REQUEST FOR PROPOSALS

RFP NUMBER: **CSP900714**
INDEX NUMBER: **MAC001**
UNSPSC CATEGORY: **80100000 and 85100000**

The state of Ohio, through the Department of Administrative Services, Office of Procurement Services, for the Office of Medical Assistance is requesting proposals for:

Home and Community Based Waiver Program Case Management

RFP ISSUED: **February 19, 2013**
INQUIRY PERIOD BEGINS: **February 19, 2013**
INQUIRY PERIOD ENDS: **March 15, 2013 at 8:00 a.m.**
PROPOSAL DUE DATE: **March 29, 2013 by 1:00 p.m.**

Proposals received after the due date and time will not be evaluated.

OPENING LOCATION: **Department of Administrative Services**
Office of Procurement Services
ATTN: Bid Desk
4200 Surface Rd.
Columbus, OH 43228-1395

Offerors must note that all proposals and other material submitted will become the property of the state and may be returned only at the state's option. Proprietary information should not be included in a proposal or supporting materials because the state will have the right to use any materials or ideas submitted in any proposal without compensation to the offeror. Additionally, all proposals will be open to the public after the award of the contract has been posted on the State Procurement Web site. Refer to the Ohio Administrative Code, Section 123:5-1-08 (E).

This Request for Proposals (RFP) consists of eight (8) parts and thirteen (13) attachments, totaling 159 consecutively numbered pages. Please verify that you have a complete copy.

PART ONE: INDEX FOR RFP

ORGANIZATION. This RFP is organized into eight (8) parts and thirteen (13) attachments. The parts and attachments are listed below.

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PART TWO: EXECUTIVE SUMMARY

2.1 PURPOSE. This is a Request for Competitive Sealed Proposals (RFP) under Section 125.071 of the Ohio Revised Code and Section 123:5-1-08 of the Ohio Administrative Code. The Department of Administrative Services (DAS), Office of Procurement Services, on behalf of the Office of Medical Assistance (the Agency), is soliciting competitive sealed proposals (Proposals) for Home and Community Based Waiver Program Case Management (Project) and this RFP is the result of that request. If a suitable offer is made in response to this RFP, the state of Ohio (State), through DAS, may enter into a contract (the Contract) to have the selected Offeror (also known as the "Contractor") perform all or part of the Project. DAS, on behalf of the Office of Medical Assistance may, at its sole discretion, negotiate with all technically qualifying Contractors for a revised cost proposal if the cost proposals of all technically qualifying Contractors are in excess of the available funding for this project. Part Four (4.1.6) of this RFP establishes further information on DAS procedures to be implemented if this occurs. This RFP provides details on what is required to submit a Proposal for the Project, how the State will evaluate the Proposals, and what will be required of the Contractor if awarded the Contract.

This RFP also gives the estimated dates for the various events in the submission process, selection process, and performance of the Project. While these dates are subject to change, prospective Offerors must be prepared to meet them as they currently stand.

Once awarded, the term of the Contract will be from the award date through 6/30/15. The State may solely renew all or part of the Contract at the discretion of DAS for a period of one month and subject to the satisfactory performance of the Contractor and the needs of the Agency. Any further renewals will be by mutual agreement between the Contractor and DAS for any number of times and for any period of time. Renewal is contingent upon the availability of funds and satisfactory performance by the selected Contractor. The cumulative time of all mutual renewals may not extend beyond 6/30/17 and is subject to and contingent upon the discretionary decision of the Ohio General Assembly to appropriate funds for this Contract in each new biennium.

Any failure to meet a deadline in the submission or evaluation phases and any objection to the dates for performance of the Project may result in DAS refusing to consider the Proposal of the Offeror.

2.2 BACKGROUND. The Office of Medical Assistance is releasing this RFP for the purpose of obtaining two Contractors per region, to provide case management for all current and future Office of Medical Assistance-administered home and community-based service waiver programs, all current and future transition to the community programs, and all future initiatives yet to be determined. These Contractors must be experienced in providing community long-term care case management services to children, adults and seniors who have disabilities, are chronically ill, or have medically complex conditions.

As the single state Medicaid agency, the Office of Medical Assistance has oversight responsibility for all expenditures using Medicaid as a source of funding. The Bureau of Long-Term Care Services & Supports, which will administer this contract, is responsible for state-level supervision and oversight of the Office of Medical Assistance-administered Home and Community Based Service waiver programs, and transition to the community projects. The Bureau of Long-Term Care Services & Supports designs, implements, and manages high-quality, cost-effective and accessible home and community-based programs for qualifying individuals. The role of the Case Management Contractor is to assist in the implementation and management of these programs throughout the state, interfacing with individuals and providers at the local level. The federal government requires waiver programs to ensure the health and welfare of each waiver participant; it is also the fundamental goal of the relationship among the Office of Medical Assistance, the Case Management Contractors, and Provider Oversight Contractor. The Contractor's responsibilities will include, but not be limited to: clinical and program management functions.

The two existing Home and Community Based Service waiver programs are the Ohio Home Care Waiver program and the Transitions II Aging Carve-Out Waiver program. The programs geared to transition individuals from institutional settings to the community include HOME Choice (Money Follows the Person) Demonstration Program, and the Ohio Access Success Project (Success Project). Future initiatives may include the Federal Balancing Incentive Payment Program (BIPP), and Integrated Care Delivery System (Duals Project), and a single Home and Community Based Service waiver program.

At Governor John Kasich's initiation, the Ohio General Assembly passed comprehensive Medicaid reforms in House Bill (H.B.) 153 that will improve the quality of health care for the 2.1 million individuals served in the Medicaid program. To that end, the Office of Medical Assistance is pursuing several initiatives to improve care coordination for individuals who receive long-term care services through the Medicaid program. These initiatives will be developed over the life of this contract and may impact initial contact, assessment, caseload, and other functions. Although details of the initiatives are not in place at the time of this writing, the selected Contractor shall perform the case management role in accordance with the requirements and goals of these initiatives. They are outlined below in 2.2.6 through 2.2.8.

It is anticipated that approximately 6,800 individuals will be served by the Office of Medical Assistance-administered Home and Community Based Service waiver programs. An unknown number of additional individuals will be served by the transition to the community projects, and the future initiative projects. Potentially, an additional 250 individuals will be served in each subsequent state fiscal year (SFY) of the Contract.

Home and Community Based Service waiver program individuals are located throughout Ohio's 88 counties, with the highest proportions in major urban counties (Franklin 12%, Cuyahoga 9%, and Montgomery 3%). After individuals transition to the ICDS Duals Project, there will be approximately 1,100 individuals in the Cincinnati region, 2,200 individuals in the Columbus region, 1,500 individuals in the Cleveland region, and 2,000 individuals in the Marietta region. Approximately 17% of Home and Community Based Service waiver program individuals are under the age of 22, 69% of individuals are between the ages of 22 and 59 years old, and 14% of individuals are 60 years of age or older. Individuals have diverse conditions and a range of acuity levels.

Currently, more than 26,000 aides/non-aides, 7,100 registered nurses (RN)/licensed practical nurses (LPN), and 22 home care attendants are enrolled as non-agency home care providers for the Office of Medical Assistance-administered home and community-based programs. Of these enrolled providers, more than 4,400 personal care aides, 1,500 RNs/LPNs, and 15 home care attendants submit claims during a given quarter. Approximately 700 home health agencies and 550 ancillary providers (*e.g.,* adult day care, emergency response service, supplemental transportation, therapy, out-of-home respite, home modification, and adaptive/assistive equipment) serve individuals on the waiver programs.

2.2.1 MULTIPLE AWARD CONTRACT. This RFP is issued to establish a mandatory-use Multiple Award Contract (MAC). A MAC is a contract made with more than one supplier of the same or similar services at varying prices for delivery within the same geographic area. The State's obligations under a MAC are subject to the Ohio Controlling Board's continuing authorization to use the MAC program authorizing the use of Multiple Award Contracts. Mandatory-use MAC contracts require state agencies that purchase these services to purchase from this contract, from one of the awarded contractors. The State offers no assurance of minimum quantities to any single MAC contractor. In the event only one Contractor is selected for a particular region, or in the event one of the selected Contractors in a region is terminated for any reason, the sole Contractor in the region will be required to service all individuals in that region.

Currently, the same statewide Contractor provides both case management and provider oversight management. For the future, the Office of Medical Assistance is seeking separate Contractors to perform the two functions. DAS intends to award the Provider Oversight RFP to one statewide Contractor and to award the Case Management RFP to one or more separate contractors on a region by region basis. The State is divided into four regions (See Attachment Twelve). The same Offeror may submit a proposal for the provider oversight contract and a proposal for each of the four regions under the case management contract. If an Offeror is selected and awarded the provider oversight contract, they are not eligible for selection or award in the case management contract. If an Offeror is not awarded the provider oversight contract, they may be eligible for selection in the case management contract and may be awarded one or more regions.

Any failure to meet a deadline in the submission or evaluation phases and any objection to the dates for performance of the Project may result in DAS refusing to consider the Proposal of the Offeror.

2.2.2 OHIO HOME CARE WAIVER PROGRAM. Created in 1998, the Ohio Home Care Waiver program offers Home and Community Based Service to individuals age 59 and younger who require services due to a physical disability or who have chronic medical conditions that require nursing care. In addition to nursing and personal care, the Ohio Home Care Waiver program provides a wide range of services to individuals to prevent or delay institutional placement or to improve the individual's independence. Waiver program eligibility and administrative case management are currently managed by an entity under contract with the Office of Medical Assistance. The Ohio Home Care Waiver program currently serves more than 8,600 individuals, however, after individuals transition to the ICDS Duals Project see 2.2.7), approximately 5,550 individuals will remain on the Ohio Home Care Waiver program. That waiver program has been approved by the Centers of Medicare and Medicaid Services (CMS) for operation through June 30, 2016.

2.2.3 TRANSITIONS II AGING CARVE-OUT WAIVER PROGRAM. The Transitions II Aging Carve-Out Waiver program was created in 2006 when the Ohio Home Care Waiver program was renewed and the maximum age was lowered from "any age" to age 59 and younger. The waiver program serves individuals who "age out" of the Ohio Home Care Waiver program when they turn 60. Transition from the Ohio Home Care Waiver program is seamless because the individual has access to the same service package and the same case management services. Currently, more than 2,100 individuals are enrolled on the Transitions II Aging Carve-Out Waiver program. After individuals transition to the ICDS Duals Project, approximately 1,250 individuals will remain on the Transitions II Aging Carve-Out waiver program. That waiver program has been approved by CMS for operation through June 30, 2014.

2.2.4 HOME CHOICE (MONEY FOLLOWS THE PERSON) DEMONSTRATION PROGRAM. The Office of Medical Assistance was awarded a Money Follows the Person (MFP) grant from the Centers for Medicare and Medicaid Services (CMS). This grant, administered by the Bureau of Long-Term Services & Supports, is known as the HOME Choice (**H**elping **O**hioans **M**ove, **E**xpanding **Choice**) Demonstration Program. Working in concert with sister state agencies, this program was built on existing long term services and supports. MFP supplemental and demonstration services wrap around and fill gaps in the current qualified home and community based service programs. HOME Choice services were developed to assist older adults and persons with disabilities to move from qualified long-term institutions and hospitals to home and community-based settings.

Enrollment into the HOME Choice program is facilitated by a HOME Choice Pre-Transition Case Manager. The Case Management Contractor awarded hereunder shall agree to also enter into a separate provider agreement to perform this role of HOME Choice Pre-Transition Case Manager, the terms and conditions of which are delineated in Attachment Thirteen.

The program also uses “transition coordinators,” unique to the HOME Choice program, to work with the HOME Choice Pre-Transition Case Manager to facilitate individual transition out of the long-term care facility or hospital by helping the individual locate housing, purchase materials and supplies for living and connect with community services.

The transition coordinators also work closely with the institution’s discharge planning staff and the individual’s case manager. Both transition coordinators and case managers become a part of the individual’s institutional discharge planning team. The HOME Choice Pre-Transition Case Manager’s role ends at the time of discharge into the community and enrollment onto HOME Choice.

Subsequent to the individual’s transition to community-based living, the Case Management Contractor shall immediately assume HOME Choice case management responsibilities under this Contract for those individuals whom it assisted as a HOME Choice Pre-Transition Case Manager under the separate Provider Agreement (Attachment Thirteen) unless otherwise advised by the Office of Medical Assistance.

The HOME Choice case manager provides traditional case management services and works closely with the Transition Coordinator. Case management is a collaborative process of assessing, planning, facilitating and advocating for options and services to meet the individual's health needs. All HOME Choice individuals will be assigned a case manager through the Contractor that administers their waiver program or Medicaid State Plan services. Case managers begin their work with an individual as plans for institutional discharge are coming together and community services and supports are being arranged. The case manager and the individual work closely to determine what HOME Choice services and other community services will meet the individual’s assessed needs prior to the time of discharge.

2.2.5 OHIO ACCESS SUCCESS PROJECT. The Ohio Access Success Project, commonly referred to as the Success Project, was originally funded through a combination of federal grant and state general revenue funds; it is now funded solely with state funds. The Success Project expands Ohio’s capacity to serve more long term care individuals in the community. The program is geared to assist individuals living in nursing facilities who desire to live in a community-based setting, and who can make that transition with relatively minimal assistance with linkages to community services and supports.

The program provides qualified nursing facility residents wishing to relocate to a community-based setting with one-time funding of up to $2,000 to assist with relocation expenses. These expenses may include, but are not limited to, rental deposits, utility deposits, home modifications, and household goods. Individuals may also receive waiver program or Medicaid state plan services in the community. Individuals must rely on family, friends or facility staff to provide assistance with discharge planning and relocation as no formal transition coordination or Success Project case management services are available through the Success Project.

2.2.6 BALANCING INCENTIVE PAYMENT PROGRAM (BIPP). Ohio is also contemplating how other long-term services and supports structural reforms can be built into the long-term services and supports delivery system. In support of these efforts, Ohio is strongly considering submitting an application to participate in the federal Balancing Incentive Payment Program, which promotes system rebalancing and structural reforms including a single entry point system, a uniform assessment tool, and conflict free case management. Ohio Medicaid, in conjunction with other stakeholders, is working toward a system of long-term care that maximizes choice and promotes community integration. For the past two years, Ohio Medicaid has been revising and reforming the State’s current Medicaid level of care determination process. Current work has centered on making short-term level of care process changes and clarifying policy and procedures. The next phase of level of care work is long-term reform of the current, fragmented, paper-based level of care determination process. Another component of this work is the development of a new assessment tool that will be used to determine eligibility for an array of Medicaid programs that serve individuals with a nursing facility level of care.

2.2.7 INTEGRATED CARE DELIVERY SYSTEM (ICDS) or (DUALS PROJECT). Approximately 182,000 Ohioans are covered by both Medicare (because they are over age 65 or disabled) and Medicaid (because they have low income). Because Medicaid and Medicare are designed and managed with almost no connection to each other, the long-term care services, behavioral health services and physical health services that are provided to individuals who are eligible for both programs are poorly coordinated. The result is a diminished quality of care, which is reflected in high costs to the Medicaid system and to taxpayers. While dual-eligible individuals make up only 14 percent of total Ohio Medicaid enrollment, they account for 40 percent of total Medicaid spending.

Congress recently created a new federal Center for Medicare and Medicaid Innovation (CMMI) to encourage states to integrate physical, behavioral, and long-term care services into a seamless and comprehensive care experience for Medicare-Medicaid enrollees. H.B. 153 authorized Ohio Medicaid to seek approval through CMMI to design and implement a Medicare-Medicaid Integrated Care Delivery System. Ohio's development of the integrated care delivery system is a work in progress. The goal of the integrated care delivery system program is to comprehensively manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid Enrollees, including long-term services and supports.

2.2.8 SINGLE HOME AND COMMUNITY BASED SERVICE WAIVER PROGRAM. H.B. 153 also authorizes the Office of Medical Assistance to create a single Home and Community Based Service waiver program to serve individuals with a nursing facility (NF) level of care in the community. This initiative would include adults and seniors currently enrolled on Ohio's five NF-based waiver programs: the PASSPORT, Choices and Assisted Living waiver programs administered by the Ohio Department of Aging (ODA), and the Ohio Home Care and Transitions II Aging Carve-Out waiver programs administered by the Office of Medical Assistance. The new waiver program would not affect individuals enrolled on the Individual Options, Level One and SELF waiver programs administered by the Department of Developmental Disabilities. This initiative work had been started and then paused. The Office of Medical Assistance may re-examine the possibility of implementing this waiver program at a later date.

2.2.9 STATE PLAN HOME HEALTH SERVICES. State Plan home health services are available to individuals enrolled on Medicaid with a medical need and doctor's orders. State Plan home health services are provided by Medicare-certified home health agencies. State Plan home health services include nursing, aide, and skilled therapies.

2.2.10 PRIVATE DUTY NURSING SERVICES. Private Duty Nursing (PDN) services are medically necessary, continuous, and complex nursing services provided by a licensed nurse in a home setting to individuals enrolled in Medicaid. Continuous nursing care is defined as more than four hours but fewer than 12 hours per visit. PDN services must be prior authorized by the Office of Medical Assistance for individuals not enrolled in a waiver program or enrolled in a waiver program administered by the Department of Developmental Disabilities or the Ohio Department of Aging. The Office of Medical Assistance or its designee determines eligibility for PDN in addition to the amount, scope, and duration of services. PDN services may be provided by a Medicare-certified home health agency, other accredited agency or by non-agency licensed nurses. PDN may be authorized as a part of the All Services Plan by the Case Management Contractor for an individual enrolled on an Office of Medical Assistance waiver program.

2.3 OBJECTIVES. The State's objective is to secure a Contractor to perform the Project on behalf of the Office of Medical Assistance in accordance with the terms, conditions, and laws related to the Ohio Home Care Waiver program, the Transitions II Aging Carve-Out Waiver program, the HOME Choice Demonstration Program, the Ohio Access Success Project, and any future initiatives related to the delivery of home and community based services. It will be the selected Contractor's obligation to ensure that the personnel the Contractor provides are qualified to perform their portions of the Project.

2.4 CALENDAR OF EVENTS. The schedule for the RFP is given below, and is subject to change. DAS may change this schedule at any time. If DAS changes the schedule before the Proposal due date, it will do so through an announcement on the State Procurement Web site area for this RFP. The Web site announcement will be followed by an addendum to this RFP, also available through the State Procurement Web site. After the Proposal due date and before the award of the Contract, DAS will make scheduled changes through the RFP addendum process. DAS will make changes in the RFP schedule after the Contract award through the change order provisions located in the general terms and conditions of the Contract. It is each prospective Offeror's responsibility to check the Web site question and answer area for this RFP for current information regarding this RFP and its calendar of events through award of the Contract. No contact shall be made with agency/program staff until contract award is announced.

2.5 DATES.

RFP Issued:	February 19, 2013
Inquiry Period Begins:	February 19, 2013
Inquiry Period Ends:	March 15, 2013 at 8:00 a.m.
Proposal Due Date:	March 29, 2013, by 1:00 p.m.
Contract Award Notification:	TBD

NOTE: These dates are subject to change. The State reserves the right to revise this schedule after providing notice.

There are references in this RFP to the Proposal due date. Prospective Offerors must assume, unless it is clearly stated to the contrary, that any such reference means the date and time (Columbus, OH local time) that the Proposals are due.

Proposals received after 1:00 p.m. on the due date will not be evaluated.

PART THREE: GENERAL INSTRUCTIONS

The following sections provide details on how to get more information about this RFP and how to respond to this RFP. All responses must be complete and in the prescribed format.

3.1 CONTACTS. The following person will represent DAS:

Sandy Herrel, CPPB
Ohio Department of Administrative Services
Office of Procurement Services
4200 Surface Road
Columbus, OH 43228-1395

During the performance of the Work, a State representative (the "Agency Project Representative") will represent the Agency and be the primary contact for matters relating to the Project. The Agency Project Representative will be designated in writing after the Contract award.

3.2 INQUIRIES. Offerors may make inquiries regarding this RFP any time during the inquiry period listed in the Calendar of Events. To make an inquiry, Offerors must use the following process:

1. Access the State Procurement Web site at http://www.ohio.gov/procure.
2. From the Navigation Bar on the left, select "Find It Fast".
3. Select "Doc/Bid/Schedule #" as the Type.
4. Enter the RFP Number found on Page 1 of the document. (RFP numbers begin with the letters "CSP").
5. Click "Find It Fast" button.
6. On the document information page, click "Submit Inquiry".
7. On the document inquiry page, complete the required "Personal Information" section by providing:
   a. First and last name of the prospective Offeror's representative who is responsible for the inquiry.
   b. Name of the prospective Offeror.
   c. Representative's business phone number.
   d. Representative's e-mail address.
8. Type the inquiry in the space provided including:
   a. A reference to the relevant part of this RFP.
   b. The heading for the provision under question.
   c. The page number of the RFP where the provision can be found.
9. Click the "Submit" button.

Offerors submitting inquiries will receive an immediate acknowledgement that their inquiry has been received as well as an e-mail acknowledging receipt of the inquiry. Offerors will not receive a personalized e-mail response to their question, nor will they receive notification when the question has been answered.

Offerors may view inquiries and responses using the following process:

1. Access the State Procurement Web site at http://www.ohio.gov/procure.
2. From the Navigation Bar on the left, select "Find It Fast".
3. Select "Doc/Bid/Schedule #" as the Type.
4. Enter the RFP Number found on Page 1 of the document. (RFP numbers begin with the letters "CSP").
5. Click "Find It Fast" button.
6. On the document information page, click the "View Q & A" button to display all inquiries with responses submitted to date.

DAS will try to respond to all inquiries within 48 hours of receipt, excluding weekends and State holidays. DAS will not respond to any inquiries received after 8:00 a.m. on the inquiry end date. The inquiries, and DAS responses to them, comprise the "DAS Inquiry Document" for this RFP. Proposals in response to this RFP are to take into account information communicated by DAS in the Q&A inquiry process.

Offerors are to base their RFP responses, and the details and costs of their Proposals, on the requirements and performance expectations established in this RFP for the future contract, not on details of any other potentially related contract or project. If Offerors ask questions about existing or past contracts using the Internet Q&A process, DAS will use its discretion in deciding whether to provide answers as part of this RFP process. Requests for copies of previous RFPs, past proposals, score sheets or contracts for this or similar past projects will be considered and treated as public records requests and are not inquiries regarding this RFP. The Q&A process is not to be used for public records requests. The posted time frames for DAS responses to Offerors' questions do not apply to public records requests.

DAS is under no obligation to acknowledge questions submitted through the Q&A process if those questions are not in accordance with these instructions or deadlines.

3.3 COMMUNICATION PROHIBITIONS. From the issuance date of this RFP until contracts are awarded, there may be no communications concerning the RFP between any potential Offeror and any employee of DAS or the Office of Medical Assistance who is in any way involved in the development of the RFP or the selection of the Contractor. Any attempts at prohibited communications by Contractors may result in the disqualification of those Contractors' proposals.

The only exceptions to this prohibition are as follows:

1. Communications conducted pursuant to Q&A inquiry process;
2. Communications necessary for any pre-existing or on-going business relationship between the Office of Medical Assistance and any potential Offeror that could submit a proposal in response to this RFP;
3. Communications during any clarification, negotiation or interview process related to this RFP;
4. Public records requests.

