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### Negotiating the New Health System at Ten: *Medicaid Managed Care and the Use of Disease Management Purchasing*

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# Negotiating the New Health System at Ten: *Medicaid Managed Care and the Use of Disease Management Purchasing*

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## **About the Center for Health Care Strategies**

The Center for Health Care Strategies (CHCS) is a nonprofit organization dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve people with chronic and costly health care needs. Its program priorities are: advancing health care quality and cost effectiveness, reducing racial and ethnic disparities, and integrating care for people with complex and special needs.

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## Introduction

In 1997, The George Washington University School of Public Health and Health Services published *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*.<sup>1</sup> This study, which presented the first national, detailed examination of state Medicaid managed care contract documents, offered insight into how state purchasing practices help shape health care access, quality, and accountability for Medicaid managed care enrollees.

Supported by both governmental and private funders,<sup>2</sup> the *Negotiating* project consisted of four rounds of analysis, with the final collection round undertaken during the 2001-2002 time period. In addition, the project led to the development of numerous online sample purchasing specifications that address specialized conditions, services, administrative functions, and population health needs.<sup>3</sup>

The *Negotiating* project had several purposes. The first was to bring greater transparency to the structure and design of Medicaid-supported health care delivery systems that effectively are built through the managed care contracting process. Understanding these systems is critical, because the high level of poverty that characterizes Medicaid beneficiaries means that they are heavily dependent on the health care that their benefits can secure for them. Managed care purchasing contracts offer one important means of understanding these systems of care and how they are expected to operate.

A second study purpose was to create a tool by which state Medicaid agencies, public health agencies, providers, consumers, and health plans could secure detailed information regarding various contracting approaches in key topical areas, such as eligibility and enrollment; benefits and coverage design; networks and health care access standards; quality performance and measurement; the interaction between general and specialty managed care arrangements, as well as between managed care and other health and health-related services; consumer protections; and data and information exchange.

A third purpose was to foster greater understanding of what arguably has been the single most important structural change in Medicaid's operational structure since the program's 1965 enactment: Medicaid's transformation from a passive, public provider claims payment mechanism into an active health care purchaser. Although this movement toward prospective,

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<sup>1</sup> S. Rosenbaum, et. al. "Negotiating the New Health Care System: A Nationwide Study of Medicaid Managed Care Contracts" (The George Washington University, Washington D.C.) Available at [http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/managedcare\\_publications.cfm](http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/managedcare_publications.cfm) (Accessed December 24, 2007).

<sup>2</sup> Funders over the years included The Pew Charitable Trusts, The Henry J. Kaiser Family Foundation, The David and Lucile Packard Center on the Future of Children, The Robert Wood Johnson Foundation, The Commonwealth Fund, The Health Resources and Services Administration, The Health Care Financing Administration, The Centers for Disease Control and Prevention, and The Substance Abuse and Mental Health Services Administration.

<sup>3</sup> Twenty-four separate sets of purchasing specifications can be viewed at [http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/managedcare\\_publications.cfm](http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/managedcare_publications.cfm) (Accessed December 24, 2007).

highly organized health care purchasing has swept both public and private insurers alike over the past generation, the reinvention of the relationship between health care financing and health care itself carries especially great meaning perhaps in the case of Medicaid given the greater health care risks faced by enrollees and their heightened dependence on third party financing for virtually all of their health care needs.

The health of the Medicaid population makes managed care purchasing especially challenging for buyers and sellers alike. Medicaid eligibility status is associated with poverty and heightened health risks, particularly because unlike other forms of insurance, Medicaid is available to children and adults in poor health, and enrollment is available at the point of need.<sup>4</sup> Medicaid's orientation thus is to a population at risk for health disparities,<sup>5</sup> and many of these health risks manifest themselves in early childhood, persist throughout the child development period and into young adulthood, and ultimately lead to the types of chronic and disabling conditions that are disproportionately associated with older low income adults, such as diabetes, cardiovascular disease, and behavioral disorders.<sup>6</sup> Even among a non-disabled population, the health disparities found within lower income persons manifest themselves in the form of higher rates of infant mortality and low birthweight, asthma, cardiovascular disease, diabetes, depression, HIV/AIDS, and certain forms of cancer.<sup>7</sup>

In sum, managing the health of patients with elevated risks becomes a central goal of Medicaid managed care purchasing and the complex contractual documents that frame these systems and practices offer important insight into the expectations of purchasers and sellers alike. Furthermore, the findings presented in *Negotiating* have underscored the degree of sophistication that Medicaid programs bring to health care purchasing. Of particular interest has been Medicaid's focus on the purchase of disease management services offering not only coverage but skilled professionals and institutions that are accessible to medically underserved communities, along with the patient supports necessary to the appropriate treatment of both physical and behavioral health conditions.

A final purpose of the *Negotiating* project was to document the variation in state health care purchasing practices. In some cases these purchasing variations clearly reflect important

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<sup>4</sup> S. Rosenbaum, Defined Contribution Plans and Limited Benefit Arrangements: Implications for Medicaid Recipients (September 2006). Available at

[http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/Rosenbaum\\_AHIP\\_FNL\\_091306.pdf](http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/Rosenbaum_AHIP_FNL_091306.pdf).

<sup>5</sup> R.G. Kronick, M. Bella, T.P. Gilmer, and S.A. Somers. *The Faces of Medicaid II: Recognizing the Care Needs of People with Multiple Chronic Conditions*. Center for Health Care Strategies, Inc., October 2007.,

[http://www.chcs.org/usr\\_doc/Full\\_Report\\_Faces\\_II.PDF](http://www.chcs.org/usr_doc/Full_Report_Faces_II.PDF) (Princeton NJ 2007) (Accessed December 24, 2007) See, esp. Exhibit 2, showing that 32 percent of Medicaid enrolled children and more than half of all Medicaid enrolled adults residing in non-institutional settings have at least one condition qualifying as a Chronic Illness and Disability Payment System (CDPS) diagnosis.; Kaiser Family Foundation, "Medicaid 101" (Slide 12, Medicaid Enrollees are Poorer and Sicker Than The Low-Income Privately Insured Population)

[http://www.kaiseredu.org/tutorials/Medicaid2005/MedicaidBasics\\_download.ppt#419,13](http://www.kaiseredu.org/tutorials/Medicaid2005/MedicaidBasics_download.ppt#419,13) (Accessed December 24, 2007).

<sup>6</sup> P. Wise. The Transformation of Child Health in the United States, *Health Affairs* 23(5) (Sept./Oct. 2004) pp. 9-25.

<sup>7</sup> See e.g., Agency for Health Care Research and Quality, "National Health Disparities Report" (Rockville, MD, 2006) <http://www.ahrq.gov/qual/nhdr06/nhdr06.htm> (Accessed December 24, 2007); Kaiser Family Foundation, "Key Facts: Race, Ethnicity and Medical Care" (Washington D.C. 2007) <http://www.kff.org/minorityhealth/upload/6069-02.pdf> (Accessed December 24, 2007).

differences in underlying community health care systems: differences in key community health concerns (e.g., a higher risk of elevated blood lead levels among children in certain states) as well as differences in the enrolled populations (e.g., a greater presence of persons with disabilities in the enrolled population). In other cases the variation reflects differences in the nature of local health care delivery systems (e.g., the extent to which public health agencies may be involved in the actual delivery of personal health care or the degree to which primary health care is available through ambulatory safety net providers such as community health centers). Yet another source of variation may lie in the health care quality performance measures that state purchasers may choose to emphasize.

While Medicaid agencies necessarily focused on chronic illness and disability, the past decade has witnessed a general growth in the level of attention given to chronic illness management for health plan enrollees. This special *Negotiating* study examines the role of disease management in Medicaid managed care purchasing.

## Disease Management: An Overview

As the purchase of health benefits tied to organized, networked delivery systems has become a health care norm, market innovations have also emerged, particularly with respect to health care techniques aimed at the control of costs. One such innovation is the concept of disease management interventions that target certain chronic illnesses and conditions.<sup>8</sup>

The Congressional Budget Office (CBO) has noted that the concept of “disease management” encompasses a range of activities that collectively attempt to correct “shortcomings of current medical practice,”<sup>9</sup> such as poor control of chronic conditions, the gap between evidence based treatment guidelines and current practice, and the health system negotiation difficulties experienced by patients with complex conditions and the need to engage in self monitoring. Disease management (DM) has grown in popularity among commercial payers over the past decade,<sup>10</sup> who view DM as a tool for targeting populations and conditions with “high but modifiable” risks of adverse outcomes that are amenable to short term cost reduction through improved management.<sup>11</sup> There is also evidence to suggest that DM techniques may now be used as a means of targeting patients who are not receiving evidence based standards of care, thereby linking DM directly to potential pay for performance (P4P) initiatives.<sup>12</sup>

CBO describes the line that demarcates DM and case management as follows: DM techniques which target individuals with specific conditions and emphasize the standardization of effective interventions such as patient education, monitoring, and care coordination; by contrast, case management emphasizes customized supports to patients with multiple conditions and high health risks. CBO also notes that a crucial aspect of DM is the assertion that its techniques can simultaneously reduce costs and improve health care quality and patient outcomes.<sup>13</sup>

DM is in limited use among Medicare populations,<sup>14</sup> although recent news reports indicate that CMS has elected to terminate a statutorily authorized Medicare DM pilot because of the lack of evidence that it has both improved health outcomes and saved money.<sup>15</sup> The pilot, which involved five Medicare Health Support Organizations (MHSOs) supporting 68,000 beneficiaries, has failed to show cost and quality results different from those achieved among comparable patients receiving traditional Medicare coverage.

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<sup>8</sup> V Villagra and T Ahmed. “Effectiveness of a Disease Management Program for Patients with Diabetes,” *Health Affairs*, 23:4 255-266 (July/August 2004).

<sup>9</sup> Letter from Douglas Holtz-Eakin to Senator Don Nickles, Oct 13, 2004. p. 2.

<sup>10</sup> G. Mays et. al, “Convergence And Dissonance: Evolution In Private-Sector Approaches To Disease Management and Care Coordination,” *Health Affairs*, 26:6 1683-91 (Nov. Dec. 2007).

<sup>11</sup> S.M. Foote. “Population Disease Management Under Fee for Service Medicare,” *Health Affairs Web Exclusive* <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.342v1?maxtoshow=&HITS=10&hits=10&RESULTFOR MAT=&fulltext=disease+management&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT> (Accessed December 31, 2007) w-342-356.

<sup>12</sup> Id.

<sup>13</sup> Letter from Douglas Holtz-Eakin, op. cit.

<sup>14</sup> Id.

<sup>15</sup> *BNA Health Care Daily*, “Medicare Pilot Ends, Because CMS Worried that It Wasn’t Cutting Cost, Improving Health” (Jan. 21, 2008).

At the same time, DM may be of interest to Medicaid. DM is focused on the standardization of care to certain identifiable chronic conditions. Thus, it seems plausible that Medicaid agencies would be interested in DM as one type of tool in the health care management armament, along with more complex case management interventions. Although the risks among the Medicaid population tend to be broader and more generalized as a result of the added burdens created by low income and higher social risks, DM nonetheless may offer a mechanism for deliberately targeting management improvements to certain conditions affecting the population.

State Medicaid agency interest in disease management may have been further stimulated as a result of a 2004 State Medicaid Directors Letter<sup>16</sup> that encouraged states to engage in disease management techniques, defined by the Centers for Medicare and Medicaid Services (CMS) as “a set of interventions designed to improve the health of individuals.”<sup>17</sup> According to CMS, a disease management intervention consists of several distinct components:

- Identifying patients and matching interventions to need
- The development and dissemination of practice guidelines to network health care professionals and providing patient monitoring support to physicians
- Services that enhance patient management and adherence
- Routine reporting and feedback to plans, providers, and patients
- Data collection and reporting.<sup>18</sup>

In its letter, CMS noted that while disease management traditionally functioned as a basic tool of managed care, the rise of separate disease management organizations (DMOs) expanded state options to contract with specialized entities either as part of a prepaid or primary care case management managed care initiative, or as a supplement to fee for service (FFS) coverage.<sup>19</sup> In other words, state Medicaid programs using general managed care arrangements can either specify disease management functions within their general purchasing agreements or “carve out” separate contracts with DMOs. Because disease management shares many common features with other care models, including patient specific preventive health services and case management and care coordination, which, the CMS letter noted that the service can be financed either as a form of medical assistance or as an administrative service.<sup>20</sup>

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<sup>16</sup> SMD 04-002 (Disease Management) (February 25, 2004).

Available at <http://www.cms.hhs.gov/smdl/downloads/smd022504.pdf> (Accessed December 24, 2007).

<sup>17</sup> Id.

<sup>18</sup> Id.

<sup>19</sup> Id.

<sup>20</sup> CMS, op. cit., p. 4. CMS also notes the ability of state programs to develop DM programs for dual enrollees.



## Study Purpose and Methods

The purpose of this study was to examine DM purchasing by state Medicaid agencies, whether through special DM contracts or as part of broader Medicaid managed care purchasing agreement, either with managed care organizations (MCOs) or other multi-service managed care entities. In keeping with CMS' definition and the state contracts, researchers defined disease management as:

A system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and empowerment strategies; and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.<sup>21</sup>

Critical to this definition is the concept of *targeted populations with specific targeted conditions*. Also crucial is the emphasis on *self care*. That is, DM is not case management. It is instead, as CBO describes, a mechanism for helping patients help themselves, as opposed to one used for patients whose health needs are so complex that they require true case management.

From a contractual point of view, DM can be purchased as a specific and separate product or as part of an overall MCO contractual arrangement. As a result, researchers collected both general agreements and specific DM agreements as part of the analysis. Key questions for review focused on certain analytic domains that are common to any managed care contract analysis,<sup>22</sup> and certain domains specific to DM and gleaned from DM literature<sup>23</sup> as well as from the CMS letter. These key domains of inquiry are:

- the conditions and populations that are the focus of the initiative;
- the benefits and services purchased;
- contractor performance expectations and measurement; and
- financing, payment, and risk allocation.

Specifically researchers examined the contracts to determine the following:

- 1) Identification of the diseases and conditions that are eligible for DM interventions;

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<sup>21</sup> Washington State RFP #HRSA/OCC-0106 "Washington Chronic Care Management Project" for January 1, 2007 to December 31, 2008.

<sup>22</sup> See methods discussion in earlier *Negotiating* studies.

<sup>23</sup> Center for Health Care Strategies, March 2001, as cited in B. Wheatley (2001) "Medicaid Disease Management: Seeking to Reduce Spending by Promoting Health," *State Coverage Initiatives Issues Brief*. Washington, DC: AcademyHealth.

- 2) The presence of a focus on patients who were likely to have complicating co-morbidities (e.g., diabetes and mental illness) that could necessitate DM techniques across systems of care;
- 3) Whether DM is mandatory or voluntary, including the use of an “opt-out” protocol that results in automatic enrollment of certain individuals, accompanied by opt-out rights;
- 4) DM benefit and service design;
- 5) The use of periodic risk assessment protocols;
- 6) The use of treatment planning protocols;
- 7) The extent to which DM programs are given authority to make resource allocation decisions through medical necessity determinations, including cross-system determinations in the case of persons with co-morbidities who may receive services across more than one plan (e.g., a general contract and a behavioral risk plan);
- 8) The financial aspects of DM, in particular the use of risk contracts;
- 9) Authority for DM entities to select and manage network providers that furnish service to the target population;
- 10) The role of DM entities in quality improvement;
- 11) The inclusion of certain patient protections including grievance and appeal rights; and
- 12) Inclusion of specific DM quality improvement and performance measures and payment incentives.

Nationwide collection took place over the 2006-2007 time period. All documents collected related to contracts that either were in effect at the time of collection or that were scheduled to take effect within the ensuing year and to be in effect for multiple years.

Request for Proposals (RFPs) or contract offers for disease management were identified through nationwide collection efforts. The RFPs and contracts were reviewed by a senior researcher and two research assistants trained by the senior researcher, using a review instrument developed to incorporate all of the research questions described above. The reviews were performed between October and December of 2007. A total of 10 states, shown in **Figure 1**, provided DM prime contracts for this study, that is, contracts that purchased DM services as a prime service rather than as a subset of more generalized managed care purchasing through use of a broader MCO contract.

For the states that produced DM prime contracts, researchers also examined the general MCO contracts in use in each state.

<b>Figure 1. Disease Management Study States</b>	
California	New York
Colorado	North Dakota
Florida	Oregon
Georgia	Texas
Illinois	Washington State

## Findings

The results of the analysis are displayed on Tables 1-3 below.

Table 1. Conditions and Populations Specifications, State DM Prime Contracts (n=15)		
State	Conditions/Populations	Interaction with General Medicaid Managed Care Plans (Yes/No)
California (n=1)	<ul style="list-style-type: none"> <li>HIV/AIDS</li> </ul>	<ul style="list-style-type: none"> <li>YES, MCO – Disease management benefit for Medi-Cal beneficiaries diagnosed with HIV/AIDS.</li> </ul>
Colorado (n=2)	<ul style="list-style-type: none"> <li>Asthma</li> <li>Diabetes</li> </ul>	<ul style="list-style-type: none"> <li>NO – Medicaid client with asthma who is not in HMO and who has agreed to participate in disease management program. Contractor identifies, selects, and enrolls 500 clients.</li> <li>NO – Medicaid client with diabetes who is not a child under age 18 and who is not in HMO. Contractor identifies, selects, and enrolls 300 clients.</li> </ul>
Florida (n=5)	<ul style="list-style-type: none"> <li>ESRD</li> <li>Congestive heart failure (CHF)</li> <li>Hemophilia</li> <li>HIV/AIDS</li> <li>Diabetes</li> </ul>	<ul style="list-style-type: none"> <li>YES, PCCM – Medicaid client with ESRD who is in PCCM or who is medically needy.</li> <li>YES, PCCM – Medicaid client with CHF who is in PCCM or who is medically needy.</li> <li>YES, PCCM – Medicaid client with hemophilia who is in PCCM or who is medically needy.</li> <li>YES, PCCM – Medicaid client with HIV/AIDS who is in PCCM or who is medically needy or who is in the AIDS waiver program.</li> <li>YES, PCCM – Medicaid client with diabetes who is in PCCM or who is medically needy.</li> </ul> <p><b>Note.</b> All five programs are for MediPass (PCCM) recipients, the medically needy, and in the case of the HIV/AIDS disease management program, individuals in the AIDS waiver program. All five programs can include TANF and SOBRA children, foster care and adoption children, SSI individuals not in Medicaid HMOs who are MediPass recipients. Explicitly excluded are individuals who are institutionalized, in hospice care program, in shelters, special needs children in CMS, SOBRA pregnant women, children in Prescribed Pediatric Extended Care Services, and individuals in PSN demonstration program.</p>
Georgia (n=1)	<ul style="list-style-type: none"> <li>Aged, Blind, Disabled (ABD)</li> </ul>	<ul style="list-style-type: none"> <li>NO – Medicaid client who is ABD but not in PCCM, Medicare dual eligible, in nursing home, in hospice care, or receiving TCM in HCBW program.</li> </ul>
Illinois (n=1)	<ul style="list-style-type: none"> <li>Disabled and Elderly diagnosed with chronic</li> </ul>	<ul style="list-style-type: none"> <li>NO – Medicaid client who is not in voluntary managed care.</li> </ul>

**Table 1. Conditions and Populations Specifications, State DM Prime Contracts (n=15)**

State	Conditions/Populations	Interaction with General Medicaid Managed Care Plans (Yes/No)
	<p>conditions, such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary, mental health or other co-morbid condition</p> <ul style="list-style-type: none"> <li>▪ Children, parents, relatives with persistent asthma</li> <li>▪ Children, parents, relatives with frequent use of ER</li> </ul>	<ul style="list-style-type: none"> <li>▪ NO – Medicaid client who is not in voluntary managed care.</li> <li>▪ NO – Medicaid client who is not in voluntary managed care.</li> </ul> <p><b>Note.</b> Excluded populations include: Participants with dual eligibility (Medicare and Medicaid); Participants who are enrolled in HFS’ voluntary managed care program; Pregnant and postpartum women and infants (this population is eligible for Family Case Management through a state-funded program); Children and adolescents whose care is subsidized by DCFS (foster care, adoption assistance, subsidized guardianship); Participants with primary medical insurance through another carrier (those with significant third party liability coverage as determined by HFS); Participants involved with hospice care; Participants enrolled in the Home and Community-Based Waiver program; Participants eligible only on a short-term basis, such as the spend-down population.</p>
<b>New York (n=1)</b>	<ul style="list-style-type: none"> <li>▪ Target group with chronic illnesses and high expenditures</li> </ul>	<ul style="list-style-type: none"> <li>▪ NO – Medicaid client who is in FFS only.</li> </ul> <p><b>Note.</b> Residents of developmental centers, mental health institutions, or hospices, enrollees of Medicaid managed care plans, enrollees of Family Health Plus (SCHIP), and individuals with HIV/AIDS diagnosis and enrolled in CM plan are explicitly excluded.</p>
<b>North Dakota (n=1)</b>	<ul style="list-style-type: none"> <li>▪ Asthma</li> <li>▪ Chronic obstructive pulmonary disease</li> <li>▪ Congestive heart failure</li> <li>▪ Diabetes</li> <li>▪ Depression</li> <li>▪ Obesity</li> </ul>	<ul style="list-style-type: none"> <li>▪ YES, PCCM – Medicaid client in PCCM.</li> <li>▪ YES, PCCM – Medicaid client in PCCM.</li> <li>▪ YES, PCCM – Medicaid client in PCCM.</li> <li>▪ YES, PCCM – Medicaid client in PCCM.</li> <li>▪ YES, PCCM – Medicaid client in PCCM.</li> <li>▪ YES, PCCM – Medicaid client in PCCM.</li> </ul> <p><b>Note.</b> Explicitly excluded are clients in MCO, ICF-MR, or receiving services related to transplants, HIV/AIDS, cancer, ESRD, hospice, Medicare</p>

