or in part, without prejudice if to do so is felt to be in the best interests of the State.

Vendor's failure to provide complete and accurate information may be considered grounds for disqualification. The State reserves the right if necessary to ask vendors for additional information to clarify their proposals. Nothing may be added to alter the written solution or method contained in the original proposal after the bid opening.

4.5 COST PROPOSAL FORMAT

Vendor Name _____

TOTAL PROJECT COST - EXCLUDING OPTIONAL SERVICES

Transition and Startup Cost _____

Year One (1) Operating Cost _____

Year Two (2) Operating Cost _____

Year Three (3) Operating Cost _____

Year Four (4) Operating Cost _____

Year Five (5) Operating Cost _____

TOTAL - Not to Exceed Cost _____

OPTIONAL SERVICES COST - Sections 3.2.27 and 3.2.28

Transition and Startup Cost _____

Year One (1) Operating Cost _____

Year Two (2) Operating Cost _____

Year Three (3) Operating Cost _____

Year Four (4) Operating Cost _____

Year Five (5) Operating Cost _____

TOTAL - Not to Exceed Cost _____

ALL INCLUSIVE HOURLY RATE FOR ADDITIONAL SERVICES ($_____)

_____ _____ _____

Signature Title Date

Introduction

The goals of the West Virginia Comprehensive Medicaid Redesign Proposal are to:

- streamline administration.
- tailor services to meet the needs of enrolled populations.
- coordinate care, especially for members with chronic conditions.
- provide members with opportunity and incentives to be responsible for maintaining and improving their and their family's health.

Prevention, personal responsibility and disease management are hallmarks of the Redesign. In the prevention arena, non-traditional services will be added to the benefits package, such as nutrition counseling and weight loss. West Virginia will introduce Healthy Rewards Accounts, which incentivize members to make healthy decisions and use health care services appropriately. Instead of increasing out-of-pocket co-pays, members would be allotted credits each quarter. Co-pays with differentials such as a lower co-pay for generic drugs and a higher co-pay for using the emergency room for non-emergent services will be applied to the account. Members could use any account balance for uncovered services.

Under the direction of Governor Joe Manchin III and West Virginia Department of Health and Human Resources (DHHR) Secretary, Martha Yeager Walker, the West Virginia Medicaid Redesign Team was formed. This team includes DHHR staff, staff from other state agencies, professional associations, providers, members and advocates. The team met every two weeks with subcommittees meeting weekly, beginning in August 2005. This expanded concept paper is the result of those efforts to fulfill the following charge:

To support an enhanced quality of life for Medicaid beneficiaries by facilitating access to appropriate, high quality, cost effective services: to provide these services in a user friendly manner to both consumers and providers; to use the state's purchasing power to foster excellence in health care quality, efficiency and service; to work collaboratively with other partners in the health care community to promote comprehensive health care; and to focus on the future by emphasizing personal responsibility, promoting preventative care and health awareness education.

Eligibility

West Virginia proposes significant changes in existing eligibility categories. Currently, coverage groups comply with Title XIX of the *Social Security Act* and regulations contained in Title 42, Section 435 of the Code of Federal Regulations. The West Virginia Medicaid Redesign Team recommends simplifying these coverage groups from the current 29 categories to four.

These categories include current eligibility groups. The groups are:

- children
- adults 65 and over
- those with special needs
- adults with children

Children

The Medicaid Children's coverage groups will not change. Children have to meet an income test, have no asset test and receive Medicaid for a continuous twelve-month period once determined eligible. West Virginia serves children at the following federal poverty level:

Age	Federal Poverty Level
Less than 1	150% FPL
1 to 6	133% FPL
6 to 19	100% FPL

When a child's income exceeds the Medicaid Federal Poverty Level a determination for the State Children's Health Insurance Program (SCHIP) is automatically completed. For Children, SCHIP income level is 200% FPL.