3.4 PROTESTS. Any Offeror that objects to the award of a Contract resulting from the issuance of this RFP may file a protest of the award of the Contract, or any other matter relating to the process of soliciting the Proposals. Such protest must comply with the following information:

1. The protest must be filed by a prospective or actual Offeror objecting to the award of a Contract resulting from the RFP. The protest must be in writing and contain the following information:
   a. The name, address, and telephone number of the protester;
   b. The name and number of the RFP being protested;
   c. A detailed statement of the legal and factual grounds for the protest, including copies of any relevant documents;
   d. A request for a ruling by DAS;
   e. A statement as to the form of relief requested from DAS; and
   f. Any other information the protester believes to be essential to the determination of the factual and legal questions at issue in the written request.
2. A timely protest will be considered by DAS, on behalf of the agency, if it is received by the DAS Office of Procurement Services (OPS) within the following periods:
   a. A protest based on alleged improprieties in the issuance of the RFP, or any other event preceding the closing date for receipt of proposals which are apparent or should be apparent prior to the closing date for receipt of proposals, must be filed no later than five (5) business days prior to the proposal due date.

b. If the protest relates to the recommendation of the evaluation committee for an award of the Contract, the protest must be filed as soon as practicable after the Offeror is notified of the decision by DAS regarding the Offeror's proposal.

3. An untimely protest may be considered by DAS at the discretion of DAS. An untimely protest is one received by the DAS OPS after the time periods set in paragraph 2 above. In addition to the information listed in paragraph 1, untimely protests must include an explanation of why the protest was not made within the required time frame.
4. All protests must be filed at the following location:

Department of Administrative Services
Office of Procurement Services
4200 Surface Road
Columbus, OH 43228-1395
SUBJECT: CSP900714 - MAC001

This protest language only pertains to this RFP offering.

3.5 ADDENDA TO THE RFP. If DAS decides to revise this RFP before the Proposal due date, an addendum will be announced on the State Procurement Web site.

Offerors may view addenda using the following process:

1. Access the State Procurement Web site at http://www.ohio.gov/procure;
2. From the Navigation Bar on the left, select "Find It Fast";
3. Select "Doc/Bid/Schedule #" as the Type;
4. Enter the RFP Number found on Page 1 of the document (RFP numbers begin with the letters "CSP");
5. Click "Find It Fast" button;
6. On the document information page, click on the addendum number to display the addendum.

When an addendum to this RFP is necessary, DAS may extend the Proposal due date through an announcement on State Procurement Web site. Addenda announcements may be provided any time before 5:00 p.m. on the day before the Proposal is due. It is the responsibility of each prospective Offeror to check for announcements and other current information regarding this RFP.

After the submission of Proposals, addenda will be distributed only to those Offerors whose submissions are under active consideration. When DAS issues an addendum to the RFP after Proposals have been submitted, DAS will permit Offerors to withdraw their Proposals.

This withdrawal option will allow any Offeror to remove its Proposal from active consideration should the Offeror feel that the addendum changes the nature of the transaction to the extent that the Offeror's Proposal is no longer in its interests. Alternatively, DAS may allow Offerors that have Proposals under active consideration to modify their Proposals in response to the addendum, as described below.

Whenever DAS issues an addendum after the Proposal due date, DAS will tell all Offerors whose Proposals are under active consideration whether they have the option to modify their Proposals in response to the addendum. Any time DAS amends the RFP after the Proposal due date, an Offeror will have the option to withdraw its Proposal even if DAS permits modifications to the Proposals. If the Offerors are allowed to modify their Proposals, DAS may limit the nature and scope of the modifications. Unless otherwise stated in the notice by DAS, modifications and withdrawals must be made in writing and must be submitted within ten (10) business days after the addendum is issued. If this RFP provides for a negotiation phase, this procedure will not apply to changes negotiated during that phase. Withdrawals and modifications must be made in writing and submitted to DAS at the address and in the same manner required for the submission of the original Proposals.

Any modification that is broader in scope than DAS has authorized may be rejected and treated as a withdrawal of the Offeror's Proposal.

3.6 PROPOSAL SUBMITTAL**.** Each Offeror must submit a Technical Proposal and a Cost Proposal as part of its Proposal package. Proposals must be submitted as two (2) separate components (Cost Proposal and Technical Proposal) in separate sealed envelopes/packages. Each Technical Proposal package must be clearly marked "CSP900714 RFP – Technical Proposal" on the outside of each Technical Proposal package's envelope. Each Cost Proposal package must be clearly marked "CSP900714 RFP – Cost Proposal" on the outside of each Cost Proposal package's envelope. Each Offeror must submit one (1) original, completed and signed in blue ink, and eight (8) copies for a total of nine (9) Proposal packages.

Any Offeror's Technical Proposal found to contain any cost information may be disqualified from consideration. Cost information is defined as any dollar amounts which might be deemed to be indicative of the relative cost or economy of the Project. Information on the assets, value, or historical business volume of the Contractor is NOT considered to be such prohibited cost information, and MAY be included in any Contractor's technical proposal as information on business capacity and stability.

The Offeror must also submit, in the sealed package, a complete copy of the Proposals on CD-ROM in Microsoft Office (Word, Excel, or Project) 2003 or higher, format and/or PDF format as appropriate. In the event there is a discrepancy between the hard copy and the electronic copy, the hard copy will be the official Proposal. Proposals are due no later than the proposal due date, at 1:00 p.m. Proposals submitted by e-mail or fax are not acceptable and will not be considered. Proposals must be submitted to:

Department of Administrative Services
Office of Procurement Services - Bid Desk
4200 Surface Road
Columbus, OH 43228-1395

DAS will reject any Proposals or unsolicited Proposal addenda that are received after the deadline. An Offeror that mails its Proposal must allow adequate mailing time to ensure its timely receipt. DAS recommends that Offerors submit proposals as early as possible. Proposals received prior to the deadline are stored, unopened, in a secured area until 1:00 p.m. on the due date. Offerors must also allow for potential delays due to increased security. DAS will reject late proposals regardless of the cause for the delay.

Each Offeror must carefully review the requirements of this RFP and the contents of its Proposal. Once opened, Proposals cannot be altered, except as allowed by this RFP.

By submitting a Proposal, the Offeror acknowledges that it has read this RFP, understands it, and agrees to be bound by its requirements. DAS is not responsible for the accuracy of any information regarding this RFP that was gathered through a source different from the inquiry process described in the RFP.

ORC Section 9.24 prohibits DAS from awarding a Contract to any Offeror(s) against whom the Auditor of State has issued a finding for recovery if the finding for recovery is "unresolved" at the time of award. By submitting a Proposal, the Offeror warrants that it is not now, and will not become subject to an "unresolved" finding for recovery under Section 9.24, prior to the award of a Contract arising out of this RFP, without notifying DAS of such finding. ORC Section 9.231 applies to this contract.
DAS may reject any Proposal if the Offeror takes exception to the terms and conditions of this RFP, fails to comply with the procedure for participating in the RFP process, or the Offeror's Proposal fails to meet any requirement of this RFP. Any question asked during the inquiry period will not be viewed as an exception to the Terms and Conditions.

3.7 CONFIDENTIAL, PROPRIETARY OR TRADE SECRET INFORMATION. DAS procures goods and services through a RFP in a transparent manner and in accordance with the laws of the state of Ohio. All proposals provided to DAS in response to this RFP become records of DAS and as such, will be open to inspection by the public after award unless exempt from disclosure under the Ohio Revised Code or another provision of law.

Unless specifically requested by the State, an Offeror should not voluntarily provide to DAS any information that the Offeror claims as confidential, proprietary or trade secret and exempt from disclosure under the Ohio Revised Code or another provision of law. Additionally, the Offeror must understand that all Proposals and other material submitted will become the property of the State and may be returned only at the State's option. Confidential, proprietary or trade secret information should not be voluntarily included in a Proposal or supporting materials because DAS will have the right to use any materials or ideas submitted in any Proposal without compensation to the Offeror.

However, if the State requests from the Offeror, or if the Offeror chooses to include, information it deems confidential, proprietary or trade secret information, the Offeror may so designate information as such and request that the information be exempt from disclosure under the Ohio Revised Code or another provision of law. The Offeror must clearly designate the part of the proposal that contains confidential, proprietary or trade secret information in order to claim exemption from disclosure by submitting both an unredacted copy and a redacted copy of its proposal in both electronic and paper (hard) format. Both electronic and paper (hard) copies shall be clearly identified as either ‘ORIGINAL COPY” or “REDACTED COPY”. Failure to properly redact and clearly identify all copies will result in the State treating all information in the original proposal as a public record.

DAS will review the claimed confidential, proprietary or trade secret information to determine whether the material is of such nature that confidentiality is warranted.

The decision as to whether such confidentiality is appropriate rests solely with DAS. If DAS determines that the information marked as confidential, trade secret, or proprietary does not meet a statutory exception to disclosure, DAS will inform the Offeror, in writing, of the information DAS does not consider confidential.

Upon receipt of DAS’ determination that all or some portion of the Offeror’s designated information will not be treated as exempt from disclosure, the Offeror may exercise the following options:

1. Withdraw the Offeror’s entire Proposal;
2. Request that DAS evaluate the Proposal without the claimed confidential, proprietary or trade secret information; or
3. Withdraw the designation of confidentiality, trade secret, or proprietary information for such information.

In submitting a proposal, each Offeror agrees that DAS may reveal confidential, proprietary and trade secret information contained in the proposal to DAS staff and to the staff of other state agencies, any outside consultant or other third parties who serve on an evaluation committee or who are assisting DAS in development of specifications or the evaluation of proposals. The State shall require said individuals to protect the confidentiality of any specifically identified confidential, proprietary or trade secret information obtained as a result of their participation in the evaluation.

Finally, if information submitted in the Proposal is not marked as confidential, proprietary or trade secret, it will be determined that the Offeror waived any right to assert such confidentiality.

DAS will retain all Proposals, or a copy of them, as part of the Contract file for at least ten (10) years. After the retention period, DAS may return, destroy, or otherwise dispose of the Proposals or the copies.

3.8 WAIVER OF DEFECTS. DAS may waive any defects in any Proposal or in the submission process followed by an Offeror. DAS will only do so if it believes that it is in the State's interests and will not cause any material unfairness to other Offerors.

3.9 ADDENDA TO PROPOSALS. Addenda or withdrawals of Proposals will be allowed only if the addendum or withdrawal is received before the Proposal due date. No addenda or withdrawals will be permitted after the due date, except as authorized by this RFP.

3.10 PROPOSAL INSTRUCTIONS. Each Proposal must be organized in an indexed binder ordered in the same manner as the response items are ordered in Attachment One of this RFP.

DAS expects clear and concise Proposals. Offerors should, however, take care to completely answer questions and meet the RFP's requirements thoroughly. All Offerors, including current contract holders, if applicable, must provide detailed and complete responses as Proposal evaluations, and subsequent scores, are based solely on the content of the Proposal.

No assumptions will be made or values assigned for the competency of the Offeror whether or not the Offeror is a current or previous contract holder.

The requirements for the Proposal's contents and formatting are contained in an attachment to this RFP.

DAS will not be liable for any costs incurred by an Offeror in responding to this RFP, regardless of whether DAS awards the Contract through this process, decides not to go forward with the Project, cancels this RFP for any reason, or contracts for the Project through some other process or by issuing another RFP.

PART FOUR: EVALUATION OF PROPOSALS

4.1 EVALUATION OF PROPOSALS. The evaluation process consists of, but is not limited to, the following steps:

1. Certification. DAS shall open only those proposals certified as timely by the Auditor of State.
2. Initial Review. DAS will review all certified Proposals for format and completeness. DAS normally rejects any incomplete or incorrectly formatted Proposal, though it may waive any defects or allow an Offeror to submit a correction. If the Offeror meets the formatting and mandatory requirements listed herein, the State will continue to evaluate the proposal.
3. Proposal Evaluation. The procurement representative responsible for this RFP will forward all timely, complete, and properly formatted Proposals to an evaluation committee, which the procurement representative will chair. The evaluation committee will rate the Proposals submitted in response to this RFP based on criteria and weight assigned to each criterion.
   a. The evaluation committee will evaluate and numerically score each Proposal that the procurement representative has determined to be responsive to the requirements of this RFP. The evaluation will be according to the criteria contained in this Part of the RFP. An attachment to this RFP may further refine these criteria, and DAS has a right to break these criteria into components and weight any components of a criterion according to their perceived importance.
   b. The committee may also have the Proposals or portions of them reviewed and evaluated by independent third parties or various State personnel with technical or professional experience that relates to the Work or to a criterion in the evaluation process. The committee may also seek reviews of end users of the Work or the advice or evaluations of various State committees that have subject matter expertise or an interest in the Work. In seeking such reviews, evaluations, and advice, the committee will first decide how to incorporate the results in the scoring of the Proposals. The committee may adopt or reject any recommendations it receives from such reviews and evaluations.
   c. The evaluation will result in a point total being calculated for each Proposal. At the sole discretion of DAS, any Proposal, in which the Offeror received a significant number of zeros for sections in the technical portions of the evaluation, may be rejected.
   d. DAS will document all major decisions in writing and make these a part of the Contract file along with the evaluation results for each Proposal considered.
4. Clarifications & Corrections. During the evaluation process, DAS may request clarifications from any Offeror under active consideration and may give any Offeror the opportunity to correct defects in its Proposal if DAS believes doing so does not result in an unfair advantage for the Offeror and it is in the State's best interests. Any clarification response that is broader in scope than what DAS has requested may result in the Offeror's proposal being disqualified.
5. Interviews, Demonstrations, and Presentations. DAS may require top Offerors to be interviewed. Such presentations, demonstrations, and interviews will provide an Offeror with an opportunity to clarify its Proposal and to ensure a mutual understanding of the Proposal's content. This will also allow DAS an opportunity to test or probe the professionalism, qualifications, skills, and work knowledge of the proposed candidates. The presentations, demonstrations, and interviews will be scheduled at the convenience and discretion of DAS. DAS may record any presentations, demonstrations, and interviews. No more than the top three (3) Proposals may be requested to present an oral presentation of their proposed Work Plan to the committee.
6. Contract Negotiations. Negotiations will be scheduled at the convenience of DAS. The selected Offeror(s) are expected to negotiate in good faith.
   a. General. Negotiations may be conducted with any Offeror who submits a competitive Proposal, but DAS may limit discussions to specific aspects of the RFP. Any clarifications, corrections, or negotiated revisions that may occur during the negotiations phase will be reduced to writing and incorporated in the RFP, or the Offeror's Proposal, as appropriate. Negotiated changes that are reduced to writing will become a part of the Contract file open to inspection to the public upon award of the Contract.

Any Offeror whose response continues to be competitive will be accorded fair and equal treatment with respect to any clarification, correction, or revision of the RFP and will be given the opportunity to negotiate revisions to its Proposal based on the amended RFP.

b. Top-Ranked Offeror. Should the evaluation process have resulted in a top-ranked Proposal, DAS may limit negotiations to only that Offeror and not hold negotiations with any lower-ranking Offeror. If negotiations are unsuccessful with the top-ranked Offeror, DAS may then go down the line of remaining Offerors, according to rank, and negotiate with the next highest-ranking Offeror. Lower-ranking Offerors do not have a right to participate in negotiations conducted in such a manner. DAS may, at its sole discretion, negotiate with all technically qualifying Offerors for a revised cost proposal if the cost proposals of all technically qualifying Offerors are in excess of the available funding for this Project.

c. Negotiation with Other Offerors. If DAS decides to negotiate with all the remaining Offerors, or decides that negotiations with the top-ranked Offeror are not satisfactory and negotiates with one or more of the lower-ranking Offerors, DAS will then determine if an adjustment in the ranking of the remaining Offerors is appropriate based on the negotiations. The Contract award, if any, will then be based on the final ranking of Offerors, as adjusted.

    i. Negotiation techniques that reveal one Offeror's price to another or disclose any other material information derived from competing Proposals are prohibited. Any oral modification of a Proposal will be reduced to writing by the Offeror as described below.

d. Post Negotiation. Following negotiations, DAS may set a date and time for the submission of best and final Proposals by the remaining Offeror(s) with which DAS conducted negotiations. If negotiations were limited and all changes were reduced to signed writings during negotiations, DAS need not require the submissions of best and final Proposals.

    i. It is entirely within the discretion of DAS whether to permit negotiations. An Offeror must not submit a Proposal assuming that there will be an opportunity to negotiate any aspect of the Proposal. DAS is free to limit negotiations to particular aspects of any Proposal, to limit the Offerors with whom DAS wants to negotiate, and to dispense with negotiations entirely.

    ii. DAS generally will not rank negotiations. The negotiations will normally be held to correct deficiencies in the preferred Offeror's Proposal. If negotiations fail with the preferred Offeror, DAS may negotiate with the next Offeror in ranking. Alternatively, DAS may decide that it is in the interests of the State to negotiate with all the remaining Offerors to determine if negotiations lead to an adjustment in the ranking of the remaining Offerors.

    iii. From the opening of the Proposals to the award of the Contract, everyone working on behalf of the State to evaluate the Proposals will seek to limit access to information contained in the Proposals solely to those people with a need to know the information. They will also seek to keep this information away from other Offerors, and the evaluation committee will not be allowed to tell one Offeror about the contents of another Offeror's Proposal in order to gain a negotiating advantage.

    iv. Before the award of the Contract or cancellation of the RFP, any Offeror that seeks to gain access to the contents of another Offeror's Proposal may be disqualified from further consideration.

    v. The written changes will be drafted and signed by the Offeror and submitted to DAS within a reasonable period of time. If DAS accepts the change, DAS will give the Offeror written notice of DAS' acceptance. The negotiated changes to the successful offer will become a part of the Contract.

    vi. Failure to Negotiate. If an Offeror fails to provide the necessary information for negotiations in a timely manner, or fails to negotiate in good faith, DAS may terminate negotiations with that Offeror and collect on the Offeror's proposal bond, if a proposal bond was required in order to respond to this RFP.

7. Best and Final Offer. If best and final proposals, or best and final offers (BAFOs), are required, they may be submitted only once; unless DAS makes a determination that it is in the State's interest to conduct additional negotiations.

In such cases, DAS may require another submission of best and final proposals. Otherwise, discussion of or changes in the best and final proposals will not be allowed. If an Offeror does not submit a best and final proposal, the Offeror's previous Proposal will be considered the Offeror's best and final proposal.

8. Determination of Responsibility. DAS may review the highest-ranking Offerors or its key team members to ensure that the Offeror is responsible. The Contract may not be awarded to an Offeror that is determined not to be responsible. DAS' determination of an Offeror's responsibility may include the following factors: the experience of the Offeror and its key team members; past conduct and past performance on previous contracts; ability to execute this contract properly; and management skill. DAS will make such determination of responsibility based on the Offeror's Proposal, reference evaluations, and any other information DAS requests or determines to be relevant.
9. Reference Checks. DAS may conduct reference checks to verify and validate the Offeror's or proposed candidate's past performance. Reference checks indicating poor or failed performance by the Offeror or proposed candidate may be cause for rejection of the proposal. In addition, failure to provide requested reference contact information may result in DAS not including the referenced experience in the evaluation process.
    a. The reference evaluation will measure the criteria contained in this part of the RFP as it relates to the Offeror's previous contract performance including, but not limited, to its performance with other local, state, and federal entities. DAS reserves the right to check references other than those provided in the Offeror's Proposal. DAS may obtain information relevant to criteria in this part of the RFP, which is deemed critical to not only the successful operation and management of the Project, but also the working relationship between the State and the Offeror.
10. Financial Ability. Part of the Proposal evaluation criteria is the qualifications of the Offeror which include, as a component, the Offeror's financial ability to perform the Contract. This RFP expressly requires the submission of the most recent financial statements from all Offerors in the Proposal contents attachment. DAS may insist that an Offeror submit audited financial statements for up to the past three (3) years if DAS is concerned that an Offeror may not have the financial ability to carry out the Contract.

    In evaluating an Offeror's financial ability, the weight DAS assigns, if any, to that financial ability will depend on whether the Offeror's financial position is adequate or inadequate. That is, if the Offeror's financial ability is adequate, the value assigned to the Offeror's relative financial ability in relation to other Offerors may or may not be significant, depending on the nature of the Work. If DAS believes the Offeror's financial ability is not adequate, DAS may reject the Proposal despite its other merits.

DAS will decide which phases are necessary. DAS has the right to eliminate or add phases at any time in the evaluation process.

To maintain fairness in the evaluation process, all information sought by DAS will be obtained in a manner such that no Offeror is provided an unfair competitive advantage.

<u>4.2 MANDATORY PROPOSAL REQUIREMENT.</u> Table 1 contains an item that is considered a minimum mandatory proposal requirement for this RFP.

Determining the Offeror's ability to meet the minimum mandatory proposal requirement is the first step of the DAS evaluation process. The Offeror must demonstrate, to DAS, it meets the minimum mandatory proposal requirement listed in the Mandatory Proposal Requirement section (Table 1). The Offeror's response to the minimum mandatory proposal requirement must be clearly labeled "Mandatory Requirements" and shall be collectively contained in Table 1 of the Offeror's Proposal in the "Cover Letter and Mandatory Requirements" section. (Refer to Attachment One of the RFP document for additional instructions.)

DAS will evaluate Table 1, alone, to determine whether the Proposal meets the minimum mandatory proposal requirement. If the information contained in Table 1 does not clearly meet the minimum mandatory proposal requirement, the Proposal may be disqualified by DAS and DAS may not evaluate any other portion of the Proposal.

TABLE 1 - MANDATORY PROPOSAL REQUIREMENT

Mandatory Requirement
1. Offerors must have a minimum of five (5) years of experience serving the disability community in the past ten (10) years AND five (5) years case management experience managing home and community based services programs in the past ten (10) years. Case management services are comprehensive services comprised of a variety of specific tasks and activities. It is defined in greater detail in Part Six, Scope of Work.

If the State receives no Proposals meeting this minimum mandatory proposal requirement, the State may elect to cancel this RFP.

4.3 PROPOSAL EVALUATION CRITERIA. If the Offeror provides sufficient information to DAS, in Table 1, of its Proposal, demonstrating that it meets the minimum mandatory proposal requirement, the Offeror's Proposal will be included in the next part of the evaluation process which involves the scoring of the Proposal Technical Requirements, followed by the scoring of the Cost Proposals. In the Proposal evaluation phase, DAS rates the Proposals submitted in response to this RFP based on the following listed criteria and the weight assigned to each criterion. The possible points allowed in this RFP are distributed as indicated in the Table 2 - Scoring Breakdown.

TABLE 2 - SCORING BREAKDOWN

Criteria	Maximum Allowable Points
Proposal Technical Requirements	815 Points
Proposal Cost	985 Points
Total	1800 Points

The scale below (0-5) will be used to rate each proposal on the criteria listed in the Technical Proposal Evaluation table.

Does Not Meet	Weak	Weak to Meets	Meets	Meets to Strong	Strong
0 Points	1 Point	2 Points	3 Points	4 Points	5 Points

DAS will score the Proposals by multiplying the score received in each category by its assigned weight and adding all categories together for the Offeror's Total Technical Score in Table 3.

Representative numerical values are defined as follows:
1. Does Not Meet (0 pts.): Response does not comply significantly with requirements or is not provided.
2. Weak (1 pt.): Response was poor related to meeting the requirements.

3. Weak to Meets (2 pts.): Response indicates the requirements will not be completely met or at a level that will be below average.
4. Meets (3 pts.): Response generally meets the requirements.
5. Meets to Strong (4 pts.): Response indicates the requirements will be exceeded.
6. Strong (5 pts.): Response significantly exceeds requirements in ways that provide tangible benefits of at least one enhancing feature.