**Table 1. Conditions and Populations Specifications,  
State DM Prime Contracts (n=15)**

State	Conditions/Populations	Interaction with General Medicaid Managed Care Plans (Yes/No)
<b>Oregon (n=1)</b>	<ul style="list-style-type: none"> <li>▪ Asthma</li> <li>▪ Diabetes</li> <li>▪ Tobacco use</li> <li>▪ High blood pressure</li> <li>▪ High blood lipids</li> </ul>	<p>benefits.</p> <ul style="list-style-type: none"> <li>▪ POTENTIALLY YES - Individuals over age 18 served by Local Public Health Authorities or designee.</li> <li>▪ POTENTIALLY YES - Individuals over age 18 served by Local Public Health Authorities or designee.</li> <li>▪ POTENTIALLY YES - Individuals over age 18 served by Local Public Health Authorities or designee.</li> <li>▪ POTENTIALLY YES - Individuals over age 18 served by Local Public Health Authorities or designee.</li> <li>▪ POTENTIALLY YES - Individuals over age 18 served by Local Public Health Authorities or designee.</li> </ul>
<b>Texas (n=1)</b>	<ul style="list-style-type: none"> <li>▪ Asthma</li> <li>▪ Diabetes</li> <li>▪ Coronary artery disease</li> <li>▪ Congestive heart failure</li> <li>▪ Chronic obstructive pulmonary</li> </ul>	<ul style="list-style-type: none"> <li>▪ NO - Disabled and TANF clients who are not in Medicaid HMOs but in FFS, including children with asthma.</li> <li>▪ NO – Disabled and TANF clients in FFS only.</li> <li>▪ NO – Disabled and TANF clients in FFS only.</li> <li>▪ NO – Disabled and TANF clients in FFS only.</li> <li>▪ NO – Disabled and TANF clients in FFS only.</li> </ul>
<b>Washington (n=1)</b>	<ul style="list-style-type: none"> <li>▪ Individuals at highest risk for high utilization of services (e.g., asthma, diabetes, heart failure)</li> </ul>	<ul style="list-style-type: none"> <li>▪ NO – Aged, blind and disabled clients who are not in Medicaid managed care.</li> </ul> <p><b>Note.</b> Explicit exclusions include: Clients receiving home and community based long term care services case managed by Aging and Disability Services Administration; Children under age 21; Clients who are eligible for enrollment in the Department’s Healthy Options managed care program; Clients receiving hospice services; and Clients enrolled in the Washington Medicaid Integration Partnership (WMIP), the Medicare/Medicaid Integration Program (MMIP), the GA-U managed care project, or the PACE program.</p>

<b>Table 2. DM Specification Language within Broader Managed Care Contracts<sup>24</sup></b>	
<b>State</b>	<b>MCO Contract Specifies Disease Management Duties for One or More Populations or Conditions</b>
<b>California</b>	Yes (can include asthma, diabetes)
<b>Colorado</b>	No
<b>Florida</b>	Yes (can include HIV/AIDS, children with chronic conditions)
<b>Georgia</b>	Yes (required for diabetes and asthma, plus two diseases/conditions, such as perinatal, obesity, hypertension, sickle cell, HIV/AIDS)
<b>Illinois</b>	Yes (e.g., ABD, TMA, Medicare, LTC resident, pregnant woman, spend-down with “specific chronic disease”)
<b>New York</b>	No <sup>25</sup>
<b>North Dakota</b>	No <sup>24</sup>
<b>Oregon</b>	No
<b>Texas</b>	Yes (includes children, elderly, persons with disabilities with “prevalent” chronic conditions)
<b>Washington</b>	No

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<sup>24</sup> Source: GW Analysis of Medicaid MCO Contracts, December 2007.

<sup>25</sup> But disease management RFP states that “managed care plans are expected to provide CM within the framework of their plan” (New York), or that enrollees of Medicaid MCOs already receive health management through other means (North Dakota).

**Table 3. Prime DM Contract Structure and Domains<sup>26</sup>**

State	Eligible conditions and populations specified?	DM contractor services available to general managed care enrollees (Y/N/NS) <sup>27</sup>	Voluntary (V) versus mandatory (M) enrollment specified?	Case management assessment, planning, and care coordination specified?	Enrollee Informing Specified?	Other benefits specified?	Network selection and oversight specified?	Utilization management specified?	Consumer protections specified?	Financial risk specified?	Coordination with other health care services specified?	Data and Reporting Duties Specified?
CA	X	Y	V & M	X	X		X	X	X	X	X	X
CO asthma	X	NS	V	X	X		X	NS	NS	X		X
CO diabetes	X	NS	V	X	X		X	NS	NS	X		
FL CHF	X	Y PCCM only	M, w/ opt-out	X	X		X	X	X	X <sup>28</sup>	X	X
FL diabetes	X	Y PCCM only	V	X	X		X	X	X	X <sup>28</sup>	X	X
FL ESRD	X	Y PCCM only	M, w/ opt-out	X	X		X	X	X	X <sup>28</sup>	X	X
FL hemophilia	X	Y PCCM only	V	X	X		X	X	X	X <sup>28</sup>	X	X
FL HIV/AIDS	X	Y PCCM only	V	X	X		X	X	X	X <sup>28</sup>	X	X
GA ABD	X	NA	M, w/ opt-out	X	X	X (prevention)	X	X	X	X <sup>29</sup>	X (other)	X
IL	X	N	V, w/ opt-out	X	X		X	X	X	X	X (other)	X
NY	X	N	M, w/ opt-out	X	NS		X	X		X		
ND	X	Y PCCM only	Automatic, w/ opt-out	X	NS		X	X	X	X	X	X
OR CC (community-based)	X	Y, potentially	NS	NS	NS			X		X	NS	NS
TX	X	Y	M, w/ opt-out	X	X	X (prevention)	X	X	X	X	X (other)	X
WA	X	NS	V	X	X		X	X		X	X (other)	X

<sup>26</sup> Source: GW Analysis of Disease Management Contracts and RFPs, December 2007.

<sup>27</sup> NS = not specified. New York and Washington do not specify populations and diseases other than “target group with chronic illnesses and high expenditures” (New York) and “individuals at highest risk for high utilization of services (e.g., asthma, diabetes, heart failure)” (Washington).

<sup>28</sup> FFS for providers, PMPM to DM for administrative costs.

<sup>29</sup> FFS.

## Populations and Conditions Targeted for DM

Table 1 shows that, consistent with the literature on disease management and population health disparities, Medicaid prime DM contracts target by condition and by specific population. Medicaid DM contracts also show evidence of targeting in relation to the conduct of the patient, e.g., use of care in a manner that is considered ineffective or inappropriate.

- The most commonly targeted conditions are asthma, diabetes, congestive heart failure, and Chronic obstructive pulmonary disease (COPD). Two states (California and Florida) also target HIV/AIDS.
- One state (Illinois) targets the population with a high use of the emergency department for any condition.
- Two states (North Dakota and Oregon) use DM to target conditions (obesity and tobacco use) that may not have converted into actual diagnoses with symptomatic manifestation but that are strong precursors to such diagnoses.

Table 1 also shows that certain states are making extensive use of DM. Florida, North Dakota, and Texas each reported 5 such contracts, while Illinois reported 3. Among these states using DM are two (Florida and Texas) that use mandatory managed care, one (Illinois) that uses voluntary MCO-style managed care, and one (North Dakota) that uses primary care case management (PCCM) arrangements. This finding suggests that DM systems have a broader appeal than the tightly managed and compulsory managed care arrangements found in certain states that use managed care for their Medicaid populations. This finding is consistent with DM surveys suggesting a relatively wide popularity for DM systems even among employers that offer less structured networked benefit plans to their employed populations.<sup>30</sup>

## Use of DM Interventions and Methods in Broader MCO Contracts

Table 2 shows that not all states that maintain DM prime contracts include DM as a specific performance expectation within their broader managed care contracts such as contracts with MCOs. Five states use general contracts that also specify DM as a contractor function (California, Florida, Georgia, Illinois and Texas). The remaining states either are silent on the role that they expect DM to play in terms of general contractor management or clarify in their DM solicitations that the DM specific contract reflects their general managed care expectations regarding DM.

This pattern suggests important differences in how states view DM in relation to regular managed care purchasing practices. Certain states appear to view DM as *a means of extending a specific benefit of managed care* (in this case, interventions that help manage an illness or condition with health and cost implications) to populations who otherwise are not part of a state's managed care initiative. Other states appear to view DM as an intervention that goes

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<sup>30</sup> Mays, op. cit.



beyond the “norms” of managed care; that is, they specify DM as an activity of their MCOs, not assuming that regular MCO activities would necessarily include DM.

## **The Domains and Structure of DM Prime Contracts**

### ***Similarity and Variation***

As in our earlier *Negotiating* analyses, our analysis of DM contracts show that states share similarities in basic approach, while varying considerably within any single domain in the degree of specificity they employ in guiding the design and operation of their DM contractors. In the context of almost any domain, one can find high variation in the extent to which contractors are given discretion to build and manage their systems. In some cases, states establish minimum standards or expectations, while in others, states permit contractors to design plan elements and operations within broad parameters.

Table 3 presents cross sectional findings related to the domains and structure of state DM contracts. These findings are accompanied by a discussion of qualitative differences in the specifications found in the contract documents, using excerpts from the contracts to illustrate these observations. Extensive excerpts can be found in **Appendix A**.

### ***Specification of Conditions and Populations***

Table 3 shows that all state DM contracts specify the populations or conditions to be targeted. This specification is, of course, consistent with managed care contracting generally. Because managed care is both an approach to administration and also a benefit of Medicaid enrollment, state agencies specify contractor obligations with care, describing the characteristics of patients or conditions to be managed with sufficient clarity so that performance can be accurately measured and payment made. The specification process also helps assure that persons eligible for DM services understand their benefits.

### ***Availability of DM Contractor Services to General Managed Care Enrollees***

Table 3 shows that as a general matter and as noted above, states that use DM take different approaches to coordination between DM and general managed care arrangements. States using PCCM contracts develop DM to supplement what is available within the PCCM contract. States that use MCO contracts in some cases expressly permit “dual enrollment” into their DM systems, while in other cases, the contracts are silent as to whether dual status is permitted. In yet other states, general managed care enrollees are excluded from DM arrangements.

### ***Mandatory Versus Voluntary Enrollment***

The literature on DM indicates that its roots lie in voluntary assistance to patients with advanced health care needs. Table 3 shows however that certain Medicaid programs consider DM to be amenable to mandatory enrollment with an opt-out. This approach has the effect of assuring patient enrollment in DM if the patient fits the eligibility profile, while simultaneously permitting patients who do not wish to use DM services to disenroll. Both states that use high cost populations as the basis for their contracts (New York and Georgia) also use mandatory

enrollment/opt-out procedures. Florida uses a mixed approach, mandating enrollment for certain conditions, allowing voluntary enrollment for others.

### ***Care Management: Plan Development, Active Intervention, and Oversight***

The heart of the DM contract is the provision of care management, and care management is an element of all contracts, as shown in Table 3. Consistent with earlier *Negotiating* analyses, states vary widely in how they define, describe, and express care management as a concept and as an operational plan function.

At the same time, and somewhat paradoxically in our view, there does not tend to be a single place in the contractual documents (as there tends to be in the case of comprehensive managed care contracts for both medical assistance and plan administration services) in which the purchaser provides a comprehensive definitional statement of the intervention that it is purchasing. Explanation of care management tends to be found throughout the documents, ranging from specifications linked to the actual operation of care management systems to performance reporting.

Consistent with state approaches to purchasing generally, states range from offering detailed contractual expectations to relatively summary descriptions of the care management function, leaving contractors with broader design and administrative discretion.

To the extent that DM has become an established industry with its own customs and practices and a relatively small group of market competitors, this variation in state approaches may not result in high operational variation. Alternatively, to the extent that DM is an emerging activity with notable operational variants, broad language may encourage and foster contractor variation.

California uses exclusionary language to help describe what it expects from its care management contractors, clarifying that their function is not to furnish medical assistance:

“The DMO will not provide direct medical services such as preventative care, authorization or denials of referrals, emergency care, or inpatient hospital services. It will provide a wide array of education and supportive services. The DMO will not be required to provide or arrange for provisions of the full scope of Medi-Cal services set forth in California Code of Regulations (CCR), Title 22, Chapter 3, Article 4, beginning with section 51301.”

By contrast, Georgia identifies at least one form of personal health care service that is considered part of the care management function:

\* \* \*

#### **4.4.11 Care Plans**

The Offeror shall develop comprehensive member care plans to include, as appropriate, but not be limited to:

- Management of disease states and co-morbid conditions;
- Severity level of care;
- Improvement of risk factors related to disease;
- Management of appropriate usage of all medications;
- ***Preventive care and wellness promotion; (emphasis added)***

- Evaluation of home environment for levels of common environmental triggers;
- Action plans for diseases that are required per clinical guidelines (i.e. asthma);
- Prevention of acute episodes including hospitalizations and emergency room visits;
- Member self-management strategies;
- Communication feedback among all the providers;
- Member and provider adherence to clinical guidelines;
- Member's compliance with care plan;
- Referrals to community resources to address socioeconomic issues related to member's health;
- Communication to treating physician regarding hospitalizations and emergency room visits;
- Member education to encourage use of 24 hour/7days a week nurse call services; and
- Education of family and caregiver(s) regarding member's disease(s) and/or condition(s).

North Dakota, in describing how it desires care management providers to relate to other health system components, offers the following explanation of care management services:

## SCOPE OF WORK

### Health Management Program Components

The health management program will include the following components.

#### **(1) Health management services available to Recipients with select chronic conditions...**

##### **b. Disease management (DM)...**

DM will provide for a system of coordinated health care interventions and communications (may include face-to-face, telephone, e-mail, videoconference, workshops, support groups and other methods to allow for adequate communication considering the State's rural nature) that result in improved self-care by the Recipient. DM will include: (1) intensive coordination with the Recipient's primary care provider (i.e., "medical home"), (2) care planning, care coordination, follow-up and monitoring by licensed nurse case managers, and (3) involvement from a "team" of ancillary medical professionals from the Recipient's "medical home" (this may include dietitians, respiratory therapists, pharmacists, etc. as appropriate considering the Recipient's condition)...

### ***Networks and Providers***

Because DM is not health care per se but instead functions as an approach to supporting certain populations or the provision of care for certain diseases, the concept of a network appears to have only a loose relationship to a DM contract. Instead, the focus of the contracts appears to be on the nature of the care coordinators and their expected range of functions. A key variant appears to be the extent to which care managers are expected to interface with treating clinicians who are part of other managed care entities, whether MCOs or PCCMs. In other words, a key issue is whether the care managers are to have clinical peer competencies as well as patient support competencies.

States also vary with respect to the extent to which they specify the credentials expected of care managers and case coordinators.

Consistent with the limited nature of DM, Table 3 shows that it is *not* the custom of states to permit their DM contractors to either select or oversee the performance of clinical providers who either are in other managed care networks or who are independent health professionals. That is, DM contractors may support the performance of managed care clinicians, but they are not expected to take on classic utilization management functions or provider selection/de-selection functions within the managed care systems with which they relate. Thus, for example, a DM contractor managing a patient with COPD would not have the authority to either exclude the patient’s treating clinician from FFS Medicaid or another managed care arrangement, nor would the contractor have the authority to deny or alter a prescribed drug covered by FFS Medicaid or as part of a separate contract.

The following excerpts from state contracts illustrate the variability in the extent to which they address competencies and credentialing of care managers and expectations for contractors to interface clinically with clinicians furnishing care to patients. Florida’s contract is particularly interesting in its expectations of the voluntary arrangements that will develop among care managers (relatively unspecified) and the health system networks actually furnishing clinical treatments. Especially striking are the voluntary arrangements that the state anticipates between specialists and primary care physicians. How the state delineates which voluntary arrangements will foster the intent of the contract versus those that the state would consider as constituting an impermissible kickback arrangement is unclear.

### **California**

“\* \* \* At a minimum, the Case Manager will be a licensed registered nurse or other healthcare professional as defined in Section 4999.2 of the California Business and Professions Code. The Contractor shall also employ the services of a licensed psychiatrist, psychologist, or licensed/certified mental health specialists, as needed, to address the behavioral and/or mental health concerns of the Member.”

### **Colorado**

#### “B. Asthma Disease Management Program

1g. The Contractor shall provide physician education, including summary reports to primary care physicians and interface with the Medical Director when Enrollees are not being treated optimally and treatment plans are not up-to-date.”

### **Colorado**

#### “II: Scope of Work

##### B. Diabetes Disease Management Program

1g. Provider Education: The Contractor shall conduct provider education by sending written educational materials on the risk factors of Enrollees, alert notifications and summary reports to primary care physicians (PCPs) and health care professionals. The alert notification shall summarize an Enrollee’s medical and contact information and areas of concern. Alert notifications are communications to the Enrollee’s physician by telephone, facsimile or letter and are prompts for the physician or case manager to call and discuss the Enrollee’s chronic condition.”

## **Florida**

### ***Invitation to Negotiate for Participation in the AIDS Disease Management Initiative of the Florida Medicaid Program***

“The DMO will solicit the voluntary cooperation of MediPass primary care providers. Additionally, the DMO may enlist qualified Medicaid specialists who volunteer to be referral sources for PCPs in order to assure cooperation and compliance with treatment protocols. DMOs must coordinate their patient management activities with the MediPass primary care providers and specialists for DMO enrollees who are also MediPass enrollees. Coordination ensures that PCPs are informed of the clinical protocols used, that they authorize medically necessary services, as well as receive feedback about services provided by specialists.

While not required, DMOs may also wish to develop relationships with hospitals, home health agencies, pharmacies, or other providers to the degree that such relationships enhance the DMO’s ability to achieve cost savings and clinical improvements and care. If the DMO does develop a relationship with a pharmacy or pharmacies, the medication formulary for use with Medicaid DMO enrollees shall not be restricted or altered from its present open and unrestricted status.

The disease management initiative places no new obligations on the enrollee, nor on the enrollee’s physicians, to utilize certain Medicaid participating providers. Beyond the existing MediPass requirements that the primary care provider be used as the initial point of contact for all routine and specialty care needs, DMO enrollees will have free choice of Medicaid providers. Thus, DMOs can only encourage — but not require — that enrollees use providers recommended by the DMO.

The individual care management provided by the DMO will be disease specific for DMO enrollees. This care management will be separate from and not conflict with the primary care management currently provided for recipients by the MediPass PCPs. DMO care management will focus on managing the chronic condition and will include direct intervention by case managers with recipients regarding education on the disease process. The DMO will direct AIDS recipients’ care towards the outpatient setting. Case managers will contact recipients at their homes and provide education to increase recipients’ self-management of their disease. Case managers will also monitor recipient compliance with care plans.

In contrast, MediPass PCPs will continue in a primary care role and continue to manage Medicaid services as outlined in the MediPass provider agreement. These services are comprehensive and include, but are not limited to, conducting adult health screenings, providing early and periodic screening, diagnosis and treatment services (EPSDT), providing acute care services, making medically appropriate referrals, and coordinating other medical services. The MediPass PCPs will continue to receive the monthly \$3.00 administrative fee per enrollee. The DMO will provide interventions to augment and complement PCPs and other provider encounters and will coordinate these actions with the MediPass PCPs.”