Adults 65 and Over

Individuals in this age group are currently eligible under the Qualified Medicaid Beneficiaries (QMB), (Specified Low-Income Medicaid Beneficiaries) SLIMB, and (Qualified Individuals) QI eligible criteria as a single individual or as a couple. Individuals must be eligible for and not just enrolled in Medicare. QMBs are only eligible for limited Medicaid coverage that includes payment of Medicare Parts A and B premium amounts and payment of all Medicare co-insurance and deductibles, including those related to nursing facility services. SLIMBs and QI coverage is limited to payment of the Medicare Part B premium. West Virginia covers 4,764 QMBs; 3,585 SLIMBs and; 2,475 QIs.

Special Needs Groups

West Virginia currently administers an Aged and Disabled (AD) Waiver and a Mentally Retarded/Developmentally Disabled (MR/DD) Waiver. These waivers will continue to operate as is and will not be incorporated into the Redesign. The Special Needs Group eligibility category for Medicaid Redesign would include:

- those who are institutionalized (exclusive of those in ICF/MR).
- people with disabilities.
- other eligibility categories, such as foster care

Because almost one third of the WV Medicaid population (78,000) are SSI recipients, we must improve the health care status of this group while controlling the increasing demand for health care and its associated costs. For this population, we plan to improve cost-effectiveness and quality through value-added delivery systems, financing, and management initiatives, which includes programs that manage the care across the continuum. In combination, prevention initiatives, managing care, and personal responsibility will provide the impetus for achieving improvements in health care outcomes while decreasing the fiscal strain that has been placed upon the state.

Adults with Children

This coverage group is currently eligible for the West Virginia Medicaid program when their circumstances fall within the State's Aid to Dependent Children (AFDC) eligibility criteria. To receive AFDC Medicaid, the income for a family of three can be no more than $243/month. This group also has a $1,000 asset test.
Currently, West Virginia serves 16,055 recipients in this category. This group may be considered for expansion when the redesign demonstrates sufficient savings.

Pregnant women are currently covered at 150% FPL. West Virginia Medicaid currently covers 55% of all births.

Benefits

The Redesign benefits packages were crafted following a comparison with private and public insurers.

The categories of benefits are broad, but provide the information necessary to understand the coverage for each eligibility category. Any constraints on specific benefits are clearly identified. Actuarial review is necessary to determine if benefits and constraints will meet cost neutrality mandates.

Healthy Rewards Accounts

One of the expected outcomes of the West Virginia Medicaid Redesign includes improving the health of Medicaid members and more efficient use of state and federal resources. A tool to assist in that effort is a new West Virginia-designed concept known as *Healthy Rewards Accounts*. The premise of these accounts is based on Consumer Directed Health (CDH) now used in the private sector.

In the private sector employers establish high deductible employee benefit plans. Along with these plans are health reimbursement accounts funded by the employer. These accounts are used to finance a portion of out-of-pocket medical expenses incurred by employees. If a person spends wisely or has no claims, the ending balance may be carried year-to-year.

While a high deductible account would not be applicable for the Medicaid program, the idea of incentives or disincentives for member behavior is appropriate. Unlike private insurance, Medicaid does not allow large meaningful or enforceable co-payments. Under this concept, if a certain class of pharmaceuticals has two equal choices, and 'A' will cost the state $1.00 and 'B' will cost the state $50.00; it would be in the best interest of the state and the member to share the savings if the member chooses 'A'; the least expensive option. Currently, if the member and his or her health care provider want 'B', the person will get 'B', with no consequence for the member or the provider. This is a situation that must be changed.

Certain private employer health plans provide an incentive for members to participate in various disease management and wellness programs In exchange they receive an incentive or premium discount for improving their health status The West Virginia Public Employees smoker-surcharge is a relevant example. Smokers pay $360 more per year for health insurance than non-smokers.

The West Virginia Health Statistics Center indicates 41% of pregnant Medicaid recipients use tobacco products. West Virginia shall initiate a plan offering incentives to members for participation in tobacco cessation programs.

The impact of Private Sector Consumer Directed Health (CDH) is well documented. Companies that employ this strategy experience better results than traditional plans. The City of Hurricane, West Virginia, uses a CDH strategy. For the 2005 plan year, their net increase in health cost was 6.05%. This is compared to a greater than 10% trend projected for the West Virginia Public Employee Insurance Agency (PEIA) for state fiscal year 2005.

