REQUEST FOR PROPOSAL
(Agency Name and RFP #)

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SECTION 1: GENERAL INFORMATION

1.1. Introduction:

The West Virginia Department of Administration, Purchasing Division (hereinafter referred to as the “Purchasing Division”) is issuing this solicitation as a request for proposal (“RFP”), as authorized by W. Va. Code §5A-3-10b, for the WV Department of Health and Human Resources (hereinafter referred to as the “Agency” or “Department”) to provide statewide managed care services for youth in the foster care system, youth at risk of entering the foster care system, and families of youth at risk of entering the foster care system. The services to be provided under this award are more fully described in Attachment X: Service Provider Agreement for Vulnerable Youth and Families. Services include, but are not limited to, reimbursement for and coordination of physical health services and behavioral health services; establishing and managing a credentialed provider network; utilization management; quality management; member services; financial management; claims management; maintaining sufficient information systems; coordinating and reimbursing for socially necessary services and assisting in reducing the number of children entering the child welfare system.

For purposes of this request, vulnerable youth populations are defined as:

- Foster care children as defined under 45 CFR 1355.20
- Former foster care children under the age of 26 as defined by the Affordable Care Act
- Post-adoptive children with subsidized care
- Children with a documented case plan with the Bureau for Children and Families.
- Families of children with a documented case plan

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.
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The Service Provider Agreement (hereinafter referred as “SPA”), has been attached to provide overall guidance in responding to this Request for Proposal. The contractual terms and/or rates outlined in this Agreement are subject to change based upon state or federal mandates and regulations, waiver modifications, or State Plan modifications. The State Fiscal Year (SFY) 2020 contract, July 1, 2019 – June 30, 2020 will be issued to the winning vendor for signature upon award. The vendor will be expected to participate in good faith.

A glossary of terms is outlined within the Appendix I.

The RFP is a procurement method in which vendors submit proposals in response to the request for proposal published by the Purchasing Division. It requires an award to the highest scoring vendor, rather than the lowest cost vendor, based upon a technical evaluation of the vendor’s technical proposal and a cost evaluation. This is referred to as a best value procurement. Through their proposals, vendors offer a solution to the objectives, problem, or need specified in the RFP, and define how they intend to meet (or exceed) the RFP requirements.

1.2. **RFP Schedule of Events:**

RFP Released to Public ................................................................. See wvOASIS
Mandatory Pre-bid Conference .................................................. xx/xx/xx
Vendor’s Written Questions Submission Deadline ....................... xx/xx/xx
Addendum Issued ........................................................................ xx/xx/xx
Technical Bid Opening Date ......................................................... xx/xx/xx
Technical Evaluation Begins ....................................................... xx/xx/xx
Oral Presentation (*Agency Option*) .......................................... xx/xx/xx
Cost Bid Opening ...................................................................... TBD
Cost Evaluation Begins .............................................................. TBD
Contract Award Made .................................................................. TBD

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SECTION 2: INSTRUCTIONS TO VENDORS SUBMITTING BIDS  

The vendor request for proposal must contain a response to each of the questions below. The vendor must be prepared to discuss their responses and answer any follow-up questions. 

In addition, the vendor must also submit a copy of all requested materials to the West Virginia Department of Health and Human Resources. These materials will be incorporated into the review and into the RFP by reference. 

Vendors will submit one hard copy and one electronic copy of the materials specified below in the vendor RFP to: 

    WV Department of Health and Human Resources 
    Cabinet Secretary’s Office 
    Attention: Jeff Wiseman 
    One Davis Square, Suite 100E 
    Charleston, WV 25301 

Responses should be formatted in the same order as the request for proposal below, with clear question references to allow for ease in reviewing.
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SECTION 3: GENERAL TERMS AND CONDITIONS

Terms and conditions begin on next page.
4.1. **Background and Current Operating Environment:** The WV Department of Health and Human Resources is located at One Davis Square, Charleston, WV 25301.

The WV Bureau for Medical Services (Medicaid) currently operates Mountain Health Trust (MHT), the Medicaid managed care program that has operated in the State of West Virginia since 1996. The program emphasizes the effective organization, financing, and delivery of health care services as a means to improve Medicaid enrollee access to care and enhance quality through the provision of coordinated services. MHT is overseen by the Office of Managed Care within the Bureau for Medical Services. Approximately 80% of all Medicaid enrollees are currently enrolled under one of the State’s four Managed Care Organizations (MCOs).

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.

4.2. **Project Goals and Mandatory Requirements:** West Virginia’s foster care population has continued to increase over the past several years due to the opioid epidemic facing our state, with 85% of cases involving substance abuse. There is a significant need to better help those families in crisis and reduce the number of children removed from their home. For those that have already been subjected to this event, the Department must implement a strategy to help better coordinate the care of those members and make sure they are receiving all of the necessary services available, in hopes that reunification may occur. Vendor should describe its approach and methodology to providing the service or solving the problem described by meet the goals/objectives identified below. Vendor’s response should include any information about how the proposed approach is superior or inferior to other possible approaches.

The vendor will be required to meet all deliverables as outlined within the Service Provider Agreement. Failure to demonstrate compliance shall result in a Service Level Agreement (“penalty”).

4.2.1. **Goals and Objectives** – The project goals and objectives are listed below.

4.2.1.1 **Enhance the coordination of care and access to services, including physical health, mental and behavioral health, dental care and socially necessary services, and improve communication amongst stakeholders.**

The vendor shall provide responses to the following questions:
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Describe the approach(es) to establishing a statewide provider network that is comprehensive and contains providers who can provide a multi-disciplinary and comprehensive service array, either through their own practice or through collaboration with other providers; is accessible to children and their caregivers; incorporates evidence-based best practices and interventions; provides for continuous communication with stakeholders; and has capacity in rural areas and across specialty lines of health services.

Describe the approach(es) to addressing deficiencies in the Essential Provider and Specialty Provider networks in relation to travel times and distances that may be experienced by a member.

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

Describe the approach(es) to measuring and regularly verifying network compliance standards, and actions that will be taken if notified of inappropriate wait times before a member is seen by a provider.

Describe the approach(es) to offering/providing crisis response to children and their caregivers, as well as families at risk.

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 meets their needs. The Department shall collaborate with the vendor by providing information about each SNS provider, the services they provide and any performance data that is available.

Describe the process the vendor will undertake for authorization reviews of SNS.

Improved Coordination of Care

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.

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).

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%202015-2019.pdf

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Describe procedures and protocols for developing and including an interdisciplinary team in the assessment and care planning process, and how this information will be transferred to the primary care provider.