#### **“Section C. Information Required from AIDS DMO Applicants**

24. Provide a list of the number and types of specialist physicians with whom the DMO has or will develop relationships and indicate whether the specialist(s) is board certified.”

## **Georgia**

### ***Request for Proposals for Disease Management Services for Medicaid Aged, Blind and Disabled Members, RFP Number 41900-001-000000025***

#### **“4.4 General Requirements**

##### **4.4.20 Collaboration**

The Offeror shall conduct Georgia Disease Management Program services collaboratively with members, treating providers, community resources, and DCH and its business partners. The program shall provide value-added information and support services for medical providers and increase coordination of member care. The Offeror will: Incentivize PCPs in a way that improves the participation in the program; as well as delivery of, compliance with, and outcomes of care; Report to the Department performance of PCPs on compliance with treatment protocols.”

##### **5.8.1 Approach to Contract Performance**

K. Describe collaboration and coordination with area providers. Please address each of the following:

- How you will work with local providers to gain their participation in the program, including coordination with the professional staff under their supervision;
- How you will incentivize PCPs to participate in and cooperate with the DM program, as well as work to improve outcomes for members;
- How you will identify and integrate with Georgia Medicaid’s provider community and infrastructure, including Federally Qualifying [sic] Health Centers, Rural Health Clinics, Public Health Departments, and high volume providers. Please specifically address how you will work with the facilities providing mental health services to members and the case managers providing services to members enrolled in the Community Care Services Program. (Both are described in Appendix G);
- Criteria you will use to determine which medical providers receive updated information on member health status;
- Criteria you will use to determine how information on member health status is relayed to providers (telephonic, email or fax reports or memos, etc.);
- How you will work with other assigned case managers to ensure that all are aware of the treatment plan and share pertinent information about the members medical and service needs;
- How you will coordinate interventions and ensure follow-up between nurse call staff, case management staff, and the treating and/or primary care providers;
- How you will work with providers in managing the complex medical needs of members with multiple conditions, including the assistance will you give to those providers; and
- How your staff will intervene if a problem with a member, provider, or collaborating state agency is identified.”

**(The following language is found in the description of what constitutes a care plan):**

“\* \* \* [C]are plans should demonstrate creativity in generating member compliance and shall take into account opportunities for prevention and education, as well as intervention and cost savings. Member care plans may be developed using a team based approach, which incorporates the skills of social workers, health aids, nurses, physicians, and therapists. However, the Contractor nurses or physician staff professionally licensed in the State of Georgia must perform final review and approval of member care plans.”

## **Texas**

*Medicaid Disease Management RFP*

### **“8.4: Service Delivery Operations**

#### **8.4.1: State/Vendor Responsibilities**

##### **8.4.1.2: Vendor Service Responsibilities – Statewide**

**B. Participating Providers:** At a minimum, the Vendor will be responsible to provide the following services for participating providers:

- B.1 Intensive recruitment of providers to participate in the DM program and will coordinate with HHSC to ensure that potential providers have current Medicaid provider agreements.
- B.2 Recruit providers to serve as primary care providers or as a medical home for DM eligible clients as needed, including recruitment of specialists as primary care providers when warranted by the patient’s condition and needs.
- B.3 Develop provider support for, and give provider education regarding, the specific evidence based guidelines selected for use.
- B.4 Ensure no barriers to medical provider input into the development of an eligible DM client’s plan of care.
- B.5 Implement a system for providers to request specific DM interventions.
- B.6 Give providers feedback on differences between recommended prevention and treatment and actual care received by eligible clients, and on client adherence to a plan of care.
- B.7 Provide assistance in assuring necessary specialist care.
- B.8 Provide reports on changes in a client’s health status to their participating primary care provider.
- 8.4.1.3 Performance Indicators
  - o State approved comprehensive Client Service Plan, including client educational materials, telephone consultation services, and client complaint system
  - o State approved comprehensive Provider Services Plan, including provider educational materials and reports to providers on changes in their eligible clients’ health status.”

## **Washington**

*Chronic Care Management Project, RFP HRSA/OCC-0106 2006*

### **“C. Project Scope**

#### **7. Local Care Management (LCM) Programs:...**

LCM contractors are encouraged to utilize staff in a range of professions, such as registered nurses, licensed social workers, and lay health workers who have specific cultural awareness of the local population. The Contractor may employ multidisciplinary teams to provide services but the principal care manager must

be an RN unless the bidder presents a compelling case for another health professional as the principal care manager. The principal care management nurse will provide an interface between the provider, social worker and lay health worker to coordinate care for enrollees, and ensure care is delivered at the most appropriate level. LCM staff will provide referral and advocacy to mental health, long term care and other community services.”

**“D. Minimum Qualifications**

**3. Statewide Care Management (SCM) Proposals:...**

Both LCM and SCM contractors must provide care management services through appropriately licensed professional staff, including at a minimum BSN level Registered Nurses licensed in the state of Washington. In addition, it is expected that the contractors will have access to resources such as: such as master’s level social workers, chemical dependency counselors, dieticians, or psychiatric nurse practitioners. Certain aspects of enrollment and assistance with referrals to transportation or other services may be performed by lay health workers.”

### **Consumer Protections**

Virtually all contracts specify compliance with certain consumer protections, as shown on Table 3. At the same time, the concept of consumer protection varies widely, since unlike the case with Medicaid MCO/MCE contracts, there is no single regulatory definition of what constitutes a consumer protection. Perhaps because the service furnished is not medical assistance itself, the question of what minimum consumer protections should be applicable has not been delineated by CMS in regulation or guidance. California and Florida illustrate the range of contrast. In California’s case, member rights encompass the provision of information, translation services, transportation, dispute resolution, and disenrollment rights. In contrast, Florida’s contract specifications address dispute resolution only.

#### **California**

“iv. Member Services Plan

a) Members Rights

- 1) Proposer shall submit a Member Services Plan that describes the firm’s ability to perform the responsibilities outlined in Exhibit A, Attachment 1, Provision E, Members Rights.
- 2) Proposer shall describe the firm’s experience that demonstrates their ability to develop and implement policies and procedures addressing Members rights and responsibilities.
- 3) Proposer shall submit an organizational chart of proposed or existing staff for Member Services which demonstrates that staffing is sufficient to support the Member Services functions.
- 4) Proposer shall submit the staff requirements and training plan that ensures staff performing Member Services functions will be knowledgeable regarding the DMPP.
- 5) Proposer shall describe the firm’s experience in developing and disseminating program information and Member Services Guides.
- 6) Proposer shall describe the firm’s experience that demonstrates their ability to maintain, collect, store, retrieve and ensure confidentiality of Members records.



- 7) Proposer shall describe any innovative Member Services activities that demonstrate their commitment to exceed the minimum requirements set forth in this RFP.”

**“Exhibit A, Attachment 1, Scope of Work – Contract Performance...**

**E. MEMBER SERVICES – MEMBERS RIGHTS**

1. Member Rights and Responsibilities

Contractor shall develop, implement and maintain written policies that address Member rights and responsibilities and shall communicate these to its Members. a. Contractor’s written policies regarding Member rights shall include the following:

- 1) To be treated with respect, giving due consideration to the Member’s right to privacy and the need to maintain confidentiality of the Member’s medical information;
- 2) CDHS approved policy for resolving disputes;
- 3) To be provided with information about the organization and its services;
- 4) To receive oral interpretation services for identified threshold languages as listed in Appendix 1-Glossary;
- 5) To have access to, and when legally appropriate, receive copies of, amend or correct their Member Record;
- 6) To disenroll at any time;
- 7) To receive written materials in alternative formats, including Braille, large size print, and audio format within 14 days of request; and
- 8) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation...

c. Contractor shall implement and maintain policies and procedures to ensure the Member’s right to confidentiality of medical information.

- 1) Contractor shall implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons.
- 2) Contractor shall inform Members of their right to confidentiality and Contractor shall obtain Member’s consent prior to release of confidential information, unless such authorization is not required.

d. Contractor shall maintain the capability to provide Member services to DMPP Members through sufficient assigned and knowledgeable staff.

e. Contractor shall ensure Member services staff is trained on all contractually required Member service functions including, policies, procedures, and scope of benefits of this Contract.

f. Contractor shall provide all new DMPP Members with written Member information. In addition, the Contractor shall provide potential Members with written Member information upon request.

- 1) Contractor shall distribute the Member information no later than seven (7) calendar days after the effective date of the Member’s Enrollment. Contractor shall revise this information, and distribute it annually to each Member.
- 2) Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate by existing Medi-Cal standards.
- 3) The written member informing materials shall be translated into the identified threshold languages (Provision H - Member Services, Access and Availability, Linguistic Services).
- 4) The written member informing materials shall be provided in alternative formats, including Braille, large size print, and audio format, within 14 days of request.

g. Contractor shall develop and provide each Member a Member Services Guide that constitutes a fair disclosure of the provisions of the covered DM services. The Member

Services Guide shall be submitted to CDHS for review and subsequent approval prior to distribution to Members. The Member Services Guide shall include the following information:

- 1) Description of the DMPP covered services and benefits and how to access them;
- 2) The importance of establishing a medical home and information on how to contact the DMO for assistance in this process;
- 3) Information explaining the importance and value of scheduling and keeping appointments;
- 4) Procedures for obtaining emergency health care;
- 5) Procedures for obtaining any transportation services available through the Medical program, and how to obtain such services. Include a description of both medical and non-medical transportation services and the conditions under which non-medical transportation is available;
- 6) The causes for which a Member shall lose entitlement to receive services under this Contract as stipulated in Provision G - Member Services – Scope of Services, Enrollment/Disenrollment;
- 7) Procedures for Disenrollment, including an explanation of the Member’s right to disenroll without cause at any time;
- 8) Information on the availability of, and procedures for obtaining, services at Federally Qualified Health Clinics (FQHC) and Rural Health Clinics (RHC); and
- 9) Any other information determined by CDHS to be essential for the proper receipt of DM services.”

## **Florida**

### ***Invitation to Negotiate for Participation in the End State Renal Disease Management Initiative of the Florida Medicaid Program***

“\* \* \* Disease management services shall begin with an initial assessment and risk screening for each enrollee. Based on the findings of the assessment, the enrollee will be categorized into a severity level. The Agency is expecting the majority of individualized interventions be focused on those enrollees who are in the moderate to severe levels. Examples of services a DMO is expected to provide include the following:

...

- Appropriate guidelines that address recipients’ complaints and avenues for resolutions;”

(\*\*\*Note: similar phrasing/level of detail used in the other Florida DM RFPs\*\*\*)

## ***Payment and Financial Risk***

Table 3 shows that the most common type of payment arrangement involves a per member per month payment with fee for service payments to network providers. Florida specifically provides for the use of shared savings incentives via a relatively elaborate payment methodology. Other states require offerors to provide per member per month bid estimates, while still others use a fee schedule. Washington State explicitly requires budget neutrality as a component of financing.

## ***Coordination with Other Parts of the Health Care System***

Virtually all contracts show coordination and data reporting responsibilities, again consistent with the fact that DM is essentially treated as an additional layer of service. The patient may be

enrolled in another MCO, in a PCCM system, or may be receiving care on a fee for service basis as a traditional Medicaid patient. Regardless of the model, coordination with clinical providers, other managed care entities (including the patient’s primary care physician), and other programs (e.g., social services for a patient with HIV) would all appear to be intrinsic to the management of a disease that has broad health and high cost implications.

As is the case with MCO contracts, the coordination language varies enormously. For example, New York State devotes extensive space to enrollee privacy, with strict prohibitions on re-disclosure of patient specific information, thereby emphasizing, if anything, the lack of expected interface with other health care providers. In this respect, the state’s prohibitions on redisclosure extend beyond the federal prohibitions of HIPAA (New York has one of the strictest state privacy legal systems in the nation), and appear to favor confidential, patient-oriented disease management that does not relate to the broader health care system in which the patient is receiving care.

North Dakota offers a study in contrast, with extensive provisions related to the various state programs with which the state expects the DM contractor to develop operational arrangements.

## **New York**

### **“Appendix N – Data Exchange Application and Agreement**

#### **Purpose:**

The purpose of this Data Exchange Application and Agreement (DEAA) is to provide information supporting the applicant’s request for the release of Medicaid confidential data (MCD) and to serve as the basis for assessing the appropriateness of releasing MCD. In addition, the DEAA, when approved by the Medicaid Confidential Data Review Committee, forms an agreement between the applicant and the New York State Department of Health as to the terms and conditions under which the release will be made.

Pursuant to the New York State Medicaid State Plan requirements, Social Security Act, Section 1902(a) (7), 42 USC 1396a (a) (7) a.d.; and federal regulations at 42 CFR 431.302, no release of MCD is permitted unless such release is directly related to the administration of the Medicaid state plan.

MCD is also protected by Social Services Law Section 369 (4), which states: \* \* \* pursuant to Section 367b(4) of the NY Social Services Law, information relating to persons Applying For medical assistance shall also be considered confidential and shall not be disclosed to persons or agencies without the prior written approval of the New York State Department of Health.

Any inconsistent provision of this chapter or other law notwithstanding, all information received by public welfare officers concerning applicants for and recipients of medical assistance may be disclosed or used only for purposes directly connected with the administration of medical assistance for needy persons.

Please note that Medicaid Confidential Data released to you may contain AIDS/HIV related confidential information as defined in Section 2780(7) of the New York Public Health Law. As required by N.Y. Pub. Health Law Section 2782(5), the New York Department of Health hereby provides the following notice:

*“This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for the release for further disclosure.”*

The applicant agrees to include the notice preceding, as well as references to statutory and regulatory citations set forth under “**Purpose**” in the DEA, in any agreement, contract or Document the Applicant enters into that involves Medicaid Confidential Data. Further, the Applicant agrees to state in any such agreement, contract or document that the subcontractor(s) or other party may not further disclose the Medicaid confidential data without the prior written approval of the New York State Department of Health.”

### **North Dakota**

*Medicaid Health Management Program, RFP 325-06-10-011  
March 13, 2006*

#### **“SECTION THREE SCOPE OF WORK**

Scope of Work...

#### **Health Management Program Components**

The health management program will include the following components.

#### **(1) Health management services available to Recipients with select chronic conditions...**

##### **c. Disease management (DM)...**

DM will provide for a system of coordinated health care interventions and communications (may include face-to-face, telephone, e-mail, videoconference, workshops, support groups and other methods to allow for adequate communication considering the State’s rural nature) that result in improved self-care by the Recipient. DM will include: (1) intensive coordination with the Recipient’s primary care provider (i.e., “medical home”), (2) care planning, care coordination, follow-up and monitoring by licensed nurse case managers, and (3) involvement from a “team” of ancillary medical professionals from the Recipient’s “medical home” (this may include dietitians, respiratory therapists, pharmacists, etc. as appropriate considering the Recipient’s condition)...

**(9) Coordination with providers, contractors, programs and other stakeholders** to avoid duplication of services and to assure a coordinated and widely accepted approach to health management service delivery. See Attachment 2 for information and recommendations for coordination with North Dakota providers and stakeholders, Medicaid contractors and other programs/services provided through DHS.”

#### **“ATTACHMENT 2**

## COORDINATION WITH PROVIDERS, CONTRACTORS, PROGRAMS AND OTHER STAKEHOLDERS

For success of the health management program, it is very important that the Offeror work closely with: (1) medical providers throughout the State, (2) contractors of the North Dakota Department of Human Services (Department), (3) other Department programs, and (4) other stakeholders, to avoid duplication of effort and to provide seamless service delivery through appropriate coordination. (The information below is not all-inclusive of the programs, services or activities provided through the Department.)

**Providers.** The Offeror will engage appropriate support and participation from the medical community and assure that the health management program does not interfere with the success of the Medicaid PCCM program, other programs run by the Department (see below) or already existing outreach and education to the provider community.

**Contractors.** The Department has contracts with many business associates. The Offeror will coordinate and interact with these associates to meet the goals of the program. The Offeror must assure a seamless operation with these associates and their systems.

**Dual Diagnosis Management, LLC (Dual Diagnosis)** – Dual Diagnosis provides preadmission screening and resident review evaluations for each individual entering a nursing facility. They also perform level of care determination for Medicaid eligible individuals or applicants requesting services in a Medicaid certified nursing facility or swing bed and services through personal care or the Home- and Community-Based Service waiver. In addition, Dual Diagnosis conducts continued stay reviews on individuals whose initial screening exhibits potential for medical improvement to the extent that discharge to a less restrictive setting may be appropriate.

Dual Diagnosis fulfills certificate of need (CON, under 21) requirements, admission reviews and continued stay reviews for acute inpatient psychiatric services and for services provided by psychiatric residential treatment facilities and non-accredited residential treatment centers.

**Health Information Designs, Inc. (HID)** – HID provides retrospective drug utilization review (DUR) services through RX Explorer and DURBaseII software. They also provide ongoing technical assistance for DUR activities.

**North Dakota Healthcare Review, Inc. (NDHCRI)** – NDHCRI provides inpatient and outpatient hospitalization utilization review as required by federal regulations to assure that Recipients are only receiving the hospital care necessary to meet their medical needs. This is accomplished through retrospective, concurrent and preadmission utilization review, quality review studies, data analysis and special studies.

**The Medstat Group, Inc. (Medstat)** – Medstat is the Decision Support System (DSS) vendor, a component of the current Medicaid Management Information System (MMIS). Medstat designed the current DSS. Medstat also completed the installation and training for the DataProbe system that allows Medicaid staff to analyze medical claims and enrollment data. Medstat also provides ongoing data analysis and support as requested by the Department.

**Programs.** The Offeror will be required to coordinate the health management program with other programs administered through the Department as described below.

**Health Tracks (formerly Early and Periodic Screening, Diagnosis and Treatment [EPSDT])** – *Health Tracks* is a preventive health program that is free to Medicaid-eligible children age 0 to 21. Program coordinators are located at local public health units in the larger cities throughout the State and services are conducted through contracted Head Start programs and local public health units. *Health Tracks* pays for screening, diagnosis and treatment services, orthodontics, glasses, hearing aids, vaccinations, counseling and other important health services. Program coordinators are available to assist with scheduling appointments for services and will also help with finding transportation to the services. Some services require prior authorization.

**Targeted Case Management (TCM) for High-Risk Pregnant Women and Infants** – This is a Medicaid program provided as a service under the Medicaid State Plan. The goals of the TCM program are to:

- Provide early and continuous prenatal care;
- Identify risk factors and develop a plan to lessen the risks;
- Connect women to support services that will contribute to a healthy baby;
- Improve current and long-term life situations;
- Enhance the maternal life course, such as employment and education; and
- Improve child health by promoting preventive health services, such as immunizations and well-baby checkups.

Additional TCM program information can be found at the following link.  
<http://www.nd.gov/humanservices/info/pubs/docs/cshs/health-data-notes-march2004.pdf>

**Ambulatory Behavioral Health Programs (Adults, Adolescents and Children)** – This is a Medicaid program that exists to assure that ambulatory behavioral health services are appropriate to each individual's symptoms according to Medicaid established protocols and medical criteria and are neither over- nor underutilized. More information on these programs can be found at the following links to provider manuals.

<http://www.nd.gov/humanservices/services/medicalserv/medicaid/docs/am-beh-health-care-adultsjan2005.pdf> (Adults)

<http://www.nd.gov/humanservices/services/medicalserv/medicaid/docs/am-beh-health-care-childrenjan2005.pdf> (Children and Adolescents)

**Home- and Community-Based Services (HCBS)** – The Department provides HCBS through several programs.

- Service Payments for the Elderly and Disabled Program (SPED)
- Expanded Service Payments for the Elderly and Disabled Program (Ex-SPED)
- Medicaid Waiver for the Aged and Disabled
- Medicaid Waiver for People With Traumatic Brain Injuries
- Older Americans Act Services

For more information on these programs, go to the following link to the Department's website:

<http://www.nd.gov/humanservices/services/adultsaging/homecare.html>.

**Children's Special Health Services (CSHS)** – CSHS provides services for children with special health care needs and their families and promotes family-centered, community-based, coordinated services and systems of health care. Though CSHS exercises discretion in defining the population eligible for services, the following programs address many of the needs experienced by children and families: (1) specialty

care program, (2) multidisciplinary clinic program, and (3) care coordination program. CSHS also provides other services not described in this paragraph. For additional information regarding CSHS, go to the following Department website: <http://www.nd.gov/humanservices/services/medicalserv/cshs/>. This website includes a list of multidisciplinary clinics, including diabetes and asthma clinics, to be conducted in the State in 2006. The Offeror should become familiar with these clinics for coordination purposes.

