Request for Information:
The Alliance Health Home Pilot

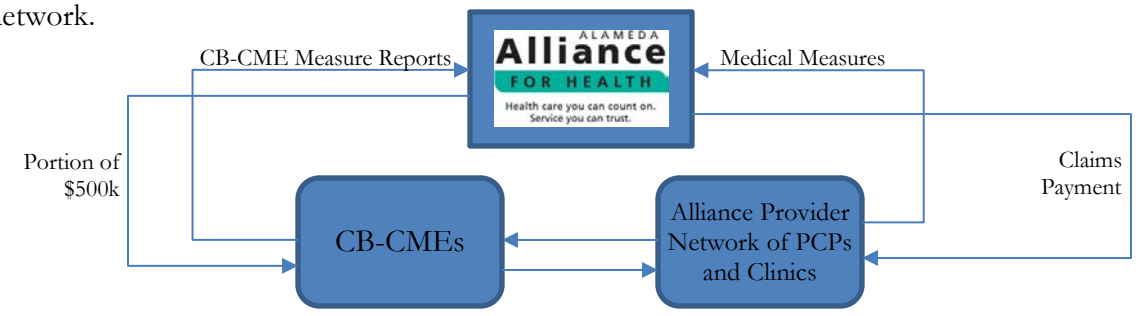
A Health Homes Program Pilot

A. Context: Medicaid Health Home State Plan

Section 2703 of the Patient Protection and Affordable Care Act created the Medicaid Health Home State Plan Option, which is being implemented in phases in California as the Health Home Program ("HHP"). Medi-Cal's HHP is structured as an intensive set of services targeted to a small subset of the highest cost three to five percent of the Medi-Cal population who require the highest levels of care coordination and who present the best opportunity for improved health outcomes through HHP services.

B. The Alliance "Pilot" / Preliminary Implementation

For 2017, Alameda Alliance for Health ("AAH" or "Plan") has setup a small, self-funded $500,000 Pilot in advance of the full implementation of the HHP in our county ("Pilot"). AAH desires to serve our members with complex conditions and link together systems of care for better health outcomes. We are intentionally positioning this Pilot to identify and develop relationships with Community Based Case Management Entities ("CB-CME") -- organizations with competencies which make them potential partners for our full program implementation. We see the CB-CMEs as the intermediary case management organizations between our Plan care team and our Provider network.



Below we define the responsibilities and minimum requirements to be considered a CB-CME for our Pilot. [Timeline and submission details are outlined in Section G, below.]

C. Pilot Target Population

AAH has targeted a subset group of our membership who are high-risk high users of multiple health care systems. This population may include, but is not limited to: 1) members with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement, 2) with chronic conditions, 3) with mental health and/or substance use disorders; or 4) who are currently

experiencing homelessness and/or individuals who are at high risk of homelessness, including individuals who will be experiencing homelessness upon release from institutions (hospitals, sub-acute care facility, skilled nursing facility, rehabilitation facility, Institution for Mental Disease, county jail, state prisons, or other).

CB-CMEs will conduct outreach and provide enhanced care coordination services to these Plan identified high risk members. CB-CMEs may also identify AAH members that meet the requirements for the target population and enroll these members into the Pilot, subject to Plan approval.

D. Selection Criteria

AAH plans to partner with CB-CME organizations for this Pilot. Such organizations might be: behavioral health entity, community mental health center, federally qualified health center, rural health center, Indian health clinic, Indian health center, hospital or hospital-based physician group or clinic, local health department, primary care or specialist physician or physician group, SUD treatment provider, provider serving individuals experiencing homelessness, disability agencies, other entities that meet certification and qualifications of a CB-CME, if selected and certified by the Alliance.

AAH has established additional required criteria for our CB-CME partners. Applicants will be measured against this required criteria including:

1. Demonstrated capacity to perform enhanced case management services, as described and based on the "RFI Submission Responses" outlined below.
2. Specific professionals who must be part of the CB-CME respondents care team:
    a. Combination of case managers, ("CM"), Registered Nurses ("RN"), Licensed Vocational Nurses ("LVN"), Licensed Clinical Social Worker ("LCSW"). Members of the team may be medical or social service in nature
3. Ensuring geographic distribution of CB-CME entities will also be taken into consideration.