Describe the process for creating an ISP, including parties to be consulted, information to be incorporated, and how the member will be involved in the process.

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

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.

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.

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.

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.

Describe how the vendor will work with pregnant populations to ensure access to needed prenatal and postpartum care, including the coordination of services offered through the Bureau for Public Health and education on drug utilization during pregnancy and long-acting reversible contraceptives (LARC).

Describe how the vendor will establish patient-centered medical homes for its enrollees, including the application process for providers, communication of service to members and annual reporting processes, that aligns with the American Academy of Pediatrics in the Health Care for Children and Adolescents in Foster Care manual.

Describe how the vendor will assign a Primary Care Provider and Behavioral Health provider, if necessary, to each enrollee.

Describe how the vendor will collaborate with hospital, psychiatric residential treatment facilities (PRTF), residential providers, behavioral providers and others on discharge planning needs of the member and ensuring outpatient services have been established prior to release, as well as ensuring coordination with the State that all needed medication is available for the member.
Communications and Training

In addition to providing initial training, ongoing training for advocates, providers, and other stakeholders will be necessary. The vendor will be required to participate in public meetings and other events at the request of the Department.

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.

Describe how the vendor will ensure that all children in temporary or permanent legal custody who are in out-of-home placement receive the full benefits of the EPSDT program.

Describe how training and technical assistance will be provided on an ongoing basis to new enrollees and their parents and caregivers, as well as new providers and other interested parties.

Provide a brief description of provider training programs. Please distinguish between training programs for PCPs, acute care providers, behavioral health and community-based services providers. The description should include:

a. The types of programs that would be offered, including the modality of training
b. What topics would be covered (billing, complaints, appeals, telemedicine, etc.)
c. Strategy for training providers on requirements of contract and unique needs of population
d. How provider trainings would be evaluated
e. The frequency of provider trainings

Describe how the vendor will work with caregivers and families to help track appointments or tests that enrollees are scheduled for and may miss without further reminders or assistance.

Describe how the vendor will collaborate with community partners to help design materials that best meet the needs of the populations being served.

Enhanced Quality and Seamless Continuity of Care

To ensure seamless continuity of care, 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.
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Describe the approach a vendor would take in developing services that range in intensity and restrictiveness (in terms of community integration) based on member situations, or an alternative approach to best meet the needs of members with varying levels of needed care.

Describe how the vendor will handle multiple placements/removals in a way that is as seamless as possible for the child.

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

Describe how the vendor would develop a plan to identify and reach out to members with the most immediate service needs leading up to and immediately following implementation of a program.

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

Describe the vendor’s approach to evaluating member and provider satisfaction.

Describe how a vendor would actively work with network providers to ensure accountability and improvement in the quality of care provided, including:
- How a vendor would reward providers who demonstrate continued excellence or significant performance improvement over time;
- How a vendor would share best practice methods or programs with other providers
- How a vendor would take action against providers who demonstrate unacceptable performance
- Strategies that could be adopted to simplify the administrative procedures

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

Identify the areas believed to be the greatest opportunities for clinical quality improvement in behavioral health, and how a vendor would work to improve clinical behavioral health outcomes.

Describe how a vendor would use telemedicine, telehealth, and telemonitoring services including opportunities to use video conferencing to improve quality or access to care.
Describe how the vendor will monitor providers to determine if new patients are being accepted.

Describe how the vendor will ensure members have 24/7 accessibility to providers.

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.

4.2.1.2 Improve health outcomes for youth and families.

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.

Describe a plan for alternative payment structures (e.g. provider incentives, overcoming limitations of diagnosis-driven eligibility) to increase health care quality and efficiency through collaboration and innovation to improve access to comprehensive health care. The plan should include:

a. Identified opportunities for cost savings
b. Reductions in inappropriate utilization of services, including inappropriate admissions and readmissions
c. Mechanics by which incentive payments to providers to improve quality of care would be made
d. Quality metrics that would be required for provider incentives and shared savings

Describe how the vendor will conduct ongoing gap analyses to determine the types of services and resources not available in the State, and how they will work with the Department and community partners to increase capacity for those services.

The vendor will be subject to a profit cap. Describe how the vendor will reinvest excess funds into the community to expand systems of care and prevention and early intervention services.

Describe how the vendor would leverage predictive modeling as a support tool to help with stratification of members into risk tiers for care management services.

4.2.1.3 Develop and utilize meaningful and complete electronic health records for each member and other information technology (IT) supports to improve data sharing.
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Describe how the vendor 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?

Describe the process for ensuring continuity of prior authorized services when a member transfers from a fee-for-service program to a managed care type of program, including how a vendor might authorize the member’s out-of-network providers to complete an existing treatment.

Describe how the vendor will establish an online portal with evaluation criteria already populated so that providers may submit authorization requests online and receive automated determinations to expedite review.

Describe how the vendor will transfer members to the Bureau for Public Health Office of Material Child and Family Health (OMCFH) toll-free hotline to obtain information on services available.

Describe how the vendor will leverage IT solutions to improve access to member health records (both by the member and provider), appeal processes, and other member rights and responsibilities.

Describe how the vendor will leverage the WV 2-1-1 resource to help members find resources available to them in their communities.

Describe how the vendor’s toll-free member services solution will allow for member transfers to other service providers, and route emergency versus traditional calls.

Describe how the vendor 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.

Describe how the vendor will capture data related to social determinants of health and incorporate this information into its care management solution.

Describe how the vendor will capture both medical and SNS provider information and establish a provider database that can be accessed by the public.

Describe how the vendor will work with the provider community to develop a standardized prior authorization form for all services.
DESCRIBE THE SYSTEM THE VENDOR WOULD LEVERAGE FOR UTILIZATION MANAGEMENT SERVICES, WHICH SHALL INCLUDE TEXT FIELDS FOR CLINICAL NOTES, INPATIENT REQUESTS, REVIEW CRITERIA AND CASE HISTORY.

4.2.1.4 Help reduce the number of children removed from the home as a result of increased family-centered care that provides necessary services to all members of the family, through the coordination of physical and socially necessary services.

Describe how the vendor will collaborate with the Bureau for Public Health to increase the number of families enrolled in the WV Home Visitation Program. This program has demonstrated that its engagement in the lives of families has helped to reduce the risk of a child being removed.

Describe how the vendor will engage community-based child welfare organizations to help provide family-centered treatment that goes beyond traditional medical care.

In the event of removal, describe how the vendor will work with existing entities to help with foster care placement. The selected vendor will not be responsible for the recruitment of foster care families but must collaborate with these entities in meaningful ways to try and help increase the number of foster care families available within the State.

