



January 2, 2006

Julie Trottier, Health Programs Administrator
Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Dear Ms. Trottier,

On behalf of Innovative Resource Group, LLC d/b/a APS Healthcare Midwest (APS), thank you for the opportunity to bid on Vermont's Request for Proposal for a Chronic Care Management Program. APS is bidding on both intervention services and health risk assessment administration. We appreciate the opportunity to submit our proposal and are eager to share our experience and provide quality services to the consumers of this program.

As specified in the Request for Proposal APS has included the following statements:

1. APS does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), gender, marital status, sexual orientation, political affiliation, national origin, or disability.
2. APS has included no cost information in the Transmittal Letter or the Narrative Proposal.
3. APS certifies that the Cost Proposal was arrived at without any conflict of interest, and it will be firm and binding for 180 business days from the proposal due date.
4. APS has received and reviewed the following addenda:
 - Addendum 1 RFP Chronic Care Services
 1. Final Written Q & A
 2. Final Bidders Conference Q&A
 3. Final List of Attendees Bid Conference
 4. Blueprint Successes Handout Bid Conf
 5. Blueprint General Facts Handout Bid Conf
 6. Chronic Illness Summary
 7. File Extract 1
 8. Draft Medicaid Covered Services Brochure
 9. The Healthier Living Workshop
 10. VT Category Code Options

- 11. CCMP Claims Extract File Sizes
- 12. Addendum to Written Q&A 12.14.06

5. APS agrees to adhere to all requirements set forth in this RFP. APS' proposal does not deviate from these requirements.

6. APS has read, understands and unconditionally accepts all requirements, responsibilities, and terms and conditions in this RFP.

7. APS agrees that any lost or reduced Federal Financial Participation (FFP), resulting from Contractor deviation from specifications and requirements, shall be accompanied by equivalent reductions in State payments to the contractor.

8. The Bidder accepts the provisions of Contract Attachments C, E, and F (Appendices 3, 4, 5 of this RFP).

APS has marked the following Cost Proposal schedules & exhibits as "Proprietary or Confidential":

- ❖ Cost Proposal Schedules:
 - Personnel Costs
- ❖ Cost Proposal Exhibits:
 - Resumes
 - Project Plan
 - Financial Statements

APS is a private company and the Financial Statements are confidential. The Project Plan, Resumes, and Schedule of Personnel Costs contain information about specific individuals, positions, and functions that is both confidential and proprietary.

As specified in the RFP, we have included one (1) original and twelve (12) copies of the narrative proposal, as well as one copy on CD-ROM, and (1) original and twelve (12) copies of the cost proposal with one copy on CD-ROM.

Thank you for your consideration of our proposal. If given the opportunity, our team pledges the highest level of dedication to offering the very best collaborative care model, which harnesses the considerable strengths of the Vermont health care community together with the strengths of properly educated, motivated consumers, to support the State's progress toward a more efficient and effective system.

Sincerely,

David Hunsaker
President, APS Public Programs

State of Vermont Agency of Human Services Office of Vermont Health Access
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3 Bidder Information Sheet(s)

1. Full name and mailing address of the bidder and, if applicable, the branch office or other subordinate entity that will perform, or assist in performing, the work described in the proposal.
Innovative Resource Group LLC d/b/a APS Healthcare Midwest (APS)
8403 Colesville Road, Suite 1600, Silver Spring, MD 20910
2. Street address (for FedEx or other mail service)
8403 Colesville Road, Suite 1600, Silver Spring, MD 20910
3. Indicate whether an individual, partnership, or corporation; if as a corporation, include the state in which it is incorporated.
Innovative Resource Group is a corporation, incorporated in the state of Wisconsin.
4. Federal ID Number (or if an individual, the bidder's social security number)
39-2013972
5. Name, title and contact information (i.e., mailing address, telephone and fax numbers, email address) of the person who would sign the contract
David Hunsaker, President, APS Public Programs
8403 Colesville Road, Suite 1600, Silver Spring, MD 20910
(Ph) 800-305-3720 x3856
(Cell) 804-363-1580
(Fax) 301-563-7337
(Email) dhunsaker@apshealthcare.com
6. Name, title and contact information (i.e., mailing address, telephone and fax numbers, email address) of the company contact person (if different)
Cynthia Weinmann, Vice President of Development, APS Public Programs
8403 Colesville Road, Suite 1600, Silver Spring, MD 20910
(Ph) 800-305-3720 x3259
(Cell) 240-315-5416
(Fax) 301-563-7337
(Email) cweinmann@apshealthcare.com

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7. For each key person: name, title, relevancy to this proposal and contact information (i.e., mailing address, telephone and fax numbers, email address)

We include resumes for management personnel in Exhibit 2 to illustrate the capabilities of our team to implement and manage this important contract. Key personnel for the project are:

David Hunsaker, President, APS Public Programs
8403 Colesville Road, Suite 1600, Silver Spring, MD 20910
(Ph) 800-305-3720 x3856
(Cell) 804-363-1580
(Fax) 301-563-7337
(Email) dhunsaker@apshealthcare.com

As the President of the division, Mr. Hunsaker acts as the overall Project Director for all of APS' programs, ensuring that contracts perform for complete client satisfaction.

Steve Thronson, Chief Operating Officer
8403 Colesville Road, Suite 1600, Silver Spring, MD 20910
(Ph) 800-305-3720
(Cell) 804-363-1580
(Email) sthronson@apshealthcare.com
(Fax) 301-563-7337

As the Chief Operating Officer, Mr. Thronson will have executive oversight for implementation. The Vermont Executive Director will report to Mr. Thronson after hire.

8. Identify all owners and subsidiaries that own more than five (5) percent of the bidder
Innovative Resource Group LLC d/b/a APS Healthcare Midwest (APS) is a wholly owned subsidiary of APS Healthcare Bethesda, Inc. (APS Bethesda).
9. Indicate the location from which the RFP requirements will be performed
Operations will be performed in Williston, Vermont and elsewhere in primary care locations in Vermont. Corporate support for human resources and finance are located in Silver Spring, Maryland. Certain management information services are located in Brookfield, Wisconsin.
10. List all subcontractors with information #1, #3, #4, #7, #8, #9 cited above
APS does not propose to use subcontractors for this project.

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4. Executive Summary

The Vermont Health Access Plan (VHAP), implemented in 1995, was one of the first programs to implement managed care to provide services for Medicaid beneficiaries. This program has now evolved into the "Global Commitment to Health," a Medicaid 1115 Waiver in which the Office of Vermont Health Access (OVHA) serves as the managed care organization for Vermont Medicaid. Beginning in 2005 and continuing for 5 years, the Global Commitment caps Medicaid spending at \$4.7 billion. In exchange for limiting federal expenditures, this waiver program allows Vermont to accomplish an even more innovative agenda than the original VHAP. As enrollment and expenditures in almost every publicly funded healthcare program continue to expand into 2007, innovation is needed to manage cost and quality to continue Vermont's stature as a state with one of the lowest rates of uninsured individuals in the nation. In an area of distinctive leadership, a projected 60,144 children will be covered by Vermont in 2007. Medicaid represents 16.8% of healthcare spending in the State, with one in four Vermonters covered through services delivered by 9,000 enrolled providers. The Global Commitment proactively advances OVHA's mission to "assist beneficiaries in accessing clinically appropriate health services; administer Vermont's public health insurance system efficiently and effectively; and collaborate with other health care system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries." In these efforts, OVHA aligns its efforts to manage the burden of chronic disease with the Vermont Blueprint for Health, an initiative to develop local resources for Vermonters with chronic disease as envisioned by the Chronic Care Model published by the foundation to Improve Chronic Illness Care (ICIC) and developed under the leadership of Dr. Ed Wagner, ICIC's Executive Director.

The Chronic Care Model is a framework for organizing the healthcare delivery system to promote *productive interactions* between providers and patients: proactive and prepared provider teams deliver services to empowered patients and family members, strengthening the delivery of and compliance with appropriate primary and specialty care. These interactions take place in the context of the larger community and healthcare system. A radical departure from earlier visions of healthcare as largely institutionally based and efficacious in healing illness, the Chronic Care Model emphasizes the community-based primary care that is required to effectively maintain health status and quality of life for people with chronic disease. As an optimal delivery system for chronic care, the Chronic Care Model is a goal advanced by the Vermont Blueprint and OVHA's current procurements. OVHA has already completed the procurement for an organization to provide consulting and evaluation strategies for the Chronic Care Management Program (CCMP). The CCMP will provide disease management services, defined by the Institute for Healthcare Improvement (IHI) as "care that builds patient and family skills and confidence, increases patient and family knowledge about the condition, increases provider's knowledge of the needs and preferences of the patient, and supports the patient and family in the psychosocial, as well as medical, responses to the condition." The key components of such care include: collaborative goal setting and shared decision making, regular follow-up, monitoring and assessment of progress towards goals, relating plans to patient's social and cultural environment, tracking and ensuring implementation, including linking support programs to the individual's regular source of medical care and monitoring their effects on a patient's health. The current procurement will complete the OVHA team needed to implement the program by conducting Health Risk Assessments (HRAs) of the eligible population enrolled in the PC Plus program and Intervention Services (IVS) to dramatically improve healthcare and health outcomes for approximately 25,000 Vermonters during the first 12 – 18 months, with expansion of the program to an additional 15,000 – 20,000 or more individuals during the remaining period in the three year contract term.

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APS, a national organization with a proven track record in public sector care management, stands ready to become OVHA's partner in this valuable effort. In this Executive Summary we provide an overview that highlights the innovative strategies we propose for the Vermont CCMP, including a discussion of our state-of-the-art information system, APS CareConnection®. APS CareConnection® is a flexible, user-friendly program management tool for Medicaid agencies, providers, beneficiaries, and APS Care Management staff that organizes information in support of productive interactions that are transparent, secure and in keeping with best practices. It is now deployed in 14 state programs, and customized for each application.

APS has been given both the "Best Government Program" and "Best Provider Engagement" national awards from the Disease Management Association of America (DMAA), and has achieved every Return on Investment (ROI) we have offered to a government client. These are certified by an independent evaluator. The assessment conducted by Milliman for the EqualityCare program in Wyoming determined that APS achieved a 3.7 to 1 ROI during the first year through similar innovative approaches that APS proposes to implement for Vermont. An experienced public sector contractor, APS and its affiliates currently operate 42 programs in 23 states and Puerto Rico, encompassing all aspects of healthcare management: behavioral health, utilization review, quality assurance, quality improvement, care/case management, employee assistance, health and wellness programming, external quality review, performance measurement, and disease management. APS is without equal in the breadth and scope of its services to public and private healthcare organizations and public agencies. With nationally recognized programs that serve people with disabilities, APS and its affiliates pioneered person-centered quality improvement and currently support one of the first consumer directed care options in West Virginia with on-line budget and program management services for Medicaid beneficiaries. The Vermont CCMP scope of work requires an organization that is flexible and diverse: the CCMP vendor must support OVHA's QAPI activities and serve a population that includes children with special health care needs and adults with severe mental illness.

The Blueprint grew out of a vision of Vermonters helping Vermonters with chronic disease achieve better quality healthcare and health status. APS has applied this principle through our proposal to establish our local service center in Williston, Vermont in close proximity to OVHA (we have identified space at 208 Hurricane Lane, just minutes from OVHA). Our operational workforce will be located in this office, estimated at 10,000 square feet. This approach is a hallmark of APS' success in the public and private sector: APS becomes an integral part of the healthcare community, employing local people who understand the challenges and opportunities presented by the community. With approximately 30 FTE located in Vermont, APS will be a vital force in Vermont's efforts to identify and intervene with individuals at risk for adverse health outcomes from chronic disease. Our local Vermont staff will be supported by corporate APS employees who are proud of APS' ability to make a difference for people who need our help. Executive and financial management is provided in our Silver Spring, Maryland office, and MIS support is located in our Brookfield, Wisconsin site. All primary services and personnel are located in Vermont.

An important feature of our approach is that we propose an integrated HRA and IVS solution. Our HRA tools are based on industry standard instruments and methods, and have been embedded in our intervention management for an efficient and comprehensive system. Just as importantly, we have learned through experience that the HRA process must feature a central role for the provider if productive interactions are to occur. Too often, vendors see the provider as a bystander in the chronic care improvement process, and their own role as primary rather than supporting. We propose that HRAs will be primarily conducted by the beneficiary's own PCP – the provider who knows them best and who will continue to be responsible for their primary care – an essential feature of the Chronic Care Model.

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Providers will receive a fee reimbursed by APS. We will conduct the HRA for the small number of beneficiaries for whom a provider cannot conduct the HRA, and we will have these HRAs validated by a provider. This approach addresses OVHA's requirement that HRAs be independent and unbiased through the natural delivery system rather than a separation of vendor responsibilities that adds administrative complexity to the CCMP.

APS strengthens the providers' ability to deliver effective services by increasing patient compliance, resolving barriers to full access, and coordinating community resources for both patient and provider. Rather than increasing the burden on providers to coordinate with another entity that gives direction to the beneficiary, APS provides skilled Health Coaches and Care Coordinators that facilitate the patient-provider relationship under the direction of a full-time Medical Director. Our resources are further guided by a Clinical Advisory Committee, and APS has already identified potential members who are healthcare leaders in Vermont. The result: better use of evidence-based guidelines, more and more timely information for patients and providers, and enhanced decision making. The key to achieving these results: APS' outstanding people use a first in the nation world-class system to support effective and cross-cutting chronic care management strategies. APS CareConnection® is an internet-based system integrating administrative, eligibility, and care management information to support effective chronic disease interventions, with a rich library of evidence-based tools and materials for provider and beneficiary education. In addition, providers and APS Health Coaches can exchange alerts, identify issues, and discuss resources through the system. This powerful information tool will also be available at no extra charge to OVHA to support Care Coordination activities in addition to OVHA's own program management – facilitating Care Coordination and CCMP activities through shared resources and information.

An important factor that will benefit Vermont is APS' relationship with the National Center for Primary Care (NCPC) at Morehouse University in Georgia. Currently directed by David Satcher, MD, PHD, FAAFP, FACPM, FACP, after serving as Surgeon General of the United States, the NCPC provides on-going clinical direction to APS in the overall development of care management programs, with specific expertise as required for individual programs. Available to provide expertise in the development and interpretation of program results will be national leaders in primary care such as George Rust, MD, MPH, FAAFP, FACPM and Deputy Director of the NCPC and Yvonne Fry, MD, Chief of Maternal and Child Health.

As the proposal that follows demonstrates, APS has developed the systems, structures, processes, and resources needed to be the proactive and informed partner OVHA expects to deliver flexible, responsive, and expert CCMP services. OVHA articulated five key procurement principles for the CCMP. The APS approach embodies those principles:

- **Transparency** – APS' methods and materials are evidence-based and transparent to the community through APS CareConnection®. Further, APS is the ONLY vendor with a published third-party evaluation in the public sector. APS is also the ONLY CCMP vendor with broad experience in transparent internet-based EHRs.
- **Shared results** – With 32 Medicaid programs in 17 states and 11 state CCMP programs, APS and its affiliates are experts at sharing strategies, results, and experience. We propose to share our EQR and QIO expertise gained through 10 state programs, as well as CMS-identified best practices created for people with developmental disabilities in our southeastern Pennsylvania Health Care Quality Unit. These programs are the most immediately relevant to the CCMP; APS will actively identify other program activities and outcomes that might be of interest to OVHA and assure that information is readily available for discussion and application if appropriate.

