

APPENDIX D

PERFORMANCE IMPROVEMENT AND CARE MANAGEMENT

Today's dynamic and competitive health care environment has generated unprecedented demand for tools and information to document the accountability of and differences among health plans and health care delivery systems. Performance monitoring tools have proven to be an effective mechanism to ensure the quality and timeliness of, and access to, services provided by health care plans to Medicaid ABD consumers. This Appendix assesses the Applicant's capabilities in three (3) key areas: 1) Care Management, 2) Clinical Performance Measures, and 3) Emergency Department Diversion.

NOTE: ODJFS reserves the right to contact Applicants subsequent to application submission for clarification.

D-1 Care Management

MCPs must offer and provide care management services which coordinate and monitor the care of members with specific diagnosis (e.g., complex health care conditions) or who require high-cost or extensive services. The MCP's care management program must include, but is not limited to, the following functions:

- identification of members who potentially meet the criteria for care management;
- completion of a health assessment of the member's medical condition(s), including physical, behavioral, social and psychological needs, to determine the need for care management;
- assignment of the member to a risk level based on the results of the identification and/or assessment processes;
- development and implementation of, and revisions to, a care treatment plan for members in care management based on the health assessment which includes member and PCP/specialist participation in all phases of the care treatment plan;
- designation of an accountable point of contact (i.e., care manager) for each member in care management who can help the member obtain medically necessary care, assist with health-related services and coordinate health care needs;
- notification to the member and the PCP/specialist of the member's enrollment in the MCP's care management program;
- coordination of care and communication between the member, PCP, other health care providers and care managers; and
- coordination with state sub-recipient agencies as appropriate [e.g., the Ohio Department of Mental Health (ODMH); the Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD); and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS)].

The Applicant should consider the following two points when completing Appendix D-1:

- 1) There are two options for an Applicant to fulfill the required care management functions in the provider agreement with the Ohio Department of Job and Family Services for the Ohio ABD Medicaid population:
 - Option 1: The Applicant may perform all required care management functions; OR
 - Option 2: The Applicant may delegate the care management functions to a delegated entity as defined in Section II.A. If the Applicant opts to contract with a delegated entity for the provision of care management services, the contract must be in place by April 2009. The delegated entity providing care management services to covered members must be held accountable by the Applicant for meeting applicable care management program requirements.
- 2) The given care management feature or function the Applicant claims having capabilities will be made available and fully operational by September, 2009, at the time of regional implementation.

Applicant Name: _____

1. Does the Applicant have experience as of February 2009, in performing care management functions for any population?

Applicant should only mark **one** of the following responses:

____ Yes, the applicant has experience as of February 2009, in performing care management functions for any population.

____ No, the applicant does not have experience as of February 2009 in performing care management functions for any population.

If the Applicant's response is NO to Question 1, please proceed to D-2, Clinical Performance Measures. Appendix D-1 will not be given consideration for further review.

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

2. The applicant should indicate below if care management functions will be performed by the Applicant for Ohio's ABD Medicaid population, or if the Applicant will contract with a delegated entity to perform care management functions.

Please select the **ONE** statement below that most accurately represents the intent of the Applicant to fulfill this requirement.

____ The applicant will perform care management functions for Ohio's ABD Medicaid population.

____ The applicant will contract with a delegated entity by April, 2009 to perform care management functions for Ohio's ABD Medicaid population.

NOTE: For Questions 3 through 6, the Applicant may respond based on the experience of the Applicant, the Applicant’s Corporate Family or of the Delegated Entity. The Applicant may only use the experience of a Delegated Entity if the Applicant affirmatively responded in Question 2 that care management functions will be performed by a Delegated Entity for the Ohio ABD Medicaid population.

3. The Applicant should identify experience with performing care management functions for a managed health care population for no more than ten (10) product lines. Include in the table below the name of the product line, state, total months of experience in care managing the population; and the highest number of members enrolled in the **Care Management** program during any month of Calendar Years (CYs) 2005, 2006, and 2007.

Entry Number	Name of Product Line	State	Total Months of Experience	Highest Number of Members Enrolled during any month of CYs 2005, 2006 and 2007	
				2005	2006
1				2005	
				2006	
				2007	
2				2005	
				2006	
				2007	
3				2005	
				2006	
				2007	
4				2005	
				2006	
				2007	
5				2005	
				2006	
				2007	
6				2005	
				2006	
				2007	
7				2005	
				2006	
				2007	
8				2005	
				2006	
				2007	
9				2005	
				2006	
				2007	
10				2005	
				2006	
				2007	

The Applicant is to identify **ONE** entry from **Question 3** that best represents the Applicant's capability to perform care management functions for the Ohio ABD Medicaid population. Please use this entry to respond to **Questions 4 and 5**.

Indicate the selected entry from Question 3: # _____.

4. The Applicant should indicate the method(s) used by the Applicant as of February 2009 to identify members who could be eligible for care management services in the table below by checking the appropriate box. The Applicant should also indicate how often the data were reviewed or analyzed.