Describe how the vendor will collaborate with the State and provider community to help implement the Family First Act and to promote access to the services being established under this Act.

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.

4.2.2. Mandatory Project Requirements – The following mandatory requirements relate to the goals and objectives and must be met by the Vendor as a part of its submitted proposal. Vendor should describe how it will comply with the mandatory requirements and include any areas where its proposed solution exceeds the mandatory requirement. Failure to comply with mandatory requirements will lead to disqualification, but the approach/methodology that the vendor uses to comply, and areas where the mandatory requirements are exceeded, will be included in technical scores where appropriate. The mandatory project requirements are listed below.
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4.2.2.1 Comply with all applicable requirements outlined in this procurement, as well as the Service Provider Agreement and any modifications pursuant to changes to State policy, state or federal laws and regulations, waiver amendments, or State Plan amendments.

4.2.2.2 Vendor shall provide coverage of service in all counties in West Virginia.

4.2.2.3 Vendor shall coordinate with the Department and stakeholders on an annual basis to evaluate the program and to update program goals, initiatives and desired outcomes for the following contract period.

4.2.2.4 The vendor will be required to have a physical presence in West Virginia, including the operation of call management services through the WV location.

4.2.2.5 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.

4.2.2.6 The vendor will be required to develop reports at the request of the State and submit within agreed upon timeframes.

4.2.2.7 The vendor must work with providers to establish electronic billing, authorization and reporting systems that are compatible with provider electronic record systems.

4.2.2.8 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.

4.2.2.9 The vendor shall submit all policies and procedures to the State for review and approval and solicit feedback from the provider community as part of its development efforts.

4.2.2.10 The vendor shall provide service authorizations for all members within 7 business days, except those identified as expedited requests, which must be processed within 2 business days.

4.2.2.11 Vendor shall provide BCF a schedule of retrospective quality reviews to be conducted on Socially Necessary service providers, with the understanding that BCF shall provide a sampling of invoices to the vendor for claims made for socially necessary services and, that as a part of the retrospective review, the vendor shall review the supporting documentation in the provider records to ensure the services invoiced and paid for have been provided and all reports have been sent to the Bureau.

4.2.2.12 Vendor shall establish a Retrospective Quality Review process for applicable Socially Necessary Services. This review process shall include analysis of the services provided by the specific provider, an assurance that the staff providing the service and/or the agency have the appropriate and current credentials necessary and that the case documentation and invoice reflect that the service was provided according to the established UM Guidelines. All providers shall be reviewed on an 18-month cycle with the exceptions allotted for special request at the discretion or direction of the applicable Bureau.

4.2.2.13 Vendor shall conduct annual audits of socially necessary services providers to ensure services being billed for are being provided in a manner consistent with utilization management guidelines as defined by BCF.

4.2.2.14 The vendor shall be required to comply with all applicable State and Federal laws concerning privacy and security, including but not limited to, the Health Insurance Portability and Accountability Act (HIPAA), HITECH Act, and all other regulations.
4.2.2.15 The vendor shall develop policies around member rights and responsibilities, appeals, etc., and process to ensure compliance with the State’s fair hearing process of providing information to members about their rights to access a fair hearing. The vendor shall be responsible for attending/testifying in fair hearings as required. Appeals shall be resolved within 30 days of request, but must also develop a policy for expedited appeal processes.

4.2.2.16 The vendor shall accept eligibility, membership and enrollment data from the Department’s Medicaid Management Information System (MMIS).

4.2.2.17 The vendor shall conduct testing with all parties to ensure accuracy of data being provided.

4.2.2.18 The vendor shall develop a Disaster Recovery Plan and Business Continuity Plan.

4.2.2.19 The vendor shall develop, implement and maintain operational procedures, manuals, forms, and reports necessary for all business functions.

4.2.2.20 The vendor shall provide a welcome packet to each member with information about their care manager, important phone numbers, etc.

4.2.2.21 The vendor shall provide a member handbook, in print and made available electronically, that outlines the services available to them.

4.2.2.22 Shall conduct a welcome call to each new member or caretaker within 14 days of receipt on the eligibility file to introduce themselves, establish a PCP, and discuss services they can provide to the member/family to assist.

4.2.2.23 Reassign the member to a new PCP in the event of relocation; notify the caretaker of the change within 2 business days. The vendor shall establish a new medical home, inclusive of behavioral health services, for the member, if the relocation occurs outside of the service area in which the member was previously located.

4.2.2.24 The vendor shall conduct an annual network assessment.

4.2.2.25 The vendor shall develop a provider manual with stakeholder input, outlining key programmatic information, including procedures for submitting complaints/appeals, utilization management guidelines, and prior authorization processes.

4.2.2.26 The vendor shall track and manage all provider inquiries and complaints related to clinical and administrative services and address within 30 days, and provide a monthly report to the Department outlining such information with resolution.

4.2.2.27 The vendor shall provide notification to providers of all policy and UM guideline changes at least 30 days in advance of implementation.

4.2.2.28 The vendor must acknowledge State and provider emails within 48 hours of receipt and either provide immediate response or estimated timeline for being able to formally respond.

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

4.2.2.30 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.

4.2.2.31 The vendor shall develop a quarterly emergency room utilization report.

4.2.2.32 The vendor shall develop an annual Quality Management Plan.
4.2.2.33 Vendor shall establish a plan for referring instances of suspected fraud to the following entities:
   a. Medicaid fraud, to the Bureau’s Office of Program Integrity (OPI);
   b. Instances of suspected fraud in the delivery of BCF socially necessary services, to the BCF Office of Finance and Administration;
   c. Instances of fraud related to BBHHF funded programs, to the BBHHF Office of Compliance and Monitoring

4.2.2.34 The vendor shall develop a Transitional Care Management Policy by which the vendor monitors follow up care after discharge.

4.2.2.35 The vendor shall provide assistance with scheduling appointments, including coordination transportation for medical appointments with the state’s Non-Emergent Medical Transportation (NEMT) vendor.

4.2.2.36 Vendor shall continuously review and remain current with evidence-based, evidenced informed, well-supported, supported, promising, practice criteria, and, if appropriate and necessary, recommend updates and/or alternative criteria, with the understanding that, if there are no specific criteria for a requested service, the vendor will research and render a recommendation subject to Department approval.

4.2.2.37 The vendor shall honor all previously established prior authorizations either under fee-for-service or through another Managed Care Organization.

4.2.2.38 Vendor shall ensure a trauma assessment screening occurs and shall maintain record of any trauma history with information about any trauma experienced to guide care management planning.

4.2.2.39 Vendor shall ensure that each member upon enrollment into program, receives or has on record a comprehensive family assessment to assist in developing case plans, making placement decisions, expediting permanency and planning.