A large provider of CDH in West Virginia reports their average trend among the company's total book of business is 7%. This is far below the national trend for standard packages of 9.2% as reported in the 2005 Kaiser Family Foundation Employer Benefits survey.

West Virginia intends to establish a Healthy Rewards Account for all Medicaid members who have the ability and capability to partner in their personal health decisions and this will be the first target population.

The account will receive a deposit of credits in accordance with a predetermined formula. The credits will carry forward and the recipient will be eligible to convert those credits to a list of items or services which may not be available through the West Virginia Medicaid program.

In the beginning, the accounts will be used for a limited number of incentives or disincentives. As the program is refined over time, Healthy Rewards can be expanded and become more comprehensive.

Disincentives:

Some examples of member behavior West Virginia Medicaid intends to target with disincentives are:

- Non-emergent use of emergency services.
- Missed medical appointments.
- Non-compliance with the preferred drug list.
- Smoking.

Medicaid programs across the country, as well as all payors, experience problems with inappropriate use of emergency services. Instead of using the normal primary care system, many members seek primary and urgent care from an emergency room. According to statistics provided by the West Virginia Hospital Association, there were 1.1 million emergency room visits in 2004 in the state of West Virginia. There were 585 visits per 1000 state residents for the general population. For West Virginia Medicaid there were 790 visits per 1000 Medicaid members.

For those with Healthy Rewards Accounts, a significant portion of credits would be used to pay a co-payment for non-emergent use of emergency services. Some may question how this might be accomplished. PEIA and other private insurers charge significant co-payments to members who use emergency services inappropriately. Medicaid can use this process.

There is a perception in the provider community that West Virginia Medicaid members have a high no-show rate. This leads to two concerns. First, providers become frustrated and refuse to treat Medicaid members. Secondly and more importantly, many medical conditions require compliance checks and follow-up visits. If a patient does not follow up, the result can be negative health outcomes or hospitalization leading to higher costs. After missing a predetermined number of visits, a certain amount of credit will be deducted from the Healthy Rewards Account.

The final disincentive in the first phase would be for failure to choose from the preferred drug list. Medicaid will move to a multi-tiered co-payment structure with non-preferred drugs having higher co-payments deducted from the Healthy Rewards Accounts. In fiscal year 2004 the average cost for a generic drug for West Virginia Medicaid was $22.31, compared to $96.73 for a brand. The generic dispensing rate was only 50.12% for WV Medicaid. (The West Virginia Public Employee Insurance Agency (PEIA) generic dispensing rate for fiscal year 2005 was 55.5%. The difference can be attributed to PEIA's ability to impose a meaningful co-payment differential on generics).

Incentives:

The first phase incentive programs would be limited to the following care management or wellness initiatives: prenatal care, well-child checkups and vaccinations, cardiovascular, asthma and diabetes care as well as tobacco cessation. As the program develops, additional disease states may be included.

Studies show that proper prenatal care will reduce the chance of a negative outcome at birth. Currently, West Virginia Medicaid pays for over 50% of the births in the state. A large percentage of Medicaid mothers are smokers. The cost for a baby born prematurely can easily exceed $200,000 in medical claims to the Medicaid program.

Pharmacy expenditures for West Virginia Medicaid amplify the need for management of the above listed disease/health states. For calendar year 2004, the program spent 9% of drug expenditures ($34,004,407) on cardiovascular medications; the plan expended $21,822,877 on anti-asthmatic medications and $20,950,033 on diabetic related medications and supplies.

As individuals comply or adhere to the programs, additional credits will be added to their account. Simplicity must be the key with this aspect of the program. The financial details in terms of the size of the monthly account deposits and the amount of credits will depend on further review of available data. Medicaid program goals will also play a large part in determining the size of incentives and disincentives.

