APPENDIX D

CARE COORDINATION

The Ohio Department of Job and Family Services (ODJFS) is interested in Applicants that have success and experience in promoting a cohesive care delivery system, where communication is clear and ensures that patients and providers have access to accurate and timely information in order to optimize care. This can be accomplished by implementing care coordination strategies such as care management programs and forging a path for primary care practices to transform to patient centered medical homes. In Ohio, Medicaid managed care plans will play a pivotal role in the implementation of these care coordination strategies.

Part A: Care Management (Total Points: 22,500)

Overview

Medicaid beneficiaries with multiple chronic conditions or severe illnesses often do not have their medical and behavioral health care managed in a coordinated manner. This Request for Applications (RFA) is designed to select Applicants that have experience in delivering intensive care management interventions and enhanced care coordination services to Medicaid beneficiaries.

Care management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet a beneficiary's health care needs across the continuum of care. It is characterized by advocacy, communication, and resource management to promote quality, cost-effective and positive outcomes.

ODJFS requires managed care plans (MCPs) to provide care management services to monitor and coordinate the care for beneficiaries with special health care needs. Beneficiaries who are eligible for care management have varying needs and require differing levels of interventions. This can range from disease management—focusing

on one condition and emphasizing prevention of exacerbations—to complex care management which uses a holistic comprehensive approach to address a beneficiary's health care needs. To that end, MCPs design their overall care management programs to reflect this range of approaches available to their beneficiaries. Most MCPs use risk stratification levels (low, medium, and high) to determine the intensity of interventions and follow up care that is required for each beneficiary enrolled in a care management program.

Acute Care Management/Disease Management

The managed care plans are afforded flexibility in the design of the care management programs for beneficiaries with less acute health care needs. At a minimum, the following components and functions must be included in the acute care management and/or disease management program:

- Identification strategy: mechanisms to identify beneficiaries eligible for care management services;
- Risk stratification level: a strategy to assign a beneficiary to a low or medium risk stratification level;
- Health assessment: completion of a health assessment to determine the beneficiary's need for care management;
- Care treatment plan: development of a care plan based on the health assessment that includes the following components:
    - Prioritized goals and actions with documentation of the beneficiary's progress in achieving the goals;
    - Continuous review and revision of the care treatment plan, including the identification of any gaps between recommended care and received care;
    - Ability for the beneficiary to provide input to the treatment plan; and
    - A provision to share the care treatment plan, when requested, with the provider.
- Care Manager/Care Management Team: Assignment of an accountable point of contact (i.e., care manager) to each beneficiary. The MCP can use a team of

health professionals to provide care management services to the beneficiary that is appropriate for his/her needs.

- Interaction with the beneficiary: Develop a communication plan that is based on the beneficiary's health care needs and includes a provision for two-way communication between the beneficiary and the MCP.

Complex / High Risk Care Management

ODJFS is placing an emphasis on targeting beneficiaries who are high risk/cost, have uncoordinated care, and the MCP can have the greatest impact on relative to improving health outcomes and reducing costs. ODJFS expects the managed care plan to care manage one percent of the overall population at a high risk level. Given that these beneficiaries will demand an intense level of management and interaction, the MCP's high risk care management program must include the following components and functions:

- Identification Strategy: Use of an industry standard predictive modeling software, a health risk assessment tool, and physician/beneficiary referrals to target costly beneficiaries for whom the plan can have the greatest impact on health outcomes and cost.

- Health Assessment: Completion of a comprehensive assessment that evaluates the beneficiary's physical, behavioral, social and psychological needs; identifies multiple chronic conditions; and identifies barriers to care. Inclusion of input from the beneficiary, caregiver/family, primary care provider, and other providers, as appropriate. Completion of the assessment within thirty days of identifying the need for care management, and re-evaluation of the beneficiary's need on a quarterly basis following the initial enrollment in to the care management program.