**Other Services** – The Department also provides for specialized services for the following groups:

- Recipients with developmental disabilities
- Recipients with mental illness
- Children at risk of abuse and neglect

**Other Stakeholders.** The Offeror should consider a regional approach to the health management program, hiring or contracting with nurse case managers in the larger cities across the state to serve a multi-county region. For example, a nurse case manager in Fargo may provide services to Cass, Traill, Steele, Richland, Sargent and Ransom county Recipients. The Offeror should also consider establishing and maintaining Regional Advisory Committees (RACs) in each region to serve as program advisors and provide a formal structure for the exchange of ideas between program staff and the communities to which they provide services. Each RAC could consist of stakeholders including a Recipient and their representatives, county social service center eligibility staff, health care providers, local public health units, community agencies and community leaders. Focus areas for the RACs may be health education/literacy, marketing and outreach, service delivery and quality assurance.”

## ***Information and Reporting***

While all contract documents specify that contractors provide certain information related to populations served, activities and performance, with all other performance specifications, those related to information and reporting vary greatly. The documents tend to stress intermediate performance information (e.g., number of specific types of case management functions performed). In no case do the contractual documents specify provision of information stratified by race/ethnicity. Florida’s contract documents are unique in their specification of reporting related to certain outcomes of care.

### **Florida**

#### ***DMO Reporting Responsibilities***

“**Monthly** reports must be received by the Agency by the tenth working day of each month and shall include:

- enrollment reports by severity level;
- disenrollment reports by severity level (with the reason for disenrollment);
- complaint logs; and
- number of recipient contacts by method of contact (for example, face-to-face, telephone, mail).

**Quarterly** reports must be received by the Agency within 30 days after the end of a quarter. The reports must document certain outcome and process measures and include the following:

- results of baseline patient knowledge and satisfaction surveys for new enrollees;
- recipient enrollment/disenrollment numbers by severity level;
- number of patients in each severity level;
- total number of days DMO enrollees spent within each severity level;
- number of emergency room visits by severity level;
- number of hospital admissions and readmissions by severity level;
- number of inpatient hospital days per admission by severity level;
- cumulative report of monthly number and percentage by severity level of recipient compliance with weight control/reduction as indicated per recipient care plan;
- cumulative report of monthly number and percentage of recipient compliance with dietary restrictions as indicated by severity level;
- cumulative report of monthly number and percentage of recipient compliance with taking prescribed medications, (e .g. ACE inhibitors, Digitalis, diuretics, etc.) by severity level;
- cumulative report of monthly number and percentage of recipient compliance with decreasing or abstaining from smoking (if applicable) by severity level;
- number of recipient deaths by month due to CHF;
- case studies (describe successful outcomes as well as cases presenting barriers to successful outcomes); and
- number of recipient contacts by method of contact (for example, face-to-face, telephone, mail).

In addition, a cumulative **annual** report must be received by the Agency within 30 days after the end of the reporting year. The report will address the following:

- results of patient knowledge and satisfaction surveys for recipients enrolled for at least six months;
- recipient enrollment/disenrollment numbers by severity level;
- number of patients in each severity level;
- total number of days DMO enrollees spent within each severity level;
- number of emergency room visits by severity level;
- number of hospital admissions and readmissions by severity level;
- number of inpatient hospital days per admission by severity level;
- clinical outcome measures as described in this document (see Attachment D);
- cumulative report of monthly number and percentage by severity level of recipient compliance with weight control/reduction as indicated per recipient care plan;
- cumulative report of monthly number and percentage of recipient compliance with dietary restrictions as indicated by severity level;
- cumulative report of monthly number and percentage of recipient compliance with taking prescribed medications, (ACE inhibitors, Digitalis, diuretics, etc.) by severity level;
- cumulative report of monthly number and percentage of recipient compliance with decreasing or abstaining from smoking (if applicable) by severity level;
- number of recipient deaths by month due to CHF;
- case studies (describe successful outcomes as well as cases presenting barriers to successful outcomes);
- number of recipient contacts by method of contact (for example, face-to-face, telephone, mail); and
- aggregate report of provider profiling information.

DMOs may have additional outcome and process measures in place or develop measures beyond those required by the Agency. The content and timing of required data



exchanges between the Agency and DMOs will be finalized during the contract negotiation process.

***Agency Reporting Responsibilities***

- A monthly list of DMO-eligible recipients who have been identified as having characteristics of a diagnosis of CHF. This list will include the recipient’s name and address as well as the names and telephone numbers of Medicaid physicians who have repeatedly cared for the recipient; and
- Quarterly paid claims information on all DMO-enrolled recipients including hospitalizations, rehospitalizations, lengths of stay, emergency room utilization as well as other Medicaid claims data.”

## Discussion

The findings presented in this analysis suggest that although not widespread, state Medicaid programs do make use of DM as a prime-contractor-level agreement. Many MCOs may use DM sub-contractors, but such sub-agreements are closely held and not available for routine collection and inspection.

DM prime agreements appear to target populations and conditions typically exempt from general MCO purchasing. Furthermore, while states with prime DM contracts offer DM services to populations typically exempt from MCO programs, states with prime DM programs do not always require that contracted MCOs offer DM services to certain members.

States appear to view DM prime contracts chiefly as a means of enhancing FFS coverage or PCCM arrangements. In this respect, DM is envisioned as an independent intervention that layers onto underlying health care systems for certain patient groups. States with DM prime contracts do not uniformly specify that their MCO contractors use DM techniques under certain circumstances.

The findings also suggest that states use DM in ways beyond the relatively pinpointed strategies that emerge from the DM literature. The DM literature suggests the utility of DM in the context of specific types of patients and specific types of conditions – that is, patients and conditions amenable to standardized monitoring and self management practices, rather than the more complex type of support interventions that fall into the rubric of “case management.” To the extent that state Medicaid programs are in fact broadening DM as a means of addressing more generalized health conditions (e.g., obesity) or generalized health care seeking behaviors (e.g., an inappropriate and ongoing reliance on emergency departments), these uses of DM would appear to mark a broadening of the relatively tightly defined DM product market to include contracts designed to address broader challenges in population health that nonetheless may be amenable to monitoring, coaching, and the development of self care capacity.

Another conclusion to be drawn from this analysis is, as with our prior *Negotiating* studies, the high degree of variability in state purchasing practices, ranging from the populations, conditions, and behaviors that are targeted to specifications related to benefits and services, company qualifications, accountability measures, and company relations with clinical treatment providers and other health care system stakeholders. Because the objectives of state DM systems and the populations to be served vary widely, so too, do states’ system specifications.

The states whose contracts were examined purport to buy DM, but their definitions vary along with their expectations regarding benefits and services, interactions with clinical providers and other parts of the health care system, and with patients and their families. Specifications related to the credentials and competencies of persons employed as disease managers also vary. Payment approaches vary, as do expected reporting performance. In some cases state DM expectations begin to approach the customized care expectations of case management. In others, the state’s expectation appears to be more limited and standardized, with a stronger emphasis on self care and routine supports.

It is beyond the scope of this study to measure the extent to which MCOs *independently* (rather than as an explicit contractual requirement) use DM as a treatment design option. Medicaid MCOs, like state Medicaid agencies and other group health care purchasers, may view DM

techniques as a means of bolstering treatment approaches in the case of certain patients and conditions that are considered amenable to cost savings and health outcome improvements through monitoring, education, and patient self care. The same questions that apply when the focus is state Medicaid use of DM prime contracts would apply in the case of MCO subcontracts with DM firms: who is targeted, the services and benefits furnished, performance expectations, relationships with patients' clinical care providers, and payment terms.

In view of the attention focused on disease management as a concept for certain high-risk populations (whether or not also enrolled in structured general managed care arrangements), it is clear that a number of state Medicaid programs are engaged in actively searching for the right combination of objectives and performance expectations, whether as part of specific disease management contracts or as a component of a broader agreement. It is also clear that these objectives and performance standards are likely to vary widely depending on the characteristics of the underlying health and social services system that serves beneficiaries who are targeted for case management.

What might be some of the take-away lessons from this analysis?

*1. Avoid blurring the lines between DM and CM but keep pushing the edge of the DM envelope.*

As the CBO analysis points out, there is a crucial difference between DM and case management. The former is envisioned as a standardized intervention that emphasizes education, monitoring, and patient self care and management. The latter is a far more customized intervention that uses well-trained care coordinators, customized patient management, and a focus on patients with complex and interactive health conditions and needs. To the extent that states are attempting to realize care management results with more limited DM interventions, the results may be limited, particularly when the patients who are targeted do not fit within the DM "norm," that is, patients with specific conditions that are amenable to routinized management and possessed of basic self management capabilities and skills. Put another way, the evidence about DM suggests that low intensity DM works well with patients who have reasonably strong health literacy skills. Among lower income and higher risk populations, health literacy remains a critical problem.<sup>31</sup> Estimates are that low literacy, a problem that is disproportionately concentrated among poorer populations, costs the U.S. health care system as much as \$325 billion annually.<sup>32</sup>

But even though DM is predicated on fairly strong health literacy, the capacity to engage in self management and the ability to navigate health care and make good choices are skills that are important to all persons, including those whose needs are complex and who must deal with their health while coping with added social, educational, and environmental challenges. Thus, even when DM alone may not be appropriate for certain patients, the self-care and health literacy dimension of DM would be important in fashioning case management interventions even in the case of higher risk populations. Furthermore, because DM also emphasizes the routinization of effective treatment guidelines through education and

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<sup>31</sup> J.A. Vernon, A. Trujillo, S. Rosenbaum, and B. DeBuono. "Low Health Literacy: Implications for National Health Policy," October 2007.

[http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/LowHealthLiteracyReport10\\_4\\_07.pdf](http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/LowHealthLiteracyReport10_4_07.pdf).

<sup>32</sup> Id.

reinforcement, the use of DM techniques would appear to be generally appropriate in light of the gap between what is known about effective care and the manner in which care is actually furnished. For this reason, rather than targeting only patients, DM techniques might also focus on educating and supporting health care professionals in order to raise their awareness of value of increasing active patient self engagement in their own care.

2. *Standardized DM expectations and purchasing terms might promote the development of a stronger and more responsive industry.*

This analysis shows the variation in state purchasing practices. Health care is an intensely localized service and goods that varies in accordance with the characteristics of particular communities and delivery systems. At the same time, in a market driven health care system such as that which exists in the U.S., achieving local changes in the way health care is practiced may necessitate focused and coordinated efforts on the part of purchasers, so that the financial incentives align in the direction of change.

In the context of Medicaid disease management, this need to align purchasing power in order to advance health care quality and reduce health and health care disparities means bringing state Medicaid purchasers together to reach consensus regarding what is expected of DM broadly speaking, what techniques and interventions common to disease management products might be appropriate to health care generally, and to develop more detailed purchasing specifications. Common expectations and common purchasing specifications in turn send important signals to the health care industry regarding health care performance expectations generally. In the case of DM for higher need populations, a joint purchasing effort might ultimately bring forth a more tiered approach to DM that allows states to incorporate DM techniques into various purchasing arrangements, including services and products that target higher need and more complex patients. To the extent that DM services of varying intensity can increase the limited health literacy of low income patients about their health care needs and what works, such a result would be an important contribution to higher health literacy.

3. *Clarity in purchasing specifications is key.*

Aside from standardization of purchasing expectations, clarity is key. The need for clarity affects both the types and nature of the performance that is expected, the data to be reported, and the applications of incentives. The findings in this analysis reveal pervasive ambiguities in terms and definitions, services and benefits, and performance duties. As with MCO services, Medicaid agencies manage their DM services through their contracts. Ambiguities were found in virtually every dimension of DM, from patients and conditions to be targeted to the qualifications of personnel and the types of activities and results expected by the purchaser. Sample contract language, developed through a joint purchasers' exercise, could do much to alleviate this ambiguity.

4. *Transparency in performance expectations, including the types of information collected and reported, and stratification of care and outcomes by race, ethnicity, and language would be valuable for both purchasers and patients.*

Clear performance expectations are important in any contractual relationship. So, too, is clarity regarding the information that providers will furnish to both purchasers and patients and the manner in which the information should be furnished. Often the focus is on the

provision of information to purchasers. But the focus must be broadened, particularly in the case of DM, where a core aspect of the intervention is to increase patients' ability to manage their health conditions. Extensive literature suggests significant disparities in health care and patient outcomes based on race, ethnicity, and language. The literature also shows large gaps in health literacy by patient status, making strengthening health literacy a major goal of any system reform. Where, as in the case of DM, improved patient literacy is a fundamental goal of a service, the stratification of results by race, ethnicity, and language becomes absolutely essential as a means of assuring that the benefits of health literacy and self management are equitably reaching the populations to be served.

5. *More focus could be brought to the interaction between DM systems and clinical care providers.*

A final observation has to do with the nature of the interaction between DM and clinical care. The purchasing documents reviewed in this study suggest an approach to DM in which DM stands apart from the structure and process of clinical care, as a sort of layer that sits on top of (or that runs alongside) the clinical care system with no real interaction.

But DM is bound up in the twin concepts of standardizing known interventions and empowering and educating patients. These two concepts are powerfully related to health care itself, and are intimately related to both health care quality and the very nature of the clinician/patient interaction. In truth, DM could be thought of in a very different fashion — not as an intervention that stands apart from clinical care, but one that is embedded in, and triggered by, the clinical care process, as a means of enabling patients with certain conditions to better care for themselves, while providing the clinical care system with important monitoring and feedback information in between patient visits. To the extent that DM is treated as an activity that is separate from clinical care itself, some of its most important potential as a mechanism for improving quality and reducing disparities may be lost.

What does this mean for DM purchasing? It may mean that rather than being bought as a separate and stand-alone product, states might consider purchasing DM as a tool for their clinical practices, one that can be drawn on for specific types of patients and conditions and as a means of both improving patient care while upgrading overall quality. Viewed in this way, DM would become a collaborative purchasing process between Medicaid agencies and health care professionals, with purchasing specifications developed as follow-on to a broad collaboration to improve the consistency of health care quality and the literacy of patients.

# Appendix A: Contractual Specification Excerpts - Network Selection and Oversight

## **California**

*Disease Management Pilot Program, RFP 05-45889*

*March 15, 2006*

"Exhibit A, Attachment 1, Scope of Work – Contract Performance...

### **A. CONTRACT ADMINISTRATION**

#### 1. Organization and Staffing

Contractor shall maintain the organizational and administrative capabilities to perform its duties and responsibilities under the Contract. This will include, at a minimum, the following:

\* \* \*;

b. Staffing in medical and other health services, and in fiscal and administrative services, is sufficient to result in the effective conduct of the organization's business; \* \* \*

#### 2. Medical Oversight

a. Contractor shall ensure that medical decisions, including those by subcontractors, are not unduly influenced by fiscal and administrative management. \* \* \*

### **G. MEMBER SERVICES – SCOPE OF SERVICES...**

#### 3. Disease/Case Management...

d. Staffing - At a minimum, the Case Manager will be a licensed registered nurse or other healthcare professional as defined in Section 4999.2 of the California Business and Professions Code. The Contractor shall also employ the services of a licensed psychiatrist, psychologist, or licensed/certified mental health specialists, as needed, to address the behavioral and/or mental health concerns of the Member."

## **Colorado**

*ASTHMA Disease Management RFP*

*November 2004*

"II: Scope of Work

#### B. Asthma Disease Management Program

1g. The Contractor shall provide physician education, including summary reports to primary care physicians and interface with the Medical Director when Enrollees are not being treated optimally and treatment plans are not up-to-date."

## **Colorado**

### ***DIABETES Disease Management RFP***

***January 2005***

#### “II: Scope of Work

##### B. Diabetes Disease Management Program

1g. Provider Education: The Contractor shall conduct provider education by sending written educational materials on the risk factors of Enrollees, alert notifications and summary reports to primary care physicians (PCPs) and health care professionals. The alert notification shall summarize an Enrollee’s medical and contact information and areas of concern. Alert notifications are communications to the Enrollee’s physician by telephone, facsimile or letter and are prompts for the physician or case manager to call and discuss the Enrollee’s chronic condition.”

## **Florida**

### ***Invitation to Negotiate for Participation in the AIDS Disease Management Initiative of the Florida Medicaid Program***

***August 24, 1998***

#### **“Section A. Background Information and Program Objectives**

##### **III. Program Design**

###### **I. Medical Management...**

The DMO will solicit the voluntary cooperation of MediPass primary care providers. Additionally, the DMO may enlist qualified Medicaid specialists who volunteer to be referral sources for PCPs in order to assure cooperation and compliance with treatment protocols. DMOs must coordinate their patient management activities with the MediPass primary care providers and specialists for DMO enrollees who are also MediPass enrollees. Coordination ensures that PCPs are informed of the clinical protocols used, that they authorize medically necessary services, as well as receive feedback about services provided by specialists.

While not required, DMOs may also wish to develop relationships with hospitals, home health agencies, pharmacies, or other providers to the degree that such relationships enhance the DMO’s ability to achieve cost savings and clinical improvements and care. If the DMO does develop a relationship with a pharmacy or pharmacies, the medication formulary for use with Medicaid DMO enrollees shall not be restricted or altered from its present open and unrestricted status.

The disease management initiative places no new obligations on the enrollee, nor on the enrollee’s physicians, to utilize certain Medicaid participating providers. Beyond the existing MediPass requirements that the primary care provider be used as the initial point of contact for all routine and specialty care needs, DMO enrollees will have free choice of Medicaid providers. Thus, DMOs can only encourage — but not require — that enrollees use providers recommended by the DMO.

The individual care management provided by the DMO will be disease specific for DMO enrollees. This care management will be separate from and not conflict with the primary care management currently provided for recipients by the MediPass PCPs. DMO care management will focus on managing the chronic condition and will include direct intervention by case managers with recipients regarding education on the disease process. The DMO will direct AIDS recipients' care towards the outpatient setting. Case managers will contact recipients at their homes and provide education to increase recipients' self-management of their disease. Case managers will also monitor recipient compliance with care plans.

In contrast, MediPass PCPs will continue in a primary care role and continue to manage Medicaid services as outlined in the MediPass provider agreement. These services are comprehensive and include, but are not limited to, conducting adult health screenings, providing early and periodic screening, diagnosis and treatment services (EPSDT), providing acute care services, making medically appropriate referrals, and coordinating other medical services. The MediPass PCPs will continue to receive the monthly \$3.00 administrative fee per enrollee. The DMO will provide interventions to augment and complement PCPs and other provider encounters and will coordinate these actions with the MediPass PCPs."

**“Section C. Information Required from AIDS DMO Applicants**

24. Provide a list of the number and types of specialist physicians with whom the DMO has or will develop relationships and indicate whether the specialist(s) is board certified.”

**Georgia**

***Request for Proposals for Disease Management Services for Medicaid Aged, Blind and Disabled Members, RFP Number 41900-001-0000000025  
March 2, 2005***

**“A. Scope of Services and Requirements**

**4.0 Project Statement of Work**

**4.4 General Requirements**

**4.4.20 Collaboration**

The Offeror shall conduct Georgia Disease Management Program services collaboratively with members, treating providers, community resources, and DCH and its business partners. The program shall provide value-added information and support services for medical providers and increase coordination of member care. The Offeror will:

- Incentivize PCPs in a way that improves the participation in the program; as well as delivery of, compliance with, and outcomes of care.
- Report to the Department performance of PCPs on compliance with treatment protocols.”



## **“B. Instructions and Information**

### **5.0 Process for Submitting Proposals**

### **5.8 Content of Technical Proposal**

#### **5.8.1 Approach to Contract Performance**

- K. Describe collaboration and coordination with area providers. Please address each of the following:
- How you will work with local providers to gain their participation in the program, including coordination with the professional staff under their supervision;
  - How you will incentivize PCPs to participate in and cooperate with the DM program, as well as work to improve outcomes for members;
  - How you will identify and integrate with Georgia Medicaid’s provider community and infrastructure, including Federally Qualifying [sic] Health Centers, Rural Health Clinics, Public Health Departments, and high volume providers. Please specifically address how you will work with the facilities providing mental health services to members and the case managers providing services to members enrolled in the Community Care Services Program. (Both are described in Appendix G);
  - Criteria you will use to determine which medical providers receive updated information on member health status;
  - Criteria you will use to determine how information on member health status is relayed to providers (telephonic, email or fax reports or memos, etc.);
  - How you will work with other assigned case managers to ensure that all are aware of the treatment plan and share pertinent information about the members medical and service needs;
  - How you will coordinate interventions and ensure follow-up between nurse call staff, case management staff, and the treating and/or primary care providers;
  - How you will work with providers in managing the complex medical needs of members with multiple conditions, including the assistance will you give to those providers; and

- How your staff will intervene if a problem with a member, provider, or collaborating state agency is identified.”