Healthy Rewards Accounts provide a tool to offer meaningful incentives or disincentives. Currently, there are few ways for West Virginia Medicaid to influence the behavior of its members. The program is limited to a $3.00 co-payment on medical services and products. Providers cannot deny services if participants do not pay. The current situation in West Virginia Medicaid is that there are no cost-sharing mechanisms, only provider payment reductions which do not impact member behavior in a healthy or positive way.

By bringing members into partnership with their health care providers, West Virginia Medicaid hopes to foster more active member participation in their health care. Not only will they

become better informed, they will be become involved in programs that will improve quality of life for themselves and their families.

Electronic Health Information

A key component to the proposed West Virginia Medicaid Redesign is to identify quality outcomes and reward both providers and members for achieving performance expectations. The ability to gather timely health information is essential to providing quality health outcomes. Electronic access to data will be a vital part of the process. West Virginia will design and implement a health information system that will allow a common framework for and of the following components:

- Electronic medical records
- Medicaid claims
- Medicare claims
- Commercial insurance claims
- Public health data
- Nursing Home MDS data and
- Mental Health data.

The State will also survey health organizations to identify what data is currently collected electronically, whether that data can be made available for State use and the specific data elements included. The State will also attempt to identify the number of providers currently using various types of electronic record keeping, such as electronic appointment or paperless record keeping systems.

The systems currently in use, as well as products available commercially and governmentally, will be assessed to ascertain which products meet the State's data collection needs. Systems will be reviewed for ease of implementation, staff training needs, maintenance, accessibility and special features (i.e. intelligence which suggests additional tests that might be necessary based on symptomatology, or which flags medications that may be contraindicated or appear to be a dosage concern).

Currently, the State of West Virginia is developing and is currently involved in several significant public health informatics projects which will promote harmonization of local and national standards. These include projects at mental health agencies, hospitals and primary care centers. The seven state facilities (two psychiatric hospitals, one acute care hospital and four nursing homes) are modifying the Veterans' Administration's Veterans Health Information Systems and Technology Architecture (VISTA) electronic health records system to meet their specific needs.

In addition to the above activities, the information gathered from health records can be combined with claims payment data. This will facilitate the development of baseline information on the health care utilization practices of individual members, providers, specific population groups, and build the foundation of data that will allow West Virginia Medicaid to meet its goal of providing appropriate health care, in the correct quantity, quality and duration to meet needs of all members. Through assessment, policy and assurance this data will

allow the State to examine over - and under - utilization of services, the use of preventive versus emergency services, and measure the improvement in the quality of members' health.

Lastly, data from electronic health records will be part of the on-going disease management activities already underway in the State. Currently, clinical staff are reviewing existing clinical protocols for disease management in targeted areas and are developing common protocols and procedures with outcome measures for these diseases.

The State will seek grants to expand the electronic capabilities of providers and is willing to partner with the federal government and/or private entities in the development of the statewide health information demonstration project.

Long-Term Care

The primary goal for long-term care services in West Virginia's Medicaid Redesign is to provide access to the most integrated setting that provides coordination of care to improve and maintain health status, while being mindful of member preference and within the state budget allowance.

Entry into Medicaid for those with long term care needs should be a single entry process. The vehicle for entry into the system is the individual needs assessment. Needs assessment should be provided by independent, resource management professionals, qualified through training and experience, certified by the state, and not attached to or associated with any provider of service. Moreover, these resource managers should be qualified to assist in the development of and, as needed, advocate for and support the member's own development and management of her or his resource management contract.

The needs assessment should be proactive in prevention and identification of needs and preferences. It should allow for a maximum level of choice, independence, and integration within state budget constraints and reduce the need for prior authorizations and additional forms and administrative processes. The goal of the needs assessment is to allow the member full participation in the management of services and care.

Once the resource manager completes the initial assessment of the member, a Resource Management Contract (RMC) will be developed. The guiding principles of the RMC are that it is self-directed, person-centered, mutually accountable, enforceable and monitored for quality of outcome The RMC has three goals:

- to provide a roadmap of the member's long term care support needs and desires.
- to document an agreement between the member and the Medicaid program for Medicaid delivered services and supports identified in the needs assessment.
- to encourage active participation in determining and managing the use of resources provided by the contract.

