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
BMS90007	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
05/10/2009				

BID OPENING DATE: 06/10/2009 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 7
1. QUESTIONS AND ANSWERS ARE ATTACHED.
2. ADDENDUM ACKNOWLEDGEMENT IS ATTACHED. THIS DOCUMENT SHOULD BE SIGNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN DISQUALIFICATION OF YOUR BID.

EXHIBIT 10

REQUISITION NO.: BMS90007

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S:

NO. 1 .....

NO. 2 .....

NO. 3 .....

NO. 4 .....

NO. 5 .....

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE

TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

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 fee.

5. All services performed or goods delivered under State Purchase Order/Contracts are to be continued for the term of the Purchase Order/Contracts, 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 may be deemed null and void, and terminated without further order.

14. 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 Cover Entity (45 CFR §160.103) and will be disclosing Protected Health Information (45 CFR §160.103) to the vendor.

15. WEST VIRGINIA ALCOHOL & DRUG-FREE WORKPLACE ACT: If this Contract constitutes a public improvement construction contract as set forth in Article 1D, Chapter 21 of the West Virginia Code ("The West Virginia Alcohol and Drug-Free Workplace Act"), then the following language shall hereby become part of this Contract: "The contractor and its subcontractors shall implement and maintain a written drug-free workplace policy in compliance with the West Virginia Alcohol and Drug-Free Workplace Act, as set forth in Article 1D, Chapter 21 of the West Virginia Code. The contractor and its subcontractors shall provide a sworn statement in writing, under the penalties of perjury, that they maintain a valid drug-free work place policy in compliance with the West Virginia and Drug-Free Workplace Act. It is understood and agreed that this Contract shall be cancelled by the awarding authority if the Contractor: 1) Fails to implement its drug-free workplace policy; 2) Fails to provide information regarding implementation of the contractor's drug-free workplace policy at the request of the public authority; or 3) Provides to the public authority false information regarding the contractor's drug-free workplace policy."

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 case 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: Department of Administration, Purchasing Division, 2019 Washington Street East, P.O. Box 50130, Charleston, WV 25305-0130

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

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ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF BIDS.

VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.

.....
SIGNATURE

.....
COMPANY

.....
DATE

REV. 11/96

END OF ADDENDUM NO. 7

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

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TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

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VENDOR QUESTIONS

	RFP SECTION	QUESTION	ANSWER
1	3.1.3 Vendor is to maintain secure electronic communications with Bureau for Medical Services (BMS), BCF, BHHF, and/or contractors which have financial, case management, and/or custody responsibilities for members.	Is there a preferred or existing electronic communication method the bidding vendor will be required to use, if so please provide more detailed information (i.e., secure FTP)	The vendor must be able to utilize any method requested by the state and federal partners.
2	3.1.8 Vendor is to have the capacity to accept all prior authorizations in a web based format.	Please clarify, is this requirement speaking to the vendor's ability to convert or accept data for all prior authorizations from the incumbent as part of the transition (open authorizations)?	The vendor will have the ability to accept web based prior authorizations.
3	3.1.10 Vendor is responsible for providing start-up and operations tasks and subtasks including access to agency or other systems including the Medicaid Management Information System (MMIS) and the Family and Children's Tracking System (FACTS), utilization review and authorization of utilization management of all behavioral and medical services listed and socially necessary services in this document. The Families and Children Tracking System (FACTS) bi-directional interface and all of the associated electronic data structures, data transmittal processing and application functionality will remain unchanged. The vendor is required to accept data transfers in the current formats and correct exceptions for processing. This	Please provide a list of the interfaces/data exchanges that the vendor will be required to interface with the MMIS and FACTS system. Please provide details of the required bi-directional interface the vendor is required to implement with the FACTS.	For all programs the vendor will be able to interface with systems as needed to meet the needs of the Bureaus. FACTS: interface – bi-directional. Vendor sends FACTS 5 files. FACTS sends Vendor 2 files. All of the files are flat files with Field Delimiter: PIPE (|) DELIMITED

	RFP SECTION	QUESTION	ANSWER
	includes but is not limited to changes in the client identification that supports utilization reporting.	Is the term bi-directional being used synonymous with data exchanges? If not, please provide the Agency's definition of bi-directional as it applies to this requirement. The link to the FACTS desk guide does not appear to be active. Is there a different URL that the vendor should access?	and have various data elements in each file. The file length various from 438 to 1300 FACTS: The term bi directional is a description of the type of data exchange in place with the current vendor. Data is sent and received by both parties. The link to the FACTS desk guides is broken. However what is located there is a "how to" guide for FACTS workers entering services; a step by step guide on how to enter a service in the Child Welfare case management system.
4	3.1.18 Vendor is to provide technical assistance and training for BHHF providers regarding trends/performance/documentation/assessment/medical eligibility for Services as requested not to exceed one per month in each agency region.	Please define each agency region.	BHHF has the following regions: North (Healthways, Northwood, Valley, United Summit, Appalachian, Potomac Highlands East Ridge, Westbrook Counties) South (Prestera East, Prestera West, Logan Mingo, Southern Highlands, FMRS, Seneca Counties)
5	3.1.2.2 Vendor shall be responsible for authorizing services in conformance with current Medicaid program coverage policy and benefit limitations. To meet this requirement, the Vendor must validate the member eligibility and Managed Care Organization (MCO) enrollment status of each request. If the member is assigned to an MCO or has other primary insurance coverage, the provider must be notified that the request must be submitted to the primary payer in conformance with the coverage, rules and	Will one system (MMIS) serve as the repository for validating member eligibility and MCO enrollment status? Will the vendor receive an eligibility file and if so, will the data be provided in the HIPAA 834	BMS – No eligibility file will be provided by the Bureau or its Fiscal Agent. Vendor will access the MMIS directly to verify eligibility. No, we will not be providing an eligibility file.

	RFP SECTION	QUESTION	ANSWER
	procedures of the MCO or primary payer. If service is not covered by the MCO or primary payer, Medicaid will not cover.	format?	
6	3.1.2.14 Vendor shall issue prior authorizations through direct entry into the prior authorization module of the Medicaid Management Information System (MMIS) or through the electronic interface with FACTS and MMIS or other means with approval from the Bureau. Section IV – Project Work Plan Paragraph 2 Vendor should comment on plans for establishment of its administrative offices locally, and of the interface between that office and the state administrative offices, Bureau for Medical Services and other Bureaus. Additional, Vendor should describe how they will interface with the Department of Health and Human Resources (AGENCY) data systems and any processing subcontractors as necessary and how they will utilize the current fiscal agents system to enter authorizations on line for an in network and out of network services within the specified timeframes.	These two requirements seem to be in direct conflict with one another. In 3.1.2.14, implies that the Agency would be open to the use of the vendor's system if approved, but the Project Work Plan requirements speaks to the need for the vendor to describe how they will utilize the current fiscal agents system to enter authorization on line. Please clarify.	Only prior authorizations for Socially Necessary Services and the out of state placement of foster children must come through the electronic interface with FACTS. The prospective vendor must utilize the current interface format and process for these service authorizations. Please note below: The FACTS interface with the vendor is comprised of two files sent by FACTS and five files sent to FACTS from the vendor. All are flat files with a pipe (I) delimiter. The files range in length from 438 to 1300 characters. File transfers are done via secure Implicit SSL FTP to a DHHR server. The files are password protected and transferred daily Monday through Friday. Procedurally, FACTS sends a referral file to the vendor requesting authorization of a service. Along with the service code and requested time frame are demographics on the client(s) that are to be served. The referral file is combined with information provided by the service provider for the vendor to render a decision. The resulting decision is sent back to FACTS in two files a header containing demographic and case identifiers and a detail file giving the authorization code and timeframe. Any changes to be made to the authorization are sent to the vendor through a rollback file. The rollback is processed and sent back to FACTS via another header and detail file. An additional file is sent to FACTS for every child placed out of state. Upon placement of the child the residential provider gives information about the child and their service needs to the vendor who then determines the appropriateness of the placement and sends FACTS an authorization. BMS- The intent is for authorizations to be entered in the most efficient way that provides all medical and behavioral information in one system. It is also more efficient to place the authorizations where the claim is adjudicated.

	RFP SECTION	QUESTION	ANSWER
			However, Medicaid is open to suggestions, but those suggestions must also be cost efficient and provide the information necessary to administratively manage members. It is BMS' decision how this will be accomplished. (The last sentence needs attention. We are asking for a Proposal and BMS/Medicaid would have to approve.)
7	3.1.4.2 BUREAU FOR CHILDREN & FAMILIES The Bureau of Children & Families provides and/or arranges for a variety of social services that are socially necessary (SN) for children, youth and families in WV. The Social Services to be covered are those direct services covered under Child Protective Services (CPS), Youth Services (YS), Foster Care and Adoption. Vendor is to utilize established Socially Necessary definitions according to BCF policies and standards. Any deviation from these standards must have BCF prior approval. Vendor is to work collaboratively with the Department and to perform functions necessary to support compliance with state and federal requirements for Child Welfare Services (Family Support, Family Perseveration, Foster Care, Reunification and Adoption).	Please provide the BCF policies and standards which the vendor is required to utilize to establish Socially Necessary definitions.	Following is a list of web sites for CPS, Foster Care, Youth Services & Adoption Policy: www.wvdhhr.org/bcf/children; adult/cps/policy.asp; www.wvdhhr.org/bcf/children adult/foster/policy.asp; www.wvdhhr.org/bcf/policy/adoption/Adoption Policy.pdf. www.wvdhhr.org/bcf/policy/youth services/yspolicy/pdf. BCF is also accredited through Council on Accreditation. Location of their standards can be found at: www.coastandards.org/standards.php. Another site which has information regarding WV & Child Welfare is: http://www.acf.hhs.gov/programs/cb/cwmonitoring/index.
8	3.1.4.4 Bureau for Medical Services d) Psychiatric Inpatient Facilities, Psych under 21 years of age, and Psychiatric Residential Treatment Facilities (PRTF) for Individuals under 21 years of age (in State and Out of State). Documentation will consist of State specified, plus any other vendor specified documentation. Any admission or continued stay approval must establish subsequent review intervals.	Please provide more details as to the required "State specified" documentation for PRTF.	Upon award, specific information will be provided. Provider manuals may be accessed at www.wvdhhr.org/bms/ manuals PRTF information is located in the Hopistal Services manual chapter 510.
9	3.1.4.4 (ff) Page 26	Please provide a list of edits the Bureau currently uses for	The Bureau will provide the vendor with a list of those lab services that may require prior authorization. To date the Bureau will be requiring prior authorization for only one lab

