STATE OF WYOMING
WYOMING DEPARTMENT OF HEALTH
DIVISION OF HEALTHCARE FINANCING

REQUEST FOR INFORMATION

CARE MANAGEMENT ENTITY
FOR MEDICAID CHILDREN

OPENING DATE AND TIME
JUNE 16, 2014 AT 2:00 P.M. (MDT)

DEPARTMENT OF HEALTH
REPRESENTATIVE: Lindsey D. Schilling, Provider Operations Administrator
TELEPHONE NO.: 307-777-6032
1.0 GENERAL INFORMATION

1.1 THE PURPOSE

This request for information (RFI) is being issued by the State of Wyoming, Department of Health (WDH), Division of Healthcare Financing (DHCF), 6101 Yellowstone Road, Suite 210, Cheyenne, WY 82002. The RFI is being issued with the intent of collecting information, comments, suggestions, recommendations, cost considerations, and creative ideas for implementing a risk-based care management entity (CME) within the State's Medicaid program. Once implemented, the CME would manage service delivery, as outlined in this RFI, for Medicaid-eligible children with serious mental and behavioral health challenges throughout the State of Wyoming. This population may include:

- Children with serious emotional disorders (SED), including a medical or educational diagnosis of serious emotional disturbance/emotional disturbance; or
- Children with one hundred (100) days or more of behavioral health services within one calendar year;
- Children at risk of out-of-home placement and/or children who currently meet Psychiatric Residential Treatment Facility (PRTF) level of care or Residential Treatment Center (RTC) level of care; and/or
- Children identified by the WDH whose current prescription drug regime exceeds standard prescribing guidelines established by the State.

1.1.1 Primary Objective for CME

The primary objective for the State of Wyoming is to select a CME that uses a high fidelity wraparound (HFWA) approach in combination with a risk-based behavioral health service provision to improve the quality and effectiveness of care for Wyoming’s children. The CME will ensure the provision of required services appropriate in type, frequency, and duration. The State anticipates that the successful implementation of a risk-based CME will result in improved clinical and functional outcomes, decreased costs, increased access to home and community based services (HCBS), and increased youth and family resiliency for the targeted population. Positive outcomes are expected as a result of the focus on more frequent preventative screenings, the inclusion of each child within a primary care medical home, the coordination of physical and mental health services, the coordination of communication and other activity across agencies, and the natural supports that develop for each child as a result of ongoing HFWA activities.

The intent of the WDH is to award an initial 32-month contract, including a startup period effective November 1, 2014 through February 21, 2015, and a 28-month
operational period effective February 21, 2015 through June 30, 2017. The contract will have an option of two (2) single year extensions terminating June 30, 2019.

1.1.2 RFI Intent

Wyoming is seeking RFI responses that will assist the State in determining the most appropriate model and contract approach for better serving Medicaid-eligible youth with serious mental and behavioral health challenges. In addition, respondents are invited to present concepts and ideas in-person to the WDH. The State’s ideal CME contractor is one that will demonstrate practical knowledge and experience with building a comprehensive system of care (SOC) specific to serving youth with complex behavioral health challenges. Additionally, the CME will possess knowledge of and demonstrate its ability to build a network of qualified providers of HFWA services, as defined by the National Wraparound Initiative (NWI). The CME will also have a basic understanding of similar initiatives in other states and how Wyoming's unique geographical challenges, to include its small population and large geographic footprint, will be considered.

The information generated from this RFI will assist the State with determining the optimal approach for implementing a risk-based CME in Wyoming, and will further inform the request for proposal (RFP) anticipated to be released in August 2014.

1.2 BACKGROUND AND OBJECTIVES

Pursuant to the Social Security Act, the DHCF within the WDH is the State's appointed entity for administration of the Medicaid program in Wyoming. The Medicaid program has operated since 1965 under Title XIX of the Social Security Act, and is funded by appropriations authorized by the Wyoming State Legislature each biennium.

Medicaid youth with complex behavioral health conditions may often receive fragmented care due to the involvement of various public and private entities in service delivery, contributing to poor outcomes and unnecessarily high costs. Youth struggle because of gaps in required care coordination, family-disruption, and distant out-of-home placements. National and state spending on youth with complex behavioral health conditions is high due in part to ineffective, uncoordinated, and/or inappropriate service delivery. By focusing on bridging these gaps, children with complex behavioral issues will be better served while costs may also be reduced.