(The following language is found in the description of what constitutes a care plan):

\* \* \* [C]are plans should demonstrate creativity in generating member compliance and shall take into account opportunities for prevention and education, as well as intervention and cost savings. Member care plans may be developed using a team based approach, which incorporates the skills of social workers, health aids, nurses, physicians, and therapists. However, the Contractor nurses or physician staff professionally licensed in the State of Georgia must perform final review and approval of member care plans.”

## **Illinois**

### ***Disease Management RFP 2006***

#### “4.3 Services Required

##### 4.3.6: Provider Education and Involvement

The Vendor shall have a written description of the program for each area of its disease management program structure and accountability and includes, at a minimum:

4.3.6.1: The Vendor shall develop a plan to collaborate and coordinate with other comprehensive disease management initiatives (e.g., Cook County Bureau of Health Services and the U.S. Department of Health and Human Services, Health Resource and Services Administration’s (HRSA) disease management learning collaborative activities within the FQHC network). Collaboration and coordination may include a subcontracting arrangement with the Cook County Bureau of Health Services to expand their disease management activities. In addition, the Vendor may subcontract with the FQHCs, directly or as a group of FQHCs, through their disease management collaborative, to achieve the goals set forth in 4.2 Goals and Objectives. All subcontracts require HFS prior approval.

4.3.6.13: The Vendor shall screen all current and prospective employees, contractors, sub-contractors, and Providers with the DM Network prior to engaging their services for its DM Program by (i) requiring them to disclose whether they are Ineligible Persons; (ii) reviewing the OIG’s list of sanctioned persons available on the World Wide Web at < <http://www.dhhs.gov/oig> >.

4.3.6.14: The Vendor shall annually screen all current employees, contractors and sub-contractors providing services under its DM Program. The Vendor shall terminate its relations with any Ineligible Person immediately upon learning that such Person or Provider meets the definition of an Ineligible Person and notify the OIG of the termination.

#### 4.4. Milestones and Deliverables:

##### 4.4.1 Readiness for Implementation:

4.4.1.1.3: A detailed work plan for implementation, including the outreach plan for Providers and training of Vendor’s DM staff. The detailed work plan must be submitted to HFS for approval.

#### 4. Terms and Conditions:

4.2 Vendor Performance and Responsibilities

4.2.7.1: The Agency/Buyer acknowledges that the Vendor may contract with third parties for the performance of any of the Vendor's obligations under this Contract. However, all subcontracts shall be subject to prior approval by the Agency/Buyer, so the Vendor must obtain the Agency/Buyer's prior written consent before allowing any Third Party to perform any of the Vendor's obligations under this Contract."

**New York**

***Request for Proposals: Medicaid Disease and Care Management Demonstration Programs***

***March 21, 2005***

**"Part II – Bid Requirements**

**B. Format for Volume 1 – Technical Proposal**

**3. Technical Approach Proposed**

**e. Demonstration Key Functions**

**2) Enrollment of Eligible Recipients and/or Providers**

Contractors will be required to actively enroll individuals and/or providers into their demonstration program."

**"Part II – Bid Requirements**

**B. Format for Volume 1 – Technical Proposal**

**3. Technical Approach Proposed**

**e. Demonstration Key Functions**

**5) Outreach and Awareness**

It is anticipated that bidders will undertake general outreach and awareness activities to gain acceptance and support among providers and/or recipients who will be involved in the demonstration."

**"Part II – Bid Requirements**

**B. Format for Volume 1 – Technical Proposal**

**3. Technical Approach Proposed**

**e. Demonstration Key Functions**

**5) Outreach and Awareness**

c) Describe strategies that will be utilized to recruit medical providers to serve as a “medical home” for enrollee as needed.”

\*\*\*Note: again, the question of network management was interpreted broadly. Since the DM contractors were required to reach out and recruit providers to work with their program, this was interpreted as a type of management, allowing them to determine who they work with.\*\*\*

## **North Dakota**

(The following language also appears in the coordination and health system relationship excerpts, shown below):

\* \* \* (coordination with) **Other Stakeholders.** The Offeror should consider a regional approach to the health management program, hiring or contracting with nurse case managers in the larger cities across the state to serve a multi-county region. For example, a nurse case manager in Fargo may provide services to Cass, Traill, Steele, Richland, Sargent and Ransom county Recipients. The Offeror should also consider establishing and maintaining Regional Advisory Committees (RACs) in each region to serve as program advisors and provide a formal structure for the exchange of ideas between program staff and the communities to which they provide services. Each RAC could consist of stakeholders including a Recipient and their representatives, county social service center eligibility staff, health care providers, local public health units, community agencies and community leaders. Focus areas for the RACs may be health education/literacy, marketing and outreach, service delivery and quality assurance.”

## **Texas**

### **Medicaid Disease Management RFP October 2003**

#### “8.4: Service Delivery Operations

##### 8.4.1: State/Vendor Responsibilities

##### 8.4.1.2: Vendor Service Responsibilities – Statewide

B. Participating Providers: At a minimum, the Vendor will be responsible to provide the following services for participating providers:

- B.1 Intensive recruitment of providers to participate in the DM program and will coordinate with HHSC to ensure that potential providers have current Medicaid provider agreements.
- B.2 Recruit providers to serve as primary care providers or as a medical home for DM eligible clients as needed, including recruitment of specialists as primary care providers when warranted by the patient’s condition and needs.
- B.3 Develop provider support for, and give provider education regarding, the specific evidence based guidelines selected for use.
- B.4 Ensure no barriers to medical provider input into the development of an eligible DM client’s plan of care.
- B.5 Implement a system for providers to request specific DM interventions.

- B.6 Give providers feedback on differences between recommended prevention and treatment and actual care received by eligible clients, and on client adherence to a plan of care.
- B.7 Provide assistance in assuring necessary specialist care.
- B.8 Provide reports on changes in a client’s health status to their participating primary care provider.
- 8.4.1.3 Performance Indicators
  - o State approved comprehensive Client Service Plan, including client educational materials, telephone consultation services, and client complaint system
  - o State approved comprehensive Provider Services Plan, including provider educational materials and reports to providers on changes in their eligible clients’ health status.”

## **Washington**

### ***Chronic Care Management Project, RFP HRSA/OCC-0106 2006***

#### **“C. Project Scope**

##### **8. Local Care Management (LCM) Programs:...**

LCM contractors are encouraged to utilize staff in a range of professions, such as registered nurses, licensed social workers, and lay health workers who have specific cultural awareness of the local population. The Contractor may employ multidisciplinary teams to provide services but the principal care manager must be an RN unless the bidder presents a compelling case for another health professional as the principal care manager. The principal care management nurse will provide an interface between the provider, social worker and lay health worker to coordinate care for enrollees, and ensure care is delivered at the most appropriate level. LCM staff will provide referral and advocacy to mental health, long term care and other community services.”

#### **“D. Minimum Qualifications**

##### **4. Statewide Care Management (SCM) Proposals:...**

Both LCM and SCM contractors must provide care management services through appropriately licensed professional staff, including at a minimum BSN level Registered Nurses licensed in the state of Washington. In addition, it is expected that the contractors will have access to resources such as: such as master’s level social workers, chemical dependency counselors, dieticians, or psychiatric nurse practitioners. Certain aspects of enrollment and assistance with referrals to transportation or other services may be performed by lay health workers.”

# Appendix B: Contractual Specification Excerpts - Utilization Management

## **California**

*Disease Management Pilot Program, RFP 05-45889*

*March 15, 2006*

### **“K. Proposal Format and Content Requirements...**

#### **3. Content Requirements...**

##### **e. Work Plan Section...**

##### **4) Work Plan Submission Requirements...**

#### iii. Utilization Monitoring (UM) Plan

- a) Proposer shall submit a UM plan that describes the firm’s ability to perform the responsibilities outlined in Exhibit A, Attachment 1, Provision D, Utilization Monitoring.
- b) Proposer shall describe the firm’s experience in developing and implementing UM strategies to minimize inappropriate utilization of emergency department services, acute care hospitalizations, specialist services, medications and other goods and services.
- c) Proposer shall describe the firm’s experience in using data and reports to improve utilization of goods and services.
- d) Proposer shall describe any innovative UM activities that demonstrate their commitment to exceed the minimum requirements set forth in this RFP.”

### **“Exhibit A, Attachment 1, Scope of Work – Contract Performance...**

#### **D. UTILIZATION MONITORING**

Utilization Monitoring (UM) allows an organization to monitor the provision of services. Reports and data on service utilization can provide the Contractor with vital information about the delivery of services. Utilization data can determine where health care dollars are being spent, which health care practitioners are providing the most appropriate health care, where Medi-Cal beneficiaries seem to prefer to access health care services, what services are being accessed, and what services may be utilized or delivered inappropriately. The DMPP emphasizes utilization monitoring as an important tool in detecting areas that need improvement. Contractor shall develop and implement strategies based on utilization monitoring to minimize under/over utilization of emergency department services, acute care hospitalizations, specialist services, medication and other goods and services. At a minimum, the Contractor will track and trend the following:

1. Utilization per member per month in total, by diagnosis and type of service.
2. Gaps in care (recommended treatment/preventive care versus actual treatment).
3. Inappropriate use of medications (per applicable clinical guidelines).

Contractor will not have the authority to approve, modify or deny services to Members. All Treatment Authorization Requests (TARs) will be processed through the existing Medi-Cal prior authorization system.”

## **Georgia**

### *Request for Proposals for Disease Management Services for Medicaid Aged, Blind and Disabled Members, RFP Number 41900-001-0000000025*

*March 2, 2005*

#### “A. Scope of Services and Requirements

##### 4.0 Project Statement of Work

##### 4.4 General Requirements

##### 4.4.12 Interventions

Interventions shall include evidence-based clinical guidelines and recommended treatments for the disease state(s), and be specific to the member’s severity level and need. Interventions shall incorporate information gleaned from Offeror’s baseline assessments and contacts with call nurses, treating providers, case managers, and caregivers. Interventions shall also include member education (focusing on self-management and prevention of acute episodes), and provider adherence to clinical guidelines.

##### 4.4.15 Case Management

The Offeror shall perform the following case management tasks where the Offeror and DCH agree to be reasonably cost-effective and clinically appropriate:

...

- Monitor cost of members care and recommend interventions for more cost effective care as appropriate”

## **Florida**

### *Invitation to Negotiate for Participation in the AIDS Disease Management Initiative of the Florida Medicaid Program*

*August 24, 1998*

#### “Section A. Background Information and Program Objectives

##### III. Program Design

##### I. Medical Management

[intervening information not directly relevant]

A DMO must demonstrate expertise with and use of treatment guidelines and protocols that have been developed by experts in the field and ensure high quality, cost-effective care delivery. These protocols must demonstrate familiarity with current technologies, treatments and literature regarding the most current approaches and methodologies for disease management. The DMO will propose the clinical guidelines to be used; however, the Agency must approve the clinical guidelines selected by the DMO prior to implementation.”

**North Dakota**

*Medicaid Health Management Program, RFP 325-06-10-011*

*March 13, 2006*

**“SECTION TWO BACKGROUND INFORMATION**

**2.01 Background Information...**

Medicaid operations including managed care enrollment, provider enrollment, the Medicaid toll-free telephone line for provider and Recipient assistance, utilization review, medical necessity reviews, transportation authorization, disability determination, etc. are not outsourced but completed through State Medicaid and/or county social service staff. (A contractor assists with some aspects of utilization and medical necessity review.)”



# Appendix C: Contractual Specification Excerpts - Consumer Protections

## California

*Disease Management Pilot Program, RFP 05-45889*

*March 15, 2006*

### “K. Proposal Format and Content Requirements...

#### 3. Content Requirements...

##### e. Work Plan Section...

#### 4) Work Plan Submission Requirements...

### iv. Member Services Plan

#### a) Members Rights

- 1) Proposer shall submit a Member Services Plan that describes the firm’s ability to perform the responsibilities outlined in Exhibit A, Attachment 1, Provision E, Members Rights.
- 2) Proposer shall describe the firm’s experience that demonstrates their ability to develop and implement policies and procedures addressing Members rights and responsibilities.
- 3) Proposer shall submit an organizational chart of proposed or existing staff for Member Services which demonstrates that staffing is sufficient to support the Member Services functions.
- 4) Proposer shall submit the staff requirements and training plan that ensures staff performing Member Services functions will be knowledgeable regarding the DMPP.
- 5) Proposer shall describe the firm’s experience in developing and disseminating program information and Member Services Guides.
- 6) Proposer shall describe the firm’s experience that demonstrates their ability to maintain, collect, store, retrieve and ensure confidentiality of Members records.
- 7) Proposer shall describe any innovative Member Services activities that demonstrate their commitment to exceed the minimum requirements set forth in this RFP

### “Exhibit A, Attachment 1, Scope of Work – Contract Performance...

## E. MEMBER SERVICES – MEMBERS RIGHTS

### 1. Member Rights and Responsibilities

Contractor shall develop, implement and maintain written policies that address Member rights and responsibilities and shall communicate these to its Members. a. Contractor’s written policies regarding Member rights shall include the following:

- 1) To be treated with respect, giving due consideration to the Member’s right to privacy and the need to maintain confidentiality of the Member’s medical information;
- 2) CDHS approved policy for resolving disputes;
- 3) To be provided with information about the organization and its services;
- 4) To receive oral interpretation services for identified threshold languages as listed in Appendix 1-Glossary;
- 5) To have access to, and when legally appropriate, receive copies of, amend or correct their Member Record;
- 6) To disenroll at any time;

- 7) To receive written materials in alternative formats, including Braille, large size print, and audio format within 14 days of request; and
  - 8) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation...
- c. Contractor shall implement and maintain policies and procedures to ensure the Member's right to confidentiality of medical information.
    - 1) Contractor shall implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons.
    - 2) Contractor shall inform Members of their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such authorization is not required.
  - d. Contractor shall maintain the capability to provide Member services to DMPP Members through sufficient assigned and knowledgeable staff.
  - e. Contractor shall ensure Member services staff is trained on all contractually required Member service functions including, policies, procedures, and scope of benefits of this Contract.
  - f. Contractor shall provide all new DMPP Members with written Member information. In addition, the Contractor shall provide potential Members with written Member information upon request.
    - 1) Contractor shall distribute the Member information no later than seven (7) calendar days after the effective date of the Member's Enrollment. Contractor shall revise this information, and distribute it annually to each Member.
    - 2) Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate by existing Medi-Cal standards.
    - 3) The written member informing materials shall be translated into the identified threshold languages (Provision H - Member Services, Access and Availability, Linguistic Services).
    - 4) The written member informing materials shall be provided in alternative formats, including Braille, large size print, and audio format, within 14 days of request.
  - g. Contractor shall develop and provide each Member a Member Services Guide that constitutes a fair disclosure of the provisions of the covered DM services. The Member Services Guide shall be submitted to CDHS for review and subsequent approval prior to distribution to Members. The Member Services Guide shall include the following information:
    - 1) Description of the DMPP covered services and benefits and how to access them;
    - 2) The importance of establishing a medical home and information on how to contact the DMO for assistance in this process;
    - 3) Information explaining the importance and value of scheduling and keeping appointments;
    - 4) Procedures for obtaining emergency health care;
    - 5) Procedures for obtaining any transportation services available through the Medi-Cal program, and how to obtain such services. Include a description of both medical and non-medical transportation services and the conditions under which non-medical transportation is available;
    - 6) The causes for which a Member shall lose entitlement to receive services under this Contract as stipulated in Provision G - Member Services – Scope of Services, Enrollment/Disenrollment;
    - 7) Procedures for Disenrollment, including an explanation of the Member's right to disenroll without cause at any time;

- 8) Information on the availability of, and procedures for obtaining, services at Federally Qualified Health Clinics (FQHC) and Rural Health Clinics (RHC); and
- 9) Any other information determined by CDHS to be essential for the proper receipt of DM services.”

## **Florida**

### *Invitation to Negotiate for Participation in the End State Renal Disease Management Initiative of the Florida Medicaid Program*

*November 20, 1998*

#### “Section A. Background Information and Program Objectives

#### III. Program Design

#### J. Patient Services

Disease management services shall begin with an initial assessment and risk screening for each enrollee. Based on the findings of the assessment, the enrollee will be categorized into a severity level. The Agency is expecting the majority of individualized interventions be focused on those enrollees who are in the moderate to severe levels. Examples of services a DMO is expected to provide include the following:

...

- Appropriate guidelines that address recipients’ complaints and avenues for resolutions;”  
\*\*\*Note: similar phrasing/level of detail used in the other Florida DM RFPs\*\*\*

## **Georgia**

### *Request for Proposals for Disease Management Services for Medicaid Aged, Blind and Disabled Members, RFP Number 41900-001-0000000025*

*March 2, 2005*

#### “A. Scope of Services and Requirements

#### 4.0 Project Statement of Work

#### 4.4 General Requirements

#### 4.4.28 Complaints and Grievances

The Offeror shall have and provide the Department with its written complaint and grievance policies and procedures for review and prior written approval within sixty (60) days of Contract Award. The Offeror will participate in hearings, whether formal or informal, when appropriate and requested by DCH, members, or providers.”

#### “B. Instructions and Information

## 5.0 Process for Submitting Proposals

### 5.8 Content of Technical Proposal

#### 5.8.1 Approach to Contract Performance

- J. Design processes and scripts for addressing Member and Provider inquiries, complaints, and refusals to participate for DCH review and approval.”

## **Illinois**

### ***Disease Management RFP 2006***

#### “4.3 Services Required

##### 4.3.4: Case Management

4.3.4.4: Procedures for addressing Member and provider feedback, including a process to respond to complaints. This includes criteria and procedures to allow a change in the DM Case Manager, as appropriate.

##### 4.3.9: Reporting Requirements:

###### 4.3.9.2.5: Complaint Reports (Members):

4.3.9.2.5.1: Number of Complaints by Type

4.3.9.2.5.2: Type of Assistance provided (Members)

4.3.9.2.5.3: Summary of Complaint logs and resolutions, which can be inspected for further detail.”

## **North Dakota**

### ***Medicaid Health Management Program, RFP 325-06-10-011 March 13, 2006***

#### **“SECTION THREE**

#### **SCOPE OF WORK**

##### **Scope of Work...**

##### **Contractor Responsibility...**

- In cooperation with the State, assure federal requirements pertaining to PAHPs are applied to the health management program. Federal requirements include applicable portions of the following sub-parts of 42

CFR, Part 438, *Managed Care...*

- Enrollee rights and protections...

- An enrollee’s right to a fair hearing from the State...”

## **Texas**

### ***Medicaid Disease Management RFP October 2003***

#### “8.2 General Contract Operations

### 8.2.2: State Responsibilities

SUS-8: Monitor service requests and complaints received from providers, recipients and outside parties in the course of the Vendor's day-to-day activities

### 8.2.3: Vendor Responsibilities

-SUG-24: Appoint a liaison to work with other Vendors as needed. The liaison will be responsible for coordinating activities with other Vendors; resolving issues related to the successful performance of Contract responsibilities; and ensuring quality customer service is delivered to the State, providers, and recipients.

- SUG-29: Develop and implement a Complaint and Tracking Reporting System...

## 8.4: Service Delivery Operations

### 8.4.1: State/Vendor Responsibilities

#### 8.4.1.2: Vendor Service Responsibilities – Statewide

A.14 Develop a process to respond to client complaints."

# Appendix D: Contractual Specification Excerpts - *Payment and Risk*

## **California**

*Disease Management Pilot Program, RFP 05-45889*

*March 15, 2006*

### **“K. Proposal Format and Content Requirements...**

#### **3. Content Requirements...**

##### **i. Rate Proposal Section...**

##### **2) General Instructions...**

b) On the Rate Proposal form, indicate the **all inclusive** case management fee to be received each month per Disease Management enrolled member.

c) When completing the Rate Proposal form, include all estimated costs in your all inclusive rate proposal to perform the services over the entire contract term, including applicable annual rate adjustments attributable to merit increases, profit margins, and inflation or cost of living adjustments. All of these factors should be contained in this all inclusive rate. CDHS will not reimburse the Contractor for any costs not included in the rate proposal represented in **Attachment 12**. These cost considerations may include, but are not limited to:

1. Personnel Costs
2. Fringe Benefits
3. Operating Expenses
4. Equipment Expenses
5. Facility Expenses
6. Subcontract Expenses
7. Travel Costs
8. Indirect Costs
9. Phase in and Phase Out Costs (unpaid portions of the contract term that need to be accounted for in your all inclusive rate proposal for the contract term).”

### **“Exhibit B, Attachment 1, Special Payment Provisions...**

#### **1. Contractor Risk in Providing Services**

The Contractor will assume total risk for providing the Covered Disease Management Services on the basis of the periodic case management fee for each Member, except as otherwise allowed in this Contract.

