

Appendix D Care Coordination

ODJFS is interested in Applicants that have success and experience in promoting a cohesive delivery system, where communication is clear and ensures that individuals and providers have access to accurate and timely information in order to optimize care. This can be accomplished by implementing care coordination strategies such as care management and forging a path for providers to transform to patient-centered medical homes. In Ohio, the selected Applicants will play a pivotal role in the implementation of these strategies that are designed to improve health outcomes and experiences of care for Medicare-Medicaid enrollees.

Part A: Care Management

Medicare and Medicaid enrollees in Ohio who have primarily received benefits through the existing fee-for-service system are a high cost population who are poorly served in a fragmented health care system. While this segment of the Medicaid population experiences significant challenges in the current system, a great opportunity presents itself with the ICDS program to create a fully integrated health system which includes a care management model that will transform the way care is delivered to Ohio's Medicare-Medicaid enrollees. Therefore, the Ohio Department of Job and Family Services is interested in Applicants with demonstrated experience in comprehensively managing a full continuum of benefits—medical, behavioral, and long term supports and services—and delivering care management services that are relevant for Ohio's Medicare-Medicaid enrollees.

Instructions for Completing Part A:

1. For all questions, the Applicant may use experience of the Applicant or the Applicant's corporate family.
2. If the applicant has no Medicaid or Medicare experience as reported in Appendix B, the Applicant shall not complete Appendix D. The Applicant will not receive points for completing Appendix D.

Questions:

1. ODJFS is interested in Applicants with at least 12 months of experience as of March 31, 2012 with providing, under contract, acute care, behavioral health care, or long term services and supports and coordinating the benefits as part of its care management program.

For each entry in Question 1, include in the table below:

- i. State and line of business as reported in Appendix B.
- ii. Mark either a yes or no response for each benefit. **Note:** For the long term services and supports benefit, the applicant may only select one of the following response options: community and institutional, or community only, or institutional only.

State and Line of Business	Does the Applicant have at least 12 months of experience as of March 31, 2012 with providing and coordinating the following benefits as part of its care management program?			
	Benefit	Yes	No	
Entry 1: State: Line of Business:	Acute care			
	Behavioral health care			
	Long term services and supports	Community and institutional		
		Community only		
	Institutional only			
Entry 2: State: Line of Business:	Acute care			
	Behavioral health care			
	Long term services and supports	Community and institutional		
		Community only		
	Institutional only			
Entry 3: State: Line of Business:	Acute care			
	Behavioral health care			
	Long term services and supports	Community and institutional		
		Community only		
	Institutional only			

2. ODJFS is interested in Applicants with at least 12 months of experience as of March 31, 2012 providing comprehensive integrated care management for enrollees receiving long term institutional care (i.e., enrollees resided or remained long term in an institutional setting).

For each entry in the table below, include the following information:

- i. State and line of business as reported in Appendix B; and
- ii. Mark either a yes or no response to the question.

State and Line of Business	Does the Applicant have at least 12 months of experience as of March 31, 2012 providing comprehensive care management for enrollees receiving long term institutional care (i.e., enrollees resided or remained long term in an institutional setting)?	
	Yes	No

Entry 1 State: Line of business:		
Entry 2 State: Line of business:		
Entry 3 State: Line of business:		

3. ODJFS is interested in Applicants with at least 12 months of experience as of March 31, 2012 with identifying enrollees who could benefit from care management services using a variety of the following mechanisms:

- a. Health risk assessment (HRA): The HRA is a questionnaire that is designed to collect information from individuals to identify risk factors and provide individualized feedback in order to inform and promote health and wellness and/or disease prevention;
- b. Administrative data assessment: This assessment is a review of administrative claims data, such as inpatient hospital visits, emergency department visits, specialist visits, pharmacy, or other category of service markers;
- c. Predictive modeling software: The predictive modeling software must be used by a substantial number of health care organizations and be recognized in the industry as a standard model for identifying future health risks; have been quantitatively studied and supported as a viable predictive model in comparative research papers; produce outputs which include a risk score component for at least one of the following: health status, disease burden, hospitalization and/or costs; apply to the Medicare or Medicaid population; and support care management activities/functions.
- d. Provider, enrollee, or service agency referrals; and
- e. Functional assessment that evaluates activities of daily living.

Include the following in the table below:

- i. State and line of business as reported in Appendix B;

- ii. Mark an “X” if at least 12 months of experience applies for rows a – e. Refer to the descriptions above, as applicable, when completing the table.

Note: If the Applicant indicates experience for rows a and/or e (i.e., by marking an “x”), the Applicant must submit a copy of the health risk assessment tool and/or the functional assessment tool, respectively. If the Applicant used the same tool in multiple states, only one copy must be submitted; however, the tool must clearly indicate the entry to which it applies. If the Applicant indicates experience for row c (i.e., by marking an “x”), the Applicant must provide the name of the predictive modeling software.

Does the Applicant have at least 12 months of experience as of March 31, 2012 with using the following mechanisms to identify enrollees for care management?	Entry 1	Entry 2	Entry 3
	State: Line of business:	State: Line of business:	State: Line of business:
	Mark “x” if at least 12 months experience applies.	Mark “x” if at least 12 months experience applies.	Mark “x” if at least 12 months experience applies.
a. Health risk assessment			
b. Administrative data assessment			
c. Predictive modeling software			
	Provide name of predictive modeling software used:	Provide name of predictive modeling software used:	Provide name of predictive modeling software used:
d. Provider, enrollee, or service agency referrals			

Does the Applicant have at least 12 months of experience as of March 31, 2012 with using the following mechanisms to identify enrollees for care management?	Entry 1	Entry 2	Entry 3
	State: Line of business:	State: Line of business:	State: Line of business:
	Mark "x" if at least 12 months experience applies.	Mark "x" if at least 12 months experience applies.	Mark "x" if at least 12 months experience applies.
e. Functional assessment that evaluates activities of daily living			

4. ODJFS is interested in Applicants with at least 12 months of experience as of March 31, 2012 with completing a comprehensive assessment that: evaluates the enrollee’s medical, behavioral health (i.e., mental health and substance abuse disorders), long term supports and services, environmental and social needs; uses comprehensive data from a variety of sources; and uses different methods to collect the data from the enrollee.

- a. Indicate if the Applicant has at least 12 months experience as of March 31, 2012 with conducting a comprehensive assessment for enrollees that included an evaluation of specified assessment domains.

Include the following in the table below:

- i. State and line of business as reported in Appendix B; and
- ii. Mark a yes or no response in each row.

Note: For any row and entry that includes a yes response, the Applicant must submit a copy of the comprehensive assessment and highlight the location of each domain in the assessment document(s) provided. Label the document with the entry number (1, 2, or 3) to which it applies.