4.2.2.40 The vendor shall provide a daily census report to the patient-centered medical home of any inpatient stay that has been authorized.

4.2.2.41 The vendor shall maintain record of all service authorization requests and decisions for at least 7 years for each member.

4.2.2.42 The vendor shall regularly monitor out of network claims to determine if services can be provided in State and make every effort to transition the child to those in-state services.

4.2.2.43 The vendor shall review services for medical or social necessity against best practices and when such documentation does not exist, provide to the State the methodology by which it has made its decision.

4.2.2.44 The vendor shall review new authorizations against existing to determine if duplication of services is being requested and notify providers accordingly.

4.2.2.45 The vendor shall provide the Agency with an annual Improvement Plan on its program, including programmatic improvement opportunities. In addition, the vendor shall establish 3 Performance Improvement Projects that target specific measures to be evaluated, such as Emergency Room utilization, that the Agency must first approve.
4.3. Qualifications and Experience: Vendor should provide information and documentation regarding its qualifications and experience in providing services or solving problems similar to those requested in this RFP. Information and documentation should include, but is not limited to, copies of any staff certifications or degrees applicable to this project, proposed staffing plans, descriptions of past projects completed (descriptions should include the location of the project, project manager name and contact information, type of project, and what the project goals and objectives were and how they were met), references for prior projects, and any other information that vendor deems relevant to the items identified as desirable or mandatory below.

4.3.1. Qualification and Experience Information: Vendor should describe in its proposal how it meets the desirable qualification and experience requirements listed below.

4.3.1.1. Vendor shall be required to provide the following key personnel: contract manager, quality oversight manager, provider relations manager, care management program lead, social services lead, program integrity lead and community engagement specialist.

4.3.1.2. Vendor shall place a liaison within the Department to ensure accurate and timely communications between parties.

4.3.1.3. Vendor shall meet staff credentials for key staff and care managers to be established by the State with input from stakeholders.

4.3.1.4. 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).

4.3.2. Mandatory Qualification/Experience Requirements – The following mandatory qualification/experience requirements must be met by the Vendor as a part of its submitted proposal. Vendor should describe how it meets the mandatory requirements and include any areas where it exceeds the mandatory requirements. Failure to comply with mandatory requirements will lead to disqualification, but areas where the mandatory requirements are exceeded will be included in technical scores where appropriate. The mandatory qualifications/experience requirements are listed below.

4.3.2.1. Have met the Certificate of Authority (COA) requirements as outlined by the WV Offices of the Insurance Commissioner and be in good standing in the State of WV. The vendor shall provide a copy of its COA with submission of its bid response.

4.3.2.2. Be a National Committee for Quality Assurance (NCQA)-accredited entity and remain so for the duration of the contract or be in the process of becoming an NCQA-accredited entity. NCQA certification shall be provided with submission of bid response.

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4.3.2.3. Vendor shall provide an organization chart outlining internal organizational structure for this project with bid submission.

4.3.2.4. Vendor shall provide a description of the roles, responsibilities and skill sets associated with each position outlined in the organizational chart.

4.3.2.5. Vendor shall provide a brief summary description of the roles and responsibilities of each key staff member and the experience that qualifies them for their role in this project. If any subcontractor is leveraged, the vendor shall describe the assurance of quality and timeliness of the work to be done. All subcontractor arrangements must be approved by the State.

4.3.2.6. Vendor shall provide their approach to staff retention and ensuring continuity of staff

4.3.2.7. Vendor shall provide a ratio of X care managers to members enrolled.

4.3.2.8. The vendor shall have at least one member of its care management team participate in all multi-disciplinary team meetings.

4.3.2.9. The vendor shall contract with specialists to assist in making medical decisions should the MCO not be proficient in a given area.

4.4. Oral Presentations (Agency Option): The Agency has the option of requiring oral presentations of all Vendors participating in the RFP process. If this option is exercised, it would be listed in the Schedule of Events (Section 1.3) of this RFP. During oral presentations, Vendors may not alter or add to their submitted proposal, but only clarify information. A description of the materials and information to be presented is provided below:

Materials and Information Requested at Oral Presentation:

4.4.1. [in person presentation outlining proposal]

4.4.2. [question and answer period]

4.4.3. [specific topics discussed]
SECTION 5: VENDOR PROPOSAL

5.1. Economy of Preparation: Proposals should be prepared simply and economically providing a concise description of the items requested in Section 4. Emphasis should be placed on completeness and clarity of the content.

5.2. Incurring Cost: Neither the State nor any of its employees or officers shall be held liable for any expenses incurred by any Vendor responding to this RFP, including but not limited to preparation, delivery, or travel.

5.3. Proposal Format: Vendors should provide responses in the format listed below:

5.3.1. Two-Part Submission: Vendors must submit proposals in two distinct parts: technical and cost. Technical proposals must not contain any cost information relating to the project. Cost proposal must contain all cost information and must be sealed in a separate envelope from the technical proposal to facilitate a secondary cost proposal opening.

5.3.2. Title Page: State the RFP subject, number, Vendor’s name, business address, telephone number, fax number, name of contact person, e-mail address, and Vendor signature and date.

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

5.3.4. Response Reference: Vendor’s response should clearly reference how the information provided applies to the RFP request. For example, listing the RFP number and restating the RFP request as a header in the proposal would be considered a clear reference.

5.3.5. Proposal Submission: All proposals must be submitted to the Purchasing Division prior to the date and time stipulated in the RFP as the opening date. All submissions must be in accordance with the provisions listed in Section 2: Instructions to Bidders Submitting Bids.
REQUEST FOR PROPOSAL  
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SECTION 6: EVALUATION AND AWARD

6.1. Evaluation Process: Proposals will be evaluated in two parts by a committee of three (3) or more individuals. The first evaluation will be of the technical proposal and the second is an evaluation of the cost proposal. The Vendor who demonstrates that it meets all of the mandatory specifications required, attains the minimum acceptable score and attains the highest overall point score of all Vendors shall be awarded the contract.

6.2. Evaluation Criteria: Proposals will be evaluated based on criteria set forth in the solicitation and information contained in the proposals submitted in response to the solicitation. The technical evaluation will be based upon the point allocations designated below for a total of 70 of the 100 points. Cost represents 30 of the 100 total points.

