Question	Response
On page 102, section 4.8 Grievances and Appeals, the "grievance and appeals procedures must be made understandable and accessible to" foster parents and other caregivers, in addition to adult enrollees, adoptive parents, and CPS workers who are currently listed.	The MCO is responsible for providing grievance process to all members. No change is being made.
On page 108 regarding Continuation of Benefits, each of the items on the bulleted list should be its own reason to continue benefits rather than requiring all of these items. In North Carolina, an excellent document (see link below) which breaks down their appeals process states the following on page 4: "Can I Keep Services During the Appeal? If you file your Reconsideration Request Form and then your OAH Appeal Form within 10 days from the date on the letters, there should be no break in your services. Your services should continue at the level you were receiving prior to your denial until a final decision is made at mediation or a hearing. If you file your OAH Appeal Form after 10 days, but before 30 days, you may have a break in services for a short period of time until your appeal is received by OAH, but then services should be reinstated." This same standard should be applied to families in West Virginia. As long as they file their appeals in a timely manner, the denied service should continue throughout the appeal process. This will ensure that children who depend on medications and regular therapies and their caregivers will not be harmed by inappropriate denial of services.	The continuation of a service pending an appeal is a current contractual requirement. The Department agrees to amend the language to more closely align with that used in North Carolina.
I recommend a document similar to the one developed in North Carolina as a mechanism for explaining the appeals process to foster, adoptive, and kinship parents. This document may be found at: https://www.sog.unc.edu/sites/www.sog.unc.edu/files/course_materials/4_Medicaid%20Appeals%20LME-MCO%203-18-16%20new%20template%20MED-03.pdf A document like this one should be developed and widely distributed to parents impacted by the transition to managed care.	A comparable document will be required to be developed by the MCO to assist with education.
I strongly support the creation of a foster are ombudsman in HB2010 and encourage the Office of the Inspector General (OIG) to begin the search for the best candidate for ombudsman as soon as possible. Until an ombudsman is hired and trained, DHHR should name a point person for foster, adoptive, and kinship parents impacted by the MCO contract to call when problems arise or they are confused about the process. This individual's name and contact information should be announced publicly and made readily available to foster parents statewide.	No change needed.
Foster, adoptive, and kinship parents continue to express the need for more services for their children and families in their communities. DHHR has stated that they lack data indicating which services are needed in which areas of the state. Collecting this data and addressing these needs must be a top priority for DHHR in the transition to managed care. Without baseline data regarding needs right now, we will have no way of knowing whether the MCO has improved access to services. Significant investment in local community-based services is absolutely crucial to both meeting the needs of children and families in the child welfare system, and to addressing the concerns of the US Department of Justice with regard to compliance with the Americans with Disabilities Act.	This is a public policy question that is being explored by the Department.
It is crucial that the MCO conduct a thorough gap analysis and ensure true network adequacy. Children in foster care tend to have complex needs and discontinuing care with a specialist, especially when there is significant history with a provider, could cause additional challenges and traumas for the child and caregiver. There needs to be clear network adequacy for Socially Necessary Services as well.	Modifications to network standards have been made based on public comment.
I have spoken with a large national MCO who is a leader in managed care for children in foster care. This MCO is not competing for this contract. They indicated that we would need at least a year between awarding the contract and full implementation of the MCO in order to ensure stakeholder input and education. The addition of Socially Necessary Services in the contract indicate that we should take even more time in making this transition. I recommend you take the time to make this transition slowly and ensure that each step is done well without creating chaos for the children and families impacted by this decision.	W.Va. Code §9-5-27 requires the contract to be in place by January 1, 2020.
I have spoken with numerous foster, adoptive, and kinship parents who have not heard about the transition to managed care and are struggling to understand how this change will impact them and their children. In the time between awarding the contract and implementing the transition, extensive efforts must be undertaken to educate families, answer questions, listen to their concerns, and provide support during and after the transition. I recommend that DHHR hold several listening sessions with foster parents and respond to their concerns accordingly.	DHHR conducts public stakeholder meetings and will continue to explore strategies to improve public feedback. W.Va. Code §9-5-27 requires a quarterly stakeholder meeting with these groups.
There remains confusion regarding how "freedom of choice" will be ensured for children in foster care. DHHR has indicated that families may choose to stay with the fee for service model, but for children in foster care, DHHR is their legal guardian and the entity that will make this choice. Indeed, on page 5 of the contract, BCF is identified as the "authorized representative." If a foster family's providers are not "in network" for the MCO, how will this family be given the freedom of choice to stay with those providers under Medicaid?	The guardian of a child within its legal authority will have the ability to choose the most appropriate delivery system.
The contract currently indicates that DHHR or a judge may request that the MCO care coordinator participate in MDT meetings. It is crucial that foster parents participate in MDT meetings and that they also be able to request the participation of the care coordinator.	Agreed.

Question	Response
There remains significant confusion among foster parents and the public regarding how the new care coordinators will interact with the existing system, including CPS workers, the courts, providers, children, foster parents, etc. In discussions about HB2010 we heard both that the care coordinator would not take on any of CPS workers' duties, and that if a foster parent is unable to reach their CPS worker, they could call the care coordinator. This seems to indicate an overlap of duties. These roles and interactions must be clearly delineated and explained to foster, adoptive, and kinship parents.	DHHR agrees the roles and responsibilities should be clearly defined.
I recommend that the Medical Loss Ratio (MLR) described in Section 8.3 be increased from the proposed level of 85% to at least 88% to 90%. I also recommend including language that requires the MLR for the WV MCO contract to not less than 1% lower than the highest MLR for MCO contracts for foster care populations in other states (ie if the highest MLR in the nation is 90% then WV's MLR would need to be at least 89%). WV should have the strongest contract in the nation, and the MLR can ensure that funds go to services and meeting the needs of families.	No change is being made to the MLR.
I recommend deleting the statement that "The Department may exclude the MCO from the MLR reporting requirement for the first Contract year it is present in a state" on page 139 of the proposed contract. The Medical Loss Ratio must be maintained beginning in the first year.	This has been deleted.
The calculation of Medical Loss Ratio in Appendix H does not include any references to Socially Necessary Services. If socially necessary services are to be included in the transition to MCO approach, then those services must be addressed in the MLR process and calculations. Determining their actuarial soundness will need to be addressed as well.	The MCO will serve solely as an administrative services organization for SNS, so it will be exempt from MLR calculations.
I am unclear how "freedom of choice" will be ensured under the MCO approach – particularly for Foster Parents when BCF is identified as the "Authorized Representative" on page 5 of the contract. If a foster parent has an existing relationship with their own medical home and family medical provider, but that provider is not in the MCO network then BCF appears to have the ability to require the Foster Family to use the MCO, which undermines their Freedom of Choice.	The MCO will provide information to the members on the available providers in network to select from.
It is CRUCIAL that Network Adequacy and the Provider Network Standards be strengthened to ensure access to all needed wrap around and prevention services – not only for Medically Necessary Services – but also for Socially Necessary Services. In order to meet the goals of this approach to reduce the number of children in out-of-home placements, out-of-state placements and in congregant care, then services need to be available in communities where families can easily access them. These include offering programs, activities, and initiatives that help families build evidence-based protective factors linked with the prevention of child abuse and neglect, including knowledge of parenting and healthy child development, parental resilience, social connections, concrete support in times of need, and social and emotional development of children.	The MCO will provide information to the members on the available providers in network to select from. I am not following this sentence.
The MCO should be required to participate in MDT meetings at the request of the foster parent or other caregiver as well as CASA or other member of the MDT – not just at the request of DHHR worker or Judge.	The MCO will provide information to the members on the available providers in network to select from.
The list of providers identified needs to be cross-referenced with the providers and community based organizations that are part of WV's service array and continuum of care. I have heard comments that some of our Crisis Respite and Crisis Response Team providers were not included in the documents that have been provided.	SNS providers will continue to bill BCF for services, so any existing provider may be leveraged that best meets the needs of the member.
What is the interaction between the MCO and other aspects of the child welfare system including DHHR workers, the court system, health care, providers, children, CASA, Safe at Home, etc.?	The MCO must be available to meet the needs of the stakeholder, and not serve as a barrier to accessing care.
When there is a difference of opinion between the MCO and the family, or the judge, or the social worker, how is that disagreement resolved?	All decisions are subject to judicial review.
The proposed RFP describes a wider scope of services to be included under Managed Care than any other state has implemented. How can we undertake that scope of services (health care, behavioral health, mental health, prevention services, etc.) smoothly?	No response.
I am a strong supporter for the inclusion of the Ombudsman, which has been included in HB 2010. I encourage DHHR to follow guidelines from the United States Ombudsman Association (USOA) in creating its Ombudsman Office – specifically: a)An Ombudsman office should be independent-free from outside control or influence; b)An Ombudsman should be impartial- receive and review each complaint in an objective and fair manner, free from bias, and treat all parties without favor or prejudice. c)The Ombudsman should control confidentiality- have the privilege and discretion to keep confidential or release any information related to a complaint or investigation; and d)The Ombudsman should create a credible review process of complaints- perform his or her responsibilities in a manner that engenders respect and confidence and be accessible to all potential complainants. [iv]	Not specific to this contract.
Coordination of Care - The court system is not identified in this section, but is a critical partner in determining coordination of care. This section does not seem to include references to socially necessary services and social work components to the same degree that medical care is addressed. Those areas should be bolstered to the same level as medical care is addressed.	All decisions are subject to judicial review.

Question	Response
Improve Health Outcomes. In addition to addressing health outcomes, the RFP should also have a section addressing child well-being and family functioning outcomes for youth and families. In order to meet the goals of reducing out-of-home placements, reductions in child maltreatment, etc. then Family Functioning Outcomes must also be a priority. As mentioned above, one option as a framework for addressing improved family functioning would be the Strengthening Families Protective Factors Framework based on comprehensive research about what family protective factors are linked with improved outcomes for children most notably reductions in child maltreatment. Many jurisdictions are applying this framework to their child welfare agencies in addition to community child abuse prevention efforts. The five protective factors that could be assessed for measure of improved family functioning are: Knowledge of Parenting and Child Development; Parental Resilience; Social Connections; Concrete Support in Times of Need; and Social and Emotional Competence of Children. An advantage of using this approach is that WV's Family Resource Centers, Home Visiting Programs, Family Resource Networks, and early childhood programs have all utilized the Strengthening Families Protective Factors Framework to guide much of their work with families.	This is independent of this contract.
We are pleased to see a priority placed on increasing enrollment in the number of families enrolled in the WV Home Visitation Program. This is a goal that we share. However, state funding has not been increased for WV home visiting programs for several years. We would request consideration of an improvement package to be proposed for the state budget to increase local capacity of home visiting programs to meet this goal. Similarly, there are other community-based prevention programs including Starting Points Centers, Family Resource Centers, prevention projects funded by the WV Children's Trust Fund, the coordination that is offered via Family Resource Networks (FRNs), etc. all of which have had level funding for several years. If we are truly going to address the growing number of children who are at risk then our support for community based prevention efforts must keep pace. We have failed to do so. These programs are being asked to do more than ever, but with stagnant funding it is increasingly more difficult to do so.	This is independent of this contract.
APPENDIX G: Service Level Agreements (SLA)/Liquidated Damages Matri - Instead of levying penalties consider withholding capitation rate payments. Within the matrix please consider the following for each item number listed below: 3. $100 per rejected encounter seems too low. The impact of a denied service can be profound.	No change.
4. Reduce the time frame from 30 days to 15 days.	No change.
5. Increase the time of notice to be provided to at least 30 days. Consider making a portion of the penalty payable to the family.	No change.
7. Bolster background check requirements.	No change.
11. Increase requirements from 95% to 98% and provide notice within 5 days not 7.	No change.
12. This is the first mention of co-payments. Charging co-payments to families at risk of foster care and families who are in foster care can be a barrier to accessing services. This needs to be handled only as a family has ability to meet them, and I would discourage co-payments for this population.	This population is exempt from co-pays.
14. Increase penalty to $500 per claim not paid within 30 days.	Change made to contract; different from recommendation.
15. The queue time needs to be as low as possible, but is not specified in the RFP.	Change made to contract to reflect call center metrics.
Please explicitly state how this is expected to impact the foster care home shortage in the state	Not applicable to contract
Will dropping back re-certification of foster homes to every 3 yrs make children ineligible for Title IV-e foster care reimbursement if the home is not re-certified every 12 months?	Not applicable to contract
Please include who is responsible for making placement decisions	DHHR is the legal authority to make this decision; all decisions are subject to judicial review.
Is it allowable for MCOs to subcontract?	Yes.
If BCF is still providing socially necessary services is what the MCO is offering duplicative?	All socially necessary services will be authorized under this contract for all recipients.
Can WV's broadband support the processes and procedures outlined int he plan?	Not applicable to contract
There are 13 Family Visitation Services in the state currently, are there plans to boost this capacity?	Not applicable to contract
Doing the first contract for less than 3 years to get back on a state fiscal cycle makes sense to me, so I'd suggest leaving this as is even with the later start date.	No change made.
The timing here seems tight. What would happen if the state or the MCO decided not to renew and you only have 30 days notice? I'm not a contracting expert but wonder if there is an interim step that should be considered to make a surprise end less likely – like a letter of intent to renew or something like that 90 days prior.	Recommendation accepted; contract amended to require 90 day notice.
I don't have an informed opinion on this, but would be good to raise with foster care experts – maybe list someone like a caseworker more specifically than the entire Bureau. (Definition of authorized rep)	This definition will be updated.
Not relevant here. Are there other things to call out for choice counselors to do? Maybe they could help with making sure it's clear that the child can disenroll from the MCO without having to lose Medicaid coverage. (Definition of Choice Counseling)	Choice counseling is not applicable under this contract and will be removed.

Question	Response
Here's the definition WV uses for medically necessary in EPSDT, which is a little clearer than this one. Medically necessary services – covered medical or other health services, which a) are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity, or limitation in function, cause illness or infirmity, endanger life, or worsen disability; b) are provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions; c) are consistent with the diagnosis of the conditions; d) are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency, and independence, and e) will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age. For more on WV's EPSDT info – see AAP fact sheet https://www.aap.org/en-us/Documents/EPSDT_state_profile_westvirginia.pdf (Definition of Medically Necessary)	Definitions updated to align with the Bureau for Public Health.
I suggest adding a refernce to Bright Futures here – it's already part of WV's EPSDT periodicity schedule, but never hurts to repeat it. https://www.aap.org/en-us/Documents/EPSDT_state_profile_westvirginia.pdf (Definition of Periodicity Schedule)	No changes made to contract.
WV provides pregnant women with all Medicaid services and does not limit to pregnancy-related services (see p. 13 https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WV/WV-15-0006.pdf). I think this is worth clarifying with the state and possibly removing the reference to pregnancy-related services to avoid confusion. If p-r services remains, the examples listed should be much broader. (Definition of Pregnant Women)	No changes made to contract.
I would like to see this specified in a way that articulates choices for all covered populations. For those in foster care, they can go back to FFS. For others, they can go back to another MCO, if they are innsured by Medicaid. (Section 4.4)	Choice counseling is not applicable under this contract and will be removed.
Again, I think there needs to be some clarification for how the enrollees will be phased in, and the process for how they disenroll if they are not satisfied with the program. (Section 4.4)	Outside scope of first year contract
These time periods will need to be updated. You can have a MCO contract that spans more than one year, but the rates must be set annually. So I think you'll need one 6-mo period, then two 12-mo periods if you want to stay on SFY. (Section 4.5)	This section has been updated.
This section should reference 42 CFR 438.66 to make sure the state is complying with all of the monitoring requirements. It would also be worth specifically mentioning 42 CFR 438.66(e)(3)(i) which requires the state to post its report on the public website. https://www.medicaid.gov/medicaid/managed-care/downloads/information-required-on-public-website.pdf (Section 4.9)	Reference to 42 CFR 438.66 has been added.
If HB 2010 does not pass, or if the amendments requiring 80 percent of the MCO staff work in WV, please require that designated positions—specifically those working in wraparound services and in community engagement—be located in the communities where services are provided. This has been an ongoing concern in community discussions as the program was being planned. Community outreach and case management can't be done remotely. I don't think that that is the intent, but it would be meaningful to specify this in the contract. (Section 5.10)	The W.Va. Code §9-5-27 requirement for staffing is outlined within the contract.
Worth asking legal aid if they have a better standard to suggest (Definition for "failing substantially, pg. 30)	No change made to contract.
This shouldn't be relevant for this population except for non-ER use of the ER and some non-preferred drugs. There are other sections of the contrat that also reference premiums and copays, probably standard language from other Medicaid MCO contracts, but they should be deleted or clarified here. (pg. 30)	These references are outlined for populations that may be subject to them during later phases of this contract.
This should be strengthened to include some of the specifics from the draft RFP (In regards to failing to maintain an adequate network, pg. 30)	Appropriate action will be taken against the MCO for failure to provide services timely, as outlined in the Service Level Agreements.
These phased in populations—many of them are not under FFS foster care. Can they choose to be under another MCO, or if once they qualify for the program, are they required to choose beween this specific MCO or FFS?	Outside scope of first year contract
Would like to require the MCO make this information available to a group of stakeholders or via an online dashboard. (EPSDT performance, pg. 56)	The MCO will be required to report on specific metrics as outlined within the contract and W.Va. Code §9-5-27.
Participation of health care providers in MDTs has been recommended for quite some time. This is an opportunity to do this, and I suggest requiring, perhaps not at all MDT meetings, as that might not be feasible, but at some meetings, a health care provider be part of the process. Health care providers have a more indepth understanding of addiction, trauma, etc. Their insight would be a valuable addition. (Section 2.6.2)	No changes made to contract.
This should reference 42 CFR 438.68, 438.206 and 438.207 (Section 3.1.1)	This has been updated.
This should be adjusted to reflect the total expected population under the contract – the number of enrollees per provider should be much lower. (Section 3.2.2)	Changes have been made to the network adequacy standards to address this concern.