Does the Applicant have at least 12 months of experience as of March 31, 2012 with assessing the following domains for enrollees?	Entry 1		Entry 2		Entry 3	
	State: Line of business:		State: Line of business:		State: Line of business:	
	Yes	No	Yes	No	Yes	No
i. Medical and behavioral health history						
ii. Behavioral health needs						
iii. Medical needs						
iv. Functional needs						
v. Cognitive needs						

Does the Applicant have at least 12 months of experience as of March 31, 2012 with assessing the following domains for enrollees?	Entry 1 State: Line of business:		Entry 2 State: Line of business:		Entry 3 State: Line of business:	
	Yes	No	Yes	No	Yes	No
vi. Social needs						
vii. Nutritional needs						
viii. Long term services and supports						
ix. Individual goals and preferences						
x. Environmental or residential assessment						
xi. Activities of daily living and/or Instrumental activities of daily living capabilities						
xii. Ability of the enrollee to self-direct community-based long term services and supports						
xiii. Willingness/readiness to change						
xiv. Discharge/transition plans						
xv. Health and welfare						
xvi. Natural supports, including family and community						
xvii. Caregiver capabilities						
xviii. Special communication needs						
xix. Health literacy						

- b. Indicate if the Applicant has at least 12 months of experience as of March 31, 2012 using data from a variety of sources when conducting the comprehensive assessment. Include the following in the table below:
- i. State and line of business as reported in Appendix B; and
 - ii. Mark a yes or no response in each row.

Does the Applicant have at least 12 months of experience as of March 31, 2012 with conducting an assessment using the following data sources?	Entry 1 State: Line of business:		Entry 2 State: Line of business:		Entry 3 State: Line of business:	
	Yes	No	Yes	No	Yes	No
i. Enrollee						
ii. Family/caregiver						
iii. Medical records						
iv. Administrative data (pharmacy, inpatient, emergency department, etc.)						
v. Primary care providers						
vi. Specialists						
vii. Long term service and support providers						

c. Indicate if the Applicant has at least 12 months of experience as of March 31, 2012 with using various methods to collect information from the enrollee for the comprehensive assessment. Include the following in the table:

- i. State and line of business as reported in Appendix B; and
- ii. Mark a yes or no response for each row.

Does the Applicant have at least 12 months of experience as of March 31, 2012 with conducting an assessment using the following methods of collecting information from the enrollee?	Entry 1		Entry 2		Entry 3	
	State:	Line of business:	State:	Line of business:	State:	Line of business:
	Yes	No	Yes	No	Yes	No
Home visit						
Telephone						
Form completed by the enrollee						

5. ODJFS is interested in Applicants with at least 12 months of experience as of March 31, 2012 with assigning enrollees to a risk/acuity level based on the results of the identification and/or assessment processes.

- a. Does the Applicant have at least 12 months of experience as of March 31, 2012 with assigning enrollees to a risk/acuity level based on the results of the identification and/or assessment processes?

Mark one of the following responses:

_____ Yes _____ No

Indicate one state and line of business from Appendix B for which this activity was completed: _____

- b. Does the Applicant have at least 12 months of experience as of March 31, 2012 with communicating the results of the assessment and the risk/acuity level assignment to enrollees?

Mark one of the following responses:

_____ Yes _____ No

Indicate one state and line of business from Appendix B for which this activity was completed: _____

- c. Does the Applicant have at least 12 months experience as of March 31, 2012 with communicating the results of the assessment and the risk/acuity level assignment to enrollees' primary care providers?

Mark one of the following responses:

_____ Yes _____ No

Indicate one state and line of business from Appendix B for which this activity was completed: _____

6. ODJFS is interested in Applicants with at least 12 months of experience as of March 31, 2012 with developing integrated, person-centered care plans for enrollees based on the comprehensive assessment that addressed key care plan components. Include the following in the table below:
- i. State and line of business as reported for Appendix B; and
 - ii. Mark a yes or no response for each row.

Does the Applicant have at least 12 months of experience as of March 31, 2012 with developing integrated, person centered care plans that address the components specified below?	Entry 1		Entry 2		Entry 3	
	State: Line of business:		State: Line of business:		State: Line of business:	
	Yes	No	Yes	No	Yes	No
a. Established goals, interventions, and anticipated outcomes, with specified timeframes for completion that address clinical and non clinical needs (i.e., medical, behavioral, environmental, social, functional, long term services and supports, nutrition, etc.) and services identified in the comprehensive assessment. The goals, interventions and outcomes must reflect the individual's preferences.						
b. Involvement and engagement of the enrollee and his/her support system in the development of the care plan. The enrollee's agreement with the initial and revised care plans shall be documented in the care plan.						
c. Established communication plan, including anticipated frequency of contacts, with the enrollee, the primary care provider and, as appropriate, other providers.						
d. A comprehensive approach to transitional care across settings to ensure communication among providers, primary care follow up, medication reconciliation, and timely provision of formal and informal supports.						
e. Referrals for the enrollee to access social and community support services and validation that the enrollee received the necessary services.						

Does the Applicant have at least 12 months of experience as of March 31, 2012 with developing integrated, person centered care plans that address the components specified below?	Entry 1		Entry 2		Entry 3	
	State: Line of business:		State: Line of business:		State: Line of business:	
	Yes	No	Yes	No	Yes	No
f. A review of the initial and revised care plan with the enrollee, family/ caregiver, primary care provider, and specialists, as appropriate, while actively seeking input from them.						
g. Continuous monitoring of service delivery and enrollee's adherence to the care plan to identify gaps between care recommended and care received, along with implementation of strategies to address the gaps in care.						
h. Ensuring the care plan is accessible to the enrollee and all providers involved in managing the enrollee's care.						

7. ODJFS is interested in Applicants with at least 12 months of experience as of March 31, 2012 with formulating a trans-disciplinary team led by a care manager, who is the single accountable point of contact responsible for the overall care management and coordination of the enrollee's needs and services.

- a. Does the Applicant have at least 12 months of experience as of March 31, 2012 with assigning a single accountable point of contact (i.e., a care manager) to each enrollee who helps the enrollee obtain medically necessary care, assists with health related services, coordinates care for the enrollee; disseminates information to the enrollee; and implements and monitors the care plan?

Mark one of the following responses:

_____ Yes _____ No

Indicate one state and line of business from Appendix B for which this activity was completed: _____

- b. Does the Applicant have at least 12 months of experience as March 31, 2012 with forming a trans-disciplinary team consisting of the enrollee, primary care provider, care manager and, as needed, specialists to effectively manage the enrollee's needs?

Mark one of the following responses:

_____ Yes _____ No

Indicate one state and line of business from Appendix B for which this activity was completed: _____

8. ODJFS is interested in Applicants with at least 12 months experience as of March 31, 2012 with interacting with enrollees who require intense levels of interaction using a variety of methods based on their unique needs.

a. Does the Applicant have at least 12 months of experience as of March 31, 2012 with conducting home visits with enrollees to either observe or assess them in their residential environment?

Mark one of the following responses:

_____ Yes _____ No

Indicate one state and line of business from Appendix B for which this activity was completed: _____

b. Does the Applicant have at least 12 months of experience as of March 31, 2012 with delivering care management services (e.g., medication reconciliation, health education, health coaching, etc.) in person with an enrollee in a residential setting or outpatient/inpatient facility?

Mark one of the following responses:

_____ Yes _____ No

Indicate one state and line of business from Appendix B for which this activity was completed: _____

c. Does the Applicant have at least 12 months of experience as of March 31, 2012 with developing and implementing a communication plan to meet an enrollee's needs that included a combination of home visits, point-of-care visits (e.g., hospital, provider's office, etc.), email or internet communication, and telephonic outreach?

