# REQUEST FOR APPLICATIONS

*Medicaid Enhanced Care Management Program*

**ISSUED BY:**

**Ohio Department of Job and Family Services**

**Office of Ohio Health Plans**

**Bureau of Managed Health Care**

**Date Issued: October 21, 2003**

**BOB TAFT**
**GOVERNOR**

**TOM HAYES**
**DIRECTOR**

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# SECTION I - INTRODUCTION: GENERAL PURPOSE AND APPLICANT INFORMATION

## I.A. Purpose

The Ohio Department of Job and Family Services (ODJFS), Office of Ohio Health Plans (OHP), is releasing this Request for Applications (RFA) for the purpose of identifying qualified organizations or collaboratives of organizations (applicant) to offer enhanced care management (ECM) and related services to a selected portion of the Medicaid population. Qualified applicants will enter into provider agreements with ODJFS to provide specified services to persons with chronic health conditions who either are or are at risk of becoming frequent and/or high-cost users of care. The ODJFS is seeking applicants with experience in providing a comprehensive care management program, including: care coordination and case management; a nurse/ health advice line; provider relations, education, and support; consumer information, education, and support; and accountability for access to and quality of care, as well as quantifiable return on investment. Through the provision of the above services, the selected applicants are expected to promote the appropriate use of cost-effective medical care, pursue rapid quality improvement, and minimize preventable or unnecessary use of emergency care and inpatient services. A key outcome anticipated for the ECM program will be the reduction of the per member rate of growth in cost of care for Ohio's Medicaid fee-for-service (FFS) Aged, Blind, or Disabled (ABD) population.

This RFA describes program parameters and objectives, as well as the specific minimum requirements and standards that the selected applicants must meet and maintain. The ODJFS believes the parameters and objectives are broad enough to allow potential applicants to submit proposals based on their own unique skills and capabilities, as well as their knowledge and familiarity with the local health care marketplace. At the same time, the RFA establishes a core set of services that must be provided under the contract, in accordance with applicable federal and state requirements, but may be adaptable to any particular community or marketplace. The ODJFS encourages the development of collaboratives to meet all program requirements and achieve program goals.

## I.B. Issuing Office

This RFA is released by, and the subsequent provider agreement(s) will be with, ODJFS. The Office of Ohio Health Plans (OHP) is responsible for state level administration and supervision of the Medicaid program. The mission of OHP is to support the quality of life of Ohioans through coverage of high quality, cost-effective, accessible health care and related services.

The responsibility for the administration and oversight of the ECM program and provider agreements will rest with the Bureau of Managed Health Care (BMHC) within OHP. The mission of BMHC is to assure access to, and improve delivery of high quality, cost effective health care services through the development, administration, and assessment of Ohio's Medicaid managed care programs.

## I.C. Background

**Ohio Medicaid:**

The Ohio Department of Job and Family Services (ODJFS) is the single state agency responsible for the implementation and administration of the Ohio Medical Assistance (Medicaid) Program authorized under Title XIX of the Social Security Act. Medicaid is a federal and state funded assistance program that provides health care coverage to certain low-income and medically vulnerable individuals of all ages. The ODJFS is also responsible for administering Title XXI of the Social Security Act, the State Children's Health Insurance Program (SCHIP), implemented in Ohio as a Medicaid expansion. Within ODJFS, the Office of Ohio Health Plans (OHP) oversees Medicaid, SCHIP, and other publicly funded health coverage programs.

Ohio Medicaid eligibility can be categorized into two general groups: Covered Families and Children (CFC; sometimes referred to as "Healthy Start / Healthy Families) and coverage for individuals who are Aged, Blind or Disabled (ABD). In State Fiscal Year (SFY) 2002, the CFC population represented approximately 73% percent of the Medicaid members and about 25% percent of total Medicaid spending. The ABD population is comprised of individuals with

disabilities and/or who are 65 or older and represents 27% percent of all Medicaid members but about 75% percent of total Medicaid spending.

From 1994 – 2001, the per member per month cost of providing care for ABD Medicaid consumers has increased by 49%, almost twice the rate for the CFC population.

## Benefits and Delivery Systems

The Ohio Medicaid program offers two distinct benefit packages: (1) acute and primary care services and (2) long term care services. All those receiving long term care benefits are eligible for acute and primary care services; however, only those meeting specified level of care criteria are eligible for long term care.

### Fee For Service:

The FFS system is a traditional indemnity health care delivery system in which payment is made to a health care provider after a service is rendered and billed. The system includes approximately 36,000 providers, including 28,000 physicians, throughout Ohio. Providers must be licensed or certified to enter provider agreements to serve Medicaid consumers. Medicaid consumers in the FFS delivery system are generally free to seek care from any provider, but the providers are not required to accept anyone who presents a Medicaid card. The FFS system is operational in all of Ohio's counties.

There are several utilization review mechanisms in place in the FFS system, including prior authorization for services not routinely covered by Medicaid, for services over normal program limits, pre-admission review and retrospective reviews conducted by a contracted organization for certain hospital services, retrospective surveillance utilization review, and drug utilization review.

### Full-Risk Managed Care:

In selected Ohio counties, CFC members can or must receive their health care services through a full-risk managed care delivery system. Under the current program, ODJFS contracts with managed care plans (MCPs) licensed by the Ohio Department of Insurance that also meet all ODJFS requirements. The MCPs are paid prospectively on a per member per month capitated

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 www.state.oh.us/ODJFS/OHP/bmhc.)

**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

a targeted basis; and implementation of additional strategies to educate consumers regarding the use of their Medicaid benefits.

# SECTION II: ECM PROGRAM DESCRIPTION AND SCOPE OF SERVICE

## II.A. Definitions / Applicable Regulations

Throughout this RFA, the terms listed below will be defined as follows:

- **Case Management:** Activities performed on behalf of ECM members to coordinate and monitor treatment.
- **Consumer**: A qualified Ohio Medicaid enrollee.
- **ECM Provider**: An organization, either a single entity or the representative of a collaborative of organizations, which has applied and been found qualified to enter a provider agreement with ODJFS to provide and perform enhanced care management services.
- **ECM Eligible**: A consumer who qualifies to participate in the ECM program based on population status, condition, and county of residence.
- **ECM Member**: An ECM eligible who is enrolled in the ECM program.
- **PCP (primary care physician)**: An individual physician (M.D. or D.O., and including specialists appropriate to the member's condition) or group medical practice who agrees to serve as the Member's primary physician, contribute to the development and implementation of the care treatment plan, participate in quality of care initiatives and reviews, and sign a provider agreement PCP amendment.

**The ODJFS' intent and ability to enter provider agreements with qualified applicants for the ECM program are subject to the availability of funds and federal approval by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).**

Based on current discussions with CMS, the ECM program and ECM providers will be considered a "prepaid ambulatory health plan (PAHP)" and will be subject to the applicable

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: December 8, 2003

ECM Waiver and/or SPA Submitted: January 5, 2004

ECM Provider Agreement drafted: February 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), or 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.

All Medicaid ABD consumers in the above groups will be considered eligible for the ECM program, except for those:

- residing in nursing facilities (NFs) or intermediate care facilities for the mentally retarded (ICFs-MR);
- enrolled in a Medicaid home and community based waiver program; or
- receiving services related to transplants, AIDS, cancer, end stage renal disease (ESRD), severe trauma, and hospice.

*Consumers meeting the above criteria who are eligible for both Medicaid and Medicare ("dual eligibles") will not be included at initial ECM program implementation. However, ODJFS intends to include this group at a later date subject to federal approval and the confirmation of data availability for ongoing identification and analysis.* (See Appendix B for further information on the estimated number of ECM eligibles by service area and condition.)

Individuals eligible for the ECM program will be identified based on the most current FFS claims data available. Claims data will be reviewed quarterly to identify anyone newly eligible. (Appendix C provides detailed information on the methodology used to identify ECM eligibles. Appendix D provides information on costs associated with the ABD community population.)

Medicaid consumers identified as ECM eligible will be notified by ODJFS. Membership in the ECM program will be automatic unless the consumer calls the ODJFS designated toll-free number to indicate that he/she does not want to be an ECM member. This voluntary membership process is one approach used in the Ohio risk-based managed health care program and is known as "preferred option." ECM members will not be required to remain in the ECM program and will have the option to end their membership each month. As an incentive for ECM eligibles to stay in the program, any future co-pays ODJFS implements will be waived for ECM members.

An ECM member who, during the time of ECM membership, enters a waiver or hospice program or becomes a resident of a nursing facility or ICF/MR will be disenrolled from the ECM program. This is to prevent conflicting care management approaches or responsibilities. Those entering NFs for short-term rehabilitative stays will not be disenrolled except at the member's

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)
Franklin County (Columbus)
Hamilton County (Cincinnati)
Lucas County (Toledo)
Montgomery County (Dayton)
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:

June 2004: Two initial service areas

October 2004: Three additional service areas

January 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

inclusion of additional populations. Future implementation of the ECM program in addition to service areas identified above will be based on the following **tentative** timetable:

July 2005: Request for Applications (next round) issued; additional populations identified

July 2006: Implementation of the remaining one-third of the population (e.g., any counties in the central / southeastern portion of the state not already included in the program)

January 2007: Implementation of the second one-third remaining population (e.g., southwest region)

July 2008: Implementation of final one-third remaining population (e.g., northwest and northeast)

## II. D. ECM Scope of Services

The ECM provider must take a comprehensive and collaborative approach to managing the ECM eligible populations and targeted conditions through effective partnerships, provider and consumer participation, and the ability to address not only the specific diagnosis but also the complexities of multiple co-morbidities, including behavioral health, and related issues such as the lack of social or family support. The ECM provider is not permitted to limit membership to a subset of the ECM eligible population, i.e., the ECM provider must provide ECM services for all consumers in the identified population. **Specifically, and in addition to meeting the applicable provisions of federal and state program rules and regulations, applicants seeking to contract with ODJFS for ECM must, at a minimum, demonstrate the ability to provide or arrange for the following services:**

1. Outreach and Assessment

The ECM provider will be required to contact each ECM member within 30 days of membership either by telephone or a home visit to provide further information regarding the program and confirm existing sources of care. The goal is to engage the ECM member as soon as possible, identify the ECM member's current providers, and assure continuity of care.

The ECM provider must arrange for or conduct a comprehensive assessment of each ECM member within 60 days of membership to assess health status and initiate the development of a care treatment plan.

2. Case Management

Based on the assessment, the ECM provider must assure and coordinate the development of a care treatment plan to be completed and in place within 90 days of membership. The ECM member (or ECM member's guardian in the case of members under the age of eighteen) and ECM member's PCP must be actively involved in the development of the care treatment plan. The plan must arrange or provide for professional care management services that are performed collaboratively by a team of professionals (which may include physicians, physician assistants, nurses, specialists, pediatricians, pharmacists, and/or social workers) appropriate for the ECM member's condition. For example, if an ECM member comorbidities requiring a complex pharmaceutical treatment, the participation of a pharmacist in the development of the plan is strongly recommended. The care plan and team should reflect not only the ECM member's primary medical diagnosis and condition (i.e., the diagnosis that resulted in ECM eligibility), but also any co-morbidities as well as the ECM member's psychological and community support needs. The treatment plan must also include specific provisions for periodic (no less than annually) reviews of the ECM member's condition and appropriate updates to the plan. Where appropriate, the plan should include coordination with other local agencies or supportive services.

3. 24/7 Health Advice Line

The ECM provider must offer a twenty-four hour, seven days a week (24/7) toll-free health advice line staffed by health care professionals providing personalized information (e.g., the ECM member's care treatment plan, PCP, and relevant utilization data) and assistance for ECM members and/or their caregivers. This line must be operated in accordance with current managed care program rules for comparable advice lines, including provisions for interpreter services.

4. Utilization Management

The ECM provider must develop and implement strategies designed to minimize inappropriate utilization of the emergency department, inpatient services, and specialists. In addition, the Medicaid fee-for-service (FFS) system utilizes several utilization management strategies that may affect ECM members. These include precertification of certain hospital admissions and prior authorization for certain services or procedures not routinely covered directly by Medicaid. Providers serving ECM members will continue submitting prior authorization of services directly to ODJFS. The ECM provider, based on information received from ODJFS, will be expected to implement and monitor approaches through provider and member education to coordinate precertification and prior authorization requests submitted to ODJFS with the goal of improving service coordination, quality, and cost-effectiveness.

5. Primary Care Physician Access

The ECM provider, based on information from ODJFS and that obtained from the ECM member, must identify the physician (if any) that is managing the overall care of the individual at the time of ECM membership. The ECM provider must contact that physician, if not already a participant with the ECM provider, and offer the opportunity to participate as a PCP, including the signing of a contract with the ECM specifying the additional expectations (see Appendix E for the Draft ECM-PCP Model Contract). The ECM provider must encourage and assist those ECM members without such a physician to establish such a relationship and must provide to ODJFS a monthly report listing each ECM member and the physician acting as that member's "PCP." Specialists may and should be identified as the PCP as appropriate for the member's condition; however, no ECM member may have more than one PCP identified.

The ECM provider must establish and administer a mechanism for the reimbursement of each physician acting as a PCP for ECM members within ODJFS parameters. This compensation is in addition to that the physician receives from ODJFS for fee-for-service claims and is intended to reflect the value of the additional services and time required as a PCP. The ODJFS has established a minimum amount for PCP compensation but the ECM provider is expected to

increase that amount based on the scope of PCP activities and level of PCP involvement in the specific ECM project. The total compensation received by any individual physician as a PCP must reflect the number of ECM members served by that physician and the intensity of services required. The ECM provider is expected also to develop and implement performance incentives that may result in additional compensation for PCPs. In addition, the ECM provider must establish a means of distributing, within ODJFS parameters, any performance incentive payments received from ODJFS among its participating organizations and providers based on quality and outcomes achieved. "Section V. Financial Information" of this RFA includes the ODJFS parameters for the PCP reimbursement and incentive arrangements.

As noted above, the ECM provider must enter with each physician serving as a PCP to any ECM member a signed agreement using the ODJFS model contract (see Appendix E) that verifies the physician's agreement to serve as the PCP for ECM member(s). The physician must also agree to participate in the development, implementation, and re-assessment of care treatment plans, use evidence-based clinical practices, assist in assuring member compliance, and cooperate with quality and performance reviews. A complete list of basic PCP expectations is found in the model contract (Appendix E). The contract must also include, subject to ODJFS approval, the ECM's reimbursement rate to the PCP as well as specify the incentive sharing arrangements.

Should a potential PCP physician not currently hold an Ohio Medicaid FFS provider agreement, the ECM must coordinate the submission of the basic FFS provider agreement and the ECM-PCP contract to ODJFS.

6. Provider Relations

The ECM provider must work with physicians and other direct service providers to assure that each individual ECM member's needs and all program requirements are met. The ECM provider must develop, implement, and evaluate approaches to educate and equip physicians with clinical guidelines, patient data, and best practice information to help provide better care to ECM members. The ECM provider collaborative must act to assure provider satisfaction, effective performance, and ongoing program participation.

7. ECM Member Education

The ECM provider must increase ECM member self-management and participation by providing condition-specific health education, outreach, and other activities. These efforts include but are not limited to the following objectives:

- improved ECM member understanding of their health condition and how to use medical resources, including drugs, appropriately;
- prevention of emergency medical situations by recognizing acute symptoms earlier so suitable care can be obtained; and
- ECM member participation in the development of and compliance with his/her treatment plan.

8. Information Systems Capacity

The ECM provider must have the information systems capability, sophistication, and experience to handle the large data files needed for operating and monitoring care management and other required services. The ability to *integrate* ECM member, PCP, claims, and other data is essential to the ECM provider's performance. Expected activities include but are not limited to: (1) tracking ECM membership, premium payments received from ODJFS, and payments made to PCPs; (2) tracking ECM member assessments, status, case management activity, and outcomes; (3) using claims and other data to profile ECM members (e.g., identify gaps between the care recommended and the care received, monitor health service utilization and determine its appropriateness); (4) profiling ECM PCPs; and (5) targeting areas for improvement. The ECM provider will be responsible for receiving ECM member, premium, pharmacy claims, and medical claims files from ODJFS at least monthly and conducting data manipulation, summarization, and data analysis functions.

The ECM provider must have the capacity and expertise necessary to meet all ODJFS reporting requirements as specified in Appendix F. The ECM provider must further demonstrate

accountability by measuring and reporting the performance of each member of the collaborative relative to access, quality, coordination of care, and cost effectiveness.