Question	Response
Please be mindful that in our more rural areas, people notice when young people enter/exit the local health department. In my experience, this has been a deterrent for not only young women seeking birth control, but for young people getting screened for an STD. There will also be times when adolescents who are covered by the MCO program have a legal right to seek reproductive services and will not want their parents/caregivers to know they are receiving them. In our rural areas, the health depts have very limited service days/hours for reproductive health issues. (Section 3.4.2)	Members are not required to use Local Health Departments, but the MCO must reimburse for services received there.
Consider making this a requirement for this population (Section 3.4.5 Contracting with SBHC)	We have reviewed this comment and no changes are being made.
Consider making this a requirement for this population. (Section 3.4.8 Contraction with CSHCN providers)	We have reviewed this comment and no changes are being made.
Believe this should just be FFS. (Section 4.2.4, pg 90)	This has been amended.
Believe this should be deleted and replaced with instructions to transfer to FFS. (Section 4.2.4.2)	This has been amended.
Continuation of Benefits Page 108 – 7. – next to last bullet should be deleted. This language is from a previous version of the regulations and was eliminated in 2016. See 42 CFR 438.230(c). This is more important than it may seem. It seems like a small fix but has huge implications for kids with chronic needs. It relates to continuation of services pending appeal. Previously, the agency has allowed MCOs to cut off aid pending appeal before a hearing decision if the end of an authorization period was reached. For example: a child was receiving 30 hours of private duty nursing services per week and the agency terminated it. If an appeal was filed before 10 days , services should continue at that level pending appeal. However, this clause in the regulation allowed MCOs to end services at the end of an authorization period. So, if the nursing services were terminated effective May 31 and the hearing decision didn't come out before that date, the MCO could cut them off. (page 108, Continuation of Benefits)	This has been amended.
Cannot stress this enough—Would love to see quarterly stakeholder meetings discussing the reports, as well as a dashboard made available online. (Section 6.11.1)	HB2010 requires stakeholder engagement and data sharing
These seems in conflict with the centralized system in HB 2010. (Section 6.11.2)	DHHR will align all provisions of the contract with W.Va. Code §9-5-27.
Some of this must also be made public per 42 CFR 438.602(g) (Section 6.11.8)	DHHR will publish all required documents.
We recommend that the dental director, or a designated staffer within the dental program, required to be a member of the state oral health coalition. (Section 10.3)	We have reviewed this comment and no changes are being made.
We recommend that the behavioral health director, or a designated staffer within the behavioral health program, required to be a member of the WV ACEs Coalition. (Section 11.2)	We have reviewed this comment and no changes are being made.
If the focus group is meant to be a meaningful opportunity for honest feedback, we suggest a third party play a role in facilitating the focus groups. (Section 12.6 and 13.2)	We have reviewed this comment and no changes are being made.
Does the procurement of a MCO to provide vulnerable youth populations with statewide managed care services require a Centers for Medicare & Medicaid Services (CMS) waiver?	Yes, a 1915(b) waiver will be submitted.
Is there any expected or anticipated interaction between the MCO awarded to provide services to foster care and at-risk youth and families and the MCOs providing managed care services to Mountain Health Trust enrollees?	There is no required interaction, but collaboration may occur to assist all parties if a child is covered by this entity and a parent/caretaker is covered under the MHT program.
The Committee on Health and Human Resources moved to amend WV HB2010 for the transition to managed care from July 1, 2019 to January 1, 2020. Should this amendment be fully approved, what are the impacts to the proposed contract term?	The contract term shall run January 1, 2020 to June 30, 2020, and then begin an annual cycle thereafter.
What is the schedule for release of the Data Book including historical experience with the RFP vendors/ bidders?	All data books will be released in conjunction with the RFP. The projected release date is June 2019.
Will the State share additional multi-year information by key categories of service or historical trend information to support cost calculations?	All data books will be released in conjunction with the RFP. The projected release date is June 2019.
Will the State share additional cost and trend information on the newly added benefits that are not in the historical data?	All data books will be released in conjunction with the RFP. The projected release date is June 2019.
Can the State share if recent increase in Opioid use is reflected in the historical data?	All data books will be released in conjunction with the RFP. The projected release date is June 2019.
Are there other items/ benefits not reflected in the FFS historical experience that needs to be considered?	All data books will be released in conjunction with the RFP. The projected release date is June 2019.
What is the process to negotiate rates?	There is no rate negotiation. The State will establish the rate range for the bidder to bid within.
Can the state provide the data feeds and their frequency that the MCO will receive from WV Bureau for Medical Services?	The MCO will receive daily enrollment files; monthly capitation. Encounter data requirements are outlined within the contract.
What is the RFP evaluation scoring methodology?	70 percent of points are awarded to vendor response; 30 percent of points to pricing.
How will enrollment work given that members have the opportunity to opt-out?	The State is collaborating with its fiscal agent to work on an enrollment process.
Is there a defined process for coordinating care with the placement agencies that will be regulated with the award of this RFP?	The Department is currently working on the operational process between the MCO and the child placing agencies.

Question	Response
What type of information pertaining to the Judicial System and services being ordered for the child will be conveyed to the MCO and how will it be delivered?	All court ordered services will be required to be covered by the MCO.
I suggest this be changed to HealthCheck age-appropriate preventive health screening form. Developed in coolrdination with the OMCFH Pediatric Medical Advisory Board, the HealthCheck preventive health screening form and health history forms aid the determination of trauma history and any current trauma-related symptoms. The forms integrate socio-behavioral factors examined in the Adverse Childhood Experiences (ACEs) Study & beginning at age 9, an abbreviated Post-Traumatic Stress Disorder (PTSD) Checklist – Civilian Version (PCL-C). By integrating this trauma screening into the regular screening activities taking place under EPSDT, West Virginia conclusively meets the requirement (of the Child and Family Services Improvement and Innovation Act of 2011) for states to include in their health care oversight plans a description of how they will screen for and treat emotional trauma associated with maltreatment and removal (for children in foster care). HealthCheck age-appropriate screening forms are revised with each iteration of AAP's Bright Futures Guidelines. https://dhhr.wv.gov/HealthCheck/providerinfo/Pages/default.aspx (Section 2.2.1)	This has been updated.
HealthCheck preventive health screening form (Section 2.2.2)	This has been updated.
If the managed care plan's contract includes coverage of services within the EPSDT benefit, the plan's enrollee handbook must include information about EPSDT, both information on services provided by the plan as well as other EPSDT services delivered outside the plan and how to access them if applicable. CMCS Informational Bulletin - January 5, 2017 https://www.medicaid.gov/federal-policy-guidance/downloads/cib010517.pdf (Section 4.4.3.1)	This will be required of the MCO handbook.
Vendor should describe the procedures and protocols for using the family service plan (FSP) information in the development of the member ISP (individualized service plan) and to authorize services. Link to additional information: https://dhhr.wv.gov/bcf/Reports/Documents/West%20Virginia%20Child%20and%20Family%20Services%20Plan%20%28CFSP%29%202015-2019.pdf •Who is responsible for completing the FSP and who is responsible for testifying at the hearings? •What type of involvement would the MCO have in this process?	The DHHR caseworker will retain the responsibility of the development of the plan. The MCO will be responsible for ensuring the services outlined in the plan are delivered timely and provide support to the DHHR caseworker on development, as needed.
Vendor should describe how a vendor would evaluate and report member progress in meeting goals identified in the ISP. a.Will DHHR maintain their existing responsibilities around the ISP?	The DHHR caseworker will retain the responsibility of the development of the plan. The MCO will be responsible for ensuring the services outlined in the plan are delivered timely and provide support to the DHHR caseworker on development, as needed.
Vendor should describe how the vendor will provide outreach and training in an ongoing manner to youth and young adults and their respective caretakers who are eligible for services. a.Can you please elaborate on what type of training you are expecting?	The MCO should discuss the types of training it would provide as a part of the RFP response.
It appears from the RFP that placement will still be primarily the role of DHHR Case Workers. How will DHHR facilitate the involvement of the MCO with the Case Worker prior to placement to help ensure placement in the best possible setting?	Placement will remain a responsibility of the DHHR caseworker. The MCO will assist as needed by the worker.
In the past, KINSHIP caregivers have not be recruited by the Foster Care providers but have been evaluated by DHHR Case Workers. Will DHHR allow MCO the ability to aggressively pursue KINSHIP placement and/or have Case Workers pursue.	This will remain a responsibility of the DHHR caseworker.
It appears from the RFP that DHHR will retain primary case management responsibility. If so, what is MCO does not concur with DHHR Case Worker decision?	The MCO shall adhere to the decision of the DHHR caseworker, MDT and/or court, but should document and provide all recommendations, as appropriate.
How will rates be developed and what components will be included in the rate development? Will there be an assumed managed care savings and if so what amount? Will amounts currently dedicated to programs such as "safe at home" be incorporated into the reimbursement and if so how will this be accomplished?	Rate documents will be provided as part of the procurement, but dollars associated with Medicaid services, dollars paid by BCF for residential services, and an administrative rate for SNS oversight will be integrated into the rate(s) development.
Section 2.6.2—states that MCO shall be responsible for participating in MDT process at the request of the worker, judge or MDT. Could there be consideration for making this mandatory? As an MCO, we are considered that there may be Case Workers who want not see the value and we believe that this is an integral part of meeting the needs of the child. By making it mandatory would ensure both sides are engaged in discussion regarding the needs of the child.	No changes made to contract.
Section 4—notes that MCO will be provided an enrollment roster on a monthly basis. One of the key components of the Foster Care process is the immediate and prompt delivery of crisis services when the child is removed from the home. How will the state ensure that the MCO is involved from this first (and often most important) event. As an MCO, we would hope to be able to direct the care to appropriate resources and ensure access to necessary services as early as possible.	DHHR is working on a strategy by which to provide a daily roster to the MCO so they may begin care coordination immediately.
Section 6.3—will the state help facilitate retention of the child in the Foster Care MCO rather than automatically transfer back to the previous MHT MCO or WVHB MCO. MCO understands that member would have the right to select any available MCO but continuity would be much enhanced if the child were able to remain in the Foster Plan unless that plan is not an available MHT MCO, etc.	While not a component of phase I, DHHR is evaluating strategies by which the child would remain with the specialized MCO even after reunification and transition back to traditional Medicaid for continuity of care purposes.

Question	Response
Questions/Comments regarding measures from 7.8: •The percentage of children the vendor has been able to successfully transition to in-state care, recognizing the limited capacity of services that may be available given specific needs of the child. oAchievement of 50% transition of all eligible youth that have the ability to transition to in-state placement shall qualify for full reimbursement of 1% of withhold amount. Please explain exactly how this will be measured and what data will be used. Also, will the MCO have the ability to initiate placement changes or will that require the approval of the DHHR Case Worker?	Withhold requirements are being removed from year 1 of the MCO contract, but will be integrated into the RFP as an evaluation criteria for how the MCO would work to achieve these goals.
•The percentage of children the vendor has placed in out-of-state care. oAny percentage less than 3% of all eligible youth shall result in full reimbursement of 1% of withhold amount. Can you provide an explanation of current results and the proposed 3% and how that will be calculated? Currently (Feb data) 28.36% of your are placed in out of state Group Residential Care and 50% are placed in long term psychiatric facilities that are out of state. The overall rate is 6.05% so in order to reach the 3% target would require a reduction of 50% or over 200 cases. This is highly unrealistic with a new program where systems of care will need to be developed with the provider community to make services more available within the state. It would seem to make more sense to require a reasonable reduction each year until less than 3% is achieved.	Withhold requirements are being removed from year 1 of the MCO contract, but will be integrated into the RFP as an evaluation criteria for how the MCO would work to achieve these goals.
•Successful implement of an electronic health record (EHR) system that serves as a health passport for members within the first year shall result in award of 2% of the withhold amount. Per the American Academy of Pediatrics, the health passport should include, at a minimum, the child's chronic health problems, allergies, medications, psychosocial and family histories, trauma history, and developmental and immunizational information. Explain how the achievement will be measured.	Withhold requirements are being removed from year 1 of the MCO contract, but will be integrated into the RFP as an evaluation criteria for how the MCO would work to achieve these goals.
5.8.5.1 Pay and Chase -- As clarification, we read this to state that Prenatal and Preventive Pediatric Services, Labor and Delivery Services and RFTS services must be paid and MCO must attempt to seek recovery from the primary coverage. The other piece under MEDICAL ENFOCEMENT SUPPORT is confusing—it states that if third party coverage is through an absent parent, that the provider must certify that it has billed a third party and must wait 30 days—What if the provider is unable to secure sufficient information from the absent parent in order to bill the third party for the services? (IE: may not even know the name of the plan, ID number, employer, etc.)	No changes made to contract; this is guidance from CMS.
8.7 IMD, assume timeframes will be change to 15 days, please confirm?	The contract will be updated to accurately reflect IMD policy and qualifying populations.
12.1—States that MCO must offer contracts to all SNS providers contracted with BCF, Questions: a.Will BCF permit the MCO to provide contractual requirements that may be more restrictive than current requirements specifically in regarding to record keeping, preauthorization of services, availability, etc? b.Will BCF permit the MCO to terminate contracts if it is determined that a provider is not effectively providing care and service and such needs can be met through other providers of service? c.Will MCO have the ability to direct care to SNS providers who have proven to provide services in the most efficient and effective manner?	During the initial contract period, the MCO shall be required to adhere to the outlined requirements within the contract, however, shall be responsible for identifying the provider of services and may direct referrals to providers performing best.
Section 12.2 thru 12.6 including Appendix J—The section describes the various socially necessary services and provides the guidelines that the state has developed for these services. This seems to limit the flexibility of the MCO to contract with providers through more effective payment mechanisms that would promote a more Holistic approach to the services and to develop comprehensive programming similar to a "safe at home" program. Will plans have the ability to develop and implement flexible payment models and review mechanisms or will the MCO be required to follow the prescribed process and reporting.	The MCO will serve as an ASO for SNS and will not be responsible for contracting/service payment in phase I. Providers will continue to submit invoices directly to BCF for reimbursement.
13.1—states that state shall define for the MCO the category by which each facility falls in alignment with FFPSA—Can further explanation of the categories and how that impacts delivery of care and services in WV be provided?	At this time, no additional information can be provided.
13.3—Children Residential Treatment Facilities and Emergency Shelters—Can MCO be provided with BCF provider agreements to better understand requirements? Are there contracts in place with out of state facilities and can these be shared?	Yes, these documents will be shared as part of the procurement library that will accompany the procurement.
14 Personal Care Services—can you provide more information on the process used by the independent assessor to determine medical necessity? What is the background of the assessor? What criteria is used to determine medical necessity? How will the need for these services be incorporated into the MDT process?	This has been amended such that the MCO must contract with an independent evaluator to determine the types of services needed, prior to the provider rendering.
Appendix J—CPS Family Support Services—Services are outlined in a very detailed manner, what flexibility is permitted with these services under the MCO management? For example, if the MCO through a value based agreement with current foster care providers/SNS providers the provision of a health risk assessment during the home visits, is the MCO able to make payment for additional Case Management services.	The MCO will not be responsible for payment of these services, but serve solely in an administrative role.
Appendix J—list IN-State and out of State Home study—would this fall under MCO since this typically occurs before placement.	The MCO will not be responsible for payment of these services, but serve solely in an administrative role.
Appendix J—is MCO required to specifically adhere to all required service limits and limits and indication or does MCO have ability to modify criteria based on	The MCO will not be responsible for payment of these services, but serve solely in an administrative role. The MCO will be required to adhere to the current BCF policy manual under Contract Year 1.
Appendix L-- Quality Measures: Believe this is a duplication of 7.8, please confirm.	Yes, this is duplicative and will be amended.

Question	Response
We would hope that sufficient data would be provided with the RFP to allow the MCO to clearly evaluate and assess the program needs. In order to do so, we would recommend at a minimum the following data elements: •Utilization statistics by patient broken down by: oInpatient oOutpatient oBH oPharmacy oSocially necessary services oResidential payments oNOTE: would need to reflect the population type and age – in 2014 file that was provided gave a rate code which enabled us to define the population unfortunately it did not give a member identifier so that we could stratify the populations to know the required resources. •Utilization/Cost statistics by provider showing provider type—if utilization data provides a provider detail a separate report would not be required. •Family Preservation Services by type of services •Adoption Preservation Services by type of services •Reunification Services •Foster Care Independence Program Services •CPS Foster Care Services •CPS Family Preservation Services •CPS FAMILY SUPPORT SERVICES	Data workbooks will be provided as part of the procurement.
Emergency Shelter Services --reporting is needed to understand where these services are currently delivered, for what period of time and at what costs. --reporting is needed to understand out of state placement frequency and what facilities are used out of state for Shelter Services	Data workbooks will be provided as part of the procurement.
Children's Residential Services --reporting that breaks out residential & SNS (what percentage and can payment be allocated differently or reporting required to validate needed SNS are provided—what if outside provider is needed for a socially necessary services that the Residential facility is not able to provide, is that paid by the facility or the MCO? --Can DHHR provide reporting and costs associated with Residential services and provide a breakdown of facilities in and out of state, the number of foster children placed in each facility, the average length of stay by facility, and what services are provided by each facility?	Data workbooks will be provided as part of the procurement.
My overall response is that the contract and other materials need to be rewritten to address the specific characteristics of the child welfare system. Attaching pages of current provider materials as an appendix does not satisfy this need. Specifically, DHHR needs to set out its own vision for its child welfare system along with the legal parameters within which it is working. These legal parameters include the principles included in the WV State Code for child welfare and juvenile justice/youth services. DHHR needs to be clear that all operations contracted out to an MCO must follow this vision and these principles.	Goals are identified within both the RFP and contract.
As part of its quality measures, DHHR needs to specify how the MCO will address 1) each of the individual recommendations of the US Department of Justice in its 2015 report; 2) any other applicable court actions or case law; 3) requirements for each of the funding sources that are being braided into supporting the contract; and 4) specifically, the new federal Family First Prevention Services Act requirements.	This will be a collaborative approach between multiple stakeholders as quality measures are defined.
DHHR must specify in detail how the MCO will interface with and build on its own child welfare and youth services casework and on the existing collaborative arrangements in each of the state's counties and DHHR service delivery regions. These specifications cannot be dictated by the MCO, or performed at its discretion, as described in the current materials. DHHR has an obligation to identify and build on what is working and to ensure that any MCO contract supplements, not overrides, the state's current capacity.	The MCO will assist with identifying service gap areas and make recommendations to the Department, who retain authority on building additional capacity.
This population of children, youth and their families, many with physical, oral, and behavioral health needs, may lack access to regular primary care, dental care or behavioral health care. For foster care youth that have transitioned to out of home placement, many have been exposed to Adverse Childhood Experiences (ACEs). This results in early toxic stress and trauma and the need for intensive care coordination to help address complex needs of this vulnerable population. *The last paragraph here does not address the need for socially necessary services. This need may be particularly critical for children and families with a documented case plan. (Section 1.1)*	We have reviewed this comment and no changes are being made.