Mark one of the following responses:

_____ Yes _____ No

Indicate one state and line of business from Appendix B for which this activity was completed: _____

- d. Provide the following information related to home visits for one state and line of business as reported in Appendix B:

Inquiry:	Response
State/Line of Business/Population submitted for Appendix B:	
Number of enrollees in care management in CY 2011:	
Average number of home visits per enrollee in care management for CY 2011: Numerator: Total number of home visits conducted in CY 2011 Denominator: Total number of enrollees in care management in CY 2011	
Average frequency of home visits per enrollee in care management for CY 2011: Numerator: Average number of home visits per month Denominator: Total number of enrollees in care management	

9. Does the Applicant have experience with contracting and delegating care management functions to a community -based entity (e.g., Center for Independent Living or Area Agencies on Aging) for long term services and supports?

Mark one of the following responses:

Yes No

If yes, then provide the following contact information for one reference:

Community based entity name: _____

Contact name: _____

Address: _____

Phone number: _____

Email: _____

10. ODJFS is interested in Applicants with at least 12 months of experience as of March 31, 2012 with supporting and evaluating a “participant- directed care model” for enrollees receiving home and community based long term services. A participant-directed care model allows the enrollee greater choice and control along a continuum of hiring, firing, training, supervising or paying independent providers.

a. Does the Applicant have at least 12 months of experience as of March 31, 2012 in supporting a participant-directed care model for enrollees receiving home and community based long term services?

Mark one of the following responses:

Yes No

Indicate one state and line of business from Appendix B for which this activity was completed: _____

b. If the response to Question 10.a. is YES, does the Applicant have at least 12 months of experience as of March 31, 2012 with evaluating whether the participant-directed care model was effective, as defined by criteria such as volume of services received, increased enrollee/family satisfaction, etc., for enrollees using this model?

Mark one of the following responses:

Yes No

Indicate one state and line of business from Appendix B for which this activity was completed: _____

c. If the response to Question 10.b. is YES, but the Applicant determined that the participant-directed care model was not effective for certain enrollees, does the Applicant have at least 12 months of experience as of March 31, 2012 with transitioning the enrollee to a traditional model of using providers who are employed by a home health or home care agency?

Mark one of the following responses:

Yes No

Indicate one state and line of business from Appendix B for which this activity was completed: _____

11. Does the Applicant currently have an electronic care management system that collects the results of the assessment and the care plan, including goals, actions and completion dates and

is linked to other databases or systems that the Applicant uses to maintain enrollee information?

Mark one of the following responses:

Yes No

Indicate one state and line of business from Appendix B for which this activity was completed: _____

12. The Applicant must provide information to demonstrate the impact and effectiveness of its care management program(s) as evidenced by performance indicators, such as reductions in emergency department visits and hospital readmissions, for both a Medicaid non-Long Term Care population and a Medicaid Long Term Care population.

a. In the table below, provide the following information about a care management program evaluation that was conducted for a Medicaid non-Long Term Care population for which the Applicant provided care management services:

Provide the following information for the Applicant's care management program that was evaluated:	State: Line of business:	
Date of care management program implementation: MM/YY		
Pre implementation measurement period: MM/YY to MM/YY		
Post implementation measurement period (must have occurred in CY 2010 or CY 2011): MM/YY to MM/YY		
Total number of individuals enrolled in the care management program during the post implementation measurement period.		
Percent of the overall population enrolled in the care management program during the post implementation time period.		
Acuity/risk levels of individuals enrolled in the care management program	Check all that apply: __ Low __ Medium __ High	
Report pre/post implementation results for all individuals enrolled in the care management program for the following indicators: (Include the numerator and denominator):	Pre-implementation Result	Post-implementation Result

Provide the following information for the Applicant's care management program that was evaluated:	State: Line of business:	
<p><u>Indicator 1: Rate of hospital readmissions:</u></p> <p>Numerator: Number of hospital readmissions within 30 days following the discharge date.</p> <p>Denominator: Number of member months for consumers with: 1) any of the following conditions: pneumonia, congestive heart failure (CHF), urinary tract infection (UTI), dehydration, or chronic obstructive lung disease (COPD)/asthma; and 2) an acute inpatient admission with a discharge date within an annual period of time multiplied by 1,000</p> <p>Exclusions: Numerator: maternity admissions, transfers on the same or next day between acute care facilities Denominator: maternity admissions, inpatient stays with discharges for death, consumers with a date of death within 30 days after original discharge date.</p>	<p>Numerator:</p> <p>Denominator:</p>	<p>Numerator:</p> <p>Denominator:</p>
<p><u>Indicator 2: Rate of emergency department visits</u></p> <p>Numerator: Number of ED visits during an annual period.</p> <p>Denominator: Number of member months of the population under study for the annual period multiplied by 1,000.</p> <p>Exclusions: urgent care visits, ED visits that result in an inpatient stay. Note: Multiple ED visits on a single day for a person must be included.</p>	<p>Numerator:</p> <p>Denominator:</p>	<p>Numerator:</p> <p>Denominator:</p>

b. In the table below, provide the following information about a care management program evaluation that was conducted for a Medicaid Long Term Care population for which the Applicant provided care management services:

Provide the following information for the Applicant's care management program that was evaluated:	State: Line of business:	
Date of care management program implementation: MM/YY		
Pre implementation measurement period: MM/YY to MM/YY		
Post implementation measurement period (must have occurred in CY 2010 or CY 2011): MM/YY to MM/YY		
Total number of individuals enrolled in the care management program during the post implementation measurement period.		
Percent of the overall population enrolled in the care management program during the post implementation time period. (Include the numerator and denominator.)		
Acuity/risk levels of individuals enrolled in the care management program	Check all that apply: <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	
Report pre/post implementation results for all individuals enrolled in the care management program for the following indicators: (Include the numerator and denominator):	Pre-implementation Result	Post-implementation Result

Provide the following information for the Applicant's care management program that was evaluated:	State: Line of business:	
<p><u>Indicator 1: Rate of hospital readmissions:</u></p> <p>Numerator: Number of hospital readmissions within 30 days following the discharge date.</p> <p>Denominator: Number of member months for consumers with: 1) any of the following conditions: pneumonia, congestive heart failure (CHF), urinary tract infection (UTI), dehydration, or chronic obstructive lung disease (COPD)/asthma; and 2) an acute inpatient admission with a discharge date within an annual period of time multiplied by 1,000</p> <p>Exclusions: Numerator: maternity admissions, transfers on the same or next day between acute care facilities</p> <p>Denominator: maternity admissions, inpatient stays with discharges for death, consumers with a date of death within 30 days after original discharge date.</p>	Numerator: Denominator:	Numerator: Denominator:
<p><u>Indicator 2: Rate of emergency department visits</u></p> <p>Numerator: Number of ED visits during an annual period.</p> <p>Denominator: Number of member months of the population under study for the annual period multiplied by 1,000.</p> <p>Exclusions: urgent care visits, ED visits that result in an inpatient stay.</p> <p>Note: Multiple ED visits on a single day for a person must be included</p>	Numerator: Denominator:	Numerator: Denominator:
<p><u>Indicator 3: Percent of individuals who reside in a nursing facility</u></p> <p>Numerator: Number of individuals residing in a nursing facility</p> <p>Denominator: Total number of individuals enrolled in care management.</p>	Numerator: Denominator:	Numerator: Denominator:

<p>Provide the following information for the Applicant's care management program that was evaluated:</p>	<p>State: Line of business:</p>	
<p><u>Indicator 4: Percent of individuals who reside in a community setting</u> Numerator: Number of individuals residing in a community setting Denominator: Total number of individuals enrolled in care management.</p>	<p>Numerator: Denominator:</p>	<p>Numerator: Denominator:</p>

ESSAY DESCRIBING CARE MANAGEMENT MODEL

13. The Applicant must submit a comprehensive description of its innovative approach for providing care management services to monitor and coordinate care for Ohio's Medicare-Medicaid enrollees. Enrollees will have varying needs and require differing levels of interventions, interactions, engagement, and services. The care management model must incorporate individuals residing in all care settings, such as nursing facilities, hospitals, assisted living facilities and at home. The Applicant's response must include a description of the following components:

- a. A strategy to identify and prioritize the timeframe by which individuals will receive an initial comprehensive assessment. Include in the response the data that will be reviewed and the criteria for case selection;
- b. The process for completing a comprehensive assessment of the enrollee's medical, behavioral health, long term services and supports, environmental and social needs with input from the enrollee, family members, caregiver, and providers. Include in the response a summary description of the assessment tool; the data sources that will be used; how the information will be collected; and the process for determining when to re-evaluate the enrollee's needs;
- c. The structure of the risk/acuity level framework. Include in the response the number of levels and if they will be risk or acuity based; the criteria for each of the risk/acuity levels; how an enrollee will be assigned to the appropriate risk/acuity level; how the risk/acuity level will be communicated to the enrollee and the primary care providers/specialists; and the minimum frequency of contacts—including face to face visits (in the residence or at the point of care), telephonic, etc. for each risk/acuity level;
- d. The process for development and implementation of an integrated, person-centered care plan with the enrollee, family members, caregiver(s) and provider(s) that addresses needs identified in the comprehensive assessment with corresponding goals, interventions and outcomes. Include in the response how the enrollee's preferences and preferred role in decision-making will be considered when developing the care plan; how the enrollee and his/her supports will be included in the development and implementation of the initial and revised care plans; and how the enrollee's providers will be included in the development and implementation of the initial and revised care plan; and how a communication plan will be established with the enrollee;
- e. The process to monitor the care plan to determine: the quality of services provided in order to achieve progress toward person-centered goals and outcomes, adherence to evidence-based practices, existence of barriers to care, the need to manage transitions across settings, appropriate service utilization, etc. Include in the response how gaps in

care will be identified and addressed; and how the care plan will be continuously reviewed and revised;

f. Strategy to formulate a trans-disciplinary care management team led by a care manager (i.e., accountable point of contact) designed to effectively manage the individual's services. The team shall consist of the beneficiary, the primary care provider, the care manager, LTSS service coordinators, and other providers, as appropriate. Include in the response: how the team composition and the care manager for each enrollee will be decided with examples of who may serve on the team and as the care manager; the role of the care manager; how information will be exchanged between the members of the care management team; an indication of whether care managers or members of the team will be field-based, centralized, or both; and include the care management staffing ratios for each of the proposed acuity/risk levels. (Note: For the calculation of the staffing ratio, the Applicant may use any team member's time, including the community based entities, as long as the team member is performing a care management activity that can be directly linked to an individual.);

g. Employment of innovative communication methods that are culturally and linguistically appropriate and consider the unique needs of the enrollee;

h. A strategy to aggressively manage care transitions, including admissions and discharges from hospitals, nursing facilities, and other settings to ensure communication among providers, primary care follow up, medication reconciliation, timely provision of formal and informal in-home supports, etc.;

i. A strategy to perform ongoing-medication reconciliation and employment of advanced pharmacy management programs, including medication therapy management, to increase adherence and eliminate contra-indicated drug use;

j. Use of a care management system that captures the assessment and care plan content; links to other internal databases or systems that are used to maintain information about the enrollee; and has the capability to produce a copy of the care plan when requested by the enrollee and the provider; and

k. A strategy to evaluate the impact of the care management program on Ohio's Medicare-Medicaid population with regard to health outcomes, enrollee satisfaction, enrollee's independent living status, functional status, and other quality indicators.

Note: All essay responses *must comply with the Essay Requirements, including the certification, described in Section III.B.3 of this RFA.* The response to Question 13 shall not exceed 20, single spaced pages and shall be organized according to the outline provided above with sections clearly labeled and referenced (i.e., a, b, c, d, etc.). For Applicants selected under this RFA to participate in the ICDS program, ODJFS reserves the right to

incorporate selected components of the Applicant's response to this question into the body of the 3-way agreement and/or the ODJFS Provider Agreement.

Part B: Patient-Centered Medical Home

Overview:

The Patient-Centered Medical Home (PCMH) is a widely accepted approach to providing comprehensive primary care for children and adults. This approach requires primary care practices to transform how care is organized and delivered to their patients. Several definitions for the PCMH exist; however, there are similar themes from the various definitions that center on the following components:

- Holistic, comprehensive care: The primary care medical home is responsible for providing all of the patient's care and arranging care as appropriate with other professionals across the continuum of care;
- Enhanced access to care: The primary care medical home provides expanded access to care through open scheduling, after hours care or optional communication methods (e.g., email) with other providers;
- Coordinated care: The primary care medical home coordinates and integrates care across the continuum of care and the patient's community; and
- Quality, safety and accountability underpin the primary care medical home and are embedded in all business processes.

ODJFS believes that the PCMH model holds promise for improving quality of care and effectiveness of care, thereby reducing the cost of care and improving outcomes for Ohio Medicare-Medicaid enrollees. Therefore, ODJFS is seeking qualified Applicants that will participate in the State's efforts to transform primary care practices into patient-centered medical homes. ODJFS is also interested in Applicants that have experience with supporting care management and care coordination activities that are performed at the practice level.

Instructions for completing Part B:

The Applicant may report its experience or that of a corporate family member. Respond to each question with a checkmark, and mark only one response.

Questions:

1. During January 2012 through March 2012, did the Applicant arrange a network of health care providers that worked collaboratively as a team of health care professionals to coordinate care and provide care management for enrollees?

Mark only one of the following responses:

Yes No

2. During January 2012 through March 2012, did the Applicant identify enrollees in need of intensive care management services through the use of predictive modeling software or a health risk assessment?

Mark only one of the following responses:

Yes No

3. During January 2012 through March 2012, did the Applicant reimburse health care providers on a per enrollee per month fee basis to perform care coordination/management services?

Mark only one of the following responses:

Yes No

4. During January 2012 through March 2012, did the Applicant have any shared risk/savings arrangements with health care providers who were tasked expressly in the arrangement of performing care coordination/management services?

Mark only one of the following responses:

Yes No

5. During January 2012 through June 2012, did the Applicant provide technical assistance to practice sites to assist them in transforming to patient-centered medical homes?

Mark only one of the following responses:

Yes No

If yes, then provide the following contact information for one example:

NOTE: If contact information is not provided then the Applicant will not receive any points for this question.