Methods Used to Identify Members Potentially Eligible for Care Management Services			Indicate how often Data is Analyzed or Reviewed to Identify Those Potentially Eligible for Care Management Services. Select the closest time frame below. Check one box only.	
a) New Member Contact (e.g., home visits, telephone interviews, or mail surveys)	Yes	No	Timeliness	
				Within 60 days of membership effective date
				Within 61-90 days of membership effective date
				>90 days from the membership effective date
b) Diagnosis	Yes	No		Daily
				Weekly
				Monthly
				Quarterly
				Semi-Annually
c) Inpatient Hospital Admissions	Yes	No		Daily
				Weekly
				Monthly
				Quarterly
				Semi-Annually
d) Emergency Department Visits	Yes	No		Daily
				Weekly
				Monthly
				Quarterly
				Semi-Annually
e) Pharmacy Claims	Yes	No		Daily
				Weekly
				Monthly
				Quarterly
				Semi-Annually
F) Referrals and/or Utilization of Other Ancillary Systems (e.g., Community or Social Support)	Yes	No		Daily
				Weekly
				Monthly
				Quarterly
				Semi-Annually
g) Grouper Methodology [i.e., Support by current industry grouping standards (e.g., ETG, ERG, DRG, RVU)]	Yes	No		Daily
				Weekly
				Monthly
				Quarterly
				Semi-Annually

5. The Applicant should indicate if the care management program included the following function(s) as of February 2009 by checking the appropriate box.

Is the Function included in the Applicant's Care Management Program?		Care Management Functions
YES	NO	
		a) A process to identify members who are potentially eligible for care management services based on administrative data reviews, provider/self referrals, telephone interviews, or home visits.
		b) A process for completion of a health assessment to identify the member's medical condition(s), including physical, behavioral, social and psychological needs, and to evaluate if the member has multiple health care conditions (i.e., co-morbid conditions).
		c) A process to assign the member to a risk stratification level, and provide the appropriate level of care management based on the health assessment.
		d) A system to monitor the delivery of specific services, including a review of service utilization, to re-evaluate the member's risk level and adjust the level of care management services accordingly.
		e) The development of a formal care treatment plan that is based on the health assessment; involves the member and his/her PCP/specialist; and includes provisions for periodic reviews and revisions.
		f) A process for verbal/written contact with the member and a provision for two-way feedback with the managed care plan.
		g) A process to identify gaps between care recommended and actual care provided, and propose and implement interventions to address the gaps in care.
		h) A provision for professional care management services to be performed collaboratively by a team of professionals appropriate to the member's health care need(s).
		i) An accountable point of contact (i.e., care

Is the Function included in the Applicant's Care Management Program?		Care Management Functions
YES	NO	
		manager) assigned to each member receiving care management to: help obtain medically necessary care, assist with health-related services, and coordinate health care needs.
		j) A mechanism to provide appropriate information to the member/family concerning the health condition; types of services that may be available; and how to access the services.
		k) A process to facilitate, maintain, and coordinate care and communication between the member, the PCP, other service providers and care managers.
		l) A mechanism to adhere to, and/or promote, evidence based clinical guidelines when developing a care treatment plan and coordinating the care management needs.

6. MCPs must offer and provide care management services which coordinate and monitor the care of members who require high-cost and/or extensive services. Members with special health care needs may have multiple chronic conditions or co-morbid conditions. The following health conditions are prevalent to the Ohio ABD Medicaid population, and members with such conditions could benefit from care management services:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes
- Non-mild hypertension
- Behavioral health (including severe mental illness, severe cognitive and/or developmental limitations, and high risk or high cost substance abuse disorders.)

For Question 6, the Applicant should indicate its experience and capability in providing care management services for conditions prevalent to the Ohio ABD Medicaid population, as well as managing high-risk, high-cost or other multiple chronic conditions. The Applicant should select one product line that best demonstrates the capacity and capability to manage the selected health care condition(s). In addition, the Applicant should indicate if the Care Management Program for which experience is being claimed addresses all of the care management functions identified in Question 5. Please check one box in each column per health care condition. **NOTE:** The Applicant may select a product line that was not used to respond to Questions 4 and 5.

Health Care Condition	Product Line Name and Location (State)	Line of Business	Population	Total Months of Experience (From CYs 2005-2007)	Indicate the highest number of members enrolled in the Care Management Program for the specific health condition during any month from CYs 2005 through 2007.	Indicate if the program for which experience is being claimed includes all of the care management functions specified in Question 5 a-l.
a) Asthma		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial	<input type="checkbox"/> ABD <input type="checkbox"/> Non-ABD <input type="checkbox"/> Other	<input type="checkbox"/> 0-12 months <input type="checkbox"/> 13 – 24 months <input type="checkbox"/> 25 – 35 months <input type="checkbox"/> ≥ 36 months		<input type="checkbox"/> Yes <input type="checkbox"/> No
b) COPD		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial	<input type="checkbox"/> ABD <input type="checkbox"/> Non-ABD <input type="checkbox"/> Other	<input type="checkbox"/> 0-12 months <input type="checkbox"/> 13 – 24 months <input type="checkbox"/> 25 – 35 months <input type="checkbox"/> ≥ 36 months		<input type="checkbox"/> Yes <input type="checkbox"/> No
c) CHF		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial	<input type="checkbox"/> ABD <input type="checkbox"/> Non-ABD <input type="checkbox"/> Other	<input type="checkbox"/> 0-12 months <input type="checkbox"/> 13 – 24 months <input type="checkbox"/> 25 – 35 months <input type="checkbox"/> ≥ 36 months		<input type="checkbox"/> Yes <input type="checkbox"/> No
d) CAD		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial	<input type="checkbox"/> ABD <input type="checkbox"/> Non-ABD <input type="checkbox"/> Other	<input type="checkbox"/> 0-12 months <input type="checkbox"/> 13 – 24 months <input type="checkbox"/> 25 – 35 months <input type="checkbox"/> ≥ 36 months		<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Diabetes		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial	<input type="checkbox"/> ABD <input type="checkbox"/> Non-ABD <input type="checkbox"/> Other	<input type="checkbox"/> 0-12 months <input type="checkbox"/> 13 – 24 months <input type="checkbox"/> 25 – 35 months <input type="checkbox"/> ≥ 36 months		<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Non-mild Hypertension		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial	<input type="checkbox"/> ABD <input type="checkbox"/> Non-ABD <input type="checkbox"/> Other	<input type="checkbox"/> 0-12 months <input type="checkbox"/> 13 – 24 months <input type="checkbox"/> 25 – 35 months <input type="checkbox"/> ≥ 36 months		<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Behavioral/Mental Health (i.e., severe mental illness,		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial	<input type="checkbox"/> ABD <input type="checkbox"/> Non-ABD <input type="checkbox"/> Other	<input type="checkbox"/> 0-12 months <input type="checkbox"/> 13 – 24 months <input type="checkbox"/> 25 – 35 months <input type="checkbox"/> ≥ 36 months		<input type="checkbox"/> Yes <input type="checkbox"/> No