	RFP SECTION	QUESTION	ANSWER
		determining payment of claims for laboratory services.	service; the Bureau reserves the right to add lab services prior authorization as needed.
10	3.1.4.4 (ff) Page 26	Please provide a list of the laboratory services "requiring prior authorization regardless of place of service".	Refer to #9.
11	3.1.4.4 (ff) Page 26	For the services referenced above, please provide the number of paid claims for each distinct service for the most recent year available.	Refer to #9
12	General	Many of the services that are being requested in the RFQ are volume driven. However, unit prices are not usually established for services of this nature because they may include some activities that are not relative to volume. Should the vendors propose unit prices for the volume driven services to accommodate increases in the vendor's compensation that are related only to	Please see #143

	RFP SECTION	QUESTION	ANSWER
		increases in volume?	
13	General	Please provide the number of case management referrals performed by the incumbent or another vendor within the last 12 months for the Bureau for Medical Services, Bureau for Behavioral Health and Health Facilities, and the Bureau for Children and Families.	BMS- There were 442 individuals case managed in CY 2008 BHHF this was not an activity of an incumbent vendor. BCF- This was not an activity of an incumbent vendor.
14	General	For which specific categories of members/services will the vendor be expected to provide case management?	BMS: Case management is provided for transplants, bariatric procedures, private duty nursing, high cost, service requirements, and any other issue referred from BMS.
15	General	How many members from each category were approved for case management by the incumbent or another vendor within the last 12 months?	BCF- this was not an activity of an incumbent vendor. For BMS, there were 442 individuals case managed in CY 2008.
16	3.1.4.4 hh	Concerning the SCHIP/PEIA Optional bid, given that the scope of work will be determined by another agency at some future time	Costs cannot be projected at this time. The vendor must show willingness and a system that could build capacity to acquire these services if requested.

	RFP SECTION	QUESTION	ANSWER
		and the RFP just requires willingness to work with these agencies, can the cost be N/A and not impact scoring rules?	
17	3.1.4.4 3.1.4.3	Some UM options and optional services indicate that some services require prior authorization and others indicate that other/all services in the program may be subject to PA at some future date. How should pricing be done to account for additional services the Department may wish to PA in the future based on the statement in 3.1.4.4 and 3.1.4.3 that "specific codes or services may be subject to change due to changes in national codes, changes in federal or state regulations, or changes in BMS/BHHF policy"?	3.1.4.3 BHHF Services – Due to changes in the operating environment some services have been identified as not being high volume services. The Bureau for Behavioral Health and Health Facilities currently will authorize the following services: Forensic Psychiatric/Forensic Psychological over BHHF cap for service– Volume – 10 per year; High Volume and/or High Cost community-based outpatient or residential services – targeted case management/service coordination, Behavioral Health Specialty, Clinic/Rehab/Behavioral Health Services for the Uninsured/Behavioral Health Support Services/Peer Support Services/Crisis Intervention 1. High volume services in this category will be authorized. They include: Crisis Stabilization (H00036) – **Volume** 28,020 units of service; Assessment by Non Physician (H0031) – **Volume**: 39,930 units of service; Psychiatric Residential Treatment Facilities (PRTF) – Barboursville Facility authorize continued stay after 30 days; **Volume** - 50 admissions per year; substance abuse residential admission authorized and continued stays – **Volume** -3283 individuals; preparation of waiver packets for certification and re-certification – **Volume** - 617 BHHF (Non-Medicaid packets) BMS: We have attempted to capture all areas requiring PA now and in the future; however, future changes at the federal and state level cannot be anticipated. We provide predicted number of prior authorizations in each area. However, these may not be exact. The vendor must anticipate the number of reviews for each category; no increase in payments will be provided for reviews that may exceed the forecast.
18	3.1.9 3.1.2.13	Are there any retroactive review requirements for	At this time, we do not require retroactive/ retrospective review activity in outpatient or inpatient medical; however, we reserve the right to request retrospective review of

	RFP SECTION	QUESTION	ANSWER
		BMS outpatient or inpatient medical services other than required retrospective review on certain service authorizations and emergency PA's?	services at any time for any service.
19	3.1.2.16 3.1.2.17 3.1.2.19	Is BHHF requesting retroactive review of BH funded treatment and support services authorized by the ASO, similar to requirements for BMS and BCF? Please clarify.	BHHF is not requesting retroactive reviews for treatment and support services authorized by the vendor for BHHF.
		Are any or all of the general and mandatory requirements applicable to any or all of the optional services? Please clarify.	The general and mandatory requirements are also applicable to the optional services.
		BHHF has previously required the ASO to validate the CSDR, administer and complete the YSS/YSS-F report and receive the military data set. These requirements/reports are not mentioned in the RFP. Will these	Data Needed to be collected from various providers may vary. Data elements need to be collected from the following providers: Behavioral Health Providers – private free-standing or distinct part psychiatric hospitals as diversion from state operated psychiatric hospitals upon admission; Data needs supplied back to BHHF in a format that will address the requirements for certain federal and state reports. Data items that need to be collected include: unique 11 digit identifier for each BH consumer; age; gender; employment status; diagnosis(es); presenting problems; race; ethnicity; living situation; services provided for SMI; schizophrenia receiving new generation meds; non forensic number served, readmissions within 30 days,

	RFP SECTION	QUESTION	ANSWER
		continue to be part of the scope of work or will these items be eliminated?	readmissions within 180 days; forensic – number served, readmissions within 30 days, readmissions within 180 days; type of setting – psychiatric inpatient or RTC; funding source (Medicaid, Non-Medicaid, Both), length of stay for discharges, those remaining as residents at end of year; satisfaction survey (YSS and YSS-F) satisfaction survey results (need capacity to add/delete data elements during the period of contract with a 90-day notice period. Please see attached BHHF Sample of Data Elements for a more comprehensive report BHHF-A
20	3.1.4.4 gg	The Nursing Home/PASRR eligibility states that the referring physician is to arrange a Level II review. What entity will be utilized for completing this work?	There are current approved Level II evaluators that complete this process.
21	4.5	Can explanatory information be included on the Vendor's Cost Proposal Format/Bid Sheet? If yes, is there any restriction on the type of information that may be included?	Yes, the bidder may include a budget narrative.
22	Page 1 – Request for Quotation – Cover Sheet	The Cover Sheet states there are two mandatory pre-bid meetings for vendors. One is scheduled for 2/11/09 at 1:30 pm and the second is scheduled	This has been updated.

	RFP SECTION	QUESTION	ANSWER
		for 3/3/09 at 1:30 pm. The second bid meeting is scheduled as the same date as the proposal submission is scheduled. Is this a typo? If not, will the Bureau require a vendor's attendance at both meetings?	
23	Page 17 – Sect. 3.1.4.2	How many children, youth and families received Socially Necessary Services in 2008? Please confirm the number of children, youth and families for whom the vendor will be required to perform prior authorization and utilization management services for in 2009, 2010, 2011, 2012 and 2013.	11,850 individual clients were receiving ASO socially necessary services in calendar year 2008. BCF is unable to project the number of children, youth and families that will need SN Services for the years requested.
24	Pages 17-19 Sect. 3.1.4.2	Please provide the total number of BCF/Socially Necessary services requiring prior authorization in 2008. (Services noted on page 18 and 19 of the RFQ, items a-aaa). Please	There were 42,716 Socially Necessary Service referrals submitted for authorization in calendar year 2008.

	RFP SECTION	QUESTION	ANSWER
		provide PA/UM review volume by service	
25	Pages 17-19 Sect. 3.1.4.2	Please provide the number of BCF/Socially Necessary service requests by service (see above) projected for 2009, 2010, 2011, 2012, 2013.	BCF is unable to project the number of SN service requests by service for the years requested.
26	Page 19 Sect. 3.1.4.3	Please provide the total number of BHHF services or programs requiring prior authorization received in 2008. (Services noted on page 19 of the RFQ, items a-n) Please provide PA/UM review volume by service.	Please refer to question #17
27	Page 19 Sect. 3.1.4.3	Please provide the number of BHHF services or programs requiring prior authorization by service (see above) projected for 2009, 2010, 2011, 2012, 2013	BHHF cannot project future number of service needs.
28	Page 19 Sect. 3.1.4.4	What is the total number of Medicaid beneficiaries effective December 31, 2008? How many of these	310,500 Medicaid beneficiaries were eligible 12/31/08. 145,379 Medicaid beneficiaries were enrolled in an HMO as

	RFP SECTION	QUESTION	ANSWER
		beneficiaries were enrolled in the Bureau's Medicaid Managed Care Program and services covered by an MCO?	of 12/31/08.
		As of 12/31/08, how many Medicaid beneficiaries were covered by the Bureau's FFS program?	165,121 Medicaid beneficiaries were covered by the Bureau's FFS program as of 12/31/08.
		Please confirm the number of Medicaid beneficiaries for whom the vendor will be required to perform medical prior authorization and utilization medical prior authorization and utilization management services in 2009, 2010, 2011, 2012 and 2013.	We can only predict the number of requests from what we have received in the past. No accommodations will be made for increases in the number of recipients. PA is required for members in FFS and for those members who are in managed care and the services are carved out. See Attachment BMS- A and BMS A-1 for services covered by the MCO and for those that are carved out of the MCO.
		Medicaid eligibility is determined monthly. Consequently, the number of eligible beneficiaries who may require prior authorization/utiliza	None. BMS Refer to #17.