Question	Response
4.1 There is currently a fragmented system of care for our youth and families at risk. The selected vendor for this procurement will provide services to foster care and at-risk youth and families statewide. A single MCO will be selected to oversee and coordinate both health and social services. Given the complex needs of the population to be served, it is encouraged, but not required, that the vendor subcontract with regional child welfare organizations to assist in the care coordination of services for this population, to combine the subject matter expertise of both fields to best meet the holistic needs of our youth. *There is no requirement that the MCO subcontract with or otherwise interface with regional and local child welfare organizations that are already successfully coordinating their services. If the MCO sets up a dual system, this can drain energy and resources from a system that is already working.*	We have reviewed this comment and no changes are being made.
Vendor should describe how the vendor will coordinate care across systems, including the educational system, and continuity of care between health care providers, child welfare providers, behavioral health providers and care managers with an integrated care plan for all children, and how this information will be shared with the member, their family or representative. *It is unclear how this integrated care plan will build on or interface with existing integrated care plans that function in some communities.*	No response provided as the vendor is required to provide insight into their approach under the procurement process and DHHR does not want to influence response.
Vendor should describe how a vendor would provide training to ensure a plan of care that is jointly developed and shared among the primary care provider and/or specialist serving as a principal coordinating physician, and the child and caregiver(s). *Again, there is an assumption that such an integrated plan does not already exist. Where it does exist, there is no requirement to use it, while the MCO has an incentive to make work for itself.*	No response provided as the vendor is required to provide insight into their approach under the procurement process and DHHR does not want to influence response.
Vendor should describe the procedures and protocols for using the family service plan (FSP) information in the development of the member ISP (individualized service plan) and to authorize services. *DHHR should be dictating its current requirements and procedures for child welfare and foster care plans and requiring the MCO to fit its work into this context. These requirements should include the use of the MDT as required in the WV State Code, while recognizing that these requirements are not being met in all jurisdictions. DHHR should focus on meeting these requirements where they are not being met.*	No response provided as the vendor is required to provide insight into their approach under the procurement process and DHHR does not want to influence response.
Vendor should describe how the vendor would establish relationships with Child Protective Service (CPS) workers and coordinate the needs of the child, so as to reduce duplication of service and improve access to the most appropriate service needs. *The WV State Code, policy, and best practice already require the CPS workers to coordinate the needs of the child. DHHR should dictate these relationships and state how the MCO can add value to them, not leave this up to the MCO to establish.*	DHHR will work with the vendor and DHHR caseworkers to establish operational procedures that add value and do not create additional barriers, but the State does seek feedback from the vendor as part of the procurement process.
Vendor should describe how the vendor will build relationships with the Judicial System to help drive the services being ordered for the child are in the child's best interest and most medically appropriate. *Likewise, the relationships with the Judicial System are already dictated in law, policy, and best practice. These relationships vary by circuit, but DHHR should take the lead in achieving a high standard in all circuits, not delegate to an MCO to come in and do this for them, even where the relationship are successfully established. The law already dictates that the services be in the child's best interest, which would include being medically appropriate.*	At times, decisions are made without all of the relevant information regarding the child. The vendor is required to build relationships with the court, guardians ad litem and caseworkers to ensure these individuals have all of relevant information to make decisions in the child's best interest.
Vendor should describe how the vendor will work with caregivers and families to help track appointments enrollees are scheduled for and may miss without further reminders or assistance. *This is supposed to be a centerpiece of the care management system, but later provisions in these materials allow the MCO to assign the children to tiers and make its own decisions on who gets care management services and at what level of intensity. Caregivers and families paid for by DHHR, e.g. through foster and kinship care, already have responsibility for tracking and ensuring that appointments are scheduled and kept. It would be more cost effective and self-sustaining to make sure that each family has a smart phone and access to cell or internet service with training on how to use universal reminder systems and apps.*	This is outside the scope of this procurement.
Vendor should describe how they would use telemedicine, telehealth, and telemonitoring services including opportunities to use video conferencing to improve quality or access to care. *There is no recognition here of the lack of broadband or cell service in many parts of the state, and/or the lack of affordability of families to maintain these services if they exist.*	This is outside the scope of this procurement.

Question	Response
Vendor should describe how the vendor would establish Intensive Care Management (ICM) teams for individuals with one or more chronic conditions, including how members would be identified for participation, plans that would be developed specific to each case and the composition of such a team. *In this provision as throughout the materials there is no requirement that a care manager ever see a child, youth or family in person. This is a major deficit in these materials and the whole approach to managed care. In order to be successful, plans must be based on in person knowledge of a child or youth, caregivers, and family of origin.*	No response provided as the vendor is required to provide insight into their approach under the procurement process and DHHR does not want to influence response.
Vendor should describe how they would leverage predictive modeling as a support tool to help with stratification of members into risk tiers for care management services. *This provision documents points to not all children and youth receiving care management, with decision made based on digital models without in person knowledge of the child or youth and their individual situation.*	No response provided as the vendor is required to provide insight into their approach under the procurement process and DHHR does not want to influence response.
4.2.1.3. Vendor should describe how they will leverage the WV 2-1-1 resource to help members find resources available to them in their communities. *This seems to be sending children, youth, and families to an easily accessible system that already exists and that they may already know about. DHHR could accomplish this through a brochure that its workers use as part of their toolkit with children, youth, and families. It doesn't require the involvement of an MCO.*	This has been deleted from the procurement.
4.2.1.4 Based on the vendor's experience and projections, the vendor must determine its expected costs under the contract, evaluate the rate methodology and related information within the solicitation, and assess whether the projected contract value is achievable. Vendors must differentiate themselves based on quality, network access, efficiency, value added services, community partner engagement and collaboration, and care management support for members as demonstrated through the technical proposal and resulting score. Reimbursement for this contract will be designed using a braided funding stream, with Medicaid and Bureau for Children and Families dollars being blended to develop a monthly capitation payment for holistic care. *The way this reads, the MCO dictates the parameters of its services, rather than DHHR. From statements made by DHHR to the legislature and elsewhere, it appears that DHHR is proposing to combine its resource for child welfare and health/behavioral health service and basically turn these over to an MCO to figure out how best to use them. However, this approach is complicated by DHHR not playing an active role in defining what its own staff is doing and how the MCO can add value, and by the fact that some families may choose to opt out of the MCO and stay with a fee for services system.* *Even if DHHR dictates that all children in state custody move under an MCO, since, as the guardian, it would make that decision, the children, youth, and families in the categories that do not involve state custody, e.g. adoptive families, youth aged out of foster care, and at risk families, could all, one hundred percent, choose to stay under fee for service. In this case DHHR will still need to retain control over its Medicaid and BCF funds in order to provide services to these populations.*	DHHR retains full authority and control over the contract.
4.2.2.2 The vendor will be required to have a physical presence in West Virginia, including the operation of call management services through the WV location. *This requirement does not preclude call management services based outside of the state. It also points to the use of phone and internet contact v. in person contact as the default position. Again, there is nothing that requires in person contact with children, youth, or families.*	The requirement to operate a call center within the State is independent of face-to-face engagement the MCO may engage in as part of its care management approach.
4.2.2.5 The vendor shall establish committees with family members, member, providers, care manager and state lead to help develop the most appropriate care plans for the member. *MDTs are already required to perform this function. Care managers are not required for all children, youth, and families. No in person contact is required.*	No change made to contract.
4.2.2.8 The vendor shall establish a provider profile report card with input from stakeholders and submit individualized results to each provider as to their scores in meeting specific measurable outcomes. *There is no recognition of existing quality control by providers, also no definition of what providers are affected or what the consequences are for poor outcomes.*	Modifications have been made to this specification.

Question	Response
Key Personnel: *None of these critical positions includes any requirements related to child welfare and foster care. The closest is the position related to socially necessary services and wraparound, but even here this experience could be based in a medical model behavioral health setting without any direct relationship to the child welfare system. Consider how this focus on insurance and Medicaid will affect all of the downstream positions and decisions, without any grounding in the casework model on which child welfare and foster care are based or in the social work ethics and values that are intrinsic to this model.*	Care managers will be dually trained in BMS and BCF policies, with staff being required to be knowledgable of child welfare, either as a result of having a social worker license or other certification.
Vendor shall meet staff credentials for key staff and care managers to be established by the State with input from stakeholders. *Even if the state dictates requirements for social work licensure or other professional credentials, these positions will be totally dependent on an administrative and management structure that is independent of them.*	No change made to contract.
Vendor shall describe their experience in at least one other State with managing the foster care population and provide statistics on quality improvement that has resulted from their participation, in addition to financial savings achieved within that state(s). *DHHR has testified to the legislature under oath that no other state is currently utilizing a comparable model to the one proposed by WV where child welfare funds will be integrated with Medicaid funds and turned over to the MCO. In this context, it's critical to realize that experience in other states cannot directly apply and this is a situation of comparing apples and oranges. It would make more sense for DHHR to state exactly the improvements it wants and ask the vendors to document their experience in achieving these results.*	No change made to contract.
4.2.2.3 The vendor shall meet with the Department and industry specific provider councils on a monthly basis during the first year of implementation and quarterly thereafter, as needed. *It's unclear what is expected from these meetings. Is this the mechanism for coordination and quality assurance? Is it only a way to facilitate the implementation of a contract over which the stakeholders have no influence? Do industry specific provider councils include the voices of foster, adoptive, and kinship families? Of youth? Is there a role for the public?*	No change made to contract.
4.3.2.6 The vendor shall have at least one member of its care management team participate in all multi-disciplinary team meetings as deemed necessary by the caseworker or court system. *Note that there is no requirement that this participation be in person or that the team member have in person contact with the child, youth, or family who is being considered.*	No change made to contract.
4.3.2.7The vendor shall contract with specialists to assist in making medical or social service decisions should the MCO not be proficient in a given area. *There is no requirement that the MCO be proficient in casework in general, How will they even know the kind of specialists they need? Again, there is no requirement that anyone have in person contact with the child, youth, and family.*	No change made to contract.
4.3.2.8The vendor shall have experience in working with vulnerable populations. *This is a generic description that could be met in a wide variety of ways. It does not require specific experience with a casework approach to the types of situations that are characteristic of the child welfare and foster care populations. This is consistent with the lack of requirements in the other provisions as noted above.*	This has been amended.
I-7 MCOs are required to have a Medicaid Administrator/Contract Liaison with substantial experience in health care, experience working with low-income populations, and cultural sensitivity. Define the timeframe for initiating and completing training of the Medicaid Administrator/Contract Liaison. Describe any additional training or materials the MCO will provide to the Member Administrator/Contract Liaison to support the enrollment of the foster care population. *Health care, low-income populations, and cultural sensitivity are all generic descriptions that are not specific to the child welfare and foster care populations. This provision acknowledges this deficit by requiring provisions for additional training or materials.*	The provider application has been deleted from the procurement package.
1-13Provide the number of current Medicaid enrollees in other states, by state. Describe any experience managing services for members in other Medicaid programs or other lines of business within West Virginia. *This provision does not include experience with child welfare and foster care or socially necessary services.*	The provider application has been deleted from the procurement package.

Question	Response
II-33Describe efforts the MCO has made or will make to contract with providers who currently serve Medicaid foster care members including providers with experience and expertise in treating populations with special health care needs. Please address multiple types of providers (e.g., physicians and other providers, facilities, pharmacies). Also include residential treatment facilities and socially necessary service providers. *The description of efforts is different from requiring involvement of these providers. There are no clear requirements for what would be included in contracts if these were utilized or what exactly DHHR is willing to pay for.*	The provider application has been deleted from the procurement package.
II-39Provide a description of the MCO monitoring process for the PCP panels. Note that the Bureau for Medical Services requires a limit of no more than 2,000 Medicaid enrollees assigned per PCP. *I cannot find clear expectations for how these panels would function.*	The provider application has been deleted from the procurement package.
II-41Provide what specialists will be able to serve as a PCP. Describe the circumstances and process under which a member may select a specialist as his/her primary care provider, including any MCO approvals required, and describe any restrictions on the types of specialists that can serve as PCPs for foster care members or other members with complex needs. *It appears that a family with a longstanding relationship with a specialist would not necessarily be able to continue in that relationship, e.g. a child with congenital heart defects who is followed by a cardiologist from the time of birth.*	The provider application has been deleted from the procurement package.
III-57For members who do not indicate a PCP preference at the time of enrollment, describe the MCO's process for notifying the member of PCP assignment, educating members of the right to change PCPs, and any follow-up communications the MCO will conduct to ensure that the member is aware of the assignment. *If the child's or youth's guardian makes the decision on his/her behalf, and all children and youth in state custody are under the state as the guardian, then who exactly makes the decision on behalf of the child or youth? DHHR has indicated that this would be done by the MDT in conjunction with the court. But all jurisdictions do not currently have functioning MDTs. This section also does not address the option of the guardian to opt out of an MCO, e.g. adoptive parents, who are guardians.*	The provider application has been deleted from the procurement package.
III-60Provide a description of any outreach and transition planning efforts directed toward beneficiaries with special health care needs who are identified through the enrollment broker's health assessment. Describe if outreach will be conducted via telephone or mail. *The language in this provision only addresses health care, not behavioral health or child welfare or foster care services. All children and youth removed from their homes may be expected to have experienced trauma. How would a special health care need be defined above and beyond this? Note too the provision for outreach by telephone or mail, with no consideration of in person contact. There is also a question of how this provision would apply to children and youth under the age of 18, which is the foster care population.*	The provider application has been deleted from the procurement package.
III-61Describe how members will be made aware of available community resources and social services (e.g., member handbook, newsletter, case managers). *It is also unclear how this provision applies to the foster care population. Again, note that there is no requirement for in person contact. The apparently interchangeable references to care mangers and case managers is also very confusing and misleading, especially if case managers are not involved with in person contacts.*	The provider application has been deleted from the procurement package.
III-71MCOs may employ a Medicaid Member Advocate who has substantial experience in health care, experience working with low-income populations, and cultural sensitivity. Describe on what specific topics, including those that support enrollment of individuals with special health care needs, the Medicaid member advocate will be prepared to address (e.g., assistance with resolving access issues, obtaining materials in alternate formats, receiving assistance with grievances and appeals, promoting continuity of care). Provide the timeframe for initiating and completing training of the Medicaid Member Advocate as well as copies of the training curricula. Please provide copies of the training materials that the MCO will provide to the Medicaid Member Advocate. *How doe this position relate to a care manger? Again, there is no specific experience required related to child welfare, foster care, or socially necessary services, or for in person contact with the child, youth, or family. It is difficult to see how this position adds value to the child welfare and foster care systems and prevents additional duplication of services and complicates coordination.*	The provider application has been deleted from the procurement package.
III-72How will the Medicaid Member Advocate be evaluated in regard to meeting and addressing foster care members' needs? *It is impossible to evaluate performance in the absence of clear expectations, as noted above.*	The provider application has been deleted from the procurement package.

Question	Response
III-75Submit for review MCO/PBM training curriculum for member services staff on WV Medicaid program requirements. Please specify whether the training curriculum addresses serving members with special health care needs. Describe how the MCO will train member services representatives on serving members with disabilities and chronic conditions, the culture of disability, and the resources available to members. *These requirements appear to be limited to disabilities, and they do not reference child welfare and foster care and the trauma involved.*	The provider application has been deleted from the procurement package.
III-82Submit for review a description of methodology for a PCP assignment. Provide member characteristics (i.e. claims history, proximity), particularly for new members when auto-assigning to a PCP. Describe any restrictions on the types of specialists that can serve as PCPs for members with complex needs. *This provision duplicates a previous one and highlights how the MCO may auto-assign a PCP without the involvement of the guardian or youth. Also, it is likely that any child in foster care may have complex needs due to the trauma of being separated from his/her parents and the prevalence of cases affected by the drug epidemic.*	The provider application has been deleted from the procurement package.
IV-98Describe how the MCO educates PCPs on their responsibility to coordinate a member's overall health. *There appears to be no provision for behavioral health and child welfare, despite the avowed purpose of an MCO to coordinate overall care.*	The provider application has been deleted from the procurement package.
IV-99Describe the MCO's protocol for conducting outreach to all specialists regarding the importance of encouraging members with complex needs to seek primary care services. *This provision is confusing related to other provisions that allow a child, youth or family to use a specialist as a PCP. This would appear to encourage duplication of services, not coordination, at least in some cases where a specialist is also qualified and wiling to provide primary care.*	The provider application has been deleted from the procurement package.
IV-100Describe how the MCO will educate and provide guidance to PCPs on coordinating physical health services and ensuring that the PCP coordinates the member's medical health services, as appropriate, with behavioral health services. *Child welfare and foster care may involve socially necessary services that are different from medical health services and behavioral health services. This is not addressed here.*	The provider application has been deleted from the procurement package.
IV-104Describe any special provider education efforts that will be used to educate primary and specialty care physicians about foster care beneficiaries and members with complex needs (e.g., opportunities for standing referrals or for specialists to serve as PCPs, availability of case management/disease management). Please provide an overall summary of provider training topics. *Expectations are still very confusing here, as indicated in notes on earlier passages. These are further complicated by the relationships with DHHR and/or foster care provider case managers, which aren't even referenced here.*	The provider application has been deleted from the procurement package.
V-105Describe how the MCO's will impose, monitor and track member copays and quarterly household maximums for medical and pharmacy services. *It's unclear how this provision relates to child welfare and foster care services, which have not required copays or maximums.*	The provider application has been deleted from the procurement package.
V-112Describe how the MCO's will impose, monitor and track member copays and quarterly household maximums for medical and pharmacy services. *See previous note.*	The provider application has been deleted from the procurement package.
V-121Describe the circumstances and process under which a member may continue an existing relationship with an out-of-network provider (or provider who leaves the MCO's network) if it is considered to be in the best medical interest of the member. Specify how long the MCO will allow members to see out-of-network providers that refuse to contract with the health plan for ongoing courses of treatment past the first 90 days. *Again, this passage only specifies the medical interest of the member. In child welfare and foster care, there will be other kinds of providers with other bases for the interest, like social necessity. This passage also seems to imply there could be limits on relationships with providers, whose services to the child, youth, or family may be in their best interests.*	The provider application has been deleted from the procurement package.