substance abuse disorders, or cognitive and/or developmental limitations						
Applicant should indicate in the space below experience with providing care management services for any high-risk or high-cost health care condition, not identified in 6a through 6g, or experience with managing multiple chronic conditions.						
h) Indicate condition(s) here:		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial	<input type="checkbox"/> ABD <input type="checkbox"/> Non-ABD <input type="checkbox"/> Other	<input type="checkbox"/> 0-12 months <input type="checkbox"/> 13 – 24 months <input type="checkbox"/> 25 – 35 months <input type="checkbox"/> ≥ 36 months		<input type="checkbox"/> Yes <input type="checkbox"/> No

Care Management References

Please identify no more than two (2) reference contacts for above programs, including name, title, organization, phone number, e-mail address, and mailing address.

REFERENCE	
Health Plan Name [i.e. Name of the Applicant as it appears on the contract for which the program operates]	
Contact Information:	
Name:	
Title:	
Organization:	
Phone Number:	
Email Address:	
Mailing Address:	

REFERENCE	
Health Plan Name [i.e. Name of the Applicant as it appears on the contract for which the program operates]	
Contact Information	
Name:	
Title:	
Organization:	
Phone Number:	
Email Address:	
Mailing Address:	

D-2 CLINICAL PERFORMANCE MEASURES

ODJFS has mechanisms in place to assure that the quality and timeliness of and access to care received by Medicaid ABD consumers meets or exceeds set standards. These mechanisms include the monitoring of clinical performance measures, which are modeled and calculated based on Healthcare Effectiveness Data and Information Set (HEDIS) technical specifications.

NOTE: For Questions 1 through 2f, the Applicant must respond based on the experience of the Applicant and/or the Applicant's Corporate Family. Experience from a Delegated Entity is NOT permissible.

Applicant Name: _____

1. Does the Applicant have direct experience using HEDIS measures as a monitoring and quality improvement tool to evaluate clinical performance of the care its members received during and after Year 2005?

Year 2005	Yes _____	No _____
Year 2006	Yes _____	No _____
Year 2007	Yes _____	No _____

If the Applicant's answer is no to years 2005-2007, please stop and proceed to Appendix D-3 Emergency Department Diversion. Appendix D-2 will not be given further consideration.

2. If the Applicant's answer is yes, proceed with the following directions.
Six (6) clinical performance measures have been identified in the following tables:

- Persistence of Beta-Blocker Treatment after a Heart Attack (AMI -related admission)
- Diabetes: Comprehensive Diabetes Care (CDC)/Eye exam
- Inpatient Utilization: General Hospital/Acute Care
- Asthma: Use of Appropriate Medications for People with Asthma
- Behavioral Health: Follow-up After Hospitalization for Mental Illness
- For the sixth clinical performance measure, the Applicant may select a HEDIS measure and a state of its choice.

The Applicant is to indicate its experience with the six (6) HEDIS measures identified above in a state of its choice.

Complete the tables below regarding the Applicant's experience with Clinical Performance Measures.

Clinical Performance Measure: 2a. Persistence of Beta-Blocker Treatment after Heart Attack (AMI -related admission)					
Name of One State (Applicant's Choice)					
Member Population Included in the HEDIS Reporting (Please check ALL appropriate Boxes)		Medicaid ABD	Medicaid Non-ABD	Medicare	Commercial
Calendar Year	Applicant has experience using this HEDIS measure		If a HEDIS Audit was Performed Indicate the Report Designation		
	Yes	No *	Not Audited	Report	Not Report
2005					
2006					
2007					

* If the Applicant's response is no to years 2005-2007, proceed to the next clinical performance measure.

Clinical Performance Measure: 2b. Diabetes: Comprehensive Diabetes Care (CDC)/Eye exam					
Name of One State (Applicant's Choice)					
Member Population Included in the HEDIS Reporting (Please check ALL appropriate Boxes)		Medicaid ABD	Medicaid Non-ABD	Medicare	Commercial
Calendar Year	Applicant has experience using this HEDIS measure		If a HEDIS Audit was Performed Indicate the Report Designation		
	Yes	No *	Not Audited	Report	Not Report
2005					
2006					
2007					

* If the Applicant's response is no to years 2005-2007, proceed to the next clinical performance measure.