The independent resource manager will oversee the RMC and its implementation, providing assurances that the member maintains an optimal level of direction over the process.

Integrating social supports and services for individuals receiving long term care is an essential component of the West Virginia Redesign

Planning of long-term care services for the future must take into consideration the historical barriers to a wide range of long-term care services and supports. These barriers have included:

- lack of access to the full range of services in many rural areas of the state.
- lack of appropriate education and training programs for those interested in working in long term care services.
- lack of adequate compensation.
- emphasis on institutional care rather than on the professionals providing habilitation, rehabilitation and other home and community based services.
- diminishing numbers of workers available to provide needed long term care services.
- provider driven services rather than consumer driven services.
- management of care that emphasized "service limiting" processes rather than service enabling.

Each of these barriers and others which may arise must be addressed in terms of system facilitation, provider education, career development programs, provider reimbursement, recruitment and retention initiatives and other ways to attract, train and keep quality professionals in our long term care system.

Quality Outcomes and Outcome Measurements

The use of performance measurement is a key component of West Virginia's Redesign Initiative Quality Outcome measures shall reflect efficiency, effectiveness and responsiveness in assuring access to health care services as well as the timeliness of those services to West Virginia Medicaid members.

In developing outcome measurements, West Virginia shall use pre-existing indicators that are evidence-based, well-tested, accepted by providers and incorporate multiple dimensions of care. Benchmarks will be established in order to:

- identify areas needing improvement and on-going monitoring.
- set performance goals and.
- assess progress towards meeting established goals in key areas of importance.

The use of a measurement matrix will allow West Virginia to construct reports for consumers, advocacy groups and members of the public to demonstrate the success of the redesign program. A measurement matrix will also enable West Virginia to make sound management decisions in its Medicaid program.

As a component of its measurement matrix, West Virginia will develop incentives to encourage and reinforce the delivery of evidence based practices and health care delivery system transformation that promote better outcomes as efficiently as possible. Employing a comprehensive set of performance measures combining elements from existing quality assurance and quality improvement monitoring activities with newly developed elements will

result in a quality monitoring strategy that is commonly referred to as a value-based purchasing (VBP) program.

Medicaid Member Agreement

The Medicaid Member Agreement is a component unique to the proposed West Virginia Medicaid Redesign. Medicaid members, guardians of children and possibly other populations would sign the agreement upon enrollment and re-determination. The agreement outlines the rights and responsibilities of individuals who become Medicaid members. The responsibilities include the expectation that Medicaid members keep their medical appointments, take their medications as directed, notify their healthcare provider if they are not feeling well and ask questions if they do not understand their medical providers' instructions.

In addition, each member agreement will have an attached addendum which describes the recommended check-ups and exams for healthy children, healthy men, healthy women and healthy diabetics. This range of addendums will be expanded as the program is further developed. Members who comply with the agreement and those who comply and improve their health status may be eligible for special benefits and/or bonus credits to their Healthy Rewards Account. Members may have credits deducted from their account if they consistently do not show up for their medical appointments, do not adhere to medical direction resulting in a reduced health status, or if they use emergency services inappropriately.

The Medicaid Member Agreement gives responsibility to members, sets expectations for behavior and rewards success. The addendum to West Virginia's member agreement is based upon the American Academy of Family Practice Clinical Preventive Guidelines, the Agency for Healthcare Research and Quality's (AHRQ) Guide to Clinical Preventive Services, recommendations of the U.S. Preventive Services Task Force (USPSTF), and the American Academy of Pediatrics Clinical Guidelines.

Conclusion

The State of West Virginia appreciates the opportunity to offer this concept paper for comment and consideration. With or without a Medicaid Redesign, the West Virginia Medicaid Program will be significantly altered in the next two years to respond to the budget constraints faced by the state and federal government. West Virginia fervently believes that unfettered from the current Medicaid regulations it could reduce Medicaid growth and maintain appropriate services for Medicaid members. As mentioned in the introduction, once this is achieved, the State would move to examine options to broaden Medicaid access to low-income working adults. The State of West Virginia looks forward to working with its federal partners to improve and refine its Medicaid program.