	RFP SECTION	QUESTION	ANSWER
		tion management services may vary. Given that this is a fixed price contract for up to 5 years, what accommodations will the Bureau authorize that will allow for adjustments in the number of eligible Medicaid beneficiaries who may require prior authorization and utilization management services?	
29	Pages 19-24 Sect. 3.1.4.4	Please provide the total number of requests received for the following services in 2008: Targeted case management; clinic, rehab services and crisis stabilization; general and acute care inpatient hospitalization and continued stay reviews; psychiatric inpatient facility, psych under 21 and psychiatric residential facility services for individuals under	*Psychiatric residential treatment facilities (PRTF) – Barboursville facility authorize continued stay after 30 days 2008 – not authorized; *Substance abuse residential admission and continued stay 2008 – not authorized *High Volume services 1. Community Psychiatric Support (Crisis Stab) H0036 2008 – not authorized; 2. Assessment by Non-Physician (H0031) 2008 not authorized; *preparation of waiver packets for certification and re-certification (this is part of optional services for the MR/DD program) 2008 – not authorized BMS: Please see #146

	RFP SECTION	QUESTION	ANSWER
		21; organ transplant services; partial hospitalization services; inpatient rehab service; general dentistry, orthodontic and oral health services; OT and PT service; speech therapy/language and audiology services; DME/Medical supplies; orthotic and prosthetic services; chiropractic services; diagnostic imaging/radiology; elective surgery procedure; out of network services; podiatry; cardiac rehabilitation; pulmonary rehabilitation; medical case management; psychiatric services; psychological services; home health; hospice; personal care; socially necessary services; MR/DD waiver packets; private duty nursing	
30	Page 21 Sect. 3.1.4.4	Please specify what DME items/medical	Please review the DME policy manual for all PA requirements. The requirements are subject to change as

	RFP SECTION	QUESTION	ANSWER
		supplies will require PA/UM	the Bureau requires. Chapter 506 DME/ Medical Supplies at www.wvdhhr.org/bms/manuals
31	Page 22 Sect. 3.1.4.4	Please include a list of all Diagnostic Imaging/Radiology Procedures that will require PA/UM	See the Radiology Manual for requirements- The requirements are subject to change as the Bureau requires. Chapter 512 Laboratory/ Radiology manual at www.wvdhhr.org/bms/manuals
32	Page 22 Sect. 3.1.4.4	Please include a list of all Elective Surgery Procedures that will require PA/UM	See the Practitioners manual- the requirements are subject to change as the Bureau requires. Chapter 519 Practicioners manual at www.wvdhhr.org/bms/manuals
33	Page 22 Sect. 3.1.4.4	Please include a list of all Out of Network services that will require PA/UM	All services being requested out-of –network and out of state require PA.
34	Page 24 Sect. 3.1.4.4	Please provide a definition/descriptio n of an MR/DD Waiver packet	Please refer to Chapter 513 MR/DD waiver manual section 513.3.1 at www.wvdhhr.org/bms/manuals
35	Pages 19-24 Sect. 3.1.4.4	Please provide the number of requests by service (see above) projected for 2009, 2010, 2011, 2012 and 2013.	See BMS response #17.
36	Pages 24-27 BMS Optional Services cc-gg	For each of the Optional services please provide review volumes for 2008: Aged & Disabled Waiver, total number of request for review received in 2008; MR/DD Waiver, total number of requests	The total number of PAS Level I submissions for 2008 is 20,238; total number of Level II referrals for 2008 is 2044. **AD waiver** July 2008- January 2009 Initial Evaluation : 3404 486 Average per month Reevaluation: 2645 378 Average per month

	RFP SECTION	QUESTION	ANSWER
		for review received in 2008; vision services, total number of vision services billed, approved and denied for payment in 2008; laboratory services, specify by code which laboratory service will require prior authorization and number of lab procedures billed, approved and denied in 2008; NH eligibility and PASRR – total number of NH and PASRR requests received in 2008.	**MR/DD Waiver** Oct. 2008- December 2008 Initials: 216 Recertification: 1566 600 vision services may require PA in the future at the discretion of BMS Lab refer to #9
37	Pages 24-27 Sect. 3.1.4.4	Please provide projected review volumes for each of the following services for 2009, 2010, 2011, 2012 and 2013: Aged & Disabled Waiver, MR/DD Waiver, Vision Services; Laboratory services; NH eligibility and PASRR	Refer to question #17
38	Page 24 Sect. V	Vendors are required to submit a fixed price bid for each of the contract's 5 years (base year and 4	Enrollment is the average number of BHHF individuals served: 55,996; BHHF utilization and review volumes: Enrollment is the average number of BHHF individuals served: 55,996; BHHF utilization and review volumes: *Forensic Psychiatric Forensic Psychological over a

	RFP SECTION	QUESTION	ANSWER
		option/renewal years). Vendors are also required to submit bids separated by Agency (BCF, BHHF and BMS). Finally, all bids must be presented in such a way as to reflect the cost of the bid with options and the cost of the bid minus options. Given this set of requirements, it is imperative that the enrollment, utilization and review volumes requested above are provided by each agency. If this information is not provided, how can a vendor prepare a proposal?	designated monetary cap –*Targeted case management/Service coordination – Behavioral Health Specialty, Clinic/Rehab/Behavioral Health Services for the Uninsured/Behavioral Health Support Services/Peer Support Services/Crisis Intervention High Volume Services include: community psychiatric support (Crisis Stab) H0036 Refer to attachment BHHF-B, Community Psychiatric Support Treatment – Assessment by Non Physician (H0031) Refer to attachment BHHF-C, Mental Health Assessment; Psychiatric Residential Treatment Facilities (PRTF) attachment BHHF-D Barboursville School only; substance abuse residential (refer to attachment BHHF-E, SA Residential Programs); preparation of waiver packets MR/DD Medicaid Manual section 513.3.1 http://www.wvdhhr.org/bms/Manuals /Common_Chapters/bms_manuals_Chapter_500_MRDD.pdf (Refer to Answer to BHHF, 3.1.4.4 aa above) BMS: Refer to #146- PA requirements are subject to change as needed by the Bureau for Medical Services.
39	Page 29 Sect. B	RFQ Section V, Cost Proposal, states that the "proposal must identify cost associated with each review function." The templates provided in RFQ 4.5 have a header that states "reviewed service/program" but do not list the review	Those identified in the Scope of Work

	RFP SECTION	QUESTION	ANSWER
		functions which are to be priced. Please define what review functions should be priced for each agency.	
40	Other	In order to prepare a technical proposal, the RFQ should include a full description of the programs to be prior authorized or a citation to the appropriate Medicaid regulations or manual where the prior authorization requirements for services are documented.	*Forensic Psychiatric/Forensic Psychological forensic evaluations over a certain financial cap; *Targeted Case Management/Service Coordination – Behavioral Health Specialty, Clinic/Rehab/Behavioral Health Services for the Uninsured/Behavioral Health Support Services/Peer Support Services/Crisis Intervention High Volume Services include: Community Psychiatric Support (Crisis Stab) H0036 Refer to attachment BHHF- B, Community Psychiatric Support; Assessment by Non Physician (H0031) Refer to attachment BHHF-C, BHHF, Mental Health Assessment ; *Psychiatric Residential Treatment Facilities (PRTF) (Refer to attachment BHHF Psychiatric Residential Treatment BHHF-D); *Substance abuse residential – refer to attachment, BHHF- E, SA Residential Programs *Preparation of Waiver Packets MR/DD Waiver Manual , section 513.3.1 located at http://www.wvdhhr. org/bms Manuals/Common_Chapters/bms_manuals _Chapter_500_MRDD.pdf BMS: Please refer to Medicaid Policy Manuals at www.wvdhhr.org/bms
41	Page 3 1.4	The RFQ states that vendors " any contact whatsoever with any member of the evaluation committee." Our organization currently has a contract and working relationship with BMS. Consequently,	Yes, they can contact with ongoing operational issues only with no discussion of the RFP

	RFP SECTION	QUESTION	ANSWER
		we may inadvertently have ongoing contact with BMS staff who may be members of the evaluation committee. May we assume that this stipulation does not apply to such contact?	
42	Page 9 – 1.19.9	Does the State's acceptance of a proposal with a prime Vendor and a Subcontractor included in the Proposal automatically imply approval by the Bureau of the subcontractor, or will additional authorization be required?	Approval of a subcontractor merely because it has been proposed does not imply acceptance.
43	Page 10 – 1.19.10	What award date should vendors use for pricing?	Please refer to state purchasing RFP
44	Page 10 – 1.19.10	Is there a difference between contract award date and when the vendor will be required to commence service?	The implementation date will be the date specified by the Bureau and dictated by Purchasing.
45	Page 10 – 1.19.10	Will the vendor be required to have all mandatory or optional programs and services fully	Yes, in many cases, particularly with the optional services, the planned date of the Bureau shall be the implementation date.

	RFP SECTION	QUESTION	ANSWER
		implemented and operational on a date(s) certain?	
46	Page 10 – 1.19.10	What is that date or dates?	For medical and behavioral health prior authorization, the implementation date will be the date specified by the Bureau and dictated by Purchasing.
47	Page 10 – 1.19.10	Will the vendor be afforded a transition/start up period to prepare for full implementation?	The implementation date will be the date specified by the Bureau and dictated by Purchasing.
48	Page 12 – 3.1.2	Please identify any and all vendors that are currently supporting the agency and with whom the contract award recipient will be required to exchange data.	The vendor will be required to exchange data with Families & Children Tracking System, (FACTS) for all Socially Necessary Services authorizations and all Out of State Foster Care Placement authorizations. BMS- The vendor must be prepared to exchange data with whoever BMS needs them to.
49	Page 12 – 3.1.2	Please describe the type, nature and frequency of any data exchange the vendor will be required to support with the agency and any of its vendors.	Behavioral data required for national and state reporting will be accepted and processed as each service provider sends it to the UM & PA entity. Data exchange requirements will be identified once the contract is awarded and systems are organized. Please refer to #48. FACTS – Interface-bi-directional. The current vendor sends FACTS 5 files; FACTS sends the vendor 2 files. All of the files are flat files with Field Delimiter: PIPE (I) Delimited and have various data elements in each file. Refer to Attachment BCF-A. The file length varies from 438 to 1300.
50	Page 12 – 3.1.2	Please describe all interface data exchanges that the vendor will be required to support	Must be compatible with service providers and agency systems. All data is to be handled as highly classified and encrypted using a 256 bit AES Encryptions method. BMS: Data exchange requirements will be identified once

	RFP SECTION	QUESTION	ANSWER
		and the specifications required to support those exchanges	the contract is awarded and systems are organized. Refer to #48.
51	Page 12 – 3.1.3	Please describe the specification that the vendor will be required to support in order to ensure secure electronic communications with the BMS, BCF, BHHF and all subcontractors.	UA & PA Entity must have a secured FTP site that the Bureau will extract files that have been compressed and encrypted using WIN ZIP 12 and encrypted using 256 bit AES Encryption method. BMS – refer to #48 and #49 FACTS – The electronic transfer will occur via secure Implicit SSL FTP to a DHHR server. The password protected files are transferred daily Monday through Saturday.
52	Page 13 – 3.1.9	Please identify those specific BMS, BCF, BHHF policies that describe or instruct the vendor on how to conduct service and retrospective reviews for authorizations.	BHHF – Retrospective Reviews for authorizations. For those codes that are parallel to Medicaid, BHHF will mirror Medicaid policy. BCF: The policies on how to conduct service and retrospective reviews for authorizations will be developed after award of the contract. Please see the Bureau's policy manuals at www.wvdhhr.org.
53	Page 13 – 3.1.11	"Vendor is to provide timely reports and accurate reporting and analysis of practices for all areas of review." What does "analysis of practices" mean in this context?	Data elements collected by the providers will need to be submitted back to BHHF in reports that can be utilized to fulfill the reporting requirements of such reports as NOMS, TEDS, Block grant, etc. Those services that are prior authorized will also need reported back to BHHF and the provider. The vendor must summarize via report on what the data is telling us.
54	Page 13 – 3.1.11	Will the State require the MMIS vendor to provide the data necessary at no cost to the PA vendor to produce the	If it is decided that all prior authorizations will be placed in the MMIS, reports will be generated from the MMIS.