Practice Name: _____

Contact Name: _____

Practice Address: _____

Phone Number: _____

6. During January 2012 through March 2012, did the Applicant provide any of the following care management supports to providers such as patient utilization summaries, inpatient discharge coordination, medical advice nurse lines, access to transportation, educational programs/materials, and access to care treatment plans?

Mark only one of the following responses:

Yes No

If yes, then provide the following contact information for one example:

NOTE: If contact information is not provided then the Applicant will not receive any points for this question.

Practice Name: _____

Contact Name: _____

Practice Address: _____

Phone Number: _____

7. During January 2012 through March 2012, did the Applicant provide technical assistance to practices to implement electronic health records?

Mark only one of the following responses:

Yes

No

If yes, then provide the following contact information for one example:

NOTE: If contact information is not provided then the Applicant will not receive any points for this question.

Practice Name: _____

Contact Name: _____

Practice Address: _____

Phone Number: _____

8. During January 2012 through March 2012, did the Applicant interact with a nurse care manager who was embedded at a practice site and performed care coordination activities such as transition planning, patient coaching, completion of health assessments, etc.?

Mark only one of the following responses:

Yes

No

If yes, then provide the following contact information for one example:

NOTE: If contact information is not provided then the Applicant will not receive any points for this question.

Practice Name: _____

Contact Name: _____

Practice Address: _____

Phone Number: _____

The remainder of this Appendix is a description of the process that will be used by ODJFS in scoring an Applicant’s responses to the questions in this Appendix. Applicants are not to fill in and return this section with their applications. However, ODJFS strongly encourages applicants to use these pages to evaluate the quality and responsiveness of their application packets prior to submission.

Appendix D – Care Coordination
Scoring Instructions and Worksheet

Total Points for Appendix D: 30,000

Part A: Care Management

Total possible points for Part A are 27,000.

Reviewers are to fill in the appropriate points based on the information submitted on the Appendix D form. Points will be awarded for each response based on the instructions provided for each question.

Questions:

1. Does the Applicant have at least 12 months of experience as of March 31, 2012 with providing and coordinating the following benefits as part of its care management program?

State and Line of Business	Points Possible			Points Awarded	
	Benefit	Yes	No		
Entry 1:	Acute care	100	0		
	Behavioral health care	100	0		
State:	Long term services and supports (only one entry may be selected)	Community and institutional	200	0	
Line of Business:		Community only	100	0	
		Institutional only	100	0	
	Add 50 points if the Line of Business is Medicare-Medicaid or Medicare.				
Total Points Awarded for Entry 1 (may not exceed 450):					
Entry 2:	Acute care	100	0		
	Behavioral health care	100	0		
State:	Long term services	Community and institutional	200	0	

State and Line of Business	Points Possible			Points Awarded	
	Benefit	Yes	No		
Line of Business:	and supports (only one entry may be selected)	Community only	100	0	
		Institutional only	100	0	
		Add 50 points if the Line of Business is Medicare-Medicaid or Medicare.			
Total Points Awarded for Entry 2 (may not exceed 450):					
Entry 3:	Acute care		100	0	
	Behavioral health care		100	0	
State:	Long term services and supports (only one entry may be selected)	Community and institutional	200	0	
Line of Business:		Community only	100	0	
		Institutional only	100	0	
		Add 50 points if the Line of Business is Medicare-Medicaid or Medicare.			
Total Points Awarded for Entry 3 (may not exceed 450):					
Total Points Awarded for Question 1					
Sum of entries 1-3 shall not exceed 1,350 points.					

2. Does the Applicant have at least 12 months of experience as of March 31, 2012 providing comprehensive care management for enrollees receiving long term institutional care (i.e., enrollees resided or remained long term in an institutional setting)?

State and Line of Business	Points Possible		Add 30 points if the Line of Business is Medicare-Medicaid or Medicare	Points Awarded
	Yes	No		
Entry 1 State: Line of business:	150			Total points awarded for each row may not exceed 180.
Entry 2 State: Line of business:	150			

Entry 3 State: Line of business:	150			
Total Points Awarded for Question 2: Sum of entries 1-3 shall not exceed 540 points.				

3: Does the Applicant have at least 12 months of experience as of March 31, 2012 with using the following mechanisms to identify enrollees for care management?

Identification mechanism	Entry 1		Entry 2		Entry 3	
	State: Line of business:	State: Line of business:	State: Line of business:	State: Line of business:	State: Line of business:	State: Line of business:
	Points Possible	Points Awarded	Points Possible	Points Awarded	Points Possible	Points Awarded
a. Health risk assessment Award zero points for any entry for which the Applicant did not attach a copy of the HRA(s) as requested.	35		35		35	
b. Administrative data assessment	30		30		30	
c. Predictive modeling software Award zero points for any entry which the Applicant did not provide the name of the predictive modeling software.	40		40		40	
	Provide name of predictive modeling software used:		Provide name of predictive modeling software used:		Provide name of predictive modeling software used:	
d. Provider, enrollee, or service agency referrals	35		35		35	

Identification mechanism	Entry 1		Entry 2		Entry 3	
	State: Line of business:		State: Line of business:		State: Line of business:	
	Points Possible	Points Awarded	Points Possible	Points Awarded	Points Possible	Points Awarded
e. Functional assessment that evaluates activities of daily living Award zero points for any entry for which the Applicant did not attach a copy of the functional assessment(s) as requested.	35		35		35	
Total Points Awarded for each entry (points may not exceed 175):						
Sum of total points awarded for entries 1 – 3. (points may not exceed 525)						
Add 15 points if the Line of Business is Medicare-Medicaid or Medicare.						
Total Points Awarded for Question 3: Sum of total points may not exceed 540.						

4. a. Does the Applicant have at least 12 months of experience as of March 31, 2012 with assessing the following domains for enrollees?

Assessment Domains	Entry 1	Entry 2	Entry 3
	State: Line of business:	State: Line of business:	State: Line of business:

Note: If the Applicant did not submit a copy of the assessment or did not highlight the location of each domain(s) for the applicable entry, award zero points for that domain and entry.	Yes	No	Yes	No	Yes	No
i. Medical and behavioral health history	30	0	30	0	30	0
ii. Behavioral health needs	30	0	30	0	30	0
iii. Medical needs	30	0	30	0	30	0
iv. Functional needs	30	0	30	0	30	0
v. Cognitive needs	30	0	30	0	30	0
vi. Social needs	30	0	30	0	30	0
vii. Nutritional needs	30	0	30	0	30	0
viii. Long term services and supports	30	0	30	0	30	0
ix. Individual goals and preferences	30	0	30	0	30	0
x. Environmental or residential assessment	30	0	30	0	30	0
xi. Activities of daily living and/or Instrumental activities of daily living capabilities	30	0	30	0	30	0
xii. Ability of the enrollee to self-direct community-based long term services and supports	30	0	30	0	30	0
xiii. Willingness/readiness to change	30	0	30	0	30	0
xiv. Discharge/transition plans	30	0	30	0	30	0
xv. Health and welfare	30	0	30	0	30	0
xvi. Natural supports, including family and community	30	0	30	0	30	0
xvii. Caregiver capabilities	30	0	30	0	30	0
xviii. Special communication needs	30	0	30	0	30	0
xix. Health literacy	30	0	30	0	30	0
Total Points Awarded for Each Entry Sum of points may not exceed 570.						