Wyoming is striving to provide youth and their families the services necessary to allow the youth to reside in their community, participate in routine daily activities, and experience long term success. Wyoming’s primary goal for pursuing the
implementation of a CME is to improve the overall health and longevity of the State’s youth.

Generally, Medicaid children with SED and children requiring a PRTF level of care have more frequent emergency room visits, significantly higher utilization of psychotropic drugs at doses that often exceed national parameters, frequent disruption of family and youth/child resiliency, and higher service costs. With the various parties typically involved with these children and the potential of out-of-home placement, the WDH recognizes the need to improve service delivery and increase the coordination of care for children with SED in order to improve health outcomes, decrease recidivism, and contain costs.

In February 2013, the WDH contracted with a vendor to operate a pilot CME model in seven (7) Wyoming counties. The current CME is overseeing the provision of HFWA services for approximately sixty (60) Wyoming youth. As the State moves forward with implementing a statewide CME, the development of a risk-based model is an important component for leveraging available resources in order to maximize potential outcomes. The contract with the current CME for the existing pilot project will expire February 21, 2015.

Wyoming Medicaid is seeking ways to improve the program’s clinical, functional, and cost outcomes, while increasing access to HCBS and improving youth and family resiliency. Collaboration with other State agencies including the Department of Family Services, the Department of Education, and the Juvenile Court System is required for the demonstrated improvement of care management, service delivery, access to resources, and outcomes for youth with SED.

As indicated in Section 1.1, above, one of Wyoming’s unique traits is its small population. According to the Wyoming Medicaid 2013 Annual Report, Wyoming Medicaid provides coverage for 55,849 low-income children. Of those 55,849 children, it is expected that between 800 and 1,500 children will qualify for participation in the CME based on the child’s age, diagnosis, Child and Adolescent Service Intensity Instrument (CASII) composite score, and financial eligibility.

The State’s primary objective in the next phase of the project is to contract with a CME to serve between 800 and 1,500 Wyoming youth through a model that utilizes HFWA and is built on the foundational SOC values and principles. Specifically, the State of Wyoming wants a CME that provides the following:

- A youth guided and family-driven strengths-based approach coordinated across agencies and providers;
- A high quality wraparound approach to service planning;
- Family Care Coordinators and Family Support Partners at a ratio of no more than 1 care coordinator or support partner per 10 youth;
• HCBS and natural supports\(^1\) as alternatives to costly residential and hospital care for children with severe behavioral health challenges;
• Linkage to family support partners that will assist families with navigating systems and providing necessary resources and support;
• Linkage to youth support partners; and
• Outcomes tracking.

Additionally, the WDH anticipates the CME will utilize appropriate health information technology to capture data regarding the children being served. The CME may opt to use a system already available or another proprietary third party system to track intensive care coordination functions, manage plans of care (POC), track expenditures for the population being served, and report on youth outcomes. The CME will be required to review each POC, capture demographic information on children being served, track costs associated with service delivery, and report on outcomes as a result of services.

Finally, the CME will be expected to utilize the HFWA model while functioning at both an administrative and service management level.

Administrative functions include:

• Ensuring that children have access to the right services, at the right time and in the right amount (i.e. utilization management at the child and family level);
• Ensuring that child and family have access to a broad, flexible array of services and informal supports in the community by organizing a provider network of both formal and informal services and supports;
• Tracking quality, costs, and outcomes;
• Orienting and training key stakeholders in the CME approach and functions;
• Building a CME model and SOC using HFWA; and,
• Utilizing information technology to ensure “real-time” data is available for care monitoring and quality improvement.

Service management level functions include:

• Ensuring screening, assessment, and clinical supervision and support are provided to youth;
• Contracting for and ensuring individualized care planning using HFWA;
• Contracting for and ensuring family care coordinators, family support

\(^1\) Natural Supports are team members drawn from family members’ networks of interpersonal and community relationships.
partners and youth support partners are available at low ratios; and,
- Ensuring families can access mobile crisis and response supports.

The CME will develop and collaborate with a network of providers and informal supports to ensure access to the appropriate mental health and medical services required to meet the needs of Wyoming’s youth.