4.4 INITIAL QUALIFYING CRITERIA.

1. Phase I Review. In order to be fully reviewed and scored, proposals submitted must pass the following Phase I. Review. Any "no" for the listed Phase I. criteria may eliminate a proposal from further consideration.
   a. Was the proposal received by the deadline as specified?
   b. Did the Offeror submit one (1) original technical and cost proposal, completed and signed in blue ink, and eight (8) copies for a total of nine (9) technical and cost proposal packages?
   c. Did the Offeror include all requirements in a cover letter as described in Attachment One (B) (1)?
   d. Did the Offeror include all information required for certification as described in Attachment One (B) (2)?
   e. Did the Offeror include two (2) originally signed, blue ink copies of the included Contract, Attachment Two as described in Attachment One (B) (3)?
   f. Did the Offeror include Attachment Four with a minimum of three (3) references for organizations and/or clients for whom the Offeror has successfully provided services on projects that were similar in their nature, size, and scope to the Work?
   g. Did the Offeror include a statement indicating whether the Offeror or any people that may work on the Project through the Offeror have a possible conflict of interest and, if so, the nature of that conflict as described in Attachment One (B) (10)?
   h. Did the Offeror include a list of assumptions that were made in preparing the proposal as described in Attachment One (B) (11)?
   i. Did the Offeror include proof of insurance as described in General Terms & Conditions (Part Eight)?
   j. Did the Offeror include a letter of commitment from a bonding company that will be equal to at least 3% of the total amount of the Contract?
   k. Did the Offeror include an address to which payments to the Offeror will be sent?
   l. Did the Offeror include Attachment Six, Offeror Performance Form?
   m. Did the Offeror include a completed Federal Form W-9, Request for Taxpayer Identification Number and Certification Form and the Contractor Information Form (OBM-5657) in their entirety?
   n. Did the Offeror include copies of approved Affirmative Action plans or an attestation to the fact that the Offeror has completed the process and is pending approval by the Equal Opportunity Department?
   o. Did the Offeror complete the Contractor/Subcontractor Affirmation and Disclosure form (Attachment Seven)?
   p. Did the Offeror submit the Cost Summary Form (Attachment Eight)?
   q. Did the Offeror submit Attachment Three A with all required information as described in Attachment One (B) (4) (a)?
   r. Did the Offeror submit its most recent financial statements and described their financial stability?
   s. Did the Offeror provide evidence that it has completed an external quality review by an external quality review organization (EQRO).
      If it has not completed this review, Offeror must provide a description of the entity that will conduct this external quality review and when it will take place if contract is awarded. (The cost of this review will not be reimbursed and will be the Offerors responsibility.)

t. Did the Offeror describe any contract termination which occurred before completion of all obligations under the initial contract provisions, for default, non-performance, or any other reason, during the past three (3) years. If no such early terminations have occurred in the past three (3) years, Offeror has declared.
u. Did the Offeror provide a staffing plan that identifies all key staff required to do the Project and their Project responsibilities and an organizational chart. The plan must have a matrix matching each key team member to the staffing requirements in this RFP.

2. Phase II. Technical Proposal Evaluation

TABLE 3 TECHNICAL PROPOSAL SCORE SHEET

ITEM #	ELEMENTS TO BE EVALUATED	Weight	Does Not Meet 0	Weak 1	Weak to Meets 2	Meets 3	Meets to Strong 4	Strong 5
1	The description of the Offeror's current operational capacity of the organization and its ability to absorb the additional workload resulting from this Project.	3						
2	The documentation of previous experience of the Offeror and its expertise described in a minimum of three (3) previous projects, similar in size, scope and complexity, in the previous five (5) years. Details of the similarities are included. Attachments Three B, C, and D are present and completed.	3						
3	Samples of at least three (3) projects or initiatives with individual and advocacy groups and diverse stakeholders the Offeror has completed in the past five years, including a description of its role, responsibilities, and outcomes.	4						
4	Three (3) examples where the Offeror implemented system changes that were directly responsible for improved quality of care for individuals.	4						
5	Evidence of Offeror's capacity to provide a diverse and experienced workforce to meet the needs of all populations served by Office of Medical Assistance-administered HCBS programs, including, but not limited to geriatrics, pediatrics, behavioral health and developmental disabilities.	3						
6	Evidence that Offeror has at least two years experience with federally or state-funded programs in the past five years.	5						
7	At least one example where the Offeror has contained program costs with average expenditures by individual.	3						
8	Evidence that Offeror has at least two years experience in maintaining individual service costs within constraints set by third-party payers.	3						
9	Results of completed individual satisfaction surveys regarding Offeror's case management services within the last two years.	3						
10	Evidence that Offeror has experience encouraging individual self-direction and independent living as part of its case management philosophy.	4						
11	Evidence that Offeror has experience serving as a local community resource. Linkage point to other local resources.	5						

ITEM #	ELEMENTS TO BE EVALUATED	Weight	Does Not Meet 0	Weak 1	Weak to Meets 2	Meets 3	Meets to Strong 4	Strong 5
12	A staffing plan with a contingency plan that shows the Offeror has the ability to add more staff if needed, including its ability to provide qualified replacement staff.	3						
13	Evidence that Offeror has demonstrated that all case managers are either licensed registered nurses (RN) or licensed social workers (LSW, LISW) with one paid year experience in home and community based services.	5						
14	The Offeror's personnel profile summaries demonstrate that all clinical supervisors are either licensed RNs or licensed social workers or licensed independent social workers (LSW, LISW) with five paid years clinical experience in home and community based services.	5						
15	The Offeror's personnel profile summaries demonstrate that one (1) key staff member has at least two years experience with quality improvement systems.	4						
16	The Offeror's personnel profile summaries demonstrate that one (1) key staff member has at least two years experience in accounting or financial analysis.	3						
17	Evidence that Offeror has demonstrated that all program management staff have at least a bachelor's degree in a business or health-related field and at least five years program management or program analysis experience.	3						
18	The Offeror's personnel profile summaries demonstrate that one (1) key staff member has at least five years of management experience in a home and community based services or health-related field.	4						
19	The Offeror's personnel profile summaries demonstrate that one (1) key program management staff member has a master's degree in a business or health-related field with at least eight (8) years of management experience.	3						
20	The Offeror's personnel profile summary demonstrates that it has on staff or subcontracts with one (1) person/organization who can complete accurate job specifications for home and vehicle modifications and who can prepare those specifications to bid. This person/organization must have a minimum of seven (7) years experience of residential architectural or construction experience that includes accessible design and construction.	4						
21	The description of the Offeror's current capacity, approach, methods, and specific work steps for doing the Work on this Project. Refer to Attachment One (B) (8).	5						
22	The description of the Offeror's organizational culture, including its mission and vision statements.	3						
23	The description of Offeror's plan for case manager to individual ratio and how that ratio will be maintained.	4						
24	The description of the Offeror's required amount of face-to-face trainings, meetings, supervisory meetings, and supervisory observation that is beyond what is required in this Contract.	3						

ITEM #	ELEMENTS TO BE EVALUATED	Weight	Does Not Meet 0	Weak 1	Weak to Meets 2	Meets 3	Meets to Strong 4	Strong 5
25	The description of the Offeror's communication plan between the clinical and program areas.	3						
26	The description of the Offeror's philosophy about person-centered planning, dignity of risk, self-determination, independent living and self direction, and how all of these tenets will be translated into its case management practice.	4						
27	The description of the Offeror's practice of crisis management, including at least three examples of past crisis management experiences with individuals.	4						
28	The description of the Offeror's practice of conflict resolution, including at least three examples of past conflict resolution.	4						
29	The description of the Offeror's multidisciplinary team meetings including how it will convene and lead them and engage with acute and long term providers (Medicaid, Medicare, and private insurers), and other case management agencies to assure coordination of services.	4						
30	The description of how the Offeror will do community outreach.	4						
31	The description of how the Offeror will monitor operations to assure quality.	5						
32	The description of how the Offeror's case managers will educate individuals applying for or enrolled on waiver programs about the waiver program and the individual's options.	3						
33	The description of the Offeror's community resource manual and how the Offeror will maintain, update, and make it available to its case management staff.	4						
34	The description of how the Offeror will train new staff and how ongoing training will be performed, including how much class work is required, whether there will be shadowing and observation, and if so, how much. Describe how often case managers will visit home health agencies, adult day care facilities, and communicate with home modification providers.	3						
35	The description of how the Offeror will provide consultation or subject matter expert access to individuals with expertise in the following subject areas: gerontology, pediatrics, developmental disabilities, education, child development, vocational services, substance abuse, behavioral health, transition planning or relocation, and independent living skills.	5						
36	The description of how the Offeror will meet the record keeping policies and procedures for the Work, including if it has experience with electronic health records.	4						

ITEM #	ELEMENTS TO BE EVALUATED	Weight	Does Not Meet 0	Weak 1	Weak to Meets 2	Meets 3	Meets to Strong 4	Strong 5
37	The description of Offeror's plan for assuring health and welfare of individuals. Include in description how the Offeror will assure health and welfare in the event of a disaster.	4						
38	The description of how the Offeror will provide 24 hour coverage, including all after hours protocols.	4						
39	The description of how the Offeror will adapt to changes in federal and state Medicaid laws, rules, and policies.	3						
40	The description of the Offeror's processes and timeframes to successfully transition individuals form one case management organization to another case management organization.	5						
41	The description of the Offeror's processes of transitioning individuals into the community or from waiver program to waiver program.	5						
42	The description of how the Offeror will interface with the statewide Provider Oversight Contractor.	5						

TOTAL TECHNICAL PROPOSAL SCORE

Column Subtotal of "Weak" points	
Column Subtotal of "Weak to Meets" points	
Column Subtotal of "Meets" points	
Column Subtotal of "Meets to Strong" points	
Column Subtotal of "Strong" points	
GRAND TOTAL SCORE:	

Based upon the Grand Total Technical Score earned, does the Offerors proposal proceed to the evaluation of its Cost Proposal? (Offerors Grand Total Technical Score must be at least 740 points.)

Yes _____ No _____ (If "No," Offerors Cost Proposal will not be opened.)
(Is Offeror a non-profit entity? If "yes" add 5 more points before Offeror's Cost Proposal is opened.)

Grand total score + non-profit entity score (5 points) = _____

In this RFP, DAS asks for responses and submissions from Offerors, most of which represent components of the above criteria. While each criterion represents only a part of the total basis for a decision to award the Contract to an Offeror, a failure by an Offeror to make a required submission or meet a minimum mandatory proposal requirement will normally result in a rejection of that Offeror's Proposal. The value assigned above to each criterion is only a value used to determine which Proposal is the most advantageous to the State in relation to the other Proposals that DAS received.

Once the technical merits of a Proposal are evaluated, the costs of that Proposal will be considered. It is within DAS' discretion to wait to factor in a Proposal's cost until after the conclusion of any interviews, presentations, demonstrations or discussions. Also, before evaluating the technical merits of the Proposals, DAS may do an initial review of costs to determine if any Proposals should be rejected because of excessive cost. DAS may reconsider the excessiveness of any Proposal's cost at any time in the evaluation process.

4.5 COST PROPOSAL POINTS. DAS will calculate the Offeror's Cost Proposal points after the Offeror's total technical points are determined, using the following method:

Cost points = (lowest Offeror's cost/Offeror's cost) x Maximum Allowable Cost Points as indicated in the "Scoring Breakdown" table. The value is provided in the Scoring Breakdown table. "Cost" = Total Not to Exceed Cost identified in the Cost Summary section of Offeror's Proposals. In this method, the lowest cost proposed will receive the Maximum Allowable Points.

The number of points assigned to the cost evaluation will be prorated, with the lowest accepted cost proposal given the maximum number of points possible for this criterion. Other acceptable cost proposals will be scored as the ratio of the lowest price proposal to the proposal being scored, multiplied by the maximum number of points possible for this criterion.

An example for calculating cost points, where Maximum Allowable Cost Points Value = 60 points, is the scenario where Offeror X has proposed a cost of $100.00. Offeror Y has proposed a cost of $110.00 and Offeror Z has proposed a cost of $120.00. Offeror X, having the lowest cost, would get the maximum 60 cost points. Offeror Y's cost points would be calculated as $100.00 (Offeror X's cost) divided by $110.00 (Offeror Y's cost) equals 0.909 times 60 maximum points, or a total of 54.5 points. Offeror Z's cost points would be calculated as $100.00 (Offeror X's cost) divided by $120.00 (Offeror Z's cost) equals 0.833 times 60 maximum points, or a total of 50 points.

Cost Score: _____

4.6 FINAL STAGES OF EVALUATION. The Offeror with the highest point total from all phases of the evaluation (Technical Points + Cost Points) will be recommended for the next phase of the evaluation.

Technical Score: _____ + Cost Score: _____ = Total Score: _____

If DAS finds that one or more Proposals should be given further consideration, DAS may select one or more of the highest-ranking Proposals to move to the next phase. DAS may alternatively choose to bypass any or all subsequent phases and make an award based solely on the proposal evaluation phase.

4.7 TIEBREAKER. In the event that two or more of the proposals have a score which is tied after final calculation of both the technical proposal and the cost proposal, the proposal with the higher score in the technical proposal will prevail.

4.8 REJECTION OF PROPOSALS. DAS may reject any Proposal that is not in the required format, does not address the minimum mandatory proposal requirement of this RFP, or that DAS believes is excessive in price or otherwise not in the interests of the State to consider or to accept. In addition, DAS may cancel this RFP, reject all the Proposals, and seek to do the Work through a new RFP or by other means.

PART FIVE: AWARD OF THE CONTRACT

5.1 CONTRACT AWARD. DAS plans to award the Contract based on the schedule in the RFP, if DAS decides the Project is in the best interests of the State and has not changed the award date.

The signature page for the Contract is included as Attachment Four of this RFP. In order for an Offeror's Proposal to remain under active consideration, the Offeror must sign, the two (2) copies enclosed, in blue ink and return the signed Contracts to DAS with its response. Submittal of a signed Contract does not imply that an Offeror will be awarded the Contract. In awarding the Contract, DAS will issue an award letter to the selected Contractor. The Contract will not be binding on DAS until the duly authorized representative of DAS signs both copies and returns one (1) to the Contractor, the Agency issues a purchase order, and notifies the Contractor that work may begin, and all other prerequisites identified in the Contract have occurred. The purchase order is expected to be issued on or about 7/1/13. Any work completed by the Contractor prior to the date of the purchase order shall not be reimbursed by the State.

DAS expects the Contractor to commence work upon receipt of a state issued purchase order. If DAS awards a Contract pursuant to this RFP and the Contractor is unable or unwilling to commence the work, DAS reserves the right to cancel the Contract and return to the original RFP process and evaluate any remaining Offeror Proposals reasonably susceptible of being selected for award of the Contract. The evaluation process will resume with the next highest ranking, viable Proposal.

It is the Office of Medical Assistance' intent to facilitate a successful transition from the existing contract to the new contract, and to equip and support the selected Contractor with the tools, program rules, technical assistance, training, etc., needed for successful contract implementation during the first six months of the Contract. The Office of Medical Assistance will provide a variety of implementation support, including but not limited to: orientation sessions for Contractor management and staff, expectations for transfer of current case records and case consultation, program overview and updates, case management training and tools, user guidance for the Office of Medical Assistance systems, reporting guidelines, billing instructions, current and proposed rules and program requirements and guidelines. The transition and implementation period will begin upon the Contract being awarded, but prior to the expected purchase order date of 7/1/13. To ensure a successful transition, it is crucial that the Contractor fully participates in the transition and training-related activities. In accepting the award of the Contract, the Contractor acknowledges that it will not expect reimbursement for its participation in the transition and training-related activities since such activities may occur prior to the purchase order date, and since the transition is not included within the Scope of Work and Specification of Deliverables. Beyond the initial implementation period, the Office of Medical Assistance staff will be available for as-needed to provide technical assistance and program guidance letters.

5.2 CONTRACT. If this RFP results in a Contract award, the Contract will consist of this RFP including all attachments, written addenda to this RFP, the Contractor's accepted Proposal and written authorized addenda to the Contractor's Proposal. It will also include any materials incorporated by reference in the above documents and any purchase orders and change orders issued under the Contract. The general terms and conditions for the Contract are contained in Attachment Three of this RFP. If there are conflicting provisions between the documents that make up the Contract, the order of precedence for the documents is as follows:

1. This RFP, as amended;
2. The documents and materials incorporated by reference in the RFP;
3. The Offeror's proposal, as amended, clarified, and accepted by DAS; and
4. The documents and materials incorporated by reference in the Offeror's Proposal.

Notwithstanding the order listed above, change orders and amendments issued after the Contract is executed may expressly change the provisions of the Contract. If they do so expressly, then the most recent of them will take precedence over anything else that is part of the Contract.

PART SIX: SCOPE OF WORK AND SPECIFICATION OF DELIVERABLES

This part describes the Project and what the Contractor must do to complete the Project satisfactorily. It also describes what the Contractor must deliver as part of the completed Project (the “Work” and "Deliverables"). The Contractor must meet all RFP requirements and perform the Scope of Work and Specification of Deliverables.

The role of the Contractor is to assist in the implementation and management of the Office of Medical Assistance-administered Home and Community Based Service programs and communicate directly with individuals at the local level. *Case management services* means services that assist individuals in gaining access to needed waiver program and other services, regardless of the funding sources for the services to which the access is gained. These services include, but are not limited to:

1. Evaluation and/or reevaluation of level of care.
2. Assessment and/or reassessment of the need for waiver program services.
3. Development and/or review of the service plan and determination of service costs.
4. Coordination of multiple services and/or multiple providers.
5. Monitoring the implementation of the service plan and individual health and welfare.
6. Addressing problems in service provision.
7. Responding to and addressing individual crisis situations & reportable incidents.

The Scope of Work includes case management functions and program management functions, as well as interfacing with the statewide Provider Oversight Contractor. The requirements of this section apply to all staff that will be performing the Scope of Work, including subcontractors. The Scope of Work must be conducted in accordance with all federal and state laws, federal and state Medicaid program requirements, and other requirements as required by the Agency.

6.1 CASE MANAGEMENT FUNCTIONS.

6.1.1 INTAKE & INFORMATION AND REFERRAL. Requests for, and inquiries about, Medicaid home health programs will be received from many sources, (*e.g.,* home health agencies, individuals, and discharge planners). The Contractor is responsible for referring inquiries appropriately (*e.g.,* to county departments of job and family services, county boards of development disability, local children’s services agencies, area agencies on aging, or adult protective services agencies) to assist individuals in obtaining the services they need. Contractor intake staff must be capable by education and experience to engage in health and social problem-solving for all populations, including providing general information about program goals, objectives, and eligibility criteria. Contractor intake staff is responsible for referring applicants to other community resources or scheduling face-to-face assessments according to the Office of Medical Assistance clinical standards.

Initial application for Office of Medical Assistance-administered waiver program enrollment is made through county departments of job and family services (CDJFS). After the Contractor is notified that a waiver program application has been filed, the Contractor will make initial contact with the applicant to determine if they wish to continue the waiver program application process. If the applicant wishes to continue, the Contractor will contact the waiver program applicant to schedule a face-to-face interview with the applicant and any other parties that the individual requests to be present, in accordance with state program rules. The Office of Medical Assistance may establish a waiting list process for applicants, when necessary. The Contractor will adhere to the waiting list process when in effect at the direction of the Office of Medical Assistance.

Program applicants must be contacted by phone within two business days of the Contractor's receipt of a waiver program application. If contact cannot be made within two business days due to extenuating circumstances (*e.g.,* incorrect phone numbers, disconnection of telephones, person's absence from the home), the Contractor must document the reason and alternative means used to establish contact (*e.g.,* contacting the County Department Job & Family Services (CDJFS) worker/discharge planner/Client Registry Information System-Enhanced (CRIS-E) authorized representative, sending a letter to the applicant, having a case manager visit the address). For more information and requirements on intake and information and referral, please refer to Attachment Ten - Case Management Guide.

6.1.2 PROGRAM ELIGIBILITY. The Contractor will document assessment information and program eligibility on the applicable the Office of Medical Assistance-approved assessment tool. The Contractor will inform the applicants/individuals of their appeal rights in accordance with state program rules. Prior to the applicant's program enrollment, the Contractor shall obtain the written physician approval that the individual meets the level of care. The Contractor shall obtain the individual's or individual representative's signature on the All Services Plan. The Contractor shall notify the applicant of program eligibility or ineligibility and due process rights.

The Contractor shall complete annual assessment within 365 days of the previous face-to-face assessment. Once an annual assessment has been completed and if the individual's level of care has changed, the Contractor must obtain the physician's written approval that the individual meets the new level of care. For more information and requirements on program eligibility, please refer to Attachment Ten - Case Management Guide.

6.1.3 ASSESSMENT. An assessment is the process of evaluating the waiver program applicant/individual's functional abilities, cognitive capacity, and social and psychological statuses, as well as his/her overall limitations, needs, strengths, and resources. A registered nurse (RN) or licensed social worker (LSW) or licensed independent social worker (LISW) will perform the face-to-face assessment at the applicant's/individual's place of residence or in another setting, as appropriate.

A face-to-face assessment using the Office of Medical Assistance-approved assessment tool must be completed within ten (10) business days following the Contractor's initial contact determining the need for a face-to-face interview or within the timeframe needed to accommodate the applicant's schedule. If the face-to-face assessment is not completed within ten (10) business days of the initial contact, the Contractor must fully document the reason(s) for the delay. Documentation must demonstrate that the delay is the result of individual's preferences or individual request. Contractor staffing or administrative issues are not acceptable reasons for delay.

When necessary and at least annually, the RN, LSW or LISW will conduct a face-to-face assessment with each individual to ensure continued program eligibility. An adverse level of care recommendation made by an LSW/LISW will require a follow-up face-to-face visit by an RN. Any significant change of the individual will require an event-based face-to-face assessment visit conducted within three calendar days of discovery. Contact with individual must be made within 24 hours of discovery. For more information on assessments, please refer to Attachment Ten - Case Management Guide.

Waiver program service delivery must be started within thirty (30) calendar days of the initial face-to-face assessment, and if that does not happen, an updated face-to-face assessment must be completed to ensure eligibility. For more information and requirements on assessments, please refer to Attachment Ten - Case Management Guide.

In special circumstances, waiver assessments that are requested by the Office of Medical Assistance may need to be completed on short notice and the Contractor must be able to complete such short notice assessments as needed.

6.1.4 ACUITY LEVEL. Each individual, regardless of the Office of Medical Assistance-administered waiver program on which they are enrolled, will be assigned an acuity level based on the Office of Medical Assistance -approved individual acuity level tool. All individual acuity levels are to be assigned by the Contractor Clinical Supervisor.

The Contractor will be responsible for assigning acuity levels for every new individual within six months of being enrolled on any the Office of Medical Assistance-administered waiver program using the Office of Medical Assistance individual acuity level tool. The acuity level tool is used to identify individual needs taking several issues into consideration, such as: medical complexity, mental health concerns, active or recent history of alcohol or other substance abuse or addiction, limited natural supports, cognitive impairments, multiple hospitalizations, and history of multiple provider changes. For more information and requirements on acuity, please refer to Attachment Ten - Case Management Guide.

6.1.5 INDIVIDUAL CONTACT SCHEDULE. An individual contact is defined as a telephone call or an e-mail exchange with individual or authorized representative. For more information and requirements on contacts, please refer to Attachment Ten - Case Management Guide. The following individual contact and visit schedule must be maintained for the first six months of enrollment for both Level One acuity and Level Two acuity individuals:

Length of Individual Enrollment	Frequency of Individual Contact	Timing of In-Person Visit
First Month	Minimum of 2 contacts with no more than 14 calendar days between contacts.	Within 20 calendar days following the Effective Date of waiver program.
Months 2-3	Monthly contact	Monthly, maximum of 30 calendar days between visits.
Months 4-6	Monthly contact	Minimum of 2 visits, maximum of 45 calendar days between visits.
Significant Event	Within 24 hours of event discovery.	A face-to-face event-based assessment* will be conducted no later than the end of the third full business day following event discovery. If the case manager decides to move the annual reassessment date due to the significant event, the case manager will complete a full assessment and level of care as required.