Evaluation Point Allocation:

Project Goals and Proposed Approach (§ 4.2)
- Approach & Methodology to Goals/Objectives (§ 4.2.1) (#) Points Possible
- Approach & Methodology to Compliance with Mandatory Project Requirements (§ 4.2.2) (#) Points Possible

Qualifications and experience (§ 4.3)
- Qualifications and Experience Generally (§ 4.3.1) (#) Points Possible
- Exceeding Mandatory Qualification/Experience Requirements (§ 4.3.2) (#) Points Possible

(Oral interview, if applicable) (§ 4.4) (#) Points Possible

Total Technical Score: 70 Points Possible

Total Cost Score: 30 Points Possible

Total Proposal Score: 100 Points Possible

6.3. Technical Bid Opening: At the technical bid opening, the Purchasing Division will open and announce the technical proposals received prior to the bid opening deadline. Once opened, the technical proposals will be provided to the Agency evaluation committee for technical evaluation.
6.4. **Technical Evaluation:** The Agency evaluation committee will review the technical proposals, assign points where appropriate, and make a final written recommendation to the Purchasing Division.

6.5. **Proposal Disqualification:**

6.5.1. **Minimum Acceptable Score (“MAS”):** Vendors must score a minimum of 70% (49 points) of the total technical points possible in order to move past the technical evaluation and have their cost proposal evaluated. All vendor proposals not attaining the MAS will be disqualified.

6.5.2. **Failure to Meet Mandatory Requirement:** Vendors must meet or exceed all mandatory requirements in order to move past the technical evaluation and have their cost proposals evaluated. Proposals failing to meet one or more mandatory requirements of the RFP will be disqualified.

6.6. **Cost Bid Opening:** The Purchasing Division will schedule a date and time to publicly open and announce cost proposals after technical evaluation has been completed and the Purchasing Division has approved the technical recommendation of the evaluation committee. All cost bids received will be opened. Cost bids for disqualified proposals will be opened for record keeping purposes only and will not be evaluated or considered. Once opened, the cost proposals will be provided to the Agency evaluation committee for cost evaluation.

The Purchasing Division reserves the right to disqualify a proposal based upon deficiencies in the technical proposal even after the cost evaluation.

6.7. **Cost Evaluation:** The Agency evaluation committee will review the cost proposals, assign points in accordance with the cost evaluation formula contained herein and make a final recommendation to the Purchasing Division.

**Cost Evaluation Formula:** Each cost proposal will have points assigned using the following formula for all Vendors not disqualified during the technical evaluation. The lowest cost of all proposals is divided by the cost of the proposal being evaluated to generate a cost score percentage. That percentage is then multiplied by the points attributable to the cost proposal to determine the number of points allocated to the cost proposal being evaluated.

**Step 1:** Lowest Cost of All Proposals / Cost of Proposal Being Evaluated = Cost Score Percentage

**Step 2:** Cost Score Percentage  X  Points Allocated to Cost Proposal = Total Cost Score

Example:

- Proposal 1 Cost is $1,000,000
- Proposal 2 Cost is $1,100,000
- Points Allocated to Cost Proposal is 30
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Proposal 1:  Step 1 – $1,000,000 / $1,000,000 = Cost Score Percentage of 1 (100%)
Step 2 – 1 X 30 = Total Cost Score of 30

Proposal 2:  Step 1 – $1,000,000 / $1,100,000 = Cost Score Percentage of 0.909091 (90.9091%)
Step 2 – 0.909091 X 30 = Total Cost Score of 27.27273

6.8. Availability of Information: Proposal submissions become public and are available for review immediately after opening pursuant to West Virginia Code §5A-3-11(h). All other information associated with the RFP, including but not limited to, technical scores and reasons for disqualification, will not be available until after the contract has been awarded pursuant to West Virginia Code of State Rules §148-1-6.3.d.

By signing below, I certify that I have reviewed this Request for Proposal in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder’s behalf; that I am authorized to bind the bidder in a contractual relationship; and that, to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

______________________________
(Company)

______________________________
(Representative Name, Title)

______________________________
(Contact Phone/Fax Number)

______________________________
(Date)
REQUEST FOR PROPOSAL
(Agency Name and RFP #)

Attachment A: Cost Sheet

Revised 08/02/2018
Appendix I: Glossary of Terms

As used throughout this Contract, the following terms will have the meanings set forth below.

**Abuse** – provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

**ACF** – Administration for Children and Families, a division within the federal Department of Health and Human Services.

**Action** – the MCO’s decision to deny or limit authorization or payment (in whole or in part) for health care services, including new authorizations and previously authorized services; the reduction, suspension, or termination of a previously authorized service; the MCO’s failure to provide services as required by the Contract; failure to resolve grievances or appeals within the timeframes specified in this Contract; or the MCO’s denial of a request by an enrollee who resides in a rural area with only one MCO to receive out-of-network services.

**Actuary** – an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this Contract, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

**Advance Directive** – a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

**Appeal** – a request for a review of the MCO’s action as defined in this Contract and 42 CFR 438.400(b) (1-6).

**Authorized Agent** – any corporation, company, organization, or person or their affiliates, not in competition with the MCO for the provision of managed care services, retained by the Department to provide assistance in this project or any other project.

**Behavioral Health Services** – services used to treat a mental illness, behavioral disorder and/or substance use disorder which necessitates therapeutic and/or supportive treatment, such services include but not limited to psychological and psychiatric services.

**Business Continuity Plan (BCP)** – a plan that provides for a quick and smooth restoration of the MCO information system after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan.
CAHPS – the Consumer Assessment of Health Plans Survey. This survey is conducted annually by the EQRO.

Capitation Payment – a payment the State makes periodically to the MCO on behalf of each beneficiary enrolled under this Contract and based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

Cardiac Rehabilitation – a comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore members with heart disease to active, productive lives.

Choice Counseling – the provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among managed care plans. Choice counseling does not include making recommendations for or against enrollment into a specific MCO.

Cold-Call Marketing – any unsolicited personal contact by the MCO with a potential member for the purpose of influencing the potential member to enroll in that particular MCO. Cold Call Marketing includes, without limitation:

- Unsolicited personal contact with a potential member outside of an enrollment event, such as door-to-door or telephone marketing.
- Any marketing activities at the enrollment events where participation is mandatory.
- Any other personal contact with a potential member if the potential member has not initiated the contact with the MCO.

Common Area (Marketing) – any area in a provider’s facilities that is accessible to the general public. Common areas include, without limitation: reception areas, waiting rooms, hallways, etc.

Complaint – an expression of dissatisfaction made about an MCO decision or services received from the MCO when an informal grievance is filed; some complaints may be subject to appeal.

Consultant/Consultant Affiliates – any corporation, company, organization, or person or their affiliates retained by the Department to provide assistance in this project or any other project; not the MCO or Subcontractor.

Corrective Action – an improvement in a business process that may be required by the Department to correct or resolve a deficiency in the MCO’s processes or actions.