In addition to the services identified above, the ECM provider must:

9. assure that all providers or participating organizations with the ECM program meet all applicable licensure requirements. Also, neither the ECM provider, nor any organization or provider participating with the ECM, may have been terminated from the Medicaid or Medicare program or not renewed as a provider in the Medicaid program for a period of at least two years prior to the effective date of any ECM provider agreement which may be executed.

10. assure program integrity in accordance with applicable federal and state requirements, including but not limited to participation in ODJFS surveillance and utilization activities.

11. agree to accept the ODJFS-established ECM reimbursement rates.

12. identify a contact person who will coordinate all communication between ODJFS and the ECM provider.

13. if selected for the readiness review phase of the application process, have an administrative office located in Ohio no later than 90 days prior to the expected effective date of the provider agreement.

14. participate in and cooperate with community-based informational activities, external quality reviews, consumer satisfaction surveys, or other studies conducted by ODJFS or its designee.

## II.E. ODJFS Responsibilities

The ODJFS will be responsible for the following:

1. the identification and notification of Medicaid consumers eligible for the ECM program. Information regarding the program will be provided in writing to all ECM eligibles and will also be available by telephone through a toll-free number.

2. the notification to each ECM provider by the first working day of each calendar month of those Medicaid eligibles who are new or continuing ECM members and those who have disenrolled, either by choice or due to the loss of program eligibility.

3. prospective monthly reimbursement to the ECM provider for each of that ECM's member according to the rates established in the provider agreement.

4. the notification to ECM providers of program policy or procedure changes and, whenever possible, sufficient time for ECM comment and implementation.

5. the identification of ODJFS contact staff.

6. the timely review of ECM applications and scheduling of meetings with selected ECM providers throughout the readiness phase to assure timely program implementation within resource limitations and dependent upon the number of applications received. **ODJFS reserves the right to suspend applications or encourage applicants to submit a joint application if in the program's and Medicaid consumers' best interests.**

7. the ongoing assessment of ECM provider compliance with all program requirements and overall program performance based on identified indicators and standards; the possible imposition of penalties for non-compliance or sub-standard performance; and the evaluation of process and outcome measures to determine potential incentive payments. (Section VI of this RFA provides more detailed information on performance standards.)

8. the continued payment of legitimate fee-for-service medical claims for ECM members, processing of prior authorization and pre-admission certification reviews, and sharing prior authorization and pre-admission certification decisions with the ECM provider.

9. informing the ECM provider of any ODJFS surveillance and utilization review activities related to an ECM member.

10. convening and participating in community-based meetings to inform local stakeholders of the availability of the ECM program and its benefits.

# 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)** |
| **1/5/04** | **Deadline for Application Submissions to ODJFS (3 p.m. EST)** |
| **1/6/04 – 2/4/04** | **Review of RFA Applications Including Follow-up Discussions** |
| **2/6/04** | **ODJFS Issues Notification Letter(s) (estimated)** |
| **TBD** | **Readiness Review Phase for Selected Applicants** |
| **TBD** | **Provider Agreement Signed** |
| **6/1/04** | **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 www.state.oh.us/odjfs/ohio/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.**

## 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).

Updates to the Applicant Library and the reports listed may be made periodically. Potential applicants are advised to check www.state.oh.us/odjfs/ohio/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 January 5, 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 June 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

specify the intended reimbursement for the PCP coordination payments as well as the proposed methodology for PCP performance payments and other incentives.

3. In separate, readily identifiable sections, describe in detail how each of the required services, items 1 through 8, identified in Section II.D. of this RFA will be performed and where the responsibility will be housed within the collaborative. For each item, the response must specify if the capacity is currently in existence or if it must be developed, and if the latter, the length of time necessary to have the capacity in place. Each item's response should also include the number and type (i.e., title, resume if available, or necessary qualifications) of the staff to be dedicated to each activity. Specific applicant capabilities which must be demonstrated throughout this narrative are:

- documented evidence and/or supporting references to verify ability to perform the services required and produce the results described in your responses;
- documented evidence and/or supporting references to verify existing collaboration with integrated care stakeholders (e.g., current provider entity or contracting partners; direct service providers; utilization review/case management vendor) for current patients or members;
- appropriate credentials and Medicaid-specific experience of all staff personnel (either current to be documented in resumes or to be required and documented in job descriptions) dedicated to the service;
- demonstrated ability to engage target populations (ABD Medicaid population) and facilitate increased coordinated access to primary care;
- ability to utilize physical health, behavioral health and social needs assessments to individually tailor a program with goals based on the patient's previous goal achievement, readiness to change behavior, capabilities, knowledge and disease acuity;
- documented ability to coordinate with and educate health care providers and sustain participation and coordination with these providers in specialized patient programs;

- demonstrated ability to identify and address quality of care issues (e.g., identify gaps between recommended prevention and treatment and actual care provided to enrollees);
- documented ability to apply nationally recognized, evidence-based clinical guidelines in the application of services;
- documented ability to educate ECM members and/or caregivers regarding their particular health care condition and needs brought about by their health problems, with the goal of increasing ECM member understanding of their disease and to enhance their effectiveness in self-care of their health problems;
- use of applicable advanced technology or creative approaches to deliver services, as well as conduct face-to-face outreach, as necessary, to ECM members that have less than adequate communication resources;
- population-based health improvement (ability to manage multiple diseases and co-morbid conditions);
- ability to assure ongoing monitoring and evaluation of ECM member health status;
- demonstrated ability to manage and analyze ECM member or patient demographic, utilization, and cost data; and
- documented ability to comply with current HIPAA regulations.

4. Written confirmation that the applicant understands and will comply with each of the ECM Responsibilities listed as items 9 through 14 in Section II.D. of this RFA.

5. Completion of the ECM Provider Premium allocation chart and provision of related information as specified in Section V.A. of the RFA.

**ODJFS reserves the right to contact applicants subsequent to application submission for clarification.**

## 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 February 6, 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

and may be returned only at the discretion of ODJFS. After the selection process is completed, the applications will be available through ODJFS as public documents.

4. News releases regarding this RFA shall not be made without prior approval by ODJFS and then only in conjunction with the issuing office.

# SECTION V – FINANCIAL INFORMATION

The selected ECM providers will receive an enhanced care management monthly premium from ODJFS for providing or arranging for the services described in this RFA. The premium will be paid prospectively for each ECM member. A portion of that monthly premium must be paid by the ECM provider to each of its participating primary care physicians for care management-related services. The financial objective of the ECM program is the reduction in the annual rate of growth in the medical costs of the ECM member population, which should be of sufficient magnitude to reduce the rate of growth of the costs in the overall ECM eligible population as well as the Aged, Blind, or Disabled (ABD) population from which the ECM eligible population is derived. The ECM provider will be assessed penalties or paid incentives based on a comparison of the actual versus expected reduction in the rate of growth in the ECM member and eligible population as outlined in Section V. C. of this RFA. **Please note that ECM providers may also be subject to financial or other penalties due to inadequate performance on certain clinical or process measures as identified in Section VI of this RFA or in the provider agreement. Performance on clinical and process measures will be based on ECM members only.**

## V. A. ECM Premium

An ECM base premium of $43.62 per member per month (PMPM) will be paid to the ECM provider by ODJFS. The ECM base premium will be adjusted for the number of members enrolled with each ECM provider. The ECM base premium will be paid for membership ranging from 2,501 to 5,000 total members. Adjustments to the premium based on membership size are the following:

| ECM Provider Membership Size | Base Premium PMPM Adjustment |
|---|---|
| 2,500 or Less | $4.03 |
| 2,501 – 5,000 | - |
| 5,001 – 10,000 | -$3.56 |
| 10,001 or More | -$8.04 |

The amount of the ECM base premium will be evaluated at least biannually. Adjustments in the premium paid to each ECM provider resulting from changes in membership size will occur as necessary. The ECM premium includes all costs associated with program intervention, administration, and provider payments. The premium reflects the associated PMPM costs for all conditions combined; there will not be separate premiums associated with each condition. Individual Medicaid providers rendering non-ECM services (e.g., treatment or diagnostic services) for ECM members will be paid by ODJFS on a fee-for-service basis for these non-ECM services according to their provider agreement with ODJFS.

There are several important components of care management that the ECM premium must cover. For the seven (7) categories below, please explain how the ECM premium will be allocated between the various components, and more specifically, please include a written description of the services included in each component, clearly indicating any variances from the definitions included below. If the ECM provider anticipates subcontracting for any piece(s) of these components, please identify the subcontractor, tasks they will be performing, and the associated fees. This response is to be included in the initial application submitted in accordance with Section IV.A.5 of this RFA.

It is important to note that the ECM provider is not bidding a premium, but is being asked to document how the premium paid by ODJFS will be used by the ECM provider to account for the expense components listed in the table below. For the purpose of completing this chart, the ECM provider applicant should assume the base premium amount of $43.62 and a membership size of 2501-5000.

**ECM Provider Premium Allocation Chart:**

| Category | PMPM Premium |
|---|---|
| Initial Health Assessment and Ongoing Care Management | |
| Health Advice Line | |
| Communication Materials / Education | |
| Measurement, Reporting and Monitoring | |
| PCP Coordination Payment | |
| PCP Performance Payment (average) | |
| Account Management / Overhead | |
| **Total** | $43.62 |

The ECM premium categories are defined as follows:

- **Initial Health Assessment and Ongoing Care Management** includes the costs of services and staff related to initial welcome calls, the assessment and clinical monitoring of health status, and the development and clinical monitoring of a treatment plan, including phone calls and home visits with the members, when necessary, related to both intervention and follow-up evaluations.
- **Health Advice Line** includes the costs of services and staff related to providing a twenty-four hour, seven day a week (24/7) toll-free health advice line staffed by health care professionals providing information and assistance for members and/or caregivers (as described in Section II.D.3).
- **Communication Materials and Education** includes the costs related to welcome kits and condition-specific educational materials or incentives for members as well as education materials for providers and other stakeholders (as described in Section II.D.7).
- **Measurement, Reporting and Monitoring** includes the costs of services and staff associated with data management, summarization and analysis, and regular reporting to ODJFS. Activities include but are not limited to: reporting to ODJFS of the physician acting as the primary care physician for each member; identifying gaps between care recommended and care received; profiling participating providers; and reporting of health advice line communications and statistics.

- **PCP Coordination Payment** includes the monthly fee paid to each primary care physician for the additional time spent with members on care coordination and treatment plan design and monitoring (see below for more details).
- **PCP Performance Payment** includes the incentive payment paid to each primary care physician for attaining certain quality and outcome performance standards as defined by the ECM provider and approved by ODJFS (see below for more details).
- **Account Management and Overhead** includes overall program coordination and general operating and management costs.

## V.B. PCP Coordination/Performance Payments

As part of the ECM premium, the ECM provider must establish a payment arrangement for physicians to encourage their participation as primary care physicians in care management and coordination, and in achieving clinical and other performance objectives. The primary care physician payment consists of two components: a required monthly fee paid to each primary care physician for care coordination and participation in treatment plan development and monitoring; and an additional payment made for attaining certain performance standards as defined by the ECM provider and approved by ODJFS.

The monthly fee paid to each primary care physician must be at least $3 per month for each ECM member the physician serves as PCP; the ECM provider is expected to increase this amount as appropriate to reflect the actual scope of ECM services required of PCPs within that specific ECM for some or all members. The amount may vary by individual PCP or by ECM member but must always be at least $3. The conditional additional monthly amount paid to each primary care physician based on performance measures is to be determined by the ECM provider. The ECM premium assumes an average amount of $2 per member per month will be paid for these performance measures. While all PCPs will receive the monthly care coordination payment of at least $3 per member, it is possible that not all PCPs will receive a monthly performance payment. [Please note that the amount paid to participating PCPs or other ECM provider collaborative members is expected to increase if incentive awards are made to the ECM provider for achieving ODJFS program targets over time.]

The ECM-related services to be provided by PCPs are further addressed in Section II.D and in the draft ECM-PCP contract found in Appendix E of this RFA. Each ECM provider must incorporate in the ECM-PCP contract the specific reimbursement arrangements, including the future distribution of ECM incentive awards, subject to ODJFS approval.

## V. C. Growth Rate Reduction Measurement and Targets

The ECM provider is expected to manage the annual rate of growth in the medical expenses for its ECM member population at a level which also results in reductions in the rate of growth for the ECM eligible population and the ABD population (after ECM exclusions) overall. The following is a sample of the calculation that will be performed to determine the ECM provider's performance on this measure.

Through a series of steps and the use of actual data, the calculation compares the actual rate of growth in medical costs for the ECM eligible population for each service area after program implementation to the reduced rate of growth expected by ODJFS. The first step of the calculation is to determine the actual claims cost per member per month for the Base ABD Community population (excluding ECM members and program exclusions such waiver participants or skilled nursing facility residents) for a baseline period and actual claims cost per member per month for the ECM eligible population for the same period. The ABD baseline period amount is then compared to the actual costs for the same group for the program period being measured. The resulting percentage or baseline growth rate is the rate of growth that would also be expected for the ECM eligible population in the absence of the ECM program. However, the ODJFS expectation as a result of the ECM program is that the rate of growth for the ECM eligible population will be reduced by either a minimum percentage (for example, 5% of the baseline growth rate) or a percentage based on a specified reduction in the rate of growth for the ECM member population (for example, 17%) that will be equal to or greater than a 5% rate reduction in the ECM eligible population. This percentage becomes the **target** growth rate for the program. This rate may change as conditions or populations covered under the ECM program are expanded, but will be specified in the provider agreements between ODJFS and ECM providers.

The next step is to calculate the variance from the expected rate of growth for each ECM provider and the program overall. To do this, the expected claims cost per ECM eligible for the period being measured is determined by trending the ECM eligible (both ECM members and non-members) claims costs from the baseline period forward at the target growth rate. This is the claims cost that ODJFS will expect as a result of the ECM program. The amount will then be compared to the actual claims cost experience **plus the ECM premiums paid** during the performance period. The "Growth Rate Variance" per ECM eligible is the resulting difference between expected and actual costs and will be the measure used to determine the incentive or penalty.

The following **sample calculation** assumes the following, which will be adjusted based on actual and most current data:

- Claims Cost/Month (CCPM) in Baseline Period:
  - Base ABD Community Population (excludes ECM members and program exclusions such waiver participants or skilled nursing facility residents): $822.02
  - ECM Eligible Population (includes both ECM members and non-members): $1,022.06
- Actual Claims Cost in the Performance Period
  - Base ABD Consumer Population (same definition): $924.77
  - ECM Eligible Population (same definition): $1,092.00
- ECM Participation Rate: 65%
- Minimum ECM Eligible Growth Rate Reduction: 5%
- ECM Member Expected Growth Rate Reduction: 17%

**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 | | $924.77 | |
| Baseline Growth Rate: | C | = (B/A - 1)x100 | 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 Baseline Performance Period will start six months after enrollment begins. 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** | January 1, 2004 to December 31, 2004 | January 1, 2005, to 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. The penalty/incentive will be used to reduce or increase the ECM premium for a 12-month period, commencing with the next premium payment following the performance determination date.

**ECM Provider Incentives/Penalties for Growth Rate Reduction:**

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

# Section VI – PROGRAM PERFORMANCE MEASURES

This Section establishes minimum performance measures and standards in key program areas. The intent is to hold ECM providers accountable for program requirements. ECM provider administrative functions and the quality of care received by ECM members will be evaluated as outlined below. ECM providers with performance levels below the performance standards will be required to take corrective action and/or be subject to financial penalties.

## VI. A. Administrative Performance Measures and Standards

The ECM provider will be held accountable for program requirements established in the applicable program rules and the provider agreement. Performance measures and minimum standards will be established in the provider agreement. ECM providers not meeting the minimum standards will be penalized for noncompliance. These measures will be based on the final program requirements which are dependent on federal program approval. The performance measures will be consistent with the current managed care program performance measures (e.g., the managed care program performance standard for timely assessments establish a maximum amount of time allowed for completion of assessments once a Medicaid consumer becomes an ECM member).