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- Flexibility in developing and modifying the program – APS is the most experienced and diverse public sector vendor. Our diversity is a key factor in our ability to be flexible and responsive – we have an encyclopedia of experience on which to base our innovations and adaptations. Our Vermont staff will be ably supported by people who know what to do.
- Population based and targeted to defined populations – APS already delivers successful programs to Medicaid beneficiaries with arthritis, asthma, diabetes, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Congestive Heart Failure, GERD, hypertension, Hyperlipidemia, hemophilia, schizophrenia, and depression. Rather than “reinvent the wheel” with time-consuming new development, we bring efficient best practices and the valuable experience of other states that face similar challenges as those in Vermont. Our programs and systems are highly adaptable to fit Vermont’s specific requirements and needs for a “best of both worlds” tailored fit that is specific to the CCMP.
- Collaboration – APS is acclaimed by our customers for our ability to work in partnership with program staff members – understanding state needs and supporting staff in their efforts to achieve agency outcomes and goals that are a priority. As one Program Manager noted, “APS works with us – we don’t feel like we’re alone.” Such relationships are at the heart of APS’ accomplishments in the public sector. An important part of our ability to collaborate is APS CareConnection®. This system provides a user-friendly and easily accessible platform for collaboration among all stakeholders around shared priorities, accurate and timely clinical and administrative information, and effective communication.

In the proposal that follows, APS responds to requirements within the RFP page limits. We provide additional and more detailed information in the proposal Exhibits. Through these materials APS demonstrates its readiness to assume responsibility as the HRA and IVS vendor for OVHA’s Chronic Care Management Program – providing national caliber support for local implementation.

5. Capability

In this section we present the capabilities of APS. We discuss our corporate structure and background; document the organization’s size and resources; and present our overall approach and exemplary client-centered management philosophy. We demonstrate that APS is the most experienced and capable partner, and best represents the shared values and goals of OVHA to develop a Chronic Care Management Program (CCMP) that sets new standards for relieving the burden of chronic disease with proactive interventions, informed by timely and comprehensive health assessments.

CORPORATE OVERVIEW

APS Healthcare Bethesda, Inc. (APS Bethesda) was established in 1993. APS Bethesda acquired the bidding entity, Innovative Resource Group, LLC, d/b/a APS Healthcare Midwest (APS) in March 2002. APS is a wholly-owned subsidiary of APS Bethesda. APS Healthcare Inc., the parent company of APS Bethesda, was incorporated in 1991. APS and its affiliates have 45 office locations across the US including two large service centers located in Milwaukee, Wisconsin and Silver Spring, Maryland. With over 1200 employees, our dedicated staff members include psychiatrists, geriatricians and other physicians; psychologists and behavioral scientists; clinical social workers; data analysts and statisticians; database administrators, network and telecommunications engineers; facility and logistics managers; technical writers, communications specialists and graphic designers; and public program and policy analysts. APS maintains a national network of licensed and Board Certified physicians in all specialties who provide

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support to state programs, as well as handling 24/7 peer review referrals. We discuss the capabilities and expertise of our executive and disease management program staff members in Section 7.1.7. APS also has a national Clinical Call Center in Maryland that provides 24/7 clinical review support.

APS and its affiliates serve more than 20 million beneficiaries, and provide services to government clients covering over 14 million people in the United States. Please see Exhibit 3 for a list of all office locations for APS and its affiliates. APS leverages this extensive national network of corporate resources to facilitate start-ups in new contracts, increase our ability to realize economies of scale between large and small offices, and provide flexible and responsive services across the country. Our expertise and experience in contract implementation, which is supported by a corporate staff that handles dozens of new contracts each year, will benefit our Vermont program with human resource support for hiring, facilities support for timely acquisition of office space and administrative resources, swift implementation of technology from our corporate IT department, thorough documentation of requirements for APS CareConnection® configuration, and ready access to APS corporate and local staff members during implementation.

APS Public Programs is the internal business unit that manages government contracts for APS and its affiliates. APS utilizes a dedicated, local service center model for administrative and clinical operations and has a proven, highly-specialized operational infrastructure specifically designed and managed to support the unique service requirements of public sector clients. The local service model is unique among Disease Management vendors. In Vermont, this model means that APS will implement the Care Coordination principle, "Vermonters helping Vermonters" through an operational staff in Williston, Vermont that is 100% local. This approach ensures knowledge of the local healthcare community, effective working relationships with OVHA staff and providers, increases local buy-in from stakeholders, and ensures OVHA that our contract in Vermont receives immediate, consistent, and informed priority. New programs require considerable flexibility and responsiveness to changing conditions; our local service center model ensures that we realize optimal performance for each client *throughout* the life of the contract. The Vermont office will receive efficient MIS, human resource, and legal and financial support services from APS corporate offices. We provide additional information on our staffing approach in Section 7.1.7.

APS and its affiliates have provided specialty healthcare management services to public sector clients since 1994. We support 42 Medicaid and other public sector programs with a variety of specialty healthcare services including disease, utilization, and case management; quality improvement and External Quality Review; behavioral health, substance abuse, and long-term care oversight and management; and provider and beneficiary training and education services. Of importance to Vermont in its role as a Medicaid managed care organization is APS' expertise in external quality review gained through our programs in Massachusetts, California, and Washington. This expertise makes APS one of the most diverse CCIP/DM vendors, ensuring our understanding of the Plan-Do-Study-Act model as well as quality improvement strategies such as the Institute for Healthcare Improvement's breakthrough collaborative model.

We have been selected to serve public sector programs in the following states: Arkansas (two programs), California, Florida, Georgia (six programs), Hawaii (two programs), Indiana, Louisiana, Massachusetts, Maryland (three programs), Missouri, Mississippi, Montana (two programs), New Jersey, New York (two programs), North Dakota, Oklahoma (two programs), Pennsylvania, South Carolina, Texas, Washington, West Virginia (four programs), Wisconsin, and Wyoming (three programs). We also cover approximately one million Medicaid recipients in the Commonwealth of Puerto Rico in addition to Active Duty Service members and their families living in Puerto Rico. Our programs in Louisiana, Mississippi, Montana, South Carolina, North Dakota, and one of our contracts in Maryland serve state employees. We operate programs

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for Medicaid clients in 17 states and Puerto Rico, each with its own local, dedicated staff and support structure, serving nearly 40% of all Medicaid recipients in the US.

The following is a list of our Current Medicaid Contracts: Arkansas Under 21 UM Program (Inpatient and Outpatient) (2), California External Quality Review Program, Florida Prior Service Authorization for DD, Georgia Person Centered Planning, Georgia Pre-Admission Screening Resident Review, Georgia Independence Plus, Georgia Leadership and Management Training Institute, Georgia Disease Management, Georgia External Review, Hawaii HMSA (2), Maryland Administrative Services, Maryland Utilization Review Services, Massachusetts External Quality Review Organization, Missouri Chronic Care Improvement, New Jersey DM, New York Department of Health (Subcontractor), Oklahoma QIO, Oklahoma Medicaid Decision Support System, Southwest Pennsylvania Health Care Quality Unit, Puerto Rico Service Center, Texas Medicaid Behavioral Health (Subcontractor), Washington External Quality Review, West Virginia Administrative Services Organization (3), West Virginia Administrative Services MR/DD Waiver Program, Wisconsin Medicaid Evaluation and Decision Support Program, and Wyoming Utilization Management (2) and Disease Management. The following is a list of our Prior Medicaid Contracts: Alaska Quality Improvement and Billing Audits (ended March 2005), Georgia Gap Analysis for Mental Health Services (completed Sep. 2005), Ohio Enhanced Care Management (discontinued by Ohio Legislature Sep. 2005), and Washington Quality Assurance Consulting Services (completed January 2006).

APS and its affiliates have extensive experience working with a wide variety of information technology systems, including our own best of breed proprietary applications that have achieved broad recognition and "industry first" status. We integrate dozens of fee-for-service, managed care encounter, eligibility, and provider/clinical information technology systems, and we produce hundreds of complex analyses on the public sector programs we manage. Some examples of our strategic analyses provided to our state clients are pharmacy utilization, emergency room usage and cost by hospital as well as hospital admission and readmission reviews. Our annual surveys measure recipient, member, and provider satisfaction with health services, with extraordinary results, and this information is used to prioritize our collaborative Continuous Quality Improvement efforts. We provide an example of these efforts in a report from our award-winning Wyoming contract in Exhibit 4. APS is therefore fully prepared to support the PDSA activities in Vermont.

The quality of APS' programs is reflected in the accreditations we enjoy from URAC. APS is fully accredited for Disease Management, Case Management, Health Utilization Management and Worker's Compensation Utilization Management. In addition, the APS designation by CMS as QIO-like entitles state payers to a 75% federal match under certain circumstances authorized by CMS. These accreditations indicate the ability and willingness of APS to engage in rigorous external review, and to hold ourselves to the highest standards of performance on behalf of our public sector clients and the vulnerable populations they serve.

INTEGRATION OF THE CHRONIC CARE MODEL

The framework for the disease management program in Vermont is the Chronic Care Model as outlined in the Blueprint for Health. This model places *productive interactions* between physicians and patients at the center of optimal care for people with chronic conditions. We engineered our disease management system to explicitly address and strengthen each component of the CCM, creating a disease management approach that is integrated with the community, uses sound behavioral science to build confidence in people that they can manage their chronic conditions (i.e. to become the "informed, active patient" the model describes), and delivers needed resources to the provider community, not increased administrative burden or interference with patient care. Key to this approach is the APS Health Coach, and we describe the requirements for this position in Section 7. Health Coaches, who are Registered Nurses, Licensed

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Practical Nurses, Social Workers, and Health Educators, are the front line of health promotion and disease management for our programs. Depending on the specific configuration of the program, which will be decided in collaboration with OVHA, our Health Coaches work side by side with providers in health care settings, including primary care clinics, physician offices, and emergency rooms to reach beneficiaries within the context of their healthcare encounters. In this Chronic Care Management program, APS Health Coaches will be Vermonters placed in primary care clinics and other locations. The diagram in Exhibit 5 illustrates the relationship between this model and our DM programs. APS' Health Coaches will coordinate their activities with the existing Vermont Care Coordination program which will be essential to assure a seamless, efficiently managed CCMP for the Medicaid population and providers of care.

SUCCESSFUL PERFORMANCE FROM A VALUED PARTNER

APS Public Programs has a proven history of business integrity and adherence to contractual obligations. *We have never lost a customer due to a performance issue.* In addition every APS public sector client has elected to renew its contract with us when the opportunity to renew agreements became available. And when state Medicaid contracts needed to be re-bid due to expiration of renewal options, APS has *won all procurements*, with many States electing to expand the scope of the services we provide.

APS and its affiliates are proud of our record of not only retaining and renewing public sector clients, but of expanding relationships based upon successful performance. For example, in the state of Georgia we have received seven contract awards since our original relationship in 1999. One of our newer contracts for Georgia is for Disease Management services for the Medicaid aged, blind and disabled (ABD) population, which is among the largest DM initiatives in the US. Organic growth in new programs and new contracts from existing, satisfied clients has been a hallmark of our success.

In our longstanding State of Wisconsin Medicaid program, we've added a host of new, innovative initiatives to our medical management programming over our 10 year relationship, to help the State improve its cost and quality outcomes. For example, we administer the State's lead testing program for children, prescription drug lock-in and many other add-on services due to the successful history in our base contract.

Our work has consistently received awards, high praise, and recognition from government agencies, industry trade groups, and individual recipients. APS was recognized in October 2005 by the Disease Management Association of America (DMAA) for the "Best Government Disease Management Program in the United States," the landmark partnership with the State of Wyoming where we have exceeded all financial and clinical performance measures. Al Lewis, President of the DMPC, called Wyoming's disease management program *"the most innovative and comprehensive disease management program in the country with more savings per capita than any other State Medicaid disease management program."* In 2006 APS followed this notable award with selection as the DMAA's "Outstanding Provider Engagement" award, acknowledging our success in making the provider community integral to our disease management programs. Our outreach to stakeholders in Vermont includes formal meetings with the Vermont Medical Society, the Vermont Association of Hospitals and Health Systems, the Bi-State Primary Care Association, the Vermont Lung Center, and representatives of the Mental Health System organizations. We have invited these organizations to participate in our Clinical Advisory Committee to be established after contract award. These efforts inform our proposal response and help to guarantee that we are an active part of the Medicaid community in Vermont from the beginning. We look forward to an award-winning partnership with OVHA and the Vermont provider community and key stakeholders in 2007 and beyond.

APS' success is due in large measure to a highly-skilled and stable workforce, the majority of which are hired locally where we provide the services. Our employees' dedication, enthusiasm and experience enable

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us to develop and sustain long-term partnerships with clients and forge relationships with key stakeholders that improve service delivery and reduce costs. Many of our employees have distinguished backgrounds in government service, healthcare, operations, information systems, or financial management. Their practical, hands-on experience with Medicaid waivers, state plan services, state and federal policies, clinical program operations, and financing allows us to provide valuable strategic and technical support that ensures smooth and timely implementation of innovative public sector programs. Our staff is supported by the most advanced technology and information support systems available in the industry. These characteristics – skilled, dedicated staff combined with state of the art technology – enable us to *meet* the requirements of our Public Program customers and *exceed* their requirements for quality and responsiveness.

IMPLEMENTATION EXPERIENCE

APS has a solid record of successfully implementing programs on time is one of the most credible indications of an organization's ability to successfully launch and manage a project. APS has never missed an operational start date. We attribute this success to our approach to implementation and system change, one that encourages respect, collaboration, and partnership among all entities serving the consumer. We believe that the best method to achieving buy-in of different stakeholders such as providers, consumers and families, advocates, and other entities of government is to involve key representatives of each of these groups in every step of the process. Stakeholders – including recipients, providers, advocates, and governmental leaders – need an opportunity to be heard and to shape program development and design. In public sector programs throughout the country, APS has developed innovative, collaborative models of utilization management, care enhancement, provider relations and quality improvement that emphasize community partnership, training and technical assistance, and compassionate clinical care. We have been highly successful in the development of alternative levels of care that increase access and improve clinical outcomes while controlling costs. This corporate philosophy makes APS the best choice for Vermont.

Our senior management staff members have achieved substantial success implementing complex programs with multiple stakeholders in condensed time periods. We have a full understanding of the expert facilitation skills and hundreds upon hundreds of steps that must be taken during implementation of this process to assure the program operates well. We are proud to offer an experienced team of highly accomplished executives and nationally recognized experts to assure that each aspect of program implementation receives the undivided attention of professionals with proven positive outcomes in complex program development and implementation. See Exhibit 6 for a summary of APS Implementations.