Question	Response
V-142Describe the MCO's process for informing PCPs on changes in a member's behavioral health status (e.g., hospitalization, emergency room usage, change of medication). Explain what constitutes a change in behavioral health status, and how the MCO will assist members to access additional services as a result of a change in behavioral health status (e.g., care manager can assist in making appointments for members). *It's unclear how this relates to child welfare and foster care services. Also, if a child, youth, or family is in a crisis that precipitates a change, the role of the care manager appears to be fairly limited and extraneous, especially if the only contact is via phone. It would make more sense for a DHHR or behavioral health case worker to be assigned a case aid to work with him or her as part of a team that actually knows the child, youth, or family.*	The provider application has been deleted from the procurement package.
VI-150Describe how the case/care management department is organized (i.e. by disease or problem type). *This passage points again to the use of a call center approach, not an approach dictated by geographical or community proximity to a child, youth, or family.*	The provider application has been deleted from the procurement package.
VI-151Describe how members are identified for participation in care management programs. Describe at a high level the MCO member screening process and screening timelines upon enrollment. Describe the MCO's protocol for assigning members to an appropriate health care professional who is formally responsible for coordinating the member's overall health care, to include behavioral health and specify whether services are coordinated by the member's primary care provider or through some other means, such as a care manager. *It is still really difficult to understand how this system is organized. This passage makes it clear that not all children, youth, and families are assigned a care manager. There is also no explanation of the relationship between the PCP and the care manager, and between either or both of them and the DHHR or provider caseworker. Again, there is no reference to child welfare or foster care or socially necessary services , only to health and behavioral health. There is also no requirement for in person contact.*	The provider application has been deleted from the procurement package.
VI-153Describe any differences in how the MCO will approach adults versus children and any internal processes that may vary between these two groups, including education, member materials, and outreach. Identify any activities or linkages with the WV Children with Special Health Care Needs (Title V) program clinics, providers, or other professionals. *DHHR should be dictating how this all works, not an MCO. It appears that work with Title V programs, providers, and other professionals is optional, not required, which would again seem to limit the role of the MCO in the coordination of services.*	The provider application has been deleted from the procurement package.
VI-154Describe identification of and services for members with special needs. Discuss any additional screening or assessment the MCO will perform and what clinical, social, or other criteria the MCO will use to determine which members require case management and assign members to case managers. If the MCO will conduct its own health risk assessment, please provide a copy of the form or protocol. *It is likely that virtually all children and youth in custody will have special needs due to the trauma of being removed from their homes and whatever led to their removal. This passages again states that it is optional whether or not a person receives case management and again seems to conflate care and case management. There is again no mention of child welfare or foster care or socially necessary services, only a health risk assessment, which is a medical model.*	The provider application has been deleted from the procurement package.
VI-155Describe identification of and services for members with behavioral health needs. Discuss any additional screening or assessment the MCO will perform and what clinical, social, or other criteria the MCO will use to determine which members require case management and assign members to case managers. If the MCO will conduct its own health risk assessment, please provide a copy of the form or protocol. Include any additional screening tools utilized in this process. *See notes on the previous passage. This is broken out for behavioral health, but there is no comparable passage related to child welfare or foster care of socially necessary services.*	The provider application has been deleted from the procurement package.

Question	Response
VI-156Describe any special member or medical management services, such as health risk assessments or targeted education programs (including those specific to members with special health care needs), that will be made available upon enrollment to members and/or their representatives. What is the MCO's process for identifying who will receive targeted education programs? What is the timeframe for creating education materials and educating the member education and care management staff? *It's unclear who these services will be addressed to, the child, youth, or caregiver. Again there is no mention of child welfare or foster care or socially necessary services. Also, what kind of value added does this represent, especially since there is no requirement for in person contact. It would seem to make more sense for caseworkers to be educated, and it would not require an MCO contract to do this.*	The provider application has been deleted from the procurement package.
VI-157Describe the qualifications and training of MCO staff who will be involved in coordinating care. Indicate whether specialized case/care managers will be used for certain conditions (e.g., experienced pediatric or cardiac nurses, behavioral health specialists). If the MCO will hire care management staff, provide the MCO's plan for hiring, including timeframes, number of the CMs, and maximum case load. *These are questions critical to the whole MCO approach. They also depend on whether or not in person contact is required, and there is nothing I have read to indicate that it is. There is also no clear design of the function of these positions or how they relate to the existing systems. Coordination of care is best achieved at the local level between caseworkers and providers who know each other and their various roles. This is a prime example of how an MCO contract establishes a duplicative and ineffective system for doing the kind of coordination that is already being done in some places and needs to be improved or expanded where it is not already in place. Also note again how child welfare and foster care and socially necessary services are not even mentioned in the mix.*	The provider application has been deleted from the procurement package.
VI-159Describe utilization analysis methods used to identify beneficiaries with special needs or receiving high cost care that would benefit from case management. *This passage points to using special needs and high costs of care as the criteria for case management. Again, it's also unclear if this is the same as care management and what its function is.*	The provider application has been deleted from the procurement package.
VI-162Describe the protocol for addressing a member that would benefit from a care manager, but does not want one or cannot be reached once a care manager has been assigned. *It's unclear if this means that it's voluntary on the part of a child, youth, or family whether or not to accept a care manager. Also who makes the decision for a child or youth in foster care, which means that they are in the custody of the state and the state is their guardian?*	The provider application has been deleted from the procurement package.
VI-163Describe the process by which the MCO will develop, update, and use clinically appropriate treatment plans that address the coordination of primary, specialty, ancillary, community and social support, and carved-out services for members identified as having special health care needs. How will the MCO identify members in need of such a care plan, and which members will receive care plans. Please provide a sample care plan. *It's unclear how this passage relates to earlier requirements for an individual treatment plan. Does this mean these plans are only available to those with special health care needs who also have a care manager? How do these plans relate to the plans now required for child welfare, foster care, and MDTs? Also, again, there is no requirement for in person contact with the child, youth, or family. In the absence of that requirement, this process makes no sense. And again the language addresses only special health care needs, not behavioral health or child welfare, foster care, or socially necessary services.*	The provider application has been deleted from the procurement package.
VI-164Provide the frequency with which care plans will be shared with PCPs and other providers and in what manner (e.g., letter, phone call). Describe who is responsible for sharing care plans with a member's PCP, and what will prompt the MCO to share care plans (i.e., events that occur before the next scheduled date to share the plan with a PCP). *This again gets to the heart of the relationship between the PCP and the care manager, if there is one, and the child, youth, or family. There is no provision here for sharing a plan with a child, youth, or family, including a foster or kinship family. There is also again no requirement for in person contact with anyone. It appears that everything is done based on call centers or some other remote kind of contact. It's still totally unclear how this adds value to the service delivery system or helps to address the real problems in the system. It just appears to be make-work for an MCO to justify giving them the funds. It takes away from the real work that needs to be done.*	The provider application has been deleted from the procurement package.
VI-165Describe which members identified as needing care management receive a treatment plan. *See notes on previous passage.*	The provider application has been deleted from the procurement package.

Question	Response
VI-167Describe episodic and/or catastrophic case management interventions. *It's unclear how this reference to case management relates to care management. It's also unclear how a person can intervene effectively by telephone in sensitive situations with vulnerable populations, and there is no requirement for in person contact.*	The provider application has been deleted from the procurement package.
VI-168Describe the protocol for addressing a provider who does not perform coordination activities. How will this be identified and what action will the MCO take to improve coordination? *It's unclear what kind of coordination activities are required, and by whom of whom. This goes back to coordination needing to be done at the local level among casework and services staff who know each other and the person being served. There is no requirement for this kind of coordination, and the call center approach can get in the way of that, as previously noted, by taking resources out of the community and requiring new layers in the decision-making process.*	The provider application has been deleted from the procurement package.
VI-169Describe MCO programs for coordination of care that include coordination of services with community resources and social services in the area served by the MCO. Include: procedures that will be in place for coordination with community resources and social services for members, including those with special health needs; timeframes for identification of such resources and services; and a plan for coordinating community resources and social services for members with special health care needs who have not been assigned to a care manager, but require these services. *See comments on previous passage. There is no recognition here of the role of existing casework staff in DHHR and other local provider agencies or of the successful models that are already in place. There is also no requirement that the MCO have boots on the ground in each locality in the state, which is where coordination must take place. It makes much more sense to invest in DHHR staff, including the staff working through the drug control policy office to facilitate local planning and coordination of services. These are almost al the same children, youth, and families, the same communities, and the same services providers. They can also work closely with the new transition managers who will be put into place as part of the Jim's Dream workforce plan for people in recovery.*	The provider application has been deleted from the procurement package.
VII-175Describe data-driven clinical initiatives that the MCO initiated within the past 24 months that have yielded improvement in clinical care for a managed care population. *It's unclear how this relates to the non-clinical aspects of the child welfare and foster care populations under this MCO contract.*	The provider application has been deleted from the procurement package.
VII-180Describe how the MCO will review complaints and grievances, PCP change requests, out-of-network referrals, emergency room usage, or other data to identify access barriers for members with special needs. *Again, virtually all of the child welfare and foster care population will have special needs.*	The provider application has been deleted from the procurement package.
VII-183Describe any enhancements that will be made to the MCO's ongoing quality monitoring activities to ensure quality for Medicaid beneficiaries and compliance with program requirements (e.g., emergency room utilization, 24-hour PCP coverage, focused clinical studies for West Virginia Medicaid). *How will this address program requirements related to child welfare and foster care and socially necessary services, plus the funding streams other than Medicaid? Since this is a new model, unprecedented in the country, this would seem to need to be spelled out and go beyond enhancements into a whole different kind of outcome measures, etc. related to the non-Medicaid aspects of the MCO contract.*	The provider application has been deleted from the procurement package.
6.4 The MCO must comply with all requirements and performance standards set forth in this Contract. The MCO agrees that failure to comply with all provisions of the Contract may result in the assessment of remedies and/or termination of the Contract, in whole or in part, in accordance with this Article. The MCO agrees and understands that the Department may pursue contractual remedies for non-performance under the Contract. At any time and at its discretion, the Department may impose or pursue one or more remedies for each item of non-performance and will determine remedies on a case-by-case basis. *What will happen to medical and social services coverage for MCO enrollees if the Department determines that the MCO has failed to meet some, or all of its contractual obligations? Having a single MCO provider could seriously jeopardize the vulnerable enrollee population, and also leave the Department with no options to provide medical and social services coverage.*	Should it be determined the vendor is no longer qualified to provide services, the State would seek an alternate vendor to replace it.

Question	Response
6.6 Whenever the Department determines non-performance by the MCO under this Contract, the Department may suspend enrollment of new enrollees into the MCO under this Contract. The Department may grant MCO enrollees the right to terminate enrollment without cause and to notify the affected enrollees of their right to disenroll and to re-enroll in another MCO. *In what other MCO does the Department envision affected enrollees finding medical coverage?*	The member would transition to fee-for-service, which is the current model.
The MCO is responsible for determining whether services are Medically or Socially Necessary and whether the MCO will require prior approval for services. Qualified medical personnel must be accessible twenty-four (24) hours each day, seven (7) days a week, to provide direction to patients in need of urgent or emergency care. *The Department is requiring the MCO to submit a number of data-driven reports. How will the Department monitor less quantifiable MCO child welfare policy decisions (Socially Necessary decisions) relating to individual cases to determine that MCO actions conform to child protection policies as established in WV State Code.*	The MCO is required to report on socially-necessary services, as well as all HB 2010 reporting requirements.
3.1.1 The MCO must establish and maintain provider networks in geographically accessible locations for the populations to be served. These networks must be comprised of hospitals, primary care providers (PCPs), dental, specialty care providers, residential treatment providers, and non-traditional providers who provide Socially Necessary Services in sufficient numbers to make available all covered services as required by the availability and access standards of the contract. The MCO must maintain a sufficient number, mix, and geographic distribution of providers. … If the MCO fails to build and/or maintain a provider network that meets the managed care network adequacy standards established by DHHR, or is unable to ensure members' access to the full array of covered services, the MCO will be prohibited from serving members in the deficient geographic areas. *Once DHHR has switched to MCO coverage, how will DHHR ensure coverage for the members in areas deemed to be deficient geographic areas of the existing MCO? What is the plan to address this situation?*	The MCO must ensure continuous accessibility to providers in all geographic areas or allow the member to be served by an out-of-network provider.
3.1.2 This network must include a panel of primary care providers from which the enrollee may select a personal primary care provider. Requirements for adequate access state that: •Routinely used delivery sites, including PCPs' offices and the offices of frequently used specialists, must be located within thirty (30) minutes travel time, including but not limited to: pediatric primary care, OB/GYN, pediatric mental health providers, pediatric Substance Use Disorder (SUD) providers, pediatric specialists, pediatric dental; •Basic hospital services must be located within forty-five (45) minutes travel time; and •Tertiary services must be located within sixty (60) minutes travel time. The intent of these standards is to provide for access to services at least as good, if not better, than access to care under the traditional Medicaid program. … Exceptions to these standards will be permitted where the travel time standard is better than what exists in the community at large. For example if the community standard for basic hospital services is sixty (60) minutes travel time, then the MCO's basic hospital service must be located within sixty (60) minutes travel time (not within forty-five (45) minutes travel time). *The description of the time requirements for basic services initially sounds very different than the current reality to access these services in remote rural areas. However, the exception to the community standard time to access services indicates that the MCO will not change access times, and the time to access these services will continue to be "business as usual."*	Network standards have been updated and will be included as part of the procurement packet.
4.3.1 The MCO must maintain a Member Services Department to assist members in obtaining Medicaid covered services. The Member Services Department, at the minimum, must be accessible during regular business hours, at least for eight (8) hours a day and through a toll-free phone number. The Member Services Department must work with Medicaid enrollees, CPS workers, Foster Care parents, and providers to handle questions and complaints and to facilitate the provision of services. *Provision of services, questions and complaints of foster parents and others responsible will only be handled during the business hours of the normal work week. How does this assist persons trying to obtain services whose work hours and work settings prevent them from contacting the MCO Member Services Department during regular business hours?*	Face to face engagement will occur through the provider/member relationship and as needed. Call center hours will be amended to be 9 hours a day. A nurse line will be available 24/7.

Question	Response
6.6.1 The MCO must provide coordination services to assist enrollees in arranging, coordinating and monitoring all medical, behavioral, socially necessary, and support services. Each PCP is to act as the coordination of care manager for his/her patients' overall care. The MCO must also designate an individual or entity to serve as a care manager for enrollees with ongoing medical conditions and special health needs. Responsibilities of the MCO's designee include assessing enrollees' conditions, identifying medical procedures to address and/or monitor the conditions, developing treatment plans appropriate for those enrollees determined to need a course of treatment or regular care monitoring, coordinating hospital admission/discharge planning and post-discharge care and continued services (e.g., rehabilitation), providing assistance to enrollees in obtaining behavioral health, Socially Necessary Services, and other community services, and providing assistance in the coordination of behavioral health, physical health and all other services. *What are the educational and training requirements for care managers for enrollees with ongoing medical conditions and special health needs?*	DHHR will mandate that the vendor ensures that the appropriate staff are knowledgable about identified child welfare policies and procedures.
The MCO's notice to an enrollee and/or provider of its decision to deny, limit, or discontinue authorization of, or payment for, a service must specify the criteria used in denying or limiting authorization and include information on how to request reconsideration of the decision pursuant to the procedures. The notice to the enrollee must be in writing. *What provisions will the MCO make to ensure that the decision letter and further request procedures are able to be understood by the enrollee if the enrollee is visually impaired or illiterate?*	The MCO is subject to federal regulations regarding member materials.
6.11.2 The MCO must provide DHHR with quarterly reports documenting the number and types of informal and formal grievances and appeals registered by enrollees and providers, and the status or disposition of all grievances and appeals. *How will the Department respond to this report? There is nothing to indicate that high numbers of grievances and appeals will trigger a response to investigate the performance of the MCO.*	The department will review reports and take appropriate action, as necessary, as the authority over the contract.
7.1 The MCO must develop and implement written policies for an ongoing quality assessment and performance improvement program (QAPI) for the services it furnishes to enrollees. The MCO must submit performance measurement data… The MCO must report on the status and results of projects annually. These initiatives can include regular reporting to the State and an annual external quality review consisting of an on-site systems performance review of quality outcomes, timeliness of, and access to services covered under this contract. *Will the Department require this report and provide an annual external review?*	Yes, this is a mandatory reporting requirement.
7.2 The MCO must develop and maintain written descriptions of its performance improvement program… The MCO must conduct performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. *Does the Department expect that there will be ongoing, significant issues that require continuing performance improvement projects?*	This is specific to improving quality of care for members and not performance of the MCO.
7.3 The MCO must correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms (such as notice from DHHR). The MCO must have written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. The MCO must prepare a corrective action plan (CAP) within thirty (30) calendar days of identification to correct any significant systemic problems. As actions are taken to improve care, the MCO must monitor and evaluate these corrective actions to assure that appropriate changes have been made, and track changes in practice patterns. The MCO must conduct follow-up on identified issues to ensure that actions for improvement have been effective. *Where is the external oversight for the CAP? The MCO appears to be largely in charge of its own performance monitoring and evaluation.*	DHHR retains full authority and control over the contract.