Covered Services (Contract Services) – health care services the MCO must arrange to provide to Medicaid members, including all services required by this Contract and state and federal law, and all Value-Added Services negotiated by the MCO and the Department.

CMS – the Centers for Medicare and Medicaid Services, a division within the federal Department of Health and Human Services.

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Corrective Action Plan – a detailed written plan that may be required by the Department to correct or resolve a deficiency in the MCO’s processes or actions.

Cost-Sharing – copays that the MCO enrollee is billed at the time of service. Copays are determined by the Department based on the member’s family income. There are no premiums or deductibles under the West Virginia Medicaid program.

Day – except where the term “working days” is expressly used, all references in this Contract will be construed as calendar days.

Default Enrollment (Assignment) – a process established by the Department through the CMS waiver authority to assign an enrollee who has not selected an MCO to an MCO.

Department or Bureau for Medical Services (BMS) – the West Virginia Department of Health and Human Resources.

DHHS – the United States Department of Health and Human Services.

Direct Mail Marketing – any materials sent to potential members by the MCOs or their agents through U.S. mail or any other direct or indirect delivery method.

Disabled Person or Person with Disability – a person under sixty-five (65) years of age, including a child, who qualifies for Medicaid services because of a disability.

Disability – a physical or mental impairment that substantially limits one (1) or more of an individual’s major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Eligible Recipient or Recipient – a person who receives Medicaid in accordance with the State Plan.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – Medically Necessary services, including interperiodic and periodic screenings, listed in Section 1905(a) of the Social Security Act. EPSDT entitles Medicaid-eligible infants, children, and adolescents to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Social Security Act if that treatment or service is necessary to “correct or ameliorate” defects and physical and mental illnesses or conditions.¹

Emergency Care – includes inpatient and outpatient services needed immediately and provided by a qualified Medicaid provider for emergency medical, behavioral health, or dental conditions where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing their health or the health of an unborn child in immediate jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part; and that are needed to evaluate or stabilize an emergency medical condition. These include accidental injury and poison related problems and complaints that may

¹Section 1905(r)(5) of the Social Security Act
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be indicative of serious, life threatening medical problems, such as chest or abdominal pain, difficulty breathing or swallowing, or loss of consciousness. If the patient presents at the hospital emergency department and requests an examination, a nurse triage screening is always allowed. In the case of behavioral health services, emergency care means those clinical, rehabilitative, or supportive behavioral health services provided for behavioral health conditions or disorders for which a prudent layperson with an average knowledge of health and medicine, could reasonably expect to result in risk of danger to a person’s self or others if not immediately treated. These include, but are not limited to, crisis stabilization treatment services.

Emergency Dental Condition – a dental or oral condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate services for relief of symptoms and stabilization of the condition; such conditions may include severe pain, hemorrhage, acute infection, traumatic injury to the teeth and surrounding tissue, or unusual swelling of the face or gums.

Emergency Medical Condition – conditions where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing the individual’s health or the health of an unborn child in immediate jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

Encounter Data – procedure-level data on each contact between an enrolled individual and the health care system for a health care service or set of services included in the covered services under the Contract.

Enrollee – a Medicaid recipient who has been certified by the State as eligible to enroll under this Contract, and whose name appears on the MCO enrollment information which the Department will transmit to the MCO every month in accordance with an established notification schedule. An enrollee is also referred to as a member.

External Quality Review- the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that the MCO or its Subcontractors furnish to Medicaid beneficiaries.

External Quality Review Organization (EQRO) – the entity contracted by the Department to conduct periodic independent studies regarding the quality of care delivered to West Virginia Medicaid managed care enrollees. EQRO must meet the competence and independence requirements set forth in 42 CFR 438.354, and perform external quality review, other EQR-related activities as set forth in 42 CFR 438.358, or both.

Family Planning Services – those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. These services include: health education and counseling necessary to make informed choices and understand contraceptive methods; limited history and physical examination; laboratory tests if medically indicated as part of decision making process for choice of contraceptive methods; diagnosis and treatment of sexually transmitted diseases (STDs) if medically indicated; screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment; follow-up care for complications associated with contraceptive methods.
issued by the family planning provider; provision of contraceptive pills/devices/supplies; tubal ligation; vasectomies; and pregnancy testing and counseling.

**Fiscal Agent** – an entity performing administrative service functions, including member eligibility and capitation payment functions, for the managed care program under a separate Contract with the Department.

**Formal Grievance** – a written expression of dissatisfaction other than those subject to appeal.

**Fraud** – an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

**Gift (Marketing)** – any promotional item or incentive offered by an MCO to members or potential members.

**Grievance** – an expression of dissatisfaction, either in writing (formal) or orally (informal), regarding any aspect of service delivery provided or paid for by the MCO, other than those MCO actions that are subject to appeal. The term grievance also refers to the overall system that includes grievances and appeals handled at the MCO level and access to the State fair hearing process.

**Grievance Process** – the procedure for addressing an enrollee’s grievances and complaints.

**Grievance System** – includes a grievance process, an appeals process, and access to the State’s fair hearing system.

**Informal Grievance** – an oral expression of dissatisfaction other than those subject to appeal.

**Information Security Plan** – a written MCO compliance plan with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and The Health Information Technology for Economic and Clinical Health Act (HITECH Act).

**Health Home** – a designated provider (including provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual to provide health home services as defined in Section 1945 of the Social Security Act. Chronic condition health homes are available for eligible individuals with certain chronic conditions. West Virginia’s requirements for health homes are defined in the Medicaid State Plan.

**HEDIS** – the Health Plan Employer Data and Information Set developed, sponsored and maintained by NCQA. HEDIS is a set of standardized performance measures designed to reliably compare the performance of managed care health plans.

**Key Personnel** – the MCO’s Chief Executive Officer, Department Managers, and other staff specifically named in the application for certification.

**Liquidated Damages** – reasonable estimates of the Department’s projected financial loss and damage resulting from the MCO’s non-performance.
Managed Care Initiative – West Virginia’s Medicaid managed care program, as described in the current state plan and federal waiver and amendments, and approved by CMS. This may include one or more MCOs and voluntary or mandatory enrollment options in a given geographic area.

Managed Care Organization (MCO) – an Health Maintenance Organization (HMO) entity licensed to do business in the State of West Virginia, that has, or is seeking to qualify for, comprehensive risk contract, and that is —

1. A Federally qualified HMO that meets the advance directives requirements of 42 CFR 489, Subpart I;
2. or Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
   i. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; and

MCO Service Area - all the counties included in any Department’s defined service area within which the MCO has been contracted to provide MCO services.