The Contractor will retain any monies not expended by the Contractor after having fulfilled these obligations under this Contract.

#### **2. Case Management Fee Rates**

DHS shall remit to the Contractor a post-paid case management fee each month for each Disease Management Pilot Program Member that appears on the approved list of Members supplied to DHS by the Contractor. The payment period for disease management services for each Member shall commence on the first day of the month following the month the Member is

enrolled. Case management fees shall be reimbursed at the rate bid per member per month, subject to Provision 4.

*Determination of Rates* listed below, in accordance with the Cost Proposal submitted in response to RFP 05-45889.

### **3. Case Management Fee Rates Constitute Payment in Full**

The case management fee constitutes payment in full for all Covered Disease Management Services required by the Member and for all Administrative Costs incurred by the Contractor in providing for or arranging those services. It does not include payment for recoupment for current or previous losses by the Contractor. DHS is not responsible for making payment for recoupment of losses.”

## **Colorado**

### ***ASTHMA Disease Management RFP***

***November 2004***

#### “III: General Provisions

##### C. Compensation/Maximum Payable

2. Reimbursement to the Contractor shall be for Enrollees only, using the following scale: \$xxx for the first completed intervention call per Enrollee and \$xxx for each of three subsequent completed intervention calls per Enrollee. Additionally, reimbursement shall include \$xx for each six-month program extension follow-up call. There will be two six-month extension calls per Enrollee. If the Enrollee does not complete participation in the program, reimbursement will be paid only for the calls completed. This amount will be paid upon receipt of an invoice.
3. Payment pursuant to this contract shall be made as earned, in whole or in part, from available State funds in an amount not to exceed \$xxxxxx for the purchase of the within-described services.
4. It is further understood and agreed that the maximum amount of State funds available for fiscal year 2005 for the purchase of the within-described services is \$xxxxxx. The liability of the State, at any time, for such payments shall be limited to the unexpended amount remaining of such funds.”

## **Colorado**

### ***DIABETES Disease Management RFP***

***January 2005***

#### “IV: General Provisions:

- D. Billing/Payment Procedure: Unless otherwise provided, and where appropriate, the Department shall establish billing procedures and pay the Contractor the contract price or rate for services performed and accepted pursuant to the terms of this contract, based on the submission of statements on forms and in a manner prescribed by the Department. Payments pursuant to this contract shall be made as earned, in whole or in part, from available funds encumbered for the purchase of the described services. The liability of the Department, at any time, for such payments shall be limited to the amount remaining of such encumbered funds. Incorrect payments to

the Contractor due to omission, error, fraud, or defalcation shall be recovered from the Contractor by deduction from subsequent payment under this contract or other contracts between the Department and the Contractor, or by the Department as a debt due to the Department.”

## **Florida**

### ***Invitation to Negotiate for Participation in the Congestive Heart Failure Disease Management Initiative of the Florida Medicaid Program November 20, 1998***

#### **“Section A. Background Information and Program Objectives**

#### **III. Program Design**

#### **M. Financial Structure**

DMOs will be paid by the Agency with a retrospective adjustment based on the level of savings that occurs versus the Agency’s expected expenditures for the DMO’s enrollees (which determines the share of the overall savings paid to the DMO versus the share retained as savings by the Agency). The Agency will continue to pay submitted Medicaid fee-for-service claims through its fiscal agent for participating recipients at no cost to the DMO. The Agency will reimburse Medicaid providers only for those services identified as compensable in the program specific Coverage and Service Limitations Handbook.

Monthly Administrative Advances: The Agency may advance funds to the DMO each month based on the number of recipients enrolled in a disease management project. These funds will be a “draw down” against the DMO’s share of anticipated cost savings. The purpose of this advance is to help the DMO invest in administrative activities (e.g. care management, education and outreach) that present short-term costs but long-term savings to the Agency. The DMO must present a cost analysis justifying the dollar amount of a proposed monthly administrative payment.

For enrollees who meet certain criteria, an enhanced per capita monthly rate may be negotiated. Recipients in the enhanced group may represent those enrollees who require, for example, exceptional intervention or high cost incurred by the DMO compared to other recipients with the disease. The DMO must develop the criteria to predict recipients eligible for the enhanced group, present the rationale for any criteria, and recommend an appropriate monthly administrative advance.

The amount of monthly advances will vary from month to month based on enrollment levels. The Agency will verify the enrollment list including those persons eligible for an enhanced monthly advance. All known adjudications to prior months’ administrative advances (due to enrollment list verification findings) shall be made in the form of adjustments to the ensuing month’s administrative payment. At the end of the contract period, the DMO will be required to reimburse the Agency within 30 days of notification, for all monthly advances incorrectly paid for recipients enrolled with the DMO.



## **Shared Savings**

DMOs may receive payment in the form of shared savings. Savings available to be shared is the difference between actual Agency payments on behalf of DMO enrollees (including specified claims payments and MediPass case management fees) and the baseline payment. The DMO's proposal must include calculations of the requested percentage of shared savings to be received by the DMO. The rationale for the requested amount must be clearly explained in the proposal.

### ***1. Establishing the Baseline Payment***

The baseline payment reflects an estimate of the level of per recipient costs the Agency would expect to incur in the absence of implementing the disease management demonstration. The baseline payment will be derived from a claims analysis involving eligible Medicaid recipients. These recipients will meet the Agency's criteria for having characteristics of CHF.

For the identified recipients, the number of Medicaid recipient case months will be calculated for the 1996-1997 fiscal year (defined as the baseline period). Paid claims for these recipients will be aggregated to determine total expenditures for the baseline period. The number of case months and the paid claims will be excluded for those months when recipients are in categories ineligible for disease management services. These expenditures will be divided by the total number of case months for recipients eligible for disease management to obtain a dollar expenditure amount per recipient per case month. This dollar expenditure amount per recipient per case month will be inflated based on yearly Medicaid budget adjustments and will be referred to as the baseline payment per recipient case month. This will be used in the calculation of the baseline payment (see Row # 4 in Attachment E).

Fiscal year 1996-1997 dates of service will be used to establish the baseline payment for the DMO's first operational year. Fiscal year 1997-1998 dates of service will be used to establish the baseline payment for the DMO's second operational year.

### ***2. Annual Reconciliation***

The reconciliation for the first contract year will be made after the first quarter of the second contract year in order to factor in the delayed submission of claims. The reconciliation for the second contract year will be made after the first quarter of the third contract year. A final reconciliation will be made a year after the end of the second operational year to precisely adjudicate the final claims totals for service dates during the first 24 months of the contract period and with payment dates encompassing the last twelve months of the contract.

All reconciliations will be made on a DMO-specific basis. Savings from one DMO project will not be used to offset losses experienced by another DMO.

The reconciliation will have the following components:

- the identification of a baseline payment;
- the determination of whether cost savings exist;
- the determination of the amount of the DMO's share of cost savings, if any, that will be paid by the Agency to the DMO; and
- the determination of the amount, if any, that must be repaid by the DMO to the Agency.

### 3. Cost Savings Calculation

Paid claims of all recipients enrolled with the DMO will be identified. Only claims with service dates during periods of DMO enrollment will be used. Paid claims will be aggregated to determine the expenditures for the identified recipients for all Medicaid service categories. Total cost savings (Row # 7 in Attachment E) will be calculated as follows:

- the DMO’s baseline payment, which includes MediPass case management fees to primary care providers, for the contract year (Row # 4 in Attachment E), minus all Medicaid paid claims, including MediPass case management fees to primary care providers, made on behalf of DMO enrollees, for dates of service during the contract year and including only claims incurred during periods of DMO enrollment (see Row # 6 in Attachment E).

### 4. Potential Repayment of Monthly Administrative Advance by DMO

The Agency does not intend for paid claims for enrolled recipients to exceed the total baseline payment. However, if the total actual payments exceed the baseline payment, the DMO will refund its monthly administrative payment to the Agency, as necessary, so that Agency payments do not exceed the total baseline payment. In a worst-case scenario, the DMO would refund its entire monthly administrative advance. The DMO will submit payment to the Agency within 90 days of notification that a refund of monthly payments is required (see Row #11 in Attachment E).

### 5. Shared Savings Payments

If total cost savings exist in a given contract year, these savings will be shared with the DMO based on the negotiated percentage of shared savings to be received by the DMO. The DMO’s proposal must include calculations of the requested percentage of shared savings to be received by the DMO. The rationale for the requested amount must be clearly explained in the proposal. It is the intent of the Agency that the DMO portion of savings will be reasonable and related to DMO costs and not reflect a disproportionate share of the cost savings.

### 6. Reconciliation Overview

Two scenarios are shown in Exhibit 1 demonstrating the interplay between the baseline payment and monthly administrative payments. A more detailed table showing examples of financial reconciliation is presented in Attachment E.

**Exhibit 1: Reconciliation Overview — Two Scenarios**

The agency Costs: Paid Claims per Case Month*	Status of Monthly Administrative Payments to the DMO	Possibility of Shared Savings with the DMO
<b>Above the Baseline Payment</b>	<u>Return</u> to the Agency to equal baseline payment	None. Shared savings do not exist
<b>Below the Baseline Payment</b>	Retained if DMO’s shared savings are equal to or exceed the total monthly management payments	Yes. If DMO’s shared savings are greater than monthly management payment. DMO determined by size of savings

\*Including MediPass Case Management Fees

**Illinois**  
***Disease Management RFP***  
**2006**

“5.3 Price Proposal

5.3.1: Method and Rate of Compensation. The Vendor shall bid a firm “per member/per month” (PMPM) price for each of the following areas:

5.3.1.1: Disease Management Services for the Disabled Adults and Elderly Population.

The PMPM capitation shall be applied over the entire disabled adults and elderly population who qualify for disease management intervention. When developing a PMPM for the Disabled Adults and Elderly Population, the Vendor shall incorporate the assumptions in Appendix E.

5.3.1.2: Persistent Asthmatics. The PMPM capitation shall be applied over the population of Members diagnosed with Persistent Asthma who are actively engaged in the disease management intervention, and only for the month(s) that they are actively engaged in the disease management intervention, as defined by receiving disease management services.

5.3.1.3: Frequent Emergency Room Users. The PMPM capitation shall be applied to the entire Family Health Population (child and parent/caretaker relative population).

4.4 Terms and Conditions:

4.4 Indemnification and Liability:

4.4.1: By the Vendor: The Vendor agrees to indemnify and hold harmless the State of Illinois and the Agency/Buyer, its officers, employees and agents (appointed and elected) and volunteers from any and all costs, expenses, losses, claims, damages, liabilities, settlements and judgments, including reasonable value of the time spent by the Attorney General’s Office, and the costs and expenses and reasonable attorneys’ fees of other counsel required to defend the State of Illinois or the Agency/Buyer, related to or arising from:

4.4.3: LIABILITY: Vendor agrees to assume, without limitation, all risk of loss and all liabilities, demands, claims, suits, losses, damages, causes of action, fines or judgments, including costs, attorneys’ and witnesses’ fees, and expenses incident thereto, relating to bodily injuries to persons (including death) and for loss of, damage to, or destruction of real and/or tangible personal property (including property of the State) resulting from the negligence or misconduct of Vendor, its employees, agents, or subcontractors in the performance of the Contract. Vendor shall assume risk of loss until delivery to the Agency/Buyer’s facility. Vendor shall do nothing to prejudice the State’s right to recover against third parties for any loss, destruction, or damage to State property, and shall at the State’s request and expense, furnish to the State reasonable assistance and cooperation, including assistance in the prosecution of suit and the execution of instruments of assignment in favor of the State in obtaining recovery. Neither party shall be liable for incidental, special or consequential damages.”

## **New York**

### ***Request for Proposals: Medicaid Disease and Care Management Demonstration Programs***

**March 21, 2005**

#### **“Part I – Introduction and Background**

##### **C. General Information for Bidders**

###### **7. Payment:**

Payment will be provided to selected contractors for the care management services provided, including approved implementation costs and operation costs. Payment will be made consistent with the contract provisions, the DOH approved definition of an intervention recipient, the bid price and the final service area(s) approved by the Department. DOH will reimburse the contractor for each intervention enrollee who is concurrently enrolled in the Medicaid program and the CMD and is subject to care management by the contractor. A per member per month (PMPM) payment process will be used (see **Attachment 7**). Reimbursement will occur on a monthly basis following implementation and will consist of a PMPM fee paid each month per intervention enrollee.

The specifications for the RFP do not employ contingency fees nor require the contractor to be at financial risk to achieve net program savings on the cost of Medicaid services. The Department shall not approve proposals utilizing such approaches. However, the Department will conduct an evaluation of the demonstration proposals to determine both the cost effectiveness of the interventions and the quality of health care outcomes achieved.”

#### **“Part IV – Contractual Provisions**

##### **B. CONTRACTOR’S PERFORMANCE AND BASIS OF PAYMENT**

###### **1. Basis of Payment**

Consideration for performance by the contractor of the tasks described in the RFP Detailed Specifications will be paid according to the terms and conditions set forth below. The contractor shall submit invoices to the State for payment. Payment shall be made in accordance with Article XI-A of the New York State Finance Law, and are exempt from late payment interest pursuant to the statutory exception for a contractor of third party payment agreements.

###### **1.1. Implementation Payments**

The State shall pay the contractor for full and proper completion of all implementation tasks included in the approved implementation plan in the contractor’s proposal as modified or supplemented in **Appendix P**, by the terms of this contract and subsequent negotiations.

**1.1.1.** Upon successful completion of implementation, the contractor shall submit one (1) voucher for payment of approved implementation costs. Payment to the contractor shall be made promptly after receipt of such voucher that is satisfactory to the DOH and the Office of the State Comptroller.

**1.1.2.** In the event that the contractor fails to achieve milestones related to implementation, or to furnish deliverables, which result in delays of implementation beyond the schedule in the final implementation plan approved by the State, the State may assess penalties for each week the implementation is not achieved beyond the scheduled delivery date. Penalties shall not be assessed for delays attributable to the State or any entity not subject to the contractor’s control

in the sole judgment of the DOH. Such penalties may be up to thirty percent (30%) of the implementation payment due the contractor at completion of implementation.

## **1.2. Operations Payments**

The State shall pay the contractor for full and proper performance of the administration of disease management functions in the RFP as amended by documented Questions and Answers and in the contractor's proposal as modified or supplemented by the terms of this contract. Payments for the care management functions shall be made monthly, based on the contractor's approved per member cost for each enrolled intervention recipient as specified in **Appendix P** of this Agreement.

**1.2.1.** The monthly payment will be based on the number of enrolled intervention recipients as of the first business day of the month and the approved per member per month (PMPM). Any disenrollment that occurs during a month will be made effective the first day of the following month in which status change occurred and paid as such. In the case where a former intervention enrollee chooses to re-enroll in the care management program, eligibility for payment will begin the first business day of the following month.

**1.2.2.** In the event that the contractor fails to meet any milestones, or furnish deliverables related to ongoing administration of care management functions, the portion of payment attributable, in the judgment of the State, to the milestones or deliverables for which the contract is deficient shall be withheld by the State, in its sole discretion, until such time as the milestones or deliverables are determined by the State to have been properly achieved or furnished.

**1.2.3.** The contractor shall submit a monthly voucher for the administration of care management functions accepted and approved by the State. The State shall, upon receipt of a properly completed voucher, pay the contractor the adjusted payment shown in **Appendix P** of this Agreement.”

## **North Dakota**

**Medicaid Health Management Program, RFP 325-06-10-011**

**March 13, 2006**

### **“SECTION THREE SCOPE OF WORK**

#### **Scope of Work...**

The health management program described here will likely qualify as a Prepaid Ambulatory Health Plan (PAHP) and will be subject to federal regulations pertaining to PAHPs. These federal regulations are referenced periodically within this RFP and can be found at the following link: [http://www.access.gpo.gov/nara/cfr/waisidx\\_04/42cfr438\\_04.html](http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr438_04.html) (Title 42 of the Code of Federal Regulations [CFR], Part 438, *Managed Care*).”

### **“ATTACHMENT I RFP DEFINITIONS...**

**Prepaid Ambulatory Health Plan (PAHP)** – An entity that: (1) provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates, (2) does not provide or

arrange for and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its members, and (3) does not have a comprehensive risk contract.”

## **Oregon**

### ***Request for Applications for Chronic Care Model Implementation Grants***

**May 2, 2006**

#### **“Section I. Purpose and Overview**

##### **C. Funding**

Projects will be funded for two years at approximately \$60,000 per year. Matching funds of \$40,000 per year will be required as cash or in-kind. Projects will not be funded for more than two years. Multi-county applications will be considered for funding up to a maximum of \$120,000 per project per year. Proportionate matching funds would be required.

Approximately 4-5 projects will be funded through a competitive application process. Projects are anticipated to begin July-August 2006.”

## **Texas**

### ***Medicaid Disease Management RFP***

**October 2003**

#### **“ 6. Financial Approach – Business Terms**

6.1 Overview of Financial Approach: ...The State has chosen to use a “Fixed Price” approach related to the administrative services included in the Contract. The payment methodologies will only be applicable for the Title XIX Medicaid recipients not enrolled in a Medicaid Managed Care Health Maintenance Organization...The Texas Department of Human Services determines eligibility for Medicaid recipients each month. This is done prospectively for the current month, with adjustments made to prior months for retroactive eligibility or ineligibility. Separate Per Member Per Month (PMPM) fees must be proposed for each respective disease management contract.”

## **Washington**

### ***Chronic Care Management Project, RFP HRSA/OCC-0106***

**2006**

#### **“SECTION I. INTRODUCTION...**

##### **E. FUNDING**

DSHS intends to pay the SCM and LCM contractors for services provided in accordance with the expectations described in this RFP. Neither the SCM nor the LCM will be at risk for producing guaranteed savings, but programs must be cost neutral, i.e., the program must save enough money in medical and pharmacy costs to pay for itself. Programs will also be expected to provide improved outcomes for clients enrolled in the program. All rates paid for services will be

evaluated by DSHS and CMS staff for their cost effectiveness. DSHS will continue to pay all medical claims for services provided to project enrollees and will track utilization of services prior to program implementation and on a quarterly basis, according to CMS rules under waived programs.

Contractors will be paid for only those enrollees who are active participants in the project, as follows:

1. LCM contractors shall be paid for all enrollees assigned to medical homes in the program within the eligible population (Categorically needy, Aged, Blind, Disabled and Dual Eligible – Medicaid/Medicare). It is expected that the funds will support both medical home and the care management program components to avert costly medical treatment for high risk clients. Payments to providers should be structured to provide incentives for high quality, evidenced based care. LCM contractors must have the ability to receive HIPAA-compliant enrollee and payment information (in the 820 and 834 format) from DSHS.
2. The SCM Contractor shall be paid for Predictive Modeling services and referral of eligible clients to Local projects as described in this RFP. The SCM Contractor shall be paid a separate per member per month fee for care management services to identified high risk clients who do not reside in a Local program service area. The SCM Contractor must also have the ability to receive HIPAA-compliant enrollee information in the 820 and 834 format from DSHS.

DSHS will enroll clients with specific contractors and will pay the contractors a per member per month fee for all eligible clients who agree to be enrolled and participate in the program through the current MMIS system. The PMPM fee will include the costs of developing and implementing the project, support for participating providers as medical homes in the LCM programs, and all care management services.

DSHS recognizes that it will be difficult for an LCM bidder to estimate numbers of enrollees without knowing the output of predictive modeling. Likewise, the SCM bidders will not know exactly what their geographic scope is until the LCM contracts are awarded. DSHS will conduct one round of rate negotiation after awarding contracts and allowing bidders to review high level summaries of other tentatively awarded contracts.”

# Appendix E: Contractual Specification Excerpts - *Supports and Coordination with Other Parts of the Health Care System*

## **California**

*Disease Management Pilot Program, RFP 05-45889  
March 15, 2006*

“Exhibit A, Attachment 1  
Scope of Work-Contract Performance

### **C. QUALITY IMPROVEMENT SYSTEM...**

#### 2. Written Description

Contractor shall develop and implement a written description of its QIS that shall include the following:...

- c. Activities designed to assure the provision of case management and coordination of services...

### **H. MEMBER SERVICES – ACCESS AND AVAILABILITY...**

#### 1. Access Requirements

The Contractor shall establish accessibility standards, which include, but are not limited to, the following:...

- b. Contractor shall ensure that all non-English-speaking, or limited English proficient (LEP) DMPP Members receive 24-hour oral interpreter services, either through interpreters or telephone language services. Contractor shall arrange or provide, at minimum, the following linguistic services at no cost to the DMPP Members:

2) Referrals to culturally and linguistically appropriate community service programs.”

