Administrative Services Organization Contract Development

The West Virginia Department of Health and Human Resources is seeking an Administrative Services Organization (ASO) to provide case management services for the State's vulnerable youth populations and their families, if applicable. The vendor shall provide services to the following populations:

- Foster care children as defined under 45 CFR 1355.20
- Former foster care children under the age of 26 as defined by the Affordable Care Act
- Post-adoptive children
- Children at risk of being removed from the home (defined as those children with an existing case plan)
- Families of those children at risk of being removed from the home

The vendor shall be responsible for overseeing the case management and utilization management for both medical services and socially-necessary services for the populations identified.

State Requirements:

- Assignment of a contract manager to oversee performance of contract
- Assignment of a contract liaison

Vendor Requirements:

Personnel

- Vendor shall be required to provide the following key personnel:
    - Contract manager, quality oversight manager, provider relations manager, case management program lead, social services lead
- Staff credentials for key staff and care managers to be established by State.
- Contract with specialists to help make medical decisions should CMO not be proficient in given area.
- Vendor shall be required to be a QIO or QIO-like entity.
- The vendor shall place a liaison within the Department to ensure accurate and timely communications between parties.

Subcontractors

- Vendor shall be allowed to use subcontractors for select specialty areas, such as behavioral health and dental care, but all subcontractor arrangements must be approved by the State.

Materials

- Development of member materials
- Development of reports and other materials at the request of the State and establishment of associated timelines for submission (set by State).

Deliverables

- Establishment of committees with family, member, providers, ASO care manager and state lead to help develop the most appropriate care plans for the member.
- Participation in public meetings and other events at the request of the Department.
- Cooperation with external evaluations of program success.
- Submission of all policies and procedures, which will be reviewed and approved by the State prior to implementation.
- Coordination with the state on an annual basis to evaluate program and to establish program goals, initiatives and outcomes for following contract year. This will include both quality and financial components.
- Coordinate with eligibility vendor to ensure all information is current; the Department will provide daily eligibility files to the vendor.
- Provide service authorizations for eligible members, with expedited requests being processed within 48 hours and all other requests within 7 business days. Extensions may be granted.
    - Coordinate with the provider in instances where Medicaid is secondary payer and authorization requests and initial billing shall be submitted to primary insurer.

Utilization Management

- Provide utilization management support for the program using nationally standardized criteria, where applicable, and with the State retaining authority to review and approve any other criteria proposed.
- Establish an appeal process in the event of a service denial, as well as a communications plan for providers and members/families as to how to submit additional information needed to authorize a service, if deemed medically necessary.
- Contractor shall establish an online portal with evaluation criteria already populated so that providers may submit online and receive automated determinations.
- Vendor shall review utilization data identifying over and underutilization of services and determine if treatment is being inappropriately sought and provide guidance.
    - Vendor shall conduct provider outreach and establish localized case management with providers.
- Review out of network claims on a regular basis to determine if services can be provided in state.
- Vendor shall have the capacity to receive data from the State's pharmacy review contractor to aid in holistic case management of the member.
- Provide the State with an annual improvement proposal on its program, including programmatic improvement opportunities.
- Promote UM that is person centered treatment, recovery and maintenance of overall health and wellbeing.
- Review services for medical necessity against best practices, and when such documentation does not exist, provide to the State the methodology by which it has made its decision.
- Coordinate with the court system on services that are ordered by the court, to explain whether they meet medical necessity, and if not, the most appropriate service the child shall receive to help meet his or her needs. The vendor shall honor any initial requests for services, but shall

work with the State to provide education on what type and duration of services are most clinically appropriate to help the member.