Assessment Domains	Entry 1		Entry 2		Entry 3	
	State: Line of business:		State: Line of business:		State: Line of business:	
	Yes	No	Yes	No	Yes	No
Note: If the Applicant did not submit a copy of the assessment or did not highlight the location of each domain(s) for the applicable entry, award zero points for that domain and entry.						
Sum of total points awarded for entries 1-3. Total points may not exceed 1,710.						
Add 190 points if line of business is Medicare-Medicaid or Medicare.						
Total Points Awarded for Question 4a. Sum of total points may not exceed 1900.						

b. Does the Applicant have at least 12 months of experience as of March 31, 2012 with conducting an assessment using the following data sources?

Data Source	Entry 1:		Entry 2:		Entry 3:	
	State: Line of business:		State: Line of business:		State: Line of business:	
	Yes	No	Yes	No	Yes	No
i. Enrollee	15	0	15	0	15	0
ii. Family/caregiver	15	0	15	0	15	0
iii. Medical records	15	0	15	0	15	0
iv. Administrative data (pharmacy, inpatient, emergency department, etc.)	15	0	15	0	15	0
v. Primary care providers	15	0	15	0	15	0
vi. Specialists	15	0	15	0	15	0
vii. Long term service and support providers	15	0	15	0	15	0
Total points awarded for each entry. (Sum of points may not exceed 105.)						

Data Source	Entry 1:		Entry 2:		Entry 3:	
	State: Line of business:		State: Line of business:		State: Line of business:	
	Yes	No	Yes	No	Yes	No
Sum of total points awarded for entries 1-3. (Sum of points may not exceed 315.)						
Add 35 points if a line of business is Medicare-Medicaid or Medicare						
Total Points awarded for Question 4b. (Sum of total points may not exceed 350.)						

c. Does the Applicant have at least 12 months of experience as of March 31, 2012 with conducting an assessment using the following methods of collecting information from the enrollee?

Methods of data collection	Entry 1:		Entry 2:		Entry 3:	
	State: Line of business:		State: Line of business:		State: Line of business:	
	Yes	No	Yes	No	Yes	No
Home visit	60	0	60	0	60	0
Telephone	30	0	30	0	30	0
Form completed by the enrollee	10	0	10	0	10	0
Total points awarded for each entry. (Sum of points may not exceed 100.)						
Sum of total points awarded for entries 1-3. (Sum of points may not exceed 300.)						

Methods of data collection	Entry 1:		Entry 2:		Entry 3:	
	State: Line of business:		State: Line of business:		State: Line of business:	
	Yes	No	Yes	No	Yes	No
Add 50 points if a line of business is Medicare-Medicaid or Medicare.						
Total Points awarded for Question 4c. (Sum of total points may not exceed 350.)						

Total Points for Questions 4a – 4c. Points may not exceed 2,600.	
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5. a. Does the Applicant have at least 12 months of experience as of March 31, 2012 with assigning enrollees to a risk/acuity level based on the results of the identification and/or assessment processes?

Response	Points Possible	Did Applicant indicate one state and line of business as reported in Appendix B? Insert yes or no. If no, then award zero points for Question 5a.	Points Awarded (0 or 100)
Yes	100		
No	0		

- b. Does the Applicant have at least 12 months of experience as of March 31, 2012 with communicating the results of the assessment and the risk/acuity level assignment to enrollees?

Response	Points Possible	Did Applicant indicate one state and line of business, as reported in Appendix B? Insert yes or no. If no, then award zero points for Question 5b.	Points Awarded (0 or 135)
Yes	135		
No	0		

- c. Does the Applicant have at least 12 months experience as of March 31, 2012 with communicating the results of the assessment and the risk/acuity level assignment to enrollees' primary care providers?

Response	Points	Did Applicant indicate one state and line of	Points
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	Possible	business as reported in Appendix B? Insert a yes or no. If no, then award zero points for Question 5c.	Awarded (0 or 135)
Yes	135		
No	0		

Total Points for Questions 5a – 5c. Points may not exceed 370.	
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6. Does the Applicant have at least 12 months of experience as of March 31, 2012 with developing integrated, person centered care plans that address the components specified below?

Care Plan Component	State: Line of business:		State: Line of business:		State: Line of business:	
	Yes	No	Yes	No	Yes	No
a. Established goals, interventions, and anticipated outcomes, with specified timeframes for completion that address clinical and non clinical needs (i.e., medical, behavioral, environmental, social, functional, long term services and supports, nutrition, etc.) and services identified in the comprehensive assessment. The goals, interventions and outcomes must reflect the individual's preferences.	165	0	165	0	165	0
b. Involvement and engagement of the enrollee and his/her support system in the development of the care plan. The enrollee's agreement with the initial and revised care plans shall be documented in the care plan.	165	0	165	0	165	0
c. Established communication plan, including anticipated frequency of contacts, with the enrollee, the primary care provider and, as appropriate, other providers.	165	0	165	0	165	0
d. A comprehensive approach to transitional care across settings to ensure communication among providers, primary care follow up, medication reconciliation, and timely provision of formal and informal supports.	165	0	165	0	165	0
e. Referrals for the enrollee to access social and community support services and validation that the enrollee received the necessary services.	165	0	165	0	165	0

Care Plan Component	State: Line of business:		State: Line of business:		State: Line of business:	
	Yes	No	Yes	No	Yes	No
f. A review of the initial and revised care plan with the enrollee, family/ caregiver, primary care provider, and specialists, as appropriate, while actively seeking input from them.	165	0	165	0	165	0
g. Continuous monitoring of service delivery and enrollee's adherence to the care plan to identify gaps between care recommended and care received, along with implementation of strategies to address the gaps in care.	165	0	165	0	165	0
h. Ensuring the care plan is accessible to the enrollee and all providers involved in managing the enrollee's care.	165	0	165	0	165	0
Total points awarded for each entry. Sum of total points may not exceed 1,320.						
Sum of total points awarded for entries 1 – 3. Points may not exceed 3,960.						
Add 90 points if a line of business is Medicare-Medicaid or Medicare.						
Grand Total points awarded. Sum may not exceed 4,050.						

7. a. Does the Applicant have at least 12 months of experience as of March 31, 2012 with assigning a single accountable point of contact (i.e., a care manager) to each enrollee who helps the enrollee obtain medically necessary care, assists with health related services, coordinates care for the enrollee; disseminates information to the enrollee; and implements and monitors the care plan?

Response	Points Possible	Did Applicant indicate one state and line of business as reported in Appendix B? Insert yes or no. If no, then award 0 points for Question 7a.	Points Awarded (0 or 270)
Yes	270		
No	0		

- b. Does the Applicant have at least 12 months of experience as March 31, 2012 with forming a trans-disciplinary team consisting of the enrollee, primary care provider, care manager and, as needed, specialists to effectively manage the enrollee's needs?

Response	Points Possible	Did Applicant indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question 7b.	Points Awarded (0 or 270)
Yes	270		
No	0		

Total Points Awarded for 7a and 7b	
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8. a. Does the Applicant have at least 12 months of experience as of March 31, 2012 with conducting home visits with enrollees to either observe or assess them in their residential environment?