	RFP SECTION	QUESTION	ANSWER
		required reports described in this section?	
55	Page 13 – 3.1.11	If not, what is the charge for this data?	There would not be a charge for reports generated by the MMIS.
56	Page 13 – 3.1.17	Who will generate the reports set forth in this section, the Dept's fiscal agent or the PA vendor?	It is dependent upon where the prior authorization is being generated.
57	Page 13 – 3.1.17	If it is the PA vendor, will the State require the fiscal agent to provide the data required for the reports to the PA vendor at no cost?	There would not be a charge for reports generated by the MMIS.
58	Page 13 – 3.1.17	If the answer to this is no, what will be the cost of the data required for the reports?	There would not be a charge for reports generated by the MMIS.
59	Page 13 – 3.1.17	"Including but not limited to claims analysis related to the services that receive prior authorization." On what schedule, in what format, will the Dept. provide the vendor with the claims to be analyzed?	Data elements collected by the providers will need to be submitted back to BHHF in reports that can be utilized to fulfill the reporting requirements of such reports as NOMS, TEDS, Block grant, etc. Those services that are prior authorized will also need reported back to BHHF and the provider. MMIS – To be determined after contract award.
60	Page 13 – 3.1.17	Please list the data elements that are to be collected.	BHHF: Refer to 3.1.1.4 #29 MMIS – To be determined after contract award.

	RFP SECTION	QUESTION	ANSWER
			FACTS – Please see Attachment BCF-A
61	Page 13 – 3.1.17	Please describe the types of claims analyses that may be required.	Provide a Quality analyses based upon data collected, prior authorization for services, continued stay, concurrent review, retrospective review and denials to BHHF or other activities as proposed by the Vendor and approved by Agency and BHHF. BMS – To be determined after contract award.
62	Page 13 – 3.1.17	What are expected volumes of claims to be analyzed?	Claim Volume is addressed in question # 17, #38 , and data elements #53 BMS – To be determined after contract award.
63	Page 14 – 3.1.2.2	In order for the vendor to validate a member's eligibility and/or MCO enrollment status, will the Bureau or its MMIS vendor provide the vendor with a copy of its member eligibility file?	The current process is that the provider submits financial eligibility to the UM & PA entity. The UM and PA entity reviews to ensure all components are completed and assigns a unique number for the member. The Bureau is open to make changes to this process to ensure the most efficient and cost effective methods are utilized. BMS – No eligibility file will be provided by the Bureau or its Fiscal Agent. Vendor will access the MMIS directly to verify eligibility.
64	Page 14 – 3.1.2.2	Could the file be transmitted daily in order to ensure accurate and complete information regarding Medicaid eligible beneficiaries?	BMS – No eligibility file will be provided by the Bureau or its Fiscal Agent. Vendor will access the MMIS directly to verify eligibility.
65	Page 14 – 3.1.2.2	Would there be any cost to the vendor for a daily transmission/receipt of a Medicaid eligibility file?	BMS – No eligibility file will be provided by the Bureau or its fiscal agent. Vendor will access the MMIS directly to verify eligibility.
66	Page 14 – 3.1.2.2	What would be the	BMS – No eligibility file will be provided by the Bureau or

	RFP SECTION	QUESTION	ANSWER
		cost of the daily transmission of that file?	its Fiscal Agent. Vendor will access the MMIS directly to verify eligibility.
67	Page 14 – 3.1.2.3	Would the Bureau consider adopting an alternative time frame for the vendor to respond to any prior authorization request or reconsideration? Specifically, would the Bureau adopt the URAC time frames for case review as an alternative standard for performance? For example: Prospective Review (UM conducted prior to the patient's admission, stay or other service or course of treatment. It is a review conducted before the care is delivered. Examples: patient is scheduled for elective total knee replacement/imaging study, etc. in the future. A. non-urgent/routine care - 15 calendar days from receipt of request B. urgent care – 72 hours from receipt of request.	No. Unlike the commercially insured, Medicaid members may only have coverage for one month; therefore, prior authorization decisions cannot take days as outlined in the question.

	RFP SECTION	QUESTION	ANSWER
		Retrospective Review – (UM conducted after services, including outpatient procedures/services) have been provided to the patient. Since most of our inpatient reviews are only approved for the admission, and not the additional length of stay, if the admission request is received after the admission date, by definition this is considered a retrospective review. Other examples include if a patient received a piece of DME equipment/imaging study/etc and the provider submitted the authorization request after providing the equipment/imaging study/etc. – 30 calendar days from receipt of request; Concurrent/continued stay review (UM conducted during patient's course of treatment including outpatient	

	RFP SECTION	QUESTION	ANSWER
		procedures and services. For outpatient services such as PT, ST, OT, etc., where X # of services are authorized, if during the treatment course the provider determines additional services are needed, then a concurrent review is conducted and additional services may or may not be authorized. The clarification on timeframes is as follows: a. If the case is an urgent care case and the request is received less than 24 hours prior to the end date of the previously certified services, then a decision must be rendered within 72 hours; b. If the case is an urgent care case, and the request is received at least 24 hours prior to the end date of the previously services, then a	

	RFP SECTION	QUESTION	ANSWER
		decision must be rendered within 24 hours.	
68	Page 14 – 3.1.2.6	Please provide the number of member hearings by category of review that have been held over the past five years and the number that are projected to be held in the next five years.	There is not a history of hearings for BHHF in the categories that have been specified for this RFP. Please refer to appeals attachment BMS- B for BMS fair hearings. Data can only be provided for calendar year 2008. The number of appeals cannot be projected into the future.
69	Page 15 – 3.1.2.14	Will the State require the current fiscal intermediary to allow automated exchange of data through EDI or Web Services?	The socially Necessary Service and Out of State Placement Authorizations must conform to the format and standards outlined by the Bureaus. Potentially, the vendor must be prepared to do whatever the Bureau decides that is most efficient for meeting the needs of the Bureau.
70	Page 15 – 3.1.2.14	Does the definition of direct data entry mean the electronic transfer of batched PA review decisions or does direct data entry mean manual entry of each individual PA review decision into the MMIS?	Potentially both. The vendor must be prepared to do whatever the Bureau decides that is most efficient for meeting the needs of the Bureau.
71	Page 15 – 3.1.2.14	Would either option be acceptable to the Bureau?	The vendor must be prepared to do whatever the Bureau decides that is most efficient for meeting the needs of the Bureau.
72	Page 15 – 3.1.2.14	Please provide exchange specifications related	Exchange specifications will be provided to the vendor once it is decided by the Bureau which method will be utilized.

	RFP SECTION	QUESTION	ANSWER
		to the direct data entry of prior authorizations (individual PA and/or batched Pas) into the PA module of the MMIS.	
73	Page 15 – 3.1.2.15	"Vendor shall review both in network and out of network services for medical necessity at the closest in network location." This requirement is unclear. Explain further.	See question #153
74	Page 16 – 3.1.3	What is the preferred method of secure electronic communication?	BMS – Through a secured FTP site for MMIS. The electronic transfer will occur via secure Implicit SSL FTP to a DHHR server. The password protected files are transferred daily Monday through Saturday. This applies to the social necessity and out of state foster care placements only.
75	Page 16 – 3.1.3.1	What data elements are required in the standard reports?	Refer to #17
76	Page 16 – 3.1.2.21	Please provide a copy of the criteria the Bureau will use to conduct its readiness assessment.	Refer to #154
77	Page 16 – 3.1.3.1	Please identify by form, content and frequency all standard reports the Bureau will require of the vendor.	BMS – to be determined after contract award.

	RFP SECTION	QUESTION	ANSWER
78	Page 16 – 3.1.3.2	How many ad hoc reports should the Vendor assume each contract year for each category of review?	That is unknown, hence, ad hoc.
79	Page 16 – 3.1.3.2	Will the vendor be reimbursed for costs it may incur in the production of any ad hoc report requested by the Bureau?	Cost of ad hoc reports will not be reimbursed separately.
80	Page 16 – 3.1.3.2	If not, please describe how the vendor will be compensated should any unbudgeted expenses be incurred in the production of ad hoc reports.	Costs should be included in the bid.
81	Page 16 – 3.1.3.3	Please identify by form and content all the standard monthly reports the Bureau will require of the vendor.	(1) Data elements need to be collected daily from various providers and submitted to BHHF daily via demographics and other data; (2) Development of reports that will assist with required reporting; (3) prior authorization will be completed on selected services and submitted back to BHHF and the provider. BMS – to be determined after contract award.
82	Page 16 – 3.1.3.3	Please identify the sub contractors to whom reports will be delivered.	Reports will be delivered to BHHF, BCF, and BMS additional reports for subcontractors will be determined after contract award.
83	Page 17 – 3.1.3.7	"Monthly Reports to include the cost of the services and the cost of UM activity." Is it correct to assume that data on	Yes

	RFP SECTION	QUESTION	ANSWER
		the cost of services will be included in the claims data the Department will provide (see 3.1.17)?	
84	Page 17 – 3.1.3.7	If the answer to the above is no, in what form will the Dept. provide data on costs of individual services to allow vendor to fulfill this requirement?	Not applicable
85	Page 17 – 3.1.3.7	Does the Bureau have a formula that the vendor should use in calculating the cost of UM activity?	No
86	Page 17 – 3.1.3.8	Please identify by form and content what the Bureau will require related to the Quarterly Report summarizing training and technical assistance activities for utilization management.	Information will be provided upon award.
87	Page 17 – 3.1.4.1	"Verify and communicate to agency if there are other payer sources involved with the services being requested." How extensive a verification does the	Refer to #156

	RFP SECTION	QUESTION	ANSWER
		Department want? This could be verification from the requesting provider, from the recipient, or from querying other payers' data, for example.	
88	Page 19 – 3.1.4.4	Please provide a matrix showing the Medicaid eligibility classifications whose Medicaid benefits/services are provided by a MCO and the services that are the responsibility of a MCO.	See Attachment BMS – A and BMS A-1 Provides those services covered by the MCO and carved out of the MCO.
89	Page 19 – 3.1.4.4	Please specify by Medicaid classification and service/benefit, those services that will require PA/UM by the vendor.	Those may be found in the RFP and Medicaid manuals.
90	Page 20 – 3.1.4.4d)	Current Bureau policy does not require the issuance of an approval letter, only a denial letter. Is this requirement a change in Bureau policy?	It is still the policy that denial letters are to be provided for every service that is denied. It is not a requirement to provide approval letters at this time, but the vendor must be able to implement a process if the Bureau should need to implement.
91	Page 20 – 3.1.4.4d)	May the vendor forward required notices to members' legal representatives by mail rather than electronically? Many	Yes.