- Coordinate with the member, family (adoptive parent, foster care parent, caregiver), and all other parties.
- Collaborate with hospital, PRTF, residential, behavioral health comprehensives, etc. staff on discharge planning needs for the member and ensure outpatient services have been established prior to release, as well as ensuring all needed medication is available for the member, and assure local case management follow up with all inpatient discharges.
- Review new authorizations against existing to determine if duplication is occurring, particularly in the event of multiple providers offering care.
- Establish a medical home for each member that aligns with standards outlined by the American Academy of Pediatrics in the Health Care for Children and Adolescents in Foster Care manual.
- Confirm that all medical services requested are covered Medicaid services and that the provider is an enrolled WV Medicaid provider.
- Coordinate with hospital emergency rooms to help educate ERs about the availability of the ASO and the members they are caring for.
- Develop a protocol for reviewing authorization requests against Intensive Care Management criteria for severe cases.
- Establish peer review requirements should a provider disagree with authorization denial.
- Vendor shall send written notice to providers and members of all authorization decisions in writing, as well as submit back to provider via fax or other method to expedite, if not submitted via web-based portal.
    - Web portal must also be available to state staff working on project.
- Maintain records of all service authorization requests and decisions for at least seven (7) years for each member.
- Maintain a UM system that has the capacity to enter and maintain text for clinical review notes, inpatient requests, review criteria, member history, etc. The system shall serve as a case management tool that encompasses medical, dental, behavioral health, and socially necessary services information on the member.
- Provide daily census report to medical home of members that have been admitted for inpatient stay.
- Vendor shall provide integrated physical and behavioral health and use predictive modeling to identify members at risk and best practice methods to encourage members engagement in self-care behaviors.
- The vendor shall coordinate a full range of recovery-based services and engage non-medical services and supports as indicated to provide holistic care focused on whole-health wellness, long-term independence, and skills building.
- Vendor shall ensure that each member upon enrollment into program, receives or has on record a comprehensive family assessment to assist in developing case plans, making placement decisions, expediting permanency and planning.
- Vendor shall ensure a trauma assessment screening occurs and shall maintain record of any trauma history with information about any trauma experienced to guide case management planning.
- Make appropriate referrals to specialists as needed based on results of assessments.

- Vendor shall conduct prior authorization reviews for medical services and establish policies for retrospective reviews of authorization requests.
- Vendor shall coordinate with member's prior Managed Care Organization, if applicable, to obtain information regarding existing prior authorizations to ensure continuity of services.
- Vendor must comply with the timeframes for completing prior authorization reviews and providing responses, as outlined in the contract.
- Vendor shall continuously review and stay current with evidence-based criteria, and, if appropriate and necessary, recommend updates and/or alternative criteria, with the understanding that, if there are no specific criteria for a requested service, the vendor will research and render a recommendation subject to Department approval.
- Establish UM guidelines for each service and request approval of the Department before publicly releasing any guidelines.

Transitional Care Policy

- Establish a transitional care management policy by which the vendor monitors follow up care for the member upon discharge.
- Provide assistance with scheduling appointments.
- Assist members with coordinating transportation to appointments via the State's non-emergency medical transportation (NEMT) vendor.

Intensive Care Management Program

- Establish an Intensive Care Management program for individuals at significantly higher risk of experiencing medical events due to one or more chronic conditions.
    - Vendor will identify members that should participate in program.
    - Promote self-efficiency and utilization of preventive care services.
    - Identify high cost services that did not yield positive outcomes.
    - Identify community supports to help member with social determinants of health.
    - Development of a personal care plan for each member enrolled.
    - ICM program shall establish a network of teams around the state to help meet the needs of children in various geographic areas that will include an ICM lead, a BH lead, a community health worker and member/family.
- Establish a predictive modeling support tool for both the ICM program and all other enrollees to help with stratification of members into risk tiers for case management services.
- Submit on an annual basis the ICM program description and any planned changes based on historical experience.
- Establish a process by which all enrollees are assigned a Primary Care Provider (PCP) and behavioral health provider, if necessary, by reviewing claims history to determine if an enrollee has historically been seeing a provider prior to assignment.

Patient Centered Medical Homes

- Establish patient-centered medical homes for members.
    - Help providers implement data-driven interventions.
    - Provide a regularly updated list of community resources to providers.

    - Participate in annual Medicaid provider workshops to educate about opportunities to participate in PCMH model.
- Conduct an annual provider and member satisfaction survey with their experience with the PCMH to identify improvement opportunities.
- Establish a program around incentive and improvement payments and clearly outline guidelines for achieving payments.
    - Calculate results of PCMH performance measures annually.
- Establish a process by which provider applications are reviewed and processed for participation in the PCMH program.
- Establishment of a dental home and behavioral health home for members.

EPSDT

- Vendor shall ensure all individuals under 21 receive EPSDT services.
- Provide written and oral communications about the availability of EPSDT services to members.
- Vendor shall coordinate with providers/community resources to assist with issues identified through the EPSDT process.
- Follow standards outlined by the American Academy of Pediatrics on care management for children in the foster care system.
- Follow the Standards for Systems of Care for Children and Youth with Special Health Care Needs in providing care/case management services.

