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To: Prospective Applicants and Interested Parties
From: Cynthia Burnell, Chief, Bureau of Managed Health Care
Subject: Amendment # 1 to October 21, 2003 Request for Applications
Date: December 3, 2003

On October 21, 2003, the Ohio Department of Job and Family Services issued a Request for Applications (RFA) for the delivery of Enhanced Care Management Services to selected Medicaid consumers. This amendment is being used to revise the following provisions of the RFA as issued:

- In order to provide more time for the development of collaboratives, ODJFS has **extended the deadline for RFA applications to March 1, 2004. Please note that this does not alter the date by which non-binding letters of intent are due, which is December 10, 2003.** Subsequent deadlines dependent on this date have also been modified. **Please replace pages 7, 10, 19, 22, 23, and 26 of the RFA with those attached to this memo.**
- The list of conditions that qualify ABD consumers as an ECM eligible has been expanded to include coronary artery disease (CAD) and non-mild hypertension. **Please replace pages 8, 38 – 40, Appendix B pages B-3, B-4, and B-8, and Appendix C of the RFA with those attached to this memo.**
- As a result of further federal guidance, the payment or recovery of program incentives or penalties has been modified. **Please replace pages 35 - 36 of the RFA with those attached to this memo.**
- The baseline Growth Rate Reduction measure has been changed from the current calendar year 2004 to state fiscal year 2003. This allows for the calculation of the ECM member expected growth rate reduction before provider agreements are signed. **Please replace page 35 of the RFA with that attached to this memo.**
- A new report, *Co-morbidities of ECM Eligibles*, has been added to the Applicant Library. **Please replace page 21 of the RFA with that attached to this memo.**
- An ODJFS right to contact potential applicants who submit a letter of intent has been added. **Please replace page 20 of the RFA with that attached to this memo.**

- An error on page 34 of the RFA has been corrected. The sentence, “The Baseline Performance Period will start six months after enrollment begins” will be modified to read, “The Initial Performance Period will start six months after enrollment begins.” **Please replace page 34 of the RFA with that attached to this memo.**
- Web addresses have been updated to reflect a global change to ODFJS’ web site. **Please replace pages 4, 20, 21, and Appendix A page A-1 of the RFA with that attached to this memo.**

All other provisions of the RFA as issued remain unchanged at this time.

We apologize for any confusion these revisions may create.

Thank you again for your interest in the Ohio Medicaid Enhanced Care Management RFA.

basis. MCPs assume the risk for all medical benefits and must also provide a number of additional services, including the following: providing or arranging access to medically necessary health services for their members; providing member services such as 24-hour nurse advice lines, care management, and care coordination; maintaining a provider network, including adequate and timely reimbursement; assuring quality of care; providing to ODJFS all required reports and documentation of performance; and participating in annual medical record reviews. (More information on the current managed care program is available at <http://jfs.ohio.gov/ohp/bmhc/managed.stm> .)

Acute Care Strategy

Today's health care environment is generating unprecedented demand for health care delivery approaches that result in more cost effective management of the use of health care services while improving access, quality, and accountability. As a health plan with a public purpose, Ohio Medicaid has developed an "Acute Care Strategy" that seeks opportunities to bring the benefits of enhanced care coordination, improved access to primary and preventive care, and expanded member services and education to additional Medicaid consumers.

Medicaid's goals for the acute care delivery system are to assure ECM members' access to services and support ongoing improvement in the quality of care. Due to the State's fiscal constraints, other major objectives of the Acute Care Strategy are to: improve cost predictability and administrative simplicity; assure the appropriate use of services and minimize preventable or unnecessary use of emergency care and inpatient services; and establish accountability for both access to care and quality of care. As a result, one of Medicaid's main priorities is to enhance systems of care management and coordination for those consumers with chronic or critical conditions who are most likely to be frequent and/or high-cost users of services (i.e., the ABD population).

The "Enhanced Care Management Program" (ECM) has been developed as part of the overall strategy to improve the acute care delivery system. Other components include the continuation and expansion of the risk-based managed care program for the CFC population; the ongoing use of pharmacy management, including cost sharing, for FFS consumers; FFS provider profiling on

provisions contained in federal statute and regulation, the Ohio Administrative Code, and ODJFS ECM provider agreement. At the time of RFA release, Ohio Administrative Code rules are under development as is the provider agreement specific to ECM. However, many of the PAHP provisions are comparable to the rules and provider agreement governing the risk-based managed care program. Appendix A of this RFA contains more detailed information on the applicable PAHP regulations and the corresponding cites in the current managed care program rules and provider agreement, which can be found in the Applicant Library (see Section III.D.). While these provisions may be modified for the ECM program, they do provide an indication of program expectations for ECM providers.

In addition, the nature of this program is expected to require the submission and approval of a federal waiver or, at a minimum, a state plan amendment (SPA). These documents are also under development.