Complete the tables below regarding the Applicant's experience with Clinical Performance Measures.

Clinical Performance Measure: 2c. Inpatient Utilization: General Hospital/Acute Care					
Name of One State (Applicant's Choice)					
Member Population Included in the HEDIS Reporting (Please check ALL appropriate Boxes)		Medicaid ABD	Medicaid Non-ABD	Medicare	Commercial
Calendar Year	Applicant has experience using this HEDIS measure		If a HEDIS Audit was Performed Indicate the Report Designation		
	Yes	No *	Not Audited	Report	Not Report
2005					
2006					
2007					

* If the Applicant's response is no to years 2005-2007, proceed to the next clinical performance measure.

Clinical Performance Measure: 2d. Asthma: Use of Appropriate Medications for People with Asthma					
Name of One State (Applicant's Choice)					
Member Population Included in the HEDIS Reporting (Please check ALL appropriate Boxes)		Medicaid ABD	Medicaid Non-ABD	Medicare	Commercial
Calendar Year	Applicant has experience using this HEDIS measure		If a HEDIS Audit was Performed Indicate the Report Designation		
	Yes	No *	Not Audited	Report	Not Report
2005					
2006					
2007					

* If the Applicant's response is no to years 2005-2007, proceed to the next clinical performance measure.

Complete the tables below regarding the Applicant's experience with Clinical Performance Measures.

Clinical Performance Measure: 2e. Behavioral Health: Follow-up After Hospitalization for Mental Illness					
Name of One State (Applicant's Choice)					
Member Population Included in the HEDIS Reporting (Please check ALL appropriate Boxes)		Medicaid ABD	Medicaid Non-ABD	Medicare	Commercial
Calendar Year	Applicant has experience using this HEDIS measure		If a HEDIS Audit was Performed Indicate the Report Designation		
	Yes	No *	Not Audited	Report	Not Report
2005					
2006					
2007					

* If the Applicant's response is no to years 2005-2007, proceed to the next clinical performance measure.

2f. Clinical Performance Measure					
Fill in the Name of the Sixth (6) Measure					
Name of One State (Applicant's Choice)					
Member Population Included in the HEDIS Reporting (Please check ALL appropriate Boxes)		Medicaid ABD	Medicaid Non-ABD	Medicare	Commercial
Calendar Year	Applicant has experience using this HEDIS measure		If a HEDIS Audit was Performed Indicate the Report Designation		
	Yes	No *	Not Audited	Report	Not Report
2005					
2006					
2007					

* If the Applicant's response is no to years 2005-2007, proceed to Appendix D-3 Emergency Department Diversion.

Clinical Performance Measures

Please identify no more than two (2) reference contacts for above programs, including name, title, organization, phone number, e-mail address, and mailing address.

REFERENCE	
Health Plan Name [i.e. Name of the Applicant as it appears on the contract for which the program operates]	
STATE CONTACT	
Name:	
Title:	
Organization:	
Phone Number:	
Email Address:	
Mailing Address:	

REFERENCE	
Health Plan Name [i.e. Name of the Applicant as it appears on the contract for which the program operates]	
STATE CONTACT	
Name:	
Title:	
Organization:	
Phone Number:	
Email Address:	
Mailing Address:	

D-3 EMERGENCY DEPARTMENT DIVERSION

Managed care plans must provide access to services in a way that assures access to primary and urgent care in the most effective settings and minimizes inappropriate utilization of emergency department (ED) services. MCPs are required to identify high utilizers of targeted ED services and implement action plans designed to minimize inappropriate ED utilization. These targeted ED services are based on an identification or a trigger mechanism that examines thresholds of cost, utilization, member risk, behavior, and/or diagnosis that can be considered as non-emergent/preventable/avoidable. (Applicant should refer to the Applicant Library, Provider Agreements for reference to Emergency Department Diversion programs.)

NOTE: For Questions 1 through 5, the Applicant must respond based on the experience of the Applicant and/or the Applicant's Corporate Family. Experience from a Delegated Entity is NOT permissible.

Applicant Name: _____

Instructions - Please identify **ONE program** of the Applicant's choice to address the following questions.

1. Does the Applicant's information system have the capability to identify high utilizers of targeted ED services, i.e., two or more non-emergent/preventable/avoidable ED visits within 6 months?
(Reference for Targeted ED Services, please see Applicant Library)

Yes _____ No _____

- 2.a Does the Applicant have direct experience of ED Diversion Program for its members as of February 2009?

Yes _____ No _____

If your answer is no to question 2.a, please stop and proceed to Appendix E Information Technology. Appendix D-3 will not be given further consideration.

If the Applicant's answer is yes

- 2.b What is this program's covered population? Please check all that apply.

_____ Medicaid ABD _____ Medicaid NON-ABD
_____ Medicare _____ Commercial

- 2.c How long has this program been in place? _____ years

- 3 How many members per year were managed by this ED Diversion Program?

3.a Year 2005: _____

3.b Year 2006: _____

3.c Year 2007: _____

4. Does the Applicant use a management information system tool (e.g., decision support system) at least monthly to identify members that might benefit from this ED Diversion Program?