- Care Treatment Plan: Development of a treatment plan that is based on the health assessment and includes the following components:
    - Prioritized goals and actions, with documentation of the beneficiary's progress towards achieving the goals;
    - A comprehensive plan for transitioning care between residential, community and inpatient settings;
    - A communication plan with the beneficiary, including anticipated frequency of contacts;
    - A communication mechanism with the provider to understand the issues/needs the provider has identified and prioritized for the beneficiary, including a process to ensure the treatment plan created by the MCP is congruent with the provider's treatment plan;
    - Identification of providers responsible for delivering services, including referrals made to specialists or providers, and confirmation that the beneficiary received the services;
    - A provision to refer the beneficiary to community, social, recovery support agencies, assist the beneficiary in contacting the agency, and validate the beneficiary received the needed service;
    - A review of the initial and updated care treatment plan with the beneficiary, family, and providers, including efforts to actively seek input from them;
    - Continuous review and revision of the care treatment plan to ensure it is adequately monitored, including identification of gaps between recommended care and actual care provided; and
    - A mechanism to report feedback to the provider on beneficiary compliance with the care treatment plan.

- Care Manager/Care Management Team: Assignment of an accountable point of contact (i.e., care manager) to each beneficiary. The MCP can use a team of health professionals to provide care management services for the beneficiary that is appropriate based on his/her needs. The MCP is expected to maintain a

staffing ratio of one full time equivalent for every twenty five beneficiaries enrolled in high risk care management. Any team member's time can be used to fulfill this requirement. The care manager/care management team is expected to conduct the following activities for each beneficiary enrolled in care management: help the beneficiary obtain medically necessary care; assist with health related services; coordinate care for the beneficiary with the primary care provider, specialists, and other care managers; and disseminate information to the beneficiary concerning the health condition, types of services that may be available and how to access the services.

- Beneficiary Interaction: Complete one face to face contact with the beneficiary each quarter. The intervention delivered during the face to face contact must be linked to the care treatment plan.

- Support services: Identify support services that are available in the community and develop a resource guide which is made available to care managers, beneficiaries, and providers.

- Care management tracking system: Capture at a minimum the results of the assessment and the care treatment plan content, including goals, actions and completion dates. The system must be linked to other databases or systems that the MCP uses to maintain information about the beneficiary. It must also have the ability to transfer information on the level of care management and enrollment spans to other entities (e.g., States, other providers, etc.).

Instructions for Completion of Part A:

1. The Applicant may use the experience of the Applicant, Applicant's corporate family or a delegated entity that performed care management functions.
2. The Applicant must only use experience in serving a Medicaid population.

3. If the Applicant has experience with the Ohio Medicaid population, it must report it first. If the Applicant has no Ohio Medicaid experience, the Applicant shall report experience for any other Medicaid population served.
4. If the Applicant has no Medicaid experience, then proceed to Part B. The Applicant will not receive any points for completing Part A.
5. For information about the scoring methodology, the Applicant should refer to Appendix D Scoring Methodology.

Questions

1. Does the Applicant have more than 24 months experience as of July 2011 in performing all of the five (5) care management functions listed below for the Medicaid population? Total Points: 1,125

For this question, care management functions are defined as:
(1) identification of a beneficiary (e.g., based on diagnosis, utilization criteria, etc.) who may be eligible for care management services;
(2) completion of a health assessment (i.e., through administrative data review or a health questionnaire) to confirm and determine the need for care management;
(3) development, implementation, and monitoring of an individualized care treatment plan;
(4) communication with the beneficiary and provider that includes outreach, education, reporting and follow up; and
(5) assignment of an accountable point of contact (e.g., care manager or disease manager) who coordinates care, disseminates information to the beneficiary, monitors the treatment plan, and assists the beneficiary with accessing medically necessary services.

Mark only one of the following responses:

___Yes, the Applicant has more than 24 months experience as of July 2011 in performing all of the care management functions (listed in question 1) for a Medicaid population.

___No, the Applicant does not have more than 24 months experience as of July 2011 in performing all of the care management functions (listed in question 1) for a Medicaid population.

If the Applicant's response is NO to Question 1, proceed to Part B – Patient Centered Medical Homes. Part A will not be given any further consideration in the scoring of Appendix D.

If the Applicant's response is YES to Question 1, proceed to Question 2.

