RFP #529-06-0293 for a Comprehensive Healthcare Program for Foster Care

Instructions: The RFP provides an opportunity to rev
comment period for the RFP will be from **July 24, 200**
comments will be accepted after this date. HHSC requ
submitted electronically on this comment form to Gwer
(Gwen.Edwards@hhsc.state.tx.us.) HHSC will post o

Date	FName	LName	Organization	Phone	Email	Section	Page	Paragraph/ Bullet
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	1.1, 1.3.2, 1.3.3	3, 8	Mission and Purpose/Project Overview/Child Protective Services and Substitute Care in Texas

8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	1.2	5	Behavioral Health Services
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org		5, 6	Service Management and Service Coordination/ Health Passport
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	2.12	19	Legal and Regulatory Constraints
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	2.16	25	Procurement Schedule

8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	3.4.5	34	Operations Readiness
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	3.4.7/4.1.7.1	37/78	Post-Transition/QA PI Program Overview
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.1	44	Performance Evaluation/3. Access to Behavioral Health Services

8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.2	45	Covered Services
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org		46	
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.2.1	46	Value-added Services

8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org		46	
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.3	48	Access to Care
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.3.1	50	Waiting Times For Appointments (# 7)

8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.4.1	53, 54, 55	Access to Network Providers
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.4.5	57	Primary Care Providers and the Medical Home
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.4.9.2	64	Provider Trainings/9. Population-specific issues related to the Target Population (b)

8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org		64	9. (c) Requirements
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.5.1	67	Member Materials
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.5.3	69	Member Handbook
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.5.6	72	Nurse and Member Hotline Requirements

8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.11	86	Coordination with DFPS
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org		86 -87	

8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org		87	
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org		87	Provider Manuals
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.11.1	89	Training for Law Enforcement Officials and Judges

8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.13	96	Services for Members with Special Health Care Needs
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.13/4.1.14/4.1.15	96/97/98	Services for Members with Special Health Care Needs/Service Management/ Service Coordination
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.18/4.1.18.3	103/109	Behavioral Health Services/Self-referral for Behavioral Health Services
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org		104	

8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org		104	
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.25	132	Continuity of Care and Out-of-Network Providers
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org		133	
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.26.7	142	Objection to Provide Certain Services

8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.27	144	Medicaid Significant Traditional Providers
8/2/2006	Tiffany	Roper	Center for Public Policy Priorities	512-320-0222, ext. 113	roper@cppp.org	4.1.30/4.1.31/4.1.31.1	146 - 147	Member Rights and Responsibilities/Member Complaint and Appeal System/Member Complaint Process

/iew and comment on before award. The
)6 through 5pm, August 2, 2006. No
uests that comments about this RFP be
n Edwards
)fficial responses on HHSC website.

Comment
This paragraph defines the target population as **children and young adults in DFPS conservatorship**. In some situations, DFPS will not have legal conservatorship of children who are placed with relatives, including one or both biological parent, although DFPS is legally involved with the family. This would be a typical FBSS (Family Based Safety Service) case. Is it your intent to include these children in the target population? Also, how will the MCO model work in those cases where DFPS has legal conservatorship of only one child in a sibling group? For example, when one child is in foster care, but the remainder of the children are in the home? Will the children be covered by two different networks of behavioral health care providers? In order to uniformly provide behavioral health care services to children involved in the Child Protective Services (CPS) system, children in FBSS cases should be included in the target population.

The last sentence of this section reads, "The Provider Network must include Providers experienced in treating victims of child abuse and neglect." Is the agency providing any specific criteria or guidelines for the MCO to follow?
These sections refer to the response of the MCO to inquiries from DFPS and the provision of information to DFPS by the MCO. Although the RFP doesn't address whether the definition of DFPS staff will include personnel of outsourced private entities until p. 9. (Section 1.3.3), it is appreciated that this definition has been clarified.
This section is left blank. Was that intentional or is there another document that needs to be referenced?
Per the procurement schedule, the transition period will last nine months. Is it the plan of HHSC that the MCO will be completely operational on September 1, 2007? Will it be operational for every child already in the target population or children entering the target population on that date?