Question	Response
7.8 Beginning July 1, 2019, the Department will place the MCO at risk for five (5) percent of the capitation payment by withholding that amount from the monthly capitation paid to the MCO by the Department under Article III, Section 7.2. The Department's objective is that the MCO achieve performance standards that enable the MCO to earn the five (5) percent withhold back. •The percentage of children the vendor has been able to successfully transition to in-state care, recognizing the limited capacity of services that may be available given specific needs of the child. oAchievement of 50% transition of all eligible youth that have the ability to transition to in-state placement shall qualify for full reimbursement of 1% of withhold amount. •The percentage of children the vendor has placed in out-of-state care. oAny percentage less than 3% of all eligible youth shall result in full reimbursement of 1% of withhold amount. •The percentage of youth readmitted to a residential care facility or PRTF. oReadmission rates of less than 5% shall result in full reimbursement of 1% of withhold amount. •Successful implement of an electronic health record (EHR) system that serves as a health passport for members within the first year shall result in award of 2% of the withhold amount. Portions of withhold for all measures as referenced above shall be earned back based on the MCO's performance against the identified goal for each measure. *How will the Department determine that the movement of these vulnerable children is in the best interest of the child and not to gain a financial bonus by the MCO??? What about vulnerable youth denied readmission to a residential care facility or PTRF???*	DHHR retains full authority and control over the contract. The child needs to receive the most appropriate care.
Article III: Statement of Work Section 5.14 •Feedback: Please clarify if in developing the FFPSA State Plan, the State will be including any evidence-based or well-supported services in addition to what the Administration for Children and Families (ACF) Clearinghouse has identified. oPage 26; Paragraph 1; Requirement: The MCO must also abide by all applicable Federal and State laws and regulations including but not limited to:….Family First Prevention Services Act (FFPSA) of 2018.	Outside the scope of procurement.
Article III: Statement of Work Section 6.3 •Feedback: During Phase I, it will be important for the State to build the capacity and network of IV Prevention Program providers that are offering non-Medicaid IV-E, well-supported and evidence-based services. We think the MCO that is chosen should also assist the State in building such capacity. We recommend that the state tailor the go-live date for Phase II to track the State's plan for implementation of the Federal Families First Prevention Services Act, and allow the MCO a significant amount of time, pre-FFPSA go-live date, to build a network of fully compliant service providers. oPage 112; Paragraph 3 Requirement: The MCO must have programs for coordination of care that include coordination of services with community and other social services generally available through contracting or non-contracting providers in the area served by the MCO.	Outside the scope of procurement.
Article III: Statement of Work Section 11.11.3.4 •Feedback: Please clarify how the State envisions working with the MCO to reduce the level of congregate or non-compliant residential care capacity in the future. Please clarify what role the State would like the MCO to play in this. oPage 156; Paragraph 2; Requirement: Residential Treatment Services.	The contract has associated performance measures for this objective. The MCO should work will all parties to identify the most appropriate treatment plan for the child.

Question	Response
Section 4.2.1 Improved Coordination of Care Draft language: Vendor should describe how the vendor will coordinate socially necessary services (SNS) for the member and/or their family, and that the most appropriate provider of those services is used to best meet their needs. The Department shall collaborate with the vendor by providing information about each socially necessary services (SNS) provider, the services they provide and any performance data that is available. **Comment** Article III, Section 12 of the draft Purchase of Service Agreement stipulates that the Bureau for Children and Family (BCF) will retain responsibility for the initial screening and enrollment of providers. It also requires the managed care organization (MCO) to establish an information technology solution through which the MCO can receive SNS authorization requests entered by the caseworker. Additionally, it states that the MCO shall authorize the services for the scope and duration requested by the caseworker. Will the State revise the contractual language to allow the MCO flexibility in determining the appropriate service levels and provider selection by removing these requirements so that the RFP response can be evaluated independently? There appears to be a conflict between the RFP question which implies that these functions would be performed by the MCO and the proposed 2020 contract term which implies that BCF will fulfill these functions. We recommend that the contract terms be amended to allow MCOs to perform this function as part of the overall care coordination of the member.	The MCO shall serve as an ASO for socially necessary services. Modifications have been made to the RFP and contract to reflect the responsibilities of both parties.
Section 4.2.2 Mandatory Project Requirements and 4.2.2.9 Draft language: The vendor shall complete the DHHR MCO application prior to contract start date (See Attachment C). **Comment** Please confirm that consistent with the 2016 Request for Quotation (RFQ), incumbent MCOs with current West Virginia Medicaid contracts will be exempted from this requirement.	The application has been deleted from the procurement package
Section 4.2.2.2 Draft language: The vendor will be required to have a physical presence in West Virginia, including the operation of call management services through the West Virginia location. **Comment** Will preference be awarded to MCOs with a more robust localized presence?	The MCO must meet all staffing requirements as outlined within HB 2010 and the MCO contract. Evaluation will be based on the vendor's ability to meet the requirements of the contract.
Section 6.2 Evaluation and Award (and related section 4.3.2 Mandatory and Qualification Requirements) **Comment** We request that the State add an additional scoring tier based on level of accreditation. Therefore, we recommend the separate scoring considered for exceeding mandatory qualifications/experiences include tiered scoring for National Committee for Quality Assurance accreditation levels	No change made to contract.
Comment • If the contract is awarded to a currently contracted MCO, will the Department waive requirements for any reporting that is duplicative of current Mountain Health Trust (MHT) and West Virginia Health Bridge (WVHB) contract requirements? Examples include the quarterly and annual financial statements.	No, the MCO would be subject to all reporting requirements on this population.
• Will the MCO be responsible for working with foster families and recruiting foster families? If so, please confirm and detail the MCO's responsibilities.	The MCO will not be responsible for recruiting foster families, but will work with foster families as part of their care management activities.
Sections 2.2 and 2.2.2 Covered Services **Comment** Will the transition of care be 90 days? How will member information and data be shared with the MCO?	Yes, the proposed transition of care policy is 90 days. Data will be provided by DHHR to the selected vendor in an agreed upon format.

Question	Response
Section 3.7.10 Alternative Payment Models, Article III, P. 92 Draft language: MCO is required to implement alternative payment models that include twenty (20) percent of provider contracts during the State fiscal year. **Comment** Aetna recommends that the measurement remain as a percent of members enrolled. This is consistent with current MHT/WVHB contract language.	No change made to contract.
Section 4.8 Grievances and Appeals Draft language: The MCO's grievances and appeals procedures must be understandable and accessible to adult enrollees, adoptive parents, and child protective services (CPS) workers on behalf of the Medicaid enrollees and must comply with federal requirements and West Virginia statutes 33-25A-12, and must be approved in writing by the Department (42 CFR 434.32). Each MCO may have only one (1) level of appeal for enrollees. **Comment** • What role will BCF play in the grievances and appeals process? Will this be outside the current appeals process? • Please clarify how grievances and appeals for SNS will be coordinated with BCF given the current contractual requirements in Article III, Section 12 require that BCF retain responsibility for provider selection and service authorization.	The contract will specify the grievance and appeal process that must be deployed by the vendor. BCF's role in the process will be as the guardian for some members. BCF does not have responsibility for service authorizations for SNS; that is the responsibility of the MCO.
6.3 Continuity and Coordination of Care Draft language: The MCO must ensure continuity and coordination of care through use of an individual or entity that is formally designated as having primary responsibility for coordinating all services for the enrollee under this contract; the MCO must provide the enrollee or his representative with information on how to contact the designated individual or entity. The MCO must have a procedure to coordinate the services that the MCO provides to the enrollee with any services provided by other entities and to promote case management. The MCO must also have procedures for timely communication of clinical and other pertinent information among providers. Regardless of the mechanism adopted for coordination of services, the MCO must ensure that each enrollee has an ongoing source of primary care. The MCO must have programs for coordination of care that include coordination of services with community and other social services generally available through contracting or non-contracting providers in the area served by the MCO. The MCO should also ensure that enrollees are informed of specific health care needs that require follow-up; receive, as appropriate, training in self-care and other measures they may take to promote their own health; and comply with prescribed treatments or regimens. In the instance where a member transfers enrollment to another MHT or WVBH MCO, the MCO is required to provide transition of care clinical information to the MHT or WVBH MCO to promote continuity of care. **Comment** Please provide a timeframe the vendor is expected to comply with regarding transitioning care from fee-for-service (FFS) and provide clarification how information will be shared by BMS and BCF? While the current MCOs have experience in transitioning care for Supplemental Security Income and Affordable Care Act membership, it is not known what level of information is available to ensure	The vendor shall have a 90 day transition of care policy. The Department will work with the vendor to exchange all necessary data in an agreed upon format.

Question	Response
Section 6.6.1 Coordination of Care, Internal Coordination of Care Draft language: The MCO must have systems in place to ensure well-managed patient care, including at a minimum: 1. Management and integration of health care through primary care provider, or other means; 2. Systems to assure referrals for Medically Necessary specialty, secondary and tertiary care; 3. Systems to assure provision of care in emergency situations, including an education process to help assure that members know where and how to obtain Medically Necessary care in emergency situations; 4. A system by which enrollees may obtain a covered service or services that the MCO does not provide or for which the MCO does not arrange because it would violate a religious or moral teaching of the religious institution or organization by which the MCO is owned, controlled, sponsored or affiliated; 5. Coordination and provision of EPSDT services as defined in Article III, Section 1.2; and 6. Policies and procedures that ensure the completeness of the case management record to include all results of referrals, consultations, inpatient records, and outpatient records. The MCO must provide coordination services to assist enrollees in arranging, coordinating and monitoring all medical, behavioral, socially necessary, and support services. Each PCP is to act as the coordination of care manager for his/her patients' overall care. **Comment** Will the State assist with coordinating access to criminal justice data or other resources such as housing?	Outside the scope of procurement.
Section 6.8 Dispute Resolution Draft language: As a response to an appeal, the Contracting Officer must issue his/her recommended course of action to the Commissioner for either the Bureau for Medical Services (BMS) or Bureau for Children and Families (BCF). The Commissioner will review the Contracting Officer's recommendation and issue a decision on the appeal within ten (10) business days. **Comment** Please clarify BCF's role in dispute resolution.	The MCO is responsible for authorization residential services and socially necessary services, which are covered by BCF, so escalation to that Bureau is appropriate for appeals specific to those services.
Section 7.8 Quality Withhold Draft language: The vendor shall be evaluated on the following performance measures, beyond the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS): • The percentage of children the vendor has been able to successfully transition to in-state care, recognizing the limited capacity of services that may be available given specific needs of the child. oAchievement of 50 percent transition of all eligible youth that have the ability to transition to in-state placement shall qualify for full reimbursement of 1 percent of withhold amount. • The percentage of children the vendor has placed in out-of-state care. oAny percentage less than 3 percent of all eligible youth shall result in full reimbursement of 1 percent of withhold amount. • The percentage of youth readmitted to a residential care facility or PRTF. oReadmission rates of less than 5 percent shall result in full reimbursement of 1 percent of withhold amount. • Successful implement of an electronic health record (EHR) system that serves as a health passport for members within the first year shall result in award of 2 percent of the withhold amount. Per the American Academy of Pediatrics, the health passport should include, at a minimum, the child's chronic health problems, allergies, medications, psychosocial and family histories, trauma history, and developmental and immunizational information. Portions of withhold for all measures as referenced above shall be earned back based on the MCO's performance against the identified goal for each measure. **Comment** Please consider removing the identifying measures and including measures that are more applicable to the foster care population. For example, we recommend including HEDIS measures such as wellchild,	The quality withhold has been deleted from the initial contract period.

Question	Response
Section 8 Financial Requirements and Payments Provisions, 8.3 Medicaid Medical Loss Ratio, Article III, P. 146 Draft language: The MCO must submit an annual combined MLR report that will be used for rebating purposes in addition to separate detail broken out for the population in accordance with Appendix H of this Contract that includes at least the following: **Comment** Aetna Better Health of West Virginia suggests creating separate MLR reporting for the foster care program. This will allow for more focus on the MLR for the foster care program for both the State and the MCOs. Once the foster care expansion is stable, this function could be incorporated into the overall MLR reporting component of the MCO's contract.	The foster care MLR is its own reporting requirement and will remain as such.
Section 8.6.7 Institutions for Mental Diseases, P. 153 Draft language: The MCO shall be responsible for inpatient treatment in an Institution for mental diseases (IMD), for up to thirty (30) days. Both voluntary and involuntary commitments are the responsibility of the MCO. Placement in an IMD is considered an emergency service and as such, the MCO cannot require a prior authorization for placement in the IMD the first forty-eight (48) hours. **Comment** Consistent with the State's email sent January 31, 2019 to all MCOs, please confirm that the MCO inpatient treatment in an institution for mental diseases will be for up to 15 days and not 30 days as stated in the draft Purchase of Service Agreement.	This has been amended.
Section 11.7 Court Ordered Services, Article III Draft language: The MCO is required to reimburse providers for all court-ordered treatment services that are covered by the MCO for the duration as specified by the court order. **Comment** We recommend the State add the following medical necessity language: "However, court-ordered services must meet medical necessity to be covered."	No change to contract made.
Section 12, Socially Necessary Services, Sections 12.1, 12.2, and 12.5, P. 168 12.1 Contracting Draft language: The MCO shall extend a contract offer to all SNS providers contracted with CF. BCF shall retain responsibility for the initial screening and enrollment of SNS providers. BCF will provide all enrollment documentation to the MCO for their contracting efforts. 12.2 Invoicing Draft Language: The MCO shall implement the invoicing requirements as defined by BCF (refer to standardized form on BCF website: https://dhhr.wv.gov/bcf/Providers/Documents/SNS%20Invoice.pdf. The MCO shall allow thirty (30) calendar days from the date of service for the provider to submit invoices. The MCO shall allow up to one year from the date of service for any corrections to be made to previously submitted invoices. 12.5 Authorization requirements Draft language: The MCO shall establish an IT solution by which the MCO can receive SNS authorization requests entered by the caseworker into the State's FACTS system. The MCO shall be required to authorize services entered into the system within twenty-four (24) hours of entry. Upon authorization of service, the MCO will select the most appropriate provider of services within the geographical area of the child that has the capacity to administer the requested services. The MCO shall authorize the services for the scope and duration of the request by the caseworker, and may reauthorize services pending review of progress by the member. **Comment** Given the oversight of SNS will remain with the State per the above contractual references, please confirm the State will likewise be responsible for the grievances and appeals process if the member disagrees with the scope and duration of services authorized. For example, will the MCO be exempt from legal responsibility in the event a SNS caseworker is found negligent or guilty of other	The MCO is fully responsible for the authorization of services requested and will be responsible for the appeal/grievance process.

Question	Response
Section 13.1, 13.3 Children's Residential Treatment Facilities/Emergency Shelters Draft language for section 13.1: The MCO is required to contract with all currently enrolled residential treatment facilities. The State shall define for the MCO the category by which each facility falls in alignment with Family First Prevention Services Act (FFPSA). **Comment** We recommend changing to the following language: "MCO is required to attempt to contract and negotiate in good faith …"	An amendment has been made to this section.
Section 13.3 Children's Residential Treatment Facilities/Emergency Provider Requirements Shelters, Provider Requirements Draft language: The MCO shall be required to ensure that children's residential treatment facilities and emergency shelters adhere to the requirements of their contract with the Bureau for Children and Families through collaboration with DHHR of this oversight. The MCO shall monitor and validate that all services, referral standards, admission standards, discharge standards, personal needs of youth, medical service requirements, and reporting requirements are adhered to. Standards for both residential providers and emergency shelter providers are outlined within the BCF provider agreements. **Comment** We recommend replacing the requirement with the following: "The MCO shall be required to assist BCF with oversight of their contract with residential providers through monitoring and validation that all services, referral standards, admission standards, discharge standards, personal needs of youth, medical service requirements, and reporting requirements to ensure adherence. Standards for both residential providers and emergency shelter providers are outlined within the BCF provider agreements."	No change made to contract.
Section 14 Personal Care Services Draft language: The MCO will be required to cover personal care services for members. The State shall leverage an independent assessor for all personal care services to be provided to determine if medical necessity is met and the service levels to be provided, in accordance with current state and federal policy regulations. The MCO will be required to accept the findings of the assessor and authorize services as determined appropriate. The MCO must collaborate with the assessor on the ongoing scope and duration of services to be received so the most appropriate care coordination plan can be established. **Comment** • Please clarify the extent to which the MCO will have input on medical necessity on levels of care determination for personal care services; allowing the MCO to have input offers greater continuity of care for the member. • If conflicts between the MCO and the assessor occur, how will these conflicts be resolved? • Please confirm that oversight of the personal care vendors will be the responsibility of the State rather than the MCO. • Please confirm that the State and the assessor will handle all grievances and appeals if the member disagrees with the medical necessity or level of care. • Please consider the delegation of utilization management and grievances and appeals to the State may impact the MCO's ability to meet NCQA standards.	This has been amended such that the MCO must contract with an independent evaluator to determine the types of services needed, prior to the provider rendering.
General question for the appendices: How do MCOs integrate the invoicing processes?	Invoicing will be the responsibility of BCF.
Appendix A **Comment** • For the children's residential services, please clarify if MCOs will be responsible for reimbursing the room and board and supervision components of the current rate or only the treatment component that Medicaid currently reimburses. • We recommend the State supply MCOs with the complete scope of the benefits that will be required as well as the rate and limitation for the behavioral health substance use disorder and serious emotional disturbance waiver services.	Yes, the MCO will be responsible for making the full payment to the residential facility. The State will provide the rates to be paid to the selected vendor. The services associated with the SED waiver are not known at this time as it is pending CMS approval.