*NOTE that event-based assessments are not to be billed as assessments, as these assessments are considered ongoing case management of the individual.

6.1.6 LEVEL ONE ACUITY CASE MANAGEMENT. Level One Acuity Case Management is provided to individuals with chronic long-term illnesses, whose conditions are considered medically stable and who are able to demonstrate their ability to safely direct their own care in accordance with state program rules. Level One Acuity Case Management will be provided to individuals who are able to safely direct their own care or live with family or friends who are able to direct their care. Each Level One Acuity individual must have been enrolled on the waiver program for more than six months. The case manager to individual ratio must not exceed one (1) case manager per 60 individuals.

The following individual contact and visit schedule must be maintained:

Length of Individual Enrollment	Frequency of Individual Contact	Timing of In-Person Visit
6 + Months	Maximum of 90 calendar days between contacts.	Maximum of 180 calendar days between visits.

6.1.7 LEVEL TWO ACUITY CASE MANAGEMENT. Level Two Acuity Case Management is provided to individuals with complex or unstable medical and/or social needs who require frequent case management intervention, education, and support and/or are unable to demonstrate their ability to safely direct their own care in accordance with state program rules. Level Two Acuity Case Management will be provided to individuals who live alone; live with a paid provider; do not attend a day program, school, or do not work; receive services only from family members; have a Acknowledgement of Responsibility Agreement (ARA) in effect; or have been without services, for any reason, for more than 30 days. The case manager to individual ratio must not exceed one (1) case manager per 45 individuals. An individual contact is defined as a telephone call or an e-mail exchange with the individual or authorized representative. The following individual contact and visit schedule must be maintained:

Length of Individual Enrollment	Frequency of Individual Contact	Timing of In-Person Visit
6 + Months	Maximum of 30 calendar days between contacts.	Minimum of 3 visits in 6 months, maximum of 60 calendar days between visits.

6.1.8 CASE MANAGER TO INDIVIDUAL RATIOS. There will be varying numbers of individuals in each waiver program and at various levels of case management acuity. To meet the case manager to individual ratio, the Contractor shall use the following point system: Level One acuity individual's ratio must not exceed 1-60 or 1.66 points each, Level Two acuity individual's ratio and all new individual's acuity ratio must not exceed 1-45 or 2.22 points each. This point system will allow the Contractor case managers to have a mix of waiver program individuals.

6.1.9 MANAGING AND MONITORING DAILY CASE MANAGEMENT AND CARE COORDINATION ACTIVITIES. The Contractor will manage the day-to-day operations of all case management and care coordination activities including, but not limited to: continued individual eligibility, case consultation, supervision, staff utilization, training, conducting chart audits, and other individual-related functions and deliverables outlined in this RFP and in accordance with federal and state program requirements. The Contractor must be a source of support for individuals. Case manager job descriptions must be clear, and evaluation and accountability must be a part of the Contractor's monitoring of its case managers. The ratio of case manager to clinical supervisor must be 12:1. Clinical supervisors will hold in-person team meetings with their case managers at least monthly. Clinical supervisors must also hold one-on-one monthly supervision meetings with case managers. For more information and requirements, please refer to Attachment Ten - Case Management Guide.

6.1.10 SERVICE PLANNING AND CARE COORDINATION. Service planning and care coordination are ongoing functions needed to address changing circumstances and/or medical conditions of the individual over time. Waiver program service delivery must be started within thirty calendar days of the initial face-to-face assessment, and if that does not happen, an updated face-to-face assessment must be completed to ensure eligibility.

Through the use of an interdisciplinary team process, the Contractor must develop a comprehensive and individual-centered service plan. The Contractor is responsible for contacting all persons requested by individual and/or all persons who are currently involved in individual's care to participate in scheduled meetings. The Contractor must seek input from all members of the individual's interdisciplinary team to identify and coordinate the community resources for the individual. The Contractor is also responsible for disseminating information and service plan updates, maintaining documentation, mediating in the event of disagreement among team members, etc. The Contractor is responsible for gathering and maintaining all documentation related to the individual's identified needs which support the services authorized on the Office of Medical Assistance All Services Plan. The Office of Medical Assistance All Services Plan must include the individual's goals and objectives.

The Contractor is responsible for the ongoing coordination of all Medicaid and non-Medicaid home and community-based services that an individual receives. Contractor must assure that only eligible Medicaid service providers are added to the All Services Plan. If a provider is no longer eligible to participate in the Medicaid program, then the provider must be removed from the All Services Plan. All services recommended by the individual's team and authorized by the Contractor must contribute to the overall goal of preventing institutionalization, in accordance with state and federal program requirements defined in the Ohio Administrative Code (http://codes.ohio.gov/oac). For more information and requirements on service planning and care coordination, please refer to Attachment Ten - Case Management Guide.

6.1.11 ONGOING MONITORING OF SERVICES AND OUTCOMES. One of the Contractor's primary responsibilities is providing ongoing monitoring of the appropriateness of service delivery and the outcomes identified in the service plan. During all contacts and home visits, the Contractor is responsible for evaluating the health and safety of the individual, reviewing any changes in condition with the individual, reviewing any recent incidents or occurrences, reviewing the current service plan including behavioral plans and whether either need revised or updated, reviewing availability of family supports or free services, and reviewing provider documentation and discussing satisfaction with services and providers with the individual. For more information and requirements on ongoing monitoring, please refer to Attachment Ten - Case Management Guide.

The Contractor must take immediate actions to ensure the individual's health and welfare. The Contractor must make all appropriate referrals to regulatory and protective agencies. The Contractor must develop the service plan for individual and monitor service implementation and quality. The Contractor staff must successfully complete training on incidents and the internal policy and procedures for reporting incidents. New staff must successfully complete training within 60 days of initial employment. Documented evidence of the completion of this training must be made available to the Office of Medical Assistance upon request.

6.1.12 INDIVIDUAL COST CAP FOR OHIO HOME CARE WAIVER PROGRAM AND TRANSITIONS II AGING CARVE-OUT WAIVER PROGRAM INDIVIDUALS. For individuals enrolled on the Ohio Home Care waiver program or Transitions II Aging Carve-Out waiver programs, the Contractor will enter one Service Utilization Cap span when consecutive monthly cost of services are in the same funding range. A single-month span entry is needed for monthly cost of services that are not in the same cost range as the previous or following month. The individual cost cap is the monthly cost up to the maximum authorized amount in the month to the nearest $1000.00. The cap shall be entered for a range of time until the amount increases or decreases over/under the next $1000.00, at which time a new authorized amount shall be entered. The Contractor shall comply with rules 5101:3-46-05 and 5101:3-50-05 of the Ohio Administrative Code.

The all services plan must provide the applicant or individual with the minimum amount of medically necessary services that ensure the applicant or individual's health and welfare. If the cost of services on the all services plan is at or below the highest point of the applicant's or individual's cost cap, the applicant or individual will accept or reject the all services plan.

If the applicant or individual does not accept the all services plan, or if the cost of services on the all services plan is greater than the applicant's or individual's cost cap, the Contractor and the Office of Medical Assistance will follow the prior authorization process. The Contractor must adhere to the prior authorization process described in Attachment Ten - Case Management Guide.

6.1.13 DISASTER PLANNING. The Contractor must assure every individual has a comprehensive disaster plan in place to assure their health and welfare. The plan must include how the Contractor will identify those individuals who will be most at risk for harm, loss, or injury during any potential natural, technological, or man-made disaster. The plan must also describe how and when it will be implemented.

The Contractor must develop and implement an Office of Medical Assistance approved Emergency Response Plan for natural disasters and other public emergencies (*e.g.,* floods, extreme heat, extreme cold, etc.). Coordination with other appropriate systems is recommended (*e.g.,* American Red Cross, Area Agencies on Aging, etc.). The Contractor will report immediately to the Office of Medical Assistance when the Emergency Response Plan has been activated.

6.1.14 PRIOR AUTHORIZATION. Prior authorization is a process for authorizing increases in waiver program services. This process will be used whenever an individual and/or case manager determines an increase in services is needed. This is a two-tier process, with both the Contractor and the Office of Medical Assistance having a role in the process. The Contractor will have the ability to approve increases up to a specified threshold and all other increases will be subject to the Office of Medical Assistance approval. The Contractor will refer to Attachment Ten - Case Management Guide for details and requirements of the process.

6.1.15 EVALUATIONS FOR INCREASED STATE PLAN HOME HEALTH SERVICES FOR CHILDREN (HEALTHCHEK). The Contractor will, when requested, evaluate any referred non-waiver individual to determine if that individual meets the criteria for the requested increased state plan home health services per rule 5101:3-12-01. If the individual meets the criteria, the Contractor will complete the required documentation. For individuals receiving the Office of Medical Assistance-administered waiver program services case managed by the Contractor, the Contractor will ensure the individual meets the criteria defined in rule 5101:3-12-01. The Contractor will also appropriately reflect this information in the service authorization section of the all services plan.

6.1.16 ALERTS PROCESS. In addition to reporting incidents to the statewide provider oversight Contractor, the Contractor is required to report critical incidents to the Bureau of Long-Term Services & Supports. The Contractor will notify the Bureau of Long-Term Services & Supports Protection from Harm Manager and the provider oversight Contractor Incident Management and Investigation Response System (IMIRS) Coordinator within one business day of the incident submission. The Contractor must take immediate action to assure the individual's health and welfare and develop and implement a prevention plan for the individual after reporting any incident. Critical incidents are defined in Attachment Ten - Case Management Guide.

6.1.17 MEDICATION MONITORING. The Contractor shall closely monitor a waiver program individuals' usage of medications in order to discover when an individual may be using medications at a frequency or in an amount that exceeds medical necessity or is less or at a frequency not prescribed. The Contractor must refer any waiver program individual suspected of prescription drug abuse or misuse to the coordinated services program described in Ohio Administrative Code rule 5101:3-20-01.

6.1.18 PARTICIPATING IN THE STATE HEARINGS PROCESS. Individuals have the right to appeal any decision regarding their Medicaid benefits, as specified in Ohio Administrative Code Chapter 5101:6-2 (http://codes.ohio.gov/oac). The Contractor will participate in the hearings process by preparing appeal summaries, providing supporting documentation, and offering testimony supporting proposed actions.

The Contractor must provide appeal summaries and supporting documentation to the hearing officer and individual/authorized representative prior to a state hearing. The Contractor will lead hearings related to home modifications, service denials, and service increases and decreases that are not prior authorized by the Office of Medical Assistance. State hearings are conducted by the Office of Medical Assistance hearing officers. During calendar year 2011, the Office of Medical Assistance and its contracted designee participated in an average of 50 hearings per month. The Office of Medical Assistance will lead all hearings related to disenrollment or waiver program denials. For more information and requirements on hearings, please refer to Attachment Ten - Case Management Guide.

6.1.19 TRANSITION PLANNING. The Contractor is responsible for coordinating services for individuals transferring from the Office of Medical Assistance-administered waivers/programs to another waiver/program, being disenrolled from an Office of Medical Assistance-administered program, relocating from one region to another, transitioning to another case management entity, transitioning between day programs, being temporarily institutionalized, etc. This includes notifying all interdisciplinary team members, providing documentation, and maintaining contact with other case managers, etc. in accordance with state program rules and requirements. For more information and requirements on transition planning, please refer to Attachment Ten - Case Management Guide.

6.1.20 INITIAL CASELOAD ASSIGNMENT; OPEN ENROLLMENT; TRANSFER OF INDIVIDUALS TO ANOTHER CONTRACTOR. Initially, each Contractor in each region will be assigned a reasonably equal share of the caseload in the region. Individuals new to the program in a region will be assigned equitably between the Contractors in that region. After initial assignments, there is no guaranteed caseload. Individuals may choose to move to a different Contractor in their region pursuant to criteria to be established by the Office of Medical Assistance, and there also may be an open enrollment period during which individuals may choose to move to a different Contractor in their region. A Contractor may not refuse any assigned or reassigned individual. The Contractor is responsible for coordinating with the other Contractor when an individual requests to transfer to another Contractor, whether that request is made during an open enrollment period or pursuant to criteria to be established by the Office of Medical Assistance. The Contractor must assure that services for individuals remain in place and that all data and documentation related to that individual is up-to-date electronically. This electronic update of data and documentation must take place within five business days of receiving notification from the Office of Medical Assistance that the individual requested reassignment to another Contractor. The Contractor must also notify all interdisciplinary team members, provide documentation, and maintain contact with other case managers, etc. in accordance with state program rules and requirements.

6.1.21 INDIVIDUAL AND CAREGIVER EDUCATION AND SUPPORT. The Contractor will interact with individuals in a positive and proactive manner, uphold individual rights, and educate individuals (and their families/caregivers) about the Office of Medical Assistance-administered Home and Community Based Service waiver programs and program requirements. For more information and requirements, please refer to Attachment Ten - Case Management Guide. The Contractor's obligations regarding support to individuals includes, but is not limited to:

1. Using person-centered language in all communication.
2. Adapting communication methods to meet the needs of individuals, *e.g.,* individuals who are visually impaired or hearing impaired and individuals who have limited English proficiency. Interpreters must be used when communicating with individuals with limited English proficiency.
3. Ensuring that all individuals are informed of their rights, including, but not limited to, an Office of Medical Assistance-developed Home and Community Based Service Program Bill of Rights and the right to file a complaint (following federal requirements defined in 42 Code of Federal Regulations (CFR) 484.10 (http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR).

4. Making one centralized toll-free live, on-call service available in the region in which the Contractor is selected to operate for all individuals, 24-hours/day, 7-days/week, and 365-days/year. The live on-call service must allow individuals to speak to a live person rather than a recorded message and provide a method for individuals to contact clinical staff who will assist with service-related issues.
5. Providing an Office of Medical Assistance individual handbook to all individuals. The handbook will contain procedures such as the functions and responsibilities of the Contractor and key clinical personnel, information about the live on-call services, how to file complaints (see more on this below), how to report incidents, how to access their records, HIPAA Privacy requirements, and what to do in an emergency (*e.g.,* when an aide does not show up for their work shift). The Contractor, at enrollment and annually, must provide and review the information within the handbook with the individual.
6. Individuals need to know who to file a complaint with when they are not satisfied with case management services. Individuals and families need to know who to contact, the complaint process, what to expect, and how to appeal decisions.
   The complaint process must be stated clearly with timelines so individuals know when they can expect responses, and contact information must be provided (phone numbers and email addresses). When individuals need answers, the process must be clear and timely. The Contractor will refer to Attachment Ten - Case Management Guide for details of the complaint process.
7. Providing an up-to-date community resource manual to all case management staff and individuals to access information about agencies and resources, other than Medicaid home care providers, in accordance with state program requirements and rules. Community resource manuals must be customized to each community and must be accessible at all times to all case managers. Community resource manuals must include, at minimum: resource name, services provided, address, contact numbers, funding source, and any applicable eligibility criteria. At a minimum, community resource manuals must be available in paper format and accessible through the Contractor's website.
8. Making available the up-to-date Medicaid home care provider directory that will be provided by the Provider Oversight Contractor to the Case Management Contractor. Provider directories will be customized to each community and must be accessible at all times to all individuals. Provider directories will include, at minimum: provider name, home care services provided, address, contact numbers, Medicaid provider number, and type of provider. At a minimum, provider directories must be available to individuals in paper format and accessible through the Contractor's website.

6.1.22 TRAINING. During the transition period for the new Contractor, orientation training and training materials shall be provided to all staff by the Office of Medical Assistance. The specific training curriculum for case management training and for staff performing clinical functions shall include, but not be limited to, training on the following subjects:

1. Federal and state laws and program requirements.
2. Initial contact and information and referral.
3. Assessment.
4. Eligibility.
5. Enrollment.
6. Level of care.
7. Care planning (goals, objectives, outcomes, and service planning).
8. Use of person-centered language in all communication.
9. Community resources and referrals.
10. Due process.
11. Service specifications, including process for requesting home and vehicle modifications and adaptive and assistive equipment.
12. Incidents.
13. Provider enrollment.
14. Provider monitoring.

15. Abuse, neglect, and exploitation, and all other incident reporting.
16. Cultural competency/diversity training – region specific regarding the culture/diversity in that region.
17. Medication management.
18. Risk and safety planning – identifying individual risks and the modifications or equipment necessary to maintain an individual in the home.
19. Individualized service planning and self-direction.
20. Restraints, seclusion, and restrictive interventions.
21. Community resources – an overview of at least one other service delivery system, how to access the services and what is available, such as, Developmental Disabilities, Mental Health, Aging, Health, etc.

After the transition period, the Contractor shall perform all staff orientation training on all of the above topics that were addressed by the Office of Medical Assistance during the transition period.
New staff shall successfully complete orientation training within 60 days of initial employment. In addition, the Contractor is required to provide annual training to all staff that includes the following topics:

1. Abuse, neglect, and exploitation, and all other incident reporting.
2. Cultural competency/diversity training – region specific regarding the culture/diversity in that region
3. Medication management.
4. Level of care.
5. Provider service specifications, including process for requesting home and vehicle modifications and adaptive and assistive equipment.
6. Risk and safety planning – identifying individual risks and the modifications or equipment necessary to maintain an individual in the home.
7. Individualized service planning and self-direction.
8. Restraints, seclusion, and restrictive interventions.
9. Community resources – an overview of at least one other service delivery system, how to access the services and what is available, such as, Developmental Disabilities, Mental Health, Aging, Health, etc.
10. HIPAA.
11. Customer service.

The Contractor shall document the completion of orientation and annual training, and shall make the documentation available to the Office of Medical Assistance upon request.

6.1.23 PROVIDING SPECIALIZED CLINICAL CONSULTATION TO CASE MANAGEMENT STAFF. The Contractor must provide and ensure that specialized clinical expertise is available to Contractor case management staff. The Contractor will identify a consultant or a subject matter expert in each of the following areas (one person may have more than one area of expertise). The required areas of expertise include: gerontology, pediatrics, developmental disabilities, education, child development, vocational services, substance abuse, behavioral health, transition planning or relocation, and independent living skills.

6.1.24 HOME AND VEHICLE MODIFICATIONS & ADAPTIVE/ASSISTIVE EQUIPMENT. The Contractor must have staff or subcontract with a person/organization who can complete accurate job specifications for home and vehicle modifications and who can prepare those specifications to bid. (Refer to 6.2.5 for further information on the requirements for this person/organization.)
The Contractor must also have staff or subcontract with a person/organization that is either a physical therapist or occupational therapist. The Contractor will refer to Attachment Ten - Case Management Guide for details of the process.

6.2 CONTRACT MANAGEMENT REQUIREMENTS.

6.2.1 ASSURING ALL ASPECTS OF THE CONTRACT ARE MET. As a designee of the Office of Medical Assistance, the Contractor, including its employees and subcontractors, shall comply with and ensure that all Contractor employees and subcontractors comply with the Contract terms and requirements.

6.2.2 COMPLYING WITH PROGRAM REQUIREMENTS, PROVIDER OVERSIGHT GUIDE, QUALITY MANAGEMENT PLAN, RULES, AND REGULATIONS. As a designee of the Office of Medical Assistance, the Contractor, including its employees and subcontractors, shall comply with state and federal program requirements, rules, and regulations (*e.g.,* Code of Federal Regulations, Ohio Revised Code, Ohio Administrative Code and approved Waivers). Changes and modifications to state and federal program requirements, regulations, the Case Management Guide, and the Quality Management Plan are to be expected during the course of this Contract and Contractor employees and subcontractors shall comply with such changes and modifications. If discrepancies exist between proposed rules and approved rules, final approved rules will always supersede. Notices of proposed rules will be forwarded to the Contractor.

6.2.3 IMPLEMENTING AND MANAGING STATEWIDE PROGRAM POLICIES, PROCEDURES, AND PROTOCOLS ALIGNED WITH FEDERAL AND STATE REQUIREMENTS. The Contractor shall provide Contractor employees and subcontractors with its policies, procedures, and protocols that support federal and state program and contractual requirements, rules, and regulations. The Contractor shall implement new and modified policies, procedures, and protocols in a timely manner, but no later than fifteen calendar days after notification by the Office of Medical Assistance of federal and state requirement changes. The Contractor shall routinely maintain and monitor its policies, procedures, and protocols.

6.2.4 ASSURING ACCESS TO CONTRACTOR MANAGEMENT STAFF. The Contractor must provide one centralized twenty-four hour, seven days a week, 365 days a year (24/7/365), toll-free live on-call services, available in the region for individuals, providers, state staff, federal staff, etc. to access Contractor management staff when program issues develop (*e.g.,* issues about efficient delivery of services, responsiveness to individuals, media situations). Access to Contractor management staff must be available twenty-four- hours a day, seven-days a week, and 365-days a year.

6.2.5 HIRING AND MAINTAINING QUALIFIED STAFF. For the purpose of performing the scope of work, the Contractor shall maintain staff that meets the following criteria, at a minimum:

Case Managers must be either licensed Registered Nurses (RN) who possess a current, valid and unrestricted license with the Ohio Board of Nursing with one year paid clinical experience in Home and Community Based Service, or licensed social workers (LSW) or licensed independent social workers (LISW) who hold a current, valid and unrestricted license to practice issued by the Counselor, Social Worker, & Marriage & Family Therapist Board in the State of Ohio, with one year paid clinical experience in Home and Community Based Service.

Clinical Supervisors must be either a licensed RN as defined by the Ohio Board of Nursing with five years' paid clinical experience in Home and Community Based Service, or licensed Social Workers (LSW), licensed independent social workers (LISW) who hold a current, valid and unrestricted license to practice issued by the Counselor, Social Worker, & Marriage & Family Therapist Board in the State of Ohio, with five years' paid clinical experience in Home and Community Based Service.

All program staff members must have at least a bachelor's degree in a business or health-related field and at least five years' home and community based service program management or home and community based service program analysis experience.

In addition, program management staff shall include the following: one staff member with a master's degree in a business or health-related field with at least eight years of management experience; one staff member with at least five years of management experience in HCBS or a health-related field; one staff member with at least two years' experience with quality improvement systems; and one staff member with at least two years' experience in accounting or financial analysis.

The Contractor must have staff or subcontract with a person/organization who can complete accurate job specifications for home and vehicle modifications and who can prepare those specifications to bid. This person/organization must have a minimum of seven (7) years experience of residential architectural or construction experience that includes accessible design and construction.

All employees of and applicants for employment with the Contractor, or its subcontractors, who have or may have face-to-face contact with or enter the homes of individuals must complete criminal background record checks and except as set forth below, such employees and applicants are subject to the same procedures and requirements as are the employees and applicants for employment with home health waiver program agencies as described in, and in accordance with, Ohio Revised Code 109.572, Ohio Revised Code 5111.033, and Ohio Administrative Code Rule 5101:3-45-07. (http://codes.ohio.gov/) Results of these checks must be kept in a separate, secure file maintained by the Contractor with restricted access by general personnel. Records of staff qualifications must be kept on file by the Contractor and must be maintained in accordance with specific licensure requirements.

The quality of the credentials of the key people (i.e., managers and supervisors) the Contractor identifies in its proposal to do the work is a material factor in the State's decision to enter into this Contract. Should the Contractor remove from the work any of the key people submitted in this proposal, or if a key person is unable to maintain employment with the Contractor, the Contractor shall notify the Office of Medical Assistance and replace these employees with individuals who have the required qualifications per the RFP.