1.3 PROPOSED SCOPE OF WORK

The State is currently considering the following approach to assisting the CME with its startup and ongoing operations in Wyoming:

Startup Phase

Upon execution of a contract, the State will award the CME $150,000 for startup costs. The scope of work for the startup phase shall include, but is not limited to the following activities:

- Submitting and receiving State approval of a training plan to train all current and prospective providers on the SOC, HFWA, and the CME model;
- Planning and executing all initial training;
- Submitting and executing a detailed project management plan;
- Outreach and marketing to expand the provider network;
- Establishing a presence in all of Wyoming’s twenty-three (23) counties (the CME must have a provider residing in each county or providers who are willing to travel to each county and, in addition, have a CME presence in every county);
- Creating all manuals, policies, procedures, guides and forms for clients and families enrolled in the CME;
- Submitting a written process for delivering customer service, including the process for handling complaints and community disputes for clients and providers;
- Creating local advisory boards/community groups throughout Wyoming to engage outside stakeholders and keep them informed of happenings with HFWA and the CME;
- Establishing connectivity to the State’s IT systems as required; and,
- Establishing a contract management process for overseeing the CME’s provider network.

The startup phase will last approximately four (4) months, from contract execution on November 1, 2014 through February 21, 2015. At the close of the startup phase, the contract will enter the operational phase.
Operational (At-Risk) Phase

The initial operational phase will last 28-months effective February 21, 2015 through June 30, 2017. The contract will have an option for two (2) single year extensions ending June 30, 2019. During the operational phase, the CME will be at-risk for the payment of required behavioral health services only. Medicaid will continue to pay for all services unrelated to the child’s behavioral healthcare needs through its fee for service system. CME duties will include, but are not limited to, the following:

- Expanding the CME’s provider network, both formal and informal;
- Providing quarterly and/or monthly updates on plans submitted during the startup phase or contained within the RFP Response;
- Demonstrating a relationship with multiple agencies and organizations;
- Demonstrating an understanding of SOC and HFWA, which are fundamental to the CME model;
- Creating local advisory boards/community groups that regularly meet to discuss issues, solutions and provide support;
- Conducting oversight, management, and monitoring of services delivered by the provider network and ensuring fidelity to the model;
- Attending and participating in all relevant meetings held by the State, providers, or families;
- Demonstrating an awareness of medication regimes for enrolled youth;
- Managing and tracking compliance with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements as part of the POC;
- Conducting prior authorization processes and utilization management processes for the CME population being served;
- Establishing and managing the POC in collaboration with the Child and Family Team (CFT);
- Establishing a crisis plan as part of each child’s overall POC;
- Supporting children by participating in (or facilitating) CFT meetings and Multi-Disciplinary Team meetings for court-ordered youth;
- Interfacing with the medical home for the target population;
- Working with State or local agency staff when critical barriers arise to effective coordination of care;
- Providing a comprehensive and integrative approach for addressing healthcare needs for children;
- Using technology and infrastructure where appropriate, to improve outreach;
- Actively tracking data, service delivery, services by providers, and other pertinent data and reporting on the outcomes (including encounter data);
- Ensuring and maintaining an adequate capacity of family support partners and youth support partners; and,
- Continuing all duties from the startup phase as outlined above.
Payments during the operational phase will be based on a per member per month (PMPM) all-inclusive rate\(^2\) as follows:

- Year 1 - $5,500 PMPM
- Year 2 - $5,000 PMPM
- Year 3 (Optional) - $4,500 PMPM
- Year 4 (Optional) - $4,000 PMPM
- Year 5 (Optional) - $3,500 PMPM

Any PMPM funds paid to the CME but not utilized for funding direct services will be shared between the State and CME equally in a shared savings agreement (50/50). Of the funds allocated to the CME’s shared savings agreement, the CME must reinvest 25% of the saved funds into the communities to build infrastructure, increase service quality, fill service gaps, or to establish flex funds for the family and/or child as indicated in their POC.

The State anticipates including a “hold harmless” provision in the contract whereby the State will split any additional costs incurred per child, above the PMPM, with the CME once the CME exceeds the PMPM by $1,000. This will be calculated at the end of each fiscal year and based on the average PMPM paid for all children in the CME.

The State encourages respondents to provide concise, thoughtful responses regarding the infrastructure as outlined above in their RFI response. In addition, the State encourages respondents to discuss innovative approaches with proven success in other states. Specific RFI response format requests are included in Section 2.1 below.