Response	Points Possible	Did Applicant indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question 8a.	Points Awarded (0 or 180)
Yes	180		
No	0		

- b. Does the Applicant have at least 12 months of experience as of March 31, 2012 with delivering care management services (e.g., medication reconciliation, health education, health coaching, etc.) in person with an enrollee in a residential setting or outpatient/inpatient facility?

Response	Points Possible	Did Applicant indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question 8b.	Points Awarded (0 or 180)
Yes	180		
No	0		

- c. Does the Applicant have at least 12 months of experience as of March 31, 2012 with developing and implementing a communication plan to meet an enrollee’s needs that included a combination of home visits, point-of-care visits (e.g., hospital, provider’s office, etc.), email or internet communication, and telephonic outreach?

Response	Points Possible	Did Applicant indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question 8c.	Points Awarded (0 or 180)
Yes	180		
No	0		

- d. Provide the following information related to home visits for one state and line of business as reported in Appendix B:

Inquiry:	Response
State/Line of Business/Population submitted for Appendix B:	Informational only. No points will be awarded for response.
Number of enrollees in care management in CY 2011:	Informational only. No points will be awarded for response.
Average number of home visits per enrollee in care management for CY 2011: Numerator: Total number of home visits conducted in CY 2011 Denominator: Total number of enrollees in care management in CY 2011	Informational only. No points will be awarded for response.
Average frequency of home visits per enrollee in care management for CY 2011: Numerator: Average number of home visits per month Denominator: Total number of enrollees in care management	Informational only. No points will be awarded for response.

Total points awarded for 8a – 8c. Points may not exceed 540.	
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9. Does the Applicant have experience with contracting and delegating care management functions to a community -based entity (e.g., Center for Independent Living or Area Agencies on Aging) for long term services and supports?

Response	Points Possible	Did Applicant include the community based entity contact information? Insert yes or no. If no, then award 0 points for Question 9.	Points Awarded (0 or 540)
Yes	540		
No	0		

10. a. Does the Applicant have at least 12 months of experience as of March 31, 2012 in supporting a participant-directed care model for enrollees receiving home and community based long term services?

Response	Points Possible	Did Applicant indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question 10a.	Points Awarded (0 or 450)
Yes	450		
No	0		

- b. If the response to Question 10.a. is YES, does the Applicant have at least 12 months of experience as of March 31, 2012 with evaluating whether the participant-directed care model was effective, as defined by criteria such as volume of services received, increased enrollee/family satisfaction, etc., for enrollees using this model?

Response	Points Possible	Did Applicant indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question	Points Awarded (0 or 450)

		10b.	
Yes	450		
No	0		

c. If the response to Question 10.b. is YES, but the Applicant determined that the participant-directed care model was not effective for certain enrollees, does the Applicant have at least 12 months of experience as of March 31, 2012 with transitioning the enrollee to a traditional model of using providers who are employed by a home health or home care agency?

Response	Points Possible	Did Applicant indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question 10c.	Points Awarded (0 or 450)
Yes	450		
No	0		

Total Points Awarded for Questions 10 a – c. Sum of points may not exceed 1,350.	
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11. Does the Applicant currently have an electronic care management system that collects the results of the assessment and the care plan, including goals, actions and completion dates and is linked to other databases or systems that the Applicant uses to maintain enrollee information?

Response	Points Possible	Did Applicant indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question 11.	Points Awarded (0 or 270)
Yes	270		
No	0		

12. a. The reviewer should evaluate information reported for a care management program for a Medicaid non-Long Term Care population for which the Applicant provided care management services:

Provide the following information for the Applicant's care management program that was evaluated:	Total Points Possible	Total Points Awarded
Date of care management program implementation: MM/YY	Informational only.	No points will be awarded.
Pre implementation measurement period: MM/YY to MM/YY	Informational only.	No points will be awarded.
Post implementation measurement period (must have occurred in CY 2010 or CY 2011): MM/YY to MM/YY	Informational only.	No points will be awarded.
Total number of individuals enrolled in the care management program during the post implementation measurement period.	Informational only.	No points will be awarded.
Percent of the overall population enrolled in the care management program during the post implementation time period. (Include the numerator and denominator.)	Informational only.	No points will be awarded.
Acuity/risk levels of individuals enrolled in the care management program	___ Low – 0 points ___ Medium – 25 points ___ High – 50 points Total points may not exceed 50.	
<u>Indicator 1: Rate of hospital readmissions:</u>	Award 125 points if there was a decrease in the rate of hospital readmissions from the pre-implementation period to the post-implementation period. Award 0 points if the Applicant did not report a rate <u>or</u> did not report the numerator and denominator for the indicator.	

Provide the following information for the Applicant's care management program that was evaluated:	Total Points Possible	Total Points Awarded
Indicator 2: <u>Rate of emergency department visits</u>	Award 125 points if there was a decrease in the rate of emergency department visits from the pre-implementation period to the post-implementation period. Award 0 points if the Applicant did not report a rate <u>or</u> did not report the numerator and denominator for the indicator.	
Sum the total points. Points may not exceed 300.		

b. The reviewer should evaluate information reported for a care management program that was conducted for a Medicaid Long Term Care population for which the Applicant provided care management services:

Provide the following information for the Applicant's care management program that was evaluated:	Total Points Possible	Total Points Awarded
Date of care management program implementation: MM/YY	Informational only.	No points will be awarded.
Pre implementation measurement period: MM/YY to MM/YY	Informational only.	No points will be awarded.
Post implementation measurement period (must have occurred in CY 2010 or CY 2011): MM/YY to MM/YY	Informational only.	No points will be awarded.
Total number of individuals enrolled in the care management program during the post implementation measurement period.	Informational only.	No points will be awarded.
Percent of the overall population enrolled in the care management program during the post implementation time period.	Informational only.	No points will be awarded.

Provide the following information for the Applicant's care management program that was evaluated:	Total Points Possible	Total Points Awarded
Acuity/risk levels of individuals enrolled in the care management program	__ Low – 0 points __ Medium – 30 points __ High – 60 points Total points may not exceed 60.	
<u>Indicator 1: Rate of hospital readmissions:</u>	Award 125 points if there was a decrease in the rate of hospital readmissions from the pre-implementation period to the post-implementation period. Award 0 points if the Applicant did not report a rate <u>or</u> did not report the numerator and denominator for the indicator.	
<u>Indicator 2: Rate of emergency department visits</u>	Award 125 points if there was a decrease in the rate of emergency department visits from the pre-implementation period to the post-implementation period. Award 0 points if the Applicant did not report a rate <u>or</u> did not report the numerator and denominator for the indicator.	
<u>Indicator 3: Percent of individuals who reside in a nursing facility</u> <u>Indicator 4: Percent of individuals who reside in a community setting</u>	Award 200 points if the following two statements are true: The percent of individuals residing in a nursing facility decreased from the pre-implementation period to the post-implementation period. The percent of individuals residing in a community setting increased from the pre-implementation period to the post-implementation period.	
Sum the total points. May not exceed 510 points.		