## VI. B. Clinical Performance Measures and Standards

ODJFS expects the ECM provider to assure that physicians treating ECM members follow nationally accepted practice guidelines. ODJFS also expects the ECM providers to assure ECM members use the most appropriate provider for health services received. Both the quality of care ECM members receive and the appropriateness of health services ECM members utilize are expected to improve over time. The ECM provider will be held accountable for clinical outcomes only in relation to its ECM member population. The clinical performance measures outlined below will be used to evaluate the ECM provider's performance during the first full calendar year after a baseline for each measure can be established. Performance targets and minimum performance improvement levels will be set after the baselines are established. The source for calculating the following clinical performance measure will be administrative data.

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**

| Condition/Measure | Performance Target & Standard |
|---|---|
| **CHF (Adults)** | |
| Overall Discharge Rate (HEDIS) | To be determined after baseline year |
| Overall ED visit rate (HEDIS) | To be determined after baseline year |
| ACE Inhibitor | To be determined after baseline year |
| Readmission for cardiac-related symptoms within 30 days | To be determined after baseline year |
| **Diabetes (Adults)** | |
| Overall Discharge Rate (HEDIS) | To be determined after baseline year |
| Overall ED visit rate (HEDIS) | To be determined after baseline year |
| Eye Exam (HEDIS) | To be determined after baseline year |
| **COPD (Adults)** | |
| Overall Discharge Rate (HEDIS) | To be determined after baseline year |
| Overall ED visit rate (HEDIS) | To be determined after baseline year |
| **Asthma (Adults & Children)** | |
| Overall Discharge Rate (HEDIS) | To be determined after baseline year |
| Overall ED visit rate (HEDIS) | 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 to December 31, 2005 | April 2006 | January 1, 2006 to 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 twelve measures listed above, the ECM provider may miss three (3) measures at no penalty. For each noncompliant measure beyond three, ODJFS will impose a monetary sanction of one-half 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.

| Condition/Measure | Source |
|---|---|
| **Diabetes (Adults)** | |
| Eye Exam (HEDIS) | Administrative Data |
| Foot Exam (HEDIS) | Administrative Data |
| HbA1c (HEDIS) | Administrative Data & Medical Record |
| Triglyceride (HEDIS) | Administrative Data & Medical Record |
| HDL Cholesterol (HEDIS) | 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 |
| Influenza | 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:
www.state.oh.us/odjfs/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.

3. PCP

Federal: The ECM must ensure that each member has a PCP for ECM services.

OAC Rule: 5101:3-26-03.1(A)(1)

In the event that the member does not have or select a PCP, the ECM must select one for the member.

OAC Rule: 5101:3-26-08.2(A)(3)

4. Treatment Plan

Federal: The ECM must implement mechanisms to assess each member and produce a treatment plan.

OAC Rule: 5101:3-26-03.1(A)(8)(iv)
MCP Provider Agreement: Appendix G(3)(c)(iii)

II. Covered Services

A. Specified in RFA, Section II. D.

B. Services that May be Covered

Federal: The ECM may elect to cover, at their own discretion and at their own expense, services that are not paid for under Medicaid.

MCP Provider Agreement: Appendix C, 14

III. Member Rights

A number of federal regulations govern member rights in Medicaid managed care programs; OAC Rule 5101:3-26-08.3 reflects these requirements and will, in large part, apply to ECM providers. Some specific examples are cited below:

A. Choice of Health Professional

Federal: The ECM shall, to the extent possible and appropriate, allow members to choose a PCP for ECM services.

OAC Rule: 5101:3-26-08.3(A)(24)

B. Guarantees

Federal: Each ECM member is guaranteed the right to: (1) be treated with respect and due consideration for his or her dignity and privacy; (2) receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand; (3) participate in decisions regarding his or her health care, including the right to refuse treatment; (4) free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; (5) request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164; and (6) exercise his or her rights, and that the exercise of those rights do not adversely affect the way the ECM provider and its PCPs or the state agency treats the member.

OAC Rule: 5101:3-26-08.3
MCP Provider Agreement: Appendix C, 15 and 23

C. Member Communication

Federal: The ECM may not prohibit, or otherwise restrict, a PCP from acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for: (1) the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (2) any information the member needs in order to decide among all relevant treatment options; (3) the risks, benefits, and consequences of treatment or non-treatment; or (4) the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

OAC Rule: 5101:3-26-05(D)(29)

IV. Member Services

A number of federal regulations govern member services in Medicaid managed care programs; OAC Rule 5101:3-26-08.2 reflects these requirements and will, in large part, apply to ECM providers. Some specific examples are cited below:

A. State Approval

The ECM must receive ODJFS approval prior to distributing any member materials, including provider directories and member handbooks (in formats to be defined for the ECM program).

OAC Rule: 5101:3-26-08.2 (B)(1)

B. Information Requirements

The ECM must ensure that informational or instructional materials are written in a manner and format that is easily understood.

OAC Rule: 5101:3-26-08(B)(2)
MCP Provider Agreement: Appendix C, 20

C. Alternative Formats

Federal: Written materials must be available in alternative formats that take into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. Members must be informed that information is available in alternative formats and how to access such information.

OAC Rules: 5101:3-26-08.2 (B)(2)(c); 5101:3-26-08.2 (B)(4)(z)(iii)

C. Language Requirements

Member materials must be printed in the prevalent non-English language of the ECM's service area.

OAC Rule: 5101:3-26-08.2(B)(2)(b)
MCP Provider Agreement: Appendix C, 19

D. Interpretation Services

The ECM must make oral interpretation services available free of charge to each potential member and member, must inform potential members and members that oral interpretation is available, and must inform members how to access oral interpretation services.

OAC Rule: 5101:3-26-08.2(A)(2)(i)
MCP Provider Agreement: Appendix C, 19

E. Basic Information, Including Provider Directories

The ECM must furnish each member with the names, locations, telephone numbers, and non-English languages spoken by current PCPs; a summary of case management services; and information on how to access case management services.

OAC Rule Cites: 5101:3-26-08.2 (B)(3)(a);5101:3-26-08.2 (B)(4)

V. Membership

General Information: OAC Rules 5101:3-26-02 and 5101:3-26-02.1
MCP Provider Agreement: Appendix C, 24. a, b, c, e, g

A. Disenrollment of a Member by an Entity, i.e. ECM Provider

An ECM Provider may submit a request to ODJFS for the termination of a member who engages in fraudulent or uncooperative behavior or where the uncooperative behavior seriously impairs the entity's ability to serve the member or other members.

OAC Rule: 5101:3-26-02.1(E)(1)

B. Change in Health Status

An ECM may not request disenrollment because of a change in the member's health status; need for health services, age, sex, sexual orientation, disability, national origin, race, color, religion, veteran's status, or ancestry; or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except as covered under V. A.)

OAC Rule: 5101:3-26-02.1(D)(12) and (E)(1) and (3)

VI. Provider Subcontracting Requirements

A. ECM Delivery Network

The ECM provider must directly provide or develop and maintain a network (or collaborative) of subcontractors and/or providers with signed, written agreements that is sufficient to provide adequate access to all ECM services covered under the contract with ODJFS. In establishing the network, the ECM provider must consider the following: anticipated ECM membership; expected utilization of ECM services; numbers and types of providers or entities required to furnish the ECM contracted services; and, where applicable, the geographic location of direct ECM service providers and ECM members.

B. Notice of Provider Termination

Specific provisions for notices to members when a PCP will no longer be contracting with the ECM will be comparable to those found at OAC 5101:3-26-05(B)(5)(c) and (f).

C. Provider Discrimination/Declining Providers

Federal: An ECM may not discriminate against PCPs who serve a high-need population and may not retaliate against providers who advocate on behalf of their members.

Federal: If an ECM declines to include individuals or a group of providers in its network, it must give the affected providers written notice of the reason for its decision. (This should not be construed to mean that the ECM must contract with providers beyond the number necessary to meet the needs of its members).

OAC Rule: 5101:3-26-05(C)(2) and (3)

D. Excluded Providers

The ECM may not contract with providers excluded from participation in Medicaid based on action in accordance with the Revised Code, the Administrative Code, Centers for Medicare and Medicaid Services, or the Medicaid fraud unit of the office of the Ohio attorney general.

OAC Rule: 5101:3-26-05(C)(1)

E. Subcontractual Relationships and Delegation

If the ECM provider intends to subcontract with another entity to provide any ECM services, the ECM provider must: evaluate the prospective subcontractor's ability to perform the activities to be delegated; maintain a written agreement with the subcontracted entity that specifies the activities and report responsibilities delegated to the subcontractor; continuously monitor the subcontractor's performance, and ensure that deficiencies are addressed.

OAC Rule: 5101:3-26-05(A)(4) and 5101:3-26-05(D) (as applicable to ECM services)

VII. Marketing

A number of federal regulations govern marketing in Medicaid managed care programs; OAC Rule 5101:3-26-08 reflects these requirements and will, in large part, apply to ECM providers. Some specific examples are cited below:

A. State Approval

The ECM must receive ODJFS approval prior to distributing any marketing materials.

OAC Rule: 5101:3-26-08(A)(2) and (B)

B. Marketing Activities

The ECM may not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

OAC Rule: 5101:3-26-08(A)(3)

E. Accurate Materials

The ECM must assure that materials are accurate and do not mislead, confuse, or defraud the member or the state agency.

OAC Rule: 5101:3-26-08(A)(1), (B), and (C)

F. Statements that Members Must Enroll to Obtain or Not to Lose Benefits

The ECM cannot assert, in writing or orally, that the member must enroll in the ECM in order to obtain benefits or in order not to lose benefits.

OAC Rule: 5101:3-26-08(B)(4)(e)

VIII. Reimbursement and Financial Responsibility

A. Liability for Payment

Federal: Medicaid members may not be held liable for: (1) debts of the ECM or its subcontractor in the event of insolvency, (2) covered services provided to the member for which ODJFS does not pay, or (3) payment for covered services furnished under a subcontract.

OAC Rules: 5101:3-26-05(D)(9) and (10); 5101:3-26-09(B)(2); and 5101:3-26-11(D).

MCP Provider Agreement: Appendix C, 30

B. Requirements for Assurances

Federal: The ECM must provide assurances satisfactorily to ODJFS showing that its provisions against risk of insolvency is adequate to ensure that its members will not be liable for debt.

OAC Rule: 5101:3-26-09 (B)(1) and (2)

C. Inspection and Audit of Financial Records

The ECM must allow ODJFS, HHS, US Comptroller General or representatives to inspect and audit any financial records of the ECM or its subcontractors.

OAC Rule: 5101:3-26-06(B), (C), (D)

IX. Program Integrity: Fraud and Abuse, Audits, Reporting, and Record Retention

A. Reporting

Federal: While the ECM is not required to have a formal fraud and abuse plan, it must nonetheless promptly report instances of fraud and abuse to ODJFS.

OAC Rule: 5101:3-26-06(A)(1)(j)

B. Federal: The ECM must certify that neither the ECM nor any principals of the ECM, is presently debarred, suspended, or proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any Federal agency.

MCP Provider Agreement: Baseline Contract, Article XII(C)

X. ECM Responsibilities

A. Cultural Considerations

Federal: The ECM must participate in ODJFS efforts to promote the delivery of services in a culturally competent manner to all members.

MCP Provider Agreement: Appendix C, 18

B. Maintenance of Records

The ECM must maintain an appropriate record system and retain records for three years after all pending matters are closed, plus additional time if an audit, litigation, or other legal action is started.

OAC Rule: 5101:3-26-06 (F)
MCP Provider Agreement: Baseline Contract, Article VII(A)

C. Use of Federal Funds

Federal: The ECM must certify that no federal funds have been used for lobbying.

MCP Provider Agreement: Baseline Contract, Article XII(B)

D. Compliance with Federal/State Laws and Regulations

Federal: The ECM must comply with all federal and state laws and regulations, including the Civil Rights Act of 1964, Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

MCP Provider Agreement: Appendix C, 16

E. Confidentiality

Federal: The ECM provider must appropriately safeguard all personal identified health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations at 45 CFR.

MCP Provider Agreement: Appendix C, 23

G. Provider/Member Communications – Moral or Religious Objections

Federal: An ECM that does not provide selected ECM services on moral or religious grounds, must furnish such information to ODJFS and potential members.

MCP Provider Agreement: Appendix C, 9

# APPENDIX B

## ECM Eligible Population Profile and Disease Stages

This appendix includes the following two reports: *Population Profile* and *Disease Stages.* These reports are limited to the ECM eligible population and are grouped by condition and county. The *Population Profile Report* includes counts of eligibles, and member months for calendar year 2002. It also contains net payment and per member per month expenditures for Medicaid services rendered during the report period. Additionally, results for HEDIS measures relevant to each condition are included. The *Disease Stages Report* includes counts of ECM eligibles for episode groups and disease stages. These and other terms used in the reports included in this appendix are defined below.

### Definitions

**Episode of Care (Epis)**
Episodes are built using the Medstat Episode Grouper (MEG) which uses claims data to create clinically specific episodes for each patient. The MEG has five primary attributes:

- Starting points- The beginning of an episode. For the ECM program, it is the first claim (physician office visits or hospitalizations) received for an episode grouping.
- Episode Grouping- MEG is based on the Disease Staging patient classification system. Disease staging classifies diseases independent of treatments and places of service. Over 600 homogeneous disease categories are included within the Disease Staging construct.
- Disease Progression/Severity of Illness- MEG incorporates the Disease staging severity stratification scheme into each of its episode groups. This allows users to profile treatments and medical interventions by the level of illness of the patient.
- Pharmacy Integration – Pharmacy information is mapped to MEG episode groups.
- End Points- The episode ends when the course of treatment is completed. Since the end of an episode is not designated on a claim, the "clean period" decision rule has been employed to establish the end date. It represents the period of time for a patient to recover from a disease or condition. The durations of a clean periods were empirically and clinically reviewed by MEDSTAT physicians and vary by disease.

**Disease Severity** Severity can be defined as the likelihood of death or residual impairment as a result of a disease, without consideration for treatment. Only clinical characteristics of a patient, measured in terms of diagnoses, symptoms, physical findings, and test results are used to define disease severity.

**Disease Stages** As a disease advances, it naturally progresses through four general stages of increasing complexity and system involvement:

- Stage 1: Conditions with no complications or problems of minimal severity.
- Stage 2: Problems limited to a single organ or system; significantly increased risk of complication.
- Stage 3: Multiple site involvement; generalized systemic involvement; poor prognosis.
- Stage 4: Death.

For the purpose of disease staging, clinical criteria have been determined for each disease to define progressive stages modeled on the above framework. Sub-stages have been defined within stages 1,2,and 3 to further specify levels of disease progression. Each stage and sub stage is defined on the basis of objective clinical findings and standard diagnostic nomenclature.

**Patients Epis** - Unique count of patients who had an episode of care within a specific disease stage. The count may not be unique across all disease stage. However, the subtotal for a county is a unique count.

Patients are included in the count if they had received facility, professional, or pharmacy services included in an episode of care.

**Length Avg Epis** - average length (in days) of all episodes of care within a particular disease stage.

**Net Pay Per Epis Total -** average total payment for all medical claims for episodes of care within the specific disease stage.

**Asthma -**the set of principal ICD9 diagnosis codes that identifies the clinical condition of asthma.

**CHF -** the set of principal ICD9 diagnosis codes that identifies clinical condition of CHF. The CHF category may be expanded to include individuals with diagnoses of Hypertension and Coronary Arterial Diseases.

**COPD -** the set of principal ICD9 diagnosis codes that identifies the clinical condition of COPD. The subset includes bronchitis, bronchiectasis, emphysema, and chronic airway obstruction NOS.

**Diabetes -** the set of principal ICD9 diagnosis codes that identifies the clinical condition of diabetes mellitus, both adult-onset type and juvenile type. This subset does not include gestational diabetes, but does include neonatal diabetes mellitus.

**Net Payments** (Total and RX)- Total net Payments is the net amount paid for all claims. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted. Net Pay Rx is the net amount paid for prescriptions filled.

**Net Payments PMPM** (Total and RX)- Net payments PMPM is the average net amount paid for all claims per member per month. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted. Net Pay PMPM Rx is the average net amount paid for prescriptions filled per member with prescription drug coverage per month.

**Inpatient Discharges Total** - the total number of acute discharges.

**Inpatient Discharges Epis** - the number of acute discharges included in an episode of care.

**Cardiac related Readmissions** - the percentage of ECM eligibles with CHF who were admitted to the hospital and then readmitted with a cardiac related condition within 30 days.

**Ophthalmology Exam -** the percentage of ECM eligibles with diabetes mellitus who received a retinal exam during the reporting year.