APS NATIONAL INITIATIVES: IMPACT ON BURDEN OF ILLNESS AND COST OF CARE

The APS senior management team is credited with developing some of the nation's most respected public sector initiatives. Our work has consistently received awards, high praise and recognition from government agencies, industry trade groups and Medicaid beneficiaries. *Examples include:*

APS Flagship Program – APS operates one of the nation's largest Medicaid DM programs, the state of Georgia's Enhanced Care Disease Management program for its Medicaid Aged, Blind and Disabled (ABD) population. We have built an outstanding model of community collaboration with health systems (i.e. Grady and Emory Health Systems), academic entities (National Center for Primary Care at the Morehouse School of Medicine), FQHCs, and private community providers as key administrators, alongside APS, in delivering the CCIP program services. This program is a population health management program where a majority of members do not have "traditional" DM conditions. We successfully blend work on medical and mental health with support for socio-economic issues for some of the state's most compromised individuals.

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A Proven Approach – APS delivers population management services to a high risk population in Wyoming, including health risk assessment and interventions. APS is the first public program disease management vendor to have undergone independent validation of our cost-effectiveness methodology and results in Wyoming, with a documented cost avoidance of nearly \$13 million in the first year of operation.

Integration of Technology and DM – APS provides a combination of disease management and systems services geared toward members of the Missouri Medicaid population with Diabetes, Asthma, COPD, GERD, and Cardiovascular Disease (Hypertension, Hyperlipidemia, and CHD). Membership is defined as the member having a signed electronic POC by their PCP. Implementation includes the development and rollout of an electronic POC at the physician office level as part of the core care management system – APS Care Connection® for Health and DM. APS also provides the structure and format for a physician incentive program that the State will fund and process. This model includes close collaboration with FQHCs and PCPs to assist with enrollment and management of members into the program.

High Risk Uninsured Program – APS was selected by the Indiana Comprehensive Health Insurance Association (ICHIA), the high risk program for uninsurable persons in Indiana. APS has been chosen to provide Utilization Management, Case Management, and Disease Management services for its 8,000 members with conditions such as Asthma, COPD, Heart Failure, Diabetes, CAD, and Low Back Pain.

State Employees' Program – The APS disease management program for the State of Louisiana public employees recently received full validation of our annual program clinical and financial ROI goals.

APS' First DM Program (1994) – In Wisconsin our Informatics contracts were renewed and expanded for pharmacy profiles, calculation of HEDIS™ performance measures, and program evaluation.

In addition to DM acclaim, APS and its affiliates have won commendations for software development, our innovative programs for HCBS work, expert EAP, new Peer Support initiatives in the mental health arena, and state of the art programs for persons with disabilities that earned CMS designation as national "Promising Practices." All of these programs are equipped with state-of-the-art web based technology and advanced telephone systems. APS has a corporate toll-free 24/7 line with experienced staff support – a "live person" answers provider and member inquires, resolves potential issues and refers callers to community resources or the PCCM after hours nurse line. APS adheres strictly to NCQA standards for its call centers. In addition to acknowledging 100% of calls within 20 seconds, APS maintains a response rate for Year to Date 2006 of 96.84% with a call volume of 186,866 inbound calls and 199,673 outbound calls.

OVERVIEW OF APS DISEASE/CASE MANAGEMENT

APS is a leader in implementing innovative Care and Disease Management programs for Medicaid populations. Within the DM industry, we are unique in the breadth of our service to both private and public clients. Our work with dozens of complex programs, our use of advanced technology, and our achievement of mission-driven, collaborative results consistently yields the strongest of references. Over the past 10 years, we have reliably demonstrated the "hands on" implementation and operational experience required to be successful. In both consultative and operational programs, APS and our parent company, APS Healthcare Bethesda, Inc. (APS Bethesda), have worked with over 20 states to design custom, local solutions that improve the quality and value of services delivered to Medicaid recipients. Underlying the success of all of our programs is a strong commitment to the goals and objectives of the client and their beneficiaries. We offer a staff with strong experience serving the needs of Medicaid members, and a market leading set of clinical protocols, social services acumen and technology solutions.

APS offers a full spectrum of disease management services, including CHF, Diabetes, Asthma,

Hypertension, COPD and complex case management for high cost and rare diseases. Table 1 shows a partial list of our chronic care improvement/disease management clients.

Table 1. APS Healthcare Disease Management Clients

Blue Cross Blue Shield of Montana	Micron Technology
State of Wyoming Medicaid Program	Mellon Financial Corporation
State of Georgia Medicaid Program	Southern Companies, Inc.
State of Louisiana OGB	Laclede Gas Company
Blue Cross Blue Shield of Hawaii	State of Wisconsin Medicaid Program
Jason Corporation	Cerner Corporation
State of Missouri Medicaid Program	New York Department of Health
State of New Jersey (with Eli Lilly)	
Indiana Comprehensive Health Insurance Association	

IN-DEPTH PROFILE: STATE OF WYOMING

In July 2004, the Wyoming EqualityCare (Medicaid) program selected APS to launch an unprecedented effort for Total Health Management of the state’s entire Medicaid population. Program impact results from promotion of lifestyle modifications and treatment plan compliance, education and support, and assistance to those living with chronic disease feel to their best and improve their overall quality of life. These specialized services are centered on the individual and strengthen the physician/patient relationship.

APS began to monitor Medicaid members who had seven visits or more to the ER immediately upon implementation. These frequent ER utilizers were cross-matched with all Medicaid members in our system to determine if they were either currently being case managed or enrolled in the DM program. Members who were not case managed or enrolled in one of our programs but met the clinical criteria were assigned to either a case manager or a disease manager depending on the diagnosis of the emergency visit.

According to a financial analysis conducted and confirmed by Milliman, a global consulting and actuarial firm, APS’ Healthy Together total population health management program delivered the state of Wyoming more than 3.7 times our fees in healthcare cost savings. Savings lowered Wyoming’s healthcare cost trend by 6.5%. Results were for the ABD Medicaid population in its first reconciliation year, which ended on July 31, 2005. APS manages an average of 7,800 members per month in programs for beneficiaries with asthma, CAD, COPD, CHF, depression and diabetes. The average savings for program participants each month was \$135, which was \$36 above the target number of \$99 savings PMPM.

Terri Green, medical policy manager for the Wyoming Department of Health stated, “APS’ health management programs have exceeded our expectations. We are fortunate to partner with a company that understands the complexity of our healthcare system and is able to tailor its programs to meet the needs of our providers and clients.” Wyoming was the first public program to receive the DMPC ROI certification.

IN-DEPTH PROFILE: STATE OF GEORGIA ENHANCED CARE PROGRAM

The Georgia Enhanced Care Program (ECP) received national recognition as it was selected by HIRC as one of the most effective Medicaid programs in the nation with the ROI certified by DMPC. This list of impressive credentials was amassed in the first 10 months of the program. The GEC program offers a unique blend of disease management and community collaborations. By identifying where GEC members receive care, APS installs Health Coaches to become a part of the health care team. Health Coaches are housed in strategic locations such as the Grady Health System, one of the nation’s largest indigent care hospitals, where nurses work closely with the emergency department and discharge planners to promote

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disease and health management techniques and act as a liaison to the health system for members. These results could not be achieved without our local service center approach that places resources where they are most effective. Recognized in 2006 for “Outstanding Provider Engagement” by the DMAA, the Georgia ECP is a best practice that will enhance our program in Vermont.

“Georgia’s Department of Community Health Disease Management Program, ‘Georgia Enhanced Care,’ will make a difference in the lives of the populations served,” said Dr. Rhonda Medows, commissioner of the Georgia Department of Community Health. “APS has been a key contributor to this success through its application of innovative strategies targeted at Georgia’s most vulnerable Medicaid members.”

6 Work Plan and Schedule

In this section we present how APS will work with OVHA to create Vermont’s own unique program that is consistent with the Blueprint for Health and synchronized with the Care Coordination initiative. Our proposal encompasses the scope of work for both Health Risk Assessment (HRA) and Intervention Services (IVS) requirements. Key points of our work plan include the following:

- ◆ “Vermonters Helping Vermonters” – Our program will have its own Vermont-staffed local service center in Williston, Vermont, supported by corporate information technology, facilities, and human resources from our corporate resource centers in Silver Spring, Maryland, and Brookfield, Wisconsin.
- ◆ Core partnerships with Vermont’s physician and primary care clinic community to assure stakeholder buy-in and a practical solution that fits with Vermont’s current and future healthcare environment.
- ◆ An information technology solution that meets current needs and is coordinated with development of the RHIO and the CCIS, with enhanced support for both Care Coordination and CCM programs.
- ◆ Flexibility to adapt the work plan to meet the evolving needs of the program as well as emerging, statewide information technology standards and platforms.

The work plan approach we propose here will be reviewed with OVHA and revised after this review with feedback from OVHA. Because the program is new to Vermont, we anticipate that this work plan will be revised over the course of the contract to reflect evolving needs. APS staff located in Vermont will attend meetings (we plan on 24 meetings in the first year in addition to ad hoc meetings) and participate in other activities as requested by OVHA. All reports and materials will be approved by OVHA in advance, with 10 working days for OVHA review and comment. APS proposes to conduct the HRAs as well IVS activities, and our work plan reflects the benefit of this integration. We have organized the scope of work discussion to address the IVS and HRA SOW separately owing to the distinct requirements for these programs. We then discuss items 2-4 in combination for the IVS and HRA SOW. We then present items 2-14 as they relate to both the IVS and HRA components of the program, since these items address unified requirements at the vendor level rather than activity level. In the Gantt chart we clearly indicate whether an activity, milestone, or deliverable relates to the HRA or IVS component.

6.1 Understanding of and Approach to Completing the Scope of Work

Work Plan for Intervention Services (IVS)

IVS GENERAL REQUIREMENTS

1. Mailings. Using the eligibility file that we will obtain and load into APS CareConnection® we will create disease-specific mailings for all beneficiaries to contain information that promotes the self-management of their chronic conditions. APS has this information already created for our CCIP/DM programs that reflects evidence-based recommendations of the literature, national specialty societies, and national disease associations. We will review material with the State and obtain approvals during the first 30 days of implementation to ensure that mailings can be conducted promptly. All information will be free of commercial bias. We will collect information from any mail returned for incorrect addresses and notify the State. In addition to this information, APS will include a welcome letter that explains the OVHA CCMP, introduces APS and describes the Health Coaches and Coordinators so that beneficiaries will be familiar with us and the way we will approach the program. The letter will explain the purpose of the health survey to be administered by their primary care provider and indicate what use APS will have for this information. We will also emphasize that all personal information will be kept strictly confidential. Finally, we will clearly identify the toll-free number (supported by a language interpreter service which APS uses for all call center support) that beneficiaries can call to receive more information or to receive APS material in another language. It is very important that the initial contact with the beneficiary be warm, informational, and reassuring as to the nature of the program. Person-centered care starts with this initial contact and must be reflected in all aspects of interactions, a focus at which APS excels in all its programs.

2. Call Center. The Vermont Chronic Care Management call center will be located in APS' Williston, Vermont office, staffed from 8 AM to 10 PM Monday thru Friday with Vermont-licensed Registered Nurses or Licensed Practical Nurses. Members of APS' national Peer Review Network will be available for call center staff at all hours, with Medical Director support from 8 AM to 5 PM Monday-Friday. Call Center staff will have access to APS CareConnection® and will therefore be able to talk with beneficiaries in the context of information about their chronic conditions, concerns, health risk assessment, and personal circumstances. Nurses will be able to provide care management feedback, coach callers on good health behaviors, register alerts or identify issues for providers, and send callers information about how to better manage their health conditions. Beneficiaries interact with APS directly through Health Coaches in primary care and hospital settings and through the Call Center. APS ensures that our communications are specific, personal, and informed so that beneficiaries gain confidence in us and with that confidence, feel empowered to improve self-management. Having Vermonters answer the calls greatly enhances our ability to provide person-centered services to CCM participants. Clinical content of materials and information is evidenced-based and will have been approved by OVHA in advance.

3. Telephone Interventions. We include a matrix of interventions in Exhibit 7 that explains how our interventions align with the results of the HRA process. Based on the risk stratification of the beneficiary, our Health Coaches will conduct outgoing calls as well as be available to receive calls from beneficiaries. Health Coaches are trained to interact with beneficiaries and provide one-on-one coaching. Health Coaches will call high risk beneficiaries, send information to them, and arrange for face-to-face meetings. At all points of contact with APS, we will ensure that eligible beneficiaries receive HRAs and interact appropriately with the primary care providers to ensure a medical home for each beneficiary. All proposed intervention strategies will be prior-approved by OVHA.

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4. Face-to-face Interventions. As we present in Section 7.1.10, we estimate there are 1,447 beneficiaries who are identified as highest risk based on our predictive modeling analysis. With one-half of APS Health Coaches placed in the field at primary care clinics and other high-volume provider locations, APS will be able to reach these beneficiaries with disease-specific interventions, talk with the beneficiaries about barriers that interfere with proactive self-management, and work with the State and primary/specialty care, nurses association, home health, behavioral health and other providers to address these barriers. We plan for specially tailored work with the State's Care Coordination teams to facilitate handoffs, avoid duplication and better coordinate services. This aspect of our program is one of its most powerful components – Vermonters helping Vermonters to become empowered health care users and healthier people. We will also be able to better coordinate with Vermont's Care Coordination program since our Health Coaches will also be in the field and will be more aware of the activities of Care Coordinators. We include a chart in Exhibit 8 that matches beneficiary distribution to potential Health Coach locations.

5. Provider Outreach and Education. APS' general approach in all of its disease management programs is to develop collaborative relationships with providers to assure provider acceptance and support for the care management program. This model has gained wide acceptance by providers and is a key factor in assuring the ultimate success of the program. APS has received the DMAA national leadership award for "Outstanding Provider Engagement". APS believes involving providers in the Vermont CCMP is critical to the success of the program for two major reasons: beneficiaries are more likely to stay involved and actively participate in the program if their providers are involved in the CCM process and access to their PCP is maintained; as the IVS vendor, APS will have more of an impact on adoption of evidenced-based treatment practices if the majority of PCPs are involved in the program and participate in associated training, educational activities and quality improvement initiatives. To be effective in increasing providers' adherence to evidence-based guidelines, APS' programs focus on how provider education is conducted, not just the content of provider education. Therefore, APS will take a very methodical, thoughtful, stakeholder-driven approach to involving providers in our team approach to the Vermont CCMP. APS has learned that developing solid relationships, gaining trust and mutual respect, and sharing common principles and vision are necessary to undertake systemic health care improvement. Working with OVHA, APS will build collaborative community partnerships to garner support from providers.

APS has reached out in communications, meetings and calls to key Vermont provider associations and stakeholders to explain its approach to provider engagement and collaboration as the basis for APS administration of the OVHA CCMP. APS discussed various methods for collaboration including participation in meetings, joint communications and participation in APS' Clinical Advisory Committee (CAC). The following is only a partial listing of the organizations and staff we have contacted:

- Michael Del Trecco, Vermont Association of Hospitals and Health Systems.
- Paul Harrington and Madeleine Mongan, Vermont Medical Society.
- Hunt Blair, Bi-State Primary Care Association.
- Charles Irvin, Ph.D. Director, Vermont Lung Center, College of Medicine, University of Vermont.
- John Cronin, American Lung Association of Vermont.
- Paul Dupre, MTh, Executive Director, Washington County Mental Health Services.
- Pam Farnham, R.N. Outreach Coordinator, Community Health Improvement, Fletcher Allen Hospital
- Peter Cobb, Director, Vermont Assembly of Home Health Agencies, Inc.

We will continue and expand this outreach to assure all OVHA program goals are met and exceeded.