Question	Response
Appendix G Service Level Agreement/Liquidated Damage Matrix **Comment** • When comparing the liquidated damages to those used in surrounding states where Aetna health plans administer the foster care population, the damages listed in this contract appear to be excessive. Will BMS consider incorporating more commonly applied liquidated damages amounts and clauses as used in other regional states, such as Virginia, where foster care is included in the Medicaid managed care program? • Liquidated damages have been established based on an event occurring within a defined period following a child's placement into foster care. Under the existing managed care model, membership and payment is received on a prospective basis, with newborns being the only exception. Historically, foster care eligibility is established as of the 15th of each month. Under the current process, MCOs would not be aware of their membership until after the service level agreement (SLA) was missed unless the State has changed or is contemplating changing the membership roster and capitation process for foster care. For example, failure to complete an initial health assessment of a child within 72 hours of placement in foster care would result in an assessment of $1,000 per child per day penalty. If foster care eligibility still occurs on the 15th of each month, the earliest the MCO would receive the roster with the child's information would be on the first day of the following month which, in this case, is well past the 72-hour requirement. If the State's intent is to have this type of liquidated damage process, will there be a separate, concurrent MCO enrollment process implemented? • Please confirm the definition of "placement." Does "placement" refer to when the child is initially placed in foster care or each time a child is moved after initial placement? • When are the SLAs enforceable?	Modifications have been made to the contract.
Appendix H **Comment** Please clarify whether socially necessary services or payments previously not covered under the Medicaid program will be included in the minimum MLR calculations.	SNS is outside of the MLR calculation.
Section: Residential Treatment/Emergency Shelter Providers **Comment** Will network standards be updated to reflect current enrolled providers including new requirements for SNS, emergency shelters, and children's residential services?	Network standards have been updated and will be included as part of the procurement packet.
Section: Network Submission and Review Process **Comment** Please confirm that pharmacy will remain a carve-out to FFS for the foster care contract.	Pharmacy will remain a carved-out service.
Behavioral Health Provider Network Standards for Vulnerable Youth **Comment** • Will the State provide updated behavioral health network standards and provider listings based on the current provider enrollment files? • Will time and distance be considered over in-state providers (will only physical boundaries be considered)?	Network standards have been updated and will be included as part of the procurement packet.
MCO Provider Application **Comment** Please confirm that consistent with the 2016 RFQ, incumbent MCOs with current Medicaid contracts will be exempted from this requirement.	The provider application has been deleted from the procurement package.
Section 4.1 •Feedback: Regarding the encouragement to subcontract with regional child welfare organizations, the State should clarify its intent for the vendor to subcontract with them, when these organizations are not medical providers. The State should clarify its intent to have all funds that are paid to Child Welfare Organizations today be paid through the managed care entities, if there was such a required subcontract relationship for statewide coverage. oSection 4.1; Page 5; Paragraph 2; Requirement: Encouraged to subcontract with regional child welfare organizations.	Child Welfare Organizations provide a knowledge base in providing care coordination assistance to these members. These entities should be seen as a resource to the MCO for assisting in this aspect, but is not required of the MCO.

Question	Response
Section 4.2.1.1 •Feedback: For the requirement to have 24-hour access to a provider/service in emergency situations, the State should clarify its definition of "emergency situations" and whether emergency situations are limited to the definitions of "Emergency Care," "Emergency Dental," and "Emergency Medical" or if it will be broader in scope and expectations of MCO response capacity. oPage 6; Paragraph 3; Requirement: Have an approach to 24-hour access to a provider/service in emergency situations.	Emergency situations are defined within the contract.
Section 4.2.1.1 •Feedback: In order to effectively coordinate care across the systems impacting child welfare involved children/youth/families, MCOs will need access to other State data bases such as DOE, DVCR, and FA. DHHS should provide existing data sharing agreements with these partner State agencies that MCOs will be able to access. If not, the MCO will have to negotiate its own data sharing agreements with each State agency impacting the WV CPS system, which could lead to data not being communicated effectively. The vendor is required to coordinate care across systems, including the educational system. The State should clarify the vendor's role vs. the child welfare caseworker's role in coordination with the educational system. The state should clarify whether it is the expectation that coordination of "care" be limited to health related services or if it is expecting an expanded responsibility of the MCO outside of health-related activities. oPage 6; Paragraph 8; Requirement: Coordinate care across systems, including the educational system.	The State will work with the selected vendor on data exchange mechanisms to ensure the vendor has all necessary information to perform contractual responsibilities.
Section 4.2.1.1 •Feedback: The data and information in the State Family Service Plan (FSP) will be valuable to any MCO in developing the ISP and in authorizing services. Currently, the FSP is contained in the State's Child Welfare Information system. It is our recommendation the State give the MCO access to the State's child welfare database. oPage 6; Paragraph 10; Requirement: Use the Family Service Plan (FSP) information in the development of the member Individualized Service Plan (ISP) and authorize services.	DHHR is exploring appropriate ways to share data with the MCOs.
Section 4.2.1.1 •Feedback: Please provide the current rate of EPSDT testing within 72 hours for all children who come into care in the State. It is our recommendation the MCO be held to a targeted rate as part of their performance measures. oPage 7; Paragraph 2; Requirement: Meet standards for EPDST testing within 72 hours of placement.	This requirement has been removed.
Section 4.2.1.1 •Feedback: The RFP requires the MCO establish relationships with CPS workers and coordinate the needs of the child. The State should clarify its current relationship with MCOs in which a Member may come in contact with a CPS worker because of an abuse and neglect allegation. We recommend that during an investigation, the State's CPS workers be made aware electronically, and through the State systems, of whether a family or child are/is covered by a Medicaid Plan. oPage 7; Paragraph 3; Requirement: Establish relationships with Child Protective Service (CPS) workers to coordinate the needs of the child.	DHHR will work with the vendor and DHHR caseworkers to establish operational procedures that add value and do not create additional barriers, but the State does seek feedback from the vendor as part of the procurement process.
Section 4.2.1.1 •Feedback: Please clarify if in collaborating with the State's pharmacy program, the intent is for a universal PDL and/or requirement to utilize the State's PBM. oPage 7; Paragraph 5; Requirement: Collaborate with the State's pharmacy program.	Pharmacy will remain a carved-out service.
Section 4.2.1.1 •Feedback: In contracting with all currently enrolled providers under the State's fee-for-service Medicaid program, and those providers contracted with the Bureau for Children and Families for social services, please clarify if Child Placing Agencies and Foster Homes are included. oPage 8; Paragraph 3; Requirement: Contract with all Medicaid FFS providers and BCF social service providers.	Child Placing Agencies and Foster Care Homes are not included in this.
Section 4.2.1.1 •Feedback: It is recommended that the MCO have the ability to develop or select its own specific decision-making tools for assessing safety, risk, placements etc. It is also recommended that the MCO be given access to the State's Child Welfare Information System, in which it will be able to observe a history, which will contain essential information so as to prevent further disruption. oPage 8; Paragraph 4; Requirement: Handling multiple placements/removals.	DHHR is exploring appropriate ways to share data with the MCOs.

Question	Response
Section 4.2.1.1 •Feedback: It is recommended that telemedicine/telehealth be used to satisfy the requirement for children to receive EPSDT services with 72-hours of placement. oPage 8; Paragraph 9; Requirement: Use telemedicine, telehealth, and telemonitoring services to improve quality or access to care.	This requirement has been removed.
Section 4.2.1.3 •Feedback: It is recommended that the State permit CPS case workers be active members of an MCO ICM team. oPage 9; Paragraph 1; Requirement: Establish Intensive Care Management (ICM) teams for individuals with one or more chronic conditions.	The MCO is responsible for keeping the CPS worker informed at the worker's request or if MCO feels necessary
Section 4.2.1.3 •Feedback: Please clarify whether “return of service authorization data” means the authorization decision. oPage 9; Paragraph 8; Requirement: Vendor should describe how they will establish a process to help expedite the submission and return of service authorization data.	Yes, the authorization decision must be provided.
Section 4.2.2.2 •Feedback: Please specify if this refers to an in-state call center dedicated to members in foster care. oPage 11; Paragraph 3; Requirement: Have a physical presence in West Virginia, including the operation of call management services.	Yes, the call center must be in State and meet the requirements of HB2010.
Section 4.2.2.4 •Feedback: If the State anticipates the billing systems would cover non-medical costs, such as Title IV E and IV B (related costs incurred by Child Welfare Organizations) we recommend it take this into consideration in terms of the overall MCO PMPM. Please clarify if this requirement also applies to non-Medicaid providers. oPage 11; Paragraph 5; Requirement: The vendor must work with providers to establish electronic billing, authorization, and reporting systems that are compatible with provider electronic record systems.	The vendor will be required to replicate the existing authorization process for non-Medicaid covered services in its role as ASO for SNS. Billing will be administered by BCF.
Section 4.2.2.9 •Feedback: Please clarify the timing of when the MCO must complete the DHHR MCO application. It is recommended that the State require the completed application be submitted at the same time as the proposal in response to when this RFP is due. Please provide details on the State’s review process of the application. If the application is not due simultaneous with the proposal, we recommend the State include the application submission and review time in the RFP schedule of events (Draft RFP Section 1.2). Please clarify if MCOs that already serve West Virginia Medicaid members are required to complete the application as well. oPage 11; Paragraph 10; Requirement: Complete the DHHR MCO application prior to contract start date.	The provider application has been deleted from the procurement package.
Section I: Organizational/Management Information •Feedback: We respectfully request the State require the MCO’s Certificate of Authority at time of readiness review to allow for participation by non-incumbents. oPage 3; Paragraph 4; Requirement: Submit a copy of the MCO's Certificate of Authority from the Office of the Insurance Commissioner and a copy of all materials submitted to the West Virginia Insurance Commissioner in accordance with the Health Maintenance Organization Application for Certificate of Authority.	The COA is required prior to contract start date.
Section II: Network Development •Feedback: We respectfully request the State require network files at time of readiness review to allow for participation by non-incumbents. oPage 9; Paragraph 3; Requirement: Submit network documentation and geographic mapping reports in accordance with the instructions for the Medicaid network standards.	Network files are required prior to contract start date and not at time of award. Vendor must meet all readiness review requirements by January 1, 2020.

Question	Response
Article I: Standard West Virginia Terms •Feedback: Please clarify the types of children's residential care services that are within the definition of Socially Necessary Services, and what the scope of benefits include that the MCO must cover within residential care services. oPage 1; Paragraph 2; Requirement: [The] Department has conducted an open solicitation for the services of a Managed Care Organization (MCO) interested in entering into a Contract to provide risk based comprehensive health services, wraparound services, children's residential care services, and Socially Necessary Services (SNS) to select West Virginia Medicaid managed care recipients who are in foster care, are receiving adoption assistance, were formerly in foster care, or are children and families at-risk of entering foster care.	The MCO is responsible for all children's residential services; this payment is a bundled rate that includes both medical and room/board services.
Article II: General Contract Terms for Managed Care Section 4.5 •Feedback: Please clarify what sources of funds will be used under the Braided Funding stream and included in the RFP. For example, will this consist of Title IV E and IV B Federal funds and TANF? oPage 18; Paragraph 1; Requirement: Capitation payments for services under this contract will be designed using a braided funding stream, with Medicaid and Bureau for Children and Families dollars being blended to develop a monthly capitation payment for holistic care of enrollees.	Funding will be made available through BCF and BMS
Article II: General Contract Terms for Managed Care Section 4.5 •Feedback: Please clarify if the responsibility for "holistic care" includes residential and individual foster care placement. oPage 18; Paragraph 1; Requirement: Capitation payments for services under this contract will be designed using a braided funding stream, with Medicaid and Bureau for Children and Families dollars being blended to develop a monthly capitation payment for holistic care of enrollees.	Placement will remain a responsibility of the DHHR caseworker. The MCO will assist as needed by the worker.
Article II: General Contract Terms for Managed Care Section 5.14 •Feedback: Please indicate if the State has asked for a Waiver under the Family First Prevention Services Act and if so, for how long. oPage: 26; Paragraph 1; Requirement: The MCO must also abide by all applicable Federal and State laws and regulations, including but not limited to:… Family First Prevention Services Act (FFPSA) of 2018.	No, a waiver is not being requested.
Article II: General Contract Terms for Managed Care Section 5.14 •Feedback: Please clarify if the MCOs will be held liable for any FFPSA-related laws and/or regulations under this contract. oPage 26; Paragraph 1; Requirement: The MCO must also abide by all applicable Federal and State laws and regulations including but not limited to:… Family First Prevention Services Act (FFPSA) of 2018.	DHHR is responsible for the implementation of FFPSA, but the MCO will be required to collaborate with the Department on its implementation.
Article III: Statement of Work Section 1 •Feedback: Under the current draft RFP, children who are removed to foster care are included in the eligible population; however, biological families of these children are not. If these families are in need of parenting support or other evidence-based programs, in order to eliminate any disruption and enhance coordination, we recommend the final RFP include biological parents and other caretakers of children that have been removed as an eligible population in Phase I. oPage 51; Paragraph 1; Requirement: The following populations will be served by the MCO: Children and youth who are in foster care (effective July 1, 2019).	No change made to contract.
Article III: Statement of Work Section 1 •Feedback: The Family First Prevention Services Act allows states to draw down Title IV E dollars for evidence-based and well-supported prevention services for children who are at "imminent risk" of removal. How the State determines which children are at imminent risk should be included in the child welfare State plan. Please clarify if the State will be including children and families who are "at risk" of removal in Phase II, as well as children who are determined to be at "imminent risk" pursuant to the Federal law. We recommend the State more broadly define the term "imminent risk" to include children that are "at risk" of removal, in order to receive the Title IV E funding for Phase II. oPage 51; Paragraph 1; Requirement: The following populations will be served by the MCO:…Children, youth, and parents at-risk of entering or re-entering foster care (to be phased in on or after July 1, 2020).	Outside the scope of procurement for year 1.

Question	Response
Article III: Statement of Work Section 2.2.1 •Feedback: Bullet #1 indicates an initial health assessment be performed within 72-hours of placement within foster care. The next paragraph indicates there may be multiple assessments performed. Please indicate if more than one assessment is to be performed within 72 hours of placement within foster care. oPage 52; Paragraph 2; Requirement: MCO must complete an initial health assessment within 72 hours of placement in Foster Care (24 hours under certain circumstances). Definitions in Article II, Section 1 notes initial medical assessments must be performed for members newly entering or re-entering Foster Care within 30 calendar days.	This requirement has been removed.
Article III: Statement of Work Section 2.2.3 •Feedback: Regarding EPSDT examinations, please clarify if the State is currently tracking data on the timeliness of completion of EPSDT examinations after entering into foster care, and the percentage completed within a certain time period (e.g., 30 days). If the State is currently tracking this data, we recommend it be shared and that the providers be identified. oPage 53; Paragraph 1; Requirement: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.	Contract language has been amended in this section to clarify timelines.
Article III: Statement of Work Section 3.4.5 •Feedback: Please clarify if School Based Health Centers are required to be in the MCO contracted network if they are going to continue to be under State direct payment. oPage 76; Paragraph 2; Requirement: The MCO is encouraged, but not required, to contract with School-based Health Centers (SBHCs).	MCOs currently reimburse School-Based Health Centers.
Article III: Statement of Work Section 4.4.4 •Feedback: To ensure members receive the most accurate change in information, please consider adjusting this requirement to read that members must be notified within 30 days of when the MCO receives notice of the change, not within 30 days before the change is made. It is also recommended that members be notified of a change in a provider's information only if they are assigned to that provider or have seen the provider in the past (based on claims data). In the event that providers give the MCO incorrect information or do not provide it timely, the member will then be guaranteed to receive the most accurate information as soon as it is verified to be correct. oPage 97; Paragraph 1; Requirement: The MCO must furnish a written notice of any change in the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients, at least thirty (30) calendar days before the intended effective date of the change.	No change to contract made.
Article III: Statement of Work Section 6.3 •Feedback: Regarding the requirement to coordinate care among social service providers, please clarify if the PMPM will consist of payments to the MCO for coordination of care among non-traditional Medicaid providers. oPage 112; Paragraph 2; Requirement: The MCO must have programs for coordination of care that include coordination of services with community and other social services generally available through contracting or non-contracting providers in the area served by the MCO.	A separate PMPM will be issued for ASO services related to SNS.
Article III: Statement of Work Section 8.3 •Feedback: We recommend the State include the non-Medicaid and Socially Necessary Services (SNS) in the calculation of the Medical Loss Ratio (MLR). oPage 138; Paragraph 4; Requirement: The MLR will be calculated by the MCO using the methodology as described in Appendix H of this Contract.	No change made to contract.
Appendix C •Feedback: Regarding the Non IV-E Foster Care eligible population, please clarify how many children of the total 3,597 estimate are placed in unlicensed relative kinship or kinship homes, versus those who are removed to non-kinship homes that are not Title IV-E eligible because of not meeting financial or other eligibility criteria. Please clarify if there are other populations that are classified as Non IV-E Foster Care. We recommend children placed in voluntary kinship, prior to any court involvement, be considered by the State as an eligible population for Phase II. oPage C-1; Paragraph 1; Requirement: Appendix C: Estimated Member Enrollment	This will be considered for Phase II.