Yes _____ No _____

5. Does the Applicant have documented/verifiable outcomes that show decreased ED utilization attributable to this ED Diversion Program?

Yes _____ No _____

Emergency Department Diversion

For the above program, please identify a State reference contact, including name, title, organization, phone number, email address, and mailing address.

REFERENCE	
Health Plan Name [i.e. Name of the Applicant as it appears on the contract for which the program operates]	
STATE CONTACT	
Name:	
Title:	
Organization:	
Phone Number:	
Email Address:	
Mailing Address:	

**RFA Score Sheet – Appendix D
Performance Improvement and Care Management**

The following score sheet and related scoring methodology will be used by ODJFS to evaluate each applicant's submitted information for this Appendix. Applicants are NOT to fill out and return the "Score Sheet" for this or any section. The score sheets are presented within this RFA to establish the criteria, and their relative importance within the entire RFA scoring process, on which applications will be evaluated and through which the successful applicant selected. Applicants are strongly encouraged to use all score sheets to evaluate their own application packages for completeness, quality, and compliance with instructions and requirements prior to submitting them to ODJFS.

Total Points: 3000

Reviewers are to fill in the appropriate point(s) which correspond to the information provided by the Applicant on the Performance Improvement and Care Management forms. Points will be assigned for each question based on the following instructions:

D-1 Care Management

- **Total Points: 2500**

Question 1: Does the applicant have experience as of February 2009, in performing care management functions for any population?

Instructions for Reviewer: Reviewer should circle the response indicated on the applicant's form for Question 1, and transfer the applicable points to the "Points Awarded" column.

Response	Points Possible	Points Awarded
Yes	100	
No	0	
Total Points for Question 1 (100 points maximum is possible.)		

Reviewers should note the following:

-If the applicant responded *no* to Question 1, please proceed to D-2, Clinical Performance Measures.

RFA Score Sheet – Appendix D
Performance Improvement and Care Management

Question 2: The Applicant should indicate if care management functions will be performed by the Applicant for the Ohio ABD Medicaid population or if the Applicant will contract with a Delegated Entity.

Instructions for Reviewer: The reviewer should place a check in front of the statement indicated by the applicant on the form, and transfer the points assigned to that response to the “Points Awarded” column. There should only be one response selected for this Question.

Response	Points Possible	Points Awarded
<input type="checkbox"/> The applicant will perform care management functions for the Ohio ABD Medicaid population.	150	
<input type="checkbox"/> The applicant will contract with a delegated entity by April 2009 to perform care management functions for the Ohio ABD Medicaid population.	50	
Total Points for Question 2 (Total maximum points possible is 150.)		

RFA Score Sheet – Appendix D
Performance Improvement and Care Management

For Questions 3 through 6, the Applicant may claim experience of the Applicant, its Corporate Family, or the Delegated Entity.

Question 3: The Applicant should identify experience with performing care management functions for a managed health care population. The Applicant can complete up to ten (10) entries to demonstrate experience. The Applicant should identify the name of the product line, state, total months of experience in care managing the population; and the highest number of members enrolled in the Applicant’s **Care Management** program during any month of Calendar Years 2005-2007.

Instructions for Reviewer: For **Volume**, the reviewer should circle the response that reflects the highest number of members enrolled in the care management program for any month in the calendar year. For **Total Months Experience**, the reviewer should circle the response that reflects the total months of experience indicated by the Applicant on the form. The corresponding point value for the volume and months experience should be transferred to the Points Awarded column. A grand total should be calculated for Entry Numbers 1-10 at the end of this table.

Entry Number	Response	Points Possible (Total Points Possible per Entry is 30 points.)	Points Awarded
1	Volume of members:	Points:	
	≥ 1,000 members	15	
	500-999 members	10	
	250-499 members	5	
	0-249 members	1	
	Total Months Experience:	Points:	
	≥ 36 months	15	
	25-35 months	10	
	13-24 months	5	
	≤12 months	1	
Entry Number	Response	Points Possible (Total Points Possible per Entry is 30 points.)	Points Awarded

RFA Score Sheet – Appendix D
Performance Improvement and Care Management

2	Volume of members:	Points:	
	≥ 1,000 members	15	
	500-999 members	10	
	250-499 members	5	
	0-249 members	1	
	Total Months Experience:	Points:	
	≥ 36 months	15	
	25-35 months	10	
	13-24 months	5	
	≤12 months	1	
Entry Number	Response	Points Possible (Total Points Possible per Entry is 30 points.)	Points Awarded
3	Volume of members:	Points:	
	≥ 1,000 members	15	
	500-999 members	10	
	250-499 members	5	
	0-249 members	1	
	Total Months Experience:	Points:	
	≥ 36 months	15	
	25-35 months	10	
	13-24 months	5	
	≤12 months	1	
Entry Number	Response	Points Possible (Total Points Possible per Entry is 30 points.)	Points Awarded
4	Volume of members:	Points:	
	≥ 1,000 members	15	
	500-999 members	10	
	250-499 members	5	