2. For the Ohio Medicaid population, will the Applicant contract out functions (2), (3), (4), and (5) of the care management functions listed in Question 1? Total Points: 1,125

Mark only one of the following responses:

____ Yes ____ No

3. Report information related to the Applicant's care management experience of a Medicaid population for a maximum of five states (see instruction on page 5). The table contains two sections to be completed by the Applicant: one to report information for disease management and/or acute care management programs (column C) and one to report information about complex/high risk care management programs (Column D). ODJFS's descriptions of what qualifies as disease/acute care management and complex/high risk care management are located in the *Overview* section of Part A of

this Appendix. For the purpose of responding to Question 3, the Applicant may report experience for a complex/high risk care management program if the Applicant has a minimum staffing ratio of 1 full time equivalent for every 200 beneficiaries (1FTE: 200 beneficiaries). Applicants may complete both sections of the table. For each entry, include in the table below:

- the state abbreviation (Column B); and
- total months of experience in administering a disease management and/or acute care management program for a Medicaid population (column C) as of December 2011; and
- total months of experience in administering a complex/high risk care management program for a Medicaid population (column D) as of December 2011.

Total Points: 1,125

Entry **(A)**	**State** **(B)**	**Total Months Experience in Administering Disease Management and/or Acute Care Management to a Medicaid Population as of December 2011** **(C)**	**Total Months Experience in Administering Complex/High Risk Care Management to a Medicaid Population as of December 2011** **(D)**
A			
B			
C			
D			
E			

The Applicant is to select one entry from Question 3 that best represents the Applicant's ability to perform care management functions for the Ohio Medicaid population. **Indicate which entry will be used from Question 3 to respond to Questions 4 through 7:**

_____.

The remaining questions in Part A will evaluate the Applicant's experience in performing care management functions that support the delivery of intensive interventions and enhanced care coordination activities. Questions 4 through 7 ask the Applicant for experience in performing functions that are congruent with ODJFS's expectations for complex/high risk care management.

4. Questions 4(a) through 4(d) asks the Applicant about its experience identifying beneficiaries who are eligible for care management using a strategy comprised of predictive modeling software and health risk assessments. Respond to questions 4(a) through 4(d) using the Applicant's experience during the timeframe of January 2011 through June 2011.

Total Points: 5,625

a. Did the Applicant use predictive modeling software (e.g., Impact Pro, Medicaid RX (MRX), Chronic Illness and Disability Payment System (CDPS), and Adjusted Clinical Groups (ACGs)) to identify beneficiaries who are eligible for care management? The predictive modeling software must meet all of the following criteria:

    1) is used by a substantial number of health care organizations and is recognized in the industry as a standard model for identifying future health care risks;

    2) has been quantitatively studied and supported as a viable predictive modeling tool in comparative research papers;

3) produces outputs which include a risk score component for at least one of the following: health status, disease burden, hospitalizations, and/or costs;

4) can be applied to the Medicaid population; and

5) can be used to support care management activities/functions.

Mark only one of the following responses:

____ Yes ____ No

If the Applicant responded to 4a with NO, then proceed to Question 5. The Applicant will not receive any points for Questions 4a through 4d.

If the Applicant responded to 4a with YES, then proceed to Question 4b.

b. Indicate with a check mark in the table below if the predictive modeling software accepts and utilizes the following inputs (Mark either 'Yes' or 'No' for each row in the table below.):

Data inputs	Yes	No
Demographic Data (gender, age, race, etc.)		
Utilization Data (inpatient admissions, emergency department visits,		

pharmaceuticals, etc.)		
Diagnosis Data		
Cost Data		

c. Indicate with a check mark in the box below if the predictive modeling software produces the following outputs (Mark either 'Yes' or 'No' for each row in the table below.):

Outputs	Yes	No
Predictive risk scores/thresholds (e.g., future costs, utilization, etc.)		
Key markers of patient disease categories, co-morbidities, indications of changes in disease status		
Alerts of recent utilization patterns		

d. Does the predictive modeling software integrate results from a health risk assessment in order to assist in the case selection process?