Question	Response
I am not a certified foster parent at this time, but I have taken in children on several different occasions. Some of which I had no relationship with. I didn't even know them before they were brought to my doorstep, but that being said with the drug epidemic in this state I felt I was obligated to step up and help these kids. I get so aggravated though to think of how this state is failing our children and the caretakers that step up and sacrifice for them! The guardian ad litems are getting paid to NOT do their job. The CPS workers are so overwhelmed with cases they can't do their job efficiently or effectively and the kids just get left behind with hope that they are going to be ok in the home they are placed in for the moment. The caretakers/foster/adoptive parents are left to figure it out on their own with little to no help financially or otherwise. I believe that forcing these kids to have private health insurance would be another kick in the face to the parents/caretakers! If the bio-parents are in prison they get free health care so why shouldn't their children whom have been forced into these situations and didn't have a choice in the matter! Why make the kids and the ones trying to help them suffer. I think this system needs a major overhaul! It is a failing system and only getting worse by the minute!	Thank you for your comment.
Care management staffing ratios: It is hard to answer this, as the total target population is not finalized. In Appendix C (estimated member enrollment) it only gives the estimates for "Phase I" (foster care, adoption, and legal guardianship) and does not give estimates for "Phase 2" - (individuals between 18 and 26 who were formerly in foster care) and (children, youth and parents at-risk of entering or re-entering foster care). These additional populations could significantly increase the total population from 18,000 to up to 40,000 (as Deputy Secretary Samples mentioned at a recent legislative committee meeting). I would say a staffing ratio of: 1 care manager to 25 members would be warranted. This is based on the previously identified extensive needs of the target population. In Section 4 (project specifications) 4.1, it states "given the complex needs of the population to be served, it is encouraged, but not required, that the vendor subcontract with regional child welfare organizations to assist in the care coordination of services for this population, to combine the subject matter expertise of both fields to best meet the holistic needs of our youth." I would like to see this more clearly articulated. It appears this might present a conflict of interest for "regional child welfare organizations" as they may also be providers of service for the population. This represents a very significant workforce need in either case (sub-contracting, or hired by the MCO).	RFP requests MCO to provide approach to stratified care coordination model; the State will work with the selected vendor on approving the operational processes.
Coordination of care amongst all involved parties: For the medical needs of the population, and to some degree the "traditional" behavioral health needs of the population, I can envision this working similarly to the current MCO involvement in children and adolescent services. However, in the social necessity areas, and the "living arrangements" (Placement) of children I am finding it hard to picture coordination of care and access to services. As Florida's (Glen Casel) model of blending foster care and managed care has presented to us, a local (regional) non profit organization could provide a better community based coordination of social necessity services, and foster care placement coordination. I think this should be further articulated in the RFP and MCO contract.	The MCO is encouraged but not required to subcontract with a child welfare agency to assist with care coordination of these services.
In the network standards documents, I suggest including foster care providers, and emergency shelter providers listed, and not just the hospitals, behavioral health clinics, etc. to further articulate the provider networks.	Emergency shelters are classified under the residential provider requirement.
Because (up to this point) the foster care population has not been based on a "primary care provider" arrangement, it might be good to further articulate how this might work. (As foster children sometimes move around across the state).	Changes made to contract to further articulate PCP model, but selected vendor, through stakeholder engagement, will assist with explaining approach to care.
To streamline the RFP process for both respondents and evaluators, we suggest the Department consider reorganizing the RFP so questions are clearly delineated by sub-sections and numbering. This will promote consistency and easier comparison across bidder responses during the scoring process. We recognize an RFP for managed care services will require substantial time to prepare and evaluate. As part of this preparation, we also recommend the Department provide a breakdown of evaluation scoring for each question or sub-section so that bidders clearly understand priorities and expectations. This will ensure the Department receives proposals that deliver results and mitigate opportunities for protests after award.	Procurement materials have been amended.
In selecting a single vendor, we strongly believe that an experienced MCO already serving West Virginia and with expertise to meet the needs of vulnerable youth populations is best positioned to offer higher quality and more available services and supports, as well as stronger fiscal accountability than an MCO with no experience in the state. We urge the Department to consider this experience when selecting a vendor. By limiting bidders to incumbents, the Department also minimizes the potential for additional administrative burden for providers.	No change made to contract.

Question	Response
Section 1 : General Information and Instructions To ensure consistent interpretation andresponses, we recommend the Department add a terminology section to the RFP. The following are examples of terms used in the Draft RFP we recommend defining: Essential Provider Specialty Provider Community Partners Intensive Care Management Specialists (see 4.3.2.7)	Changes have been made to the contract to reflect new definitions for specific terms.
We recognize not all children and families who will be enrolled during Phase Two of the program may be eligible for or covered by Medicaid. As such, will the Department clarify its expectations for the MCO to manage their health benefits? For those children and families who are not Medicaid-eligible or enrolled, please confirm that the MCO will only manage their socially necessary services (SNS). To better facilitate care coordination, we recommend all populations covered by this Contract who are Medicaid-eligible or Medicaid recipients be transferred to the selected vendor to manage their Medicaid benefits, including those that may be receiving services through fee-for-service (FFS) or another plan.	The MCO will be responsible for the foster care population for Medicaid and residential services, and for all members accessing SNS.
Section 4.2.1.1 Enhance Coordination of Care and Access to Services Vendor should describe the approach to offering/ providing crisis response to children, their caregivers, and families at risk. We appreciate the value a high-quality crisis continuum of care provides for children, youth, and parents/caregivers in de-escalating and preventing a crisis that results in more restrictive, disruptive, or costly interventions. To better understand the Department's goals and expectations for delivering a 24/7 crisis response system, we request further clarification on the vendor's role. Please confirm the Department expects the selected vendor to coordinate crisis response services, leveraging our provider network inclusive of children's mobile health crisis response and other community behavioral health resources, for all.	To the extent these services are covered under the BMS SED Waiver, crisis services will be covered and coordinated under this contract. For crisis services outside of the waiver, DHHR is exploring carving these services under managed care in the future.
4.2.1.1 Enhance Coordination of Care and Access to Services: Vendor should describe how the vendor will coordinate socially necessary services (SNS) for the member and/or their family, and that the most appropriate provider of these services is used to best meet their needs. Vendor should describe the process the vendor will undertake for authorization reviews of SNS. We encourage the Department to require data sharing as part of this process, which would include MCO access to FACTS and/or a requirement that Child Protective Services (CPS) workers must share available information (such as Child and Adolescent Needs and Strengths (CANS) results or family service plans) so the MCO has a comprehensive picture for SNS authorization reviews.	No change made to contract.
4.2.1.1 Improved Coordination of Care Vendor should describe the procedures and protocols for using the Family Service Plan (FSP) information in the development of the member Individualized Service Plan (ISP) and to authorize services. Vendor should describe how a vendor would evaluate and report member progress in meeting goals identified in the ISP. As indicated in the Draft Contract definitions, the ISP will be developed as part of a Multidisciplinary Team meeting that may not include the vendor. Therefore, we request the Department define which entity will be "owner" of the ISP by including language in the final RFP that clearly outlines ownership and its vision for the vendor's role in developing individual care plans.	The DHHR caseworker will retain the responsibility of the development of the plan. The MCO will be responsible for ensuring the services outlined in the plan are delivered timely and provide support to the DHHR caseworker on development, as needed.
4.2.1.1 Improved Coordination of Care Vendor should describe how the vendor will meet standards for American Academy of Pediatrics (AAP) for Early & Periodic Screening, Diagnosis and Treatment (EPSDT) testing within 72 hours of placement. The Draft Contract language allows the MCO 30 calendar days after placement within foster care for a child to receive a comprehensive EPSDT exam and 72 hours (or fewer dependent on child needs) for the initial health assessment. We request that the Department amend the RFP to reflect the language in the Contract that aligns with current AAP standards for a Comprehensive Health Assessment within 30 days of placement.	This section has been updated.

Question	Response
4.2.1.1 Improved Coordination of Care Vendor should describe how the vendor will collaborate with the State's pharmacy program to help provide coordinated care for the member, particularly those accessing psychotropic medications. We agree with Government Accounting Office (GAO) findings that children in foster care are frequently overmedicated with psychotropic medications. To support a fully integrated system, UniCare recommends carving in pharmacy benefits, to be administered by the selected vendor. There are many benefits to this fully integrated model, including a simplified system that can better identify and address care gaps, and that can apply pharmacy and medical data in a more accurate, unified way that will lead to better outcomes.	No change made to contract.
4.2.1.1 Communications and Training Vendor should describe how the vendor will work with caregivers and families to help track appointments enrollees are scheduled for and may miss without further reminders or assistance. We recommend the Department clarify whether the vendor will assume the role of the Health Check Liaison. If the vendor will not assume responsibility for this role, we recommend the Department clarify its expectations for coordination with CPS workers for scheduling of appointments. To facilitate access to care and help improve outcomes, we recommend the Department give the vendor authority to work directly with the foster parent or caregiver to schedule appointments.	The vendor is encouraged to coordinate with the Bureau for Public Health, who currently serves as the Health Check Liaison.
4.2.1.1 Enhanced Quality and Seamless Continuity of Care Vendor should describe how they would identify and track new enrollees with high physical or behavioral health needs to assure continuity of care. To enable rapid care coordination, we recommend the Department provide an indicator on the 834 enrollment file, when known, so the selected vendor can easily identify children and youth who have high physical or behavioral health needs.	Members enrolled in the CSHCN program will have an indicator that will be provided on the 834 file.
4.2.1.2 Improve Health Outcomes for Youth and Families Vendor should describe what measures beyond traditional HEDIS scores the vendor would use to determine its programs and policies are having the most significant impact on West Virginia's youth and families. We encourage the Department to include clinical quality outcomes in addition to the child welfare indicators identified in the Quality Withhold Program (Section 7.8 of Draft Contract). We suggest modifying the program to reallocate half (1%) of the 2% weight currently assigned to the electronic health record system to a HEDIS® clinical quality measure relevant to vulnerable youth, such as Child and Adolescent Access to Primary Care Providers.	The quality withhold has been deleted from the initial contract period.
4.2.1.3 Develop and utilize meaningful and complete EHRs Vendor should describe how they will coordinate with the enrollee's PCP and behavioral health provider to ensure each provider has access to the most up-to-date medical records? We suggest the Department modify this RFP question from "medical records" to "medical information" to make sure that vendors remain fully compliant with HIPAA and other relevant privacy laws, while also being able to share relevant data.	No change made to RFP.
4.2.1.3 Develop and utilize meaningful and complete electronic health records Vendor should describe how they will leverage its website to help meet the needs of members and providers, which shall include, but is not limited to, information about the member, authorization statuses, medical records, and eligibility information. To maintain the appropriate privacy and security levels, we request the Department clarify this question and define its concept of Health Passport (including who has access to it and whether SNS are included). Throughout the RFP, the Department makes alternating references to an information technology (IT) solution, an electronic health record, and a website. Understanding the Department's expectations and who will be allowed access to the information will help drive the development of a comprehensive, compliant IT and information sharing platform.	This has been amended in the RFP.

Question	Response
4.2.2.4 The vendor must work with providers to establish electronic billing, authorization and reporting systems that are compatible with provider electronic record systems. We recommend the Department move this subsection from mandatory requirements to Section 4.2.1. Providers can vary substantially in their capacity and technology, which means that the selected vendor must have flexibility in meeting providers where they are and working with them to establish electronic billing, authorization, and reporting systems. While we intend to work with all providers, we recommend the Department reframe its question to how a vendor will work with providers to establish these systems.	This has been amended in the RFP.
4.2.2.8 The vendor shall establish a provider profile report card with input from stakeholders and submit individualized results to each provider as to their scores in meeting specific measurable outcomes. We recommend the Department move this subsection from mandatory requirements section to Section 4.2.1, given this will require developing a report card system and obtaining input from stakeholders. We suggest the Department reframe it to request detail from the vendor on an approach to establishing the report card system and scoring.	This has been amended in the RFP.
4.2.2.9 The vendor shall complete the DHHR MCO application prior to contract start date (See Attachment C). To successfully meet this mandatory requirement, please confirm the Department only seeks assurance from the bidder that it will complete the application prior to Contract start date.	The provider application has been deleted from the procurement package.
4.2.2.10 Vendor shall accept the rate established by the State on a per member per month basis. Please clarify whether the Department intends for potential vendors to submit a cost proposal, given this language indicates the Department has an established rate. In addition, as a general recommendation for the final contract, we suggest the Department consider a risksharing mechanism, such as establishing a risk corridor, to minimize risk for both the State and the selected MCO.	A cost proposal is required by the vendor and is part of the procurement package; a risk corridor has been added to the contract for Medicaid services.
4.3.1.3 Vendor shall place a liaison within the Department to ensure accurate and timely communications between parties. We request that the Department outline what the Liaison role entails and the goals for the position. Additionally, we request the Department indicate whether this will be a colocated position.	This has been amended.
4.3.1.4 Vendor shall meet staff credentials for key staff and care managers to be established by the State with input from stakeholders. Does the Department intend to use current Contract requirements, or will there be additional stakeholder feedback received prior to the final RFP that will inform this section? We recommend the Department provide more specificity around its requirement for key staff and Care Coordinators, input from stakeholders, and detail on the credentials and background each position must meet.	This has been amended in the RFP.
In addition to providing a full breakdown of scoring for each question in the RFP, we recommend the cost scoring be reduced from 30% to 10%, given the population that will be served. To support the complex needs of children, youth, and families, the Department will need to select a vendor with the experience and resources to serve this vulnerable population. By allocating 30% of scoring to costs, the Department may risk selecting a vendor that bids at an unsustainable level or one that does not allow for appropriate staffing of Care Coordinators, familial supports, full care coordination, and provider incentives — all of which are key to effectively meeting the needs of children and their families.	This cannot be adjusted.
Because West Virginia's Code excludes trade secrets from public disclosure, we suggest the Department consider giving respondents the opportunity to redact content that may be a trade secret or confidential in their responses.	No change made.

Question	Response
To ensure consistent interpretation and compliance, we appreciate the Department has defined general terms used in the Contract. In addition, we request that the Department add and/or clarify the following: Crisis Services Care Coordination, Care Management, and Case Management (define each term given these are often used interchangeably or in different ways, to provide clarity among system partners and their roles) Covered Services (clarify inclusion of SNS and whether the Department is limiting SNS to Medicaid members) Eligible Recipient or Recipient Health Passport Intensive Care Management Family Service Plan (clarify which entity will be primary owner and developer) Individual Service Plan (clarify who is responsible for overseeing its development) Medical Assessment (clarify whether assessments must be completed 30 calendar days from placement for existing members or upon enrollment notification with the MCO, and align this definition with requirements for comprehensive EPSDT exam referenced later in the Contract)	Additional definitions have been added to the procurment package.
4.2 Enrollment The Department will notify the MCO of such enrollments by means of a monthly enrollment roster report which explicitly identifies those additions who were not enrolled in the MCO during the previous month. We suggest the Department consider other alternatives, such as daily files, a notification system, or other ad hoc process that eliminates the month lag time. To rapidly connect members and set up the State's mandated appointments, it will be imperative that the vendor receive real-time information on children who enter care or enroll in the plan.	This has been amended in the contract and DHHR will work with the vendor to best operationalize.
With regard to the 834 file, please clarify where the Case ID and Client ID will be located (specific loop and segment). In addition, we recommend that the Department submit a separate 834 file for the foster care Contract, or include a foster care flag for these members on an existing 834 with a foster care flag. Files should include notification for those who have been given provisional coverage or pending eligible coverage for services.	This will be coordinated with the selected vendor. The foster care procurement is completely independent of the Mountain Health Trust procurement, and thus 834s would be separate.
Please confirm that the estimated member enrollment in Appendix C does not include the Phase Two enrollment of at-risk youth and families.	This section has been removed, but was specific to phase I only.
4.5 Capitation Payments to Managed Care Organization Within this section, the Department indicates payment to the MCO will be based on enrollment data transmitted from the Department to its Fiscal Agent each month, and upon the monthly claims invoices submitted by the MCO to the Fiscal Agent. We recommend the Department provide further detail in the final RFP that details how it is defining "claims invoices submitted by the MCO to the Fiscal Agent."	The contract has been amended with respect to capitation payments.
4.5 Capitation Payments to Managed Care Organization The Contract indicates that the participant population (member months) was developed based on historical FFS participation. Is the Department including SNS/family preservation participation in this statement? How does the Department intend to factor the cost of SNS for consumers, such as biological parents, into the capitation rate? We suggest the Department consider providing a current SNS fee schedule as part of the RFP supporting documents.	SNS is outside of the capitation calculation and will paid separately as a PMPM for ASO services.
We recommend the Department also provide a detailed enrollment report that includes geographical distribution of members by county. With this information, the vendor will be better able to determine the services and providers needed in a given area, and work rapidly to address gaps so that members and families continually have access to services they need.	Data workbooks will be provided as part of the procurement.
2.1 Covered MCO Services Additionally, the MCO's providers must meet the provider requirements as specified by the West Virginia Medicaid program. This requirement appears to exclude SNS providers. Please clarify the requirements for these providers. Also, please clarify remit requirements for SNS.	The MCO shall serve as an ASO for socially necessary services. Modifications have been made to the RFP and contract to reflect the responsibilities of both parties.