RFA Score Sheet – Appendix D
Performance Improvement and Care Management

	0-249 members	1	
	Total Months Experience:	Points:	
	≥ 36 months	15	
	25-35 months	10	
	13-24 months	5	
	≤12 months	1	
Entry Number	Response	Points Possible (Total Points Possible per Entry is 30 points.)	Points Awarded
5	Volume of members:	Points:	
	≥ 1,000 members	15	
	500-999 members	10	
	250-499 members	5	
	0-249 members	1	
	Total Months Experience:	Points:	
	≥ 36 months	15	
	25-35 months	10	
	13-24 months	5	
	≤12 months	1	
Entry Number	Response	Points Possible (Total Points Possible per Entry is 30 points.)	Points Awarded
6	Volume of members:	Points:	
	≥ 1,000 members	15	
	500-999 members	10	
	250-499 members	5	
	0-249 members	1	
	Total Months Experience:	Points:	
	≥ 36 months	15	
	25-35 months	10	
	13-24 months	5	
	≤12 months	1	

**RFA Score Sheet – Appendix D
Performance Improvement and Care Management**

Entry Number	Response	Points Possible (Total Points Possible per Entry is 30 points.)	Points Awarded
7	Volume of members:	Points:	
	≥ 1,000 members	15	
	500-999 members	10	
	250-499 members	5	
	0-249 members	1	
	Total Months Experience:		
	≥ 36 months	15	
	25-35 months	10	
	13-24 months	5	
≤12 months	1		
Entry Number	Response	Points Possible (Total Points Possible per Entry is 30 points.)	Points Awarded
8	Volume of members:	Points:	
	≥ 1,000 members	15	
	500-999 members	10	
	250-499 members	5	
	0-249 members	1	
	Total Months Experience:	Points:	
	≥ 36 months	15	
	25-35 months	10	
	13-24 months	5	
≤12 months	1		
Entry Number	Response	Points Possible (Total Points Possible per Entry is 30 points.)	Points Awarded

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9	Volume of members:	Points:	
	≥ 1,000 members	15	
	500-999 members	10	
	250-499 members	5	
	0-249 members	1	
	Total Months Experience:	Points:	
	≥ 36 months	15	
	25-35 months	10	
	13-24 months	5	
	≤12 months	1	
Entry Number	Response	Points Possible (Total Points Possible per Entry is 30 points.)	Points Awarded
10	Volume of members:	Points:	
	≥ 1,000 members	15	
	500-999 members	10	
	250-499 members	5	
	0-249 members	1	
	Total Months Experience:	Points:	
	≥ 36 months	15	
	25-35 months	10	
	13-24 months	5	
	≤12 months	1	

Total Points Awarded for Entries 1-10: _____
 Total maximum points possible for Question 3 are 300.

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Question 4: The Applicant should indicate the method(s) used by the Applicant (or delegated entity) as of February 2009, to identify members who could be eligible for care management services in the table below by checking the appropriate box. The Applicant should also indicate how often the data were reviewed

Instructions for Reviewer: The reviewer should circle the response that reflects the applicant’s response to Question 4 on the form. The corresponding point values for the identification method(s) and frequency of data review should be transferred to the Points Awarded Column. A total score by row should be identified in the Total Points column.

Identification Methods		Points		Frequency of Data Review	Points		Total Points
		Possible	Awarded		Possible	Awarded	
a) New Member Contact	Yes	40		Within 60 days of membership effective date	20		Total maximum points are 60.
	No	0		Within 61-90 days of membership effective date	15		
				>90 days from membership effective date	10		
b) Diagnosis	Yes	40		Daily	20		Total maximum points are 60.
	No	0		Weekly	15		
				Monthly	10		
				Quarterly	5		
				Semi-Annually	1		
				Annually	0		
c) Inpatient Hospital	Yes	50		Daily	30		
				Weekly	25		

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Admission	No	0		Monthly	20		Total maximum points are 80.
				Quarterly	10		
				Semi-Annually	1		
				Annually	0		
d) ED Visits	Yes	50		Daily	30		Total maximum points are 80.
				Weekly	25		
				Monthly	20		
	No	0		Quarterly	10		
				Semi-Annually	1		
				Annually	0		
e) Pharmacy Claims	Yes	50		Daily	30		Total maximum points are 80.
				Weekly	25		
				Monthly	20		
	No	0		Quarterly	10		
				Semi-Annually	1		
				Annually	0		
f) Referrals and/or Utilization of Other Systems	Yes	50		Daily	30		Total maximum points are 80.
				Weekly	25		
				Monthly	20		
	No	0		Quarterly	10		
				Semi-Annually	1		
				Annually	0		
g) Grouper Methodology	Yes	40		Daily	20		Total maximum points are 60.
				Weekly	15		
				Monthly	10		
	No	0		Quarterly	5		
				Semi-Annually	1		
				Annually	0		

Enter Combined Total for entries 4A through 4G: _____
 Total maximum points for Question 4 are 500.

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Question 5. The Applicant should indicate if its care management program included the following components as of February 2009 by checking the appropriate box.

Instructions for Reviewer: The reviewer should check the box below if the applicant indicated on the form (with a response of yes) that the program addressed the specific care management program function. The reviewer should assign the appropriate score according to the number of total check marks indicated in Column 2. The directions for assigning the total points are located in the table below.

Care Management Program Component (Column 1)	Indicate with a check mark if the applicant marked the “yes” column on the application form for the corresponding care management program component. (Column 2)
5a	
5b	
5c	
5d	
5e	
5f	
5g	
5h	
5i	
5j	
5k	
5l	

Scoring Directions for Question 5:

The reviewer should add the total number of check marks in Column 2. Place the total number of check marks on this line: _____.