6.2.6 CUSTOMER SERVICE. Customer service must be fundamental to all of the case management activities outlined in this RFP. Consistent service from case managers across regions along with a healthy customer service attitude is expected. The Contractor must always aspire to customer satisfaction – that is, the sense that individuals' expectations of the waiver programs have been met. The perceived success of every interaction with individuals, providers, family, and stakeholders are dependent on the Contractor staff. Customer service must be included as part of an overall approach to systematic improvement. A customer service experience can change the entire perception an individual has of the Contractor and therefore the Office of Medical Assistance-administered waiver programs.

6.2.7 COMPLAINT PROCESS. The Contractor shall set up a complaint process pursuant to the criteria set forth in Attachment Ten – Case Management Guide. The Contractor shall use a shared web-based OMA-approved complaint system. As part of the complaint process, the Contractor shall respond to questions, problems, or complaints from individuals, providers, nurses, family members, friends, or advocates concerning community long term care services by identifying, investigating, substantiating and working to resolve the issue that prompted the complaint. The Contractor shall respond to complaints in accordance with the timeframes in Attachment Ten – Case Management Guide.

6.2.8 CONTRACTOR'S STAFF AND SUBCONTRACTOR'S STAFF DEVELOPMENT TRAINING. Development activities (*e.g.,* training, workshops, conferences, peer mentoring, etc.) shall be routinely offered and/or coordinated by the Contractor at least quarterly for all Contractor staff and subcontractor staff as part of ongoing performance goals. The Contractor staff shall participate in Office of Medical Assistance-sponsored training seminars and information sessions.

Training seminars and information sessions may be conducted in Columbus, Ohio for all Contractor staff (generally two to four hours in duration) on an as needed basis to resolve contract issues, but no more than quarterly. All costs (*e.g.,* travel, phone) associated with these activities are the responsibility of the Contractor. Following initiation of the contract, all Contractor staff shall attend orientation sessions if offered by the Office of Medical Assistance.

6.2.9 CONTRACTOR'S MANAGEMENT STAFF MEETINGS WITH THE OFFICE OF MEDICAL ASSISTANCE. Contractor's management staff shall participate in a staff meeting with the management of the Office of Medical Assistance at least every other month at the Office of Medical Assistance location. These management meetings are generally two hours in duration, and will be conducted at the discretion of the Office of Medical Assistance either in-person or via conference call. All costs (*e.g.,* travel, phone) associated with these activities are the responsibility of the Contractor. More frequent meetings and/or conference calls may be conducted in the first six months of the Contract or when needed to resolve contract or regional issues.

6.2.10 COMMUNITY EDUCATION. The Contractor must proactively identify opportunities for community education and collaborate with other home and community-based stakeholders as needed. The Contractor must be a member of the Aging, Disability & Resource Network. The Contractor will respond to community organizations (*e.g.*, area agencies on aging, Alcohol, Drug, Addiction, and Mental Health (ADAMH) boards, county boards of Developmental Disabilities, county job and family services agencies, individual advocacy groups, etc.) seeking technical assistance and/or education about Office of Medical Assistance-administered Home and Community Based Service waiver programs. However, pre-approval by the Office of Medical Assistance must be obtained prior to Contractor giving the technical assistance or education.

The Contractor must use a variety of media to perform this education function (*e.g.,* newsletters, public announcements, community forums, and agency-specific training sessions). All materials developed and activities conducted must be made accessible to persons with special needs (*e.g.,* individuals who are visually impaired or hearing impaired, individuals who have limited English proficiency) and must incorporate person-centered language. Any materials given to individuals or providers must be pre-approved by the Office of Medical Assistance.

6.2.11 FORMS MANAGEMENT. The Contractor shall use Office of Medical Assistance-approved forms. If other forms are needed for operational purposes, all forms must be pre-approved by the Office of Medical Assistance. If changes need to be made to Office of Medical Assistance forms, those changes must be made by the Office of Medical Assistance. If changes to other forms are needed, the Contractor shall get pre-approval by the Office of Medical Assistance. Any communication or tracking mechanism, including but not limited to forms, reports, and letters to individuals, providers, or other stakeholders, which are created by the Contractor to support program policies, procedures, and protocols, shall be reviewed and prior-approved by the Office of Medical Assistance staff before implementation. Communication and tracking mechanisms identified by the Office of Medical Assistance as inconsistent with State program and contractual requirements, guidelines, rules, or regulations may require changes before implementation or, if already implemented, modified to address any inconsistencies.

6.2.12 USING TECHNOLOGY WHEN COMMUNICATING WITH STAKEHOLDERS. In addition to paper-based methods of communication, the Contractor shall use technology in communicating with individuals and other stakeholders. At a minimum, the Contractor shall use secure electronic-mail and maintain an up-to-date website which includes program information, organizational information, and other information as required throughout this RFP (*e.g.,* community resource manual, etc.). The Contractor shall give the Office of Medical Assistance advance notice of updates and changes to any materials on its website. The Contractor's website must adhere to State IT Policy ITP F.35 Moratorium on the Use of Advertisements, Endorsements and Sponsorships on State-Controlled Websites. If requested by the Office of Medical Assistance, the Contractor shall make changes to its website.

6.2.13 USING OFFICE OF MEDICAL ASSISTANCE COMPUTER SYSTEMS. The Office of Medical Assistance will be acquiring its own case management/provider oversight system, and the Contractor must use the Office of Medical Assistance system throughout the duration of the Contract. The Contractor may be required to take an active role in the development, testing, and implementation of whatever case management system might be used, including participation in the Implementation Team, Joint Application Development (JAD) sessions, and user testing. The Implementation Team's purpose is to work through issues that arise as system modules are developed. JAD sessions are a group approach to developing systems that work as effectively and efficiently as possible, and are conducted at varying levels of development. Inherent in all system releases is a user-testing phase. The Contractor may be asked to participate in user testing, based on test scripts provided by the Office of Medical Assistance, and provide sign-off upon completion.

The Contractor shall also use the following Office of Medical Assistance computer systems, including but not limited to: the Client Registry and Information System-Enhanced (CRIS-E) and the Medicaid Information Technology System (MITS). The Medicaid Information Technology System processes and stores data on all claims submitted for Medicaid and other health programs administered by the Office of Medical Assistance. The system also maintains information on Medicaid individual eligibility, approved equipment/medications/services, reimbursement rates, Medicaid providers, and the prior authorization process. The Client Registry Information System-Enhanced, establishes eligibility for a variety of programs, including Medicaid, food stamps, and Ohio Works First payments. County department of job and family services staff use CRIS-E to conduct interactive eligibility interviews with applicants and individuals. Nightly data feeds from CRIS-E transfer health plan eligibility information to MITS.

For Medicaid waiver program services to earn federal match, each service must be authorized in an All Services Plan. All Service Plans are unique for each person enrolled on the waiver program and the plans are amended very frequently. As a result, it is essential that the Contractor is able to update, on a regular and ongoing basis, information about the specific services authorized in All Service Plans in order to prevent payment for non-authorized services.

The Contractor must be able to transmit and receive information to and from the statewide provider oversight Contractor and other case management entities in order to support core operations, communication, and coordination associated with: provider compliance findings; incident management and investigation; and provider enrollment.

6.2.14 CONTRACTOR TECHNOLOGY REQUIREMENTS. The Contractor must agree to comply with all Office of Medical Assistance security requirements. Data integrity and security are an important element of system utilization. The Contractor is required to use their own virtual private network (VPN) to access Office of Medical Assistance systems. The cost of this VPN or any other Office of Medical Assistance-required access technology is to be absorbed by the Contractor. The Contractor is responsible for the purchase of all software and hardware not otherwise supplied by the Office of Medical Assistance.

As needed, Contractor representatives will be included in the Office of Medical Assistance's discussions, meetings, and project testing for system modifications and new system modules impacting the administration of the Office of Medical Assistance-administered Home and Community Based Service waiver programs described in this Contract. All system functions, transactions, and data must be in compliance with any and all HIPAA requirements and other applicable federal and state system standards and requirements.

Upon termination of the Contract, the Contractor must provide all of the Project data not included in the OMA-approved system, at no cost to the Office of Medical Assistance, in accordance with a format and transfer plan to be agreed upon between the Office of Medical Assistance and the Contractor at least 180 calendar days prior to the conclusion of the Contract.

This transfer plan must be developed and shared with the Office of Medical Assistance within 90 days of the start of the contract. The Contractor must update the transfer plan quarterly and this plan must be made available to the Office of Medical Assistance when requested.

6.2.15 CASE MANAGEMENT QUALITY MANAGEMENT PLAN. The Contractor is subject to the terms of Attachment Eleven - Quality Management Plan – Requirements for the Case Management Contractor. The Contractor shall participate and cooperate in any and all matters related to the Quality Management Plan. The Office of Medical Assistance may amend the Quality Management Plan each State fiscal year throughout the duration of this Contract, and the Contractor shall be subject to all amendments.

6.2.16 MAINTAINING PHYSICAL AND ELECTRONIC FILES FOR EACH INDIVIDUAL. All records, including individual and provider information records related to this Contract, must be kept by the Contractor at a centrally located Contractor regional office. The Contractor will assume the cost of collecting, organizing, and providing any technology needed to access the records whenever the State or anyone else with audit rights requests access to the Contractor's work records. The Contractor will do so within and not to exceed five (5) business days. The files must include at least the following information:

1. All program eligibility tools and documentation.
2. All service planning tools and documentation.
3. Any other individual documentation.
4. Any other information necessary for effective coordination of individual's care.

The Contractor must have appropriate policies and procedures to maintain the confidentiality of individual records and assure individuals have access to their own records upon request. The Contractor must ensure that individual records are kept confidential, and must have a procedure which explains release of records to parties other than members of the individual's team, in compliance with any and all HIPAA and Office of Medical Assistance requirements. Any breach of protected health information must be promptly reported to the Office of Medical Assistance. The Contractor must retain records in accordance with federal and state law. If the Contractor intends to maintain paper records, at the conclusion of the project the Contractor shall deliver the records in accordance with instructions provided by the Office of Medical Assistance. If the Contractor intends to create and maintain electronic records, the Contractor must comply with the additional requirements set forth in Attachment Nine.

The Contractor shall maintain all records, and upon termination of the Contract by either party, the Contractor is responsible for providing all records not located in the OMA-approved system to the Office of Medical Assistance at least 30 days prior to termination date or on a date mutually agreed to by the Office of Medical Assistance and the Contractor.

6.2.17 OFFICE LOCATION/ENVIRONMENT/HOURS. The Contractor must have at least one physical office location in each region awarded for the coordinating site to manage and administer the Scope of Work in this Contract. Personal residences are not acceptable regional office locations. All physical office locations must be accessible for business purposes related to the Contract work and must be fully compliant with Americans with Disabilities Act (ADA) access standards.

All physical office locations must be on a public transportation line or in a community where public transportation is available and provided to the specific location. The Contractor's office locations must have the capacity to copy and fax, as well as have computers capable of compiling data in formats compatible with all Office of Medical Assistance applications. The main coordinating office location must have at least two on-site conference rooms to comfortably accommodate six or more people and be available for meetings with state staff, Office of Medical Assistance site reviews, etc.

Access to large conference or training rooms for regional training seminars, etc. must be available either offsite or in the main coordinating office location. Normal working hours for the administrative offices will be Monday through Friday (except for State holidays only) from 7:00 a.m. to 6:00 p.m., Eastern Standard Time.

6.3 INTERFACING WITH STATEWIDE PROVIDER OVERSIGHT CONTRACTOR. Currently, case management services and provider oversight services are performed by the same Contractor. Effective with this contract period, the two services will be performed by different Contractors. The Case Management Contractor(s) shall interface with the statewide Provider Oversight Contractor who, among other things, will perform the incident management and investigation as outlined in Ohio Administrative Code rule 5101:3-45-05, and the structural review process as outlined in Ohio Administrative Code rule 5101:3-45-06 (the rules will be amended to reflect this new structure). The Ohio Administrative Code rule 5101:3-45-05 defines incidents; the reporting, notification and response requirements; investigation requirements; the process for substantiating incidents; and recommending provider sanctions to the Office of Medical Assistance. In addition, the Contractor must report all incidents, as currently defined and as amended in the future, to the statewide provider oversight Contractor for investigation. The Contractor may only use eligible Medicaid service providers as identified in MITS, and must remove from the All Services Plan any providers that become ineligible.

6.4 SPECIFICATION OF DELIVERABLES. In addition to performing the Work, the Contractor must submit the following additional deliverables:

6.4.1 INTAKE REPORT. Intake reports, based on a format defined by the Office of Medical Assistance, must be submitted to the Office of Medical Assistance monthly. The report must include information about initial contacts completed during the previous month (*e.g.,* the Intake Report submitted in August must include information about initial contacts completed in July.) All reports are due by the 15th calendar day of the following month or on the next business day when the 15th falls on a Saturday, Sunday, or State or Federal holiday. The first report must be submitted following the first full month after the Contract is initiated. Payment for initial contacts will be based on the Office of Medical Assistance acceptance of the monthly Intake Report.

6.4.2 ASSESSMENT REPORT. Assessment Reports, based on a format defined by the Office of Medical Assistance, must be submitted to the Office of Medical Assistance monthly. The Assessments Report must include information about initial and waiver program specific annual and event-based assessments completed during the previous month (*e.g.,* the Assessment Report submitted in August must include information about assessments completed in July.) All reports are due by the 15th calendar day of the following month or on the next business day when the 15th falls on a Saturday, Sunday, or State or Federal holiday. The first report must be submitted following the first full month after the Contract is initiated. Payment for initial and annual assessments will be based on the Office of Medical Assistance acceptance of the monthly Assessment Report.

6.4.3 CASELOAD REPORT. Caseload Reports, based on a format defined by the Office of Medical Assistance, must be submitted to the Office of Medical Assistance monthly. The Caseload Report must include information about the number of waiver program specific cases managed during the previous month (*e.g.,* the Caseload Report submitted in August must include information about the number of cases managed in July). All reports are due by the 15th calendar day of the following month or on the next business day when the 15th falls on a Saturday, Sunday, or State or Federal holiday. The first report must be submitted following the first full month of the initial Contract period. Payment for the numbers of cases managed will be based on the Office of Medical Assistance acceptance of the monthly Caseload Report.

6.4.4 MONTHLY PERFORMANCE REPORT. Performance Reports, based on a format defined by the Office of Medical Assistance, must be submitted to the Office of Medical Assistance monthly. All reports are due by the 25th calendar day of the following month or on the next business day when the 25th falls on a Saturday, Sunday, or State or Federal holiday. The first report must be submitted following the first full month after the Contract is initiated. Each performance report must include waiver program specific data about how well each regional site and the overall Contractor is meeting key waiver program assurances described in the Scope of Work. There is not a separate payment for this deliverable.

6.4.5 QUARTERLY MANAGEMENT REPORT. Management Reports, based on a format defined by the Office of Medical Assistance, must be submitted to the Office of Medical Assistance quarterly, i.e. no later than 30 calendar days after December 31, March 31, June 30, and September 30 or on the next business day when the 30th calendar day falls on a Saturday, Sunday, or State or Federal holiday. The Management Report must detail performance trends/patterns and their impact on the Quality Management Plan components. The report must summarize:

1. How monthly performance results impact the Quality Management Plan.
2. What actions the Contractor plans for continuous improvement of the day-to-day management of the program(s).

Specifically, each Management Report must include data supporting the current Quality Management Plan goals and standards, progress made toward goals and standards, planned quality improvements or corrective actions based on analyzed data, any new or updated goals, and other updates or changes to the Quality Management Plan. Information must be presented in a way that supports evaluation of the Contractor's regional site(s). While data from Monthly Performance Reports will be summarized for the Management Report, the Management Report is a separate and distinct reporting mechanism and has a broader scope than the Monthly Performance Report. Both types of reports are required to be submitted. There is not a separate payment for this deliverable.

The Office of Medical Assistance reserves the right to set and/or change minimum standards after the first six months of Contractor performance.

PART SEVEN: SPECIAL PROVISIONS

7.1 THE OFFEROR'S FEE STRUCTURE. The Contractor will be paid as proposed on the Cost Summary Form after the Agency approves the receipt of all deliverables.

7.2 REIMBURSABLE EXPENSES. None.

7.3 BILL TO ADDRESS.

The Office of Medical Assistance -BLTCSS
P.O. Box 182709
50 W. Town St., 5th Floor
Columbus, OH 43218

7.4 CONTRACTOR LIMITATIONS. The Contractor or any of its subcontractors may not provide direct home health or waiver program services to any individuals enrolled in the Office of Medical Assistance-administered Home and Community Based Service waiver programs through the entire term of the Contract.

7.5 FINANCIAL ABILITY. Once awarded the contract, the Contractor will have an audit of its financial statements performed in compliance with Generally Accepted Auditing Standards (GAAS) every year. Copies of the audited financial statements and reports produced using the above standards shall be submitted to DAS within six (6) months of the end of the Contractor's financial reporting period. If the State determines within three (3) months of the receipt of the audit that the Contractor's financial ability is inadequate, the contract is subject to termination after receipt of a formal intent to terminate the contract. In any case, a 30-day notice shall be given by the State.

7.6 SUBPOENAS, COURT ORDERS, AND LEGAL NOTICES. Any subpoena or court order received by the Contractor which relates to the Scope of Work and deliverables under the Contract shall be directed to the Office of Medical Assistance, with a copy also forwarded to the Contractor's legal counsel. Upon receipt, the Contractor's legal counsel shall promptly contact the Office of Medical Assistance' legal counsel to determine how to proceed. The Contractor shall also notify the Office of Medical Assistance of any litigation or other legal matters which involve or otherwise pertain to the Scope of Work under this Contract. In the event that the Contractor possesses or has access to information and/or documentation needed by the Office of Medical Assistance with regard to the above, the Contractor agrees to cooperate with the Office of Medical Assistance in gathering and providing such information and/or documentation.

7.7 PUBLIC RECORD REQUESTS. The Contractor is responsible for responding to any request for records which it receives related to the Contract, and shall promptly notify the Office of Medical Assistance of any such request that the Contractor receives. The Scope of Work under this Contract involves certain information which is subject to confidentiality, safeguarding, and/or public records requirements, and the Contractor agrees and understands that it is bound by all state and federal laws which pertain thereto. Upon receipt of any request for records related to the Contract, the Contractor shall determine whether the requested records are exempted from release under the provisions of Ohio Revised Code Section 149.43, or if the records are otherwise made confidential by another state or federal law. If the Contractor determines that any of the requested records, or portions thereof, are public records and are therefore required to be produced under Ohio Revised Code Section 149.43, the Contractor shall promptly prepare the records and make them available to the requester for inspection or copying. If the request is ultimately denied, in part or in whole, the Contractor shall provide the requester with an explanation, including legal authority, setting forth the reasons for denial.

7.8 PREVAILING WAGE REQUIREMENTS. The Contractor will be required to comply with prevailing wage standards, as established in ORC 4115.03-4115.16.

PART EIGHT: GENERAL TERMS AND CONDITIONS

8.1 SCOPE OF WORK. The RFP and the Offeror's Proposal (collectively referred to as the "RFP") are a part of this Contract and describe the work the Contractor will do (the "Work") and any materials the Contractor will deliver (the "Deliverables") as part of the Project that is the subject of this Contract. The Contractor will perform the Work in a professional, timely, and efficient manner and will provide the Deliverables in a timely and proper fashion. The Contractor will also furnish its own support staff necessary for the satisfactory performance of the Work.

The Contractor will consult with the appropriate State representatives and others necessary to ensure a thorough understanding of the Project and satisfactory performance. The State may give instructions to or make requests of the Contractor relating to the Project. The Contractor will comply with those instructions and fulfill those requests in a timely and professional manner. Those instructions and requests will be for the sole purpose of ensuring satisfactory completion of the Project and will not amend or alter the scope of the Project.

8.2 TERM. Unless this Contract is terminated, or expires without renewal, it will remain in effect until the Project is completed to the satisfaction of the State and the Contractor is paid. The current Ohio General Assembly cannot commit a future Ohio General Assembly to an expenditure. Therefore, this Contract will automatically expire at the end of each biennium. The State however, may renew this Contract in the next biennium by issuing written notice to the Contractor of the decision to do so. This expiration and renewal procedure will also apply to the end of any subsequent biennium during which the Project continues. Termination or expiration of this Contract will not limit the Contractor's continuing obligations with respect to the Work and Deliverables that the State paid for before termination or limit the State's rights in such Work or Deliverables.

It is understood that the State's funds are contingent upon the availability of lawful appropriations by the Ohio General Assembly. If the Ohio General Assembly fails at any time to continue funding for the payments and other obligations due as part of this Contract, the State's obligations under this Contract are terminated as of the date that the funding expires without further obligation of the State

The Project has a completion date that is identified in the RFP. The RFP may also have several dates for delivery of Deliverables or reaching certain milestones in the Project or completion of the Project. The Contractor must make those deliveries, meet those milestones, and complete the Project within the times set forth in the RFP and the mutually agreed Work Plan. If the Contractor does not meet those dates, the Contractor will be in default, and the State may terminate this Contract under the termination provision contained below. The State may also have certain obligations to meet. Those obligations, if any, are also listed in the RFP. If the State agrees that the Contractor's failure to meet the delivery, milestone, or completion dates in the RFP is due to the State's failure to meet its own obligations in a timely fashion, then the Contractor will not be in default, and the delivery, milestone, and completion dates affected by the State's failure to perform will be extended by the same amount of time as the State's delay. The Contractor may not rely on this provision unless the Contractor has in good faith exerted all professional management skill to avoid an extension and has given the State meaningful written notice of the State's failure to meet its obligations within five (5) business days of the Contractor's realization that the State's delay will impact the Project. The notice to the State must be directed at making the State aware of its delay and the impact of its delay. It must be sent to the Agency Project Representative and the State Procurement Representative. Remedies resulting from the State's delay will be at the State's discretion.

The State seeks a complete Project. Any incidental items omitted in the RFP will be provided as part of the Contractor's not-to-exceed fixed price. The Contractor must fully identify, describe, and document all systems that are delivered as a part of the Project. All hardware, software, supplies, and other required components (such as documentation, conversion, training, and maintenance) for the Project to be complete and useful to the State are included in the Project and the not-to-exceed fixed price.

8.3 COMPENSATION. In consideration of the Contractor's promises and satisfactory performance, the State will pay the Contractor the amount(s) identified in the RFP (the "Fee"). In no event will payments under this Contract exceed the “not-to-exceed” amount in the RFP without the prior, written approval of the State and, when required, the Ohio Controlling Board and any other source of funding. The Contractor's right to the Fee is contingent on the complete and satisfactory performance of the Project or, in the case of milestone payments or periodic payments of an hourly, daily, weekly, monthly, or annual rate, all relevant parts of the Project tied to the applicable milestone or period. Payment of the Fee is also contingent on the Contractor delivering a proper invoice and any other documents required by the RFP.

An invoice must comply with the State's then-current policies regarding invoices and their submission. The State will notify the Contractor in writing within fifteen (15) business days after it receives a defective invoice of any defect and provide the information necessary to correct the defect. The Contractor will send all invoices under this Contract to the “bill to” address in the RFP or in the applicable purchase order.