Mark only one of the following responses:

____ Yes ____ No

5. Are the Care Management Functions listed below documented and operational in the Applicant's care management program as of July 2011? **Total Points: 7,875**
Mark either 'Yes' or 'No' where indicated in the table below:

Is the Function operational as of July 2011?		**Care Management Function**
Yes	**No**	
		a) Completion of a health assessment that evaluates the beneficiary's physical, behavioral (i.e., mental health and substance abuse disorders), social and psychological needs; identifies access to care barriers; and seeks input from the provider and the beneficiary.
		b) Development of an individualized care treatment plan based on the assessment that includes the following (i. through vii.) :
		i. Prioritized goals and actions with timeframes for completion;
		ii. A plan for transitions of care between institutional, community and residential settings;
		iii. A communication plan with the beneficiary and the primary care

Is the Function operational as of July 2011?		Care Management Function
		provider/specialists;
		iv. Referrals for the beneficiary to access recovery/social support services in the local community, and validation that the beneficiary received the needed services;
		v. A review of the initial and revised care treatment plans with the beneficiary, family/caregiver, and primary care provider/specialists, while actively seeking input from them;
		vi. Identification of gaps between care recommended and care received, and implementation of interventions to address the gaps in care; and
		vii. A feedback mechanism to the provider on beneficiary compliance with the care treatment plan.
		c) A single accountable point of contact (i.e., care manager) assigned to each beneficiary who will help the beneficiary obtain medically necessary care; assist with health related services; coordinate care for the beneficiary; disseminate information to the beneficiary; and

Is the Function operational as of July 2011?		Care Management Function
		implement/monitor the care treatment plan.
		d) Formation of a team of health professionals that will deliver care management interventions that are appropriate for the beneficiary's needs.
		e) Application of evidence based guidelines when developing and implementing care management interventions.

6. Applicants must be able to interact with beneficiaries with complex health care needs at a demanding level in order to adequately meet their needs. Complete the following questions based on the Applicant's experience with interacting with beneficiaries at a high level of intensity through their care management program. **Total Points: 3,375**

a. During the month of July 2011, did the Applicant deliver care management interventions (e.g., implementation of treatment plan goals, patient education, etc.) in person (i.e., face to face) with a beneficiary at a residential setting, practice site, or inpatient/outpatient facility? **Total Points: 1,500**

Mark only one of the following responses:

____ Yes ____ No

b. The following is a two part question that will be utilized by ODJFS to derive a staffing ratio for the Applicant's complex/high risk care management program. Refer to

the description of complex/high risk care management located in the *Overview* section of Part A of this Appendix. Note: If the Applicant does not have experience with administering a complex/high risk care management program, proceed to Question 7.

Total Points: 1,875

Indicate the number of full time equivalents (i.e., care manager and/or any member of the care management team) in CY 2011 who were working directly with beneficiaries enrolled in the Applicant's complex/high risk care management program. Include contracted staff, if applicable. Note: 2080 paid hours per year equals one full time equivalent (FTE).

Number of FTEs in CY 2011: _____

Indicate the average number of beneficiaries enrolled in the Applicant's complex/high risk care management program in CY 2011.

Average number of beneficiaries in CY 2011:_____

Example calculation of average number of beneficiaries in CY 2011:

Month	Number of beneficiaries in high risk care management
January	1000
February	2000
March	2000
April	2000
May	2000
June	1000
July	1000
August	1000

September	2000
October	2000
November	1000
December	1000
Annual total	18,000

Average number of beneficiaries enrolled in high risk care management during CY 2011:

18,000 beneficiaries/12 months = 1,500

Example of ratio calculation:

50 FTEs/1,500 beneficiaries = .033

7. Does the Applicant currently have an electronic care management tracking system that collects the results of the assessment and the care treatment plan, including goals, actions and completion dates and is linked to other databases or systems that the Applicant uses to maintain beneficiary information? **Total Points: 2,250**

Mark only one of the following responses:

____ Yes ____ No

Part B: Patient Centered Medical Homes (Total Points: 7,500)