**Foot Exam -** the percentage of ECM eligibles with diabetes mellitus who received a foot exam during the reporting year.

**Appropriate Asthma Medications -** the percentage of ECM eligible with asthma who received the appropriate medication during the reporting year.

**Ace Inhibitor use by patients with CHF**- the percentage of ECM eligibles with CHF who received an ace inhibitor during the reporting year.

Population definitions and measures were calculated by ODJFS, Thomson Medstat, Inc. Thomson Medstat, Inc. is the supplier of the Medicaid Decision Support System for ODJFS, which includes the Medstat Episode Grouper, Disease Staging Grouper, and the Advantage Suite Data Base system.

# Population Profile

## Adult ECM Eligibles with Congestive Heart Failure

CY 2002

| | POPULATION | | TOTAL MEDICAL EXPENDITURES | | | | INPATIENT DISCHARGES | | | | ED VISITS | | CARDIAC RELATED READMISSIONS WITHIN 30 DAYS | | ACE INHIBITORS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **COUNTY** | Eligibles | Eligible Months | Net Payment | Net Pay Rx | Net Payment PMPM | Net Payment Rx PMPM | Discharges | Discharges 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 | $ 21,705,105.36 | $ 4,014,382.67 | $ 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 | $ 11,343,596.41 | $ 2,795,092.24 | $ 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 | $ 8,632,211.56 | $ 1,650,492.87 | $ 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 | $ 7,460,189.55 | $ 1,274,606.10 | $ 2,187.10 | $ 373.68 | 100 | 12 | 29.3 | 3.5 | 875 | 256.5 | 2 | 2.00% | 199 | 45.23% |
| Montgomery | 454 | 3,718 | $ 7,418,974.23 | $ 1,421,114.77 | $ 1,995.42 | $ 382.23 | 84 | 16 | 22.6 | 4.3 | 879 | 236.4 | 0 | 0.00% | 223 | 49.12% |
| Stark | 257 | 1,762 | $ 2,879,801.77 | $ 707,067.95 | $ 1,634.39 | $ 401.29 | 35 | 3 | 19.9 | 1.7 | 611 | 346.8 | 2 | 5.71% | 101 | 39.30% |
| Summit | 408 | 3,157 | $ 6,859,390.91 | $ 1,286,901.53 | $ 2,172.76 | $ 407.63 | 87 | 16 | 27.6 | 5.1 | 855 | 270.8 | 0 | 0.00% | 171 | 41.91% |
| Zanesville Cluster | 196 | 1,423 | $ 2,074,393.09 | $ 602,542.05 | $ 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** | **$ 68,373,662.88** | **$ 13,752,200.18** | **$ 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: October 1, 2003

# Population Profile

## Adult ECM Eligibles with Diabetes

CY 2002

| COUNTY | POPULATION | | TOTAL MEDICAL EXPENDITURES | | | | INPATIENT DISCHARGES | | | | ED VISITS | | OPTHALMOLOGY 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 | $ 34,123,495.63 | $ 10,520,941.66 | $ 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 | $ 28,242,869.24 | $ 10,701,827.53 | $ 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 | $ 18,035,544.44 | $ 5,812,647.02 | $ 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 | $ 12,722,828.02 | $ 4,295,999.32 | $ 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 | $ 12,683,426.39 | $ 4,452,525.65 | $ 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 | $ 7,261,337.16 | $ 2,667,392.35 | $ 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 | $ 10,665,806.76 | $ 3,812,079.89 | $ 1,152.69 | $ 411.98 | 131 | 8 | 14.2 | 0.9 | 1,502 | 162.3 | 154 | 16.16% | 107 | 11.2% |
| Zanesville Cluster | 727 | 6,825 | $ 6,306,615.98 | $ 2,810,545.70 | $ 924.05 | $ 411.80 | 111 | 18 | 16.3 | 2.6 | 907 | 132.9 | 199 | 27.37% | 109 | 15.0% |
| **Total** | **12,606** | **123,164** | **$ 130,041,923.62** | **$ 45,073,959.12** | **$ 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: October 1, 2003

# Population Profile

## Adult ECM Eligibles with COPD

CY 2002

| | POPULATION | | TOTAL MEDICAL EXPENDITURES | | | | INPATIENT DISCHARGES | | | | ED VISITS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| COUNTY | Eligibles | Eligible Months | Net Payment | Net Pay Rx | Net Payment PMPM | Net Payment Rx PMPM | Discharges | Discharges Epis COPD | Discharges per 1000 Eligible Months | Discharges COPD per 1000 Eligible Months | Visits Patient | ED Visits per 1000 Eligible Months |
| Cuyahoga | 1,728 | 17,116 | $ 16,186,786.88 | $ 4,347,409.44 | $ 945.71 | $ 254.00 | 299 | 28 | 17.5 | 1.6 | 3,337 | 195.0 |
| Franklin | 1,935 | 19,643 | $ 18,368,706.45 | $ 7,584,152.91 | $ 935.13 | $ 386.10 | 271 | 35 | 13.8 | 1.8 | 3,010 | 153.2 |
| Hamilton | 871 | 8,380 | $ 8,024,123.93 | $ 2,465,147.60 | $ 957.53 | $ 294.17 | 125 | 12 | 14.9 | 1.4 | 1,632 | 194.7 |
| Lucas | 855 | 8,540 | $ 8,609,642.70 | $ 2,394,240.11 | $ 1,008.15 | $ 280.36 | 132 | 12 | 15.5 | 1.4 | 2,132 | 249.6 |
| Montgomery | 617 | 6,172 | $ 6,375,207.87 | $ 2,062,961.34 | $ 1,032.92 | $ 334.25 | 83 | 3 | 13.4 | 0.5 | 1,242 | 201.2 |
| Stark | 515 | 5,014 | $ 4,250,714.74 | $ 1,464,467.93 | $ 847.77 | $ 292.08 | 41 | 6 | 8.2 | 1.2 | 1,308 | 260.9 |
| Summit | 620 | 6,220 | $ 6,135,690.96 | $ 2,239,344.64 | $ 986.45 | $ 360.02 | 72 | 2 | 11.6 | 0.3 | 1,289 | 207.2 |
| Zanesville Cluster | 654 | 6,133 | $ 5,295,263.78 | $ 1,939,495.86 | $ 863.41 | $ 316.24 | 100 | 8 | 16.3 | 1.3 | 1,105 | 180.2 |
| **Total** | **7,788** | **77,218** | **$ 73,246,137.31** | **$ 24,497,219.83** | **$ 948.56** | **$ 317.25** | **1,123** | **106** | **14.5** | **1.4** | **15,055** | **195.0** |

Data Source: OHP DSS
Date: October 1, 2003

# Population Profile

## Adult ECM Eligibles with Asthma

CY 2002

| | POPULATION | | TOTAL MEDICAL EXPENDITURES | | | | INPATIENT DISCHARGES | | | | ED VISITS | | ASTHMA EPISODES | | | ASTHMA APPROPRIATE MEDICATIONS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| COUNTY | Eligibles | Eligible Months | Net Payment | Net Pay Rx | Net Payment PMPM | Net Payment Rx PMPM | Discharges | Discharges Epis Asthma | Discharges per 1000 Eligible Months | Discharges Asthma per 1000 Eligible Months | Visits Patient | ED Visits per 1000 Eligible Months | Total Asthma Episodes | Episodes per 1000 Eligible Months | Pats Epis Asthma % Flare Up | Total Medicated Asthma Patients | % of patients with Appropriate Medications |
| Cuyahoga | 846 | 8,741 | $ 4,820,494.36 | $ 1,068,603.79 | $ 551.48 | $ 122.25 | 134 | 21 | 15.3 | 2.4 | 1,402 | 160.4 | 655 | 75 | 12.96% | 270 | 31.91% |
| Franklin | 501 | 5,014 | $ 2,515,081.31 | $ 769,895.83 | $ 501.61 | $ 153.55 | 48 | 0 | 9.6 | 0.0 | 661 | 131.8 | 358 | 71 | 4.09% | 155 | 30.94% |
| Hamilton | 468 | 4,704 | $ 2,533,812.41 | $ 613,044.68 | $ 538.65 | $ 130.32 | 60 | 3 | 12.8 | 0.6 | 772 | 164.1 | 352 | 75 | 10.33% | 165 | 35.26% |
| Lucas | 311 | 3,174 | $ 1,623,532.23 | $ 380,547.76 | $ 511.51 | $ 119.90 | 36 | 4 | 11.3 | 1.3 | 652 | 205.4 | 226 | 71 | 6.63% | 90 | 28.94% |
| Montgomery | 335 | 3,408 | $ 1,822,492.84 | $ 553,462.90 | $ 534.77 | $ 162.40 | 31 | 0 | 9.1 | 0.0 | 629 | 184.6 | 258 | 76 | 10.05% | 106 | 31.64% |
| Stark | 119 | 1,126 | $ 485,808.32 | $ 161,391.79 | $ 431.45 | $ 143.33 | 9 | 2 | 8.0 | 1.8 | 248 | 220.2 | 72 | 64 | 2.90% | 33 | 27.73% |
| Summit | 240 | 2,504 | $ 1,179,715.74 | $ 424,149.38 | $ 471.13 | $ 169.39 | 11 | 0 | 4.4 | 0.0 | 450 | 179.7 | 176 | 70 | 6.00% | 61 | 25.42% |
| Zanesville Cluster | 144 | 1,467 | $ 652,618.30 | $ 243,602.61 | $ 444.87 | $ 166.05 | 13 | 0 | 8.9 | 0.0 | 185 | 126.1 | 100 | 68 | 2.17% | 44 | 30.56% |
| **Total** | **2,961** | **30,138** | **$ 15,633,555.51** | **$ 4,214,698.74** | **$ 518.73** | **$ 139.85** | **342** | **30** | **11.3** | **1.0** | **4,999** | **165.9** | **2,197** | **73** | **55.13%** | **924** | **31.21%** |

Data Source: OHP DSS

Date: October 1, 2003

# Population Profile

## Child ECM Eligibles with Asthma

CY 2002

| | POPULATION | | TOTAL MEDICAL EXPENDITURES | | | | INPATIENT DISCHARGES | | | | ED VISITS | | ASTHMA EPISODES | | | ASTHMA APPROPRIATE MEDICATIONS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **COUNTY** | Eligibles | Eligible Months | Net Payment | Net Pay Rx | Net Payment PMPM | Net Payment Rx PMPM | Discharges | Discharges Epis Asthma | Discharges per 1000 Eligible Months | Discharges Asthma per 1000 Eligible Months | Visits Patient | ED Visits per 1000 Eligible Months | Total Asthma Episodes | Episodes per 1000 Eligible Months | Pats Epis Asthma % Flare Up | Total Medicated Asthma Patients | % of patients with Appropriate Medications |
| Cuyahoga | 825 | 8,160 | $4,478,194.49 | $923,424.60 | $ 548.80 | $ 113.16 | 118 | 19 | 14.5 | 2.3 | 966 | 118.4 | 618 | 76 | 15.48% | 401 | 48.61% |
| Franklin | 448 | 4,228 | $2,040,400.80 | $460,003.19 | $ 482.59 | $ 108.80 | 25 | 2 | 5.9 | 0.5 | 490 | 115.9 | 423 | 100 | 24.01% | 221 | 49.33% |
| Hamilton | 400 | 3,777 | $2,025,640.21 | $358,746.44 | $ 536.31 | $ 94.98 | 40 | 0 | 10.6 | 0.0 | 544 | 144.0 | 295 | 78 | 13.69% | 186 | 46.50% |
| Lucas | 395 | 3,918 | $1,672,152.81 | $348,391.59 | $ 426.79 | $ 88.92 | 49 | 5 | 12.5 | 1.3 | 408 | 104.1 | 325 | 83 | 14.23% | 182 | 46.08% |
| Montgomery | 216 | 2,075 | $819,068.76 | $177,578.26 | $ 394.73 | $ 85.58 | 8 | 1 | 3.9 | 0.5 | 286 | 137.8 | 195 | 94 | 33.33% | 106 | 49.07% |
| Stark | 60 | 575 | $309,148.12 | $66,627.14 | $ 537.65 | $ 115.87 | 5 | 3 | 8.7 | 5.2 | 77 | 133.9 | 36 | 63 | 12.90% | 25 | 41.67% |
| Summit | 191 | 1,872 | $1,093,782.90 | $215,830.21 | $ 584.29 | $ 115.29 | 19 | 4 | 10.1 | 2.1 | 345 | 184.3 | 142 | 76 | 19.64% | 92 | 48.17% |
| Zanesville Cluster | 39 | 383 | $156,522.73 | $57,975.01 | $ 408.68 | $ 151.37 | 5 | 1 | 13.1 | 2.6 | 40 | 104.4 | 31 | 81 | 12.00% | 19 | 48.72% |
| **Total** | **2,571** | **24,988** | **$12,594,910.82** | **$2,608,576.44** | **$ 504.04** | **$ 104.39** | **269** | **35** | **10.8** | **1.4** | **3,156** | **126.3** | **2,065** | **83** | | **1,232** | **47.92%** |

Data Source: OHP DSS

Date: October 1, 2003

# 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 Condition | Discharges per 1000 Eligible Months | Condition Discharges per 1000 Eligible Months | Visits Patient | ED Visits per 1000 Eligible Months |
| Cuyahoga | 8,574 | 82,272 | $81,314,077 | $20,874,762 | $988 | $254 | 1,593 | 215 | 19.4 | 2.6 | 12,855 | 156.3 |
| Franklin | 6,208 | 60,866 | $62,510,654 | $22,310,972 | $1,027 | $367 | 920 | 105 | 15.1 | 1.7 | 8,347 | 137.1 |
| Hamilton | 4,025 | 37,948 | $39,251,333 | $10,900,079 | $1,034 | $287 | 690 | 72 | 18.2 | 1.9 | 6,717 | 177.0 |
| Lucas | 3,218 | 30,913 | $32,088,345 | $8,693,785 | $1,038 | $281 | 528 | 55 | 17.1 | 1.8 | 6,180 | 199.9 |
| Montgomery | 2,785 | 26,801 | $29,119,170 | $8,667,643 | $1,086 | $323 | 365 | 34 | 13.6 | 1.3 | 4,862 | 181.4 |
| Stark | 1,679 | 15,380 | $15,186,810 | $5,066,947 | $987 | $329 | 197 | 24 | 12.8 | 1.6 | 3,683 | 239.5 |
| Summit | 2,412 | 23,006 | $25,934,387 | $7,978,306 | $1,127 | $347 | 320 | 30 | 13.9 | 1.3 | 4,441 | 193.0 |
| Zanesville Cluster | 1,760 | 16,231 | $14,485,414 | $5,654,161 | $892 | $348 | 294 | 40 | 18.1 | 2.5 | 2,543 | 156.7 |
| **Total** | **30,622** | **293,417** | **$299,890,190** | **$90,146,654** | **$1,022** | **$307** | **4,907** | **575** | **16.7** | **2.0** | **49,628** | **169.1** |