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APS views provider education and training as an opportunity for dialogue to improve delivery of services and our relevance to the provider needs. Education and training are cornerstones of APS' approach that emphasize quality improvement, provider participation, and appropriate and efficient use of services. APS has achieved positive education and training outcomes by collaborating with state officials, providers, and beneficiaries to address system needs for improvement in clinical, administrative, and fiscal functions. APS training and education programs are highly-acclaimed by each of our state government partners. We have developed tools and technologies to efficiently train large groups in disparate locations. Training is an integral part of our overall provider outreach and relationship building strategy, and we devote considerable time and resources to developing and providing these services through existing provider venues. APS has developed programs for providers that recognize the unique attributes of Medicaid populations and stress approved clinical guidelines and best practices for management of patients with chronic disease.

Our approach offers training, education, and discussion with providers in their offices, at grand rounds within hospitals, via mail and email, and through teleconferences. APS will also seek opportunities to coordinate activities with provider groups we have already engaged to promulgate approved clinical guidelines and best practices for the diseases being treated by their members. In addition, APS has a comprehensive library of clinical information all based on nationally recognized evidenced-based guidelines which we have developed for other state government programs. APS will use these and other printed materials which include disease-specific guidelines for education and training on Vermont's highest volume, highest impact conditions. Also, in dedicating staff to the consultation and training function, APS will deliver a thoughtful provider education model which considers the needs and environment of Vermont providers as it works in partnership with OVHA and our CAC to implement a "best in class" program. APS' provider education rollout plan will be submitted to OVHA for approval and will support OVHA's ongoing commitment to process improvement based on a systems approach.

IVS MINIMUM REQUIREMENTS

1. Perform Risk Stratification. We consider risk stratification part of a holistic health risk assessment process and have discussed our approach in detail in our response to the HRA scope of work. We have already conducted this process at a preliminary level using case finding algorithms developed and validated by APS. We will work with the State on screening beneficiaries for inclusion in the program, and conduct final risk stratification during implementation. We also revise risk stratification on a routine basis to ensure beneficiaries are appropriately identified if their risk levels shift into higher or lower categories.
2. Develop Best Practice Indicators. Because many of our Health Coaches work in the field at primary care provider sites, APS is adept at identifying best practices and sharing them through APS CareConnection® once they have been reviewed and agreed upon by OVHA. Our CAC also offers a continuing source of thoughtful recommendations.
3. Use Replicable Tools and Methods. APS has emphasized the use of evidence-based and commercially available tools and methods for key aspects of our work to avoid the "black box" of disease management so common in the industry. Basing our interactive risk assessment on the SF-X set of tools and national guidelines ensures that the State will be able to replicate our basic findings. The use of ACGs in predictive modeling provides a readily available and well-supported framework for these analyses. APS will also discuss our proprietary programming, such as the Treatment Gap Analysis, with the State should the State wish to replicate it or other programming already completed by APS.

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4. Report Intervention Metrics. We cannot emphasize enough the importance of validated information and the contribution that APS CareConnection® makes in this area. The transparency of the information to the State and provider community provides a level of oversight that many vendors do not offer and helps to ensure the State that interventions have been conducted as reported. We provide examples of report formats and schedules in Exhibit 9 with the intervention metrics we propose, subject to State approval. A detail case listing is provided with the summary report to for verification of beneficiaries as needed to validate interventions. Also, our annual beneficiary satisfaction survey will provide validation.

5. Support Vermont's QAPI Efforts. As the External Quality Review Organization for the States of California, Washington and the Commonwealth of Massachusetts, APS is thoroughly familiar with QAPI requirements for MCOs – and is the *only* CCIP/DM vendor to also serve as an EQRO. Support for this effort will come from our internal Vermont team, as well as from our Massachusetts EQRO service center in Boston. During our interactions with primary care and other providers, we will identify barriers and opportunities for improvement, as well as provide performance metrics that the State can use in its QAPI program. We welcome the opportunity to act as a partner to OVHA in this aspect of the program.

6. Improve Care Management for Children with Special Health Needs and Adults with Mental Illness. As the most diverse vendor in the industry, APS has more than a decade of experience in behavioral healthcare. We identify the presence of special needs and severe mental illness through the HRA screening process, program enrollment, claims analysis, and provider referrals. Dr. Robert Sack, a Board-certified Psychiatrist and the APS Medical Director for Behavioral Health, will provide guidance to increase consistency with the federal SAMHSA Framework, which outlines optimal care processes and person-centered goals for children with emotional disturbances as well as adults with mental illness. Kevin McElligott, the Executive Director for APS' Health Care Quality Unit, which provides quality education and improvement services for people with special needs in Southeastern Pennsylvania, will provide guidance and recommendations on strategies to improve care for children with special needs and developmental disabilities.

7. Recommend Pay for Performance Strategies. Interest in quality incentive systems has grown since the inaugural national payment for performance (P4P) demonstration reported first year figures in 2005. The Medicare Hospital Pay for Performance Demonstration project showed dramatic improvements as follows:

- From 90 percent to 93 percent for patients with acute myocardial infarction (heart attack).
- From 86 percent to 90 percent for patients with coronary artery bypass graft.
- From 64 percent to 76 percent for patients with heart failure.
- From 85 percent to 91 percent for patients with hip and knee replacement.
- From 70 percent to 80 percent for patients with pneumonia.

With 270 hospitals reporting results on 34 reported measures in the domains listed above, over 400,000 patients receive higher quality care for the five conditions during the first year alone. These results provide incentives themselves for states and other purchasers to evaluate the benefit of increasing reimbursement for performance on selected measures. In concert with the emergence of public reporting initiatives to promote consumer choice among providers and plans, pay for performance programs promise improved quality. We applaud Vermont's interest in investigating P4P programs as part of its comprehensive efforts to measure and improve quality of care for all Vermonters. While no Vermont hospitals were listed Premier-Medicare demonstration, 14 hospitals participated in the Institute for Improvement's 100k Lives campaign, which lays the groundwork for a successful P4P program for Vermont. In this section we discuss program features and implementation issues that Vermont must consider in anticipation of a P4P initiative.

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Medicare and Premier, the hospital organization participating in the Medicare P4P demonstration, evaluated hundreds of performance measures before settling on 34 measures in five categories. Measures were selected with input from JCAHO and the National Quality Forum and subjected to considerable debate before the cohort was finalized. The specific measures were published and validated as representing optimal, evidence-based care; the conditions themselves were identified as associated with high cost and high frequency of hospitalizations for Medicare patients. These features – validated measures accepted as indicators of best practice and priority conditions in the population – are essential to successful P4P programs. Performance measures have to be accepted by the participating provider community as representing optimal care for the population before providers will participate. Further, the conditions selected as the focus of the program must be sufficiently prevalent for a P4P program to be cost-effective, since the point of these programs is to reduce costs and avoid adverse outcomes associated with poor quality care. Much like performance incentives and penalties for disease management organizations, P4P programs expect that the benefit will outweigh the cost. APS' proposal for primary care providers to conduct the HRA component of the CCMP is itself a P4P strategy. We know from the Chronic Care Model and associated literature that proactive primary care provider teams are associated with better health outcomes and consistency with evidence-based best practice. The process of conducting the HRA brings providers into *productive interactions* with their patients to ensure they are aware of patient health issues.

We agree that a P4P program should be phased in and summarize our recommendations below:

- a. Focus on ambulatory care. Chronic conditions are managed at the lowest cost and with highest patient quality of life in the community. The P4P system should therefore provide incentives to deliver care in community rather than institutional settings.
- b. Begin with a voluntary program that offers positive incentives during Year Two of the CCMP. Even though institutional providers have responded positively to appropriately configured P4P programs on a national level, the process of public reporting is daunting for physicians and clinics if it has not been done before. Enrolling high performing providers will support the success of the program since they are more likely to achieve scores that result in increased reimbursement – therefore demonstrating the success of the program within the broader provider community. Rewards should be retroactive based on measured results from Year One, and should thereafter be calculated on a quarterly basis.
- c. Determine the extent to which measures will be publicly reported or will be used only for determining enhanced reimbursement. If measures are to be publicly reported, explicit identification of the target audiences(s) is necessary to ensure that reporting methods and formats are appropriate. For example, while clinicians appreciate the presence of confidence levels around a number, consumers may not be interested in more complex reporting schemes and may prefer a single number or symbol. Consumers, providers, and legislators are audiences often addressed by P4P reports. We recommend a high level “lay person” summary for consumers and legislators, with more detailed discussions of methods and results for clinicians and researchers. We also recommend a consensus process to select measures, reporting formats, and timeframes. This process is more time-consuming but yields greater buy-in.
- d. Select a limited number of key performance measures that providers agree are logically related to quality of care for conditions that are a high priority in Vermont. We suggest a focus on the top five chronic conditions to be addressed by the Chronic Care Management and Care Coordination programs. The National Quality Measure Clearinghouse maintained by the Agency for Healthcare Research and Quality lists 784 measures according to a variety of domains such as specific disease (www.qualitymeasures.ahrq.gov). Talking Quality, a federal website dedicated to assisting users in

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presenting quality measure information, includes detailed suggestions for selecting measures, collecting data, and reporting results (www.talkingquality.gov). The use of nationally published performance measures provides many benefits – assurance that the measures have been validated, the potential for benchmarking, and avoidance of poorly constructed measures that may not perform as intended. Considerations for the performance measures should also include feasibility and cost of collection, periodicity of recommended reporting, and suitability for the selected audience.

- e. Focus on improvement over time as well as absolute scores. After an initial reporting period needed to establish baseline scores, providers can be rewarded for improving their scores over a prior period as well as absolute scores on performance measures. This approach has the benefit of encouraging lower performing providers to participate in the program – even though they may not reach benchmarks for payment, improving their performance allows them to participate in the increased reimbursement pool.
- f. Pilot the P4P program in counties or among providers who serve a large number of beneficiaries with the targeted conditions. Validating the measures at the local level is essential to ensuring that they are relevant to local provider practices and provide information as intended. Piloting the program among low volume providers would not permit the State to evaluate unintended effects that may not emerge until a fairly large numbers of providers and patients participate.
- g. Frame the P4P program within the larger context of quality improvement, including developing tools and processes to assist providers with improving quality and adopting evidence-based practice. Vermont is a state with a few large providers and many primary care clinics and individual physician practices. Providers who may be left out of a P4P program because of size or location will need encouragement to join a process that may at first seem designed to publicize deficiencies in their services. Including technical assistance and tool kits (such as flow sheets and alerts) demonstrates a commitment to improving quality at the system level for all providers, not just a few large practices.
- h. As noted in the RFP, align measures and incentives with state and national initiatives to reduce provider burden and leverage other activities that reward quality. It is better to have too few measures than too many, since both providers and consumers become confused by too much information and return to “rule of thumb” measures such as family recommendations.

APS is committed to assisting Vermont with this process. APS CareConnection® is an ideal platform to support a P4P program since it provides an information rich environment as well as the tools needed to assist providers with quality improvement – such as alerts, reminders, and guidelines for reference. APS also brings its own best practices accumulated from almost two decades of experience with Medicaid programs, beneficiaries, and providers in more than twenty states. As the only CCIP/DM company to specialize in the difficult work of public sector healthcare management, APS Public Programs is uniquely prepared to assist Vermont with knowledgeable staff, state of the art systems, and improvement expertise.

8. Request Approval from the State in Advance for Clinical Content. All materials will be approved in advance by the State, and we have addressed this requirement in our work plan timeframes.

Work Plan for Health Risk Assessment Services (HRA)

APS is the most experienced vendor in public sector chronic care improvement in terms of our universal successes and number of programs nationwide. We have achieved our success through a combination of evidence-based predictive modeling and beneficiary-centered health risk assessment. In this section we present our approach to conducting all aspects of the HRA work plan.

BACKGROUND

Health Risk Assessments are an integral part of effective disease management programs, identifying opportunities to target interventions for optimal health status improvement. APS has developed a two phase program that leverages administrative data and interactive risk assessment to provide a comprehensive profile of each beneficiary's acuity and health coaching needs. Our HRA approach is integrated with our interventions and for this reason we have proposed to conduct both aspects of the program. As our discussion indicates we are fully prepared to provide HRAs that are free of organizational bias through an innovative solution that also brings Vermont's primary care providers into the foreground of productive interactions with program participants. We look forward to participating in collaborative PDSA cycles to improve the CCMP, and will recommend opportunities for improvement in reports and meetings.

SCOPE OF WORK REQUIREMENTS

We discuss our approach to the scope of work requirements with a narrative overview of activities to demonstrate our understanding of all aspects of this program. We then present a work plan with timeline, milestones, and deliverables to illustrate the organization and sequencing of activities required to fully implement the program within required timeframes. This work plan will be reviewed and discussed with OVHA, and adjustments to the activities and schedule will be made based on OVHA comment.

APS proposes to act as both the HRA vendor as well as the IVS vendor. A requirement of the HRA program component is the assurance that HRAs will be obtained without the possibility of bias from the process of conducting interventions. Having undergone an independent evaluation of our health risk assessment and intervention programs in both Wyoming and Georgia, we are alert to the issues that must be addressed in quality assurance of both functions, and have formulated our approach to achieve the goal of independence and objectivity. APS delivers high performance CCIP/DM programs to extremely high risk and high intensity populations. Achieving optimal performance demands a closely coupled system with maximum integration of functionality and technology support. The health risk assessment tool that APS uses has been integrated into our care management IT platform, APS CareConnection® to assure accurate collection of data elements and immediate access to information by Health Coaches, PCPs, and beneficiaries. For this reason we propose an integrated program.

Effective CCIP/DM interventions begin with an accurate and timely evaluation assessment of the health status and health risk of the individuals in the program. With valid and reliable information at the person-level, it is possible to tailor an intervention program at this individual level for the type of person-centered approach that is most successful in all populations. During the first 12-18 months of the program, we will complete both phases of our Health Risk Assessment on approximately 25,000 beneficiaries and an additional 15,000 – 20,000 beneficiaries will be assessed during the subsequent 12 months.

HRA General Requirements

1. Conduct Health Risk Assessments. We provide analytic results for the beneficiary population in Exhibit 10 and summarize participating beneficiaries in Table 2. Eligibility records indicated a total of 148,229 individuals in the population, after selecting individual records according to OVHA's inclusion criteria. In addition to the chronic diseases identified by OVHA, APS includes other chronic diseases observed in the data to thoroughly address the disease burden of the population. Of this population, 82.2% (121,810 beneficiaries) had one or more claims during the analytic period accounting for over \$767 million in program dollars. The need for a proactive and effective chronic care management program is indicated - 19.9% of the population (24,121 beneficiaries) with chronic diseases identified by APS account for 41.2% of the cost (\$316 million). APS uses a clinical hierarchy to assign individuals to unique conditions for analysis

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based on the highest burden of disease identified through claims data. We identify and address ALL conditions in our HRA and IVS processes. APS understands that the risk stratification process is part of the IVS scope of work. We consider the predictive modeling part of our integrated assessment process but can perform health risk assessments with or without a predictive modeling component.