The timeline for the development of the above documents is as follows:

ECM OAC Rules Proposed: February 6, 2004

ECM Waiver and/or SPA Submitted: March 1, 2004

ECM Provider Agreement drafted: April 15, 2004

II.B. ECM Program Description and Objectives

The ECM program will provide care management and related services to certain Medicaid consumers with identified health conditions who either are or are at risk of becoming high cost users of care. Eligible applicants are those organizations or groups of organizations which demonstrate the capacity to offer the specified services to the ECM eligible population (see below) and meet all program requirements for accountability and quality. The ability to forge collaborative relationships is essential to the ECM concept, which seeks to build on existing capacity (whether in one or multiple organizations) to leverage better care, more cost-effective service delivery, and greater accountability.

The ECM program is designed to meet the following objectives:

Accountability: Expectations for performance, as measured by both process and outcomes, will be established and ECM providers held accountable for their achievement;

Return on Investment: Initial financial investments made in the ECM program through payments to ECM providers will realize a return quick enough to justify further expansion and demonstrate cost avoidance potential;

Slower rate of growth: Over time, ECM will slow the per member per month rate of growth in expenditures for the ABD population; and

Quality Improvement: ECM will demonstrate improvement in the quality of care for members of the program.

More specific ECM program and provider expectations can be found in Section II.D. of this RFA.

II.C. ECM Population and Service Areas

Covered Population

The ECM program will initially target all of the following populations and clinical conditions:

- adult ABD consumers with a diagnosis of: congestive heart failure (CHF); coronary arterial disease (CAD); non-mild hypertension; diabetes; chronic obstructive pulmonary disease (COPD); or asthma
- ABD consumers under the age of 21 with asthma.

ODJFS has targeted these populations and clinical conditions based on the potential for improvements in quality of care and cost savings over a relatively short period of time. It is possible that ODJFS may add additional populations and conditions to the ECM program in the future.

request. An ECM member who begins receiving treatment for transplants, cancer, ESRD, AIDS, or severe trauma, or who becomes Medicare-eligible, will only be disenrolled from the ECM program at the member's request. Continued inclusion of such ECM members in the program will be taken into consideration when calculating ECM provider performance. Also, in exceptional cases that pose unique care management challenges or require extremely specialized medical care (e.g., traumatic brain injury), the ECM provider will be permitted to request ODJFS consideration and approval of a member's disenrollment.

Service Areas

The ECM program is initially seeking applications for the following service areas:

Cuyahoga County (Cleveland)	Lucas County (Toledo)
Franklin County (Columbus)	Montgomery County (Dayton)
Hamilton County (Cincinnati)	Stark County (Canton)
	Summit County (Akron)

Zanesville Service Area (comprised of Muskingum, Coshocton, Guernsey, Morgan, Noble, and Perry Counties).

The implementation of program operation in any of the above service areas will depend on the ECM provider's demonstrated capacity and provider agreement readiness; the readiness of the community; and the administrative resources of ODJFS. Service areas will be phased-in according to the following tentative schedule:

September 2004:	Two initial service areas
January 2005:	Three additional service areas
April 2005:	Three additional service areas

Applications for additional service areas or for additional counties contiguous with those listed above will be considered based on available resources. It is the intent of ODJFS to expand the ECM program over the next five years but the initial emphasis will be on those counties or areas where the volume is sufficient to support the ECM provider as well as to demonstrate the return on investment and quality improvements that will justify further expansions. Also, the experience gained in identifying and serving the ECM eligible population will inform the

SECTION III – APPLICATION PROCESS

III.A. Calendar of Events

Following is the timeline associated with this RFA:

10/21/03	ODJFS Releases RFA; Question & Answer Period Opens
11/12/03	Deadline for Submitting Questions to ODJFS (3 p.m. EST)
11/14/03	Potential Applicants Notify ODJFS of Intent to Attend Applicant Conference (3 p.m. EST)
11/19/03	Mandatory Applicant Information Conference (10 a.m. - 12:00 noon EST)
12/3/03	ODJFS Provides Final Applicant Questions & Answers
12/10/03	Potential Applicants Notify ODJFS of Intent to Submit Application (3 p.m. EST)
3/1/04	Deadline for Application Submissions to ODJFS (3 p.m. EST)
3/2/04 – 4/1/04	Review of RFA Applications Including Follow-up Discussions
4/5/04	ODJFS Issues Notification Letter(s) (estimated)
TBD	Readiness Review Phase for Selected Applicants
TBD	Provider Agreement Signed
9/1/04	Initial Program Phase-In

III.B. Applicant Notifications and Inquiries

Potential applicants may submit all notifications and questions related to this RFA beginning with RFA release. The notifications and questions may be submitted in electronic format (via email) or via fax to the attention of :

Cynthia Burnell, Chief, Bureau of Managed Health Care

Fax: 614.728.4516 Email: bmhc@odjfs.state.oh.us

All questions (unattributed) and responses will be posted at <http://jfs.ohio.gov/ohp/bmhc/applibrary.stm>. Questions to be addressed at the Applicant Conference will be accepted until November 12, 2003 at 3 p.m. Applicants will also be able to submit questions for two days following the Applicant Conference, with all answers posted on or before December 3, 2003.