Data Source: OHP DSS
Date: October 1, 2003

# Disease Stages

## Adult ECM Eligibles with CHF

**CY 2002**

| County | Episode Group | High Disease Stage Code | High Disease Stage | Patients Epis | Episodes | Length Avg Epis |
|---|---|---|---|---|---|---|
| **Cuyahoga** | **Acute Myocardial Infarction** | **3.3** | Acute myocardial infarction and congestive heart failure | 35 | 35 | 18.51 |
| | **Angina Pectoris, Chronic Maintenance** | **2.3** | Angina pectoris with congestive heart failure | 118 | 121 | 101.77 |
| | **Cardiomyopathy** | **3.3** | Cardiomyopathy with congestive heart failure | 115 | 124 | 97.79 |
| | **Dis. of Mitral Valve** | **3.3** | Mitral disease with congestive heart failure | 15 | 15 | 42.60 |
| | **Essential Hypertension, Chronic Maintenance** | **2.4** | Hypertensive congestive heart failure | 102 | 108 | 65.82 |
| | **Heart Dis., NEC** | **3.1** | Acute myocarditis, heart failure, other ill-defined heart disea | 680 | 767 | 34.14 |
| | **Hypothyroidism** | **3.1** | Hypothyroidism with congestive heart failure | 14 | 14 | 49.86 |
| | **Nonsp. Heart Dis.** | **3.1** | Heart failure, unspecified | 11 | 11 | 10.09 |
| | **Rheumatoid Arthritis** | **3.2** | Rheumatoid arthritis with congestive heart failure | 1 | 1 | 56.00 |
| | **Trauma Chest Wall/Breast Incl. Fract. Rib & Stern.** | **3.4** | Chest trauma, Fx of rib, sternum w/ CHF | 1 | 1 | 1.00 |
| **Cuyahoga Subtotal** | | | | **985** | **1,197** | **50.03** |
| **Franklin** | **Acute Myocardial Infarction** | **3.3** | Acute myocardial infarction and congestive heart failure | 17 | 18 | 21.50 |
| | **Angina Pectoris, Chronic Maintenance** | **2.3** | Angina pectoris with congestive heart failure | 47 | 48 | 114.29 |
| | **Cardiomyopathy** | **3.3** | Cardiomyopathy with congestive heart failure | 37 | 40 | 96.15 |
| | **Dis. of Mitral Valve** | **3.3** | Mitral disease with congestive heart failure | 10 | 10 | 36.10 |
| | **Essential Hypertension, Chronic Maintenance** | **2.4** | Hypertensive congestive heart failure | 27 | 27 | 69.48 |
| | **Heart Dis., NEC** | **3.1** | Acute myocarditis, heart failure, other ill-defined heart disea | 348 | 396 | 36.70 |
| | **Hypothyroidism** | **3.1** | Hypothyroidism with congestive heart failure | 6 | 6 | 14.67 |
| | **Nonsp. Heart Dis.** | **3.1** | Heart failure, unspecified | 7 | 9 | 90.56 |
| | **Rheumatoid Arthritis** | **3.2** | Rheumatoid arthritis with congestive heart failure | 1 | 1 | 102.00 |
| | **Trauma Chest Wall/Breast Incl. Fract. Rib & Stern.** | **3.4** | Chest trauma, Fx of rib, sternum w/ CHF | 1 | 1 | 8.00 |
| **Franklin Subtotal** | | | | **447** | **556** | **49.46** |
| **Hamilton** | **Acute Myocardial Infarction** | **3.3** | Acute myocardial infarction and congestive heart failure | 12 | 12 | 16.33 |
| | **Angina Pectoris, Chronic Maintenance** | **2.3** | Angina pectoris with congestive heart failure | 28 | 29 | 105.34 |
| | **Cardiomyopathy** | **3.3** | Cardiomyopathy with congestive heart failure | 34 | 34 | 88.74 |
| | **Dis. of Mitral Valve** | **3.3** | Mitral disease with congestive heart failure | 7 | 8 | 32.63 |
| | **Essential Hypertension, Chronic Maintenance** | **2.4** | Hypertensive congestive heart failure | 47 | 51 | 55.53 |
| | **Heart Dis., NEC** | **3.1** | Acute myocarditis, heart failure, other ill-defined heart disea | 263 | 289 | 34.81 |
| | **Hypothyroidism** | **3.1** | Hypothyroidism with congestive heart failure | 1 | 1 | 1.00 |
| | **Nonsp. Heart Dis.** | **3.1** | Heart failure, unspecified | 3 | 3 | 53.67 |
| | **Rheumatoid Arthritis** | **3.2** | Rheumatoid arthritis with congestive heart failure | 1 | 1 | 184.00 |
| | **Trauma Chest Wall/Breast Incl. Fract. Rib & Stern.** | **3.4** | Chest trauma, Fx of rib, sternum w/ CHF | 1 | 1 | 1.00 |
| **Hamilton Subtotal** | | | | **357** | **429** | **46.08** |
| **Lucas** | **Acute Myocardial Infarction** | **3.3** | Acute myocardial infarction and congestive heart failure | 15 | 15 | 7.13 |
| | **Angina Pectoris, Chronic Maintenance** | **2.3** | Angina pectoris with congestive heart failure | 32 | 34 | 107.35 |
| | **Cardiomyopathy** | **3.3** | Cardiomyopathy with congestive heart failure | 16 | 17 | 124.12 |
| | **Dis. of Mitral Valve** | **3.3** | Mitral disease with congestive heart failure | 12 | 13 | 26.69 |
| | **Essential Hypertension, Chronic Maintenance** | **2.4** | Hypertensive congestive heart failure | 14 | 14 | 53.07 |
| | **Heart Dis., NEC** | **3.1** | Acute myocarditis, heart failure, other ill-defined heart disea | 218 | 243 | 36.70 |
| | **Hypothyroidism** | **3.1** | Hypothyroidism with congestive heart failure | 2 | 2 | 20.00 |
| | **Nonsp. Heart Dis.** | **3.1** | Heart failure, unspecified | 2 | 2 | 1.00 |
| | | **3.2** | Rheumatoid arthritis with congestive heart failure | 1 | 1 | 131.00 |

# Disease Stages

**Adult ECM Eligibles with CHF**

**CY 2002**

| County | Episode Group | High Disease Stage Code | High Disease Stage | Patients Epis | Episodes | Length Avg Epis |
|---|---|---|---|---|---|---|
| **Lucas Subtotal** | | | | **282** | **341** | **47.06** |
| **Montgomery** | **Acute Myocardial Infarction** | **3.3** | Acute myocardial infarction and congestive heart failure | 9 | 9 | 16.67 |
| | **Angina Pectoris, Chronic Maintenance** | **2.3** | Angina pectoris with congestive heart failure | 29 | 29 | 90.83 |
| | **Cardiomyopathy** | **3.3** | Cardiomyopathy with congestive heart failure | 29 | 30 | 92.73 |
| | **Dis. of Mitral Valve** | **3.3** | Mitral disease with congestive heart failure | 3 | 3 | 25.67 |
| | **Essential Hypertension, Chronic Maintenance** | **2.4** | Hypertensive congestive heart failure | 42 | 44 | 65.43 |
| | **Heart Dis., NEC** | **3.1** | Acute myocarditis, heart failure, other ill-defined heart disea | 213 | 249 | 41.21 |
| | **Hypothyroidism** | **3.1** | Hypothyroidism with congestive heart failure | 1 | 1 | 1.00 |
| | **Nonsp. Heart Dis.** | **3.1** | Heart failure, unspecified | 1 | 1 | 1.00 |
| | **Rheumatoid Arthritis** | **3.2** | Rheumatoid arthritis with congestive heart failure | 1 | 1 | 249.00 |
| **Montgomery Subtotal** | | | | **291** | **367** | **51.87** |
| **Stark** | **Acute Myocardial Infarction** | **3.3** | Acute myocardial infarction and congestive heart failure | 9 | 9 | 11.67 |
| | **Angina Pectoris, Chronic Maintenance** | **2.3** | Angina pectoris with congestive heart failure | 21 | 22 | 113.00 |
| | **Cardiomyopathy** | **3.3** | Cardiomyopathy with congestive heart failure | 19 | 19 | 96.89 |
| | **Dis. of Mitral Valve** | **3.3** | Mitral disease with congestive heart failure | 1 | 1 | 12.00 |
| | **Essential Hypertension, Chronic Maintenance** | **2.4** | Hypertensive congestive heart failure | 8 | 8 | 11.50 |
| | **Heart Dis., NEC** | **3.1** | Acute myocarditis, heart failure, other ill-defined heart disea | 110 | 122 | 30.58 |
| | **Hypothyroidism** | **3.1** | Hypothyroidism with congestive heart failure | 3 | 3 | 64.67 |
| | **Nonsp. Heart Dis.** | **3.1** | Heart failure, unspecified | 3 | 3 | 91.67 |
| **Stark Subtotal** | | | | **155** | **187** | **46.72** |
| **Summit** | **Acute Myocardial Infarction** | **3.3** | Acute myocardial infarction and congestive heart failure | 16 | 16 | 25.69 |
| | **Angina Pectoris, Chronic Maintenance** | **2.3** | Angina pectoris with congestive heart failure | 38 | 38 | 118.37 |
| | **Cardiomyopathy** | **3.3** | Cardiomyopathy with congestive heart failure | 17 | 18 | 86.17 |
| | **Dis. of Mitral Valve** | **3.3** | Mitral disease with congestive heart failure | 2 | 2 | 19.00 |
| | **Essential Hypertension, Chronic Maintenance** | **2.4** | Hypertensive congestive heart failure | 24 | 25 | 48.20 |
| | **Heart Dis., NEC** | **3.1** | Acute myocarditis, heart failure, other ill-defined heart disea | 174 | 202 | 34.89 |
| | **Hypothyroidism** | **3.1** | Hypothyroidism with congestive heart failure | 6 | 6 | 22.33 |
| | **Nonsp. Heart Dis.** | **3.1** | Heart failure, unspecified | 3 | 3 | 63.00 |
| | **Rheumatoid Arthritis** | **3.2** | Rheumatoid arthritis with congestive heart failure | 1 | 1 | 211.00 |
| | **Trauma Chest Wall/Breast Incl. Fract. Rib & Stern.** | **3.4** | Chest trauma, Fx of rib, sternum w/ CHF | 2 | 2 | 1.00 |
| **Summit Subtotal** | | | | **254** | **313** | **48.84** |
| **Zanesville Cluster** | **Acute Myocardial Infarction** | **3.3** | Acute myocardial infarction and congestive heart failure | 7 | 8 | 8.00 |
| | **Angina Pectoris, Chronic Maintenance** | **2.3** | Angina pectoris with congestive heart failure | 20 | 21 | 63.24 |
| | **Cardiomyopathy** | **3.3** | Cardiomyopathy with congestive heart failure | 4 | 4 | 25.75 |
| | **Dis. of Mitral Valve** | **3.3** | Mitral disease with congestive heart failure | 5 | 5 | 66.00 |
| | **Essential Hypertension, Chronic Maintenance** | **2.4** | Hypertensive congestive heart failure | 3 | 3 | 90.00 |
| | **Heart Dis., NEC** | **3.1** | Acute myocarditis, heart failure, other ill-defined heart disea | 86 | 98 | 25.16 |
| | **Hypothyroidism** | **3.1** | Hypothyroidism with congestive heart failure | 1 | 1 | 1.00 |
| | **Nonsp. Heart Dis.** | **3.1** | Heart failure, unspecified | 1 | 1 | 183.00 |
| | **Rheumatoid Arthritis** | **3.2** | Rheumatoid arthritis with congestive heart failure | 1 | 1 | 2.00 |
| **Zanesville Cluster Subtotal** | | | | **119** | **142** | **33.43** |
| **Unique Count Grand Total** | | | | **2,890** | **3,532** | **48.42** |

Data Source: OHP DSS
Date: September 22, 2003

# Disease Stages

**Adult ECM Eligibles with Diabetes**

**CY 2002**

| County | Episode Group | High Disease Stage Code | High Disease Stage | Patients Epis | Episodes | Length Avg Epis |
|---|---|---|---|---|---|---|
| **Cuyahoga** | **Diabetes Mellitus, Chronic Maintenance** | **1.1** | Asymptomatic diabetes mellitus or hyperglycemia | 1,045 | 1,113 | 74.74 |
| | | **1.2** | Symptomatic diabetes mellitus | 274 | 287 | 93.97 |
| | | **1.3** | Type I diabetes mellitus (insulin dependent diabetes mellitus) | 762 | 808 | 136.23 |
| | | **2.1** | Diabetes w/ retinopathy, glomerulosclerosis, neuropathy, PVD azotemia | 795 | 826 | 138.70 |
| | | **2.3** | Diabetes mellitus with urinary tract infection | 12 | 12 | 176.17 |
| | | **3.4** | Diabetes mellitus with renal failure | 3 | 3 | 145.00 |
| | **Diabetes with Gangrene & Osteomyelitis** | **2.4** | Diabetes mellitus with gangrenous infection | 9 | 9 | 49.89 |
| | | **2.5** | Diabetes mellitus with osteomyelitis | 25 | 26 | 46.58 |
| | **Diabetes with Leg Ulcer & Cellulitis** | **2.1** | Diabetes mellitus with leg ulcer | 5 | 5 | 2.00 |
| | | **2.3** | Diabetes mellitus with cellulitis | 8 | 8 | 4.38 |
| | **Diabetes with Other Severe Complication** | **3.2** | Diabetes mellitus with ketoacidosis | 281 | 363 | 31.19 |
| | | **3.5** | Diabetes mellitus with septicemia | 2 | 2 | 10.00 |
| | | **3.6** | Diabetes mellitus with coma | 18 | 21 | 27.10 |
| | | **3.7** | Diabetes mellitus with hyperosmolar coma | 17 | 17 | 11.18 |
| | | **3.8** | Diabetes mellitus with shock | 1 | 1 | 5.00 |
| **Cuyahoga Subtotal** | | | | **2,817** | **3,501** | **100.30** |
| **Franklin** | **Diabetes Mellitus, Chronic Maintenance** | **1.1** | Asymptomatic diabetes mellitus or hyperglycemia | 734 | 772 | 81.52 |
| | | **1.2** | Symptomatic diabetes mellitus | 444 | 477 | 108.15 |
| | | **1.3** | Type I diabetes mellitus (insulin dependent diabetes mellitus) | 307 | 323 | 139.96 |
| | | **2.1** | Diabetes w/ retinopathy, glomerulosclerosis, neuropathy, PVD azotemia | 512 | 534 | 134.34 |
| | | **2.3** | Diabetes mellitus with urinary tract infection | 4 | 4 | 173.00 |
| | | **3.4** | Diabetes mellitus with renal failure | 3 | 3 | 156.00 |
| | **Diabetes with Gangrene & Osteomyelitis** | **2.4** | Diabetes mellitus with gangrenous infection | 5 | 5 | 11.80 |
| | | **2.5** | Diabetes mellitus with osteomyelitis | 5 | 5 | 33.40 |
| | **Diabetes with Leg Ulcer & Cellulitis** | **2.1** | Diabetes mellitus with leg ulcer | 2 | 2 | 1.00 |
| | | **2.3** | Diabetes mellitus with cellulitis | 2 | 2 | 72.00 |
| | **Diabetes with Other Severe Complication** | **3.2** | Diabetes mellitus with ketoacidosis | 99 | 111 | 23.21 |
| | | **3.5** | Diabetes mellitus with septicemia | 3 | 3 | 15.33 |
| | | **3.6** | Diabetes mellitus with coma | 7 | 7 | 52.29 |
| | | **3.7** | Diabetes mellitus with hyperosmolar coma | 50 | 58 | 105.03 |
| | **Diabetes with Retinal Hemorrhage** | **2.1** | Diabetes mellitus with retinal hemorrage | 2 | 2 | 1.00 |
| **Franklin Subtotal** | | | | **1,944** | **2,308** | **104.89** |
| **Hamilton** | **Diabetes Mellitus, Chronic Maintenance** | **1.1** | Asymptomatic diabetes mellitus or hyperglycemia | 595 | 646 | 70.80 |
| | | **1.2** | Symptomatic diabetes mellitus | 150 | 156 | 118.23 |
| | | **1.3** | Type I diabetes mellitus (insulin dependent diabetes mellitus) | 334 | 353 | 140.59 |
| | | **2.1** | Diabetes w/ retinopathy, glomerulosclerosis, neuropathy, PVD azotemia | 266 | 273 | 139.15 |
| | | **2.3** | Diabetes mellitus with urinary tract infection | 2 | 2 | 55.00 |
| | | **3.4** | Diabetes mellitus with renal failure | 1 | 1 | 165.00 |
| | **Diabetes with Gangrene & Osteomyelitis** | **2.4** | Diabetes mellitus with gangrenous infection | 3 | 3 | 9.33 |
| | | **2.5** | Diabetes mellitus with osteomyelitis | 16 | 16 | 34.56 |
| | **Diabetes with Leg Ulcer & Cellulitis** | **2.1** | Diabetes mellitus with leg ulcer | 1 | 1 | 1.00 |
| | | **2.3** | Diabetes mellitus with cellulitis | 7 | 7 | 10.14 |
| | **Diabetes with Other Severe Complication** | **3.2** | Diabetes mellitus with ketoacidosis | 83 | 99 | 31.39 |
| | | **3.5** | Diabetes mellitus with septicemia | 1 | 1 | 14.00 |
| | | **3.6** | Diabetes mellitus with coma | 6 | 8 | 17.25 |
| | | **3.7** | Diabetes mellitus with hyperosmolar coma | 15 | 15 | 17.07 |
| **Hamilton Subtotal** | | | | **1,299** | **1,581** | **98.82** |
| **Lucas** | **Diabetes Mellitus, Chronic Maintenance** | **1.1** | Asymptomatic diabetes mellitus or hyperglycemia | 369 | 401 | 63.90 |
| | | **1.2** | Symptomatic diabetes mellitus | 87 | 91 | 77.54 |
| | | **1.3** | Type I diabetes mellitus (insulin dependent diabetes mellitus) | 291 | 303 | 132.14 |
| | | **2.1** | Diabetes w/ retinopathy, glomerulosclerosis, neuropathy, PVD azotemia | 213 | 215 | 150.38 |
| | | **2.3** | Diabetes mellitus with urinary tract infection | 4 | 4 | 159.00 |
| | | **3.4** | Diabetes mellitus with renal failure | 2 | 2 | 18.00 |
| | **Diabetes with Gangrene & Osteomyelitis** | **2.4** | Diabetes mellitus with gangrenous infection | 4 | 4 | 13.50 |
| | | **2.5** | Diabetes mellitus with osteomyelitis | 4 | 4 | 30.00 |
| | **Diabetes with Leg Ulcer & Cellulitis** | **2.1** | Diabetes mellitus with leg ulcer | 2 | 2 | 10.50 |
| | | **2.3** | Diabetes mellitus with cellulitis | 1 | 1 | 2.00 |
| | **Diabetes with Other Severe Complication** | **3.1** | Diabetes mellitus with hyperosmolar state | 1 | 1 | 2.00 |
| | | **3.2** | Diabetes mellitus with ketoacidosis | 33 | 38 | 14.82 |
| | | **3.5** | Diabetes mellitus with septicemia | 1 | 1 | 16.00 |
| | | **3.6** | Diabetes mellitus with coma | 1 | 1 | 2.00 |
| | | **3.7** | Diabetes mellitus with hyperosmolar coma | 5 | 5 | 6.00 |
| **Lucas Subtotal** | | | | **921** | **1,073** | **99.28** |