Prenatal Care

- Vendor shall identify all pregnant members and enroll in specialized care management.
- Coordinate with the ICM team on members that are pregnant and enroll in program (if member approves) – Community Health Worker can assist with community resources for member.
- Coordinate with programs offered by the Bureau for Public Health (e.g. Birth to Three, WIC, etc.) to help ensure expecting mothers have all the information they need as early as possible.
- Conduct prenatal risk assessments to identify high risk members.
- Assist with coordinating prenatal/postpartum appointments, as well as dental care.
- Educate members about drug utilization during pregnancy, as well as LARC initiative.

Coordination with Other State Agencies; Home and Community Based Waiver Programs

- Vendor shall coordinate with the Bureau for Children and Families, Bureau for Behavioral Health and Health Facilities, Bureau for Public Health and Bureau for Medical Services (Medicaid) to ensure all services needed are being coordinated.
- Vendor shall coordinate with the State's waiver program administrator to assist with application for waiver services, if applicable.

Quality Management

- The vendor shall measure access to care, demand for services, quality of care, health outcomes, and client satisfaction, and analyze utilization data to drive quality improvement strategies.

- Vendor shall report on all HEDIS measures, CMS Adult and Child Core measures, and other requested elements by the Department or Legislature
- Establish a provider profile report card and submit individualized results to each provider as to their scores in meeting specific measurable outcomes .
- Develop a quarterly ER utilization report showing trend analysis.
- Establish three (3) Quality Improvement Projects in collaboration with the Department.
- The vendor shall identify quality deficiencies in the delivery of services to members and conduct investigations as to why and ways to improve care and submit reports to the Department.
- The vendor shall establish a collection methodology to measure service quality not related to clinical-services (e.g. performance of the ASO).
- Develop a member and provider survey to assess elements such as call center experience, ease of use of website, etc.
- Establish a service quality subcommittee that will annually review results of surveys and implement strategies for performance improvement.
- Submission of an Annual Quality Management Plan.
- Vendor shall be subject to, and comply with, the terms of an independent Annual Evaluation and Analysis Report on the prior year's quality management program
- Ensure sufficient network adequacy to meet the demands of membership, including access options to providers that may not be enrolled with WV Medicaid and strategies to have those providers enroll if needed.
- Adhere to all reporting requirements and deliverable dates.
- Report performance outliers and improvement plan to the Department on those health measures, providers, etc. that are not meeting expectations.
- Participate in meetings with stakeholders to explain results of quality reports.
- Vendor shall establish a plan for referring instances of suspected fraud to the following entities:

    a. Medicaid fraud, to the Bureau's Office of Program Integrity (OPI);
    b. Instances of suspected fraud in the delivery of BCF socially necessary services, to the BCF Office of Finance and Administration;
    c. Instances of fraud related to BBHHF funded programs, to the BBHHF Office of Compliance and Monitoring

Provider Relations

- The vendor shall promote ongoing and seamless communication between the provider(s) and the vendor.
- Include providers in subcommittees as appropriate.
- Provide onsite consultation to providers as needed to assist with clinical and administrative issues.
- Educate providers on web-based platform used for submission of prior authorizations.
- Make all policies and procedures available electronically for direct provider access.
- Monitor provider complaints.
- Develop training that can be utilized in person or through web-based applications.
- Vendor must respond to State and provider emails within 48 hours of receipt.

Provider Materials and Supports

- Develop a provider manual, outlining key programmatic information.
- Develop a standard prior authorization form for all services.
- Develop procedures for submitting complaints/appeals
- The vendor shall provide notification to providers of all policy changes prior to implementation at least thirty (30) days in advance.
- Provide training and targeted technical assistance on any necessary elements.
- Track and manage all provider inquiries and complaints related to clinical and administrative services and address within thirty (30) days.
- Provide monthly reports to the Department related to inquiry and complaint monitoring to ensure timeliness in addressing.

Web-Based Communication

- The vendor shall maintain a website specifically to serve ASO providers and members.
- Program changes shall be reflected on the website in a timely manner to be agreed upon by the Department.
- Tool shall be used to allow for the submission of prior authorizations, maintaining policies, provider look up functionality, provider application for PCMH participation, access to member utilization information by providers in which the member is enrolled in their care, and other functionality as defined by the Department.