III.C. Letters of Intent and Applicant Conference

A mandatory Applicant Conference will be held November 19, 2003 from 10 a.m. to 12 p.m. at:

Rhodes State Office Tower
Lobby Hearing Room
30 East Broad St, First Floor
Columbus, OH 43215

Potential applicants must notify ODJFS of their intent to attend the Applicant Conference by 3:00 p.m., November 14, 2003. These notifications must be submitted as described in Section III.B. At least one member of the collaborative intending to submit an application must attend the Applicant Conference. Because ODJFS' independent actuary will be presenting information regarding premium development at the Applicant Conference, it is strongly recommended that the potential applicant also include in attendance a representative with a financial background.

Potential applicants with an interest in submitting an application must notify ODJFS by submitting a non-binding letter of intent no later than December 10, 2003 at 3:00 p.m. EST. These notifications must be submitted as described in Section III.B.

Attendance at the Applicant Conference and submission of a letter of intent to submit an application are required in order to submit an application. ODJFS reserves the right to communicate with potential applicants who submit a letter of intent regarding their interest.

III. D. Applicant Library

Additional information for this RFA can be found in the Applicant Library at the same web site as the RFA. The Applicant Library includes:

- Provider Utilization Summary Report which lists the individual providers ECM Eligibles visited in 2002 sorted by condition, county, and category of service;
- Ohio Medicaid Report for general background information on Ohio Medicaid;
- Managed Care Program Rules and Provider Agreement for referencing current program requirements; and
- Sample Readiness Review Tools (used in the current managed care program).
- Co-Morbidity of ECM Eligibles report

Updates to the Applicant Library and the reports listed may be made periodically. Potential applicants are advised to check <http://jfs.ohio.gov/ohp/bmhc/applibrary.stm> for announcements.

SECTION IV. APPLICATION SUBMISSION AND SELECTION

IV. A. Initial Application

The initial application from a potential ECM provider must include the information specified in this section and must reflect the capability to perform all the responsibilities identified in Section II.D. of this RFA. The ODJFS recognizes that the applicant or collaborative may not currently meet all of these requirements. Therefore, the applicant should clearly indicate in their response if it can currently meet each specific requirement or the length of time it anticipates necessary to meet that requirement as well as program specifications overall. **The ODJFS will not enter any provider agreement prior to the applicant demonstrating to ODJFS's satisfaction that it can and will meet all program requirements. ODJFS reserves the right to implement or not implement the ECM program in any service area as it determines appropriate and in the best interests of the program and Medicaid consumers.**

Process:

One signed original, four hard copies, and an electronic copy of the initial application must be received by ODJFS, Bureau of Managed Health Care no later than 3 p.m. EST on March 1, 2004, in order to receive further consideration. The electronic copy must be on a separate CD-ROM, in non-re-writeable CD format (PDF format is preferred, but at minimum, documents on the CDs must be readable to ODJFS using standard, commonly available software programs). Faxes will not be accepted. Applications must be addressed to:

If mailed: Cynthia Burnell, Chief, Bureau of Managed Health Care
Ohio Department of Job and Family Services
30 East Broad Street, 31st Floor
Columbus, Ohio 43215-3414

If hand-delivered or by courier: Cynthia Burnell, Chief, Bureau of Managed Health Care
Ohio Department of Job and Family Services
255 E. Main St., 2nd Floor
Columbus, Ohio 43215-5222

All submissions must be received by mail or hand delivery by the above date and time. No confirmations of mailed applications received will be sent.

Content:

The items which must be submitted in the initial application are as follows:

1. A transmittal letter with the following elements:

(a) a statement identifying the lead organization assuming responsibility as the ECM provider and a contact person, including that individual's title, address, telephone, fax, and e-mail information;

(b) a list and brief description of the participating organizations in the collaborative ;

(c) a statement of affirmative action that organizations participating in the collaborative do not discriminate in the employment practices with regard to race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status, or need for health services;

(d) a statement that the organization will accommodate site visits to its administrative offices and those of all ECM participating organizations and providers ;

(e) a statement specifying the county or service area the applicant is proposing to serve;

(f) a statement specifying the start date the applicant is proposing (to be no earlier than September 1, 2004); and

(g) signature by an authorized representative of the applicant organization.