### 1.4 IMPLEMENTATION TIMELINE

As discussed in Section 1.3, above, the goal is to have an executed contract by November 1, 2014 to allow for a four-month startup period before the CME is expected to serve Wyoming’s youth. Figure 1 denotes the estimated contract timeline:

\(^2\) The rate may include, but is not limited to, PRTF, RTC, Medicaid covered costs, outpatient therapy, and HFWA. The rate is exclusive of medications, ER visits for physical injury or illness, and physical health. This is not a complete list of included or excluded costs, but is provided for informational and assessment purposes.
1.5 LIABILITY

This RFI has been issued to obtain information only and is not intended to result in a contract or vendor agreement with any respondent. The State is seeking vendor community insight and information prior to finalizing business, functional, operational, and technical requirements for a RFP. The RFI does not commit the State to procuring or purchasing any business services at this time or awarding any contract.

The State shall not be held liable for any costs incurred by the respondent in the preparation of its response. The issuance of an RFP as a result of information gathered from these responses is solely at the discretion of the State. Should an RFP be issued, it will be open to qualified vendors, whether or not those vendors chose to submit a response to this RFI. This RFI is not a pre-qualification process.

2.0 RESPONSE INSTRUCTION

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<tr>
<td>RFI Issued</td>
<td>June 16, 2014</td>
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<tr>
<td>Questions from respondents pertaining to the RFI</td>
<td>June 26, 2014</td>
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<td>Respondent responses due</td>
<td>July 3, 2014</td>
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<td>Respondents meet with and demo for the State Team (optional)</td>
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Respondents must submit their responses by July 3, 2014, by 2:00 PM (MST). Please provide an original hard copy and four (4) duplicate copies of your response along
with five (5) electronic copies of the response in Microsoft Word (preferred) or in a PDF format on thumb drives. Emailed responses will also be accepted. Please send responses to:

**Wyoming Department of Health, Division of Healthcare Financing**  
**Lindsey Schilling, Provider Operations Administrator**  
**6101 Yellowstone Road, Suite 210**  
**Cheyenne, WY 82002**  
**Lindsey.Schilling@wyo.gov**

For inquiries regarding this RFI, please contact Lindsey Schilling.

**2.1 RESPONSE CONTENT AND FORMAT**

The State appreciates any information and assistance respondents provide. If you choose not to respond, it will have no impact on the Department’s future contract considerations with your firm. If you do choose to respond, please comply with all aspects of the RFI as thoroughly as possible. Only entities that respond to this RFI will have the option of meeting with the State team to further discuss the proposed organization and approach.

The State is asking that all responding parties submit a response containing the following information. Entities should refer to the numbers below in their responses to enable efficient Department review. Responses should be limited to a total of fifteen (15) pages.

1. Provide a main contact name, address, e-mail address, and telephone number in each response.

2. Briefly describe your organization, client base, financial stability and history. Please keep generalized marketing material to a minimum.

3. Briefly describe the ideal staffing structure required within a CME in order to ensure compliance with the operational and service requirements outlined in Section 1.3.

4. Briefly discuss innovative approaches or add-ons to the CME and SOC model and any success with the proposed model you have seen in other places.

5. Discuss any lessons learned and share advice from similar work your organization has done in other states. Include how these successes or lessons learned could be applied to Wyoming’s project.

6. Explain how an ideal organization would need to adapt its approach in order to serve Wyoming’s small population and large rural frontier.
7. Briefly discuss any concerns regarding the payment outlined in Section 1.3, Proposed Approach. Please provide constructive solutions to address the concern.

8. Discuss thoughts, approach, and costs of a mobile crisis response unit in Wyoming and within the CME model.

9. Discuss any thoughts on the SOC/CME model, HFWA and its ability to succeed in Wyoming.

10. Every project has certain inherent risks. Describe the top three (3) significant risk factors associated with the CME implementation in Wyoming and ways an ideal CME would mitigate these risks.

11. As a respondent, would you be interesting in attending a meeting with the State to discuss the enclosed responses to the RFI? These will be scheduled during the week of July 14-18, 2014.

3.0 CLOSING

The WDH thanks you for your efforts in preparing a response. Although this RFI does not require the State to issue a formal RFP or to award a contract, it is anticipated that the information gathered through this RFI will inform the State’s upcoming decision-making process.