	RFP SECTION	QUESTION	ANSWER
		members' representatives will not be able to receive information electronically.	
92	Page 23 – 3.1.4.4y)	Please provide a copy of the Bureau's criteria for prior authorization for Personal Care or a reference to a location where it may be found.	Chapter 517 Personal Care Policy Manual at http://www.wvdhhr.org/bms/Manuals/Common_Chapters/bms_manuals_Chapter_500_Pers_Care.pdf
93	Page 24 – BMS Optional Service	Is the vendor required to include in its proposal a program description and budget for each optional service?	Yes
94	Page 24 – BMS Optional Service cc) A&D Waiver	Please clarify the Bureau's intent" "Contact must be established with the initial applicant, and arrange for a face to face evaluation in order to meet the time frame of a completed review within 30 days of the referral date." Is this 30 calendar days or 30 working days?	Working days
95	Page 24 – BMS Optional Service cc)A&D Waiver	If the vendor is to complete reviews within 30 days, and members must be given a 2 week advance notice of	Correct

	RFP SECTION	QUESTION	ANSWER
		review, it only leaves 10 days for the completion of the assessment and issuance of a determination. Is that correct?	
96	Page 24 – BMS Optional Service cc) A&D Waiver	Would the Bureau be willing to consider exceptions to this requirement in the event reviews are cancelled or need to be rescheduled for reasons not directly controlled by the vendor or in instances where a potential closure decision is issued?	To be determined upon award
97	Page 24 – BMS Optional Service cc)A&D Waiver	Does the Bureau mean the assessment must be completed within 30 days or that the final determination must be issued within 30 days?	Assessment must be completed within 30 days.
98	Page 26 – BMS Optional Service gg) Nursing Home	Current Bureau policy does not require physician review of a PAS request that could not be approved by a nurse. Is this a new program requirement?	This process is currently in place with other authorization denials. The need for physician review would occur only "if a decision cannot be made at the RN level of review."
99	Page 26 – BMS Optional Service gg) Nursing Home	What is the effective date of this new	This would be effective immediately upon award of this contract.

	RFP SECTION	QUESTION	ANSWER
		requirement?	
100	Page 26 – BMS Optional Service gg) Nursing Home	Will this change also be made in the Aged/Disabled Waiver program to maintain consistency between the two programs?	This section does not address the Aged/Disabled Waiver Program.
101	Page 26 – BMS Optional Service gg) Nursing Home	The Bureau's existing process does not require the vendor to seek additional information from the provider in order to complete the initial review of the PAS. Please elaborate on when a vendor will be expected to request additional information.	When appeals are filed for hearings, the supportive documentation is needed and therefore the vendor will provide the information for this denial to support their decision and be referenced during the hearing.
102	Page 27 – BMS Optional Service gg) Nursing Home	The Bureau currently requires only that denial letters be sent to the member or his/her legal guardian. Is it a policy change to start sending approval letters?	It is still the policy that denial letters are to be submitted to the member, approval letters are not required at this time.
103	NA General Information	Would the Agency please provide the names of all vendors that attended the Mandatory Prebid Conference on February 11, 2009.	See attachment BMS- C sign in sheet

	RFP SECTION	QUESTION	ANSWER
104	General	Please provide the number of prior authorization reviews performed by the incumbent or another vendor within the last 12 months for the Bureau for Medical Services, Bureau for Behavioral Health and Health Facilities, and the Bureau for Children and Families.	Refer to #146
105	General	Please provide the number of retrospective reviews performed by the incumbent or another vendor within the last 12 months for the Bureau for Medical Services, Bureau for Behavioral Health and Health Facilities and the Bureau for Children and Families.	20,154 retrospective reviews within the last 12 months were completed.
106	General	Please provide the number of hearings initiated from review performed by the incumbent or another vendor within the last 12 months for the BMS,	BHHF-There were none in the last 12 months. There have not been any hearings related to SN Services within the last 12 months. Please see attachment D for calendar year 2008 for Medicaid fair hearings.

	RFP SECTION	QUESTION	ANSWER
		BBHF and the BCF.	
107	General	Please provide the number of retroactive quality reviews performed by the incumbent or another vendor within the last 12 months for the BMS, BBHF, and BCF.	BHHF – None BCF: Between November 2006 and June 2008, 95 providers were reviewed. This involved a record review of 850 unduplicated consumers' records and service documentation. For those providers with minimal clients, desk reviews were performed. All others were on site. BMS: Between Nov. 2006- April 2008 310 reviews conducted
108	General	Please provide the name of the incumbent for each of the current contracts listed in this RFQ.	May be requested through state purchasing.
109	General	Please provide the contract dollar amounts and time frames for each of the current contracts listed in this RFQ.	Contract information may be requested through state purchasing
110	General	Please provide the names of the companies that attended the Mandatory Prebid Conference.	See sign in sheet attachment BMS-C
111	General	May the due date for the proposal be extended?	The due date has been extended
112	General – Terms & Conditions – 1.2 Project, p. 3	Would QIO-like status be acceptable in regards to your preference for a QIO firm?	Yes
113	General – Part 3, Scope of Work, 3.1.6, p. 12	Please provide	The process and other regulations for the specific services

	RFP SECTION	QUESTION	ANSWER
		further information on "Special Medical Card" process and other regulations for out of state residential facilities.	covered under the "Special Medical Card" is the same as those for individuals covered through Medicaid. The process and other regulations for out of state residential facilities is the same as for those similar type facilities within WV. Special medical card is a limited eligibility passed to MMIS from FACTS, in the form of an eligibility identifier and an eligibility period.
114	Part 3, Scope of Work, 3.1.14, p. 13	Please verify if the vendor will develop the process for the health assessment or the analysis of the health assessment.	Page 24 3.1.4.4 V references that this will be developed in conjunction with the contractor.
115	Part 3, Scope of Work, 3.1.9, p. 13	This section refers to providing authorization requests as outlined in policy. May we obtain the policy for review?	BHHF – Refer to attachments. BHHF – E SA Residential Programs; BHHF-C, Mental Health Assessments; BHHF –B Community Psychiatric Support, and BHHF- D Psychiatric Residential Treatment BMS: All policy manuals can be obtained at our website, www.wvdhhr.org.
116	Part 3, Scope of Work, 3.1.2.3, p. 14	Please clarify if 48 hours is considered two business days in the review process.	Yes.
117	Part 3, Scope of Work, cc-hh, pp. 24-27	Are the optional services listed currently being performed by the incumbent or another vendor?	The optional services have a variety of different deliverables within the optional services. There are multiple vendors that do some pieces of the optional services.
118	Part 3, Scope of Work, BMS, cc-hh, pp. 24-27	If the optional services listed are currently being performed by the incumbent, or another vendor, please provide the number of reviews	Refer to # 36 for Nursing Home, MR/DD Waiver and AD Waiver information

	RFP SECTION	QUESTION	ANSWER
		performed by the incumbent or another vendor within the last 12 months for the BMS.	
119	3.1.4.4 hh	Concerning the SCHIP/PEIA Optional bid, given that the scope of work will be determined by another agency at some future time and the RFP just requires willingness to work with these agencies, can the cost be N/A and not impact scoring rules?	Refer to #16
120	3.1.4.4 - 3.1.4.3	Some UM options and optional services indicate that some services require prior authorization and others indicate that other/all services in the program may be subject to PA at some future date. How should pricing be done to account for additional services the Dept. may wish to PA in the future based on the statement in 3.1.4.4 and 3.1.4.3 that "specific codes	The contract is a fixed price contract. Refer to #17

	RFP SECTION	QUESTION	ANSWER
		or services may be subject to change due to changes in national codes, changes in federal or state regulations, or changes in BMS/BHHF policy"?	
121	3.1.9 – 3.1.2.13	Are there any retroactive review requirements for BMS outpatient or inpatient medical services other than required retrospective review on certain service authorizations and emergency PA's?	No, not at this time.
122	3.1.2.16 – 3.1.2.17 – 3.1.2.19	Is BHHF requesting retroactive review of BH funded treatment and support services authorized by the ASO, similar to requirements for BMS and BCF? Please clarify.	No
		Are any or all of the general and mandatory requirements applicable to any or all of the optional services? Please clarify.	Yes all.
		BHHF has previously required	Refer to 3.1.1.4 question #29

	RFP SECTION	QUESTION	ANSWER
		the ASO to validate the CSDR, administer and complete the YSS/YSS-F report and receive the military data set. These requirements/reports are not mentioned in the RFP. Will these continue to be part of the scope of work or will these items be eliminated?	
123	3.1.4.4 gg	The Nursing Home/PASRR eligibility states that the referring physician is to arrange the Level II review. What entity will be utilized for completing this work?	Refer to #20
124	4.5	Can explanatory information be included on the Vendor's Cost Proposal Format/Bid Sheet? If yes, is there any restriction on the type of information that may be included?	Refer to #21
125	Part 3 – Scope of Work	Must vendors bid on all options as well as the mandatory sections of the RFP?	Yes with the exclusion of PEIA and SCHIP