Provider and Medical Home Network Development

- The contractor shall provide network management and development functions including the development of a provider file, PCMH qualifications review, assess demand, conduct network adequacy analyses, and provide network enrollment assistance.
- Provide technical assistance to providers to support ongoing operations of PCMHs and other service delivery innovations.
- Receive information from the State's MMIS vendor to conduct provider gap analyses and encourage providers to contract with the State if providers exist in those identified areas.
- Ensure employee access to all necessary files.
- Conduct an annual network assessment, as well as ad hoc, in the event of notification of provider network terminations.
- Conduct a semi-annual analysis of providers accepting new patients.
- Implement processes to ensure providers have 24/7 accessibility and that members may make appointments in a timely manner.
- Conduct ongoing data analysis via member surveys, phone calls, etc. as to service gaps, not limited to geographic area or provider type.
- Conduct provider satisfaction surveys and develop strategies to improve provider relations based on feedback on an annual basis.
- Provide a website to providers to access information about the member, including but not limited to, authorization status, medical records, eligibility information, etc.

Member Services

- Vendor shall provide a welcome packet to each member with information about their case manager, important phone numbers, etc.
- Provide members with a member handbook that outlines the services available to them.
- Shall conduct a welcome call to each new member or caretaker within 14 days of receipt on the eligibility file to introduce themselves, establish a PCP, and discuss services they can provide to the member/family to assist.
- Provide member materials throughout the year on important program changes, benefit changes, etc.
- Conduct monthly calls with each member as a status check or assure local targeted case management.
- Follow all Centers for Medicare and Medicaid Services (CMS) regulations specific to the development and distribution of member materials and provide sufficient staffing to accommodating the level of case management needed for this population.
- Vendor shall develop a reference manual for staff to assist members with specialized cases, such as where to refer members and address member inquiries.
- Develop a tracking inventory to address complaints, FAQs, authorization request status, appeals status, etc.
- Vendor shall meet with State staff at least monthly to review member reports.
- Provide a website for members to access member materials.
- Reassign the member to a new PCP in the event of relocation; notify the caretaker of the change within 2 business days. The vendor shall establish a new medical home, inclusive of behavioral health services, for the member, if the relocation occurs outside of the service area in which the member was previously located.

Telephone Call Management

- Provide and operate call management services through a WV location.
- Develop, implement and maintain operational procedures, manuals, forms, and reports necessary for operating telephone call management services.
- Establish a toll-free line for members and providers, with the ability to conduct warm transfers and eligibility checks.
- Establish a tree log to route emergency services v. traditional calls.
- Meet all state-specified call center performance metrics.
- Develop an automatic call distribution report that provides data related to the performance metrics outlined by the State.

Program Reporting and Data Storage Requirements

- Vendor shall store all operational data collected in an information system to be specified by State.
- Ensure that the information system's reporting capacity is capable of using data elements from all different functions or processes as required.
- Develop and maintain a data dictionary.

- Collaborate with the State on reporting timelines; the State shall identify all needed reports and timelines to be met by the vendor.
- Provide ad hoc reports to the Department as requested.

Information System

- Coordinate with the State's MMIS vendor to provide authorization data, PCP information, PCMH information, etc. Authorization file shall be transmitted daily.
- Vendor shall accept eligibility, membership and enrollment data from the Department and the MMIS.
- Conduct testing with all parties to ensure accuracy of data.
- Build and maintain a provider database based on information received from the MMIS and Bureau for Children and Families Socially Necessary Services program.
- Capture data as part of the welcome call to members that identifies social determinants of health and incorporate this information into its case management solution and strategy for assisting members.
- Shall have access to paid/denied claims information from the MMIS vendor to help with case management.
- Vendor shall have access to the State's data warehouse for analysis on members.
- Develop a disaster recovery and business continuity plan.

Notices of Action, Denial Notices, Appeals and Fair Hearings

- The contract shall meet or exceed the Notice of Action (NOA) and Denial notices requirements as specified in the contract.
- Maintain a member appeals process including policies and procedures related to the administration of the Notices of Action, Denial Notices, and internal appeals processes.
- Vendor shall generate notices specific to each member and each type of action and be in compliance with all federal requirements.
- Appeals shall be resolved within 30 days of request but must also develop a policy to accommodate expedited appeals in the event such delay in a decision may jeopardize the life of the member.
- Develop policies around member rights and responsibilities, appeals, etc., and process to ensure compliance with the State's fair hearing process of providing information to members about their rights to access a fair hearing. The vendor shall be responsible for attending/testifying in fair hearings as required.
- Vendor shall schedule hearings with the State Hearing's Officer, DHHR, member or guardian and provider.