# Disease Stages

**Adult ECM Eligibles with Diabetes**

**CY 2002**

| County | Episode Group | High Disease Stage Code | High Disease Stage | Patients Epis | Episodes | Length Avg Epis |
|---|---|---|---|---|---|---|
| **Montgomery** | **Diabetes Mellitus, Chronic Maintenance** | **1.1** | Asymptomatic diabetes mellitus or hyperglycemia | 314 | 337 | 74.66 |
| | | **1.2** | Symptomatic diabetes mellitus | 72 | 74 | 91.08 |
| | | **1.3** | Type I diabetes mellitus (insulin dependent diabetes mellitus) | 291 | 306 | 128.48 |
| | | **2.1** | Diabetes w/ retinopathy, glomerulosclerosis, neuropathy, PVD azotemia | 264 | 275 | 140.18 |
| | | **2.3** | Diabetes mellitus with urinary tract infection | 3 | 3 | 146.33 |
| | **Diabetes with Gangrene & Osteomyelitis** | **2.4** | Diabetes mellitus with gangrenous infection | 3 | 3 | 43.33 |
| | | **2.5** | Diabetes mellitus with osteomyelitis | 8 | 9 | 20.44 |
| | **Diabetes with Leg Ulcer & Cellulitis** | **2.1** | Diabetes mellitus with leg ulcer | 1 | 2 | 49.50 |
| | | **2.3** | Diabetes mellitus with cellulitis | 10 | 10 | 11.30 |
| | **Diabetes with Other Severe Complication** | **3.2** | Diabetes mellitus with ketoacidosis | 43 | 48 | 26.23 |
| | | **3.5** | Diabetes mellitus with septicemia | 3 | 3 | 57.67 |
| | | **3.6** | Diabetes mellitus with coma | 3 | 3 | 20.33 |
| | | **3.7** | Diabetes mellitus with hyperosmolar coma | 7 | 7 | 12.14 |
| **Montgomery Subtotal** | | | | **897** | **1,080** | **103.99** |
| **Stark** | **Diabetes Mellitus, Chronic Maintenance** | **1.1** | Asymptomatic diabetes mellitus or hyperglycemia | 178 | 193 | 89.81 |
| | | **1.2** | Symptomatic diabetes mellitus | 50 | 51 | 105.63 |
| | | **1.3** | Type I diabetes mellitus (insulin dependent diabetes mellitus) | 185 | 197 | 134.27 |
| | | **2.1** | Diabetes w/ retinopathy, glomerulosclerosis, neuropathy, PVD azotemia | 150 | 157 | 149.46 |
| | | **2.3** | Diabetes mellitus with urinary tract infection | 3 | 3 | 71.33 |
| | **Diabetes with Gangrene & Osteomyelitis** | **2.4** | Diabetes mellitus with gangrenous infection | 1 | 1 | 4.00 |
| | | **2.5** | Diabetes mellitus with osteomyelitis | 7 | 7 | 14.71 |
| | **Diabetes with Leg Ulcer & Cellulitis** | **2.3** | Diabetes mellitus with cellulitis | 3 | 3 | 11.00 |
| | **Diabetes with Other Severe Complication** | **3.2** | Diabetes mellitus with ketoacidosis | 31 | 36 | 15.53 |
| | | **3.7** | Diabetes mellitus with hyperosmolar coma | 3 | 3 | 2.33 |
| **Stark Subtotal** | | | | **548** | **651** | **112.99** |
| **Summit** | **Diabetes Mellitus, Chronic Maintenance** | **1.1** | Asymptomatic diabetes mellitus or hyperglycemia | 262 | 277 | 77.90 |
| | | **1.2** | Symptomatic diabetes mellitus | 73 | 80 | 85.36 |
| | | **1.3** | Type I diabetes mellitus (insulin dependent diabetes mellitus) | 194 | 203 | 142.13 |
| | | **2.1** | Diabetes w/ retinopathy, glomerulosclerosis, neuropathy, PVD azotemia | 223 | 231 | 142.83 |
| | | **2.3** | Diabetes mellitus with urinary tract infection | 1 | 1 | 120.00 |
| | **Diabetes with Gangrene & Osteomyelitis** | **2.4** | Diabetes mellitus with gangrenous infection | 3 | 3 | 80.00 |
| | | **2.5** | Diabetes mellitus with osteomyelitis | 4 | 4 | 24.25 |
| | **Diabetes with Leg Ulcer & Cellulitis** | **2.3** | Diabetes mellitus with cellulitis | 4 | 4 | 7.25 |
| | **Diabetes with Other Severe Complication** | **3.2** | Diabetes mellitus with ketoacidosis | 76 | 93 | 32.27 |
| | | **3.6** | Diabetes mellitus with coma | 2 | 2 | 7.00 |
| | | **3.7** | Diabetes mellitus with hyperosmolar coma | 4 | 4 | 51.75 |
| **Summit Subtotal** | | | | **733** | **902** | **104.17** |
| **Zanesville Cluster** | **Diabetes Mellitus, Chronic Maintenance** | **1.1** | Asymptomatic diabetes mellitus or hyperglycemia | 292 | 321 | 82.94 |
| | | **1.2** | Symptomatic diabetes mellitus | 47 | 53 | 100.13 |
| | | **1.3** | Type I diabetes mellitus (insulin dependent diabetes mellitus) | 107 | 111 | 124.53 |
| | | **2.1** | Diabetes w/ retinopathy, glomerulosclerosis, neuropathy, PVD azotemia | 154 | 160 | 135.68 |
| | | **2.3** | Diabetes mellitus with urinary tract infection | 1 | 1 | 3.00 |
| | **Diabetes with Gangrene & Osteomyelitis** | **2.5** | Diabetes mellitus with osteomyelitis | 3 | 3 | 32.67 |
| | **Diabetes with Leg Ulcer & Cellulitis** | **2.3** | Diabetes mellitus with cellulitis | 2 | 2 | 6.50 |
| | **Diabetes with Other Severe Complication** | **3.2** | Diabetes mellitus with ketoacidosis | 42 | 55 | 47.49 |
| | | **3.5** | Diabetes mellitus with septicemia | 1 | 1 | 119.00 |
| | | **3.6** | Diabetes mellitus with coma | 3 | 3 | 5.67 |
| | | **3.7** | Diabetes mellitus with hyperosmolar coma | 5 | 5 | 31.40 |
| **Zanesville Cluster Subtotal** | | | | **583** | **715** | **98.57** |
| **Unique Count Grand Total** | | | | **9,736** | **11,811** | **102.13** |

Data Source: OHP DSS
Date: September 22, 2003

# Disease Stages

## Adult ECM Eligibles with COPD

CY 2002

| County | Episode Group | High Disease Stage Code | High Disease Stage | Patients Epis | Episodes | Length Avg Epis |
|---|---|---|---|---|---|---|
| Cuyahoga | Chronic Obstructive Pulmonary Dis. | 1.1 | Chronic bronchitis | 279 | 283 | 24.14 |
| | | 1.2 | Acute exacerbation of chronic bronchitis | 4 | 4 | 3.50 |
| | | 2.1 | Chronic obstructive pulmonary disease, mild, or emphysematous | 766 | 832 | 67.65 |
| | | 2.2 | Chronic obstructive pulmonary disease, moderate | 3 | 3 | 62.00 |
| | | 3.1 | Chronic obstructive pulmonary disease and pulmonary hypertensi | 2 | 2 | 75.50 |
| | | 3.2 | Chronic obstructive pulmonary disease and cor pulmonale | 4 | 4 | 100.25 |
| | | 3.3 | Chronic obstructive pulmonary disease and acute respiratory failu | 16 | 16 | 131.81 |
| **Cuyahoga Subtotal** | | | | **1,062** | **1,144** | **57.67** |
| Franklin | Chronic Obstructive Pulmonary Dis. | 1.1 | Chronic bronchitis | 232 | 247 | 34.59 |
| | | 2.1 | Chronic obstructive pulmonary disease, mild, or emphysematous | 1,003 | 1,113 | 81.70 |
| | | 3.3 | Chronic obstructive pulmonary disease and acute respiratory failu | 20 | 20 | 140.95 |
| **Franklin Subtotal** | | | | **1,247** | **1,380** | **74.13** |
| Hamilton | Chronic Obstructive Pulmonary Dis. | 1.1 | Chronic bronchitis | 173 | 174 | 27.01 |
| | | 1.2 | Acute exacerbation of chronic bronchitis | 1 | 1 | 1.00 |
| | | 2.1 | Chronic obstructive pulmonary disease, mild, or emphysematous | 378 | 413 | 69.54 |
| | | 2.2 | Chronic obstructive pulmonary disease, moderate | 2 | 2 | 226.00 |
| | | 3.2 | Chronic obstructive pulmonary disease and cor pulmonale | 2 | 2 | 167.50 |
| | | 3.3 | Chronic obstructive pulmonary disease and acute respiratory failu | 9 | 9 | 134.67 |
| **Hamilton Subtotal** | | | | **555** | **601** | **58.94** |
| Lucas | Chronic Obstructive Pulmonary Dis. | 1.1 | Chronic bronchitis | 163 | 168 | 24.94 |
| | | 1.2 | Acute exacerbation of chronic bronchitis | 1 | 1 | 77.00 |
| | | 2.1 | Chronic obstructive pulmonary disease, mild, or emphysematous | 364 | 395 | 69.89 |
| | | 3.3 | Chronic obstructive pulmonary disease and acute respiratory failu | 12 | 12 | 136.92 |
| **Lucas Subtotal** | | | | **531** | **576** | **58.19** |

# Disease Stages

## Adult ECM Eligibles with COPD

**CY 2002**

| County | Episode Group | High Disease Stage Code | High Disease Stage | Patients Epis | Episodes | Length Avg Epis |
|---|---|---|---|---|---|---|
| **Montgomery** | **Chronic Obstructive Pulmonary Dis.** | **1.1** | Chronic bronchitis | 83 | 86 | 32.28 |
| | | **2.1** | Chronic obstructive pulmonary disease, mild, or emphysematous | 285 | 315 | 73.40 |
| | | **3.1** | Chronic obstructive pulmonary disease and pulmonary hypertensi | 1 | 2 | 187.50 |
| | | **3.3** | Chronic obstructive pulmonary disease and acute respiratory failu | 7 | 7 | 68.57 |
| **Montgomery Subtotal** | | | | **370** | **410** | **65.25** |
| **Stark** | **Chronic Obstructive Pulmonary Dis.** | **1.1** | Chronic bronchitis | 126 | 129 | 33.22 |
| | | **2.1** | Chronic obstructive pulmonary disease, mild, or emphysematous | 192 | 220 | 72.29 |
| | | **2.2** | Chronic obstructive pulmonary disease, moderate | 1 | 1 | 178.00 |
| | | **3.3** | Chronic obstructive pulmonary disease and acute respiratory failu | 5 | 5 | 96.40 |
| **Stark Subtotal** | | | | **319** | **355** | **58.73** |
| **Summit** | **Chronic Obstructive Pulmonary Dis.** | **1.1** | Chronic bronchitis | 84 | 87 | 26.17 |
| | | **1.2** | Acute exacerbation of chronic bronchitis | 1 | 1 | 1.00 |
| | | **2.1** | Chronic obstructive pulmonary disease, mild, or emphysematous | 263 | 285 | 76.12 |
| | | **3.1** | Chronic obstructive pulmonary disease and pulmonary hypertensi | 2 | 2 | 109.00 |
| | | **3.3** | Chronic obstructive pulmonary disease and acute respiratory failu | 9 | 9 | 79.78 |
| **Summit Subtotal** | | | | **354** | **384** | **64.86** |
| **Zanesville Cluster** | **Chronic Obstructive Pulmonary Dis.** | **1.1** | Chronic bronchitis | 94 | 96 | 22.69 |
| | | **2.1** | Chronic obstructive pulmonary disease, mild, or emphysematous | 299 | 337 | 75.83 |
| | | **2.2** | Chronic obstructive pulmonary disease, moderate | 1 | 1 | 84.00 |
| | | **3.1** | Chronic obstructive pulmonary disease and pulmonary hypertensi | 1 | 1 | 2.00 |
| | | **3.2** | Chronic obstructive pulmonary disease and cor pulmonale | 1 | 1 | 223.00 |
| | | **3.3** | Chronic obstructive pulmonary disease and acute respiratory failu | 9 | 9 | 131.78 |
| **Zanesville Cluster Subtotal** | | | | **401** | **445** | **65.68** |
| **Unique Count Grand Total** | | | | **4,838** | **5,295** | **64.01** |

Data Source: OHP DSS
Date: September 22, 2003

# Disease Stages

## Adult ECM Eligibles with Asthma

CY 2002

| County | Episode Group | High Disease Stage Code | High Disease Stage | Patients Epis | Episodes | Length Avg Epis |
|---|---|---|---|---|---|---|
| Cuyahoga | Asthma with Complication | 3.1 | Severe bronchial asthma or status asthmatic | 70 | 82 | 10.50 |
| | | 3.2 | Bronchial asthma with respiratory failure | 2 | 2 | 27.50 |
| | Asthma, Chronic Maintenance wo Active C | 1.1 | Asymptomatic bronchial asthma | 434 | 466 | 44.80 |
| | | 2.1 | Mild bronchial asthma | 100 | 105 | 74.92 |
| **Cuyahoga Subtotal** | | | | **548** | **655** | **45.28** |
| Franklin | Asthma with Complication | 3.1 | Severe bronchial asthma or status asthmatic | 13 | 15 | 18.40 |
| | Asthma, Chronic Maintenance wo Active C | 1.1 | Asymptomatic bronchial asthma | 280 | 304 | 56.25 |
| | | 2.1 | Mild bronchial asthma | 38 | 39 | 49.62 |
| **Franklin Subtotal** | | | | **318** | **358** | **53.94** |
| Hamilton | Asthma with Complication | 2.2 | Moderate bronchial asthma | 1 | 1 | 2.00 |
| | | 3.1 | Severe bronchial asthma or status asthmatic | 27 | 29 | 7.45 |
| | | 3.2 | Bronchial asthma with respiratory failure | 3 | 3 | 4.67 |
| | Asthma, Chronic Maintenance wo Active C | 1.1 | Asymptomatic bronchial asthma | 229 | 248 | 47.09 |
| | | 2.1 | Mild bronchial asthma | 69 | 71 | 53.03 |
| **Hamilton Subtotal** | | | | **300** | **352** | **44.53** |
| Lucas | Asthma with Complication | 3.1 | Severe bronchial asthma or status asthmatic | 13 | 15 | 15.53 |
| | Asthma, Chronic Maintenance wo Active C | 1.1 | Asymptomatic bronchial asthma | 163 | 175 | 47.17 |
| | | 2.1 | Mild bronchial asthma | 35 | 36 | 58.67 |
| **Lucas Subtotal** | | | | **196** | **226** | **46.90** |