RFQ No. _____

AFFIDAVIT

West Virginia Code §5A-3-10a states:
No contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and the debt owned is an amount greater than one thousand dollars in the aggregate

DEFINITIONS:
"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Debtor" means any individual, corporation, partnership, association, limited liability company or any other form or business association owing a debt to the state or any of its political subdivisions. "Political subdivision" means any county commission; municipality; county board of education; any instrumentality established by a county or municipality; any separate corporation or instrumentality established by one or more counties or municipalities, as permitted by law; or any public body charged by law with the performance of a government function or whose jurisdiction is coextensive with one or more counties or municipalities. "Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

EXCEPTION:
The prohibition of this section does not apply where a vendor has contested any tax administered pursuant to chapter eleven of this code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

LICENSING:
Vendors must be licensed and in good standing in accordance with any and all state and local laws and requirements by any state or local agency of West Virginia, including, but not limited to, the West Virginia Secretary of State's Office, the West Virginia Tax Department, West Virginia Insurance Commission, or any other state agencies or political subdivision. Furthermore, the vendor must provide all necessary releases to obtain information to enable the Director or spending unit to verify that the vendor is licensed and in good standing with the above entities.

CONFIDENTIALITY:
The vendor agrees that he or she will not disclose to anyone, directly or indirectly, any such personally identifiable information or other confidential information gained from the agency, unless the individual who is the subject of the information consents to the disclosure in writing or the disclosure is made pursuant to the agency's policies, procedures and rules. Vendors should visit **www.state.wv.us/admin/purchase/privacy** for the Notice of Agency Confidentiality Policies.

Under penalty of law for false swearing (West Virginia Code, §61-5-3), it is hereby certified that the vendor acknowledges the information in this said affidavit and are in compliance with the requirements as stated.

Vendor's Name: _____

Authorized Signature: _____ Date: _____

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AGREEMENT ADDENDUM

In the event of conflict between this addendum and the agreement, this addendum shall control:

1 **ARBITRATION** - Any references to arbitration contained in the agreement are hereby deleted Disputes arising out of the agreement shall be presented to the West Virginia Court of Claims

2 **HOLD HARMLESS** - Any clause requiring the Agency to indemnify or hold harmless any party is hereby deleted in its entirety

3 **GOVERNING LAW** - The agreement shall be governed by the laws of the State of West Virginia This provision replaces any references to any other State's governing law

4 **TAXES** - Provisions in the agreement requiring the Agency to pay taxes are deleted As a State entity, the Agency is exempt from Federal, State, and local taxes and will not pay taxes for any Vendor including individuals, nor will the Agency file any tax returns or reports on behalf of Vendor or any other party

5 **PAYMENT** - Any references to prepayment are deleted Payment will be in arrears

6 **INTEREST** - Should the agreement include a provision for interest on late payments, the Agency agrees to pay the maximum legal rate under West Virginia law All other references to interest or late charges are deleted

7 **RECOUPMENT** - Any language in the agreement waiving the Agency s right to set-off, counterclaim, recoupment, or other defense is hereby deleted

8 **FISCAL YEAR FUNDING** - Service performed under the agreement may be continued in succeeding fiscal years for the term of the agreement, contingent upon funds being appropriated by the Legislature or otherwise being available for this service In the event funds are not appropriated or otherwise available for this service, the agreement shall terminate without penalty on June 30. After that date, the agreement becomes of no effect and is null and void However, the Agency agrees to use its best efforts to have the amounts contemplated under the agreement included in its budget Non-appropriation or non-funding shall not be considered an event of default

9 **STATUTE OF LIMITATION** - Any clauses limiting the time in which the Agency may bring suit against the Vendor, lessor, individual, or any other party are deleted

10 **SIMILAR SERVICES** - Any provisions limiting the Agency's right to obtain similar services or equipment in the event of default or non-funding during the term of the agreement are hereby deleted