Managing Employee – a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency, in accordance with 42 CFR 455.101.

Marketing – any communication, from the MCO to a Medicaid-eligible person who is not enrolled in the MCO, that can reasonably be interpreted as intended to influence such person to enroll in that particular MCO’s Medicaid program, or either to not enroll in, or to disenroll from, another MCO’s Medicaid program. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan.

Medically Necessary – refers to items or services furnished or to be furnished to a patient for diagnosing, evaluating, treating, or preventing an injury, illness, condition, or disease, based on evidence-based clinical standards of care. Medically necessary services are accepted health care services and supplies that are reasonable and necessary for the diagnosis or treatment of illness or injury; to improve the functioning of a malformed body member; to attain, maintain, or regain functional capacity; for the prevention of illness; or to achieve age-appropriate growth and development. Determination of medical necessity is based on specific criteria.

Medicaid – the West Virginia Medical Assistance Program operated and funded by the Department pursuant to Title XIX, Social Security Act (42 U.S.C. §1396 et seq.), and related State and Federal rules and regulations (same as Medical Assistance).

Medicaid Policy – collectively refers to documents and other written materials including the State Medicaid plan, program instructions, attendant provider manuals, program bulletins, and all published policy decisions issued by BMS. These materials are available through BMS.

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Medicaid Program Provider Manuals – service-specific documents created by the Bureau for Medical Services to describe policies and procedures applicable to the program generally and that service specifically.

Medical Loss Ratio – the ratio of the sum of total medical expenses and the total capitation revenue, including monthly capitation and delivery kick payments, received by the MCO and subject to any applicable adjustments, as provided under this Contract and Appendix H.

Member – the individual enrolled in the program and receiving direct services.

Mountain Health Trust – the name of West Virginia’s Medicaid mandatory managed care program for TANF and TANF-related children and adults who are eligible to participate in managed care.

National Committee for Quality Assurance (NCQA) – the independent organization that accredits MCOs, managed behavioral health organizations, and accredits and certifies Disease Management programs.

Non-Emergency Services – any care or services that are not considered emergency services as defined in this Contract. This does not include any services furnished in a hospital emergency department that are required to be provided as an appropriate medical screening examination or stabilizing examination and treatment under section 1867 of the Social Security Act.

Non-Participating Provider – a doctor, hospital, facility, or other licensed health care professional who has not signed a contract or had a contract signed on his/her behalf agreeing to provide services to the MCO’s members.

Open Panel – PCPs who are accepting new patients for the MCO.

Overpayment – money paid to a Provider by an MCO for a claim or claims, which exceeds the amount which should have been paid by the MCO.

Patient-Centered Medical Home – “a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patients’ families and communities. A patient-centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a physician or physician practice that leads a multidisciplinary health team, which may include, but is not limited to, nurse practitioners, nurses, physician’s assistants, behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the needs of the patient in all aspects of preventive, acute, chronic care and end-of-life care using evidence-based medicine and technology. At the point in time that the Center for Medicare and Medicaid Services includes the nurse practitioner as a leader of the multidisciplinary health team, this state will automatically implement this change (§16-29 H-9 of the West Virginia State Code).”

Participating Provider – a doctor, hospital, facility, or other licensed health care professional who has signed a contract or had a contract signed on his/her behalf agreeing to provide services to the MCO’s members.
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PPACA – the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA).

Periodicity Schedule – the requirements and frequency by which periodic screening services are provided and covered. Schedule must meet current standards of pediatric medical and dental practice and specify screening services applicable at each stage of the recipient’s life, beginning with a neonatal examination, up to the age at which an individual is no longer eligible for EPSDT services.

Post-stabilization Services – services subsequent to an emergency medical condition that a treating physician views as Medically Necessary after an enrollee’s condition has been stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee’s condition.

Potential Enrollee – a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO.

Pregnant Women or Pregnancy-Related Services – All women receiving related services and services for other conditions that might complicate the pregnancy, unless specifically identified in the State Plan as not being related to the pregnancy. This includes counseling for cessation of tobacco use and services during the postpartum period. The pregnancy period for which these services must be covered includes the prenatal period through the postpartum period (including the 60-day postpartum period following the end of pregnancy; see 42 CFR 440.210(a)(3).

Primary Care Provider (PCP) – a specific clinician responsible for coordinating the health care needs of certain enrollees.

Primary Services – basic or general health services rendered by general practitioners, family practitioners, internists, obstetricians, and pediatricians.

Provider – an individual or entity that is engaged in the delivery of health services, or ordering or referring for those services, who meets the requirements of the West Virginia Medicaid Program and is a member of the MCO’s network.

Prior Authorization/Preauthorization – approval granted for payment purposes by the MCO for its active, specified enrollees, or the Medicaid Program to a provider to render specified services to a specified recipient.

Pulmonary Rehabilitation – individually tailored multidisciplinary approach to the rehabilitation of members who have pulmonary disease.

Readiness Review (MCO) – the assurances made by a selected MCO and the examination conducted by the Department, or its agents, of MCO’s ability, preparedness, and availability to fulfill its obligations under this Contract, State Plan, and federal waiver.

Recipient – see Eligible Recipient.

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Regulation – a Federal or State agency statement of general applicability designed to implement or interpret law, policy, or procedure.

Request for Proposal (RFP) – a document, containing the specifications or scope of work and all contractual terms and conditions, which is used to solicit written bids.

Risk – the possibility of monetary loss or gain by the MCO resulting from service costs exceeding or being less than payments made to it by the Department.

Routine Care – basic primary care services including the diagnosis and treatment of conditions to prevent deterioration to a more severe level or minimize/reduce risk of development of chronic illness or the need for more complex treatment.

Service Authorization – (also Prior Authorization); includes an enrollee’s request for the provision of a service.

Socially Necessary Service (SNS) – Services provided to improve relationships and social functioning, with the goal of preserving the individual’s tenure in the community or the integrity of the family or social system. Socially necessary services are interventions designed to maintain or establish safety, permanency and well-being for targeted populations.

Specialist – a provider who focuses on a specific kind of health care, such as a surgeon or a cardiologist.

Start Date – the date the Contract for services becomes effective.

State of West Virginia, Department of Administration Purchasing Division – agency responsible for the timely, responsive, and efficient procurement of goods and services for state government.

Subcontract – any written agreement between the MCO and another party to fulfill any requirements of this Contract.

Subcontractor – party contracting with the MCO to perform any services related to the requirements of this Contract. Subcontractors may include, without limitation, affiliates, subsidiaries, and affiliated and unaffiliated third parties.