The State will pay the Contractor interest on any late payment as provided in Section 126.30 of the Ohio Revised Code (the "Revised Code"). If the State disputes a payment for anything covered by an invoice, within 15 business days after receipt of that invoice, the State will notify the Contractor, in writing, stating the grounds for the dispute. The State may then deduct the disputed amount from its payment as a non-exclusive remedy. If, in the opinion of the State, a material breach has occurred by the Contractor, the State retains the right to withhold payment from the Contractor. The State will consult with the Contractor as early as reasonably possible about the nature of the claim or dispute and the amount of payment affected. When the Contractor has resolved the matter to the State's satisfaction, the State will pay the disputed amount within 30 business days after the matter is resolved. No payments are required to be made by the State until the matter is resolved.

If the State has already paid the Contractor on an invoice, but later disputes the amount covered by the invoice, and if the Contractor fails to correct the problem within 30 calendar days after written notice, the Contractor will reimburse the State for that amount at the end of the 30 calendar days as a non-exclusive remedy for the State.

8.4 REIMBURSABLE EXPENSES. The Contractor will assume all expenses that it incurs in the performance of this Contract. Travel should be folded into the overhead, per diem, or the hourly rates which are built into the cost of the deliverables.

8.5 CERTIFICATION OF FUNDS. None of the rights, duties, or obligations in this Contract will be binding on the State, and the Contractor will not begin its performance, until all the following conditions have been met:

1. All statutory provisions under the Revised Code, including Section 126.07, have been met.
2. All necessary funds are made available by the appropriate state agencies.
3. If required, approval of this Contract is given by the Ohio Controlling Board.
4. If the State is relying on Federal or third-party funds for this Contract, the State gives the Contractor written notice that such funds have been made available.

8.6 EMPLOYMENT TAXES. Each party will be solely responsible for reporting, withholding, and paying all employment related taxes, payments, and withholdings for its own personnel, including, but not limited to, Federal, state and local income taxes, social security, unemployment or disability deductions, withholdings, and payments (together with any interest and penalties not disputed with the appropriate taxing authority). All people the Contractor provides to the State under this Contract will be deemed employees of the Contractor for purposes of withholdings, taxes, and other deductions or contributions required under the law.

8.7 SALES, USE, EXCISE, AND PROPERTY TAXES. The State is exempt from any sales, use, excise, and property tax. To the extent sales, use, excise, or any similar tax is imposed on the Contractor in connection with the Project; such will be the sole and exclusive responsibility of the Contractor. The Contractor will pay such taxes, together with any interest and penalties not disputed with the appropriate taxing authority, whether they are imposed at the time the services are rendered or at a later time.

8.8 NOTICE ON THE USE OF SOCIAL SECURITY NUMBERS AS FEDERAL TAX IDENTIFICATION NUMBERS. The Department of Administrative Services (Department) requires Contractors and Contractors wishing to do business with the State to provide their Federal Taxpayer Identification Number to the Department. The Department does this so that it can perform statutorily required "responsibility" analyses on those Contractors and Contractors doing business with the State and, under limited circumstances, for tax reporting purposes. If you are a Contractor or Contractor using your Social Security Number as your Federal Taxpayer Identification Number, please be aware that the information you submit is a public record, and the Department may be compelled by Ohio law to release Federal Taxpayer Identification Numbers as a public record. If you do not want to have your Social Security Number potentially disclosed as a Federal Taxpayer Identification Number, the Department encourages you to use a separate Employer Identification Number (EIN) obtained from the United States Internal Revenue Service's to serve as your Federal Taxpayer Identification Number.

8.9 RELATED CONTRACTS. The Contractor warrants that the Contractor has not and will not enter into any contracts without written approval of the State to perform substantially identical services for the State such that the Project duplicates the work done or to be done under the other contracts.

8.10 PROHIBITING THE EXPENDITURE OF PUBLIC FUNDS ON OFFSHORE SERVICES. The Contractor affirms to have read and understands Executive Order 2011-12K and shall abide by those requirements in the performance of this Contract. Notwithstanding any other terms of this Contract, the State reserves the right to recover any funds paid for services the Contractor performs outside of the United States for which it did not receive a waiver. The State does not waive any other rights and remedies provided the State in this Contract.

8.11 SUBCONTRACTING. The Contractor may not enter into subcontracts for the Work after award without written approval from the State. The Contractor will not need the State's written approval to subcontract for the purchase of commercial goods that are required for satisfactory completion of the Project. All subcontracts will be at the sole expense of the Contractor unless expressly stated otherwise in the RFP.

The State's approval of the use of subcontractors does not mean that the State will pay for them. The Contractor will be solely responsible for payment of its subcontractor and any claims of subcontractors for any failure of the Contractor or any of its other subcontractors to meet the performance schedule or performance specifications for the Project in a timely and professional manner. The Contractor will hold the State harmless for and will indemnify the State against any such claims.

The Contractor will assume responsibility for all Deliverables whether it, a subcontractor, or third-party manufacturer produces them in whole or in part. Further, the State will consider the Contractor to be the sole point of contact with regard to contractual matters, including payment of all charges resulting from the Contract. The Contractor will be fully responsible for any default by a subcontractor, just as if the Contractor itself had defaulted.

If the Contractor uses any subcontractors, each subcontractor must have a written agreement with the Contractor. That written agreement must incorporate this Contract by reference. The agreement must also pass through to the subcontractor all provisions of this Contract that would be fully effective only if they bind both the subcontractor and the Contractor. Among such provisions are the limitations on the Contractor's remedies, the insurance requirements, record keeping obligations, and audit rights.

Some sections of this Contract may limit the need to pass through their requirements to subcontracts to avoid placing cumbersome obligations on minor subcontractors. This exception is applicable only to sections that expressly provide exclusions for small-dollar subcontracts. Should the Contractor fail to pass through any provisions of this Contract to one of its subcontractors and the failure damages the State in any way, the Contractor will indemnify the State for the damage.

8.12 RECORD KEEPING. The Contractor will keep all financial records in accordance with generally accepted accounting procedures consistently applied. The Contractor will file documentation to support each action under this Contract in a manner allowing it to be readily located. The Contractor will keep all Project-related records and documents at its principal place of business or at its office where the work was performed.

The Contractor will keep a separate account for the Project (the "Project Account"). All payments made from the Project Account will be only for obligations incurred in the performance of this Contract and will be supported by contracts, invoices, vouchers, and any other data needed to audit and verify the payments. All payments from the Project Account will be for obligations incurred only after the effective date of this Contract unless the State has given specific written authorization for making prior payments from the Project Account.

8.13 AUDITS. During the term of this Contract and for three (3) years after the payment of the Contractor's Fee, on reasonable notice and during customary business hours, the State may audit the Contractor's records and other materials that relate to the Project. This audit right will also apply to the State's duly authorized representatives and any person or organization providing financial support for the Project.

Unless it is impracticable to do so, all records related to this Contract must be kept in a single location, either at the Contractor's principle place of business or its place of business where the work was done. If this is not practical, the Contractor will assume the cost of collecting, organizing, and relocating the records and any technology needed to access the records to the Contractor's office nearest Columbus whenever the State or anyone else with audit rights requests access to the Contractor's Project records. The Contractor will do so with all due speed, not to exceed five (5) business days.

If any audit reveals any material deviation from the Project's specifications, any misrepresentation, or any overcharge to the State, the State will be entitled to recover damages, as well as the cost of the audit.

For each subcontract in excess of $25,000, the Contractor will require its subcontractors to agree to the requirements of this section and of the record-keeping section. Subcontracts with smaller amounts involved need not meet this requirement. The Contractor may not artificially break up contracts with its subcontractors to take advantage of this exclusion.

8.14 INSURANCE. The Contractor shall provide the following insurance coverage at its own expense throughout the term of this Contract:

1. Workers' compensation insurance, as required by Ohio law, and, if some of the Project will be done outside Ohio, the laws of the appropriate state(s) where work on the Project will be done. The Contractor shall also maintain employer's liability insurance with at least a $1,000,000 limit.
2. Commercial General Liability insurance coverage for bodily injury, personal injury, wrongful death, property damage. The defense cost shall be outside of the policy limits. Such policy shall designate the state of Ohio as an additional insured, as its interest may appear. The policy shall also be endorsed to include a blanket waiver of subrogation.

a. At a minimum, the limits of the insurance shall be:
   $2,000,000 General Aggregate
   $2,000,000 Products/Completed Operations Aggregate
   $1,000,000 per Occurrence Limit
   $1,000,000 Personal and Advertising Injury Limit
   $100,000 Fire Legal Liability
   $10,000 Medical Payments
   The policy shall also be endorsed to provide the State with 30-day prior written notice of cancellation or material change to the policy. It is agreed upon that the Contractor's Commercial General Liability shall be primary over any other insurance coverage.

3. Commercial Automobile Liability insurance with a combined single limit of $500,000.
4. Professional Liability Insurance covering all staff with a minimum limit of $1,000,000 per incident and $3,000,000 aggregate. If the Contractor's policy is written on a "claims made" basis, the Contractor shall provide the State with proof of continuous coverage at the time the policy is renewed. If for any reason the policy expires, or coverage is terminated, the Contractor must purchase and maintain "tail" coverage through the applicable statute of limitations.

Certificates for Worker's Compensation and proof of insurance must be provided. The certificate(s) must be in a form that is reasonably satisfactory to the State as to the contents of the policies and the quality of the insurance carriers. All carriers must have at least an "A-"rating by A.M. Best.

8.15 STATE PERSONNEL. During the term of this Contract and for one (1) year after completion of the Project, the Contractor will not hire or otherwise contract for the services of any state employee involved with the Project.

8.16 REPLACEMENT PERSONNEL. If the Offeror's Proposal contains the names of specific people who will work on the Project, then the quality and professional credentials of those people were material factors in the State's decision to enter into this Contract. Therefore, the Contractor will use all commercially reasonable efforts to ensure the continued availability of those people. Also, the Contractor will not remove those people from the Project without prior notice, to the State and will replace them with people with similar experience and qualifications.

The State has an interest in providing a healthy and safe environment for its employees and guests at its facilities. The State also has an interest in ensuring, and right to ensure, that its operations are carried out in an efficient, professional, legal, and secure manner. The State, therefore, will have the right to require the Contractor to remove any individual working on the Project if the State determines that any such individual has or may interfere with the State's interests identified above. In such a case, the request for removal will be treated as a case in which an individual providing services under this Contract has become unavailable, and the Contractor will follow the procedures identified above for replacing unavailable people. This provision applies to people engaged by the Contractor's subcontractors if they are listed as key people in the Proposal.

8.17 CONTRACT NON-COMPLIANCE. A primary goal of the Office of Medical Assistance is to assure that the program receives high quality services from the Contractor. To this end, the Office of Medical Assistance will work in partnership with the Contractor(s) to meet this goal. The partnership is defined by the Contract and it is important that communication between the Contractor and state agencies be open and supportive. Should contract non-compliance be an issue, the Office of Medical Assistance shall make every effort to resolve the problem.

1. Non-Compliance Issues. Contractor non-compliance with the specifications and terms and conditions outlined in the Contract may result in the imposition of remedies as explained below in paragraph 2. The Office of Medical Assistance must be promptly notified of any procedural changes outside the technical requirements listed herein.

2. Resolution for Contract Non-Compliance. The Office of Medical Assistance will be responsible for monitoring the Contractor's performance and compliance with the terms, conditions, and specifications of the contract, including Attachment Eleven – Quality Management Plan.
   a. For any infractions not remedied by the Contractor, the Office of Medical Assistance will notify DAS through a Complaint to Vendor (CTV) process to help resolve the infraction.
   b. DAS, in conjunction with the Office of Medical Assistance, will impose upon the Contractor remedies for non-compliance regarding contract specifications and terms and conditions. Remedies imposed will be in proportion with the severity of the non-compliance.

8.18 SUSPENSION AND TERMINATION. The State may terminate this Contract if the Contractor defaults in meeting its obligations under this Contract, or if a petition in bankruptcy (or similar proceeding) has been filed by or against the Contractor, regardless of whether or not actual or liquidated damages are assessed. The State may also terminate this Contract if the Contractor violates any law or regulation in doing the Project, or if it appears to the State that the Contractor's performance is substantially endangered through no fault of the State. In any such case, the termination will be for cause, and the State's rights and remedies will be those identified below for termination for cause.

DAS, in conjunction with the Office of Medical Assistance, may require the Contractor to cure its default and may provide up to 30 calendar days to so cure any breach of its obligations under this Contract, provided the breach is curable. If the Contractor fails to cure the breach within 30 calendar days after written notice or if the breach is not one that is curable, the State will have the right to terminate this Contract. Some provisions of this Contract may provide for a shorter cure period than 30 calendar days or for no cure period at all. Those provisions will prevail over this one. If a particular section does not state what the cure period will be, this provision will govern.

The State may also terminate this Contract for its convenience and without cause or if the Ohio General Assembly fails to appropriate funds for any part of the Project. If a third party is providing funding for the Project, the State may also terminate this Contract should that third party fail to release any Project funds. The RFP identifies any third party source of funds for the Project.

The notice of termination, whether for cause or without cause, will be effective as soon as the Contractor receives it. Upon receipt of the notice of termination, the Contractor will immediately cease all Work on the Project and take all steps necessary to minimize any costs the Contractor will incur related to this Contract. The Contractor will also immediately prepare a report and deliver it to the State. The report must be all-inclusive; no additional information will be accepted following the initial submission. The report must detail the work completed at the date of termination, the percentage of the Project's completion, any costs incurred in doing the Project to that date and any Deliverables completed or partially completed but not delivered to the State at the time of termination. The Contractor will also deliver all the completed and partially completed Deliverables to the State with its report. If delivery in that manner would not be in the State's interest, then the Contractor will propose a suitable alternative form of delivery.

If the State terminates this Contract for cause, it will be entitled to cover for the Project by using another Contractor on such commercially reasonable terms as it and the covering Contractor may agree. The Contractor will be liable to the State for all costs related to covering for the Project to the extent that such costs, when combined with payments already made to the Contractor for the Project before termination, exceed the costs that the State would have incurred under this Contract. The Contractor will also be liable for any other damages resulting from its breach of this Contract or other action leading to termination for cause.

If the termination is for the convenience of the State, the Contractor will be entitled to compensation for any work on the Project that the Contractor has performed before the termination. Such compensation will be the Contractor's exclusive remedy in the case of termination for convenience and will be available to the Contractor only once the Contractor has submitted a proper invoice for such, with the invoice reflecting the amount determined to be owing to the Contractor by the State. The State will make that determination based on the lesser of the percentage of the Project completed or the hours of work performed in relation to the estimated total hours required to perform the entire applicable unit(s) of Work.

The State will have the option of suspending rather than terminating the Project where the State believes that doing so would better serve its interests. In the event of a suspension for the convenience of the State, the Contractor will be entitled to receive payment for the work performed before the suspension. In the case of suspension of the Project rather than termination for cause, the Contractor will not be entitled to any compensation for any work performed. If the State reinstates the Project after suspension for cause, rather than terminating this Contract after the suspension, the Contractor may be entitled to compensation for work performed before the suspension, less any damage to the State resulting from the Contractor's breach of this Contract or other fault. Any amount due for Work performed on the Project before or after the suspension for cause will be offset by any damage to the State from the default or other event giving rise to the suspension.

In the case of a suspension for the State's convenience, the amount of compensation due to the Contractor for Work performed on the Project before the suspension will be determined in the same manner as provided in this section for termination for the State's convenience. The Contractor will not be entitled to compensation for any other costs associated with a suspension for the State's convenience. No payment under this provision will be made to the Contractor until the Contractor submits a proper invoice.

Any notice of suspension, whether with or without cause, will be effective immediately on the Contractor's receipt of the notice. The Contractor will prepare a report concerning the Project just as is required by this Section in the case of termination. After suspension of the Project, the Contractor will perform no work without the consent of the State and will resume work only on written notice from the State to do so. In any case of suspension, the State retains its right to terminate this Contract rather than to continue the suspension or resume the Project. If the suspension is for the convenience of the State, then termination of the Contract will be a termination for convenience. If the suspension is with cause, the termination will also be for cause.

The State will not suspend the Project for its convenience more than once during the term of this Contract, and any suspension for the State's convenience will not continue for more than 30 calendar days. If the Contractor does not receive notice to resume or terminate the Project within the 30-day period, then this Contract will terminate automatically for the State's convenience at the end of the 30 calendar day period.

Any default by the Contractor or one of its subcontractors will be treated as a default by the Contractor and all of its subcontractors. The Contractor will be solely responsible for satisfying any claims of its subcontractors for any suspension or termination and will indemnify the State for any liability to them. Each subcontractor will hold the State harmless for any damage caused to them from a suspension or termination. They will look solely to the Contractor for any compensation to which they may be entitled.

The Contractor may, at its discretion, request termination with a minimum 90 day notice in writing. The State will review the request and respond in writing to the Contractor with its findings.

8.19 CONTRACT REMEDIES.

1. Actual Damages. Contractor is liable for and upon demand by the State of Ohio shall pay all actual damages caused by Contractor's default including without limitation, payments made to an entity providing services to individuals that otherwise would not be payable under the Medicaid program (*e.g.*, equipment or services that should not have been authorized), regardless of whether or not the State has the right to collect monies from the entity. In the event that the State has not yet paid such an entity, payment shall be made directly to the entity by the Contractor if so directed by the State. The State may buy substitute supplies or services, from a third party, for those that were to be provided by Contractor. The State may recover the costs associated with acquiring substitute supplies or services, less any expenses or costs saved by Contractor's default, from Contractor. Contractor shall pay actual damages to the State without limiting the State's right, when appropriate, to collect liquidated damages and to terminate this Contract for default as provided elsewhere.
2. Liquidated Damages. The parties agree that Contractor's failure to perform its obligations under this Contract will cause the State to incur actual damages and losses of types, and in amounts, which are impossible to compute and ascertain with certainty as a basis for recovery by the State for actual damages for certain specified defaults, including without limitation damages related to the increased oversight of the Contractor and responses to Contractor's defaults, as well as increased costs related to the administration of and damage to the integrity of the Medicaid program, and for those defaults that liquidated damages represent a fair, reasonable and appropriate estimate thereof. Accordingly, for those defaults, the Contractor agrees that liquidated damages shall be assessed and upon demand by the State of Ohio, Contractor shall pay liquidated damages without the State being required to present any evidence of the amount or character of actual damages sustained. Therefore, upon demand of the State, Contractor shall pay liquidated damages for the defaults and in the amount set forth in Attachment Eleven. Attachment Eleven may be revised by the State each State fiscal year, and the Contractor shall be bound by any revisions. Such liquidated damages are intended to represent estimated actual damages and are not intended as a penalty, and Contractor shall pay them to the State without limiting the State's right to collect actual damages and to terminate this Contract for default as provided elsewhere.
3. Payment of Damages. The Contractor shall submit payment for the damages as directed upon written notice from the State. The State may make demand for actual and/or liquidated damages by including it in a Notice of Quality Assurance Monitoring and Oversight Review issued pursuant to Ohio Administrative Code rule 5101:3-45-09.

8.20 REPRESENTATIVES. The State's representative under this Contract will be the person identified in the RFP or a subsequent notice to the Contractor as the "Agency Project Representative". The Agency Project Representative will review all reports made in the performance of the Project by the Contractor, will conduct all liaison with the Contractor, and will accept or reject the Deliverables and the complete Project. The Agency Project Representative may assign to a manager, responsibilities for individual aspects of the Project to act as the Agency Project Representative for those individual portions of the Project.

The Contractor's Project Manager under this Contract will be the person identified in the Proposal as the "Project Manager." The Project Manager will conduct all liaisons with the State under this Contract. Either party, upon written notice to the other party, may designate another representative. The Project Manager may not be replaced without the approval of the State if that individual is identified in the Proposal as a key individual on the Project.

8.21 WORK RESPONSIBILITIES. Unless otherwise provided in the RFP, the Contractor will be responsible for obtaining all official permits, approvals, licenses, certifications, and similar authorizations required by any local, state, or Federal agency for the Project and maintaining them throughout the duration of this Contract.

8.22 INDEPENDENT STATUS OF THE CONTRACTOR. The parties will be acting as independent Contractors. The partners, employees, officers, and agents ("Personnel") of one party, in the performance of this Contract, will act only in the capacity of representatives of that party and not as Personnel of the other party and will not be deemed for any purpose to be Personnel of the other. Each party assumes full responsibility for the actions of its Personnel while they are performing services pursuant to this Contract and will be solely responsible for paying its Personnel (including withholding of and/or paying income taxes and social security, workers' compensation, disability benefits and the like). Neither party will commit, nor be authorized to commit, the other party in any manner. The Contractor's subcontractors will be considered the agents of the Contractor for purposes of this Contract.

8.23 CONFIDENTIALITY. Contractor shall maintain the confidentiality of information and records which state and federal laws, rules, and regulations require to be kept confidential. The State may disclose to the Contractor written material or oral or other information that the State treats as confidential ("Confidential Information"). Title to the Confidential Information and all related materials and documentation the State delivers to the Contractor will remain with the State. The Contractor must treat such Confidential Information as secret if it is so marked, otherwise identified as such, or when, by its very nature, it deals with matters that, if generally known, would be damaging to the best interests of the public, other Contractors or potential Contractors with the State, or individuals or organizations about whom the State keeps information. By way of example, information should be treated as confidential if it includes any proprietary documentation, materials, flow charts, codes, software, computer instructions, techniques, models, information, diagrams, know-how, trade secrets, data, business records, or marketing information. By way of further example, the Contractor also must treat as confidential materials such as police and investigative records, files containing personal information about individuals or employees of the State, such as personnel records, tax records, and so on, court and administrative records related to pending actions, any material to which an attorney-client, physician-patient, or similar privilege may apply, and any documents or records expressly excluded by Ohio law from public records disclosure requirements.

The Contractor will restrict circulation of Confidential Information within its organization and then only to people in the Contractor's organization that have a need to know the Confidential Information to do the Project. The Contractor will be liable for the disclosure of such information whether the disclosure is intentional, negligent, or accidental, unless otherwise provided below.

The Contractor will not incorporate any portion of any Confidential Information into any Work, other than a Deliverable, and will have no proprietary interest in any of the Confidential Information. Furthermore, the Contractor will cause all of its employees who have access to any Confidential Information to execute a confidentiality agreement incorporating the obligations in this section.

The Contractor's obligation to maintain the confidentiality of the Confidential Information will not apply where such:

1. Was already in the Contractor's possession before disclosure by the State, and such was received by the Contractor without obligation of confidence;
2. Is independently developed by the Contractor;
3. Is or becomes publicly available without breach of this Contract;
4. Is rightfully received by the Contractor from a third party without an obligation of confidence;
5. Is disclosed by the Contractor with the written consent of the State; or
6. Is released in accordance with a valid order of a court or governmental agency, provided that the Contractor
   a. Notifies the State of such order immediately upon receipt of the order and

b. Makes a reasonable effort to obtain a protective order from the issuing court or agency limiting disclosure and use of the Confidential Information solely for the purposes intended to be served by the original order of production. The Contractor will return all originals of any Confidential Information and destroy any copies it has made on termination or expiration of this Contract.

The Contractor may disclose Confidential Information to its subcontractors on a need-to-know basis, but the subcontractors will be obligated to the requirements of this section.

8.24 HEALTH INSURANCE PORTABILITY & ACCESSIBILITY ACT (HIPAA) REQUIREMENTS. The Contractor, and any subcontractor(s) will comply with 42 U.S.C. Sections 1320d through 1320d-8, and to implement regulations at 45 C.F.R. Section 164.502 (e) and Sections 164.504 (e) regarding disclosure of protected health information under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Protected Health Information (PHI) is information received by the Contractor from or on behalf of the Office of Medical Assistance that meets the definition of PHI as defined by HIPAA and the regulations promulgated by the United States Department of Health & Human Services, specifically 45 CFR 164.501 and any amendments thereto.