Based on the total number of check marks, the applicant will be assigned a score. The reviewer should reference the table below. The reviewer should indicate the total points awarded on this line for Question 5: _____.

The maximum points possible for Question 5 are 800.

Total Number of Check Marks	Total Points Possible
12	800
9-11	640
7-8	480
6	400
3-5	200
1-2	80

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Question 6: For Question 6, the Applicant should indicate its experience and capability in providing care management services for the prevalent conditions, as well as managing high-risk, high-cost or multiple chronic conditions. The Applicant should select one product line that best demonstrates the capacity and capability to manage the selected health care condition(s). In addition, the Applicant should indicate if the Care Management Program for which experience is being claimed addresses all of the care management program components from Question 5. **NOTE:** The Applicant may select a product line that was not used to respond to Questions 4 and 5.

Instructions for Reviewer: The reviewer should circle the response that reflects the responses indicated on the application form for line of business, population, years of experience, and volume of members enrolled in the care management program for specific health care conditions. The reviewer should total the points awarded by row and place in the Total Points Awarded column.

Health Care Condition	Line of Business	Population	Months of Experience	Highest Volume of Members Enrolled in the Care Management Program for any month during CYs 2005-2008	Total Points Awarded	Bonus Points: The reviewer should check the box below if the Applicant indicated in Question 6 that the care management program included all of the CM functions included in Question 5A – 5L.
					Total maximum points possible per row is 80 points.	
a) Asthma	Medicaid =20 Medicare = 20 Commercial = 10 Max points is 20.	ABD = 20 Non-ABD = 15 Other = 10 Max points is 20.	≥ 36 months = 20 25-35 months = 15 13-24 months = 10 0-12 months = 5 Max points is 20.	≥1,000 = 20 500-999 = 15 250-499 = 10 0-249 = 5 Max points is 20.		
b) COPD	Medicaid =20 Medicare = 20 Commercial = 10 Max points is 20.	ABD = 20 Non-ABD =15 Other = 10 Max points is 20.	≥ 36 months = 20 25-35 months = 15 13-24 months = 10 0-12 months = 5 Max points is 20.	≥1,000 = 20 500-999 = 15 250-499 = 10 0-249 = 5 Max points is 20.		

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c) CHF	Medicaid =20 Medicare = 20 Commercial = 10 Max points is 20.	ABD = 20 Non-ABD = 15 Other = 10 Max points is 20.	≥ 36 months = 20 25-35 months = 15 13-24 months = 10 0-12 months = 5 Max points is 20.	≥1,000 = 20 500-999 = 15 250-499 = 10 0-249 = 5 Max points is 20.		
d) CAD	Medicaid =20 Medicare = 20 Commercial = 10 Max points is 20.	ABD = 20 Non-ABD = 15 Other = 10 Max points is 20.	≥ 36 months = 20 25-35 months = 15 13-24 months = 10 0-12 months = 5 Max points is 20.	≥1,000 = 20 500-999 = 15 250-499 = 10 0-249 = 5 Max points is 20.		
e) Diabetes	Medicaid =20 Medicare = 20 Commercial = 10 Max points is 20.	ABD = 20 Non-ABD = 15 Other = 10 Max points is 20.	≥ 36 months = 20 25-35 months = 15 13-24 months = 10 0-12 months = 5 Max points is 20.	≥1,000 = 20 500-999 = 15 250-499 = 10 0-249 = 5 Max points is 20.		
f) Non mild hypertension	Medicaid =20 Medicare = 20 Commercial = 10 Max points is 20.	ABD = 20 Non-ABD = 15 Other = 10 Max points is 20.	≥ 36 months = 20 25-35 months = 15 13-24 months = 10 0-12 months = 5 Max points is 20.	≥1,000 = 20 500-999 = 15 250-499 = 10 0-249 = 5 Max points is 20.		
g) Behavioral Health/Mental Health	Medicaid =20 Medicare = 20 Commercial = 10 Max points is 20.	ABD = 20 Non-ABD = 15 Other = 10 Max points is 20.	≥ 36 months = 20 25-35 months = 15 13-24 months = 10 0-12 months = 5 Max points is 20.	≥1,000 = 20 500-999 = 15 250-499 = 10 0-249 = 5 Max points is 20.		

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h) Multiple Condition (indicated by applicant)	Medicaid =20	ABD = 20	≥ 36 months = 20	≥1,000 = 20		
	Medicare = 20	Non-ABD = 15	25-35 months = 15	500-999 = 15		
	Commercial = 10	Other = 10	13-24 months = 10	250-499 = 10		
	Max points is 20.	Max points is 20.	0-12 months = 5	0-249 = 5		
			Max points is 20.	Max points is 20.		
Total Points Awarded for Entries a) to h). (640 points maximum)						
Bonus Points (10 extra points possible): The reviewer should add 10 points to the score if an applicant indicated on the form with a “YES” that at least three (3) of the health care condition management programs included all of the CM program components from Question 5.						
Grand Total for Question 6 (Total Points Possible is 650)						

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Scoring Summary for D-1:

Question #	Points Possible	Points Awarded
1	100	
2	150	
3	300	
4	500	
5	800	
6	650	
Total The total should not exceed 2500 points.	2500	

RFA Score Sheet – Appendix D
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D-2 Clinical Performance Measures