Subcontractor Monitoring Plan – a written plan describing how obligations, services, and functions performed by the MCO’s Subcontractor will be reviewed to ensure that such obligations, services, and functions are performed to the same extent that they were performed by MCO.

Systems Quality Assurance Plan – a written plan developed by the MCO that describes the processes, techniques, and tools that the MCO will use for assuring that the MCO information systems meet the Contract requirements.

Temporary Assistance to Needy Families (TANF) – the federally funded program that provides assistance to single parent families with children who meet the categorical requirements for aid.

Tertiary Services – highly specialized medical services administered in a specialized medical facility.

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Third Party – any individual entity or program which is or may be liable to pay all or part of the expenditures for Medicaid furnished under a State Plan.

Title XIX – refers to Title XIX of the Social Security Act codified at 42 United States Code Annotated Section 1396 et. Seq., including any amendments thereto (see Medicaid).

Value-Added Services – services that include additional value benefits that are actual health care services, benefits, or positive incentives that will promote healthy lifestyles and improve health outcomes among members.

Urgent Care – refers to circumstances in which the individual requires prompt medical attention for the care and management of a significant physical or mental disorder, but there is no immediate threat to the individual’s life.
## Appendix II: Service Level Agreements

<table>
<thead>
<tr>
<th>#</th>
<th>Program Non-Performance</th>
<th>Measurement Period</th>
<th>Liquidated Damages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Failure to submit required reports, information requests, documentation, ad hoc reports, data certification forms, or any other data required within the timeframes provided by this Contract or by the Department. The MCO may have a one business day grace period following the due date of the data, report, or form. Article II, 4.12, unless otherwise specified in this Appendix.</td>
<td>Ongoing</td>
<td>$250 per day per each item that is overdue until the satisfactory submission of the required report, documentation, ad hoc report, data certification form, or data required to meet any State or federal reporting requirements. After three (3) instances of non-performance during the Contract period, the amount is increased by $1,000 per day per each item that is overdue.</td>
</tr>
<tr>
<td>2</td>
<td>Failure to comply with encounter data submission requirements including the failure to address or resolve problems with encounter records in a timely manner as required by Article III, 5.11.</td>
<td>Monthly</td>
<td>$1,000 per single encounter file per reporting period.</td>
</tr>
<tr>
<td>3</td>
<td>Failure to meet a 95% encounter acceptance rate as required by Article III, 5.11</td>
<td>Monthly</td>
<td>$100 per each rejected encounter below the 95% acceptance rate threshold.</td>
</tr>
<tr>
<td>4</td>
<td>Failure to resolve at least 98% of member appeals within 30 calendar days from the date the appeal is filed with the MCO, unless an enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee. Article III, 3.8.</td>
<td>Quarterly</td>
<td>$1,000 for each percentage point below 98% if the MCO fails to meet the standard.</td>
</tr>
<tr>
<td>5</td>
<td>Failure to notify affected members of program or service site changes, at least fourteen calendar days before the intended effective date of the change. Article III, 3.4.</td>
<td>Ongoing</td>
<td>$250 per each incident per affected member.</td>
</tr>
</tbody>
</table>
### Appendix II: Service Level Agreements

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<tr>
<td>6</td>
<td>Failure to report timely to BMS significant network changes as described in Article III, 2.1, Network Changes.</td>
<td>Ongoing</td>
<td>$500 per incident of non-compliance.</td>
</tr>
<tr>
<td>7</td>
<td>Failure to meet provider credentialing requirements, including background screening requirements, specified in Article III, 2.1, Provider Qualification and Selection.</td>
<td>Ongoing</td>
<td>$500 per incident of non-compliance.</td>
</tr>
<tr>
<td>8</td>
<td>Failure to comply with the marketing requirements, or engagement in prohibited marketing practices. Failure to meet all social media marketing requirements, or engagement in any prohibited social media practices. Article III, 3.1 and Appendix D.</td>
<td>Ongoing</td>
<td>$1,000 per each incident of non-compliance.</td>
</tr>
<tr>
<td>9</td>
<td>Failure to pay 7% annual interest on the same date as an in-network clean claim that remained unpaid beyond the 30-day claims payment deadline. Article III, 2.7, Timely Payment Requirement.</td>
<td>Quarterly</td>
<td>$500 per each in-network clean claim for which the interest remained unpaid on the same date as a claim’s payment.</td>
</tr>
<tr>
<td>10</td>
<td>Failure to provide timely MCO covered services as described in Appendix A of this Contract when, in the determination of BMS, such failure results in actual harm to a member or places a member at risk of imminent harm.</td>
<td>Ongoing</td>
<td>$7,500 per day for each incident of non-compliance.</td>
</tr>
</tbody>
</table>
### Appendix II: Service Level Agreements

<table>
<thead>
<tr>
<th>#</th>
<th>Program Non-Performance</th>
<th>Measurement Period</th>
<th>Liquidated Damages</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Failure to make at least 95% of authorization decisions and provide written notice of denials within seven (7) calendar days of receiving the request for service for the purposes of standard authorization decisions as described in Article III, Section 5.4. Approval notices need not be in writing, but must meet contractual timelines.</td>
<td>Quarterly</td>
<td>$250,000 for each quarter in which the threshold is not met</td>
</tr>
<tr>
<td>12</td>
<td>Failure to administer member copayments, including charging excess copayments for covered services, as determined by the Department and outlined in Article III, Section 3.9.</td>
<td>Ongoing</td>
<td>$100 per each copay incident imposed in error.</td>
</tr>
<tr>
<td>13</td>
<td>Failure to hold or improperly release funds subject to a credible allegation of fraud payment hold.</td>
<td>Ongoing</td>
<td>Amount held or released improperly.</td>
</tr>
<tr>
<td>14</td>
<td>Failure to pay clean claims within 30 days for in-network providers.</td>
<td>On-going</td>
<td>$100 per claim not paid.</td>
</tr>
</tbody>
</table>
Appendix II: Service Level Agreements

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</thead>
<tbody>
<tr>
<td>15</td>
<td>Vendor is required to meet an average time in queue for its call center of less than X.</td>
<td>On-going</td>
<td>$10,000 per quarter in which standard is not met.</td>
</tr>
</tbody>
</table>
Appendix III: Performance Measures

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.
- The number of children the vendor has placed in out-of-state care.
- The number of children the vendor has been successful in transitioning out of the child welfare system.
- Submission of accurate and valid encounter data to the State on members in care.
- The effectiveness of preparation members receive to transition into adulthood and being able to be self-sufficient; the percentage of youth that have established a youth transition plan).
- The percentage of children accessing well-care visits.
- Call center metrics (to be defined).