E. Measuring the Programs Success

AAH's Pilot will be a success if Target Member health and patient metrics are improved. Some of these metrics are the responsibility of the CB-CME to track and report; listed below as CB-CME Reported Measures. Additionally, while some measures (Medical Measures) are not maintained nor expected to be reported by CB-CMEs, the Pilot will be a success if the Target population shows positive movement for these criteria. Some types of both of these measures, though not all, are listed below:

CB-CME Reported Measures

- Target population engagement, enrollment, and retention in CB-CME's program
- Increased access to member's core provider team, including increased primary care, specialty care, behavioral health visits. Needs might include:
    - transportation coordination

    - appointment coordination
    - assistance formulating questions to ask medical provider at visits
    - interpretation of medical provider results
- Disposition of outreach efforts
- Development/management of housing specific programs, including skills training, personal care training, independent living training. Assistance signing up for Section 8 or other housing programs as available
- Hospital discharge planning, documentation; including steps down in care
- Successful transfer of all member encounter data
- Increased medication adherence
- Ability to create, maintain, update, and communicate standard reports

Medical measures

- Increased Primary Care and Specialty Care member visits
- Fewer emergency department visits; fewer hospital admissions

F. RFI Submission Responses

We will judge CB-CME RFI response submissions based on the following qualifications:

Question	Explain your responses for each question outlined below:
1.	What case management services does your organization currently provide to our Target high-risk population? Specifically, explain your organizational capabilities specific to those who have: *(Maximum response: 3 pages for all Q1)*
1a.	Patients with chronic conditions.
1b.	Patients with mild, moderate or severe mental health and/or substance use disorders.
1c.	Patients with repeated (avoidable) emergency use, hospital admissions, or nursing facility placement.
2.	Familiarity with special needs of local homeless populations. Specifically, explain your organizational capabilities with: *(Maximum response: 3 pages for all Q2)*
2a.	Individuals who are currently experiencing homelessness and/or individuals who are at a high risk of homelessness.
2b.	Identifying and assessing and working with those who would most benefit from housing.
2c.	Development and administration of housing skills courses, including personal care, independent living, and others.
2d.	Working with housing agencies.
2e.	Working with county housing related agency or participating in (a) housing consortiums.
3.	Patients transitioning from one level of care to another is of particular interest to this Pilot. Please describe your global experience with care transitions. Please include experience with patients with repeated hospitalizations or nursing facility placements.

	(Maximum response: 2 pages)
4.	Provide a list of documents, assessments, reports included in your Care Plan(s). Describe how you engage a member in the Care Plan process. *(Maximum response: 2 pages)*
5.	Give examples of your programs which resulted in decreased emergency department/hospital visits. *(Maximum response: 2 pages)*
6.	What professionals (RNs, Case managers, LVNs, LCSWs) work in your organization? Please provide short biographies of each. Additionally: *(Maximum response: 4 pages for all Q6))*
6a.	Who are your organizational leaders, owners, principals? Please provide short biographies for each.
6b.	Provide a copy of your organization's most current license(s).
6c.	Provide an organizational chart.
6d.	Describe your organization's language capabilities in our four threshold languages: English, Spanish, Chinese, Vietnamese, and any specific examples of cultural competence.
7.	Describe any other organizational value-add services offered that complement our Pilot. *(Maximum response: 1 page)*
8.	Please include anything we may have missed that we should know about your organization. *(Maximum response: 1 page)*

G. Timetable and Contact

Timetable	
Begin Distribution of the RFI	December 7, 2016
RFI Information Session (Conference Call / Webinar)	December 21, 2016
RFI Submissions Due to AAH	Electronic Submission on or before January 9 at 5pm
Level 1 - Review of All Submissions with Recommendations	Completed by January 13
Level 2 - Decision-Maker Review	Completed by January 20
All RFI Submitters Informed of Decision	Completed by January 27
Decisions Announced Publicly	January 30

Note: Decisions will be made based on responses submitted in response to this RFI. The Alliance maintains discretion for all decision making and all decisions are final.

When submitting RFI response, please include the following details to allow us to contact you for any clarifications needed:

Representative Name
CB-CME Entity Name
Address
Email Address
Telephone

If you have any questions regarding this Request for Information or the Alliance Health Home Pilot, email your questions to HealthHomePilot@alamedaalliance.org

Submit RFI responses electronically to:

Alliance Health Home Pilot
HealthHomePilot@alamedaalliance.org
Please include the following in the Subject Line: RFI Submission to the Alliance Health Home Pilot

Electronic submissions must be received by **5:00pm Pacific Standard Time on January 9, 2017**, in order to be considered.