11 **ATTORNEY FEES** - The Agency recognizes an obligation to pay attorney's fees or costs only when assessed by a court of competent jurisdiction Any other provision is invalid and considered null and void

12 **ASSIGNMENT** - Notwithstanding any clause to the contrary, the Agency reserves the right to assign the agreement to another State of West Virginia agency, board or commission upon thirty (30) days written notice to the Vendor and Vendor shall obtain the written consent of Agency prior to assigning the agreement

13 **LIMITATION OF LIABILITY** - The Agency, as a State entity, cannot agree to assume the potential liability of a Vendor. Accordingly, any provision limiting the Vendor's liability for direct damages or limiting the Vendor's liability under a warranty to a certain dollar amount or to the amount of the agreement is hereby deleted In addition, any limitation is null and void to the extent that it precludes any action for injury to persons or for damages to personal property

14 **RIGHT TO TERMINATE** - Agency shall have the right to terminate the agreement upon thirty (30) days written notice to Vendor

15 **TERMINATION CHARGES** - Any provision requiring the Agency to pay a fixed amount or liquidated damages upon termination of the agreement is hereby deleted. The Agency may only agree to reimburse a Vendor for actual costs incurred or losses sustained during the current fiscal year due to wrongful termination by the Agency prior to the end of any current agreement term

16 **RENEWAL** - Any reference to automatic renewal is hereby deleted The agreement may be renewed only upon mutual written agreement of the parties

17 **INSURANCE** - Any provision requiring the Agency to insure equipment or property of any kind and name the Vendor as beneficiary or as an additional insured is hereby deleted

18 **RIGHT TO NOTICE** - Any provision for repossession of equipment without notice is hereby deleted However, the Agency does recognize a right of repossession with notice

19 **ACCELERATION** - Any reference to acceleration of payments in the event of default or non-funding is hereby deleted

20 **AMENDMENTS** - All amendments, modifications, alterations or changes to the agreement shall be in writing and signed by both parties No amendment, modification, alteration or change may be made to this addendum without the express written approval of the Purchasing Division and the Attorney General

ACCEPTED BY:

STATE OF WEST VIRGINIA

Spending Unit: _____

Signed: _____

Title: _____

Date: _____

VENDOR

Company Name: _____

Signed: _____

Title: _____

Date: _____

West Virginia Department of Health & Human Resources
FEDERAL PROGRAM PARTICIPATION ACKNOWLEDGMENT, AUTHORIZATION, CONSENT, AND RELEASE

No person who is currently excluded, debarred, suspended, or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs shall be hired by the West Virginia Department of Health and Human Resources.

I am ☐ am not ☐ currently excluded, debarred, suspended, or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs

_____ _____
Signature ***Date***

I authorize and consent to a background check by the West Virginia Department of Health and Human Resources specifically to determine whether I am currently excluded, debarred, suspended, or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs. If hired, I also agree to periodic conduct of additional such background checks during the course of employment by the West Virginia Department of Health and Human Resources.

I release any persons and the West Virginia Department of Health and Human Resources and its agents, officials, representatives, employees, officers, or related personnel both individually and collectively, from any and all liability for damages of any kind that may result because of compliance with this acknowledgment and authorization.

For positive identification purposes, the following information is required when conducting a background check. This information is confidential and will not be used for any other purposes (**please print**):

Name _____ _____ _____
last name *first name* *middle initial*

Maiden/Other Names _____
(This should include other married names by which you have been known.)

Current Address _____ _____ _____
street/box# *city* *state*

NOTE: Your social security card must be presented for verification purposes.

Social Security # ___ - ___ - _____ **Date of Birth** _____
month/day/year

Driver's License Number _____ **State of Issue** _____

_____ _____
Signature ***Date***

EMPLOYING UNIT INFORMATION

Office/Facility/Region/District Contact Person

Fax Number Phone Number

FOR OPS USE ONLY

HHS Match Outcome ☐ Positive ☐ Negative

GSA Match Outcome ☐ Positive ☐ Negative Initial _____ Date _____

The completed form must be included with the employment package to be sent to the Office of Personnel Services