# Disease Stages

## Adult ECM Eligibles with Asthma

**CY 2002**

| County | Episode Group | High Disease Stage Code | High Disease Stage | Patients Epis | Episodes | Length Avg Epis |
|---|---|---|---|---|---|---|
| **Montgomery** | **Asthma with Complication** | **3.1** | Severe bronchial asthma or status asthmatic | 21 | 24 | 6.25 |
| | | **3.2** | Bronchial asthma with respiratory failure | 1 | 1 | 36.00 |
| | **Asthma, Chronic Maintenance wo Active C** | **1.1** | Asymptomatic bronchial asthma | 165 | 183 | 51.11 |
| | | **2.1** | Mild bronchial asthma | 49 | 50 | 50.06 |
| **Montgomery Subtotal** | | | | **219** | **258** | **46.68** |
| **Stark** | **Asthma with Complication** | **3.1** | Severe bronchial asthma or status asthmatic | 2 | 2 | 1.00 |
| | **Asthma, Chronic Maintenance wo Active C** | **1.1** | Asymptomatic bronchial asthma | 49 | 49 | 37.04 |
| | | **2.1** | Mild bronchial asthma | 20 | 21 | 55.38 |
| **Stark Subtotal** | | | | **69** | **72** | **41.39** |
| **Summit** | **Asthma with Complication** | **3.1** | Severe bronchial asthma or status asthmatic | 7 | 8 | 1.00 |
| | | **3.2** | Bronchial asthma with respiratory failure | 2 | 2 | 19.50 |
| | **Asthma, Chronic Maintenance wo Active C** | **1.1** | Asymptomatic bronchial asthma | 113 | 125 | 36.10 |
| | | **2.1** | Mild bronchial asthma | 36 | 41 | 60.10 |
| **Summit Subtotal** | | | | **150** | **176** | **39.90** |
| **Zanesville Cluster** | **Asthma with Complication** | **3.1** | Severe bronchial asthma or status asthmatic | 1 | 1 | 1.00 |
| | | **3.2** | Bronchial asthma with respiratory failure | 1 | 1 | 4.00 |
| | **Asthma, Chronic Maintenance wo Active C** | **1.1** | Asymptomatic bronchial asthma | 75 | 82 | 49.89 |
| | | **2.1** | Mild bronchial asthma | 15 | 16 | 30.13 |
| **Zanesville Cluster Subtotal** | | | | **92** | **100** | **45.78** |
| **Unique Count Grand Total** | | | | **1,892** | **2,197** | **46.37** |

Data Source: OHP DSS
Date: September 22, 2003

# Disease Stages

**Child ECM Eligibles with Asthma**

**CY 2002**

| County | Episode Group | High Disease Stage Code | High Disease Stage | Patients Epis | Episodes | Length Avg Epis |
|---|---|---|---|---|---|---|
| **Cuyahoga** | **Asthma with Complication** | **3.1** | Severe bronchial asthma or status asthmaticu | 77 | 87 | 8.43 |
| | | **3.2** | Bronchial asthma with respiratory failure | 2 | 2 | 1.50 |
| | **Asthma, Chronic Maintenance wo Active Co** | **1.1** | Asymptomatic bronchial asthma | 422 | 458 | 43.91 |
| | | **2.1** | Mild bronchial asthma | 66 | 71 | 61.56 |
| **Cuyahoga Subtotal** | | | | **504** | **618** | **40.80** |
| **Franklin** | **Asthma with Complication** | **3.1** | Severe bronchial asthma or status asthmaticu | 73 | 99 | 5.73 |
| | **Asthma, Chronic Maintenance wo Active Co** | **1.1** | Asymptomatic bronchial asthma | 221 | 238 | 53.22 |
| | | **2.1** | Mild bronchial asthma | 81 | 86 | 82.62 |
| **Franklin Subtotal** | | | | **304** | **423** | **48.08** |
| **Hamilton** | **Asthma with Complication** | **3.1** | Severe bronchial asthma or status asthmaticu | 32 | 41 | 12.51 |
| | | **3.2** | Bronchial asthma with respiratory failure | 1 | 1 | 65.00 |
| | **Asthma, Chronic Maintenance wo Active Co** | **1.1** | Asymptomatic bronchial asthma | 168 | 179 | 30.64 |
| | | **2.1** | Mild bronchial asthma | 69 | 74 | 57.97 |
| **Hamilton Subtotal** | | | | **241** | **295** | **35.09** |
| **Lucas** | **Asthma with Complication** | **3.1** | Severe bronchial asthma or status asthmaticu | 34 | 46 | 4.02 |
| | | **3.2** | Bronchial asthma with respiratory failure | 2 | 2 | 3.50 |
| | **Asthma, Chronic Maintenance wo Active Co** | **1.1** | Asymptomatic bronchial asthma | 216 | 242 | 46.99 |
| | | **2.1** | Mild bronchial asthma | 31 | 35 | 70.26 |
| **Lucas Subtotal** | | | | **246** | **325** | **43.14** |
| **Montgomery** | **Asthma with Complication** | **3.1** | Severe bronchial asthma or status asthmaticu | 46 | 58 | 5.86 |
| | **Asthma, Chronic Maintenance wo Active Co** | **1.1** | Asymptomatic bronchial asthma | 84 | 89 | 52.65 |
| | | **2.1** | Mild bronchial asthma | 45 | 48 | 55.44 |
| **Montgomery Subtotal** | | | | **138** | **195** | **39.42** |
| **Stark** | **Asthma with Complication** | **3.1** | Severe bronchial asthma or status asthmaticu | 4 | 4 | 2.00 |
| | **Asthma, Chronic Maintenance wo Active Co** | **1.1** | Asymptomatic bronchial asthma | 27 | 29 | 44.69 |
| | | **2.1** | Mild bronchial asthma | 3 | 3 | 147.00 |
| **Stark Subtotal** | | | | **31** | **36** | **48.47** |
| **Summit** | **Asthma with Complication** | **3.1** | Severe bronchial asthma or status asthmaticu | 22 | 29 | 1.72 |
| | **Asthma, Chronic Maintenance wo Active Co** | **1.1** | Asymptomatic bronchial asthma | 75 | 80 | 33.86 |
| | | **2.1** | Mild bronchial asthma | 31 | 33 | 75.39 |
| **Summit Subtotal** | | | | **112** | **142** | **36.95** |
| **Zanesville Cluster** | **Asthma with Complication** | **3.1** | Severe bronchial asthma or status asthmaticu | 3 | 6 | 11.33 |
| | **Asthma, Chronic Maintenance wo Active Co** | **1.1** | Asymptomatic bronchial asthma | 23 | 23 | 59.17 |
| | | **2.1** | Mild bronchial asthma | 2 | 2 | 94.00 |
| **Zanesville Cluster Subtotal** | | | | **25** | **31** | **52.16** |
| **Unique Count Grand Total** | | | | **1,601** | **2,065** | **41.76** |

Data Source: OHP DSS
Date: September 22, 2003

# 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)
  - Diabetes
  - Chronic Obstructive Pulmonary Disease (COPD)
  - 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.

## APPENDIX D

## ABD Community Per Member Per Month Costs

This appendix contains the *ABD Community Per Member Per Month Costs Report.* This report includes the amount paid to providers, the member months for state fiscal year 2002, and per member per month calculation for the report period. It is grouped by county and category of service. This report covers the ABD population with the following exclusions: waiver, institutionalized, and dually eligibles. No other exclusions, such as those listed under the Clinical Criteria in Appendix C, *ECM Eligible Identification Process*, were made for this report.

# ABD Community Per Member Per Month Costs

(This report excludes waiver, institutionalized, and dually eligibles)

SFY 2002

| COUNTY | *CATEGORY OF SERVICE | ABD COMMUNITY POPULATION | | | | |
|---|---|---|---|---|---|---|
| | | | PAID | Member Month | | PMPM |
| CUYAHOGA | DENTAL SERVICES | $ | 2,687,744.68 | 314,031 | $ | 8.56 |
| CUYAHOGA | FED QUALIFIED HEALTH CENTER | $ | 944,387.22 | 314,031 | $ | 3.01 |
| CUYAHOGA | HOME HEALTH SERVICES | $ | 5,182,707.89 | 314,031 | $ | 16.50 |
| CUYAHOGA | HOSPICE SERVICES | $ | 2,443,664.78 | 314,031 | $ | 7.78 |
| CUYAHOGA | INPATIENT HOSPITAL | $ | 89,849,835.67 | 314,031 | $ | 286.12 |
| CUYAHOGA | MENTAL HEALTH SERVICES | $ | 29,072,438.14 | 314,031 | $ | 92.58 |
| CUYAHOGA | NURSING FACILITIES | $ | 950,900.68 | 314,031 | $ | 3.03 |
| CUYAHOGA | OUTPATIENT HOSPITAL | $ | 26,852,269.94 | 314,031 | $ | 85.51 |
| CUYAHOGA | PHYSICIAN SERVICES | $ | 26,030,592.08 | 314,031 | $ | 82.89 |
| CUYAHOGA | PRESCRIBED DRUGS | $ | 53,681,514.06 | 314,031 | $ | 170.94 |
| CUYAHOGA | SUPPLIES AND MEDICAL EQUIP | $ | 6,068,975.38 | 314,031 | $ | 19.33 |
| CUYAHOGA | ALL OTHERS | $ | 8,488,864.26 | 314,031 | $ | 27.03 |
| **SUM** | | **$** | **252,253,894.78** | 314,031 | **$** | **803.28** |
| | | | | | | |
| FRANKLIN | DENTAL SERVICES | $ | 1,909,860.86 | 184,519 | $ | 10.35 |
| FRANKLIN | FED QUALIFIED HEALTH CENTER | $ | 277,870.53 | 184,519 | $ | 1.51 |
| FRANKLIN | HOME HEALTH SERVICES | $ | 12,285,810.62 | 184,519 | $ | 66.58 |
| FRANKLIN | HOSPICE SERVICES | $ | 1,217,454.44 | 184,519 | $ | 6.60 |
| FRANKLIN | INPATIENT HOSPITAL | $ | 43,676,879.40 | 184,519 | $ | 236.71 |
| FRANKLIN | MENTAL HEALTH SERVICES | $ | 18,990,206.67 | 184,519 | $ | 102.92 |
| FRANKLIN | NURSING FACILITIES | $ | 507,885.83 | 184,519 | $ | 2.75 |
| FRANKLIN | OUTPATIENT HOSPITAL | $ | 15,054,913.32 | 184,519 | $ | 81.59 |
| FRANKLIN | PHYSICIAN SERVICES | $ | 17,383,951.81 | 184,519 | $ | 94.21 |
| FRANKLIN | PRESCRIBED DRUGS | $ | 44,071,359.69 | 184,519 | $ | 238.84 |
| FRANKLIN | SUPPLIES AND MEDICAL EQUIP | $ | 3,959,726.73 | 184,519 | $ | 21.46 |
| FRANKLIN | ALL OTHER | $ | 4,374,140.67 | 184,519 | $ | 23.71 |
| **SUM** | | **$** | **163,710,060.57** | 184,519 | **$** | **887.23** |

| COUNTY | *CATEGORY OF SERVICE | ABD COMMUNITY POPULATION PAID | Member Month | PMPM |
|---|---|---|---|---|
| HAMILTON | DENTAL SERVICES | $ 1,120,222.94 | 156,010 | $ 7.18 |
| HAMILTON | FED QUALIFIED HEALTH CENTER | $ 658,854.58 | 156,010 | $ 4.22 |
| HAMILTON | HOME HEALTH SERVICES | $ 1,625,381.46 | 156,010 | $ 10.42 |
| HAMILTON | HOSPICE SERVICES | $ 1,988,458.54 | 156,010 | $ 12.75 |
| HAMILTON | INPATIENT HOSPITAL | $ 49,965,148.12 | 156,010 | $ 320.27 |
| HAMILTON | MENTAL HEALTH SERVICES | $ 15,759,229.49 | 156,010 | $ 101.01 |
| HAMILTON | NURSING FACILITIES | $ 579,439.77 | 156,010 | $ 3.71 |
| HAMILTON | OUTPATIENT HOSPITAL | $ 14,704,139.40 | 156,010 | $ 94.25 |
| HAMILTON | PHYSICIAN SERVICES | $ 11,811,488.31 | 156,010 | $ 75.71 |
| HAMILTON | PRESCRIBED DRUGS | $ 29,587,779.55 | 156,010 | $ 189.65 |
| HAMILTON | SUPPLIES AND MEDICAL EQUIP | $ 2,699,516.62 | 156,010 | $ 17.30 |
| HAMILTON | ALL OTHERS | $ 3,481,748.89 | 156,010 | $ 22.32 |
| **SUM** | | **$ 133,981,407.67** | 156,010 | **$ 858.80** |
| | | | | |
| LUCAS | DENTAL SERVICES | $ 694,396.30 | 114,598 | $ 6.06 |
| LUCAS | FED QUALIFIED HEALTH CENTER | $ 180,189.56 | 114,598 | $ 1.57 |
| LUCAS | HOME HEALTH SERVICES | $ 876,291.55 | 114,598 | $ 7.65 |
| LUCAS | HOSPICE SERVICES | $ 708,250.26 | 114,598 | $ 6.18 |
| LUCAS | INPATIENT HOSPITAL | $ 29,207,811.94 | 114,598 | $ 254.87 |
| LUCAS | MENTAL HEALTH SERVICES | $ 10,410,726.95 | 114,598 | $ 90.85 |
| LUCAS | NURSING FACILITIES | $ 411,810.66 | 114,598 | $ 3.59 |
| LUCAS | OUTPATIENT HOSPITAL | $ 9,745,909.57 | 114,598 | $ 85.04 |
| LUCAS | PHYSICIAN SERVICES | $ 8,711,125.35 | 114,598 | $ 76.01 |
| LUCAS | PRESCRIBED DRUGS | $ 20,182,943.30 | 114,598 | $ 176.12 |
| LUCAS | SUPPLIES AND MEDICAL EQUIP | $ 1,515,908.82 | 114,598 | $ 13.23 |
| LUCAS | ALL OTHERS | $ 2,496,786.29 | 114,598 | $ 21.79 |
| **SUM** | | **$ 85,142,150.55** | 114,598 | **$ 742.96** |
| | | | | |
| STARK | DENTAL SERVICES | $ 474,806.32 | 53,964 | $ 8.80 |
| STARK | FED QUALIFIED HEALTH CENTER | $ 856.54 | 53,964 | $ 0.02 |
| STARK | HOME HEALTH SERVICES | $ 909,807.43 | 53,964 | $ 16.86 |
| STARK | HOSPICE SERVICES | $ 153,231.25 | 53,964 | $ 2.84 |
| STARK | INPATIENT HOSPITAL | $ 10,764,430.85 | 53,964 | $ 199.47 |
| STARK | MENTAL HEALTH SERVICES | $ 6,377,425.12 | 53,964 | $ 118.18 |
| STARK | NURSING FACILITIES | $ 69,033.08 | 53,964 | $ 1.28 |
| STARK | OUTPATIENT HOSPITAL | $ 5,219,875.65 | 53,964 | $ 96.73 |
| STARK | PHYSICIAN SERVICES | $ 5,411,373.85 | 53,964 | $ 100.28 |
| STARK | PRESCRIBED DRUGS | $ 12,125,609.84 | 53,964 | $ 224.70 |
| STARK | SUPPLIES AND MEDICAL EQUIP | $ 952,786.15 | 53,964 | $ 17.66 |
| STARK | ALL OTHERS | $ 1,010,035.52 | 53,964 | $ 18.72 |
| **SUM** | | **$ 43,469,271.60** | 53,964 | **$ 805.52** |

| COUNTY | *CATEGORY OF SERVICE | ABD COMMUNITY POPULATION | | | | |
|---|---|---|---|---|---|---|
| | | | PAID | Member Month | | PMPM |
| SUMMIT | DENTAL SERVICES | $ | 959,216.88 | 93,441 | $ | 10.27 |
| SUMMIT | FED QUALIFIED HEALTH CENTER | $ | 63,751.22 | 93,441 | $ | 0.68 |
| SUMMIT | HOME HEALTH SERVICES | $ | 1,887,806.45 | 93,441 | $ | 20.20 |
| SUMMIT | HOSPICE SERVICES | $ | 449,176.56 | 93,441 | $ | 4.81 |
| SUMMIT | INPATIENT HOSPITAL | $ | 25,707,212.12 | 93,441 | $ | 275.12 |
| SUMMIT | MENTAL HEALTH SERVICES | $ | 11,553,978.35 | 93,441 | $ | 123.65 |
| SUMMIT | NURSING FACILITIES | $ | 131,693.70 | 93,441 | $ | 1.41 |
| SUMMIT | OUTPATIENT HOSPITAL | $ | 8,370,018.26 | 93,441 | $ | 89.58 |
| SUMMIT | PHYSICIAN SERVICES | $ | 7,165,159.82 | 93,441 | $ | 76.68 |
| SUMMIT | PRESCRIBED DRUGS | $ | 20,591,941.97 | 93,441 | $ | 220.37 |
| SUMMIT | SUPPLIES AND MEDICAL EQUIP | $ | 1,755,022.98 | 93,441 | $ | 18.78 |
| SUMMIT | ALL OTHERS | $ | 1,233,633.94 | 93,441 | $ | 13.20 |
| **SUM** | | **$** | **79,868,612.25** | 93,441 | **$** | **854.75** |