2. Documentation of collaborative arrangements in the form of, at a minimum, letters of agreement which specify respective roles and responsibilities, including which ECM requirement each will perform and the mechanisms for coordination. The documentation must also provide a description of all financial arrangements (e.g.; physician "PCP" payments; incentive sharing; other obligations) among all ECM provider participants. The physician "PCP" payments must

IV.B. Selection and Readiness Review Phase

ODJFS will review submitted applications and will notify applicants who have qualified for the readiness review phase on or around April 5, 2004. A comprehensive readiness assessment of selected applicants will be conducted prior to program implementation to ensure the applicant is prepared to meet all program requirements. The first step of the readiness review will be a meeting between the applicant and ODJFS to determine a potential time line and identify all necessary submissions to document readiness for program implementation. It is anticipated that this phase will continue for three to six months. (Appendix G provides a summary of the likely submissions.)

Depending on the number of qualified applicants and the respective readiness of each, the ODJFS will determine the order in which potential ECM providers enter the readiness review process.

IV.C. Implementation

Prior to implementation and the initial membership with the ECM provider, ODJFS or its designee may conduct a site visit to confirm all necessary components are in place. The ODJFS retains the right to phase-in ECM service areas based on ECM provider as well as community readiness.

IV. D. General Information

1. The state of Ohio and ODJFS have no liability or responsibility for any costs incurred by applicants in preparing a response to this RFA. All such costs are the responsibility of the applicants.
2. The contents of the application will be incorporated in the provider agreement by reference.
3. Subject to the requirements of state and federal law, information provided in the applications will be held in confidence and not be revealed or discussed prior to acceptance for a provider agreement. All submissions become the property of ODJFS

SAMPLE CALCULATION

		Formula	Base ABD-Community Population	ECM-Eligible Population
Development of Baseline Growth Rate				
CCPM in Baseline Period:	A		\$822.02	
Actual CCPM in Performance Period:	B		<u>\$924.77</u>	
Baseline Growth Rate:	C	$= (B/A - 1) \times 100$	12.5%	
Development of Expected Growth Rate				
ECM Participation Rate:	D			65%
ECM Member Expected Growth Reduction:	E	See Above		17%
Expected Growth Rate for ECM Members:	F	$= (1 - E) \times C$		10.4%
Baseline Growth Rate for Non-Participating Eligibles:	G	$= C$		12.5%
Expected Growth Rate for ECM Eligibles:	H	$= (D \times F) + (1 - D) \times G$		11.1%
Maximum Allowed Growth Rate (95% of Baseline—See Above):	I	$= 95\% \times C$		11.9%
Target Growth Rate for ECM Eligibles:	J	= Minimum (H or I)		11.1%
Development of Growth Rate Variance				
CCPM in Baseline Period per ECM Eligible:	K			\$1,022.06
Target Growth Rate for ECM Eligibles:	L	$= J$		11.1%
Expected CCPM in Performance Period:	M	$= K \times (1 + L)$		\$1,135.51
Actual Eligible CCPM in Performance Period:	N			\$1,092.00
ECM Premium PMPM:	O			\$43.62
ECM Participation Rate:	P	$= D$		65%
ECM Premium per Eligible:	Q	$= O \times P$		\$28.35
Actual Total ECM Eligible Cost:	R	$= N + Q$		\$1,120.35
Growth Rate Variance per Eligible: (+ = savings)	S	$= M - R$		\$15.16

Report Period: The timing of the Baseline and Initial Performance Periods will vary, depending upon when the provider enters the program. The Initial Performance Period will start six months after enrollment begins and may vary in length to align all ECM providers with the same future performance period (i.e., calendar year). The schedule of dates outlined below assumes a program entry of July 1, 2004. The ECM provider will be evaluated against the performance measures six months following the end of the performance period. For example, if the

provider's Initial Performance Period is January 1, 2005 – December 31, 2005, performance will be evaluated July 1, 2006 to allow for a six-month claims lag Experience for the Base ABD Community and ECM eligible populations will include any individuals with three months of continuous eligibility during the 12-month period.

	Baseline Performance Period	Initial Performance Period	Initial Evaluation Date	Future Performance Periods
Period	July 1, 2002 – June 30, 2003	January 1, 2005 - December 31, 2005	July 1, 2006	January 1 – December 31
Purpose	Determine Baseline claims costs	Evaluation of ECM provider's growth rate reduction	Actual date of evaluation to allow for claims runout and data collection.	Ongoing evaluation.

Performance Incentives and Penalties: Starting at the initial evaluation date, the ECM provider will be assessed incentives or penalties based on the Growth Rate Variance. ODJFS will determine incentives paid to or penalties on the ECM provider according to the table outlined below, *ECM Provider Incentives/Penalties for Growth Rate Reduction*. The incentive/penalty percentage determined from the table will be applied to the ECM provider's average premium during the 12-month performance period. The resulting PMPM will then be multiplied by the ECM provider's total member months during the performance period. A sample calculation of an incentive payment is outlined below.