Sum of total points for 12 a and b. Total points may not exceed 810.	
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13. Responses will be evaluated on whether the Applicant’s submitted ICDS care management model does not meet, partially meets, meets, or exceeds the expectations expressed in the Appendix D form and the ICDS proposal and will assign the appropriate point value, as follows:

0 Does not meet expectations	40 Partially meets expectations	70 Meets Expectations	100 Exceeds Expectations
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The total score for question 13 will be the sum of the point value for all of the evaluation criteria.

Proposal acceptance criteria:

Was the Applicant’s response in accordance with the following: 1) the submission guidelines specified in Section III.B.3, Essay Requirements, of this RFA; 2) the 20, single spaced page limitation; and 3) organized according to the instructions specified in this Appendix, Question 13 with sections clearly referenced and labeled?

Yes No

If the response is yes, proceed with evaluating the Applicant’s response.

Evaluation Criteria	Weight	0 Doesn’t Meet	40 Partially Meets	70 Meets Expectations	100 Exceeds Expectations	Points Awarded
Identification strategy						
The Applicant provided a description of the strategy to identify and prioritize the timeframe by which individuals will receive an initial comprehensive assessment.	4.5					
The Applicant provided a description of the data that will be reviewed.	4.5					
The Applicant provided a description of the criteria that will be used for case selection.	4.5					
Comprehensive assessment						
The Applicant described its process for completing a comprehensive assessment of	5.4					

Evaluation Criteria	Weight	0 Doesn't Meet	40 Partially Meets	70 Meets Expectations	100 Exceeds Expectations	Points Awarded
the enrollee's medical, behavioral health, long term services and supports, environmental and social needs with input from the enrollee, family members, caregiver, and providers.						
The Applicant provided a summary description of the assessment tool.	5.4					
The Applicant described the data sources that will be used.	5.4					
The Applicant described how the assessment information will be collected.	5.4					
The Applicant described the process for determining when to re-evaluate the enrollee's needs.	5.4					
Risk/Acuity Levels						
The Applicant indicated the structure of the levels by providing number of levels and if they will be risk or acuity based.	2.25					
The Applicant described the criteria for each of the risk/acuity levels.	2.25					
The Applicant described how an enrollee will be assigned to the appropriate risk/acuity level.	2.25					
The Applicant described how the risk/acuity level will be communicated to the enrollee.	2.25					
The Applicant described how the risk/acuity level will be communicated to the primary care providers/specialists.	2.25					
The Applicant indicated the minimum frequency of contacts—including face to face visits (in the residence or at the point of care), telephonic, etc.--established for each risk/acuity level.	2.25					
Care Plan						
The Applicant described the process for developing and implementing an integrated,	5.5					

Evaluation Criteria	Weight	0 Doesn't Meet	40 Partially Meets	70 Meets Expectations	100 Exceeds Expectations	Points Awarded
person-centered care plan with the enrollee, family members, caregiver(s) and provider(s) that addresses needs identified in the comprehensive assessment with corresponding goals, interventions and outcomes.						
The Applicant described how the enrollee's preferences and preferred role in decision-making will be considered when developing the care plan.	5					
The Applicant described how the enrollee and his/her supports will be included in the development and implementation of the initial and revised care plans.	5					
The Applicant described how the enrollee's providers will be included in the development and implementation of the initial and revised care plan.	5					
The Applicant identified how a communication plan will be established with the enrollee.	5					
The Applicant described a process to monitor the care plan to determine: the quality of services provided in order to achieve progress toward person-centered goals and outcomes, adherence to evidence-based practices, existence of barriers to care, the need to manage transitions across settings, appropriate service utilization, etc	5					
The Applicant described how gaps in care for an enrollee will be identified and addressed.	5					
The Applicant described how the care plan will be continuously reviewed and revised.	5					
Care Manager and Care Management Team						
The Applicant described the strategy to formulate a trans-	2.7					

Evaluation Criteria	Weight	0 Doesn't Meet	40 Partially Meets	70 Meets Expectations	100 Exceeds Expectations	Points Awarded
disciplinary care management team led by a care manager (i.e., accountable point of contact) designed to effectively manage the individual's services. The team shall consist of the beneficiary, the primary care provider, the care manager, LTSS service coordinators, and other providers, as appropriate.						
The Applicant described how the team composition and the care manager for each enrollee will be decided with examples of who may serve as members of the team and the care manager.	2.7					
The Applicant described the role of the care manager;	2.7					
The Applicant indicated whether care managers or members of the team will be field-based, centralized, or both.	2.7					
The Applicant identified the care management staffing ratios for each of the proposed acuity/risk levels.	2.7					
Communication Methods						
The Applicant described the use of innovative communication methods that are culturally and linguistically appropriate.	3.25					
The Applicant described how it will employ innovative communication methods that consider the unique needs of the enrollee.	3.25					
Managing Care Transitions						
The Applicant described a strategy to aggressively manage care transitions, including admissions and discharges from hospitals, nursing facilities, and other settings to ensure communication among providers, primary care follow up, medication reconciliation, timely provision of formal and informal in-home supports, etc.	7					

Evaluation Criteria	Weight	0 Doesn't Meet	40 Partially Meets	70 Meets Expectations	100 Exceeds Expectations	Points Awarded
Medication Reconciliation						
The Applicant described a process to perform ongoing-medication reconciliation and employment of advanced pharmacy management programs, including medication therapy management, to increase adherence and eliminate contra-indicated drug use;	2.7					
Care management system						
The Applicant described a care management system that captures the assessment and care plan content.	1.8					
The Applicant described a care management system that links to other internal databases or systems that are used to maintain information about the enrollee.	1.8					
The Applicant described a care management system that has the capability to produce a copy of the care plan when requested by the enrollee and the provider.	1.8					
Program Evaluation						
The Applicant described a strategy to evaluate the impact of the care management program on Ohio's Medicare-Medicaid population with regard to health outcomes, enrollee satisfaction, enrollee's independent living status, functional status, and other quality indicators.	5.4					
Grand Total of Points Awarded						

Part B: Patient-Centered Medical Home

Total points possible for Part B are 3,000.

Fill in the appropriate points based on the information submitted on the Appendix D form. Points will be awarded for each response based on the instructions provided for each question.

Question	Points Possible	Did the Applicant provide the contact information as requested? Insert yes or no. If no, then zero points will be awarded for the question.	Points Awarded.
1	750	Not applicable.	
2	450	Not applicable	
3	300	Not applicable.	
4	300	Not applicable.	
5	150		
6	450		
7	150		
8	450		
Total Points			

**Appendix D: Care Coordination
Summary Scoring Sheet**

Applicant Name: _____

Part A: Care Management

Question	Points Possible	Points Awarded
1.	1,350	
2.	540	
3.	540	
4.	2,600	
5.	370	
6.	4,050	
7.	540	
8.	540	
9.	540	
10.	1350	
11.	270	
12.	810	
13.	13,500	
Total	27,000	

Part B: Patient Centered Medical Home

Question	Points Possible	Points Awarded
1.	750	
2.	450	
3.	300	
4.	300	
5.	150	
6.	450	
7.	150	
8.	450	
Total	3,000	

Grand Total for Appendix D:

Part A	
Part B	
Total Points	