Table 2. Prevalence of Chronic Disease – Eligible Beneficiaries

Condition	Count	Condition	Count
Arthritis	2,042	Schizophrenia	661
Asthma		Depression	6,509
Adult	3,451	Diabetes	
Child	2,036	Adult	4,619
Back	1,054	Child	170
Breast Cancer	301	Hemophilia	51
Chronic Obstructive Pulmonary Disease	584	Hyperlipidemia	314
Chronic Renal Failure	268	Hypertension	700
Colon Cancer	79	Lung Cancer	81
Congestive Heart Failure	371	Prostate Cancer	86
Coronary Artery Disease	864		
		Total Count	24,241

To ensure that program resources are applied meaningfully, it is therefore important that each beneficiary’s individual health risk be assessed and interventions prioritized. APS conducts health risk assessments in two stages: predictive data modeling and interactive risk assessment, which we describe in this section.

Phase 1 – Setting the Stage for Accurate Health Risk Assessment: Predictive Modeling

The initial stage of our comprehensive approach entails predictive modeling with administrative data. This aspect of our assessment will be transparent to OVHA and subject to quality assurance verification and provider validation, ensuring that the initial and any subsequent modeling is completely free of interventional bias. APS is experienced at conducting predictive modeling through a variety of statistical and analytical tools to predict, with a high degree of accuracy, clients who are at risk for a future health care utilization and costs. APS and its affiliates have been providing predictive modeling services for nearly a decade and currently conduct such analytics for Medicaid and commercial clients that cover approximately 8 million members. Predictive modeling is a component of each CCIP/DM program. The chart below indicates programs in which APS conducts health risk assessments. We include examples of the HRA instruments we use in Exhibit 11. For Vermont, we propose to use a tool such as the SF-36v2.

APS Disease and Care Management Customers

- | | |
|--|-------------------------------|
| Blue Cross Blue Shield of Montana | Micron Technology |
| State of Wyoming Medicaid Program | Mellon Financial Corporation |
| State of Georgia Medicaid Program | Southern Companies, Inc. |
| State of Louisiana OGB | Laclede Gas Company |
| Blue Cross Blue Shield of Hawaii | Jason Corporation |
| State of Wisconsin Medicaid Program | Cerner Corporation |
| State of Missouri Medicaid Program | New York Department of Health |
| Indiana Comprehensive Health Insurance Association | |

APS conducts predictive modeling through an internal department dedicated to health informatics. To conduct the predictive modeling for the Vermont CCMP, APS will draw on the expertise of our team of dedicated and experienced professionals from our Healthcare Informatics Division. Our informatics group

brings exceptional experience working with administrative and reference data sources and has produced thousands of analyses and reports on behalf of our customers. These experienced professional analysts provide a unique combination of specialized expertise in areas of clinical and data analysis, and have routinely conducted predictive modeling analytics for commercial and Medicaid customers.

A predictive analytic approach increases the effectiveness of any care management or disease management model. It serves to identify individuals who are *at risk* for intensive service utilization but who have not yet engaged in these services. Through outreach and early intervention, this approach serves both to alleviate future suffering and to promote entry into service at a lower intensity of care.

APS' Approach to Predictive Modeling for the Vermont Chronic Care Management Program

For the CCMP, APS will use a comprehensive and evidence-based suite of predictive modeling tools – both propriety and external – to identify high-risk patients. Our tools analyze demographic data, historical medical, behavioral, and pharmaceutical claims data using statistical algorithms that take into account all major disease diagnoses, since high-risk cases are generally comprised of multiple diagnoses. The results of our initial stratification are included in Section 7.1.10. APS will perform initial risk stratification through predictive modeling on each eligible member of the CCMP. The initial stratification will result from our predictive modeling tools and be performed immediately after OVHA sends claims information to APS. This stratification is based on an analysis of eligibility and claims data, including pharmacy, behavioral health and laboratory data, and total costs. APS' initial stratification process will result in each beneficiary being classified along a continuum based on their probability of incurring future costly health care episodes.

In addition to the initial stratification through predictive modeling tools, APS will perform a secondary stratification on each beneficiary based on health risk assessments, including baseline knowledge surveys. These tools are intended to further stratify the enrolled population by considering the individuals' functional status, risk behaviors, and risk for non-adherence to recommended care or poor self-management.

Initial Stratification of High-Risk

Eligibility and health claims data received from OVHA will be consolidated within the data repository (i.e. data warehouse) of APS CareConnection®. From this information, APS will employ a comprehensive set of analytic tools to perform predictive modeling. This set of tools utilizes both nationally recognized and APS' proprietary informatics tools to stratify individuals by their illness burden. We explain these tools below.

For the Vermont CCMP, this information will guide APS in identifying clients who have a "high risk" potential for costly episodes of care and poor health outcomes. The initial identification also sets priorities for conducting HRAs and baseline knowledge surveys, as well as outreach and enrollment activities.

For predictive modeling, APS proposes to use the following (* indicates a proprietary tool):

- APS' Chronic Disease Identification*
- APS' Behavioral Health Predictive Modeling*
- JHU ACGs Predictive Modeling System
- APS' Treatment Gap Analysis*

The output of these powerful informatics tools will be creatively combined for Vermont's CCMP to define and identify clients at risk of higher medical utilization, and associated costs using current eligibility files and three years of data. In Exhibit 12 we describe each tool in more detail and address how they determined risk stratification of beneficiaries we identify in our proposal.

Phase 2 – Adding the Voice of Patient and Provider – Interactive Risk and Status Assessment

APS has experience conducting population-based Health Risk Assessments (HRAs), through both our Informatics work and in the operation of our health and disease management programs. HRA tools we are familiar with include many risk screening tools developed by national organizations, such as the American

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Diabetes Association, National Cholesterol Education Program, and National Heart, Lung, and Blood Institute-Obesity Education Initiative. APS is currently conducting PHQ-9 surveys in conjunction with our depression predictive modeling. For APS care management programs, we typically employ Quality Metrics SF™ generic health surveys, or similar tools. The SF™ generic surveys are an excellent tool for health assessment of populations receiving public assistance¹. These survey tools have also been extensively used in health outcomes research. During implementation we will review the health risk assessment tools and items in APS CareConnection® and finalize items to be included in the Health Risk Assessment. With information from evidence-based guidelines that are not proprietary to APS as well as commercially available tools such as the SF-8, the APS HRA is a holistic assessment that provides a comprehensive assessment of the beneficiary's mental and physical health status, health risk behaviors (such as smoking), health beliefs, and readiness to assume increased responsibility for his or her care management. This information is essential to appropriate and effective disease management. Just as importantly, it is a critical component of *productive interactions* between patients and providers and only one example of the ways in which APS' disease management strengthens provider relationships with patients.

The results of the predictive modeling analysis are loaded into APS CareConnection® for each beneficiary assessed. This process creates a baseline profile of the beneficiary's recent utilization and captures the diagnoses that have been coded on claims. As our Work Plan Gantt chart demonstrates, during implementation we will integrate beneficiary and provider demographics into APS CareConnection® and enroll Medicaid providers (chiefly primary care physicians; with specialist, pharmacist and allied health practitioners available upon request) for access to the patient-level information system. Each provider will receive a welcome letter with information about enrolling staff members and directions on accessing enrollment materials through the website. Providers will apply to be HRA Administrators during this process of enrollment, and indicate staff members who will be authorized to update and change HRA information in APS CareConnection®. APS has embedded condition-specific as well as generic risk assessment items into our assessment screens, which are easy to access and complete. Providers will be compensated on a quarterly basis for the verified HRAs they have administered. The verification process will be conducted by APS Health Coaches/Care Coordinators, who will ensure that all HRA fields have been completed. It is important to note that the Health Coaches will not change any HRA values that they question. Rather, they will contact the provider to discuss the field in question and determine with the provider the correct value for the assessment field. In the event that a provider does not conduct an HRA for a member, the APS staff member will complete an HRA and validate the results with the provider. The HRA data will be transparent to providers, beneficiaries, and the State to examine the information and provide feedback to APS.

2. Impartiality of Health Risk Assessments. We propose two methods by which the impartiality of the HRA results will be assured. The first phase of health risk assessment – the predictive modeling analysis – provides transparent results based on third party data. We provide a summary of our initial predictive modeling in Exhibit 10. We will review our predictive modeling methods with OVHA to assure that they are independent of any intervention data. In addition to basing predictive modeling on industry standard analytic methods, we propose that providers will have the first option to administer the interactive HRAs. This approach also verifies the predictive modeling because providers will view administrative data through

¹ Mainieri T., Danzinger S. (2001). *Designing Surveys of Welfare Populations*. Report funded by DHHS Office of the Assistant Secretary for Planning and Evaluation and the National Institute of Mental Health (R24-MH51363).

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APS CareConnection®. We anticipate the majority of HRA's will be conducted by beneficiaries' primary care providers based on discussions with Vermont associations. For the relatively small number of HRAs we propose to conduct through outreach efforts directly to the participant, we will also verify the HRA results with the primary care provider and indicate approval on the APS CareConnection® record. These verification methods will ensure that our HRAs are valid and that the primary care providers agree with our assessment – a valuable quality assurance step in the process.

3. Receive Transferred Calls from IVS Nurse Call Center. As an active partner in the State's CCMP, APS will facilitate communication between program components. We have proposed a staffing plan that will assure we receive and answer calls placed to the IVS Nurse Call Center – the APS Call Center, since in our proposal we have integrated call center activities to ensure the minimal amount of call transfer activities. When a call is received from a beneficiary, the APS staff member will verify the beneficiary's record in APS CareConnection® and document the call. In the process of interacting with the member the Call Center representative will determine what further action needs to be taken. Call outcomes include sending the member specific information (such as wellness materials), issuing an alert or message for the primary care provider, calling the provider, or conducting initial or follow up HRAs. Each staff member interacting with the beneficiary will document the discussion and any required follow-up, with notification to the assigned Health Coach. This approach ensures “one-stop shopping” for the beneficiary, comprehensive documentation for the provider, and a clear and complete audit trail for the State to ensure that HRAs are independent and that APS completes both HRA and IVS activities promptly and accurately.

4. Reporting Format and Frequency. We include proposed report formats in Exhibit 9 of the proposal, and will review these formats with OVHA during implementation. With input and approval from the State, we will finalize the reporting formats and timeframes. We propose to update the results of HRAs on a nightly basis to assure the timeliness of IVS initiation. This process will be managed with an HRA transfer control report that documents the new HRAs on a daily basis. This report will be generated at the same time the upload file is created, and submitted to the State each morning. This report will be at the person level of detail. As the IVS vendor, APS will use this control report to ensure that all records have been accurately submitted to the State and that no records failed State update edits. On a weekly basis, we will provide an activity detail summary that identifies new HRAs completed, existing HRA's updated, and changes to risk status (e.g., from moderate to high) by county and separately by primary care provider. This report will be created and submitted on Monday morning for the previous week. Monthly, we will provide a summary report with a count of new HRAs, updated HRAs, and changes in status. The monthly report will also include a narrative that discusses any HRA issues, opportunities to improve the HRA process, and activities that are planned for the month following. This report will be submitted within 10 days of the close of the month.

COLLABORATION AND INTEGRATION REQUIREMENTS

A cornerstone of Vermont's CCMP is that it must succeed in the context of the larger healthcare agenda for Vermont. To this end, the program must collaborate and coordinate with the State's Medicaid initiatives, the Blueprint for Health and existing Rule 10 requirements and activities undertaken by BISHCA. In addition, the management information system must keep pace with the VITL initiatives to implement the RHIO. The HRA vendor must also collaborate and coordinate with the CC program to assure that the HRA vendor and OVHA share information about beneficiaries as they transition between the CCM and the CC programs, and work collaboratively with OVHA to promote the ability of Vermont providers to understand and

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strengthen a shared understanding of, and commitment to, chronic care quality management and improvement. The IVS represents another program stakeholder for shared HRA vendor support.

These needs illustrate the purpose and strength of APS' local service center and transparent IT approaches – with a diverse group of stakeholders and an active state healthcare environment, “distance management” cannot be successful. Chronic care management is not effective when conducted at arm's length by an organization whose decision-making team is based in another state. APS' Vermont program will be managed locally from our planned service center in Williston, Vermont, staffed by Vermonters who work in this office as well in primary care settings across the state, and supported by decision tools that are available via internet, statewide. This approach has enabled APS to demonstrate exemplary success in various states and settings, and will prove equally effective in Vermont. We detail our staffing and management approach in Section 7.

To maximize the collaborative interactions between the CC program and APS staff members, APS will support case management of the CC program beneficiaries within APS CareConnection® should OVHA wish to use it. At no additional cost, Dr. Strenio and CC staff members will be able to manage their workload using APS CareConnection® – establishing care plans, sharing information with providers, documenting interactions with beneficiaries and providers, sending and receiving alerts, and using APS' library of evidence-based literature and wellness materials to support CC participants. A web-based application, APS CareConnection® can be accessed anywhere in the state without the need for proprietary software or additional hardware. This system is ideally suited for field staff use – without cumbersome additional equipment or software. The use of this application will enable OVHA to quickly and easily move beneficiaries between CC and CCM programs while maintaining longitudinal documentation concerning program membership and interventions. A key component of APS' commitment to the transparency of our disease management program, APS CareConnection® will permit OVHA staff members to review, comment on, and validate data elements in beneficiary profiles. RHIO and other Vermont EHR initiatives can be easily linked to the database (and vice-versa) to facilitate data integration.

ELECTRONIC AND DATA REQUIREMENTS

We provide details of our innovative disease and program management platform, APS CareConnection® below. APS will comply with all aspects of this section, including making available person level data to primary providers and the IVS staff through APS CareConnection®. In our model, APS staff members and primary care providers are interactive partners in developing care plans, working with consumers, and identifying optimal care.

1. Distribute person-level data to primary care providers. As we discuss in our sections on HRA and IVS scope of work requirements, providers will administer HRAs and document these results in APS CareConnection®. HRA and intervention information will be therefore easily accessible to primary care and allied providers. In the event that providers do not use this information system, we will forward data to the primary care providers and care management staff providing IVS to assist in the development of individual care plans in a format agreeable to all parties, including OVHA. APS will send providers a file of results in Microsoft format (SQL, Word, Excel, or Access) or as a text file (.txt; .csv; etc.). During implementation we will work with OVHA and providers to develop a standard file format and transmission schedule. Patient-specific data will also be sent.
2. Incorporate person-level contact information from the State. During implementation we will discuss data transmission and storage with OVHA, and configure APS CareConnection® to maintain appropriate person-level files. We will be able to receive and transmit data between APS and the State in a “flat file”

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(i.e., not variable length or a relational database). We will receive the contact information from the State for the purpose of identifying beneficiaries for HRA administration, and maintain the confidentiality of consumers. We propose to make available completed HRA data to the State, IVS staff, and primary care providers on a nightly basis or as determined during implementation. The nightly schedule is one that APS employs to update eligibility information into APS CareConnection® and we therefore anticipate a daily exchange of information for eligibility updates and transmission of validated HRA data. For the IVS component, we will accept data from EDS for names and addresses of eligibility beneficiaries, as well as other information from the State and incorporate this information into our electronic files. Note that we expertly partner with EDS for services in many states, often serving as their primary analytic team.

3. Transmit raw data to the State and IVS vendor. In item (2) above we propose to transmit data nightly or as agreed. APS CareConnection® uses guideline and evidence-based algorithms to identify risk and disease categories for administration of HRA questions, a process that helps to ensure that HRAs are accurate and based in clinical science.