SAMPLE CALCULATION

		Formula	Sample Incentive/Penalty Calculation
Growth Rate Variance Per Eligible:	A		\$15.16
Incentive/Penalty Percentage:	B		+ 2.5%
Provider ECM Premium PMPM:	C		\$43.62
Incentive/Penalty PMPM:	D	= B x C	\$1.09
ECM Provider Member Months:	E		36,000
Total Incentive/Penalty Payment:	F	= D x E	\$39,240

ECM Provider Incentives/Penalties for Growth Rate Reduction

Growth Rate Variance per Eligible	Incentive (+) / Penalty (-) As a Percentage of ECM Premium
Greater than \$56.00	10.0%
\$42.01 <i>to</i> \$56.00	7.5%
\$28.01 <i>to</i> \$42.00	5.0%
\$14.01 <i>to</i> \$28.00	2.5%
\$14.00 <i>to</i> -\$14.00	No Adjustment
-\$14.01 <i>to</i> -\$28.00	-2.5%
-\$28.01 <i>to</i> -\$42.00	-5.0%
-\$42.01 <i>to</i> -\$56.00	-7.5%
Less than -\$56.00	-10.0%

The above incentives and penalties are based on expectations for the first year of the ECM program. ODJFS expects ECM providers during the first year to produce a 1:1 or better return on investment (ROI). Providers achieving this minimum level of ROI during the first year will not be penalized as detailed above. Over time, ODJFS expects the ECM program to produce an improved return on investment and may make adjustments to the incentive/penalty associated with the Growth Rate Variance to correspond with future performance expectations.

Baseline and performance level determinations will take place four months after the end of the evaluation period to allow for claims lag.

Clinical Performance Measures

<u>Condition/Measure</u>	<u>Performance Target & Standard</u>
CHF (Adults)	
Overall Discharge Rate	To be determined after baseline year
Overall ED visit rate	To be determined after baseline year
Received ACE Inhibitor /Angiotensin receptor Blocker	To be determined after baseline year
Readmission for cardiac-related symptoms within 30 days	To be determined after baseline year
Coronary Artery Disease (CAD)	
Overall Discharge Rate	To be determined after baseline year
Overall ED visit rate	To be determined after baseline year
Readmission for cardiac-related symptoms within 30 days	To be determined after baseline year
Beta-Blocker Treatment after Heart Attack (HEDIS)	To be determined after baseline year
Received LDL-Screening after Acute Cardiovascular Event (HEDIS)	To be determined after baseline year
Hypertension (excluding mild hypertension)	
Overall Discharge Rate	To be determined after baseline year
Overall ED visit rate	To be determined after baseline year
Diabetes (Adults)	
Overall Discharge Rate	To be determined after baseline year
Overall ED visit rate	To be determined after baseline year
Eye Exam (HEDIS)	To be determined after baseline year
COPD (Adults)	
Overall Discharge Rate	To be determined after baseline year
Overall ED visit rate	To be determined after baseline year
Asthma (Adults & Children)	
Overall Discharge Rate	To be determined after baseline year
Overall ED visit rate	To be determined after baseline year
Use of Appropriate Medications for People with Asthma (HEDIS)	To be determined after baseline year

Report Periods: The following chart is an example of the report periods for an ECM provider entering the program in October 2004.

	Baseline Performance Period	Date Baseline Performance Determined	Initial Performance Period	Date Performance Determined	Future Performance Periods
Period	January 1, 2005 - December 31, 2005	April 2006	January 1, 2006 - December 31, 2006	April 2007	Every Calendar Year
Purpose	Determine Baseline performance and set standards			Actual date of evaluation to allow for claims runout	

Penalty for Non-Compliance: Out of the nineteen measures listed above, the ECM provider may miss five (5) measures at no penalty. For each noncompliant measure beyond five, ODJFS will impose a monetary sanction of one-third of one percent of the ECM premium paid during the evaluation period.

VI. C. Quality of Care Studies

In addition to the above clinical measures, ODJFS will conduct, at a minimum, the quality of care studies listed below to evaluate the quality of care received by ECM members. These measures will provide additional information on the effectiveness of the ECM provider in assuring physician compliance with nationally accepted practice guidelines. ECM-participating physicians will be required to participate in these and other clinical studies if a medical record is needed for the evaluation.

<u>Condition/Measure</u>	<u>Source</u>
Coronary Artery Disease (CAD)	
LDL-C Level after Acute Cardiovascular Event (HEDIS)	Medical Record
Hypertension (excluding mild hypertension)	
Controlling High Blood Pressure (HEDIS)	Medical Record
Diabetes (Adults)	
Eye Exam (HEDIS)	Administrative Data
Foot Exam	Administrative Data

HbA1c (HEDIS)	Administrative Data & Medical Record
LDL-C screening (HEDIS)	Administrative Data & Medical Record
Triglyceride	Administrative Data & Medical Record
HDL Cholesterol	Administrative Data & Medical Record
COPD (Adults)	
Episode Rate (Medstat DSS)	Administrative Data
Spirometer	Medical Record
Asthma (Children & Adults)	
Episode Rate (Medstat DSS)	Administrative Data
Asthma Flare-up rate (Medstat DSS)	Administrative Data
Received Influenza Vaccination	Medical Record
Lung Assessments	Medical Record

Thank you for your interest in the ECM program.