Provider Reevaluation Process

- Providers may submit requests to the vendor for reconsideration of a denial for medical necessity or administrative action.
- The vendor shall develop and maintain policies and procedures for this process.

Security and Confidentiality

- Vendor shall be required to comply with all applicable state and federal laws concerning privacy and security of all applicant and client information that is provided.
- Vendor shall be compliance with HIPAA privacy and security rules, HITECH Act, and all other applicable state and federal statutes, regulations, policies, etc.

Bureau for Children and Families:

- The vendor shall assist the State in finding appropriate placement for children in state, unless such placement is unavailable or the placement occurs with an out of State family member. Failure to identify placement after 30 days shall result in a penalty of $100 per day, per child.
- The vendor shall be responsible for coordinating the socially necessary services (SNS) of the child and assigning the child/family to the most appropriate provider of these services based on the provider's ability to meet the needs of the child.
- The vendor will provide authorization reviews for socially necessary services.
- The vendor shall be responsible for utilization management of socially necessary services.
- Vendor shall conduct annual audits of socially necessary services providers to ensure services being billed for are being provided in a manner consistent with utilization management guidelines as defined by BCF.
- Vendor shall collaborate with the State in implementing, and being in compliance with, the Family First Act to help promote/coordinate access to preventive care services to reduce the number of children removed from the home in a prospective manner, rather than being reactive.
- Vendor shall describe their plan for reviewing Council on Accreditation (COA) standards or other applicable service, program or certification standards as identified and recommended by BCF.
- Vendor shall establish a Retrospective Quality Review process for applicable Socially Necessary Services. This review process shall include analysis of the services provided by the specific provider, an assurance that the staff providing the service and/or the agency have the appropriate and current credentials necessary and that the case documentation and invoice reflect that the service was provided according to the established UM Guidelines. All providers shall be reviewed on an 18-month cycle with the exceptions allotted for special request at the discretion or direction of the applicable Bureau.
- Vendor shall provide BCF a schedule of retrospective quality reviews to be conducted on Socially Necessary service providers, with the understanding that BCF shall provide a sampling of invoices to the vendor for claims made for socially necessary services and, that as a part of the retrospective review, the vendor shall review the supporting documentation in the provider records to ensure the services invoiced and paid for have been provided and all reports have been sent to the Bureau.

Bureau for Public Health (BPH):

- The vendor shall serve as a referral source for individuals needing assistance with BPH programs.
- The vendor shall provide a warm handoff to the BPH Office of Maternal Child and Family Health toll-free hotline.

BHHF:

- Data collection will require the collection and validation of demographic, diagnostic and service level data for BBHHF funded treatment, residential and community support services provided to both licensed and other BBHHF funded providers throughout the state. The plan shall address and allow for modifications to data sets and reports as needs and requirements change.

Outcomes/Contract Compliance (options for consideration by stakeholders):

- Failure to meet deliverable timelines, $250 per day in which deliverable is not met.
- Implementation of a strike system in which the penalty against the ASO is driven by the number of strikes accumulated for failing to meet deliverables. Penalties at each level increase.
- Establishment of a performance withhold, with "bonus" payments being made for reaching specific quality measure targets. Examples of such targets for this contract would be:
    - Percentage of children being placed in OOS care is less than x%
    - Percentage of children transitioned back in state from OOS placement is greater than x%
    - The number of children accessing well-care visits exceeds x%
    - Youth transitioning out of foster care are prepared to live on their own once they turn 21 (a youth transition plan %).
    - A measure that is established in coordination with the education system.
- Penalties for system failures (e.g. $25,000 fine for each occurrence after 3).
- Failure to make at least 95% of medical authorization decisions and provide written notice within seven (7) calendar days of receiving the request for service for the purposes of standard authorization decisions, per quarter, shall result in a $250,000 penalty per quarter.
- Failure to identify placement for children after 30 days shall result in a penalty of $100 per day, per child.