	RFP SECTION	QUESTION	ANSWER
		Do time frames in the RFP refer to business or calendar days?	Business days.
126	3.1.6	Does this include review of medical necessity for adults covered under Special Medical Cards or only children?	No, it will not include adults through our Adult Services policy/programs.
127	3.1.8	Please clarify this requirement "Vendor is to have the capacity to accept all prior authorizations in a web based format".	Providers are moving to EHR, thus, we need to be prepared to receive medical documentation through the internet.
128	3.1.10	What level of access and types of data files will be available to complete vendor requirements?	BMS – See attached BMS-DInput Prior Authorization File and Field Information. However, this is subject to change if BMS chooses to do so. (The winning vendor will be granted access to the files containing the submitted SNS authorization requests. (attachment BCF-A show the file format and data sent to the current vendor. Actual files can not and will not be shared with the general public. The files are uploaded to web server that is then accessed by the current vendor.
129	3.1.15	What is the role of socially necessary providers in this section?	There will be similar basic information about children, youth and their families that will be expected to be gathered, including but not limited to: demographic information, eligibility for SN services, out of state placement, special medical card, level of service need, information to be collected upon initial entry into the system, at regular intervals and at critical junctures. The

	RFP SECTION	QUESTION	ANSWER
			ability to "cross-reference" this population with BMS & BHHF will allow for a total picture of what resources a child, youth and their families are receiving.
130	3.1.2	This section indicates "Vendor is responsible for any data processing or system modifications required to accomplish system access during the life of the contract without the requiring of modifications to the existing (agency) systems." A) Since the agency is requesting a comprehensive UM system that would be used across the Bureaus, will the agency provide additional details about the points of contact for each of the existing systems, i.e., MMIS, FACTS or other systems currently used by the Bureaus involved in this bid? B) Will the agency be able to provide any advance information on file layouts expected for each of the Bureau's	The vendor will be able to provide interfaces and system modifications to meet the needs of the Bureaus. FACTS: There is bi directional file exchange in place for the socially necessary services and out of state foster care authorizations. Thecurrent vendor accesses a secured web server to download the service referrals needing to be authorized and to up load the authorizations for referrals previously downloaded. Server addresses, and the names of system administrators for the FACTS system will not be shared at this time. The file layouts for the files that FACTS sends attachment BCF-AThere are no vendors involved with the FACTS system, it is administered and supported by DHHR/ Management Information Systems personnel.

	RFP SECTION	QUESTION	ANSWER
		systems? C) Who are the current vendors for each of the existing systems who the successful offeror will have to interface with?	
131	3.1.2.2	Indicates that other primary coverage must be verified and the provider must be notified that there is another primary payer. In instances when there is verification of another primary payer, prior authorization requests would not be processed. Is this understanding correct?	TPL policies can be found in Chapter 800, the policy manuals, at http://www.wvdhhr.org/bms/Manuals/Common_Chapters/bms_manuals_Chapter_800.pdf
132	3.1.2.2	This section spells out the actions the vendor must take to validate a member's eligibility and Managed Care enrollment status of each request. Can the vendor build an interface to the agency's eligibility system so eligibility can be validated electronically within	BHHF: Currently the BHHF provider submits the eligibility in an approved BHHF format to the UM entity BMS – No eligibility file will be provided by the Bureau or its Fiscal Agent. Vendor will access the MMIS directly to verify eligibility.

	RFP SECTION	QUESTION	ANSWER
		the vendor's own system. Please clarify.	
133	3.1.2.21	Clarify the implementation/start-up period and how it relates to the turnover plan.	The turnover plan relates to how the bidder would transition services to a new vendor.
134	3.1.2.6	This section requires the vendor to attend the hearing either in person or telephonically when a member disputes their denial of services. Can the agency furnish data on the annual volume for the latest report period of how many disputed hearings were held?	BHHF – None BCF: For SN Services currently the vendor does not participate in the state-level denial conference. We have not had any hearings. Should the denial move to a hearing level, our expectation would be that they participate. Please see the attachment BMS-B BMS fair hearings for calendar year 2008.
134	3.1.3.1	What specific reports are considered "standard" by each Bureau?	BCF: Reports are generated monthly, quarterly and annually. These reports include: 1. The Socially Necessary Providers Data Submission Activity Report is an aggregate reports that includes: • *Socially Necessary Service Providers Aggregate Report information* that includes service requests by the provider (licensed behavioral health, private in-state and out-of-state), such as, Service Requests (provider description, requested received, request errors, duplicates, those automatically closed, those processed, and percentages of those processed), Processed Service Requests (provider description, those processed, denials, those pending to close, pending to authorization, those automatically authorized, and authorized percentage rate), and Authorization Adjustments: Modification of

	RFP SECTION	QUESTION	ANSWER
			an Existing Authorization (provider description, modification that increased authorized units and/or expanded the authorized data rage, and modification decreased the authorized units and/or decreased the authorized data range. • *The Socially Necessary Service Request Dispostion* report include an Individual Provider Summary that summarizes referrals processed, denials, those pending to close and authorize, those that were automatically authorized. • *The Social Necessity Providers Data Submission Activity* Report provides information on each individual provider. 2. The Socially Necessary Authorized Service Breakdown report provides information on all socially necessary service by services, the program (Child Protective Services or Youth Services) and program areas. This same information is provided by BCF DHHR Region, county, and individual provider. 3. The Out of State Providers Data Submission Activity Report provides both an aggregate and individual report on out of state residential providers. This report includes the disposition of submissions and the disability group by authorized and review of services. Ad hoc reports are requested to assist in completing federal reports, legislative requests, etc. We would anticipate at a minimum one per month, not to exceed six per month. BHHF and BMS will discuss and determine reports after the award with the vendor.
135	3.1.4.1	This section states that "the fiscal agents of Medicaid and subcontractors' online system can assist with the verification of some of the following factors:" 1) Can this	BMS – No eligibility file will be provided by the Bureau or its Fiscal Agent. Vendor will access the MMIS directly to verify eligibility. (Fine, but does the vendor have an interface to MMIS system?)

	RFP SECTION	QUESTION	ANSWER
		verification be accomplished within the vendor's own system through an interfaced data set? 2) Can the agency identify the different systems with which the vendor will have to interface?	FACTS is one of the systems.
136	3.1.4.1	Will an eligibility feed be available from MMIS? If not, who will be providing eligibility information?	BMS – No eligibility file will be provided by the Bureau or its Fiscal Agent. Vendor will access the MMIS directly to verify eligibility.
137	3.1.4.1	Who will provide provider enrollment data, including NPI?	BMS – The Bureau's Fiscal Agent will provide the provider enrollment data including NPI for Medicaid either through the current MMIS or by some other means.
138	3.1.4.2 aaa	Other Socially Necessary Services (optional) are these additional SN services within the current program areas or are these new program areas and/or target populations?	We anticipate the expansion of SN Services now referred to ASO Chafee Pre-Placement Activities. Phase Two-Part One & Phase Two-Part Two to be replaced with a minimum of 10 but no more than 15 more descriptive SN services for this population. In addition to these additional services, BCF may request additional SN services in each major program of 5 additional SN services than what currently is being offered.
139	3.1.4.4 n	The RFP references n."Diagnostic Imaging/Radiology Services" as mandatory. Diagnostic Imaging/Radiology services are found within Chapter 512 Laboratory and	Diagnostic imaging/radiology services require prior authorizations, per the Chapter 512 Laboratory/ Radiology manual at www.wvdhhr.org/bms/manuals policy manual and refer to question #9.

	RFP SECTION	QUESTION	ANSWER
		Radiology. Laboratory Services are listed as optional on page 26 section 3.1.4.4 ff. Are additional laboratory services in Chapter 512 going to require prior authorization. Please specify.	
140	3.1.4.4 ee Vision (Optional)	Prior authorization in the Chapter 52 vision services states prior authorization is only required for those participants in MCO's. Will these prior authorizations now be the responsibility of the ASO? Will additional members' vision services require prior authorization as well? If so, which services will be subject to prior authorization?	When Medicaid members are enrolled in MCO's, the MCO determines prior authorization requirements for services provided by the MCO. Some vision services may require prior authorization if the member is in FFS Medicaid. At the direction/ discretion of Medicaid.
141	3.1.4.4	This section lists the different areas the vendor is responsible for prior authorizing services. Can the	Refer to #146 Refer to #13 Refer to #145 Refer to attachment BMS- B Appeals

	RFP SECTION	QUESTION	ANSWER
		agency provide data on the most recent 12 months for the volumes of prior auth requests in each of these areas? This infor will assist the vendor in determining the level of effort required for each, staffing levels and appropriate pricing for the cost proposal. Please include following info: 1) volume of prior auths by service type (e.g. DME, acute inpatient) 2) Volume of concurrent reviews for applicable service types, by type of service 3) Volume of retroactive reviews by type of service 4) Number of individuals currently under case management 5) Percent of each review type (prior auth, concurrent, retroactive)referred to physician for review 6) Percent of each review type denied; 7) Percent of	

	RFP SECTION	QUESTION	ANSWER
		each review type appealed or reconsidered	
142	3.1.4.4	Are these medical necessity/authorization reviews submitted electronically by providers? If they are not, can the Bureau identify the estimated percent that are received telephonically or by fax?	BHHF and BCF- 100% of behavioral health and socially necessary services are web based submissions. BMS -Estimated medical/ behavioral health PA 62.6%fax, 16% telephone, 14% electronic, 6.9% mail.
143	Section V	This section states "The bids shall be separated by Agency (BCF, BHHF and BMS) but the total is the evaluated cost. Bid prices must be expressed as a fixed price bid for each of the 5 years. Proposal must identify cost associated with each	BHHF: Data elements need to be collected daily from various providers and submitted to BHHF daily via demographics elements and other data elements; development of reports that will assist with required reporting; prior authorization will be completed on selected services and submitted back to BHHF and the provider. 1. Yes 2. No all sections will be included in the evaluation 3. See section 3.1.4.2, 3.1.4.3, 3.1.4.4 4. Refer to #146 5. Yes, the annual aggregate cost per line item should be provided

	RFP SECTION	QUESTION	ANSWER
		review function". Related to this, Section 4.5ff has Cost Proposal Format/Bid Sheets. We have several questions related to these Bid Sheets: 1) Does the agency expect 3 separate bid cost proposals by Agency but one integrated technical proposal to conduct all of the services in the RFP? 2) Are the mandatory technical and cost proposals scored separately from the optional technical and cost proposal(s)? If not, how will the Bureau handle the evaluation for components that are not selected? 3) The section states the proposer must identify cost associated with each review function. In order to provide a level of detail that is consistent, will the agency consider identifying all review areas that have to be priced individually	

	RFP SECTION	QUESTION	ANSWER
		or this left to the discretion of bidder? It would appear that different bidders will provide different levels of detail since the specific review functions are not identified on the Cost Proposal/Bid Sheets. Can the Agency clarify this so that price comparisons among Vendors can be consistent?4) Will bidders be provided with utilization and cost data for the mandatory and optional scope of work in the RFP? 5) 3.1.4.4 – this section a)-bb) identifies all of the different required review areas. Section 4.5 Cost Proposal Format Bid Sheet/Bid proposal lists Reviewed Service/Programs categories: i. Is a Vendor to supply an annual aggregate cost for each of these specific review areas (a-bb) on the Cost Proposal form? ii.	