APPENDIX A

Federal/State Regulations Summary

Based on ODJFS discussions with the federal Centers for Medicare and Medicaid Services (CMS), ECM providers will be considered “prepaid ambulatory health plans” (PAHPs) and will be subject to the applicable provisions contained in federal statute and regulation, the Ohio Administrative Code (OAC) rules, and the ODJFS ECM provider agreement as well as the specifications found in this RFA. At the time of RFA release, OAC rules for the ECM program are under development, as is the ODJFS-ECM provider agreement. These documents will provide detailed specifications for the ECM program. This appendix is intended to offer a resource and preliminary indication to potential ECM applicants of the anticipated scope of activities under the ECM program that result from known federal regulations and state requirements. Again, it does not represent the complete list of ECM program requirements. Federal regulations governing Medicaid managed care programs are located in the Code of Federal Regulations, 42 CFR 438. As the federal provisions governing PAHPs are comparable to those reflected in the OAC rules and provider agreement for the risk-based managed care program, a review of those documents may also inform potential ECM applicants of expectations for the ECM program, as well as ODJFS' overall approach to managed care. The rules for Ohio's Medicaid managed care programs and the current provider agreement can be accessed through:

<http://jfs.ohio.gov/ohp/bmhc/applibrary.stm>.

Appendix A is organized by key program areas. If a specific federal regulation is known to apply, it is noted; if a current managed care program rule or provider agreement section provides more specifications that may apply to the ECM program, it is cited.

Please be aware that the provisions in this Appendix are likely to be modified based on further state and federal review.

I. Care Coordination

A. Specified in RFA (Section II. D.)

1. Availability of Health Advice Line

OAC Rule: 5101:3-26-03.1(A)(6)

2. Timely Access

Federal: The ECM must assure that PCPs meet state standards for timely access to ECM services.

MCP Provider Agreement: Appendix H, 6.

Population Profile

Adult ECM Eligibles with Congestive Heart Failure

Adult ABD Population

COUNTY	POPULATION		TOTAL MEDICAL EXPENDITURES				INPATIENT DISCHARGES				ED VISITS		CARDIAC RELATED READMISSIONS WITHIN 30 DAYS		ACE INHIBITORS	
	Eligibles	Eligible Months	Net Payment	Net Pay Rx	Net Payment PMPM	Net Payment Rx PMPM	Discharges	Discharges Epis CHF	Discharges per 1000 Eligible Months	Discharges CHF per 1000 Eligible Months	Visits Patient	ED Visits per 1000 Eligible Months	Cardiac Related Readmissions	Readmission Rate	Eligibles that used an Ace Inhibitor	% of Eligibles using Ace Inhibitors
Cuyahoga	1,578	13,067	\$21,705,105	\$4,014,383	\$1,661.06	\$307.22	447	85	34.2	6.5	2,623	200.7	10	2.24%	764	48.42%
Franklin	745	6,419	\$11,343,596	\$2,795,092	\$1,767.19	\$435.44	186	44	29.0	6.9	1,204	187.6	13	6.99%	361	48.46%
Hamilton	620	4,952	\$8,632,212	\$1,650,493	\$1,743.18	\$333.30	149	34	30.1	6.9	1,099	221.9	6	4.03%	269	43.39%
Lucas	440	3,411	\$7,460,190	\$1,274,606	\$2,187.10	\$373.68	100	12	29.3	3.5	875	256.5	2	2.00%	199	45.23%
Montgomery	454	3,718	\$7,418,974	\$1,421,115	\$1,995.42	\$382.23	84	16	22.6	4.3	879	236.4	0	0.00%	223	49.12%
Stark	257	1,762	\$2,879,802	\$707,068	\$1,634.39	\$401.29	35	3	19.9	1.7	611	346.8	2	5.71%	101	39.30%
Summit	408	3,157	\$6,859,391	\$1,286,902	\$2,172.76	\$407.63	87	16	27.6	5.1	855	270.8	0	0.00%	171	41.91%
Zanesville Cluste	196	1,423	\$2,074,393	\$602,542	\$1,457.76	\$423.43	65	13	45.7	9.1	306	215.0	2	3.08%	78	39.80%
Total	4,696	37,909	\$68,373,663	\$13,752,200	\$1,803.63	\$362.77	1,153	223	30.4	5.9	8,452	223.0	35	3.04%	2,166	46.12%