4. Provide data to the State, the IVS vendor, and primary care providers. APS will provide data in a timely manner to all parties. During implementation we will determine transmission timeframes for submission of HRA data, as well as an electronic format for the file and valid values in the event any fields are coded (such as gender or participation in the CC program). Once we have agreed to timeframes we will submit data according to those timeframes. It is important to note that these timeframes may change over the course of the contract, and APS will be flexible in adjusting to evolving data needs. For example, after the administration of the initial 25,000 HRAs, the IVS staff may prefer a weekly data transmission rather than nightly. APS will work with all stakeholders to assure timely transmission of accurate data.

5. Aggregate and analyze Health Risk Assessment data in a timely manner. We describe the data analyses we perform in our approach to conducting HRAs. We will aggregate and analyze this information on a weekly basis to provide timely information to providers, IVS, and the State to provide summary information on the respondents, such as volume of HRAs, number by acuity level, changes in Phase I acuity based on Phase II results and subgroup summaries by demographic and geographic characteristics.

6. Accept and send files. APS is adept at exchanging files with a variety of entities, and currently conducts successful file exchanges with many Medicaid MMIS vendors, member management, and pharmacy vendors – over 1 million records daily. We document the volume of file updates and transmissions in our discussion of our information technology approach below. A data acceptance requirement for IVS is to accept pharmacy data from the PBA. Pharmacy data is integrated into our predictive modeling analyses and incorporated into APS CareConnection® for reference by Health Coaches, OVHA, and providers.

7. Data Input and Output. For the IVS component, we will collect self-reported patient level information and maintain it in our HIPAA compliant data warehouse. We will provide patient-specific information to the State and appropriate health care providers, including the Blueprint clinical registry in easily accessible formats.

Meeting Requirements

With a local service center to be located in Williston, Vermont, APS will be accessible for all meetings with stakeholders, and in fact we expect our Vermont team to be active participants in Vermont's exciting and innovative program. We plan to attend meetings at least every two weeks with stakeholders in the CCM, and will be available for other meetings as needed. The Executive Director will be the point of contact to arrange attendance at meetings not already scheduled.

PERFORMANCE STANDARDS

We propose the following deliverables and associated performance standards for the implementation phase and on-going operations. Sample formats for the reporting deliverables are included in Exhibit 9. These deliverables are aligned with our proposed payment methodology presented in the cost proposal.

HRA Deliverables

- Approval of HRA instrument and administration/submission process within 60 days of contract start.
- Completion of HRAs
 - Completion of 1400 per month in first 18 months.
 - Completion of 1250 – 1700 per month over next 12 months.
- Submission of HRA patient level detail files.
 - Submission of records nightly with control report submitted the next morning.
 - Records processed by IVS system with 95% acceptance rate.

APS will submit weekly update reports on the status of HRA completion and submission by close of business Monday following the end of the previous week. We understand that we may be assessed \$1,000 per week for each standard that is not met.

IVS Deliverables

- Initial approval of IVS risk stratification methodology (implementation).
- Initial approval of IVS intervention strategies, tools, and frequency (implementation).
- APS CareConnection® implementation (implementation).
 - Data loaded to APS CareConnection® (claims, enrollment, pharmacy, etc.).
 - APS CareConnection® go-live for OVHA.
 - APS CareConnection® go-live for providers.
- OVHA Accepted Monthly Intervention Report (detail level) (on-going).
- OVHA Accepted Quarterly Findings Report (summary level) (on-going).
- OVHA Accepted Annual Summary & Recommendations Report (on-going).
- Quarterly Provider Education and Outreach Conferences (calls and meetings).

PAYMENT STRUCTURE

We propose that APS will bill for implementation deliverables when they are approved by the State; thereafter, APS will bill on a monthly basis for accepted deliverables. We will finalize the payment structure after award in consultation with OVHA.

6.2 Acquisition and utilization of staff

We explain our approach to staffing the contract and hiring staff in Section 7. Since the inception of our public programs division, APS has implemented well over a dozen local service centers. Our structured approach is managed through the work plan under the supervision of Ron Breitenbach, the APS Director of Implementation. Hiring is supervised by Michael Mercado, Director of Administration, with assistance from Toni Moser, Director of Human Resources. We begin with the recruitment of the Executive Director (ED). We have already identified a strong candidate pool, subject to approval from the State. The ED joins the company within the first 30 days of project implementation and thereafter oversees further hiring as well as reporting to the State and coordinating deliverables. The full cadre of staff is onboard within 15 calendar days of go live to allow time for training and system testing. We include job descriptions the Executive Director, Medical Director, Health Services Manager, Health Coach, Outreach Coordinator and Health Specialist positions to be located in the Vermont Service Center in Exhibit 13.

6.3 Utilization of Staff Resources to Accomplish Milestones & Deliverables

Table 3 presents the allocation of direct staff resources to the accomplishment of listed milestones and deliverables. The final Project Plan that we will submit will have final staff allocations and resource levels for confirmed milestones and deliverables.

Table 3. Staff Allocation by Week for Milestones and Deliverables		
Milestone/Deliverable	Position	Weeks
<u>HRA Component</u>		
• Approval of HRA instruments and process (M/D)	Medical Director	2
	Health Services Manager	8
• Completion of HRAs/Support to PCPs (D)	Health Services Manager	0.5
	Peer Support Coordinator	FT
• Submission of nightly Patient Level Files		
○ Initial submission (M)	Reporting Analyst	3
○ Nightly submission (D)	Reporting Analyst	0.01
<u>IVS Component</u>		
• Approval of risk stratification methodology and tools (M/D)	Medical Director	10
	Health Services Manager	
• Approval of intervention strategies and materials (M/D)	Medical Director	10
	Health Services Manager	
• Configuration of APS CareConnection® for CCMP (M/D)	J. Smith	12
	Reporting Analyst	
• Monthly Interventions Report		
○ Initial submission (M)	Health Services Manager	2
	Reporting Analyst	
○ Monthly submission (D)	Health Services Manager	0.25
	Reporting Analyst	
• Quarterly Findings Report		
○ Initial submission (M)	Executive Director	3
	Medical Director	
○ Quarterly submission (D)	Health Services Manager	2
	(Same)	
• Annual Summary Report (D)	Executive Director	6
	Medical Director	
• Provider Education and Outreach (D) (Monthly)	Health Services Manager	2.5
	Outreach Coordinator	

6.4 Approach to Facilities and Infrastructure Acquisition

One of the benefits of the APS local approach is the corporate support for facilities and infrastructure development. APS proposes to locate all CCM operational staff in Vermont, with support from corporate offices for very limited services that are best delivered on a larger scale basis. During implementation, local staff members focus on contract milestones and deliverables, development of stakeholder relationships, and coordination with the State to ensure that project implementation is timely and efficient. APS' Facilities staff, led by Shelly Shaffer, is responsible for the acquisition of office space, office equipment and

furnishings, and incidentals required for opening a new APS office. APS has already identified potential office space near the OVHA office in Williston, Vermont – a principle of APS operations is that our local service centers be in close proximity to clients. Facilities acquisition will be managed according to the implementation project plan supervised by Ron Breitenbach.

6.5 Implementation approach (4 months: March 1, 2007 – June 30, 2007)

We provide week-by-week project plan in Exhibit 14 and summarize our implementation approach here. APS implements projects with a proven corporate team that includes experienced CCIP/DM executives as well as corporate staff that facilitates all aspects of implementation. We describe the roles and responsibilities of these staff members in Section 7. A dedicated project manager will be assigned to oversee the project plan for APS CareConnection® configuration who will work with Mr. Breitenbach and Julie Smith, who leads the requirements gathering for APS CareConnection®. Recruiting and hiring will be overseen by the Director of Administration, with assistance from the Human Resources Director. A dedicated recruiting and screening specialist will assist Ms. Toni Moser with selection of candidates for Vermont positions. Steve Thronson, APS COO for Public Programs, will recruit and hire the Executive Director with comment and approval from the State. Table 4 summarizes a very condensed listing of high level implementation achievements by month.

Table 4. High Level Implementation Achievements			
March 2007	April 2007	May 2007	June 2007
Kick-off meeting	Requirements finalized	Data exchange protocols and formats finalized	Final testing for data exchange in CC
Finalization of Project Plan	Regional provider meetings	CareConnection® configuration tested	Administrative staff start and are trained
Job descriptions finalized	Interviews with staff	Provider training for CC	Test HRAs conducted by pilot provider sites
Advertisements for Staff	Office equipment ordered	Health Coaches and Coordinators start and receive training	Final predictive modeling complete/loaded into CC
Facility leases signed	Executive Director starts	State staff training on CC	Regional provider and bi-weekly meetings
Office plan finalized	HRA/Interventions approved	Provider training for CC and HRA administration	Go-live approved for 7/1
Equipment plan approved	Providers sites recruited		
Telephone lines ordered	Training plans finalized		
Executive Director hired	Provider staff logons issued		
Bi-weekly meetings held	Provider Relations Director hired and starts		
*State signs off on all plans			

Our implementation approach is successful because it builds on best practices from prior experience as well as the skills and capabilities of our corporate staff members. Throughout these activities we will coordinate with State staff members to ensure open communication and approval at each step as needed.

6.6 Approach to relations with State staff and Stakeholders

APS enjoys highly successful and professional relations with State staff and stakeholders, with impeccable references in all areas of our business. We are active participants in the local healthcare community because of our grass roots approach. Our employees are residents of the State, and familiar faces to key stakeholders, working tirelessly with our clients and stakeholders to improve our own operations, contribute to quality improvement with external stakeholders, and provide creative and innovative contributions to their local communities. We understand that it is an honor for APS to serve the Vermont through this program, and we will work to fulfill our obligations with pride and enthusiasm as we do in all state programs.

6.7 Use of Subcontractors

APS does not propose to use subcontractors (providers must only be in good standing with OVHA to participate in administration of the HRA, and no contract will be required).

6.8 Cost Containment Mechanisms

APS places high emphasis on the efficiency of our operations, and we employ a number of cost containment measures to ensure maximum value to our clients. The local service center approach reduces corporate cost overhead while benefiting from local employment markets. Placing Health Coaches at strategic locations around the State increases provider buy-in and lessens costs associated with provider outreach as well as costs associated with interventions at the beneficiary level. We propose incentives for providers to conduct HRAs, thereby reducing the number of staff for the HRA component as well as increasing the validity and independence of HRA results and optimizing the role of providers in the project. By proposing to act as the HRA and IVS vendors, we provide an efficient staffing complement without duplicate management costs. Most importantly, we leverage APS' significant investment in technology by proposing to use APS CareConnection® as the information technology platform supporting our own CCIP activities, the State's Care Coordination program (at the State's discretion and at no additional cost to the State), and the health care provider at the point of care. These advantages decrease time for implementation, increase coordination across the entire system of care, and complement the State's own emerging health information technology architecture across the State.

6.9 Assumptions or Constraints - Work Plan and Schedule

Key assumptions in our work plan and schedule include the following: (1) The majority of HRAs will be administered by providers using APS CareConnection®; (2) APS will locate Health Coaches at primary care provider and ER sites; (3) APS proposes to conduct HRA and IVS services.

6.10 Gantt Chart

We include a Gantt chart in Exhibit 14 with activities, milestones, and responsibilities for implementation.

6.11 Handling of Potential and Actual Problems

The CCMP is new to Vermont and therefore problems may arise during implementation and operations. APS handles project issues as we do everything else – with open communication, collaborative and creative problem-solving and effective follow through. We use two mechanisms to identify and mitigate risk. The project plan outlines anticipated activities, dates, deliverables, and milestones required to successfully implement the project. Our weekly implementation meetings bring all participants together to discuss progress on the plan, identified barriers, and resources required to address and resolve barriers. The Director of Implementation monitors selected strategies, reporting to the COO. APS' implementation team leadership will maintain close communication with OVHA leadership throughout this process, reporting on implementation status, discussing resolution of issues and seeking OVHA direction and approval when needed. We also report issues to our clients that may impact deliverables. After implementation, we use our deliverable schedule as an organizing document for risk identification and resolution. The Executive Director (ED) is responsible for deliverables as well as identifying and resolving issues. Reporting to the COO, the ED ensures that escalation of problems is accomplished on a timely basis, involving APS and our clients to resolve issues.

6.12 Relationship of Scope of Work (SOW) to Effective Outcomes

Very little happens as a result making telephone calls or sending letters to individuals with chronic diseases, and many efforts to identify return on investment for CCIP/DM programs demonstrated this finding and led to considerable skepticism about them as an effective tool to contain cost and improve utilization and health status. All of the leading CCIP/DM firms except APS have experienced program terminations and failures to renew as a result. Poor health literacy – even poor literacy in general – works against Medicaid beneficiaries as do lack of continuity in addresses and telephone numbers. A CCMP that

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attempts to meet the scope of work by acting outside of the patient-provider relationship – going directly to the beneficiary with health promotion and disease management messages – will not produce optimal results. OVHA is aware of this concern. For that reason OVHA has emphasized the Chronic Care Model as a framework for disease management, and literature supports the relationship between this model and preferred outcomes in primary care. To address the requirements of this section we therefore speak to the way in which APS' approach implements the scope of work to promote *productive interactions* between beneficiaries and providers. APS' two phase HRA process generates sound analytic results that position the beneficiary on the continuum of health and chronic illness. APS maps this position to evidence-based literature that specifies optimal care for each illness. Our materials will be readily available to OVHA and providers through our APS CareConnection® library. APS establishes relationships with the provider community at all levels – through associations, working groups, our CAC, and OVHA initiatives – with an emphasis on the relationship between our Health Coaches and primary care providers for each beneficiary. We become part of the integrated team that serves the needs of the beneficiary – identifying gaps in care, social and economic barriers that prevent access, and individual barriers such as poor self-efficacy – and working to remove barriers to effective healthcare. Our approach is multi-faceted and multi-directional: making and receiving calls to providers and beneficiaries; setting alerts for providers and reminders for beneficiaries; identifying community resources to address gaps in access; providing valid and timely assessments of health status; empowering beneficiaries to ask for productive interactions with providers; training providers to communicate with cultural competency; placing Health Coaches at the point of care to serve as resources within provider offices; creating provider profiles for peer comparisons; and ensuring that each beneficiary has a medical home *and knows what that means*. By strengthening the ability of providers and beneficiaries to conduct productive interactions, we strengthen the system as a whole and help to ensure improved health and cost-effective care.

6.13 Performance Measurement and Program Evaluation

Goals for the program include achievement of scope of work deliverables and milestones as well as beneficiary level results such as the process and outcome measures included in the RFP. In Exhibit 15 we indicate performance measures we will collect for the population and report to OVHA on a monthly or quarterly basis. In particular, we will report on hospitalizations for Ambulatory Care Sensitive Conditions (indicators of gaps in ambulatory care that yield preventable admissions) and emergency department use. We anticipate that utilization will shift from institutional to ambulatory providers; hospitalizations for targeted chronic conditions will decrease; and incidence of adverse outcomes will decline. We will work with OVHA to determine specific indicators that APS will report for evaluation purposes and other indicators to be used in evaluating the program that may be collected through other activities. In addition, we will conduct annual provider and beneficiary surveys to collect information on community experience with APS as a partner in the CCMP. The survey questions will be reviewed and approved by OVHA prior to use and will be based on questionnaires published in the literature with modifications for local validity in the Vermont program.