Thank you for recognizing the importance of communication between the MCO and those in direct contact with the target population and including a requirement that the MCO must: **Develop and submit to HHSC a communication plan for ongoing coordination with HHSC, DFPS Staff, and their contractors that includes sharing strategies for sharing information and resolving issues.** In addition to DFPS staff, however, it will be vital that the MCO develop a plan for communicating with other persons involved in a child of the target population, including his guardian and/or attorney ad litem, parent, and/or caregiver. Is this an oversight and will this be addressed?
It is much appreciated that the MCO will be required to "participate in and work proactively to resolve issues or problems identified by the provider community, DFPS staff, **and other stakeholders**." Who will be included in the definition of other stakeholders?
Although we would like to see the distance requirement reduced for rural areas, also, thank you for changing the measure regarding access to behavioral health providers from within 75 miles of the child, to 30 miles in urban areas. Given the specialized needs of the target population and the desire to prevent any further disruption to these children's lives and daily routines, this is vastly more workable.

Whereas the draft RFP seemed to omit much mention of the overlap between the MCO and DFPS, this RFP clearly requires the MCO to comply with DFPS requirements related to covered services in laws, rules, and regulations, including requirements for assessments and court ordered services. The medical care model for the target population and the DFPS system cannot work independently. How does HHSC plan to educate the MCO regarding these requirements?
The RFP notes that "The MCO must allow Covered Services to be provided by an Out-of-Network (OON) provider if a Network Provider is **not available**. Is "not available" defined anywhere within the RFP or its attending documents?
Will value-added services include family therapy for the parents of a child within the target population? Often in DFPS cases, if the permanency plan for the child is reunification, family therapy is provided to address issues which led to the child become involved with DFPS and to assist the child's transition back into its family home. This type of service must occur in many reunification cases.

While we understand the precedent of value-added services in the Texas Medicaid STAR program, we are concerned that the requirement that the MCO provide value-added services at no additional cost to HHSC may serve as a disincentive to provide these types of services. We hope HHSC is not relying on this approach for services that should be included in the cost of capitation. Is there an appeals process for denial of this type of service? Who can appeal? DFPS staff? Caregivers? Biological or adoptive parents? Guardians or attorneys ad litem?
The paragraph requiring an Emergency Services and crisis Behavioral Health Services Hotline, available 24/7, is certainly needed with this target population, when emergencies related to behavioral health needs tend to occur after normal business hours.
Thank you for requiring the MCO to provide annual physicals for children ages 7 and 9, even though they are not specifically noted in the THSteps periodicity schedule. Sadly, too many children in the target population have not received routine well-child check-ups or even routine medical care. Having additional annual physicals authorized will hopefully allow any medical needs previously undetected to be found and addressed.

As we mentioned in our comments to the draft RFP, the network access is too standardized and it fails to take into account population and geographical size in Texas. Although we truly appreciate the change from 75 miles to 30 miles for behavioral health providers in urban areas, the other distance maximums should be decreased as well.
Can these terms be further defined and contrasted: ICP model vs. co-location of services; parallel vs. integrated care; sequential vs. IPC care? A majority of the target population needs behavioral health care and it is unclear under this RFP how the MCO and ICP model will impact current behavioral health care that members are receiving, including how current providers will be worked into the MCO and/or ICP model.
Thank you for recognizing the importance of coordinating care with persons and entities who play a large role in determining what happens to members of the target population. We suggest that the MCO be required to have staff that can provide health care information to these entities, rather than relying on the network providers to do so. As can be expected, a network provider may be overwhelmed by the additional duties of coordinating care with all of these entities, in comparison to doing so with a set of parents.

Providers must be trained in Texas Family Code, DFPS policy, and other related requirements. This model cannot work if these requirements are not followed. How will the MCO be trained in order to provide adequate training regarding these requirements?
The welcome letter should include information about the complaints and appeals process. Why isn't this required by the RFP?
What is meant by coordination between DFPS and CPS? How will coordination be ensured in this model, especially in regions that are outsourced?
Section 9, referring to clinical and non-clinical questions pertaining to accessing services that the MCO does not provide or arrange for, is very important. The target population often has needs that can't be addressed by health services alone. Having this type of information readily available will assist in improving the whole picture of each child. What type of information will be provided?