- Total: 250 points

Instructions for Reviewers

1. Look up the response(s) for each question indicated on the Applicant’s RFA
2. Select the appropriate points on this scoring sheet corresponding to the Applicant’s response for each question.
3. Enter the points into the space allotted for Points Awarded for each question

Question	Response	Points Possible				Points Awarded
1. Does the Applicant have direct experience using HEDIS measures as a monitoring and quality improvement tool to evaluate clinical performance of the care its members received during and after Year 2005 (Total: 50 points)	Year 2005	Yes: 10 No: 0				
	Year 2006	Yes: 20 No: 0				
	Year 2007	Yes: 20 No: 0				
2. Applicant’s HEDIS experience using the six specified clinical performance measures	<u>2a. Persistence of Beta-Blocker Treatment after Heart Attack (AMI-related admission)</u> (Total: 50 Points)	3 yrs	2 yrs	1 yr	0	
	1) At least ABD	50	40	30	0	
	2) No ABD & At least Non-ABD or Medicare	40	30	20	0	
	3) Commercial Only	30	20	10	0	

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Question	Response	Points Possible				Points Awarded
2. Applicant's HEDIS experience using the six specified clinical performance measures	<u>2b. Diabetes: Comprehensive Diabetes Care (CDC)/Eye Exam</u> (Total: 50 Points)	3 yrs	2 yrs	1 yr	0	
	1) At least ABD	50	40	30	0	
	2) No ABD & At least Non-ABD or Medicare	40	30	20	0	
	3) Commercial Only	30	20	10	0	
	<u>2c. Inpatient Utilization: General Hospital/Acute Care</u> (Total: 50 Points)	3 yrs	2 yrs	1 yr	0	
	1) At least ABD	50	40	30	0	
	2) No ABD & At least Non-ABD or Medicare	40	30	20	0	
	3) Commercial Only	30	20	10	0	
	<u>2d. Asthma: Use of Appropriate Medications for People with Asthma</u> (Total: 50 Points)	3 yrs	2 yrs	1 yr	0	
	1) At least ABD	50	40	30	0	
	2) No ABD & At least Non-ABD or Medicare	40	30	20	0	
	3) Commercial Only	30	20	10	0	

RFA Score Sheet – Appendix D
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Question	Response	Points Possible				Points Awarded
2. Applicant's HEDIS experience using the six specified clinical performance measures	<u>2e. Behavioral Health: Follow Up after Hospitalization for Mental Illness</u> (Total: 50 Points)	3 yrs	2 yrs	1 yr	0	
	1) At least ABD	50	40	30	0	
	2) No ABD & At least Non-ABD or Medicare	40	30	20	0	
	3) Commercial Only	30	20	10	0	
	<u>2f. Applicant Selected Measure</u> (Total: 50 Points)	3 yrs	2 yrs	1 yr	0	
	1) At least ABD	50	40	30	0	
	2) No ABD & At least Non-ABD or Medicare	40	30	20	0	
	3) Commercial Only	30	20	10	0	
Sub-Total for D-2	Select the highest 4 scores (4 out 6 measures, 2a-2f)	200				
Total		250				

RFA Score Sheet – Appendix D
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D-3 Emergency Department Diversion

- Total: 250 points

Instructions for Reviewers

1. Look up the response(s) for each question indicated on the Applicant’s RFA
2. Select the appropriate points on this scoring sheet corresponding to the Applicant’s response for each question
3. Enter the points into the space allotted for Points Awarded for each question

Question	Response	Points Possible	Points Awarded
1. Does the Applicant’s information system have the capability to identify high utilizers of <u>targeted ED services</u> , i.e., two or more non-emergent/preventable/avoidable ED visits within 6 months? (Total: 50 points)	Yes	50	
	No	0	
2.a Does the Applicant have direct experience of ED Diversion Program for its members as of February 2009? (Total: 20 points)	Yes	20	
	No	0	
2.b The program’s covered population (Total: 60 points)	1) At least ABD	60	
	2) No ABD & At least Non-ABD or Medicare	30	
	3) Commercial Only	10	
2c. How long has the program been in place (Total: 10 points)	1-24 months	5	
	More than 2 years	10	

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Question		Response	Points Possible	Points Awarded
3. How many members per year were managed by this ED Diversion Program (Total: 60 points)	3a. Year 2005 (Total: 20 points)	≥ 100 members	20	
		50- 99 members	10	
		0-49 members	0	
	3b. Year 2006 (Total: 20 points)	≥ 100 members	20	
		50- 99 members	10	
		0-49 members	0	
	3c. Year 2007 (Total: 20 points)	≥ 100 members	20	
		50- 99 members	10	
		0-49 members	0	
4. Does the Applicant use a management information system tool (e.g., decision support system) at least monthly to identify members that might benefit from this ED Diversion Program? (Total: 30 points)	Yes	30		
	No	0		
5. Does the Applicant have documented/verifiable outcomes that show decreased ED utilization attributable to this ED Diversion Program (Total: 20 points)	Yes	20		
	No	0		
Total			250	

RFA Score Sheet – Appendix D
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Scoring Summary Sheet

Section	Total Points Possible	Total Points Awarded
Care Management	2500	
Clinical Performance Measures	250	
Emergency Department Diversion	250	

_____ **FINAL SCORE TOTAL for D (Maximum of 3000 Points)**