6.14 Scope of Work Innovations

APS pioneered the use of trained Health Coaches located at key sites where Medicaid beneficiaries are most likely to receive care and be accessible to health messaging delivered by caring professionals. This approach also leads to significantly greater buy-in from providers because APS works to strengthen the relationship between provider and patient, increase patient compliance, and resolve issues that prevent patients from fully accessing available services both in the provider office and the community. Our holistic approach has been unsuccessfully copied in part by our competitors – who do not support staff in the field with world class information technology, do not embrace the systems view of quality improvement, and

have been unable to adopt the framework of the Chronic Care Model for their operations. The combination of human creativity with supportive technology is our most enduring innovation and one which we nurture.

7.1.6.1 Technology Approach and Requirements

1. The Proposed System. Our proposed health and disease management software, APS CareConnection®, will run on APS' state of the art information system. This system provides comprehensive support to all APS contracts and will support implementation of the Vermont Chronic Care Management Program. APS' advanced technology platform provides cutting edge technology to place information in the hands of the individuals who need it. Our system provides a central repository in which the latest clinical, administrative and claims data will be captured and made available to OVHA and Vermont providers. APS CareConnection® maintains all information in a relational database. Information can enter the system both via the secure web based user interface or data through batch programs. The system tracks a wide range of data, from patient eligibility information to assessments and medical records, facilitating easy systematic access, retrieval, and analysis of data. Highly customized, APS CareConnection® includes:

- Automated, customized assessment tools – for CCMP these tools will include an SF-X questionnaire.
- Assessment-driven, automated stratification to clinical pathways and care strategies.
- A proprietary clinical impact tool (exceeds URAC case management standards).
- Assessment driven, auto generated care plans which include goals, interventions, and monitoring and evaluation timelines that are based on national standards and practice guidelines and have been highly customized to meet the needs of public programs.
- Automated prompts and updates to facilitate on-going clinical decision-making and intervention.

APS and its affiliates employ APS CareConnection® in 14 different public sector programs. These facilities are all connected via a centrally managed Wide Area Network. Our facilities range in size from five person offices to 500 plus person regional service centers. This variety gives us experience setting up and supporting virtually any size office in any geographic location. Our current operations use more than 108 servers providing support for myriad activities including hosting health information and wellness website products, claims payment systems, email, advanced statistical predictive modeling, statistical and qualitative reporting, and collaborative team tools. This section and Exhibit 17 include an overview of APS' data and communications systems to be deployed for the Vermont CCMP.

2. Compatibility of Proposed Interfaces. APS has over two decades of experience establishing effective interfaces, and more importantly, partnerships with our state government clients and their Medicaid fiscal agents/State MMIS program managers. Therefore, APS knows what it takes to establish interfaces which conform to the specific requirement of State Medicaid programs. APS will begin by working with OVHA to develop an interface plan for APS CareConnection®. Through our extensive experience, we understand that establishing open lines of communication between APS, OVHA and other partners from the very beginning is critical to data transfer and management functions. APS will assure seamless coordination between all systems including but not limited to the OVHA's fiscal agent, care management organizations, pharmacy benefit manager, decision support system and provider's offices. APS assures that all of its applications, operating software, middleware and networking hardware and software shall be able to interface with the state's systems and conform to the data specifications detailed in the RFP. APS will bring all of the technical resources that are necessary for successful implementation.

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3. Accept data from, and provide data to, State and other systems. APS has the ability to accept client and provider information in a variety of electronic formats. Data exchange protocols will be developed during the implementation period and may include Internet, SFTP, BBS, diskette, tape-to-tape, Iomega Zip, Castlewood Orb, CD-ROM, etc. APS will accept a flat file of mutually accepted format, when provided with a current data dictionary. We will create the interfaces needed to import this data into our application for Health Coaches to use in the care management process. We will also convert the data into the RDBMS format needed for the APS Informatics team to analyze and report to OVHA. Because of the complexity of the data, APS will work with OVHA to define and import various interfaces including claims, HRA, and other types of data exchange. Where possible, APS will include this data within our system's datasets or in a general notes field. The APS CareConnection® system is fully configured and carefully designed to track the key data points needed to conduct the scope of care management in the RFP. In the event that the state wishes APS to add additional specific fields for reporting, we will work with OVHA to assure appropriate design and change orders are executed to achieve this change in the most advantageous manner, balancing time, cost, and quality to meet your goals.

4. Send and receive data. APS has the ability to accept client and provider information in a variety of electronic formats and proposes that APS provide flat files to meet specific format requirements required by the state to populate other applications and datasets. APS will work collaboratively with OVHA to ensure that clear specifications are developed among all trading partners. We will support test cycles to establish that the specifications have been met, and will make necessary corrections.

APS recommends that we identify the requirements and then provide specific extracts of mutually agreed datasets to fulfill the state's ongoing data needs. APS will provide data in either SQL tables or flat files, as requested for each dataset. Online systems against our reporting instance of the database (refreshed nightly) will be available during all periods when reporting access is available. File extracts can be run weekly, monthly, or quarterly, as specified by the state.

5. Segment, isolate, and secure AHS data and ensure it is not compromised. APS' systems are designed and maintained to secure data received from OVHA or other trading partners. Protection against the compromise of sensitive data is accomplished through a combination of processes and system configuration. APS CareConnection® uses an automatic, electronic receipt system for all data transfer. This process notifies providers or fiscal agents when or if a file is corrupt, has failed to meet required formatting standards, or when files have been successfully transferred. Our file transmission protocol also identifies when data has been completely transmitted to various authorized recipients. This system provides APS with a 100% guarantee of notification of data receipt, transmission and accuracy.

6. Provide the State with a comprehensive security plan and procedures. APS is pleased to offer a data repository and care management solution operating in a HIPAA compliant environment. APS has driven the development of HIPAA compliant user password and system data security features, to service a wide variety of customers without compromising confidentiality of either individual clients or customer groups. APS implemented the new HIPAA security rules well in advance of the spring 2005 deadline. We maintain our systems and the platforms we run on in a manner fully compliant with our broad knowledge of the security requirements. Existing safeguards include strong passwords at host, application, and database levels. APS and its affiliates provides strong network perimeter protection including firewalls, securing external network access points, and fully encrypted VPNs for remote connections. APS has a Chief Privacy Officer who oversees all aspects of the HIPAA compliance program; a profile of Ms. Chestler is in Exhibit 16.

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7. Disaster Recovery and Business Continuity. APS systems are extremely reliable, and take advantage of Microsoft SQL Server's recovery features. The appropriate checkpoint and restart capabilities are enabled and ensure reliable recovery, including full disaster recovery in the event of a catastrophic system failure. Tables in the database are normalized for optimum efficiency. Information is stored in the tables with appropriate data type definitions for each column. Changes to any rows within a table are tracked and a history of changes is maintained within the database. This approach provides the ability to audit changes and troubleshoot any data discrepancy.

8. Make all files, programs, and data available to the State upon request. A major contributor to the success of APS' health and disease programs is our ability to capture clinical and operational data to perform ongoing monitoring and reporting of the impact of our programs. Our ability to successfully track and monitor the health indicators of each disease state is attributed to a state-of-the-art electronic clinical record capable of merging claims data with information gathered directly from clients and providers, a proven disease-specific program protocol for gathering critical clinical information from program participants, and experienced analytical reporting staff.

The hallmark of all of APS' programs is our comprehensive data collection process and flexible reporting capabilities. Through our APS CareConnection® system, we capture and analyze substantial information about individual patients to facilitate their care that is entered into a relational data base for flexible reporting. The data repository of APS CareConnection® in which the latest clinical, administrative, and claims data will be captured and made available to call center (i.e. service center) staff, Health Coaches, and providers. By interfacing with the service center, data captured through claims files, client assessments, provider updates, and care management notes are integrated into a single comprehensive data repository to support program evaluation, monitoring, and reporting.

In addition to the more than 100 experienced technical professionals in our Healthcare Informatics and MIS area, APS will employ data specialists to be located in our Vermont-based service center. These professional staff will have access our extensive data repository to produce monthly, quarterly, and annual reports as required for the Vermont Chronic Care Management Program. APS provides our customers with access for the full range of service submission requests, data reporting and querying 24 hours a day, 7 days a week, 365 days a year (except during scheduled downtime to perform system maintenance).

The combination of our comprehensive data warehouse and experienced Health Informatics personnel and external partnerships will assure that APS is able to meet OVHA requests for special reports and ad hoc data queries. APS will use this data collection capacity to provide OVHA with customized analyses, as we typically do for our customers, in addition to required reports.

9. Work cooperatively and in good faith with State technical staff, and other State contractors. This area is one in which APS excels. APS employs approximately 65 information professionals nationwide and another 10 FTEs in consulting resources. The senior IT management team, comprised of five directors and a Chief Information Officer, has over 80 years of combined IT management experience. Each team member brings to us unparalleled electronic data interface expertise, and have a wealth of experience importing and exporting client data for our customers. For the CCMP, APS will employ 3 full-time technical staff in Vermont to work with OVHA and VITL to integrate our health information technology structure with state-wide health information infrastructure under development. These dedicated resources, supported by APS entire IT Division, will be available to ensure APS is an active and engaged partner in the realization of Vermont's vision for a comprehensive and integrated health information system.

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10. Ownership of work products, data, technical information, related materials. APS acknowledges all work products, data, technical information, related materials and deliverables produced under contract with OVHA will be the property of the State of Vermont.

11. The bidder must provide its own personal computers for this project. APS acknowledges it must provide its own personal computers for the Vermont Chronic Care Management Program. Virus protection is provided via a centrally managed, nationally recognized antivirus solution configured to conduct full system scans with reporting to APS central servers.

12. Bidder must state any related limitations or special requirements. APS makes note of no limitations or special requirements in this area.

13. Future Electronic Transactions. APS recognizes the critical importance of health information technology (HIT) in reforming health care in America. We are excited about the opportunity to partner with OVHA, through participation in the CCMP, in the development of the Blueprint CCIS. HIT saves time and money. More importantly, HIT positively impacts health care processes, fosters improved outcomes, reduces the chance of medical error, and saves lives. DHHS Secretary Leavitt often notes that the nation's health care sector is not a "system" comparable to telephone or banking sectors with developed protocols allowing participants to easily access and exchange information while maintaining market competition. He is a leading advocate for building a value-driven healthcare system. APS expertly models use of the CMS' four interconnected cornerstones:

- **Connecting the System:** Every medical provider has some system for health records. Increasingly, those systems are electronic. Standards need to be identified so all health information systems can quickly and securely communicate and exchange data.
- **Measure and Publish Quality:** Every case, every procedure, has an outcome. Some are better than others. To measure quality, we must work with doctors and hospitals to define benchmarks for what constitutes quality care.
- **Measure and Publish Price:** Price information is useless unless cost is calculated for identical services. Agreement is needed on what procedures and services are covered in each "episode of care."
- **Create Positive Incentives:** All parties - providers, patients, insurance plans, and payers - should participate in arrangements that reward both those who offer and those who purchase high-quality, competitively-price health care

We also have thoroughly reviewed Blueprint for Health and have been actively following activities of VITL. The schematic in Exhibit 17 represents how APS CareConnection® will meet the technology requirements necessary to integrate clinical EDI transactions to service the CCIS. States continue to be large purchasers of health care services, and as such OVHA is uniquely positioned to drive major changes to healthcare financing and delivery within Vermont. Parallel to President Bush's plan to ensure that most Americans have electronic health records within the next 10 years, the federal Medicaid Commission appointed in 2005 by Secretary Leavitt is recommending all Medicaid beneficiaries will have an EHR by 2012. With our proposal, Vermont will lead the nation by implementing this statewide in the next year. We believe that Vermont's advances in the adoption of HIT will have a profound impact as an HIT best practice model to improve the nation's health care system through the formation of a statewide data exchange to connect providers, payers and patients. We are eager to partner with OVHA and other Vermont stakeholders in leading the way to more efficient health care delivery systems through the adoption of HIT.

7 Organization and Staffing

One of the cornerstones of our success in providing top tier services to state Medicaid agencies is our local service center model. The local, dedicated service center model is the only model for services to Medicaid beneficiaries that APS supports, because it provides the kind of dedicated state program specific attention to recipients and providers that is needed in order to facilitate system change and cost savings. The savings realized from CCIP/DM in Wyoming, the cost effective case management system changes in West Virginia, and the successful introduction of external quality review for prepaid behavioral health plans in California are not possible from afar. Our exemplary Executive Directors have the accountability and authority to *meet customer requirements* and *exceed customer expectations* for quality – and they accomplish these goals daily. The local service center approach results in excellent staff morale, a shared mission of positive outcomes, and quality care for recipients, clinical excellence and sound fiscal results.

APS has thoughtfully reviewed the specifications of the RFP, both in regard to staff qualifications and to the tasks that must be completed with the following overriding values and practices for program success:

- The vision and integrity of the contractor to work in tandem with OVHA's leadership to build a public-private partnership to facilitate and assure sustainability of new clinically and financially sound care management services, accomplished through a dedicated Vermont based service center.
- The success of the integrated HRA-IVS program is predicated on a staffing plan that provides sufficient personnel with superior credentials to accurately and sensitively assess program participants' needs.
- The success of the integrated HRA-IVS program relies upon the partnership skills of the contractor to build on existing successful care management programs and to partner with physicians to assist members in receiving timely, appropriate, and evidenced-based care.

We will hire an Executive director with specific experience working with Vermont providers and a first hand knowledge of the complex medical and social needs of Medicaid beneficiaries. The program organization chart is in section 7.1.7.2. We demonstrate that our staffing for both the HRA and IVS services is well-integrated to deliver a seamless approach. As the organizational chart indicates, our Vermont-based executive staff and Health Coaches will work in an atmosphere with ample support and resources from our corporate offices. Our corporate staff will lend substantial experience and knowledge of patient self-management, health care system and professional practice change and information technology initiatives to the locally hired staff with significant Vermont community development and provider relations.

APS recognizes that a variety of difficulties can occur in the implementation of new programs and processes. We are proud to offer an experienced team of highly accomplished executives and nationally recognized experts to assure that each aspect of program implementation receives the undivided attention of professionals with proven positive outcomes in complex program development and implementation.