8.25 HANDLING OF THE STATE'S DATA. The Contractor must use due diligence to ensure computer and telecommunications systems and services involved in storing, using, or transmitting State data are secure and to protect that data from unauthorized disclosure, modification, or destruction. To accomplish this, the Contractor must:

1. Apply appropriate risk management techniques to ensure security for all sensitive data, including but not limited to any data identified as Confidential Information elsewhere in this Contract.
2. Ensure that its internal security policies, plans, and procedures address the basic security elements of confidentiality, integrity, and availability.
3. Maintain plans and policies that include methods to protect against security and integrity threats and vulnerabilities, as well as and detect and respond to those threats and vulnerabilities.
4. Maintain appropriate identification and authentication process for information systems and services associated with State data.
5. Maintain appropriate access control and authorization policies, plans, and procedures to protect system assets and other information resources associated with State data.
6. Implement and manage security audit logging on information systems, including computers and network devices.

The Contractor must maintain a robust boundary security capacity that incorporates generally recognized system hardening techniques. This includes determining which ports and services are required to support access to systems that hold State data, limiting access to only these points, and disable all others. To do this, the Contractor must use assets and techniques such as properly configured firewalls, a demilitarized zone for handling public traffic, host-to-host management, Internet protocol specification for source and destination, strong authentication, encryption, packet filtering, activity logging, and implementation of system security fixes and patches as they become available. The Contractor must use two-factor authentication to limit access to systems that contain particularly sensitive State data, such as personally identifiable data.

Unless the State instructs the Contractor otherwise in writing, the Contractor must assume all State data is both confidential and critical for State operations, and the Contractor's security policies, plans, and procedure for the handling, storage, backup, access, and, if appropriate, destruction of that data must be commensurate to this level of sensitivity.

As part of the Contractor's protection and control of access to and use of data, the Contractor must employ appropriate intrusion and attack prevention and detection capabilities. Those capabilities must track unauthorized access and attempts to access the State's data, as well as attacks on the Contractor's infrastructure associated with the State's data.

Further, the Contractor must monitor and appropriately address information from its system tools used to prevent and detect unauthorized access to and attacks on the infrastructure associated with the State's data.

The Contractor must use appropriate measures to ensure that State's data is secure before transferring control of any systems or media on which State data is stored. The method of securing the data must be appropriate to the situation and may include erasure, destruction, or encryption of the data before transfer of control. The transfer of any such system or media must be reasonably necessary for the performance of the Contractor's obligations under this Contract.

The Contractor must have a business continuity plan in place. The Contractor must test and update the IT disaster recovery portion of its business continuity plan at least annually. The plan must address procedures for response to emergencies and other business interruptions. Part of the plan must address backing up and storing data at a location sufficiently remote from the facilities at which the Contractor maintains the State's data in case of loss of that data at the primary site. The plan also must address the rapid restoration, relocation, or replacement of resources associated with the State's data in the case of a disaster or other business interruption. The Contractor's business continuity plan must address short- and long-term restoration, relocation, or replacement of resources that will ensure the smooth continuation of operations related to the State's data. Such resources may include, among others, communications, supplies, transportation, space, power and environmental controls, documentation, people, data, software, and hardware. The Contractor also must provide for reviewing, testing, and adjusting the plan on an annual basis.

The Contractor shall not allow the State's data to be loaded onto portable computing devices or portable storage components or media unless necessary to perform its obligations under this Contract properly. Even then, the Contractor may permit such only if adequate security measures are in place to ensure the integrity and security of the data. Those measures must include a policy on physical security for such devices to minimize the risks of theft and unauthorized access that includes a prohibition against viewing sensitive or confidential data in public or common areas. At a minimum, portable computing devices must have anti-virus software, personal firewalls, and system password protection. In addition, the State's data must be encrypted when stored on any portable computing or storage device or media or when transmitted from them across any data network. The Contractor also must maintain an accurate inventory of all such devices and the individuals to whom they are assigned.

Any encryption requirement identified in this provision must meet the Ohio standard as defined in Ohio IT standard ITS-SEC-01, "Data Encryption and Cryptography".

The Contractor must have reporting requirements for lost or stolen portable computing devices authorized for use with State data and must report any loss or theft of such to the State in writing as quickly as reasonably possible. The Contractor also must maintain an incident response capability for all security breaches involving State data whether involving mobile devices or media or not. The Contractor must detail this capability in a written policy that defines procedures for how the Contractor will detect, evaluate, and respond to adverse events that may indicate a breach or attempt to attack or access State data or the infrastructure associated with State data.

In case of an actual security breach that may have compromised State data, including but not loss or theft of devices or media, the Contractor must notify the State in writing of the breach within 24 hours of the Contractor becoming aware of the breach, and fully cooperate with the State to mitigate the consequences of such a breach.

This includes any use or disclosure of the State data that is inconsistent with the terms of this Contract and of which the Contractor becomes aware, including but not limited to, any discovery of a use or disclosure that is not consistent with this Contract by an employee, agent, or subcontractor of the Contractor.

The Contractor must give the State full access to the details of the breach and assist the State in making any notifications to potentially affected people and organizations that the State deems are necessary or appropriate. The Contractor must document all such incidents, including its response to them, and make that documentation available to the State on request. In addition to any other liability under this Contract related to the Contractor's improper disclosure of State data, and regardless of any limitation on liability of any kind in this Contract, the Contractor will be responsible for acquiring one year's identity theft protection service on behalf of any individual or entity whose personally identifiable information is compromised while it is in the Contractor's possession.

8.26 OWNERSHIP OF DELIVERABLES. All Deliverables produced by the Contractor and covered by this Contract, including any software modifications, and documentation, shall be owned by the State, with all rights, title, and interest in all intellectual property that come into existence through the Contractor's custom Work being assigned to the State.

8.27 GENERAL WARRANTIES. The Contractor warrants that the recommendations, guidance, and performance of the Contractor under this Contract will:

1. Be in accordance with sound professional standards and the requirements of this Contract and without any material defects;
2. Unless otherwise provided in the RFP, be the work solely of the Contractor; and
3. No Work or Deliverable will infringe on the intellectual property rights of any third party.

Additionally, with respect to the Contractor's activities under this Contract, the Contractor warrants that:

1. The Contractor has the right to enter into this Contract;
2. The Contractor has not entered into any other contracts or employment relationships that restrict the Contractor's ability to perform the contemplated services;
3. The Contractor will observe and abide by all applicable laws, regulations, policies and guidance including without limitation those pertaining to case management under the Medicaid program;
4. The Contractor has good and marketable title to any goods delivered under this Contract and in which title passes to the State; and
5. The Contractor has the right and ability to grant the license granted in any Deliverable in which title does not pass to the State.

All warranties will be continuing warranties. Without limiting the State's right to damages, if any portion of the Project fails to comply with these warranties, the Contractor will correct such failure with all due speed and will promptly pay damages incurred by the State. The Contractor will also indemnify the State for any damages and claims based on a breach of these warranties. This obligation of indemnification will not apply where the State has modified, except as permitted by the Contract, the Work or Deliverables and the claim is based on the modification. The State agrees to give the Contractor notice of any such claim as soon as reasonably practicable. However, failure to give prompt notice shall not affect Contractor's indemnity obligation. If a successful claim of infringement is made, or if the Contractor reasonably believes that an infringement claim that is pending may actually succeed, the Contractor will do one (1) of the following four (4) things:

1. Modify the Work or Deliverable so that it is no longer infringing;
2. Replace the Work or Deliverable with an equivalent or better item;

3. Acquire the right for the State to use the infringing the Work or Deliverable as it was intended for the State to use under this Contract; or
4. Remove the Work or Deliverable and refund the amount the State paid for the Work or Deliverable and the amount of any other Work or Deliverable or item that requires the availability of the infringing Work or Deliverable for it to be useful to the State.

8.28 GENERAL EXCLUSION OF WARRANTIES. The State makes no warranties, express or implied, other than those express warranties contained in this contract. The Contractor also makes no warranties of merchantability or fitness for a particular purpose except as follows: If the Contractor has been engaged under the Scope of Work in the RFP to design something to meet a particular need for the State, then the Contractor does warrant that the Contractor's Work and Deliverable will meet the stated purpose for that Work or Deliverable.

8.29 INDEMNITY. The Contractor will indemnify the State for any and all claims, damages, law suits, costs, judgments, expenses, and any other liabilities including without limitation those resulting from bodily injury to any person (including injury resulting in death) or damage to property that may arise out of or are related to Contractor's performance under this Contract.

The Contractor will also indemnify the State against any claim of infringement of a copyright, patent, trade secret, or similar intellectual property rights based on the State's proper use of any Work or Deliverable under this Contract. This obligation of indemnification will not apply where the State has modified or misused the Work or Deliverable and the claim of infringement, is based on the modification or misuse. The State agrees to give the Contractor notice of any such claim as soon as reasonably practicable and to give the Contractor the authority to settle or otherwise defend any such claim upon consultation with and approval by the Office of the State Attorney General. If a successful claim of infringement is made, or if the Contractor reasonably believes that an infringement claim that is pending may actually succeed, the Contractor will take one (1) of the following four (4) actions:

1. Modify the Work or Deliverable so that is no longer infringing.
2. Replace the Work or Deliverable with an equivalent or better item.
3. Acquire the right for the State to use the infringing Work or Deliverable as it was intended for the State to use under this Contract.
4. Remove the Work or Deliverable and refund the fee the State paid for the Work or Deliverable and the fee for any other Work or Deliverable that required the availability of the infringing Work or Deliverable for it to be useful to the State.

8.30 LIMITATION OF LIABILITY. Notwithstanding any provisions contained in the RFP and the documents and materials incorporated by reference into this Agreement, the parties agree as follows: The State will not be liable for any indirect, incidental or consequential loss or damage of any kind, including but not limited to lost profits, even if the parties have been advised, knew, or should have known of the possibility of such damages.

8.31 STANDARDS OF PERFORMANCE AND ACCEPTANCE. If the RFP does not provide otherwise, the acceptance procedure will be an informal review by the Agency Project Representative to ensure that the Work, Deliverables, milestones and the Project as a whole comply with the requirements of this Contract

8.32 ENTIRE DOCUMENT. This Contract is the entire agreement between the parties with respect to the subject matter and supersedes any previous statements or agreements, whether oral or written.

8.33 BINDING EFFECT. This Contract will be binding upon and inure to the benefit of the respective successors and assigns of the State and the Contractor.

8.34 AMENDMENTS – WAIVER. Except as otherwise provided in the Contract, no change to any provision of this Contract will be effective unless it is in writing and signed by both parties. The failure of either party at any time to demand strict performance by the other party of any of the terms of this Contract will not be a waiver of those terms. Waivers must be in writing to be effective. Either party may at any later time demand strict performance.

8.35 SEVERABILITY. If any provision of this Contract is held by a court of competent jurisdiction to be contrary to law, the remaining provisions of this Contract will remain in full force and effect to the extent that such does not create an absurdity.

8.36 CONSTRUCTION. This Contract will be construed in accordance with the plain meaning of its language and neither for nor against the drafting party.

8.37 HEADINGS. The headings used herein are for the sole sake of convenience and will not be used to interpret any section.

8.38 NOTICES. For any notice under this Contract to be effective it must be made in writing and sent to the address of the appropriate contact provided elsewhere in the Contract, unless such party has notified the other party, in accordance with the provisions of this section, of a new mailing address. This notice requirement will not apply to any notices that this Contract expressly authorized to be made orally.

8.39 CONTINUING OBLIGATIONS. The terms of this Contract will survive the termination or expiration of the time for completion of Project and the time for meeting any final payment of compensation, except where such creates an absurdity.

8.40 COMPLIANCE WITH LAW. The Contractor agrees to comply with all applicable federal, state, and local laws in the conduct of the Work.

8.41 DRUG-FREE WORKPLACE. The Contractor will comply with all applicable state and Federal laws regarding keeping a drug-free workplace. The Contractor will make a good faith effort to ensure that all the Contractor employees, while working on state property, will not have or be under the influence of illegal drugs or alcohol or abuse prescription drugs in any way.

8.42 CONFLICTS OF INTEREST. No Personnel of the Contractor may voluntarily acquire any personal interest that conflicts with their responsibilities under this Contract. Additionally, the Contractor will not knowingly permit any public official or public employee who has any responsibilities related to this Contract or the Project to acquire an interest in anything or any entity under the Contractor's control if such an interest would conflict with that official's or employee's duties. The Contractor will disclose to the State knowledge of any such person who acquires an incompatible or conflicting personal interest related to this Contract. The Contractor will take steps to ensure that such a person does not participate in any action affecting the Work under this Contract. This will not apply when the State has determined, in light of the personal interest disclosed, that person's participation in any such action would not be contrary to the public interest.

8.43 ETHICS LAW. Contractor represents that it and its employees engaged in the administration or performance of this Agreement are knowledgeable of and understand the Ohio Ethics laws. Contractor further represents and certifies that neither Contractor nor any of its employees will do any act that is inconsistent with such laws.

8.44 POLITICAL CONTRIBUTIONS. The Contractor affirms that, as applicable to the Contractor, all personal and business associates are in compliance with Chapter 3517 of the Ohio Revised Code regarding limitations on political contributions and will remain in compliance for the duration of the Contract and with all applicable provisions that extend beyond the expiration of the Contract.

8.45 DEBARMENT. Contractor represents that it is not debarred from consideration for contract awards by the Director of the Department of Administrative Services, pursuant to either R. C. 153.02 or R. C. 125.25.

8.46 EQUAL EMPLOYMENT OPPORTUNITY. The Contractor agrees to comply with all state and federal laws regarding equal employment opportunity, including Ohio Revised Code Section 125.111 and all related Executive Orders.

Before a contract can be awarded or renewed, an Affirmative Action Program Verification Form must be completed using the Ohio business Gateway Electronic Filing Web site at:

http://business.ohio.gov/efiling/ .

Approved Affirmative Action Plans can be found by going to the Equal Opportunity Department's Web site:

http://eodreporting.oit.ohio.gov/searchAffirmativeAction.aspx .

8.47 INJUNCTIVE RELIEF. Nothing in this Contract is intended to limit the State's right to injunctive relief if such is necessary to protect its interests or to keep it whole.

8.48 ASSIGNMENT. The Contractor may not assign this Contract or any of its rights or obligations under this Contract without the prior, written consent of the State.

8.49 GOVERNING LAW. This Contract is governed by the laws of Ohio, and venue for any disputes will lie exclusively with the appropriate court in Franklin County, Ohio.

ATTACHMENT ONE: REQUIREMENTS FOR PROPOSALS

A. PROPOSAL FORMAT. Each Proposal must include sufficient data to allow the State to verify the total cost for the Project and all of the Offeror's claims of meeting the RFP's requirements. Each Proposal must respond to every request for information in this attachment whether the request requires a simple "yes" or "no" or requires a detailed explanation. Simply repeating the RFP's requirement and agreeing to comply will be an unacceptable response and may cause the Proposal to be rejected.

These instructions describe the required format for a responsive Proposal. The Offeror may include any additional information it believes is relevant. An identifiable tab sheet must precede each section of a Proposal, and each Proposal must follow the format outlined below. All pages, except pre-printed technical inserts, must be sequentially numbered. Any material deviation from the format outlined below may result in a rejection of the non-conforming Proposal.

Each Proposal must contain the following information, chronologically in order, with tabbed sections as listed below:

1. Cover Letter and Mandatory Requirements.
2. Certification.
3. Signed Contracts.
4. Offeror Profile and Prior Projects.
5. Offeror References.
6. Staffing Plan.
7. Personnel Profile Summary.
8. Work Plan.
9. Specific Information Requests.
10. Conflict of Interest Statement.
11. Assumptions.
12. Proof of Insurance.
13. Performance Bond.
14. Payment Address.
15. Contract Performance.
16. W-9 Form and Additional Contractor Information Form.
17. Affirmative Action Plan.
18. Affirmation and Disclosure Form (Offshore Services).
19. Cost Summary Form.

B. REQUIREMENTS.

(1) Cover Letter. The cover letter must be in the form of a standard business letter and must be signed by an individual authorized to legally bind the Offeror. The cover letter will provide an executive summary of the Proposal. The letter must also have the following:

a. A statement regarding the Offerors legal structure (*e.g.*, an Ohio corporation), Federal tax identification number, and principal place of business.
b. A statement indicating whether Offeror is for-profit or non-profit. If non-profit, provide verification of status.
c. A list of the people who prepared the Proposal, including their titles.
d. The name, phone number, fax number, e-mail address, and mailing address of a contact person who has authority to answer questions regarding the Proposal.
e. A list of all subcontractors, if any, that the Offeror will use on the Project if the Offeror is selected to do the Work, and describe the duties to be performed by each.

f. For each proposed subcontractor, the Offeror must attach a letter from the subcontractor, signed by someone authorized to legally bind the subcontractor, with the following included in the letter:
   i. The subcontractor's legal status, tax identification number, and principal place of business address.
   ii. The name, phone number, fax number, e-mail address, and mailing address of a person who is authorized to legally bind the subcontractor to contractual obligations.
   iii. A description of the work the subcontractor will do.
   iv. A commitment to do the work if the Offeror is selected.
   v. A statement that the subcontractor has read and understood the RFP and will comply with the requirements of the RFP.
   vi. A statement that the SubContractor will maintain any permits, licenses, and certifications required to perform work.
g. A statement that the Offerors Proposal for the Project meets all the requirements of this RFP.
h. A statement that the Offeror has not taken any exception to the Terms and Conditions.
i. A statement that the Offeror does not assume there will be an opportunity to negotiate any aspect of the proposal.
j. A statement indicating the Offeror will comply with all Federal and Ohio Revised Code Laws and Administrative Code Rules as those law and rules are currently enacted and promulgated, and as they may subsequently be amended and adopted.
k. A statement that the Contractor shall not substitute, at Project start-up, different personnel from those evaluated by the State except when a candidate's unavailability is no fault of the Contractor (*e.g.*, Candidate is no longer employed by the Contractor, is deceased, etc.).
l. A statement that the Offeror is not now, and will not become subject to an "unresolved" finding for recovery under Revised Code Section 9.24, prior to the award of a Contract arising out of this RFP, without notifying DAS of such finding.
m. A statement that all the Offerors personal and business associates are in compliance with Chapter 3517 of the Revised Code regarding limitations on political contributions and will remain in compliance for the duration of the Contract and with all applicable provisions that extend beyond the expiration of the Contract. Refer to the Political Contributions paragraph in Part Eight, 8.44, of this RFP document.
n. All Contractors from whom the State or any of its political subdivisions make purchases in excess of $2500.00 shall have a written affirmative action program for the employment and effective utilization of economically disadvantaged persons, as referred to in division (E)(1) of section 122.71 of the Revised Code. Annually, each such Contractor shall file a description of the affirmative action program and a progress report on its implementation with the Equal Employment Opportunity office of the Department of Administrative Services. Provide a statement that the Offeror has been approved through this affirmative action program. Refer to the Affirmative Action paragraph in Attachment Two and to the Equal Employment Opportunity paragraph in Attachment Three, Part Seven of this RFP.
o. Registration with the Secretary of State. By the signature affixed to this Offer, the Offeror attests that the Offeror is:
   i. An Ohio corporation that is properly registered with the Ohio Secretary of State; or
   ii. A foreign corporation, not incorporated under the laws of the state of Ohio, but is registered with the Ohio Secretary of State pursuant to Ohio Revised Code Sections 1703.01 to 1703.31, as applicable.

   Any foreign corporation required to be licensed under Sections 1703.01 to 1703.31 of the Ohio Revised Code, which transacts business in the state of Ohio, without being so licensed, or when its license has expired or been canceled, shall forfeit not less than $250 nor more than $10,000 dollars. No officer of a foreign corporation shall transact business in the state of Ohio, if such corporation is required by Section 1703.01 to 1703.31 of the Revised Code to procure and maintain a license, but has not done so. Whoever violates this is guilty of a misdemeanor of the fourth degree.

Offeror attests that it is registered with the Ohio Secretary of State.

The Offerors Charter Number is: _____.

Questions regarding registration should be directed to (614) 466-3910 or visit the Web site at:
http://www.sos.state.oh.us

p. A description of any relationships the Offeror, or its subcontractors, may have or have had with the State of Ohio over the last twenty-four (24) months. If no such relationship exists, the Offeror must declare. If the Offeror has contracted with the State of Ohio, identify the contract number and/or any other information available to identify such contract(s). If no such contracts exist, so declare.
q. A declaration for which region(s) Offeror proposes to perform the Work.

All Offerors who seek to be considered for a contract award must submit a response that contains an affirmative statement using the language in paragraphs (a) through (q) above.

Responses to all Mandatory Requirements from Table 1 must be included in this section (Tab 1).

(2) Certification. Each Proposal must include the following certification signed by the individual Offeror.

(*Insert Company name*) affirms they are the prime Offeror.

(*Insert Company name*) affirms that all personnel provided for the Project, who are not United States citizens, will have executed a valid I-9 form and presented valid employment authorization documents.

(*Insert Company name*) affirms that any small business program individuals will provide necessary data to ensure program reporting and compliance.

(*Insert Company name*) agrees that it is a separate and independent enterprise from the state of Ohio, the Agency, and the Department of Administrative Services. (*Insert Company name*) has a full opportunity to find other business and has made an investment in its business. Moreover (*Insert Company name*) will retain sole and absolute discretion in the judgment of the manner and means of carrying out its obligations and activities under the Contract. This Contract is not to be construed as creating any joint employment relationship between (*Insert Company name*) or any of the personnel provided by (*Insert Company name*), the Agency, or the Department of Administrative Services.

(*Insert Company name*) affirms that the individuals supplied under the Contract are either: (1) employees of (*Insert Company name*) with (*Insert Company name*) withholding all appropriate taxes, deductions, or contributions required under law; or (2) independent Contractors to (*Insert Company name*).

If the Offeror's personnel are independent Contractors to the Offeror, the certification must also contain the following sentence:

(*Insert Company name*) affirms that it has obtained a written acknowledgement from its independent Contractors that they are separate and independent enterprises from the state of Ohio and the Department of Administrative Services and the Agency for all purposes including the application of the Fair Labor Standards Act, Social Security Act, Federal Unemployment Tax Act, Federal Insurance Contributions Act, the provisions of the Internal Revenue Code, Ohio tax law, worker's compensation law and unemployment insurance law.

(3) Signed Contracts. The Offeror must provide two (2) originally signed, blue ink copies of the included Contract, Attachment Two. Offeror must complete, sign and date both copies of the Contract and include it with their Proposal. (Attachment Two).