Why aren't attorneys and guardians ad litem included in this section? The section should read: Service coordinators and service managers must be available to provide information to and assist members, caregivers, medical consenters, **attorneys and guardians ad litem**, and DFPS staff with access to care and coordination of services…. Attorneys and guardians ad litem represent the interests and best interests, respectively, of members of the target population, and these ad litems routinely request provision of physical and behavioral health services as deemed necessary. Ad litems must be included in the loop of persons given information regarding care and coordination of services.
Why isn't there a deadline for basic level children? The RFP should also require a turnaround time for assessment and recommendations for target population members exhibiting a basic level of characteristics, rather than leaving this open-ended.

Although the two paragraphs dealing with providers having to testify in court and court-ordered health care services may seem unreasonable to those in the provider community, these issues are a fact of the legal side of CPS cases. Medical affidavits submitted by providers will be legally insufficient in many court proceedings; testimony will be required. Additionally, courts often order health care services as deemed necessary for the child if DFPS has not ensured that the child receives those services. Again, this is an unfortunate necessity in some cases.
Why aren't other pertinent persons included in the provision regarding medical records? The provider manuals must include information regarding 3. Providing medical records to DFPS, **members, member caregivers, parents of members, attorneys representing DFPS, and attorneys and guardian ad litems.** The MCO must make all providers aware that persons other than DFPS staff have a right to and/or a need for this information.
Why were guardians ad litem omitted from this section? **Guardians** ad litem needs to be added to this laundry list of persons in the first paragraph, and # 1 in the list of issues.

Continuity of care should include the requirement that if a network provider with the level or skill necessary to treat the member is unavailable, treatment by an out-of-network provider must be authorized. As noted in the RFP, some of these members have complex health care needs and they shouldn't have to change providers unnecessarily.
The attorneys and guardians ad litem appointed by the courts to represent members should be able to request service management and coordination, also. Due to high turnover of DFPS substitute care staff, attorneys and guardians ad litem may sometimes be the only source of valuable health care information for target population members.
Prior authorization should not be required for members of the target population needing behavioral health services. These children often need immediate crisis counseling and other behavioral health interventions. Requiring prior authorization in these situations could result in the endangerment of the child's mental well-being. Even if a child has not been previously assessed, an incident requiring immediate attention cannot wait for prior authorization.
Thank you for recognizing the need to reduce the amount of disruption to the members' school and home lives by requiring that the member travel to see behavioral health specialists. Providers must be available to provide these services in schools, homes, and other locations as appropriate.

Thank you for requiring that behavioral health providers be available to testify in court as needed. Most child protection litigation could not be successful without the testimony of a behavioral health specialist.
How will the MCO be required to ensure continuity of care for the target population members -- either newly enrolled or existing?
What if a network provider without comparable skill and level to the out-of-network provider cannot be located within 90 days? Who will be responsible for reimbursement of the out-of-network provider? Quibbles over bearing the cost of a necessary out-of-network provider should not occur -- the MCO should be obligated to pay the out-of-network provider for medically necessary services as long as needed.
If the MCO objects to certain covered services based on moral or religious grounds, who will ensure that these covered services are provided to members?

This RFP provision rightly recognizes the existing network of providers who either contract directly with DFPS or sub-contract with a contractor of DFPS to provide covered services to the target population. We applaud any effort to maintain continuity of providers for the target population. However, we feel this provision would be far stronger if the RFP also explicitly spelled out the requirements of the MCO to minimize disruptions in health care services for members already in the foster care system. What efforts should the MCO make to include these providers? Will these providers be given incentives to become MCO providers?
Why aren't the court-appointed ad litems for members of the target population included in this process? Provision needs to be made to allow attorneys and guardians ad litem to take part in this process on behalf of a member.