Question	Response
We believe the MCO must play a role in the Multidisciplinary Team (MDT) process to help coordinate services, share information, and support children and youth. We recommend the selected vendor receive all MDT recommendations so the vendor can support their implementation as well as facilitate comprehensive care coordination and authorization of services.	No change made to contract.
3.1 General Requirements 3.1.4 Provider Qualification and Selection 3.1.4.1 Enrollment with the State The MCO is not required to contract with a provider enrolled with the Department that does not meet their credentialing or other requirements. Please clarify expectations for contracting with all providers. The Draft RFP Page 8, Enhanced Quality and Seamless Continuity of Care, states that "…the vendor will be required to contract with all currently enrolled providers under the State's fee-for-service Medicaid program, and those providers contracted with the Bureau for Children and Families for social services." The language in the Draft Contract, Section 3.1.4 seems to contradict this statement.	The MCO shall serve as an ASO for socially necessary services. Modifications have been made to the RFP and contract to reflect the responsibilities of both parties.
3.2.3 Assignment of PCP MCOs must make a PCP assignment within five (5) calendar days after a Medicaid beneficiary is enrolled in the MCO. The Department indicates PCP assignments must be made by the MCO within five calendar days. However, in another section of the Draft Contract (4.2.2), the Department indicates that "the MCO must set a period of time during which an enrollee may select a PCP, not to exceed 10 calendar days after enrollment. Upon expiration of this time period, the MCO must assign the enrollee to a PCP." We request that the Department update the language to reflect that assignment must be made by the MCO within five calendar days following expiration of the choice period.	This has been corrected in the contract.
4.3.1 General Requirements The Member Services Department must work with Medicaid enrollees, CPS workers, Foster Care parents, and providers to handle questions and complaints and to facilitate the provision of services. We believe in providing frequent communication and support to help families navigate the health care system, access the services they need, and to make sure their health care is fully coordinated. To ensure full compliance with the Department's expectations and requirements regarding communication, we recommend defining in more detail exactly with whom the MCO can communicate and which methods are acceptable, and any limitations on the information that can be shared. For example, we suggest the Department separately and explicitly add language that allows the MCO to communicate with foster parents and also indicate if the foster parent will be a covered individual under HIPAA. We also request the Department consider adding kinship caregivers and other individuals who may need to give consent for medical treatment.	The DHHR caseworker will retain the responsibility of the development of the plan. The MCO will be responsible for ensuring the services outlined in the plan are delivered timely and provide support to the DHHR caseworker on development, as needed. DHHR will work to develop operational policies with the selected vendor.
The MCO must issue all enrollees a permanent identification card within five (5) business days of enrollment. Please clarify the address where the Member ID card must be mailed to (for example, the foster parent/caregiver or the case worker). If Member ID cards must be issued and mailed to the foster parents or caregiver, the MCO will need information on the enrollment file to facilitate this.	This section of the contract has been amended.
4.8 Grievance and Appeals Does the Department intend to have a separate resolution process for SNS?	The MCO shall establish a grievance and appeals process for SNS that may mirror its process for medical services or replicate the current BCF process. This will be coordinated after award.
6.9 Enrollee Medical Records and Communication of Clinical Information The MCO must compile and maintain, in a centralized database, encounter-level data on all services provided under this contract We recommend the Department amend the Draft Contract language under Section 6.9, so that SNS are explicitly indicated as exceptions for the MCO in compiling and maintaining encounter-level data in a centralized database. The MCO will not have access to encounterlevel data on SNS invoicing (such as the National Provider ID, taxonomy, and the State Medicare Coverage Database ID).	This section of the contract has been amended.
6.9 Enrollee Medical Records and Communication of Clinical Information The MCO must ensure that an initial assessment of each enrollee's health care needs is completed within ninety (90) calendar days of the effective date of enrollment. Please clarify whether this initial assessment must be completed for all enrollees, given that the Department has outlined separate requirements for Persons with Special Health Care Needs. In addition, please confirm that the Department is referring to an initial screening process, rather than the health assessment outlined in Section 2.2.1 that must be completed within 72 hours.	This section of the contract has been amended.

Question	Response
6.11.6 National Core Health Care Quality Measures Reporting The MCO must report annually to DHHR results for all identified core adult and child quality measures relevant to the Contract covered services following the technical specifications provided by CMS. Please clarify expectations for reporting HEDIS and CMS Core Measures. Does the Department expect the selected vendor to submit separate HEDIS and CMS Core Measure results for youth in foster care?	Yes, the vendor will be required to submit data specific to this population.
7.2 Performance Improvement Projects 7.2.2 Projects The MCO must maintain at least three projects at a time Will the Department confirm that its expectation is to have three total projects, which will include children in foster care as part of a broader Medicaid population, or does the Department expect three projects that are specific to foster care only?	There must be three projects specific to the foster care population. This contract is independent of the Mountain Health Trust contract.
11.6 Children's Inpatient Care for Behavioral Health The MCO is not responsible for claims incurred within the inpatient behavioral health or psychiatric treatment setting if a member entered the treatment setting as a fee-forservice member Please clarify whether this section's requirement includes psychiatric residential treatment facilities (PRTFs).	Yes, this includes PRTFs, but the vendor does assume responsibility for care management and identifying the most appropriate treatment.
12.3 Reporting The MCO shall be required to collect a monthly progress report for each family served by the 10th day of each month. This document is the same as that to be submitted to the Department. The MCO reserves the right to withhold payment in the event such report is not submitted timely. Providers of home studies, clinical reviews and CAPS reports are not required to submit monthly progress reports, but may only submit their invoice once the home study, clinical review or CAPS report has been provided to the caseworker. The MCO shall coordinate with the caseworker to determine if this deliverable has been met. Please confirm that the provider will be required to send a copy of the progress report to the vendor in addition to the copy currently sent to the Department. Regarding the requirement for the provider to submit the home study, clinical reviews, and CAPS reports to the Department before submitting an invoice, we recommend the Department require the provider to submit a standardized attestation or formal report documenting the submission of these items to the Department prior to submitting an invoice to the vendor.	Yes, the vendor will be required to submit the report to both entities. The invoicing section of the contract has been amended.
12.5 Authorization Requirements The MCO shall be required to authorize services entered into the system within twentyfour (24) hours of a complete entry. Upon authorization of service, the MCO will select the most appropriate provider of services within the geographical area of the child that has the capacity to administer the requested services. We recommend the Department amend this requirement from entering authorized services into the system within 24 hours of a complete entry to "within one business day." Further, we ask the Department to confirm that the selection of providers will occur after the authorization timeline.	No change made to contract.
The MCO will be required to cover personal care services for members. The State shall leverage an independent assessor for all personal care services to be provided to determine if medical necessity is met and the service levels to be provided, in accordance with current state and federal policy regulations. The MCO will be required to accept the findings of the assessor and authorize services as determined appropriate. Please define the specific roles of an independent assessor and the MCO with regard to personal care services, as well as the tool that will be used to determine medical necessity. Further, please confirm the independent assessor will be responsible for determining if exclusion criteria (Appendix A) apply.	This has been amended such that the MCO must contract with an independent evaluator to determine the types of services needed, prior to the provider rendering.
APPENDIX G: Service Level Agreements (SLA)/Liquidated Damages Matrix We recommend the Department consider changing penalties (in #17 and #18) from per child per day to a population-based metric using benchmarks or percentages. Aligning penalties with more standardized health care measures will help ensure process improvement while also taking into consideration the complexity of the health care delivery system.	This section of the contract has been amended.

Question	Response
APPENDIX L: Quality Withhold Program We recommend the Quality Withhold Program take effect in the second year of the Contract, or later, to allow time to collect baseline data and test performance measures, which will provide the Department with valuable information about whether the targets identified are appropriate. We also anticipate the targets may need to change each year as the West Virginia child welfare system improves. Specifically, we expect that out-of-state placements should decline during the life of the vendor's contract; thus, a gradual shift in expectations will be necessary for the number of children who remain in out-of-state placement in later years and who can be appropriately relocated. Additionally, to appropriately measure the percentage of youth readmitted to a residential facility or PRTF, we suggest the Department use a tiered measure or a higher percentage in year one, moving to a lower percentage over time as the MCO builds a community based service infrastructure during the first year. Further, we recommend the Department consider a risk-sharing mechanism, such as establishing a risk corridor to minimize risk for both the State and the MCO.	The quality withhold has been deleted from the initial contract period.
To promote continuity of care, we support the State's expectation that the selected MCO contract with all current providers. As an overall recommendation, we suggest the Department add caveat language recognizing not all providers may be willing to contract with the selected MCO. For example, we suggest language such as "good faith attempts or best efforts to contract with all currently enrolled providers" be considered to allow for exceptions. Alternatively, if the Department keeps the requirement as is, we suggest incorporating a corresponding requirement for providers, mandating they must contract with the MCO at the prevailing FFS rate. UniCare's additional questions and recommendations on the Draft MCO Provider Network Standards are summarized in the following table.	These references within the contract have been amended.
The intent of these standards is to provide for access to services at least as good, if not better, than access to care under the traditional Medicaid program. Exceptions to the network requirements will be considered based on current patterns of care and where the travel time standard differs significantly than what exists in the community at large, as allowed in West Virginia's 1915(b) Waiver. Will the Department define the exception review process?	DHHR reviews network submissions by the MCO on an annual basis. The MCO reports if there are areas in which a provider of a particular service does not exist within the defined time/distance requirement. DHHR confirms this information and grants an exception, but the service must still be covered by the MCO at an alternative provider. The MCO must identify how it will address the deficiency.
Other Specialists MCO members must have access to at least one specialist of each type that is accepting new patients within 60 minutes travel time of their residence. Some specialists may provide services in the home, such as personal care or durable medical equipment. We suggest the Department update the language for these types of services to be more specific to the areas served, such as by county.	Provider network standards have been amended and will be part of the procurement packet.
Dental: Due to the rural nature of the state, many beneficiaries travel beyond county lines to receive care. In most cases, beneficiaries primarily use providers within the region or contiguous counties. With this in mind, BMS established thresholds of providers who served FFS beneficiaries residing in each of 12 designated regions. The thresholds include providers who treated at least 25 patients statewide according to FFS claims data from State Fiscal Year 2012. Appendix B contains the FFS dental benchmarks and network criteria, including allowable contiguous counties, for MHT beneficiaries. We request further detail on what the Department means by "threshold," given there are no specifics outlined in this section. Is the Department referring to the count of FFS providers by region outlined in Appendix B, Table 1? Will the Department provide a data file identifying these providers, based on the FFS claims data?	Provider network standards have been amended and will be part of the procurement packet.
Given the single MCO model for this population, 100% adequacy must be achieved. We recommend the Department consider including an exception process for instances beyond the MCO's control. Through our affiliates' experience in other states as well as our knowledge and history serving West Virginia, we know there are areas where gaps can develop, often from lack of specialty providers in a certain area.	No change made to contract.
Appendix A contains the FFS behavioral health benchmarks and network criteria, including allowable contiguous counties. Will the Department also provide a data file identifying providers?	Provider network standards have been amended and will be part of the procurement packet; data workbooks with provider information will also be provided.

Question	Response
Behavioral Health: In general, the MCO must contract with all highvolume facilities for each provider type. Highvolume facilities are defined as providers that had a higher number of unique patient visits than the established thresholds, based on statewide utilization..." Will the MCO receive an updated listing of which facilities the Department has classified as "high-volume" based on utilization data?	Provider network standards have been amended and will be part of the procurement packet.
The contract with Amerigroup was for physical and behavioral health services, with stated goals of achieving safety, permanency and well-being in a trauma-informed environment. It is anticipated they will be involved in addressing "social determinants of health" in a subsequent contact after the implementation of the Family First Prevention Services Act. The speakers considered the program and care managers to function in complementary role with CPS caseworkers, assisting with such activities as preparing care plans, identifying resources, managing health records, and in discharge planning. Caseworkers often said there was "not enough time" for everything. Amerigroup would also assist scheduling appointments and "bringing providers to you," addressing training needs. They expressed a desire to operate in an "open, vocal and honest" environment.	Comment only.
Care Coordination – Case Management – Caseload Size: Georgia Family 360 employs salaried, regionally located Care Coordinators who are licensed social workers and counselors. A number are former CPS caseworkers were attracted to apply for these positions for personal advancement. Importantly, Amerigroup discussed "case management" as the provision of direct services that are separate and distinct from overall care management. Case managers are those most closely involved with the child, such as the CPS caseworker or FQHC provider/staff. This demonstrates that while direct service providers may have a significant role in care management, they do so only within the scope of services provided. Individual care management cases are rated by level of complexity as 1, 2 or 3 and are assigned accordingly to care managers and "specialty care managers." It was indicated that 100 cases might be a suitable caseload for a care manager handling the least complex cases, while 20-25 per care manager might be suitable for a caseload of children with the most complex needs. Care management can be provided in person. However it was clear that telehealth and video conferencing were preferred by the MCO, particularly in rural and "low resource" areas. Recommendation: West Virginia should clarify its concepts and expectations regarding care coordination and case management. •The contract should require the MCO to employ care managers and to refrain from allowing the MCO to subcontract with provider organizations for overall care management. •Similarly, the contract should require that care managers be of the highest possible levels of education, experience, training and certification/license •Caseload sizes should be clarified and proscribed to assure quality of care and responsiveness. •Finally, care management should primarily be provided on a face-to-face basis. The MCO contact should, at minimum, require that initial child visits be face-to-face in nature, with subsequent visits allowable by telehealth technology only if agreed to by the Multi-Disciplinary Team (MDT) and if in the best interests of the child.	No change made to contract.

Question	Response
Cooperation with Child Protective Service Workers: The Georgia Family 360 speakers described care managers as offering to assist CPS caseworkers in the development of care plans, identifying client resources, obtaining health records, and discharge planning. Further, they indicated that every child under the age of five years receives a 'Trauma Assessment." This was specifically described as being helpful in determining whether a subsequent psychological assessment is necessary. This being said, care managers are also obviously focused on avoiding what the MCO might consider to be unnecessary or duplicative services. In giving an example of how a care manager might be involved in developing a care plan, the speakers said a care manager might recommend against a judge's ruling to obtain a subsequent comprehensive psychological evaluation on the basis that the 'Trauma Assessment" is sufficient for the MDT to develop a suitable care plan. In West Virginia, this specific example could frequently put the MCO and care manager in conflict with the recommendations of a judge and/or the recommendations of a clinical provider who is more familiar with the child than is the care manager. Recommendation: A judge, or one or more MDT participants, could rightfully call a care manager's clinical expertise into question when the care manager has no demonstrated clinical expertise. The MCO contract should specify that the decision to accept the findings of a "Trauma Assessment" vs. authorizing a subsequent psychological evaluation, or similar decision, is made by only a 'specialized care manager' who is licensed in West Virginia as an independent clinical mental health practitioner, as a WV licensed physician, or as a WV licensed nurse practitioner.	No change made to contract.
Multi-Disciplinary Teams: It was identified that care managers may attend the MDT "if invited." Recommendations: •Care managers should routinely be invited to attend and participate in Multi-Disciplinary Team Meetings. •Care managers should be required to participate in MDT meetings at the request of the foster parent or other caregiver, a CASA volunteer, or other member of the MDT, not only at the request of a DHHR staff person or Judge.	This is the current language of the contract. MDT participation is by request.
Ombudsman Position/s: As the speakers described it, BOTH the Georgia Department of Family and Children's Services AND Amerigroup/GA Family 360 employ ombudsmen. The employment of an ombudsman by Anthem/Amerigroup was a mandated feature of the MCO contract with DFACS. Further, they suggested that the MCO ombudsman was much more actively involved in cases, that the nature of concerns and complaints directed to the ombudsman evolved over time, and that the DFACS ombudsman positon was ultimately eliminated. Recommendations: •The WV DHHR contact should require the MCO to immediately employ a family/child advocate. The MCO family/child advocate will act as a focal point for receiving and responding to family and child concerns and complaints regarding denials of service, to request urgent decision-making to avert health emergencies and/or prevent re-traumatization of at-risk children and children in care, to assure provider network adequacy, etc. •Under the provisions of HB 2010, seek to employ the ombudsman situated with DHHR in a timely manner.	No change made to contract.
Innovations (observation) – "We knew it couldn't be business as usual" Amerigroup/Georgia Family 360 initiated new programs to meet specific contract requirements. Specifically, they developed a mobile juvenile health integration vehicle, and additionally a health clinic that was situated in one courthouse to assure the completion of timely health assessments. Among 'value added" benefits, Amerigroup offered memberships in Weight Watchers©, Boys & Girls Clubs, funding for GED completion, and free over-the-counter medicines.	The MCO will offer valued-added services.
Medical Loss Ratio: Recommendations: •The MCO will have the benefit of serving a 'captured' population as the sole provider and should therefore have an MLR of 88% to 90%. •The MLR should NOT be excluded from the first contract year. •Socially Necessary Services must be defined and addressed in the MLR process and calculation.	Modifications have been made to this section of the contract.
Freedom of Choice: Recommendation: •Foster parents should be clearly authorized to determine Freedom of Choice' with regard to choosing whether to be covered under traditional Medicaid or the MCO provider network.	The authorized representative may choose to have the member enrolled under managed care or FFS.

Question	Response
Provider Network Adequacy: Recommendations: •At least during the initial contract year, and to assure the network includes as many community based services and providers as possible, the MCO contract should stipulate that "Any Willing Provider" be empaneled as a service provider for Medically Necessary Services (physical, behavioral) as well as Social Necessary Services (SNS). •Community Based Services Moving to Fee-for-Service: The MCO contract should specify that the MCO will work with existing community based service and provider organizations to assist them in successfully transitioning to a fee-for-service and/or contract-based provider environment. Community based services are typically grant/donation funded nonprofit organizations with little or no experience in the fee for-service realm. However, to be successful, children and families will depend on the availability of existing local services. •Community Based Services Populations Moving from Voluntary to Non-Voluntary: The MCO contract should specify that the MCO will work with existing community based service and provider organizations to assist them in successfully transitioning between serving a largely 'voluntary' population to a sometimes 'non-voluntary' population. At present, the clients of many community based services and programs are 'voluntary' in nature in that they elect to apply or affiliate. These organizations will be expected to work with a 'non-voluntary' population (for in-home family education, family reunification services, etc.), particularly as the requirements of the Family First Prevention Services Act roll out. •Provider/Service Directories: An accurately maintained and robust list of providers needs to be available through a variety of media (in print, online, via social media, via WV 211, etc.). The list should be cross-referenced with the community based providers and organizations that are part of West Virginia's service array and continuum of care.	In specific circumstances, the MCO will be required to make all reasonable efforts to contract with all providers of a service, but not as a universal policy.