	RFP SECTION	QUESTION	ANSWER
		Should the cost reflected on these line item reflect all Vendor costs (i.e., implementation, ongoing review costs, occupancy costs, personnel and related costs)?	
144	Page 26 – Section 3.1.4.4 gg	Would the State consider alternative streamline methods (such as a web-based system) to perform and track PASRR as long as it was compliant with Federal statutes? Is this for Level 1 or Level 2 of PASRR reviews?	The PASRR evaluations will not be able to be web based. The state regulations for signatures that are required when the PASRR Level II evaluator completes the onsite, face to face assessment must be on file. This assessment can be completed on individuals that are placed out of state and are seeking placement in WV who trigger a Level I. However, the face to face assessments with record and staff interviews have an "actual" time limit. This can only be completed by an approved Level II PASRR evaluator.
145	Page 15 3.1.2.7	Is there a current percent of cases that are referred to peer review? What is the current denial rate?	Total requests for prior authorization were 130,648 with 108,920 requests initially approved. 108,016 requests were denied at the first level physician reviewer. 2,890 requests denied were referred to a second physician reviewer and denials were upheld. The current denial rate is 16%.
146	Page 19 – 24 3.1.4.4 a-bb	Please provide the review volumes that occurred in the last contract for each review type. The number of initial prior authorization requests,	The number of initial prior authorization requests, reconsiderations, and appeals: Prior authorizations – 130,648 Reconsiderations – 6,360 Appeals –refer to fair hearing attachment BMS-B Refer to attachment BMS-E for detailed PA requests

	RFP SECTION	QUESTION	ANSWER
		reconsiderations, and appeals.	Behavioral health outpatient CY 2008 # of individual service requests submitted 348,421 MR/DD Waiver # of individual service requests submitted 136,358
147	Optional – Vision (ee)	Total number of vision services billed, approved and denied for payment in 2008?	76,696 vision services were billed, 76,696 paid, and none denied. Vision services may require PA in the future at the direction of BMS.
148	Optional – Laboratory (ff)	Please specify by code which laboratory service will require prior authorization. The number of lab procedures billed, approved and denied in 2008.	Refer to #9
149	Page 14 – 3.1.2.2	There is a possibility that at the time the prior authorization is approved, the benefit level or eligibility could be updated subsequently and therefore the prior authorization determination made may appear to be inaccurate retrospectively. Is it Medicaid's fiduciary responsibility services approved outside of the benefit plan or eligibility?	If the benefit, eligibility and insurance are verified before the authorization is given, and policy requirements are met, then there should be very few episodes where this scenario would occur.
150	Page 14 – 3.1.2.3	Please define the	The response relates to the outcome of the review. If

	RFP SECTION	QUESTION	ANSWER
		word "respond" in this section. Does the "response" include the prior authorization number? What if the case needs to be referred for physician review? Is more time allowed for this function?	information provided is enough to authorize the service, it is expected that the authorization number would be communicated within 48 hours of the request. If the information received from the provider is not adequate, it would be expected that the provider would also be notified of this as well. Added on the end
151	Page 15 – 3.1.2.7	Please provide the number of meetings to take place and where they will take place.	Meetings will take place at any time at the request of Medicaid.
152	Page 15 – 3.1.2.11	Please define which approval notices need to be provided in writing. Is electronic notification sufficient?	At this time, Medicaid does not provide approval notices; however, the vendor shall be ready to implement such a process in the event Medicaid requires it. No additional payments will be made for this service.
153	Page 15 – 3.1.2.15	Please define what is meant by "closest in the network location". Closes to what/whom?	Regardless of requested service location, if the service requested can be provided in state, the member should be directed back to their PCP and facility closest to their home. For example, a member living in Charleston needs a coronary bypass, an authorization to Cleveland Clinic would not be approved unless extenuating circumstances existed; the member should be directed to CMAC.
154	Page 16 – 3.1.2.21	Please provide a copy of the criteria the Bureau will use to conduct its readiness assessment.	At this time, there is no criteria.
155	Page 17 – 3.1.3.9	What is the expected source for the "symptom otology"	This relates to the information collected for the prior authorization.

	RFP SECTION	QUESTION	ANSWER
		data for this report?	
156	Page 17 – 3.1.4.1 Bullet #5	Please define "verify and communicate to agency if there are other payer sources involved with the services being requested." Is the contractor supposed to track every telephone call and request received and the outcome of the call?	If there is another payer source found during conversations with providers or members, that information must be communicated to BMS. Processes may be defined/ agreed to after contract award.
157	Page 17 – 3.1.4.1 Bullet #8	Please define "verify that appropriate CPT/HCPCS codes and service codes have been identified for the service requested." To what extent should the contractor verify the codes submitted?	Obtaining CPT/HCPCS codes in order to PA the request is required. Those must be verified for PA purposes only with the information provided.
158		Can the vendor assume that the list of reporting in Section 3.1.3 of the RFP is inclusive of all standard reports?	No.
159		In the interest of efficiency and economics, may denials be provided electronically for providers?	Yes
160		Please clarify from	Refer to # 63

	RFP SECTION	QUESTION	ANSWER
		exactly what entity the eligibility files will come from and for which programs.	
161		Is a Letter of Intent a commitment to bid?	No
162	Page 15 – Section 3.1.2.16	Please define the retrospective review process. How is the contractor supposed to verify that the services were provided? What is the outcome of the review? Where are the results submitted?	The retroactive quality review process is conducted by the vendor on site. The vendor establishes criteria and methodology based on the UM guidelines and approved by BMS. The provider's documentation must meet the standard set by BMS and vendor upon review. If the standard is not met then the provider authorizations are denied and monies recouped. The vendor will notify the provider and BMS the results of each review.
163	Page 16 – Section 3.1.2.17	While conducting the retrospective review, the Vendor will review the supporting documentation. Will the Provider need to copy and mail this documentation to the Vendor and will the Provider need to be reimbursed for these costs?	The retroactive quality review vendor will review documentation site or could be provided EHR documentation when available. Providers are responsible for their submissions.
164	3.1.4.2 Bureau for Children & Families Pages 17 & 18 – Section 3.1.4.2.a-zz	Please provide the review volumes that occurred in the last contract for each review type, the number of initial prior authorization requests,	Refer to # 107 regarding the reviews. There were 42,716 Socially Necessary Service referrals submitted for authorizations calendar year 2008. BCF does not have data regarding the number of reconsiderations. BCF District/Central office staff oversee appeals related to denials. BCF has not had any requests for a hearing.

	RFP SECTION	QUESTION	ANSWER
		reconsiderations and appeals.	
165	3.1.4.3 Bureau of Health & Health Facilities Page 19 – Section 3.1.4.3.a-n	Please provide the review volumes that occurred in the last contract for each review type, the number of initial prior authorization requests, reconsiderations and appeals.	Refer to #17
166	3.1.4.4 Bureau for Medical Services – Optional Services – Page 24 thru 27 – Section 3.1.4.4 cc-hh	Can the State provide any estimated volumes for these optional services?	Refer to #36
167	Page 26 – Section 3.1.4.4 gg	Would the State consider alternative streamline methods (such as a web-based system) to perform and track PASRR as long as it was compliant with Federal Statutes? Is this for Level 1 or Level 2 of PASRR reviews?	Refer to #144
168	Part 4 – Proposal Format 4.5 Cost Proposal Format/Bid Sheets Page 31 – Section 4.5	The instructions for completion of the cost proposal describe identifying the costs associated with each review function. On the Bid Sheets themselves there is a column	Refer to #143

	RFP SECTION	QUESTION	ANSWER
		entitled "Reviewed Service/Program". Can the State clarify if it is looking for an annual review cost only? For example, on the Bureau for Children and Families Bid Sheet would the first Reviewed Service/Program be Needs Assessment/Service Plan and the Vendor would need to place the annual price for performing these reviews under the Blocks for Years 1-5? Is the State looking for a detailed, itemized price breakdown by expense category, i.e., copying, labor, data processing, or should the Bid Sheets only provide the annual cost for the different services requiring prior authorization as listed under Secs. 3.1.4.2, 3.1.4.3 and 3.1.4.4?	No we do not require an itemized breakdown
169	Part 3 – Scope of Work 3.1 General Requirements – Page 12 – Section 3.1.5	The RFQ outlines the Vendor is to communicate denial	Denial notices to the member/ member legal representative must be mailed. In some cases the vendor may choose to send certified mail. The vendor may propose the best

	RFP SECTION	QUESTION	ANSWER
		notices to the provider, member and/or member's legal representative. Can these notices be sent electronically via fax/email, or do they need to be sent via regular mail? If they are to be sent regular mail, do they have to be sent certified mail?	method to communicate denials to the other parties.
170	Page 13 – Section 3.1.10	Is it possible to obtain file transfers for eligibility, benefit levels, and prior authorization numbers? Are these files provided on a daily basis? What eligibility information is available in the file? Can file layouts be provided for all 3 of these files?	Refer to # 63
171	Page 13 – Section 3.1.13	Please provide a historical breakdown for the method of prior authorization receipts. For example, how many have been received via the web, mail, by phone/fax?	Refer to # 142
172	Page 13 – Section 3.1.14	Are any of these basic medical/behavioral	ABS-RC2; CAFAS; ASI; WV Functional Assessment are examples of assessments currently used by BHHF. The medical behavioral health assessments will be addressed

	RFP SECTION	QUESTION	ANSWER
		health assessments currently being performed or is this a new function? If they do currently exist, will the current questionnaire be made available to the contractor?	with the vendor upon award. Vendor may wish to suggest assessment upon award. . The ABS-RCS, CAFAS, ASI; WV Functional Assessment are assessments that are available to the public.
		Does this information need to be transferred/entered into any WV Medicaid system or only reported on from contractor?	It is not entered into the Medicaid system
		Please define "regular intervals" for collection of data and "at critical treatment junctures". Does this require Contractor to prospectively seek out individuals for which these events occur to collect data or is there a requirement for providers to report this for contractor to "collect"?	Data collection initially, annually and at critical junctures. Provider are required to submit.