Data Source: OHP DSS
Date: 11/14/03

Population Profile

Adult ECM Eligibles with Coronary Artery Disease (CAD)
CY 2002

COUNTY	POPULATION		TOTAL MEDICAL EXPENDITURES				INPATIENT DISCHARGES		ED VISITS		CARDIAC RELATED READMISSIONS WITHIN 30 DAYS	
	Eligibles	Eligible Months	Net Payment	Net Pay Rx	Net Payment PMPM	Net Payment Rx PMPM	Discharges	Discharges per 1000 Eligible Months	Visits Patient	ED Visits per 1000 Eligible Months	Cardiac Related Readmissions	Readmission Rate
Cuyahoga	1,029	9,414	\$7,420,388	\$1,050,199	\$788.23	\$111.56	200	21.2	1,518	161.2	5	2.50%
Franklin	424	3,864	\$3,089,777	\$596,787	\$799.63	\$154.45	60	15.5	483	125.0	0	0.00%
Hamilton	308	2,431	\$2,086,079	\$311,515	\$858.12	\$128.14	53	21.8	372	153.0	0	0.00%
Lucas	288	2,411	\$2,844,114	\$307,973	\$1,179.64	\$127.74	60	24.9	481	199.5	2	3.33%
Montgomery	282	2,524	\$2,647,343	\$393,579	\$1,048.87	\$155.93	52	20.6	499	197.7	0	0.00%
Stark	196	1,494	\$1,061,686	\$209,344	\$710.63	\$140.12	27	18.1	262	175.4	0	0.00%
Summit	204	1,824	\$1,848,052	\$268,434	\$1,013.19	\$147.17	29	15.9	322	176.5	1	3.45%
Zanesville Cluste	224	1,550	\$1,078,800	\$206,367	\$696.00	\$133.14	46	29.7	216	139.4	1	2.17%
Total	2,952	25,512	\$22,076,240	\$3,344,197	\$865.33	\$131.08	527	20.7	4,153	162.8	9	1.71%

*The 'Discharges Epis CAD' measure is not available at this time.

Data Source: OHP DSS
Date: 11/14/03

Population Profile

Adult ECM Eligibles with Hypertension*
CY 2002

COUNTY	POPULATION		TOTAL MEDICAL EXPENDITURES				INPATIENT DISCHARGES				ED VISITS	
	Eligibles	Eligible Months	Net Payment	Net Pay Rx	Net Payment PMPM	Net Payment Rx PMPM	Discharges	Discharges Epis Hypertension	Discharges per 1000 Eligible Months	Discharges Hypertension per 1000 Eligible Months	Visits Patient	ED Visits per 1000 Eligible Months
Cuyahoga	537	5,446	\$3,254,550	\$603,717	\$597.60	\$110.86	111	8	20.4	1.5	677	124.3
Franklin	258	2,629	\$1,503,228	\$367,583	\$571.79	\$139.82	30	2	11.4	0.8	240	91.3
Hamilton	111	1,088	\$527,353	\$135,658	\$484.70	\$124.69	12	0	11.0	0.0	124	114.0
Lucas	59	583	\$468,401	\$77,682	\$803.43	\$133.24	12	1	20.6	1.7	175	300.2
Montgomery	127	1,228	\$672,049	\$167,722	\$547.27	\$136.58	11	1	9.0	0.8	142	115.6
Stark	50	484	\$231,176	\$78,046	\$477.64	\$161.25	2	0	4.1	0.0	47	97.1
Summit	110	1,170	\$551,598	\$165,738	\$471.45	\$141.66	8	0	6.8	0.0	158	135.0
Zanesville Cluste	44	410	\$231,903	\$61,020	\$565.62	\$148.83	2	1	4.9	2.4	44	107.3
Total	1,296	13,038	\$7,440,258	\$1,657,165	\$570.66	\$127.10	188	13	14.4	1.0	1,607	123.3

*Cases with minimal hypertension have been excluded.