## **Georgia**

*Request for Proposals for Disease Management Services for Medicaid Aged, Blind and  
Disabled Members, RFP Number 41900-001-0000000025  
March 2, 2005*

“A. Scope of Services and Requirements

#### 4.0 Project Statement of Work

#### 4.4 General Requirements



#### 4.4.20 Collaboration

The Offeror shall conduct Georgia Disease Management Program services collaboratively with members, treating providers, community resources, and DCH and its business partners. The program shall provide value-added information and support services for medical providers and increase coordination of member care.”

#### “A. Scope of Services and Requirements

#### 4.0 Project Statement of Work

#### 4.4 General Requirements

#### 4.4.24 System Coordination and Data Integration

The Offeror, at their own cost, shall assure seamless coordination between other systems including but not limited to: the State’s fiscal agent, Care Management Organizations, pharmacy benefit manager, decision support system, and provider’s offices. All of the Offeror’s applications, operating software, middleware, and networking hardware and software shall be able to interface with the State’s systems and will conform to the data specifications. These specifications are detailed in the Contract.”

### **Illinois**

#### ***Disease Management RFP 2006***

#### 4.3 Services Required

##### 4.3.6: Provider Education and Involvement

4.3.6.9: The Vendor shall facilitate opportunities for the involvement of the primary care providers and other involved providers and specialists in the development of the care plan for the DM Members.

4.3.6.12: The Vendor shall be responsible for coordinating its DM Program with the PCCM [Primary Care Case Management Program] initiative and shall maintain ongoing coordination. The coordination includes at a minimum providing PCCM providers with a list of Members in their panel who are enrolled in the DM Program, on no less than a quarterly basis.

##### 4.3.8: Reduction in Emergency Room Utilization:

4.3.8.5: The Vendor shall provide the PCCM Administrator with a listing of individuals identified as frequent emergency room users, as the PCCM Administrator will operate a Nurse Consultation Line for individuals to call to discuss whether they should seek emergency room services.”

## **New York**

### **Request for Proposals: Medicaid Disease and Care Management Demonstration Programs**

**March 21, 2005**

#### **“Appendix N – Data Exchange Application and Agreement**

##### **Purpose:**

The purpose of this Data Exchange Application and Agreement (DEAA) is to provide information supporting the applicant’s request for the release of Medicaid confidential data (MCD) and to serve as the basis for assessing the appropriateness of releasing MCD. In addition, the DEAA, when approved by the Medicaid Confidential Data Review Committee, forms an agreement between the applicant and the New York State Department of Health as to the terms and conditions under which the release will be made.

Pursuant to the New York State Medicaid State Plan requirements, Social Security Act, Section 1902(a) (7), 42 USC 1396a (a) (7) a.d.; and federal regulations at 42 CFR 431.302, no release of MCD is permitted unless such release is directly related to the administration of the Medicaid state plan.

MCD is also protected by Social Services Law Section 369 (4), which states: \* \* \* pursuant to Section 367b(4) of the NY Social Services Law, information relating to persons Applying For medical assistance shall also be considered confidential and shall not be disclosed to persons or agencies without the prior written approval of the New York State Department of Health.

Any inconsistent provision of this chapter or other law notwithstanding, all information received by public welfare officers concerning applicants for and recipients of medical assistance may be disclosed or used only for purposes directly connected with the administration of medical assistance for needy persons.

Please note that Medicaid Confidential Data released to you may contain AIDS/HIV related confidential information as defined in Section 2780(7) of the New York Public Health Law. As required by N.Y. Pub. Health Law Section 2782(5), the New York Department of Health hereby provides the following notice:

***“This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for the release for further disclosure.”***

The applicant agrees to include the notice preceding, as well as references to statutory and regulatory citations set forth under “**Purpose**” in the DEA, in any agreement, contract or Document the Applicant enters into that involves Medicaid Confidential Data. Further, the Applicant agrees to state in any such agreement, contract or document that the subcontractor(s) or other party may not further disclose the Medicaid confidential data without the prior written approval of the New York State Department of Health.”

## **North Dakota**

*Medicaid Health Management Program, RFP 325-06-10-011*

*March 13, 2006*

### **“SECTION THREE**

#### **SCOPE OF WORK**

Scope of Work...

#### **Health Management Program Components**

The health management program will include the following components.

#### **(1) Health management services available to Recipients with select chronic conditions...**

##### **d. Disease management (DM)...**

DM will provide for a system of coordinated health care interventions and communications (may include face-to-face, telephone, e-mail, videoconference, workshops, support groups and other methods to allow for adequate communication considering the State’s rural nature) that result in improved self-care by the Recipient. DM will include: (1) intensive coordination with the Recipient’s primary care provider (i.e., “medical home”), (2) care planning, care coordination, follow-up and monitoring by licensed nurse case managers, and (3) involvement from a “team” of ancillary medical professionals from the Recipient’s “medical home” (this may include dietitians, respiratory therapists, pharmacists, etc. as appropriate considering the Recipient’s condition)...

**(10) Coordination with providers, contractors, programs and other stakeholders** to avoid duplication of services and to assure a coordinated and widely accepted approach to health management service delivery. See Attachment 2 for information and recommendations for coordination with North Dakota providers and stakeholders, Medicaid contractors and other programs/services provided through DHS.”

### **“ATTACHMENT 2**

#### **COORDINATION WITH PROVIDERS, CONTRACTORS, PROGRAMS AND OTHER STAKEHOLDERS**

For success of the health management program, it is very important that the Offeror work closely with: (1) medical providers throughout the State, (2) contractors of the North Dakota Department of Human Services (Department), (3) other Department programs, and (4) other stakeholders, to avoid duplication of effort and to provide seamless service delivery through appropriate coordination. (The information below is not all-inclusive of the programs, services or activities provided through the Department.)

**Providers.** The Offeror will engage appropriate support and participation from the medical community and assure that the health management program does not interfere with the success of the Medicaid PCCM program, other programs run by the Department (see below) or already existing outreach and education to the provider community.

**Contractors.** The Department has contracts with many business associates. The Offeror will coordinate and interact with these associates to meet the goals of the program. The Offeror must assure a seamless operation with these associates and their systems.

**Dual Diagnosis Management, LLC (Dual Diagnosis)** – Dual Diagnosis provides preadmission screening and resident review evaluations for each individual entering a nursing facility. They also perform level of care determination for Medicaid eligible individuals or applicants requesting services in a Medicaid certified nursing facility or swing bed and services through personal care or the Home- and Community-Based Service waiver. In addition, Dual Diagnosis conducts continued stay reviews on individuals whose initial screening exhibits potential for medical improvement to the extent that discharge to a less restrictive setting may be appropriate.

Dual Diagnosis fulfills certificate of need (CON, under 21) requirements, admission reviews and continued stay reviews for acute inpatient psychiatric services and for services provided by psychiatric residential treatment facilities and non-accredited residential treatment centers.

**Health Information Designs, Inc. (HID)** – HID provides retrospective drug utilization review (DUR) services through RX Explorer and DURBaseII software. They also provide ongoing technical assistance for DUR activities.

**North Dakota Healthcare Review, Inc. (NDHCRI)** – NDHCRI provides inpatient and outpatient hospitalization utilization review as required by federal regulations to assure that Recipients are only receiving the hospital care necessary to meet their medical needs. This is accomplished through retrospective, concurrent and preadmission utilization review, quality review studies, data analysis and special studies.

**The Medstat Group, Inc. (Medstat)** – Medstat is the Decision Support System (DSS) vendor, a component of the current Medicaid Management Information System (MMIS). Medstat designed the current DSS. Medstat also completed the installation and training for the DataProbe system that allows Medicaid staff to analyze medical claims and enrollment data. Medstat also provides ongoing data analysis and support as requested by the Department.

**Programs.** The Offeror will be required to coordinate the health management program with other programs administered through the Department as described below.

**Health Tracks (formerly Early and Periodic Screening, Diagnosis and Treatment [EPSDT])** – *Health Tracks* is a preventive health program that is free to Medicaid-eligible children age 0 to 21. Program coordinators are located at local public health units in the larger cities throughout the State and services are conducted through contracted Head Start programs and local public health units. *Health Tracks* pays for screening, diagnosis and treatment services, orthodontics, glasses, hearing aids, vaccinations, counseling and other important health services. Program coordinators are available to assist with scheduling appointments for services and will also help with finding transportation to the services. Some services require prior authorization.

**Targeted Case Management (TCM) for High-Risk Pregnant Women and Infants** – This is a Medicaid program provided as a service under the Medicaid State Plan. The goals of the TCM program are to:

- Provide early and continuous prenatal care;
- Identify risk factors and develop a plan to lessen the risks;
- Connect women to support services that will contribute to a healthy baby;
- Improve current and long-term life situations;
- Enhance the maternal life course, such as employment and education; and
- Improve child health by promoting preventive health services, such as immunizations and well-baby checkups.

Additional TCM program information can be found at the following link.

<http://www.nd.gov/humanservices/info/pubs/docs/cshs/health-data-notes-march2004.pdf>

**Ambulatory Behavioral Health Programs (Adults, Adolescents and Children)** – This is a Medicaid program that exists to assure that ambulatory behavioral health services are appropriate to each individual’s symptoms according to Medicaid established protocols and medical criteria and are neither over- nor underutilized. More information on these programs can be found at the following links to provider manuals.

<http://www.nd.gov/humanservices/services/medicalserv/medicaid/docs/am-beh-health-care-adultsjan2005.pdf> (Adults)

<http://www.nd.gov/humanservices/services/medicalserv/medicaid/docs/am-beh-health-care-childrenjan2005.pdf> (Children and Adolescents)

**Home- and Community-Based Services (HCBS)** – The Department provides HCBS through several programs.

- Service Payments for the Elderly and Disabled Program (SPED)
- Expanded Service Payments for the Elderly and Disabled Program (Ex-SPED)
- Medicaid Waiver for the Aged and Disabled
- Medicaid Waiver for People With Traumatic Brain Injuries
- Older Americans Act Services
- For more information on these programs, go to the following link to the Department’s website:

<http://www.nd.gov/humanservices/services/adultsaging/homecare.html>.

**Children’s Special Health Services (CSHS)** – CSHS provides services for children with special health care needs and their families and promotes family-centered, community-based, coordinated services and systems of health care. Though CSHS exercises discretion in defining the population eligible for services, the following programs address many of the needs experienced by children and families: (1) specialty care program, (2) multidisciplinary clinic program, and (3) care coordination program. CSHS also provides other services not described in this paragraph. For additional information regarding CSHS, go to the following Department website: <http://www.nd.gov/humanservices/services/medicalserv/cshs/>. This website includes a list of multidisciplinary clinics, including diabetes and asthma clinics, to be conducted in the State in 2006. The Offeror should become familiar with these clinics for coordination purposes.

**Other Services** – The Department also provides for specialized services for the following groups:

- Recipients with developmental disabilities
- Recipients with mental illness
- Children at risk of abuse and neglect

**Other Stakeholders.** The Offeror should consider a regional approach to the health management program, hiring or contracting with nurse case managers in the larger cities across the state to serve a multi-county region. For example, a nurse case manager in Fargo may provide services to Cass, Traill, Steele, Richland, Sargent and Ransom county Recipients. The Offeror should also consider establishing and maintaining Regional Advisory Committees (RACs) in each region to serve as program advisors and provide a formal structure for the exchange of ideas between program staff and the communities to which they provide services. Each RAC could consist of stakeholders including a Recipient and their representatives, county social service center eligibility staff, health care providers, local public health units, community agencies and community leaders. Focus areas for the RACs may be health education/literacy, marketing and outreach, service delivery and quality assurance.”

## **Texas**

### ***Medicaid Disease Management RFP***

**October 2003**

#### “1. Introduction

1.6 Objectives: Improved coordination of care with other HHSC agencies...”

#### “ 8.3 Contract Program Management:

8.3.1. State Responsibilities: ...Facilitate contact and coordination between the vendor and other state agencies and organizations for outreach to eligible disease management participants experiencing health disparities...”

## **Washington**

### ***Chronic Care Management Project, RFP HRSA/OCC-0106***

**2006**

#### **“SECTION I. INTRODUCTION...**

##### **B. PROJECT SCOPE...**

##### **5. Client Activities**

- a. Both LCM and SCM contractors will be required to attempt to engage all high-risk clients referred or identified by the methods outlined above and provide the following to all enrollees in the care management program, regardless of disease or condition:...
- c. Develop a care plan specific to the identified areas of risk above, and including goals set together with enrollee, so the enrollee is:...
- d) Able to appropriately utilize the health care system, making and keeping scheduled appointments with primary care providers or other providers;...

- f. Refer enrollees to medical, mental health, chemical dependency service providers, and other social services to meet needs identified in assessment; and
- g. Address barriers to using the health care system appropriately...

**D. MINIMUM QUALIFICATIONS**

- 1. Local Care Management Proposals:...
- 2. Requirements for participating providers in LCM contracts (previously described in Section I.C.5.):...
  - iii. Utilize a team approach in coordination with other providers and organizations...”

# Appendix F: Contractual Specification Excerpts - Reporting

## California

*Disease Management Pilot Program, RFP 05-45889*

*March 15, 2006*

### “Exhibit A, Attachment 1

#### Scope of Work-Contract Performance

#### A. Contract Administration...

##### 3. Reporting Requirements

Many of the data elements required below may be combined into grouped reports of related elements. Additionally, the Contractor may use electronic spreadsheets to track and report necessary data elements. All reports provided to CDHS must be user friendly (easily viewable and printable) and not contain excessive amounts of unsolicited data. The Contractor will submit the following reports:

##### a. Monthly Reports

The Contractor shall send monthly reports to CDHS that include the following information. CDHS must receive these monthly reports by the tenth calendar day of each month.

- 1) Identification of potential Members, including but not limited to the listing provided by CDHS, and the method and date of initial contact with the potential Member;
- 2) Identification of Members enrolled in the DMPP, or the date the Potential Member opted-out;
- 3) Identification of Provider/Primary Care Provider (PCP) providing DM services to DM Members;
- 4) Identification of individual Member 30-day evaluation due dates and completion dates;
- 5) Identification of individual Member 90-day Individual Treatment Plan (ITP) deadline date and ITP initiation date;
- 6) Identification of Members who have been disenrolled, disenrollment date and the reasons for disenrollment. (This report is intended to report disenrollments after they have occurred. All Contractor requests for disenrollment must be approved by CDHS through a separate process. See Member Services - Scope of Services - Enrollment/Disenrollment below);
- 7) Health advice line activity, including the number and type of calls; and
- 8) Other reports to be determined by CDHS.

##### b. Quarterly Reports

The Contractor shall send quarterly reports to CDHS that include the following information. CDHS must receive these quarterly reports within thirty (30) calendar days after the end of the quarter.

- 1) Provider training;
- 2) Incidence of sentinel events and mortality; and
- 3) Other reports to be determined by CDHS.



c. Semi-Annual Reports

The Contractor shall send semi-annual reports to CDHS that include the following information. CDHS must receive semi-annual reports within thirty (30) calendar days after the end of each 6-month period:

- 1) Member status reports and
- 2) Other reports to be determined by CDHS.

d. Annual Report

The Contractor shall send annual reports to CDHS that including the following information. CDHS must receive these annual reports within thirty (30) calendar days after the end of each 12-month period:

- 1) Quality improvement summary;
- 2) Contractor operational self-assessment; and
- 3) Other reports to be determined by CDHS.”

**“K. Proposal Format and Content Requirements...**

**3. Content Requirements...**

**e. Work Plan Section...**

**4) Work Plan Submission Requirements...**

i. Management Information System (MIS) Plan

- a) Proposer shall submit a MIS plan that describes the firm’s ability to perform the responsibilities outlined in Exhibit A, Attachment 1, Provision B, Management Information System.
- b) Proposer shall describe the firm’s experience that qualifies them to perform the MIS requirements.
- c) Proposer shall describe any innovative MIS activities that demonstrate their commitment to exceed the minimum requirements set forth in this RFP.”

**“Exhibit A, Attachment 1**

**Scope of Work-Contract Performance**

**B. MANAGEMENT INFORMATION SYSTEMS**

1. Management Information System

Contractor’s Management Information System (MIS) shall have processes that support the interactions between Financial; Member and Provider; Eligibility; Encounter Claims; Quality Improvement; Utilization Monitoring and Report Generation subsystems. The interactions of the subsystems must be compatible, efficient and successful. Contractor shall develop and maintain a MIS that provides, at a minimum:

- a. CDHS reporting requirements as specified in Provision A.3;
- b. All DMPP eligibility data;
- c. Information on Members enrolled in the DMPP, such as, Member assessments, status, case management activities, and outcomes;
- d. Financial information as specified in Exhibit E, Additional Provisions; and
- e. Drug utilization data sufficient to identify under and/or over utilization of medication.

## 2. MIS/Data Correspondence

Upon receipt of written notice by CDHS of any problems related to the submittal of data to CDHS, or any changes or clarifications related to Contractor's MIS system, Contractor shall submit to CDHS a Corrective Action Plan with measurable benchmarks within thirty (30) calendar days from the date of the postmark of CDHS' written notice to Contractor. Within thirty (30) calendar days of CDHS' receipt of Contractor's Corrective Action Plan, CDHS shall approve the Corrective Action Plan or request revisions. Within fifteen (15) calendar days after receipt of a request for revisions to the Corrective Action Plan, Contractor shall submit a revised Corrective Action Plan for CDHS approval. 3. Health Insurance Portability and Accountability Act of 1996 (HIPPA) Contractor shall comply with Exhibit G - Health Insurance Portability and Accountability Act of 1996 (HIPPA) requirements and all federal and State regulations promulgated from this Act, as they become effective."

## **Colorado**

### ***ASTHMA Disease Management RFP November 2004***

#### II: Scope of Work

##### C. Reporting

- 1c. The Contractor shall provide an activity report. The activity report shall include Enrollee specific information including the Enrollee's status, their ID number, their physician, the date the Enrollee was referred and enrolled, and all of the interventions the Enrollee received. The totals from this report shall be used for invoicing."

## **Florida**

### ***Invitation to Negotiate for Participation in the Congestive Heart Failure Disease Management Initiative of the Florida Medicaid Program November 20, 1998***

#### **"Section A. Background Information and Program Objectives**

#### **III. Program Design**

##### **L. Reporting Requirements**

The disease management company will measure the quality of care by evaluating both patient outcomes and patient satisfaction levels. These evaluations will include an examination of the patient's medical record to collect clinical outcome data as specified in Attachment D as well as patient surveys including self-assessments.

The DMO will also determine quality of care outcomes by reviewing each patient's individualized care plan to insure that identified intervention opportunities, specific protocols, treatment guidelines, and critical pathways have been followed to the greatest extent possible. In addition, claims data will be reviewed as part of the analysis of patient outcomes.

Determination of patient satisfaction and health will involve a review of cumulative data from the DMO administered questionnaire which will be completed by patients upon their initial project enrollment and at the end of each contract year for the duration of their enrollment. The Agency shall approve patient satisfaction and assessment surveys (and survey methodology) prior to dissemination. After the initial survey, a recipient must be enrolled in the program a minimum of six months (need not be consecutive) to be included in the end of the contract year satisfaction survey.

### ***DMO Reporting Responsibilities***

**Monthly** reports must be received by the Agency by the tenth working day of each month and shall include:

- enrollment reports by severity level;
- disenrollment reports by severity level (with the reason for disenrollment);
- complaint logs; and
- number of recipient contacts by method of contact (for example, face-to-face, telephone, mail).

**Quarterly** reports must be received by the Agency within 30 days after the end of a quarter. The reports must document certain outcome and process measures and include the following:

- results of baseline patient knowledge and satisfaction surveys for new enrollees;
- recipient enrollment/disenrollment numbers by severity level;
- number of patients in each severity level;
- total number of days DMO enrollees spent within each severity level;
- number of emergency room visits by severity level;
- number of hospital admissions and readmissions by severity level;
- number of inpatient hospital days per admission by severity level;
- cumulative report of monthly number and percentage by severity level of recipient compliance with weight control/reduction as indicated per recipient care plan;
- cumulative report of monthly number and percentage of recipient compliance with dietary restrictions as indicated by severity level;
- cumulative report of monthly number and percentage of recipient compliance with taking prescribed medications, (e .g. ACE inhibitors, Digitalis, diuretics, etc.) by severity level;
- cumulative report of monthly number and percentage of recipient compliance with decreasing or abstaining from smoking (if applicable) by severity level;
- number of recipient deaths by month due to CHF;
- case studies (describe successful outcomes as well as cases presenting barriers to successful outcomes); and
- number of recipient contacts by method of contact (for example, face-to-face, telephone, mail).