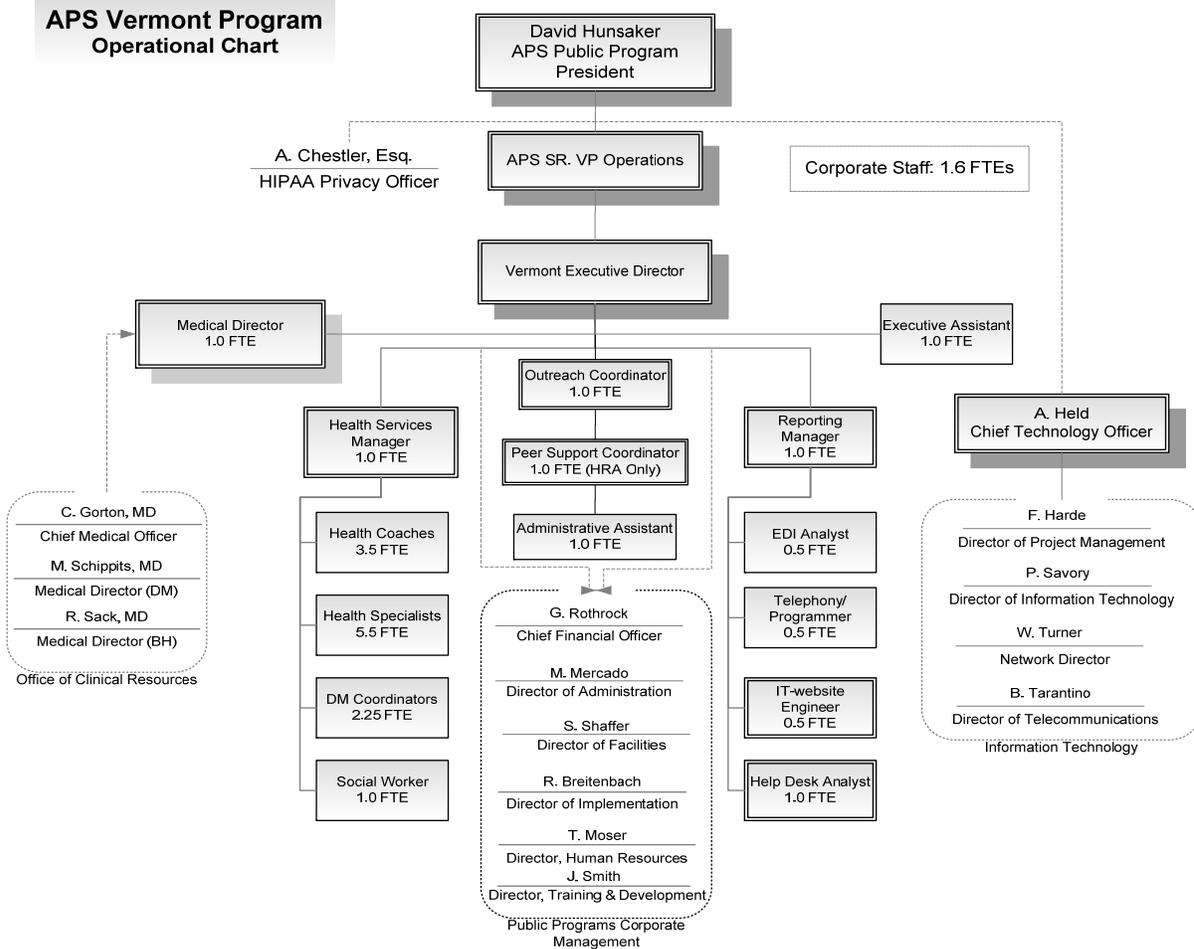
If issues should arise after implementation regarding interpretation of the contract, contract amendments, or other issues, APS will work with the State and the appropriate Department/Division to come to a quick, mutually agreeable resolution through dialogue and compromise.

7.1 Project Manager

The Vermont Executive Director (ED) will be the Project Manager for this contract. Please see the job description in Exhibit 13. Consistent with our local service center approach, the ED has the authority and accountability to manage resources to meet contract deliverables and milestones to the complete satisfaction of the State. The State will approve the final Executive Director Candidate before hiring.

7.2 Organizational Charts

The figure in this section provides our proposed staffing structure for the Vermont CCMP.



7.3 Management and Key Staff References and Resumes

Key staff for the project will be David Hunsaker, President, and Steve Thronson, COO. Additional corporate staff resumes are included in Exhibit 2 and resume information for key staff members are in Table 5.

Table 5. Key Staff Resumes	
<p>David Hunsaker has served as president of APS Healthcare’s Public Programs division since early 1998. Hunsaker has served in senior level positions in health care organizations for more than 20 years. Prior to APS, he was president Global Village HealthCare where he led joint venture healthcare partnership development in New York, Kentucky, Pennsylvania, Oregon and Washington.</p>	
<p><u>College:</u> Old Dominion University, 1981</p>	
<p><u>Georgia Department of Community Health</u> Mark Trail, Chief, Medical Assistance Plans Phone: 404-651-8681 Email: MTrail@dch.ga.gov</p>	<p><u>State of Wyoming</u> Teri Green, Medicaid Policy Manager (Phone) 303-777-7908 (Email) tgreen1@state.wy.us</p>

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Table 5. Key Staff Resumes	
Date Range of Work Performed: October 2005 to present	Date Range of Work Performed: July 2004 to present
<p><u>Morehouse School of Medicine</u>, George Rust, MD., Director, National Center for Primary Care (Phone) 404-756-5740 (Email) grust@msm.edu Date Range of Work Performed: October 2005 to present</p>	
<p>Steve Thronson is senior vice president and chief operating officer, and responsible for APS Public Programs specialty healthcare and health management divisions. He has more than 20 years of senior leadership experience in healthcare and the public sector. Mr. Thronson previously served as chief of operations for the Orange County Health Care Agency in Santa Ana, California, with responsibilities for public health services that served more than three million beneficiaries.</p>	
<p><u>College:</u> St. Olaf College, Pepperdine University (MBA),</p>	
<p><u>George L. Oestreich, PharmD, MPA, Deputy Director DMS, Clinical Services</u> Phone: 573-751-6961/Fax: 573-522-8514 george.l.oestreich@dss.mo.gov 205 Jefferson St., Jefferson City State Office Building, 10th Floor, Suite 1015 Jefferson City, MO 65101 (Since May 2006)</p>	<p><u>Angela Shoffner RNC, MLS, Director of Quality Assurance/Improvement, OHCA</u> 405-522-7355 angela.shoffner@okhca.org 4545 N. Lincoln Blvd, Ste. 124 Oklahoma City, OK 73105 (Since April 2006)</p>
<p><u>Michelle Harker, Medical Care Coordinator</u> Wyoming Department of Health 307-777-5854 mharke@state.wy.us 6101 Yellowstone Rd., Suite 210 Cheyenne, WY 82002 (Since March 2006)</p>	

7.4 Staff Responsibilities

Staff roles are explained in the Table 6. APS conducts provides a professional working climate that results in one of the lowest turnover rates in the industry. Positions are supported by corporate staff to help limit the learning curve for new hires. With a full-time HR Director and Specialist allocated to Public Programs, APS also has an industry-leading track record for recruiting to start time to quickly fill new positions or those vacated within 30 days of posting. APS uses a combination of full-time corporate staff and local contract staff as needed to ensure continuity of contract operations while positions are filled.

Table 6. Vermont CCMP Roles and Responsibilities	
Executive Director	The ED is responsible for the day to day management of the contract reporting to the COO of APS Public Programs, and services as the contract contact for OVHA. The ED is also accountable for submission and acceptance of contract deliverables.
Medical Director	The MD reports to the ED and provides clinical oversight for all aspects of the project with an emphasis on outreach to local providers. The MD also assists with development of provider outreach and education programs. All clinical concerns are reported to the MD, who is also available to address clinical questions from OVHA.
Health Services Manager	The Health Services Manager reports to the ED and is responsible for supervision of Health Coaches, Social Workers, Health Specialists, and DM Coordinators and assists with reporting deliverables. The HSM must be an RN licensed in the State of

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Table 6. Vermont CCMP Roles and Responsibilities

Health Coach	Vermont. The HSM also conducts quality assurance of HRA and IVS activities. Health Coaches provide face-to-face interventions with high risk beneficiaries and also interact with beneficiaries in other risk groups as needed. Health Specialists and DM Coordinators work under the supervision of Health Coaches. Health Coaches are RNs licensed in the State of Vermont and may be co-located with high volume providers. Health Coaches also assist with provider education.
Social Worker	The Social Worker is an MSW and licensed in the State of Vermont. Social Workers assist providers and APS staff to identify and address social and other community issues that impact beneficiaries, and also work directly with beneficiaries.
Health Specialist	Health Specialists are LPNs who work with providers and with beneficiaries who are moderate to low risk under the direction of the MD and HCs.
DM Coordinator	DM Coordinators are non-clinical staff with psychology or social work backgrounds who assist HC and HS staff with follow-up activities, such as reminder calls, mailings, and provider staff contacts.
Outreach Coordinator	Outreach Coordinators work with the provider community to develop education and training programs, provide information about the program to providers, and coordinate registration for APS CareConnection® and recruiting for HRAs.
Peer Support Coordinator	Peer Support Coordinators provide support directly to the provider community, assisting with HRA recruiting and administration.
Reporting Analyst	Reporting Analysts are responsible to develop report formats and content, and submit deliverables and other reports to OVHA, APS, and others.

Table 7 presents a summary of staff allocation by IVS and HRA services. APS uses a standard FTE estimate and an estimate of hours is therefore incorporated into this FTE allocation.

Table 7. Summary of FTEs (Hours) by Task Category

IVS Services			HRA Services	
High Risk		FTE	All Risk Categories	FTE
	Health Coach	2.07	Peer Support Coordinator	2.0
	Health Specialist / LPN	1.70		
	Coordinator / Assistant	0.20		
	Subtotal	3.97		
Moderate				
	Health Coach	0.97		
	Health Specialist / LPN	2.49		
	Coordinator / Assistant	0.58		
	Subtotal	4.04		
Low Risk				
	Health Coach	0.52		
	Health Specialist / LPN	1.22		
	Coordinator / Assistant	1.45		
	Subtotal	3.19		

8 References

1. Customer Name: Georgia Department of Community Health

Contact: Mark Trail, Medicaid Director

Phone: 404-657-1502 Email: mtrail@dch.state.ga.us

Description: Population and disease management services to 48,000 aged, blind or disabled members, covering 53 counties, including Atlanta and surrounding metropolitan area for health coaching, care coordination, education, provider assistance, a 24-hour nurse call center, and pharmacy consultation.

Contract Term: Began October 15, 2005 with annual renewals.

2. Customer Name: State of Wyoming Medicaid (EqualityCare)

Contact: Michelle Harker, Medical Care Coordinator, EqualityCare

Phone: 307-777-5854 Email: mharke@state.wy.us

Description: APS manages two programs for Wyoming EqualityCare: Healthy Together, the health management program, with a 3.7 – 1 ROI; and utilization management/peer review for providers.

Contract Term: July 26, 2004, through July 25, 2009, with an option to renew.

3. Customer Name: State of Wisconsin

Contact: Dr. Michelle Urban, Wisconsin Department of Health and Family Services

Phone: 608-267-7999 Email: UrbanME@dhsf.state.wi.us

Description: As a subcontractor to EDS, APS provide a wide array of administrative, analytical, and operational services for the Wisconsin Medicaid Program. APS provides satisfaction surveys, treatment pattern and trends analyses, profiling and modeling, provider audit support, and program evaluation.

Contract Term: 1994- 2011 with an option for a five-year renewal.

8.1 State of Vermont Contracts

APS has not contracted with the State of Vermont in the past.

8.2 Contract Terminations

Terminated Medicaid Business

(1) Cobalt Blue Cross Blue Shield (BCBS-WI)/Compicare Medicaid

Dr. Lowell Kepple, Medical Director,
(262) 787 3400

Provided Care Management Services
Termed 6/30/04 Client Exited Market

(2) Unity Health Plan

Dr. Marvin Wiener, Medical Director
(608) 643 1463

Provided Care Management Services
Termed 6/30/04 Client Exited Market

(3) Harmony Health Plan of Illinois & Indiana

Dr. Henry Hollander, Executive Director

(312) 516 4906 Provided Care Management Services

Termed 11/30/02 IRG terminated this risk account with 90 days notice, unable to negotiate on rates

(4) Ohio Department of Job and Family Services

Mitali Ghatak, Director, (phone) 614-466-4693, (email) ghatam@odjfs.state.oh.us

Enhanced Care Management Program for three counties in Ohio.

Termed Sept. 2005. Contract was rescinded when the legislature ceased funding the program.

(5) Department of Social and Health Services, Dave Daniels, (Ph) 360 902-0864
APS was awarded this contract to provide a variety of quality assurance consulting services to the Washington Department of Social and Health Services, relating to the State Hospitals Integrated Patient Information System (SHIPS). The contract ended in January of 2006 when the Washington Department of Social and Health Services ceased funding for the SHIPS program.

Terminated DM Clients

- | | |
|---|---|
| (1) WEA Trust
Peg Smelser, VP of Member Services
(608) 661 6684
Provided Maternity Disease Management Services
Termed 12/31/04 Brought services in house | (2) Cobalt Blue Cross Blue Shield (Blue Cross Blue Shield of WI)
Dr. Lowell Kepple, Medical Director
(262) 787 3400
Provided Disease Management Services
Termed 6/30/04 Purchased by Wellpoint Health and brought services in-house |
| (3) Milwaukee County Employee Benefit Plan
Matthew Janes, Manager of Employee Benefits
(414) 278 4570
Provided Disease Management Services
Termed 12/31/02 Consolidated business under new health carrier | |

9. Financial Statements

Financial Statements are included in Exhibit 18.

10. IVS Bidders Only

Table 8 in this section presents our anticipated interventions, clinical, and financial outcomes for the 24,241 beneficiaries we identified through data analysis and predictive modeling, for an overall weighted return on investment of 2:1. We will finalize projected outcomes with OVHA and strive to generate industry leading financial outcomes in this project through proactive interventions with the beneficiary population as well as by working collaboratively with the provider community to increase preferred both clinical and financial outcomes. The source of the information below is based upon our current best practices with our existing State Medicaid health management programs notably in Wyoming and Georgia. Please refer to Exhibit 4 for additional information.

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Table 8				
Risk Group	Number of Beneficiaries	Proposed Interventions	Clinical Outcomes	Financial Outcomes
Low	16,312	<ul style="list-style-type: none"> - Identification & Stratification Based on Claims and/or Referrals - Welcome Letter / Self-care Handbook - 24/7 Access to a Clinician - 24/7 Access to Web-based Education and Behavior Change Tools - Bi-annual Newsletters - Smoking Cessation - Obesity/Weight Management 	Reduction in <ul style="list-style-type: none"> - ER utilization - Unnecessary hospitalizations - LOS - Readmissions - Unneeded specialty referrals Increase in <ul style="list-style-type: none"> - Symptom Recognition - Disease Self-Management - Physician office visits - Smoking cessation advice - Weight management plans 	1.6: 1
Medium	6,482	Above, and additionally <ul style="list-style-type: none"> - Comprehensive Baseline Assessment w/Diagnosis Confirmation - Telephonic Care Management w/Ongoing Assessments, Monitoring and Follow-up- Minimum of 4 Outbound Calls to Client - Physician Outreach Activities 	Reduction in <ul style="list-style-type: none"> - ER utilization - Unnecessary hospitalizations - LOS - Readmissions Increase in <ul style="list-style-type: none"> - Symptom Recognition - Disease Self-Management - Physician office visits - Smoking cessation - Weight management 	2.6:1
High	2,206	Above, and additionally <ul style="list-style-type: none"> - Intensive Telephonic Care Management w/Telephonic Support 	Reduction in <ul style="list-style-type: none"> - ER utilization - Unnecessary hospitalizations - LOS - Readmissions - Depressive symptoms Increase in <ul style="list-style-type: none"> - Symptom Recognition - Disease Self-Management - Physician office visits - Smoking cessation - Weight management - Satisfaction with program - Reported Self-efficacy 	3.3:1
Total	24,241			2:1