Data Source: OHP DSS
Date: 11/14/03

Population Profile

Adult ECM Eligibles with Diabetes
CY 2002

COUNTY	POPULATION		TOTAL MEDICAL EXPENDITURES				INPATIENT DISCHARGES				ED VISITS		OPHTHALMOLOGY EXAM		ROUTINE FOOT EXAM	
	Eligibles	Eligible Months	Net Payment	Net Pay Rx	Net Payment PMPM	Net Payment Rx PMPM	Discharges	Discharges Epis Diabetes	Discharges per 1000 Eligible Months	Discharges Diabetes per 1000 Eligible Months	Visits Patient	ED Visits per 1000 Eligible Months	Patients with an Ophthalmology Exam	% of Eligibles with an Ophthalmology Exam	Patients with routine foot exam	% of eligibles with a Foot Exam
Cuyahoga	3,597	35,188	\$34,123,496	\$10,520,942	\$969.75	\$298.99	595	62	16.9	1.8	4,527	128.7	833	23.16%	499	13.9%
Franklin	2,579	25,562	\$28,242,869	\$10,701,828	\$1,104.88	\$418.66	390	24	15.3	0.9	2,982	116.7	576	22.33%	313	12.1%
Hamilton	1,666	16,135	\$18,035,544	\$5,812,647	\$1,117.79	\$360.25	316	23	19.6	1.4	2,670	165.5	318	19.09%	167	10.0%
Lucas	1,217	11,870	\$12,722,828	\$4,295,999	\$1,071.85	\$361.92	211	22	17.8	1.9	2,113	178.0	361	29.66%	124	10.2%
Montgomery	1,163	11,428	\$12,683,426	\$4,452,526	\$1,109.86	\$389.62	159	14	13.9	1.2	1,826	159.8	325	27.94%	82	7.1%
Stark	728	6,903	\$7,261,337	\$2,667,392	\$1,051.91	\$386.41	107	10	15.5	1.4	1,439	208.5	238	32.69%	81	11.1%
Summit	953	9,253	\$10,665,807	\$3,812,080	\$1,152.69	\$411.98	131	8	14.2	0.9	1,502	162.3	154	16.16%	107	11.2%
Zanesville Cluste	727	6,825	\$6,306,616	\$2,810,546	\$924.05	\$411.80	111	18	16.3	2.6	907	132.9	199	27.37%	109	15.0%
Total	12,606	123,164	\$130,041,924	\$45,073,959	\$1,055.84	\$365.97	2020	181	16.4	1.5	17,966	145.9	3,004	23.83%	1,482	11.8%

Data Source: OHP DSS
Date: 11/14/03

Population Profile

Adult and Child ECM Eligibles Summary

CY 2002

COUNTY	POPULATION		TOTAL MEDICAL EXPENDITURES				INPATIENT DISCHARGES				ED VISITS	
	Eligibles	Eligible Months	Net Payment	Net Pay Rx	Net Payment PMPM	Net Payment Rx PMPM	Discharges	Discharges Epis	Discharges per 1000 Eligible Months	Discharges per epis 1000 Eligible Months	Visits Patient	ED Visits per 1000 Eligible Months
Cuyahoga	10,140	97,132	\$91,989,015	\$22,528,678	\$947.05	\$231.94	1,904	223	19.6	2.3	15,050	154.9
Franklin	6,890	67,359	\$67,103,659	\$23,275,342	\$996.21	\$345.54	1,010	107	15.0	1.6	9,070	134.7
Hamilton	4,444	41,467	\$41,864,764	\$11,347,251	\$1,009.59	\$273.65	755	72	18.2	1.7	7,213	173.9
Lucas	3,565	33,907	\$35,400,860	\$9,079,439	\$1,044.06	\$267.77	600	56	17.7	1.7	6,836	201.6
Montgomery	3,194	30,553	\$32,438,561	\$9,228,943	\$1,061.71	\$302.06	428	35	14.0	1.1	5,503	180.1
Stark	1,925	17,358	\$16,479,673	\$5,354,337	\$949.40	\$308.47	226	24	13.0	1.4	3,992	230.0
Summit	2,726	26,000	\$28,334,037	\$8,412,477	\$1,089.77	\$323.56	357	30	13.7	1.2	4,921	189.3
Zanesville Cluste	2,028	18,191	\$15,796,117	\$5,921,548	\$868.35	\$325.52	342	41	18.8	2.3	2,803	154.1
Total	34,870	331,967	\$329,406,687	\$95,148,016	\$992.29	\$286.62	5,622	588	16.9	1.8	55,388	166.8

Data Source: OHP DSS

Date: 11/14/03

APPENDIX C

ECM Eligible Identification Process

The methodology for defining the baseline ECM eligible population involves multiple criteria for inclusion or exclusion of Medicaid consumers. A brief description of these criteria is included below.

Medicaid Eligibility/Delivery System Criteria

- Inclusions:
 - Aged, Blind or Disabled (ABD) Medicaid consumers for CY 2002 residing in the selected counties,
 - Age Groups Adults (Age 21 and over), Children (Age 0 thru 20) for Asthma.
- Exclusions:
 - Dually eligible (eligible for Medicaid and Medicare) consumers; consumers in nursing homes or ICF/MR homes or in Medicaid Waiver programs (PASSPORT, Ohio HomeCare, PACE, or MR/DD Waivers).

Clinical Criteria

- Inclusion Hierarchy⁽¹⁾: Medicaid consumers with episodes of care for any of the following conditions in CY 2001 or CY 2002.
 - Congestive Heart Failure (CHF)
 - Coronary Artery Disease (CAD)
 - Diabetes
 - Chronic Obstructive Pulmonary Disease (COPD)
 - Hypertension
 - Asthma
- ⁽¹⁾ Eligibles were included in clinical groups in the order listed above, i.e., a patient with CHF and diabetes was listed in the CHF clinical group, etc.
- Exclusion: patients who had an episode of care for any of the following conditions or received the following services
 - Inpatient admission for solid organ transplantation,
 - Episode of Acquired Immune Deficiency Syndrome
 - Episode of any type of cancer
 - Episode of end stage renal disease
 - Episode of severe trauma
 - Received services for hospice care.