Overview

The Patient Centered Medical Home (PCMH) is a widely accepted approach to providing comprehensive primary care for children and adults. This approach requires primary care practices to transform how care is organized and delivered to their patients. Several definitions for the PCMH exist; however, there are similar themes from the various definitions that center on the following components:

- Holistic, comprehensive care: The primary care medical home is responsible for providing all of the patient's care and arranging care as appropriate with other professionals across the continuum of care;
- Enhanced access to care: The primary care medical home provides expanded access to care through open scheduling, after hours care or optional communication methods (e.g., email) with other providers;
- Coordinated care: The primary care medical home coordinates and integrates care across the continuum of care and the patient's community; and
- Quality, safety and accountability underpin the primary care medical home and are embedded in all business processes.

ODJFS believes that the PCMH model holds promise for improving quality of care and effectiveness of care, thereby reducing the cost of care and improving outcomes for Ohio Medicaid beneficiaries. Therefore, ODJFS is seeking qualified Applicants that will participate in the State's efforts to transform primary care practices into patient centered medical homes. ODJFS is also interested in Applicants that have experience with supporting care management and care coordination activities that are performed at the practice level.

Instructions for completing Part B:

The Applicant may report its experience or that of a corporate family member. Respond to each question with a checkmark, and mark only one response. For information about the scoring methodology, the Applicant should refer to Appendix D Scoring Methodology.

Questions:

1. During January 2011 through June 2011, did the Applicant arrange a network of health care providers that worked collaboratively on a team of health care professionals to coordinate care and provide care management for beneficiaries?
Total Points: 1,875

Mark only one of the following responses:

____ Yes ____ No

2. During January 2011 through June 2011, did the Applicant identify beneficiaries in need of intensive care management services through the use of predictive modeling software or a health risk assessment?
Total Points: 1,125

Mark only one of the following responses:

____ Yes ____ No

3. During January 2011 through June 2011, did the Applicant reimburse health care providers on a per beneficiary per month fee basis to perform care coordination/management services?
Total Points: 750

Mark only one of the following responses:

____ Yes ____ No

4. During January 2011 through June 2011, did the Applicant have any shared risk/savings arrangements with health care providers who were tasked expressly in the arrangement of performing care coordination/management services?

Total Points: 750

Mark only one of the following responses:

____ Yes ____ No

5. During January 2011 through June 2011, did the Applicant provide technical assistance to practice sites to assist them in transforming to patient centered medical homes?

Total Points: 375

Mark only one of the following responses:

____ Yes ____ No

If yes, then provide the following contact information for one example:

NOTE: If contact information is not provided then the Applicant will not receive any points for this question.

Practice Name: _____

Contact Name: _____

Practice Address: _____

Phone Number: _____

6. During January 2011 through June 2011, did the Applicant provide any of the following care management supports to providers such as patient utilization summaries, inpatient discharge coordination, medical advice nurse lines, access to transportation, educational programs/materials, and access to care treatment plans?

Total Points: 1,125

Mark only one of the following responses:

____ Yes ____ No

If yes, then provide the following contact information for one example:

NOTE: If contact information is not provided then the Applicant will not receive any points for this question.

Practice Name: _____

Contact Name: _____

Practice Address: _____

Phone Number: _____

7. During January 2011 through June 2011, did the Applicant provide technical assistance to practices to implement electronic health records?

Total Points: 375

Mark only one of the following responses:

____ Yes ____ No

If yes, then provide the following contact information for one example:

NOTE: If contact information is not provided then the Applicant will not receive any points for this question.

Practice Name: _____

Contact Name: _____

Practice Address: _____

Phone Number: _____

8. During January 2011 through June 2011, did the Applicant interact with a nurse care manager who was embedded at a practice site and performed care coordination activities such as transition planning, patient coaching, completion of health assessments, etc.?

Total Points: 1,125

Mark only one of the following responses:

____ Yes ____ No

If yes, then provide the following contact information for one example:

NOTE: If contact information is not provided then the Applicant will not receive any points for this question.

Practice Name: _____

Contact Name: _____

Practice Address: _____

Phone Number: _____