	RFP SECTION	QUESTION	ANSWER
173	Page 13 – Section 3.1.16	Is there a current listing of the "basic information" that is currently being collected and can that listing be made available to the contractor? Does this information need to be transferred/entered into any WV Medicaid system or only reported on from contractor? Please define "regular intervals" for collection of data and "at critical treatment junctures". Does this require contractor to prospectively seek out individuals for which these events occur to collect data or is there a requirement for providers to report this to contractor to "collect"?	The vendor will need to collect the information necessary to render a decision for each Socially Necessary service. Each service has different rules so slightly different information sets may be required to determine the authorization. Basic demographic information will be required for all service authorizations. Information does not need to be entered into the Medicaid system. Information is currently collected every 90 or 45 days Providers are required to submit the data.
174	Page 14 – Section 3.1.18	the Vendor is to provide technical assistance and training to BHHF	Refer to # 190 for total number of BHHF providers For purposes of technical assistance, BHHF in the Northern Region has (8) provider and in the Southern Region (6)

	RFP SECTION	QUESTION	ANSWER
		providers. Can the State provide the total number of BHHF providers? How many agency regions are there and where are they located?	providers - BHHF has the following regions: North (Healthways, Northwood, Valley, United Summit, Appalachian, Potomac Highlands East Ridge, Westbrook counties) South (Prestera East, Prestera West, Logan Mingo, Southern Highlands, FMRS, Seneca counties) (
175	Page 14 – 3.1.2.6	Please provide the volumes of hearings that occurred in the last contract. How many of these required in person attendance by the contractor? Where did the hearing take place?	Refer to Attachment BMS-B Fair Hearings The contractor can attend hearings via conference call. The hearings take place in variety of offices throughout the state.
176		Per the list of BHHF reviews listed in Section 3.1.4.3, please provide historical volume levels for each review. At a minimum, please provide at least two years of historical data. Additionally, if possible, please provide the amount for which each review level is	Please refer to #17. BHHF does not have any historical data for prior authorization of these services. As reflected in # 17, we have attempted to capture all areas requiring PA; however, future changes cannot be anticipated.

	RFP SECTION	QUESTION	ANSWER
		reimbursed.	
177		Please confirm the number of eligible members that WV covers for the BHHF. Additionally, please provide the number of eligible members who access WV services for BHHF.	Refer to #17
178		In addition to the list of reviews provided in Section 3.1.4.3 of the RFP, will the vendor be responsible for administering any additional reviews? If so, specify the additional reviews for which the vendor will be responsible and specify if these additional reviews will require prior authorization. Please provide case volume levels for these additional reviews.	Prior Authorization requirements are subject to change as needed by BHHF. BHHF cannot predict future services that might need prior authorizations.
179		Please specify when the reviews listed in Section 3.1.4.3 of the RFP are eligible for preauthorization (i.e. 9 months, 90 days, etc.)	To be determined by the vendor and the BHHF upon award.
180		Please provide your historical length of	It is unknown as to the historical length of time for each review level. BMS requires the vendor to complete each review within

	RFP SECTION	QUESTION	ANSWER
		time for each review level for which the vendor is responsible.	the amount of time described in the RFP.
181		Please provide a brief description for the following review levels: Preparation of waiver packets, forensic psychiatric, forensic psychological, service coordination, behavioral health services for the uninsured, behavioral health support services, peer support services.	Refer to #40
182		Please provide the historical annual value of the services listed in the RFP by bureau.	Please refer to state purchasing contracts of current vendors. (BMS50644, BMS30748, BMS30747, BMS90002
183		Per Section 3.1.10 of the RFP, how often will the vendor be accepting data transfers from the State?	For all programs the vendor will be able to interface with systems as needed to meet the needs of the Bureaus. The frequency of data transfers will be as needed to meet the needs of the Bureaus.
184		Please provide the historical number of member hearings for case disputes/denials that the State has experienced. If possible, specify what review level	Refer to attachment BMS-B Fair Hearings

	RFP SECTION	QUESTION	ANSWER
		type for each dispute.	
185		How would inpatient evaluations be conducted for Forensic Psychiatric or Forensic Psychological if required.	To be determined by the vendor and the BHHF upon award.
186		The noted bid open date per the RFP is 3/3/09. Please provide the estimated award date and anticipated start date for this contract.	Refer to #43
187		Please provide the historical numbers of requests submitted via each modality: web, telephonic and in writing.	Refer to #142 for percent of request by modality. However, the bureau does not have data reflecting the breakdown by service type.
188		Can the Vendor assume that the list of reporting in Section 3.1.3 of the RFP is inclusive of all standard reports?	No. The Bureau reserves the right to ask for additional reports as noted in 3.1.3.2
189		In reference to Section 3.1.15, please provide the exact demographic information that the state wishes to collect.	Data items that need to be collected include but are not limited to: Age; gender; employment status; presenting problems; race; ethnicity; living situation –Also, please refer to Attachment BHHF-A. Data Elements are subject to change from time to time; therefore, there will be a need to have the capacity to add/delete data elements. Exact data elements to be determined after contract award.
190		Please provide the current number of	FY 2007 269 SN Providers

	RFP SECTION	QUESTION	ANSWER
		eligible licensed behavioral health providers and socially necessary providers pursuant to 3.1.16 and 3.1.18.	FY 2007 243 Behavioral Health
191		In the interest of efficiency and economies, may denials be provided electronically for providers?	Refer to #169
192		For retrospective reviews as defined in Section 3.1.2.17, is the vendor to propose a statistical methodology for conducting these reviews or does the state have an annual threshold of the number of providers with whom the vendor is to conduct retrospective reviews?	Refer to # 162
193		How will the optional services in Section 4.3 be scored as part of the evaluation?	The optional services are considered a part of the overall proposal and will be incorporated in all parts of the scoring.
194	Page 19 – Sect. 3.1.4.3	Please provide the total number of BHHF services or programs requiring prior authorization received in 2008. (services noted on	Refer to #17

	RFP SECTION	QUESTION	ANSWER
		page 19 of the RFQ, items a-n). Please provide PA/UM review volume by service.	
195	Section IV – Project Work Plan Paragraph 2	Vendor should comment on plans for establishment of its administrative offices locally and of the interface between that office and state administrative offices, BMS and other bureaus. Additionally Vendor should describe how they will interface with the DHHR data systems and any processing subcontractors as necessary and how they will utilize the current fiscal agents system to enter authorizations on line for an in network and out of network services within specified timeframes. These two requirements seem to be in direct conflict with one another. In 3.1.2.14, it implies the Agency would be open to the	The intent is for authorizations to be entered in the most efficient way that provides all medical and behavioral information in one system. It is also more efficient to place the authorizations where the claim is adjudicates. However, the Bureau is open to suggestions, but those suggestions must also be cost efficient and provide the information necessary to administratively manage members. The interface used by FACTS is described in the response to questions 3, and 6.

	RFP SECTION	QUESTION	ANSWER
		use of the vendor's system if approved but the Project work Plan requirements speaks to the need for the vendor to describe how they will utilize the current fiscal agents system to enter authorization on line. Please clarify.	
196		3.1.4.4D, 3.1.5, 3.1.2.11 and 3.1.2.12 are not congruent. Please clarify. Some sections indicate the denial must be in writing and others electronic. Some sections require legal representative and others don't.	The denial must be in writing and must be communicated to the referring and/or treating physician, the provider as appropriate, the facility as appropriate, and the member and his/her legal representative as appropriate. BHHF: Will establish hearing appeals criteria. 3.1.4.4d – The member/legal representative, as well as all of the other parties who are participating in these facilities, must be informed of the approval or the denial. This will be a needed service with your company.
197		P14 3.1.2.6 Please provide the volumes of hearings that occurred in the last contract. How many of these required in person attendance by the contractor? Where did the hearing take place?	Please refer to attachment BMS-B, Data on place of the hearing is unavailable, the contractor must attend but can attend most hearings via phone
198		3.1.4.4 dd How is the Initial Determination of Medical Eligibility and the Annual Redetermination of Medical Eligibility	BMS will determine after contract award as this process will be subject to CMS approval in the 2010 waiver application.

	RFP SECTION	QUESTION	ANSWER
		currently performed by an independent entity pertinent to the vendor's scope of work related to certification/ recertification?	
199		3.1.4.4 dd Please clarify the vendor's scope of work related to "a process for independently assessing member certification and recertification."	BMS will determine after contract award as this process will be subject to CMS approval in the 2010 waiver application.
200		3.1.4.4 cc If there is a limit to the number of active members on the Aged & Disabled Waiver program, will the vendor be required to manage a wait list?	Yes, the vendor would be required to be an active participant in the management of a wait list.
201		3.1.4.4 cc Does the number of active members on the Aged & Disabled Waiver program have a specified annual limit? If so, what is the limit?	SFY 2009 5300 members SFY 2010 5200 members However, the state can choose to amend the waiver if necessary.
202		3.1.4.4 cc Is prior authorization in the Aged and Disabled Waiver Option granted as a global authorization for services requiring PA or are individual service/provider-specific authorizations required? If individual service and provider specific authorizations are required, does BMS have plans to increase the number of services that require individual	Currently, the only ADW service requiring a prior authorization is Homemaker (S5130). We do intend to require prior authorizations for all other ADW services including Case Management (G9002), Transportation (A0160), and Nursing (T1001 & T1002). However, our plan is to incorporate all these services on a single authorization template for each member.

	RFP SECTION	QUESTION	ANSWER
		prior authorization?	