In addition, a cumulative **annual** report must be received by the Agency within 30 days after the end of the reporting year. The report will address the following:

- results of patient knowledge and satisfaction surveys for recipients enrolled for at least six months;
- recipient enrollment/disenrollment numbers by severity level;
- number of patients in each severity level;
- total number of days DMO enrollees spent within each severity level;

- number of emergency room visits by severity level;
- number of hospital admissions and readmissions by severity level;
- number of inpatient hospital days per admission by severity level;
- clinical outcome measures as described in this document (see Attachment D);
- cumulative report of monthly number and percentage by severity level of recipient compliance with weight control/reduction as indicated per recipient care plan;
- cumulative report of monthly number and percentage of recipient compliance with dietary restrictions as indicated by severity level;
- cumulative report of monthly number and percentage of recipient compliance with taking prescribed medications, (ACE inhibitors, Digitalis, diuretics, etc.) by severity level;
- cumulative report of monthly number and percentage of recipient compliance with decreasing or abstaining from smoking (if applicable) by severity level;
- number of recipient deaths by month due to CHF;
- case studies (describe successful outcomes as well as cases presenting barriers to successful outcomes);
- number of recipient contacts by method of contact (for example, face-to-face, telephone, mail); and
- aggregate report of provider profiling information.

DMOs may have additional outcome and process measures in place or develop measures beyond those required by the Agency. The content and timing of required data exchanges between the Agency and DMOs will be finalized during the contract negotiation process.

#### ***Agency Reporting Responsibilities***

- A monthly list of DMO-eligible recipients who have been identified as having characteristics of a diagnosis of CHF. This list will include the recipient's name and address as well as the names and telephone numbers of Medicaid physicians who have repeatedly cared for the recipient; and
- Quarterly paid claims information on all DMO-enrolled recipients including hospitalizations, rehospitalizations, lengths of stay, emergency room utilization as well as other Medicaid claims data.

#### ***Data Use and Disclosure***

1. The Agency maintains ownership of the data sets and all patient records used in this project.
2. All data sets and reports must be returned to the Agency upon request.
3. No data (such as utilization and trends) shall be disseminated, published or incorporated into a separate central database or warehouse without the expressed prior written consent of the Agency.
4. The Agency will be allowed to download DMO data on an ad-hoc basis for analysis.
5. The DMO may not use the data for marketing purposes without the expressed prior written consent of the Agency.
6. The data are to be used solely for this project.

## **Georgia**

### ***Request for Proposals for Disease Management Services for Medicaid Aged, Blind and Disabled Members, RFP Number 41900-001-0000000025***

***March 2, 2005***

#### **“Appendix L:**

#### **REPORTING REQUIREMENTS**

The Offeror shall create Reports using the formats, including electronic formats, instructions, and timetables as specified by DCH and at no cost to DCH. Changes to the format or frequency of the reports must be approved by DCH.

The Offeror shall submit the Deliverables and Reports for DCH review and approval according to the following timelines, unless otherwise indicated.

- Weekly Reports shall be submitted on the same day of each week, as determined by DCH;
- Monthly Reports shall be submitted within fifteen (15) Calendar Days of the end of each month;
- Quarterly Reports shall be submitted by March 30, June 30, and September 30, and December 30, for the quarter immediately proceeding the due date; and
- Annual Reports shall be submitted within thirty (30) Calendar Days following the twelfth (12<sup>th</sup>) month Members are enrolled in the DM Program.

#### ***Reporting Categories and Minimum Data Elements Required***

##### ***Implementation Status Report***

- Tasks, activities, deliverables, and project milestones described in the Offeror’s Project Plan, in response to the Technical Proposal Section 5.9 A.1

##### ***Member Tracking Report***

- Member eligibility file updates in detail eligibility file format;
- Members who are not findable in detail eligibility file format; and
- Members who move outside region in detail eligibility file format

Note: Minimum data elements required for these reports are described in the Contract.

##### ***General Member Report***

- Number of members contacted and the method of contact;
- Number of members who are not findable;
- Number of members enrolled in DM (total);
- Number of members with non-common chronic or mental health conditions contacted;
- Number of members disenrolled with explanation of reason for disenrollment;

- Member complaint logs in a format provided by Offeror;
- Number of members enrolled by disease state and risk level;
- Number of members achieving National Standard Guidelines for their diseases; and
- Total number of days members enrolled within the Georgia Disease Management Program

#### ***Nurse Call Center and Internet Activity Report***

- Call volume;
- E-mail volume;
- Average call length;
- Average hold time;
- Call abandonment rate; and
- Content of call or e-mail and resolution

#### ***Utilization and Medical/Pharmacy Financial Reports***

- Number/cost of hospital admissions and readmissions for enrolled members;
- Number/cost of inpatient days per admission for enrolled members;
- Number/cost of ER visits and ambulatory care visits;
- Number/cost of prescription drugs;
- Number/cost of prescription drugs by disease state; and
- Number/cost of office visits

#### ***Provider Reports***

- Number of providers who refuse to participate and reason for refusal
- Number of providers educated on evidence-based guidelines
- Number of members enrolled by provider
- Number of providers adhering to evidence-based clinical guidelines
- Aggregate provider feedback report

#### ***Provider Feedback Report (submitted to Providers)***

- Number of patients enrolled in the program by disease state;
- Number of patients by risk level;
- Changes in patient health status;
- Gaps in member care; and
- Patient adherence to care plans

#### ***Complaints Report (Providers and Members)***

- Number of complaints by type; and
- Type of assistance provided

#### ***Case Management Reports***

- Number of members receiving case management services and encounters for the same;
- Number of attempts to reach members;

- Number of initial screenings completed;
- Number of follow up calls made based on the level of care;
- Number of appointments made for face-to-face assessments;
- Measured progress toward stated goals for each member (describe successful outcomes as well as barriers);
- Number of high risk, face-to-face assessments completed; and
- Number of nurse calls made to providers

### **Quality Reports**

- Member overall health status to be measured by tool agreed upon by DCH and Offeror;
- Member meeting quality variables outlined in Appendix J; and
- Comparison of DCH results to other State and/or DSM programs

### **Satisfaction**

- Number of members and providers satisfied with DM program as measured by survey tool agreed upon by DCH and Offeror

### **Education**

- A brief synopsis (2-3 sentences) on the 100 most involved cases detailing what diseases and what instructions are being provided to members who do not have common chronic or mental health conditions; and
- Disease knowledge and self-management surveys and comparisons jointly developed by the Offeror and DCH.

### **Documentation and Reporting Deliverables Schedule**

<b>Policies/Plans</b>	<b>Due Date</b>
Cultural Competency Plan	Within 60 Calendar days of Contract Award
Practice Guidelines	Within 10 Calendar Days of Request
Complaint and Grievance Policies and procedures	Within 60 days of Contract Award
<b>Reports</b>	<b>Due Date</b>
Implementation Status Report	Weekly (June-August 2005)
Member Tracking Report	Monthly
General Member Report	Monthly
Nurse Call Center and Internet Activity Report	Monthly
Utilization and Medical/Pharmacy Financial Reports	Annual
Case Management Report	Monthly
Provider Report	Monthly
Provider Feedback Report	Monthly
Complaints Report	Quarterly
Quality Reports	Quarterly; Annual
Member Satisfaction Report	Annual
Education Report	Annual

**Illinois**  
**Disease Management RFP**  
**2006**

“4.4. Milestones and Deliverables:

4.4.1 Readiness for Implementation:

4.4.1.1: Operational Capabilities:

4.4.1.1.4: A system that accepts data electronically from HFS

4.4.1.1.5: A system that transmits data electronically to HFS

4.8 Other Specifications

4.8.3: Data Systems. The Vendor must interface with HFS’ data system for the exchange of information. Vendor must transmit and retrieve all electronic data using a connection approved by HFS and CMS.

4.8.3.6: Extract Files. The Vendor must have the capability of managing the data electronically and refreshing its data system on an ongoing basis each time data files are provided by HFS to the Vendor.

4.8.3.6.1: Monthly Recipient Extract File. Each calendar month, HFS will create provide the Vendor with a master Recipient Extract File containing eligibility information for all persons eligible for the DM Program, and as applicable, the PCP assignment. The Recipient Extract File will contain the following identifying information: name, date of birth, county of residence, case number, recipient number, address and phone number.

4.8.3.6.2: Daily Recipient Extract Files. HFS will create a daily file for the Vendor to retrieve containing changes made to HFS’ recipient database for persons eligible for the DM Program. The Vendor must be able to accommodate a file size of at least 2 gigabytes. The Vendor must import the data contained in the daily file into its system, per a schedule approved by HFS.

4.8.3.6.3: Monthly Provider File. Each month, HFS will create a Master Provider Extract File for the Vendor to retrieve containing Provider enrollment information. The Provider File will contain the following information: provider name, provider address, payee address, provider phone number, provider type and provider specialty(ies).

4.8.3.6.4: Claims Data. HFS will provide the Vendor with a one time historical file containing two (2) years of data and thereafter, a weekly file containing claims data information. Such data will include:

4.8.3.6.4.1: Master Pending Payable Claims Extract File of all claims for all disabled adults and elderly individuals eligible for disease management

4.8.3.6.4.2: Master Paid Claims Extract File of all claims for all disabled adults and elderly individuals eligible for disease management

4.8.3.6.4.3 Master Pending Payable Claims Extract File of all claims for all individuals with persistent asthma who have been identified for the disease management intervention

4.8.3.6.4.4 Master Paid Claims Extract File of all claims for all individuals with persistent asthma who have been identified for the disease management intervention

4.8.3.6.4.5 Master Emergency Room Pending Payable Claims Extract File for all emergency room users within the Family Health population

4.8.3.6.4.6 Master Paid Claims Extract File of all claims for Emergency room users within the Family Health Population



4.8.3.6.5 Data Files from the PCCM Administrator. The Vendor shall accept data files from any Vendor under contract with HFS as a PCCM Administrator and the data files will provide detailed information on the PCP assignment and authorized referrals, including identifying information of the referral Providers.

4.8.3.7. Data Transmission from the Vendor

4.8.3.7.1 Monthly Case Management File. The Vendor shall provide to HFS in an electronic format approved by HFS, a monthly file that identifies all individuals being served by the Vendor's intervention during the prior month as well as information on the Disabled Adults and Elderly Population who opt out. This file shall be coded to identify the population served (e.g., disabled adults and elderly, persistent asthmatics, or frequent emergency room users). This file shall be submitted to HFS within fifteen (15) calendar days of the end of the reporting month."

## **North Dakota**

### **Medicaid Health Management Program, RFP 325-06-10-011**

**March 13, 2006**

#### **“SECTION THREE**

#### **SCOPE OF WORK**

##### **3.03 Scope of Work...**

#### **Health Management Program Components**

The health management program will include the following components...

**(6) Computer Information System (CIS)** capability to handle the data needed for operating and monitoring the program. The CIS must meet all Health Insurance Portability and Accountability Act (HIPPA) requirements.

The CIS should:

- (1) Receive, store, analyze and report on Recipient and provider specific data in order to meet program requirements for service delivery and reporting, including:
  - a. Tracking Recipient contacts (face-to-face, telephone, e-mail, videoconference), medical events, clinical interventions and outcomes;
  - b. Sharing health information with providers to assure that all involved parties have a comprehensive picture of a Recipient's health status; and
  - c. Generating reports to both the State and providers as described under "Reporting."
- (2) Allow for access to Recipient-level health information by THIL and DM nurses.
- (3) Accept claims data from the State for identification of Recipients eligible for the health management program for enrollment purposes, to stratify Recipients for level of care and to identify areas for improvement in health care (i.e., identify gaps between the care recommended and the care received, monitor health service utilization and appropriateness, etc.).
- (4) Include a scalable database repository that supports large data sets and exponential growth in total database size over the life of the contract....

#### **Reporting**

The Contractor will report the following items to the State as specified.

- Number of Recipients enrolled in the health management program (monthly)
- Number of Recipients disenrollments and reason for disenrollment (monthly)
- Number of Recipients with co-morbidities and description of the co-morbidities (monthly)
- Number of Recipients receiving DM (monthly)
- Number of Recipients who called the THIL and the reason for the call (monthly)
- Number of Recipients contacts by the Contractor and method of contact (monthly)
- Number of “hits” on the health management program website (monthly)
- Number of hospital admissions (quarterly)
- Number of inpatient days per admission (quarterly)
- Number of emergency visits (quarterly)
- Results of progress toward defined performance indicators (quarterly)
- Self-assessment by the Contractor describing efforts and level of performance in meeting contract activities (quarterly)
- Case studies of select Recipients that describe positive outcomes or barriers encountered (semi-annually)
- Results of Recipient knowledge surveys (semi-annually)
- Results of Recipient satisfaction surveys (semi-annually)
- Results of Provider satisfaction surveys (semi-annually)

The Contractor will report the following items to the primary care provider semi-annually.

- Number of the primary care provider’s patients served by the Medicaid health management program
- Number of contacts by the Contractor and method of contact per Recipient
- Results of the primary care provider’s efforts in providing care to each Recipient consistent with clinical practice guidelines

The Contractor must report Recipient-level information upon request by the State. Reports will be due 45 days after the end of a reporting period. Quarterly reports will reflect the following schedule: January 1-March 31, April 1-June 30 and July 1-August 31, October 1-December 31. Semi-annual reports will reflect January 1-June 30 and July 1-December 31. The report for the last quarter of the contract period (i.e., April 1-June 30, 2007) must be submitted by August 15, 2007 (after the end of the contract period).

Reporting activities are subject to change at the State’s discretion. Payment to the Contractor is contingent upon the State’s receipt of specified reports on schedule; late or insufficient reports will result in the State withholding payment until adequate reports are received.

Transfer of acquired program data to a subsequent Contractor is required, if necessary.”

## **Oregon**

### ***Request for Applications for Chronic Care Model Implementation Grants May 2, 2006***

#### **“Section III. Application Requirements**

## **B. Application Instructions**

### **3. Reporting Requirements**

LPHA or designee shall submit semi-annual progress reports to the Department. The reports shall be due the last working day of January (for July-December) and July (for January-June) of each year. The reports must include, at a minimum, progress during the reporting period towards completing activities described in its work plan, and measurement of progress towards completion of work plan outcomes. Outcome data will also be submitted for the population of patients covered in the project per section 1.a.iv. above. For any activities not completed as scheduled, the report must include a reasonable justification for why the activity was not completed and how LPHA or designee plans to complete the activity.”

## **Texas**

### ***Medicaid Disease Management RFP October 2003***

#### “4. Submission Requirements

##### 4.2 Format and Content

4.2.1.1: Transmittal Letter:...A statement that, in providing services to HHSC, the Vendor’s staff may be required to work with and coordinate activities with HHSC or other State employees...

#### 6. Financial Approach – Business Terms

##### 6.3 Financial Accounting and Reporting Requirements:

##### 6.3.5.2 Vendor Responsibilities:

- FRC-02 Provide a monthly report to the State that shows a summary of the various services by each respective Disease Management initiative provided by the Vendor during the previous month. Monthly reports will be due on or before the seventh working day following the end of the previous month. Monthly reports will be submitted electronically on a spreadsheet format utilizing Microsoft Word, Microsoft Excel or any other electronic format acceptable by the State.
- FRC-3 Provide a quarterly accounting report of the Disease Management services provided under the Contract. This accounting report shall include monthly and quarterly expense information similar to the information submitted in Appendix 3. Quarterly accounting reports will be due on or before the seventh working day of the month following the end of the previous quarterly reporting period.
- FRC-4 Provide monthly reports documenting the Vendor’s Historically Underutilized Business (HUB) program efforts and accomplishments.

#### 7. Implementation Phase/ Scope of Work

##### 7.2 Project Management Requirements

7.2.2: General State Responsibilities...Assist the Vendor in dealing with the user community, external agencies, and current Medicaid contractors, including the current Claims and PCCM contractors

7.2.3.1.2: Quality Management: The vendor will prepare a plan that documents its quality assurance program. Items that must be addressed in the quality management plan include:

- o Description of processes and procedures that will be implemented to ensure the cooperation and coordination of activities and operations with other Medicaid Vendors and state agencies

7.3 Contract Start-up and Planning: The State and Vendor will work together during the initial Contract start-up phase to define project management and reporting standards, establish communication protocols between the State and the Vendor, and establish contacts within the provider community. Work teams, composed of State and Vendor representatives, will be established related to the development and coordination of Vendor activities.

## 8.2 General Contract Operations

### 8.2.2: State Responsibilities

SUS-7: Determine the adequacy of records developed and maintained by the Vendor to allow for monitoring of all performance requirements and standards

### 8.2.3: Vendor Responsibilities

-SUG-12: Develop, maintain, and provide access to those records needed by the State to monitor the performance requirements and standards detailed in each of the functional area descriptions of this RFP

-SUG-13: Provide documentation and prepare detailed reports to assist the State with the preparation of the State’s Medicaid Cost Allocation Plan (CAP).

-SUG-24: Appoint a liaison to work with other Vendors as needed. The liaison will be responsible for coordinating activities with other Vendors; resolving issues related to the successful performance of Contract responsibilities; and ensuring quality customer service is delivered to the State, providers, and recipients.”

## **Washington**

### ***Chronic Care Management Project, RFP HRSA/OCC-0106 2006***

#### **“SECTION I. INTRODUCTION...**

#### **C. PROJECT SCOPE...**

##### **6. Provider Activities:**

##### **a. LCM contractors will:**

i. Engage providers to participate in the program. Providers must meet the following requirements:...

b. Maintain a patient registry;...

f. Provide outcomes data (e.g., lab results) by disease;...

ii. Specific medical home activities which may be shared by the LCM include:... sharing information among the patient, family and consultants;...

vii. Obtain quality measures from providers and relay feedback on performance to providers;...

##### **b. The SCM contractor will:**

i. Communicate with providers to inform them of the enrollee’s participation in the program;

ii. Provide updates on enrollee’s condition;

iii. Provide utilization data on enrollees....

8. Predictive Modeling: Predictive modeling must be a component of the Statewide Care Management bidders' Care Management program, either provided by the bidder agency itself, or through a subcontract with another entity that has the ability to:...

f. Reporting on the enrolled population must include:

- i. Average ER and hospital utilization per enrollee;
- ii. Top 25% of utilizers, with detailed data showing pattern of utilization and link to providers; and
- iii. Profile of utilization of enrollees with chronic conditions...

#### **F. EVALUATION and REPORTING...**

3. The following reports will be required from the contractors in order to evaluate the success of the care management program.

a. Monthly, LCM and SCM contractors shall provide:

- i. A client specific report listing all enrollees engaged in the care management intervention. This file will be used for enrollment and payment in the MMIS system.
- ii. A client specific report for all identified high risk clients describing the risk profile, attempts to contact, and result of contact attempts.
- iii. The following information for each client who was assessed and enrolled in the program in the previous month:
  - Self-identified race and ethnicity;
  - Date of assessment;
  - Results of screening;
  - Start and end date of care plan for intervention;
  - Identified medical home (name of primary care provider);
  - Disease profile.

b. Quarterly, the following information for all enrollees as summary measures:

- i. Disease-specific measures reflecting evidence-based medicine collected pre intervention and at quarterly intervals as long as intervention continues;
- ii. Non-disease specific measures of risk such as smoking, exposure to second hand smoke, immunization against flu and pneumonia, nutritional status, etc.;
- iii. Prescription counseling, including poly-pharmacy, poly-prescribers and client adherence;
- iv. Referrals for mental health and chemical dependency treatment;
- v. Client education about self-management skills;
- vi. Client health status.

c. Quarterly, the following utilization measures will be reported for clients in care management, with racial and ethnic breakdowns, as reported by the SCM:

- i. Proportion of clients with emergency department visits;
- ii. Proportion of clients with hospitalizations;
- iii. Proportion of clients with primary care provider visits.

d. The Contractor must have in place a written Quality Assurance and Improvement Program, including the methods that the Contractor will utilize to measure and improve the indicators listed below. These indicators must be reported quarterly with racial and ethnic breakdowns:

- i. The number of hospital admissions related to the enrollees' chronic condition;
- ii. The medical home "assignments" for enrollees who did not have medical homes upon enrollment;

- iii. The proportion of enrollees with identified need for substance abuse treatment who are referred to DASA for treatment; follow-up indicates successful completion of treatment;
- iv. The proportion of enrollees with identified need for mental health services who are referred and have appropriate follow up for mental health services;
- v. The proportion of enrollees with chronic pain diagnosis who are referred to a pain management specialist and have an active care plan developed and implemented by an interdisciplinary health care team;
- vi. The proportion of clients who receive narcotic prescriptions through the ER or from multiple prescribers;
- vii. The proportion of clients adhering to prescribed treatment, including keeping office appointments and making progress in stabilizing or improving their condition.”