**ZANEVILLE SERVICE AREA** - (Includes Muskingum, Coshocton, Guernsey, Morgan, Noble and Perry Counties)

| COUNTY | *CATEGORY OF SERVICE | | PAID | Member Month | | PMPM |
|---|---|---|---|---|---|---|
| ZANEVILLE | DENTAL SERVICES | $ | 563,153.64 | 55,286 | $ | 10.19 |
| ZANEVILLE | FED QUALIFIED HEALTH CENTER | $ | 41,281.49 | 55,286 | $ | 0.75 |
| ZANEVILLE | HOME HEALTH SERVICES | $ | 721,818.06 | 55,286 | $ | 13.06 |
| ZANEVILLE | HOSPICE SERVICES | $ | 183,897.33 | 55,286 | $ | 3.33 |
| ZANEVILLE | INPATIENT HOSPITAL | $ | 10,725,868.71 | 55,286 | $ | 194.01 |
| ZANEVILLE | MENTAL HEALTH SERVICES | $ | 3,448,268.37 | 55,286 | $ | 62.37 |
| ZANEVILLE | NURSING FACILITIES | $ | 28,192.68 | 55,286 | $ | 0.51 |
| ZANEVILLE | OUTPATIENT HOSPITAL | $ | 4,468,479.81 | 55,286 | $ | 80.82 |
| ZANEVILLE | PHYSICIAN SERVICES | $ | 4,638,856.60 | 55,286 | $ | 83.91 |
| ZANEVILLE | PRESCRIBED DRUGS | $ | 13,038,158.13 | 55,286 | $ | 235.83 |
| ZANEVILLE | SUPPLIES AND MEDICAL EQUIP | $ | 1,079,270.53 | 55,286 | $ | 19.52 |
| ZANEVILLE | ALL OTHERS | $ | 1,513,784.78 | 55,286 | $ | 27.38 |
| **SUM** | | **$** | **40,451,030.13** | 55,286 | **$** | **731.67** |

*The following categories of service were summarized:
**Nursing Facilities** = SNF + ICF/MR
**Physician Services** = Physician Services + Clinic Services
**Mental Health Services** = Mental Health Services + Mental Retard Services + Ohio Dept. Alc & Drug Addiction
**All Others** = Mental Inpatient Hospital + Advanced Practice Nurse Svcs + Physiological Lab Svcs + Independent Lab Svcs +
Family Planning Services + Rual Health Services + Eyeglasses + Home Care Facilitator Svcs + Ambulance Services + Ambulette Services
Ambulatory Surgical Svcs + Optometric Services + Psychological Services + Private Duty Nursing + CRNA or Ansthesiology Ass. Svcs +
Physical Therapy Services + Speech Therapy Services + Podiatry Services + Chiropractic Services + Nursing Home Therapies +
Maternal Global Fee + MH Support Services

Data Source: Ohio Medicaid MMIS files
Date: September 25, 2003

# APPENDIX E

## Draft ECM – PCP Model Contract

This contract establishes the relationship between **(ECM Provider Name)** and **(PCP Name)** effective **(Date)** and running concurrently with the term of the provider agreement between **(ECM Provider Name)** and the Ohio Department of Job and Family Services. This contract is limited to the terms and conditions governing the provision of certain services provided to Aged, Blind, or Disabled (ABD) Medicaid members under the Ohio Medicaid Enhanced Care Management program.

**CONTRACT DEFINITIONS**
The following defines key terms in this Contract:

**"Case Management"** means activities performed on behalf of ECM members to coordinate and monitor treatment.

**"Consumer"** means a qualified Ohio Medicaid enrollee.

**"ECM Provider"** means an organization, either a single entity or the representative of a collaborative of organizations, which has applied and been found qualified to enter a provider agreement with ODJFS to provide and perform enhanced care management services.

**"ECM Eligible"** means a consumer who qualifies to participate in the ECM program based on population status, condition, and county of residence.

**"ECM Member"** means an ECM eligible who is enrolled in the ECM program.

**"PCP (Primary Care Provider)"** means an individual physician (M.D. or D.O. and including specialists appropriate to the ECM Member's condition) or group medical practice who agrees to serve as the ECM Member's primary source of care and to the terms of this contract.

**"Medicaid"** means medical assistance provided under a state plan approved under Title XIX of the Social Security Act.

**"Aged, Blind, or Disabled"** means financially qualifying Ohioans who are 65 or older, blind, or have a disability. The ABD category encompasses people, including children, with a wide variety of physical and mental disabilities.

**"OAC"** means the Ohio Administrative Code.

**"ODJFS"** means the Ohio Department of Job and Family Services.

# CONTRACT PROVISIONS

## GENERAL:

The PCP agrees to abide by all of the following specific terms:

1. PCP will serve as the ongoing source of primary care for identified ECM Members.

2. PCP will participate, along with other health care professionals, in the timely development, monitoring, and updating of appropriate and targeted care treatment plans for each identified ECM member.

3. PCP will educate identified ECM members about their condition(s) and encourage treatment plan compliance and self-management.

4. PCP will assist with coordination of the member's overall care, including notifying the ECM of any prior authorization requests or other service arrangements.

5. PCP will utilize and follow evidenced-based clinical practices as appropriate.

6. PCP will comply with the provisions for record keeping and auditing in accordance with Chapter 5101:3-26 of the Ohio Administrative Code.

7. PCP will not to discriminate in the delivery of services based on the ECM member's race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

8. PCP will hold harmless both ODJFS and the ECM member in the event that the ECM Provider cannot or will not pay for services covered under this contract.

9. PCP will be duly licensed or certified under applicable state and federal statutes and regulations to provide the services that are subject of this Contract.

10. PCP agrees that the services covered by under this Contract are governed by and shall be construed in accordance will all laws, regulations, and contractual obligations of the ECM Provider.

    (A) ODJFS will notify the ECM Provider and the ECM Provider shall notify the PCP of any changes in applicable

state or federal law, regulations, waiver, or contractual obligations of the ECM Provider.

(B) This Contract shall be automatically amended to conform to such changes without the necessity for executing written amendments.

11. *ECM Provider to insert terms of the contract relating to the beginning date and expiration date or automatic renewal clause, as well as the methods of extension, renegotiating and termination of this contract.*

12. Notwithstanding Item 11 of this Contract, the ECM Provider must give the ECM PCP at least 60 days prior notice for the nonrenewal or termination of this contract except in case where an adverse finding by a regulatory agency or quality of care concern dictate that the Contract be terminated sooner. If the ECM Provider issues a notice to renew or terminate this Contract due to an adverse finding by a regulatory agency or quality of care concern, the ECM Provider must notify ODJFS within one working day of issuing the notice.

13. Notwithstanding Item 12 of this Contract, the PCP may nonrenew or terminate the Contract if:

A. The PCP gives the ECM Provider at least 60 days prior notice for the nonrenewal or termination of this contract and the effective date for the nonrenewal or termination must be the last day of the month; or

B. ODJFS has proposed to terminate, non-renew, or amend the ECM-ODJFS provider agreement action, regardless of whether the action is appealed, or if quality of care concern dictates that the agreement be terminated sooner than sixty days, the PCP's nonrenewal or termination notice must be received by the ECM Provider within fifteen working days prior to the end of the month in which the ECM PCP is proposing nonrenewal or termination. If the notice is not received by this date, the PCP must extend the nonrenewal or termination date to the last day of the subsequent month.

14. PCP agrees to serve members through the last day the contract is in effect.

15. ECM Provider agrees not to prohibit, or otherwise restrict a PCP acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

(A) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

(B) Any information the member needs in order to decide among all relevant treatment options.

(C) The risks, benefits, and consequences of treatment versus non-treatment.

(D) The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

16. PCP agrees in providing services to members to identify and where indicated arrange for the following at no cost to the member:

    (A) Sign language services;

    (B) Oral interpretation services.

17. PCP agrees not to identify the addressee as a Medicaid member on the outside of the envelop when contacting members by mail.

18. PCP agrees not to bill members for missed appointments.

19. PCP shall not discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services by reason of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry in the performance of this Contract or in the hiring any employees for the performance of services under this Contract.

20. PCP shall not in any manner discriminate against, intimidate, or retaliate against any employee hired for the performance of services under this Contract on account of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry.

21. PCP will make ECM member medical records available for transfer to a new provider at no cost to the member.

22. PCP will cooperate with the ECM Provider's quality assurance and performance improvement program.

23. PCP will cooperates with the ODJFS external quality review identified in rule 5101:3-26-07 of the OAC, as it pertains to the ECM program.

24. PCP will allow ODJFS or its designee and the ECM Provider access to all ECM member medical records for a period of not less than six years from the date of service and allow access to all record-keeping, audits, financial records, and medical records to ODJFS or its designee or other entities as specified in paragraph (B) of rule 5101:3-26-06 of the OAC.

25. PCP agrees to be bound by the same standards of confidentiality which apply to ODJFS and the state of Ohio as described in rule 5101:1-1-03 of the Administrative Code, including unauthorized use of or disclosure of personal health information.

**REIMBURSEMENT:**

***(ECM Provider Name)*** *will reimburse* ***(PCP Name)*** *for identified ECM members at the monthly rate of $ __ for each ECM member the physician serves as PCP. In addition, the* ***(ECM Provider Name)*** *shall reimburse* ***(PCP Name)*** *based on performance pursuant to the method and in the amounts specified in* ***Appendix ___*** *of this Contract.*

IN WITNESS WHEREOF, the parties hereto have executed this Contract this **_____** day of **________**, **____**.

**(ECM Provider Name)**

___________________________
By

___________________________
Printed Name

___________________________
Title

___________________________
Date

**(ECM PCP Name)**

______________________________
By

______________________________
Printed Name

______________________________
Title

______________________________
Date

## APPENDIX F

## ODJFS Reporting Requirements Summary

- Case Management/Screening, Assessment, and Case Management File (SACMS) (Monthly)

- ECM Call Center Reports (Monthly)
  - 24/7 nurse line reporting
  - Response times, live voice

- Members' Designated Primary Care Physician File

- Financial Cost Reports
  - Premium Allocation
  - PCP Coordination and Performance Payments

- BMHC reserves the right to request other reports or information as necessary

# Appendix G

## Summary of Readiness Review Submissions

ODJFS will conduct a comprehensive readiness review prior to program implementation to ensure that selected ECM applicants are prepared to meet all program requirements. The first step of the readiness review will be a meeting between the applicant and ODJFS to review a time line and discuss all necessary submissions to document readiness for program implementation. As a follow-up to the meeting, ODJFS will provide the prospective ECM providers with a letter further outlining the pre-contracting requirements and the projected timetable required for the ECM to receive a provider agreement. Certain requirements will be documented through the use of a "readiness review tool" which the ECM applicant will complete and submit to ODJFS for review. (Samples of these tools may be found in the web-based Applicant Library.) Prior to program implementation, ODJFS or its designee may also conduct a site visit to confirm that all necessary components are in place.

The following list identifies program provisions for which each selected ECM applicant must submit specific policies, procedures, or other information demonstrating to ODJFS the ECM's readiness to serve members. This list is subject to change as a result of further state and federal review and the determination by ODJFS that all program requirements have been satisfied.

- Outreach: Specify how (e.g. phone, mail, visits) the ECM will conduct and assess outreach to assure that ECM members are contacted within established time frames.

- Assessment: Describe how the ECM will complete assessments and assure timeliness. A copy of the assessment tool to be used must be submitted for ODJFS approval and must be consistent with ODJFS assessment tool specifications.

- Care plans: Describe how the ECM will develop treatment plans within established time frames. How will the case management team be formed? What will be the criteria to determine the team's members? How will the member and the member's caregivers be included? How will the information be shared with all providers and maintained by the ECM? What will be the process for assessing and updating each plan?

- Staffing: Identify the types and number of staff dedicated to each of the following activities: outreach, assessment, and care management. The types must be in accordance with ODJFS specifications and the numbers provided as ratios of staff per member.

- PCP provisions:
    - Describe how the ECM will inform each PCP in a timely way of new members who the PCP will be serving and will notify the PCP of any changes in the membership status of current members.

    - Describe the ECM's process for identifying, educating, and enrolling PCPs into the program.

- Describe how the ECM will educate and equip PCPs with evidenced-based clinical practice guidelines, patient data, and best practice information? Specify both group and individual approaches.

- The ECM must submit to ODJFS for review and approval a copy of the PCP-ECM subcontract it will use, including the specification of PCP reimbursement and incentive information. The ECM must also submit copies of fully executed agreements to ODJFS.

- Care management:
  - Describe the ECM's utilization management approaches to minimize inappropriate use of the emergency department, inpatient services, and specialists.

  - Describe how the ECM will use information provided by ODJFS to coordinate any provider precertification and prior authorization requests submitted to ODJFS for the ECM member. What other strategies will the ECM use to identify these requests before submission to ODJFS?

  - Specify how the ECM will identify and manage a member's comorbidities, as well as any behavioral health and/or community support needs.

  - Describe how the ECM will establish and maintain relationships with non-ECM providers and/or community agencies to better coordinate all services and programs the ECM member is or may be accessing.

- Member Services:

  - The ECM must submit the contract or agreement to provide the 24/7 health advice line, which must be in accordance with ODJFS specifications, to ODJFS for approval. The ECM must be prepared and agree to meet the American Accreditation HealthCare Commission/URAC-designed Health Call Center Standards (HCC) for call center abandonment rate, blockage rate, and average speed of answer.

  - The ECM must prepare and submit to ODJFS for approval a provider directory for distribution to potential members upon request and to all new members upon ECM membership.

  - The ECM must prepare and submit to ODJFS for approval a member handbook for distribution to all new members which explains available ECM services and processes, how to contact the ECM with questions or problems, and other information including but not limited to the availability of the health advice line, the ECM's member complaint resolution process, how to select or change a PCP, and how to access other providers.

- The ECM must describe and be prepared to submit to ODJFS any general information to be used to educate ECM members about their medical condition (for example, disease-specific brochures that the ECM did not develop but will be using).

- Describe how the ECM will encourage and support a member's compliance with the course of treatment. Will the approach vary by condition or other circumstances? How will effectiveness be assessed and adjustments made?

- Describe the ECM's mechanisms for assuring or providing interpreter services needed by hearing-impaired or limited English proficient (LEP) members.

- Describe the ECM's process, which must comply with ODJFS specifications, for accepting, resolving, and tracking member complaints. The ECM must be prepared to participate, if necessary, in the state hearing process and the ODJFS member complaint process.

- Management Information Systems: The ECM will be expected to identify and submit any contracts related to the responsibility for all aspects of data management. This includes: analysis of claims data; provider profiling; operation and oversight of the care management program; and integration of ECM member demographic information, provider performance, claims, and utilization data. The ODJFS or its designee may conduct an on-site review to assure all systems components are in place

  - The ECM will be required to submit test data files to ODJFS in order to demonstrate the ECM's ability to successfully meet the case management and PCP-member reporting requirements. Other test files may be required as applicable.