(4) Offeror Profile and Prior Projects. Each Proposal must include a profile of the Offeror's capability, capacity, and relevant experience working on similar projects. Unless otherwise indicated, a separate page for each section must be used. The profile must include in separate sections the following:

a. Offeror's legal name; address; telephone number; fax number; e-mail address; home office location; date established; ownership (such as public firm, partnership, or subsidiary); firm leadership (such as corporate officers or partners); number of employees; number of employees engaged in tasks directly related to the Work; and any other background information that will help the State gauge the ability of the Offeror to fulfill the obligations of the Contract. Please use Attachment Three A.
b. A description of the financial stability of the company. This section should include the submission of the most recent financial statements from the Offeror.
c. The Offeror must provide evidence that Offeror has completed an external quality review by an external quality review organization (EQRO). If the Offeror has not completed such a review, the Offeror must provide a description of the entity that will conduct this external quality review of the Offeror and when it will take place if the contract is awarded to the Offeror. (The cost of this review will not be reimbursed and will be the Offeror's responsibility.)
d. A description of any contract termination of the Offeror, which occurred before completion of all obligations under the initial contract provisions, for default, non-performance, or any other reason, during the past three (3) years. If no such early terminations have occurred in the past three years, so declare.
e. Offerors must describe current operational capacity of the organization and the Offeror's ability to absorb the additional workload resulting from this Project.
f. The Offeror must document previous experience and expertise in providing a minimum of three (3) previous projects, similar in size, scope and complexity, in the previous five (5) years. Details of the similarities must be included. Please use Attachments Three B, C, and D.
g. The Offeror must provide samples of at least three projects or initiatives with individual and advocacy groups and diverse stakeholders completed within the past five years. Describe the Offeror's role, responsibilities, and the outcomes.
h. The Offeror must provide three examples of how the Offeror implemented system changes that were directly responsible for improved quality of care for program individuals.
i. The Offeror must provide evidence of capacity to provide a diverse and experienced workforce to meet the needs of all populations served by this RFP, including, but not limited to geriatrics, pediatrics, mental health and developmental disabilities.
j. The Offeror must provide evidence that it has at least two years' experience with federally or state-funded programs within the past five years.
k. The Offeror must provide one example of cost containment of program costs with average expenditures by individual.
l. The Offeror must provide evidence of at least two years' experience maintaining individual service costs within constraints set by third-party payers.
m. The Offeror must provide results of individual satisfaction surveys completed regarding case management services within the last two years.
n. The Offeror must provide evidence of the Offeror's experience encouraging individual self-direction and independent living as part of its case management philosophy.
o. The Offeror must provide evidence of its experience serving as a local community resource and as a linkage point to other local resources.

(5) Offeror References. The Offeror must include a minimum of three (3) references for organizations and/or clients for whom the Offeror has successfully provided services on projects that were similar in their nature, size, and scope to the Work.

These references must relate to work that was completed within the past five (5) years. This RFP includes an Offeror Reference Form as Attachment Four. Failure to recreate the form accurately may lead to the rejection of the Offeror's Proposal.

The State does not assume that since the experience requirement is provided at the top of the page that all descriptions on that page relate to that requirement. Offerors must reiterate the experience being described, including the capacity in which the experience was performed and the role of the Offeror on the Project. It is the Offeror's responsibility to customize the description to clearly substantiate the qualification. Previous experience must include the conduct, management, and coordination of projects. Incumbents must ensure specifics are addressed. Evaluations will not be based on intrinsic knowledge of evaluation committee members.

The description of the related service shows the Offeror's experience, capability, and capacity to develop this Project's deliverables and/or to achieve this Project's work and deliverables and/or to achieve this Project's milestones. Details such as the size of the contracting organizations, duration of involvement, level of responsibility, significant accomplishments, as well as a thorough description of the nature of the experience will be required for appropriate evaluation by the committee.

a. Contact Information. The contact name, title, phone number, e-mail address, company name, and mailing address must be completely filled out. If the primary contact cannot be reached, the same information must be included for an alternate contact in lieu of the primary contact. Failure to provide requested contact information may result in the State not including the reference in the evaluation process.
b. Project Name. The name of the project where the mandatory experience was obtained and/or service was provided.
c. Dates of Experience. Must be completed to show the length of time the Offeror performed the experience being described, not the length of time the Offeror was engaged for the reference. The Offeror must complete these dates with a beginning month and year and an ending month and year.
d. Description of the Related Service Provided. The State does not assume that since the experience requirement is provided at the top of the page that all descriptions on that page relate to that requirement. Offerors must reiterate the experience being described, including the capacity in which the experience was performed and the role of the Offeror on the Project. It is the Offeror's responsibility to customize the description to clearly substantiate the qualification.
e. Description of how the related service shows the Offeror's experience, capability and capacity to develop this Project's work and deliverables and/or to achieve this Project's milestones.
f. The Offeror's project experience must be listed separately and completely every time it is referenced, regardless of whether it is on the same or different pages of the form.

When contacted, each reference must be willing to discuss the Offeror's previous performance on projects that were similar in their nature, size, and scope to the Work.

<u>(6) Staffing Plan.</u> The Offeror must provide a staffing plan that identifies all key personnel required to do the Project and their responsibilities on the Project. The State is seeking a staffing plan that matches the proposed Project personnel and qualifications to the activities and tasks that will be completed on the Project. In addition, the plan must have the following information:

a. A matrix matching each key team member to the staffing requirements in this RFP.
b. A contingency plan that shows the ability to add more staff if needed to ensure meeting the Project's due date(s).
c. A discussion of the Offeror's ability to provide qualified replacement personnel.

(7) Personnel Profile Summary**.** This RFP includes Offeror Candidate Forms as Attachments Five A, B and C. The Offeror must use these forms and fill them out completely for each key candidate referenced. The key candidates for this RFP include all management and supervisory staff. The forms must be completed using typewritten or electronic means. The forms may be recreated electronically, but all fields and formats must be retained. Failure to recreate the forms accurately may lead to the rejection of the Offeror's Proposal.

All candidate requirements must be provided using the Offeror Candidate Forms (See Attachments Five A, B and C.) The various sections of the form are described below:

For each reference the following information must be provided:

a. Candidate's Name.
b. Contact Information. The contact name, title, phone number, e-mail address, company name, and mailing address must be completely filled out.
   If the primary contact cannot be reached, the same information must be included for an alternate contact in lieu of the primary contact. Failure to provide requested contact information may result in the State not including the reference experience in the evaluation process.
c. Dates of Experience. Must be completed to show the length of time the candidate performed the technical experience being described, not the length of time the candidate worked for the company. The Offeror must complete these dates with a beginning month and year and an ending month and year.
d. Description of the Related Service Provided. The State does not assume that since the technical requirement is provided at the top of the page that all descriptions on that page relate to that requirement. Contractors must reiterate the technical experience being described, including the capacity in which the experience was performed and the role of the candidate in the reference project as it relates to this RFP. It is the Contractors' responsibility to customize the description to clearly substantiate the candidate's qualification.
   i. Candidate References. If fewer than three (3) projects are provided, the Offeror must include information as to why fewer than three (3) projects were provided. The State may disqualify the proposal if fewer than three (3) projects are given. (Refer to Attachment Five A.)
   ii. Education and Training. This section must be completed to list the education and training of the proposed candidates and will demonstrate, in detail, the proposed candidate's ability to properly execute the Contract based on the relevance of the education and training to the requirements of the RFP. Offeror must include copies of any pertinent licenses and or certificates. (Refer to Attachment Five B.)
   iii. Required Experience and Qualifications. This section must be completed to show how the candidate meets the required experience requirements. If any candidate does not meet the required requirements for the position the candidate has been proposed to fill, the Offeror's Proposal may be rejected as non-responsive. (Refer to Attachment Five C.)

The candidate's project experience must be listed separately and completely every time it is referenced, regardless of whether it is on the same or different pages of the form.

Offeror must also provide evidence that all case managers are either licensed Registered Nurses (RN) as defined by the Ohio Board of Nursing, or licensed Social Workers (LSW or LISW) as defined by the Counselor, Social Worker, & Marriage & Family Therapist Board in the State of Ohio, with one year paid clinical experience in home and community based services.

(8) Work Plan. Offeror must fully describe its current capacity, approach, methods, and specific work steps for doing the Work on this Project. The State encourages responses that demonstrate a thorough understanding of the nature of the Project and what the Contractor must do to complete the Project satisfactorily.

To this end, the Offeror must submit for this section of the Proposal the Project plan that will be used to create a consistent, coherent management plan of action that will be used to guide the Project. The Project plan should include detail sufficient to give the State an understanding of the Offeror's knowledge and approach.

The Work Plan must demonstrate an understanding of the requirements of the Project as described in Part Six – Scope of Work. Describe the methodologies, processes and procedures it will utilize in the implementation and production of the Scope of Work. Provide a comprehensive Work Plan that gives ample description and detail as to how it proposes to accomplish this Project and what resources are necessary to meet the deliverables.

The State seeks insightful responses that describe proven state-of-the-art methods. Recommended solutions should demonstrate that the Offeror would be prepared to immediately undertake and successfully complete the required tasks. The Offeror's Work Plan should clearly and specifically identify key personnel assignments. (NOTE: The staffing plan should be consistent with the Work plans).

Additionally, the Offeror should address potential problem areas, recommended solutions to the problem areas, and any assumptions used in developing those solutions.

(9) Specific Information Requests. In addition to providing a Work Plan, Offeror must provide responses to each of the following information requests:

a. Describe Offeror's organizational culture, and included Offeror's mission and vision statements.
b. Describe the required amount of face-to-face trainings, meetings, supervisory meetings, and supervisory observation that the Offeror will require beyond what is required in this contract.
c. Describe how the clinical and program areas will communicate with each other.
d. Describe what Offeror's philosophy is about person-centered planning, dignity of risk, self-determination, independent living and self direction, and how all of these tenets will be translated into its case management practice.
e. Describe Offeror's practice of crisis management and provide at least three examples of past crisis management experiences with individuals.
f. Describe Offeror's practice of conflict resolution and provide at least three examples of past conflict resolution.
g. Describe how Offeror will convene and lead multidisciplinary team meetings including how Offeror will engage with acute and long term care providers (Medicaid, Medicare and private insurers) and other case management agencies to assure coordination of services.
h. Describe how Offeror will do community outreach.
i. Describe Offeror's customer service philosophy.
j. Describe how Offeror's will monitor operations to assure quality.
k. Describe how case managers will educate individuals applying for or enrolled on the waiver program about the waiver programs and the individuals' options.
l. Describe the Offeror's community resource manual and how it will be maintained, updated, and made available to case management staff.
m. Describe how new staff will be trained and how ongoing training will be performed. Describe how much class work will be required. Describe whether there will be shadowing, and observation, and if so, how much. Describe how often case managers will visit home health agencies, adult day care facilities, and communicate with home modification providers.

n. Describe how Offeror will have consultation access to individuals with expertise in the following subject areas: psychology, gerontology, counseling, pediatrics, developmental disabilities, mental health, education, child development, vocational services, family support, guardianship, adult transition, substance abuse, behavioral health, rehabilitation, and special education.
o. Describe how Offeror will meet the record keeping policies and procedures for the Work. Describe Offeror's experience with electronic health records.
p. Describe the Offeror's plan for assuring the health and welfare of individuals in the event of a disaster.
q. Describe how the Offeror will provide 24 hour coverage, including all after hours protocols.
r. Describe how the Offeror will adapt to changes in federal and state Medicaid laws, rules and policies.
s. Describe Offeror's processes and timeframes to successfully transition individuals from one case management organization to another case management organization.
t. Describe Offeror's processes of transitioning individuals into the community or from program to program.
u. Describe how the Offeror will interface with the statewide Provider Oversight Contractor.

(10) Conflict of Interest Statement. Each Proposal must include a statement indicating whether the Offeror or any people that may work on the Project through the Offeror have a possible conflict of interest (*e.g.*, employed by the State of Ohio, etc.) and, if so, the nature of that conflict. The State has the right to reject a Proposal in which a conflict is disclosed or cancel the Contract if any interest is later discovered that could give the appearance of a conflict.

(11) Assumptions. The Offeror must provide a comprehensive listing of any and all of the assumptions that were made in preparing the proposal. If any assumption is unacceptable to the State, it may be cause for rejection of the Proposal. No assumptions shall be included regarding negotiation, terms and conditions, and requirements.

(12) Proof of Insurance. In this section, the Offeror must provide the certificate of insurance required by the General Terms & Conditions, Part Eight. The policy may be written on an occurrence or claims made basis.

(13) Performance Bond. The Contractor must provide a performance bond. The amount of the performance bond must be equal to at least 3% of the total amount of the Contract and must remain in place through each fiscal year of the Contract. Each Offeror must enclose a letter of commitment from a bonding company for the performance bond with its Proposal. The performance bond may be renewed annually. The Contractor is solely responsible for all costs associated with the performance bond.

(14) Payment Address. The Offeror must provide the address to which payments to the Offeror will be sent.

(15) Contract Performance. The Offeror must complete Attachment Six, Offeror Performance Form.

(16) W-9 Form and Contractor Information Form. The Offeror must complete Federal Form W-9, Request for Taxpayer Identification Number and Certification form and the Contractor Information Form (OBM-5657) in their entirety. At least one (1) original of each form (signed in blue ink) must be submitted in the "original" copy of the Proposal. All other copies of the Proposal may contain duplicates of these completed forms. If a subsidiary company is involved, Offerors must have an original W-9 and OBM-5657 for both the parent and subsidiary companies. These documents and directions can be found on the OBM Web site under the heading "Contractor Forms" at
http://www.ohiosharedservices.ohio.gov/Contractors.aspx

(17) Affirmative Action. Before a contract can be awarded or renewed, an Affirmative Action Program Verification Form must be completed using:
http://das.ohio.gov/Divisions/EqualOpportunity/AffirmativeActionProgramVerification/tabid/133/Default.aspx.

Approved Affirmative Action Plans can be found by going to the Equal Opportunity Department's Web site:
http://eodreporting.oit.ohio.gov/searchAffirmativeAction.aspx

Copies of approved Affirmative Action plans shall be supplied by the Offeror as part of its Proposal or inclusion of an attestation to the fact that the Offeror has completed the process and is pending approval by the EOD office.

(18) Prohibiting the Expenditure of Public Funds on Offshore Services. The Offeror must complete the Contractor/Subcontractor Affirmation and Disclosure form (Attachment Seven) to abide with Executive Order 2011-12K issued by the Governor of Ohio, affirming no services of the Contractor or its subcontractors under this Contract will be performed outside the United States.

During the performance of this Contract, the Offeror must not change the location(s) of the country where the services are performed, change the location(s) of the country where the data are maintained, or made available without express written authorization of the Department of Administrative Services.

(19) Cost Summary Form. The Cost Summary Form (Attachment Eight) must be submitted with the Offeror's Proposal. The Offeror's total cost for the entire Project must be represented as the firm fixed price, for a not-to-exceed fiscal year cost. Offerors shall provide a comprehensive cost analysis; this cost must include all ancillary costs. All costs for furnishing the services must be included in the Cost Proposals as requested. No mention of or reference to, the Cost Proposals may be made in responses to the general, technical, performance, or support requirements of this RFP.

All prices, costs, and conditions outlined in the proposal shall remain fixed and valid for acceptance for 120 days, starting on the due date for proposals. The awarded Contractor must hold the accepted prices and/or costs for the entire contract period. No price change shall be effective without prior written consent from DAS, OPS.

NOTE: Offerors should ensure Cost Proposals are submitted separately from the Technical Proposals, as indicated the Proposal Submittal paragraph of this RFP (see Part Three). This information should not be included in the Technical Proposal.

The State shall not be liable for any costs the Offeror does not identify in its Proposal.

ATTACHMENT TWO
CONTRACT

This Contract, which results from RFP CSP900714, entitled Home and Community Based Waiver Case Management is between the state of Ohio, through the Department of Administrative Services, Office of Procurement Services, on behalf of the Office of Medical Assistance (the "State") and

_____
(The "Contractor").

If this RFP results in a contract award, the Contract will consist of this RFP including all attachments, written addenda to this RFP, the Contractor's proposal, and written, authorized addenda to the Contractor's proposal. It will also include any materials incorporated by reference in the above documents and any purchase orders and change orders issued under the Contract. The form of the Contract is this one (1) page attachment to the RFP, which incorporates by reference all the documents identified above. The general terms and conditions for the Contract are contained in another attachment to the RFP. If there are conflicting provisions between the documents that make up the Contract, the order of precedence for the documents is as follows:

1. This RFP, as amended;
2. The documents and materials incorporated by reference in the RFP;
3. The Contractor's Proposal, as amended, clarified, and accepted by the State; and
4. The documents and materials incorporated by reference in the Contractor's Proposal.

Notwithstanding the order listed above, change orders and amendments issued after the Contract is executed may expressly change the provisions of the Contract. If they do so expressly, then the most recent of them will take precedence over anything else that is part of the Contract.

This Contract has an effective date of the later of July 1, 2013 or the occurrence of all conditions precedent specified in the General Terms and Conditions.

IN WITNESS WHEREOF, the parties have executed this Contract as of the dates below.

_____	Department of Administrative Services
(Contractor)	(State of Ohio Agency)
_____	_____
(Signature)	(Signature)
_____	Robert Blair
(Printed Name)	(Printed Name)
_____	Director, Department of Administrative Services
(Title)	(Title)
_____	_____
(Date)	(Date)

ATTACHMENT THREE A
OFFEROR PROFILE FORM

Offeror's Legal Name:	Address:	
Phone Number:	Fax Number:	E-mail Address:
Home Office Location:	Date Established:	Ownership:
Firm Leadership:	Number of Employees:	Number of Employees Directly involved in Tasks Directly Related to the Work:
Additional Background Information:		

ATTACHMENT THREE B
OFFEROR PRIOR PROJECT FORM

Customer Company Name:	Contact:	
Address:	Phone Number: E-mail:	
Project Name:	Beginning Date of Project (Month/Year):	Ending Date of Project (Month/Year):

The Offeror must document previous experience and expertise in providing a minimum of three (3) previous projects working, similar in size and complexity, in the previous five (5) years. These projects must be of similar size, scope and nature. Details of the similarities must be included. Attachment Three B, C, and D must be filled out completely for each of the three (3) projects provided. The Offeror must use these forms and fill them out completely to provide the Offeror requirement information. Failure to recreate the form accurately to include all fields, may lead to the rejection of the Offeror's Proposal.

ATTACHMENT THREE C
OFFEROR PRIOR PROJECT FORM

Customer Company Name:	Contact:	
Address:	Phone Number: E-mail:	
Project Name:	Beginning Date of Project (Month/Year):	Ending Date of Project (Month/Year):

The Offeror must document previous experience and expertise in providing a minimum of three (3) previous projects working, similar in size and complexity, in the previous five (5) years. These projects must be of similar size, scope and nature. Details of the similarities must be included. Attachment Three B, C, and D must be filled out completely for each of the three (3) projects provided. The Offeror must use these forms and fill them out completely to provide the Offeror requirement information. Failure to recreate the form accurately to include all fields, may lead to the rejection of the Offeror's Proposal.

ATTACHMENT THREE D
OFFEROR PRIOR PROJECT FORM

Customer Company Name:	Contact:	
Address:	Phone Number: E-mail:	
Project Name:	Beginning Date of Project (Month/Year):	Ending Date of Project (Month/Year):

The Offeror must document previous experience and expertise in providing a minimum of three (3) previous projects working, similar in size and complexity, in the previous five (5) years. These projects must be of similar size, scope and nature. Details of the similarities must be included. Attachment Three B, C, and D must be filled out completely for each of the three (3) projects provided. The Offeror must use these forms and fill them out completely to provide the Offeror requirement information. Failure to recreate the form accurately to include all fields, may lead to the rejection of the Offeror's Proposal.

ATTACHMENT FOUR
OFFEROR REFERENCES
PAGE ONE

Three (3) professional references who have received services from the Offeror in the past five (5) years

Company Name:	Contact Name:	
Address:	Phone Number: E-Mail Address:	
Project Name:	Beginning Date of Project: (Month/Year)	Ending Date of Project: (Month/Year)
Description of project size, complexity and the Offeror's role in this project.		

ATTACHMENT FOUR
OFFEROR REFERENCES
PAGE TWO

Company Name:	Contact Name:	
Address:	Phone Number: E-Mail Address:	
Project Name:	Beginning Date of Project: (Month/Year)	Ending Date of Project: (Month/Year)
Description of project size, complexity and the Offeror's role in this project.		
Company Name:	Contact Name:	
Address:	Phone Number: E-Mail Address:	
Project Name:	Beginning Date of Project: (Month/Year)	Ending Date of Project: (Month/Year)
Description of project size, complexity and the Offeror's role in this project.		

ATTACHMENT FIVE A
OFFEROR'S CANDIDATE REFERENCES
PAGE ONE

Candidate's Name: _____

Candidate's Proposed Position: _____

Three (3) professional references who have received services from the candidate in the past three (3) years

Company Name:	Contact Name:	
Address:	Phone Number: E-mail:	
Project Name:	Beginning Date of Project: Month/Year	Ending Date of Project: Month/Year
Description of project size, complexity, and the candidate's role in this project.		

ATTACHMENT FIVE A
OFFEROR'S CANDIDATE REFERENCES
PAGE TWO

Company Name:	Contact Name:	
Address:	Phone Number: E-mail:	
Project Name:	Beginning Date of Project: Month/Year	Ending Date of Project: Month/Year
Description of project size, complexity, and the candidate's role in this project.		
Company Name:	Contact Name:	
Address:	Phone Number: E-mail:	
Project Name:	Beginning Date of Project: Month/Year	Ending Date of Project: Month/Year
Description of project size, complexity, and the candidate's role in this project.		

ATTACHMENT FIVE B
OFFEROR'S CANDIDATE INFORMATION
EDUCATION AND TRAINING

Candidate's Name: _____

Education and Training: This section must be completed to list the education and training of the proposed candidate.

Name and Address	Months/Years	Degree/Major
College		
Technical School		
Licenses		
Certifications		

ATTACHMENT FIVE C
OFFEROR'S CANDIDATE EXPERIENCE REQUIREMENT

Candidate's Name: _____

Candidate's Proposed Position: _____

Client Company Name:	Client's Project Supervisor Contact Name:	
Address:	Phone Number: E-Mail:	
Project Name:	Beginning Date of Project: Month/Year	Ending Date of Project: Month/Year
Description of the related services provided:		
Client Company Name:	Client's Project Supervisor Contact Name:	
Address:	Phone Number: E-Mail:	
Project Name:	Beginning Date of Project: Month/Year	Ending Date of Project: Month/Year
Description of the related services provided:		
Client Company Name:	Client's Project Supervisor Contact Name:	
Address:	Phone Number: E-Mail:	
Project Name:	Beginning Date of Project: Month/Year	Ending Date of Project: Month/Year
Description of the related services provided:		

ATTACHMENT SIX
OFFEROR PERFORMANCE FORM

The Offeror must provide the following information for this section for the past seven (7) years. Please indicate yes or no in each column.

Yes/No	Description
	The Offeror has had a contract terminated for default or cause. If so, the Offeror must submit full details, including the other party's name, address, and telephone number.
	The Offeror has been assessed any penalties in excess of five thousand dollars ($5,000), including liquidated damages, under any of its existing or past contracts with any organization (including any governmental entity). If so, the Offeror must provide complete details, including the name of the other organization, the reason for the penalty, and the penalty amount for each incident.
	The Offeror was the subject of any governmental action limiting the right of the Offeror to do business with that entity or any other governmental entity.
	Has trading in the stock of the company ever been suspended? If so provide the date(s) and explanation(s).
	The Offeror, any officer of the Offeror, or any owner of a twenty percent (20%) interest or greater in the Offeror has filed for bankruptcy, reorganization, a debt arrangement, moratorium, or any proceeding under any bankruptcy or insolvency law, or any dissolution or liquidation proceeding.
	The Offeror, any officer of the Offeror, or any owner with a twenty percent (20%) interest or greater in the Offeror has been convicted of a felony or is currently under indictment on any felony charge.

If the answer to any item above is affirmative, the Offeror must provide complete details about the matter. While an affirmative answer to any of these items will not automatically disqualify an Offeror from consideration, at the sole discretion of the State, such an answer and a review of the background details may result in a rejection of the Offeror’s proposal. The State will make this decision based on its determination of the seriousness of the matter, the matter’s possible impact on the Offeror’s performance on the project, and the best interests of the State.

ATTACHMENT SEVEN
CONTRACTOR / SUBCONTRACTOR AFFIRMATION AND DISCLOSURE
PAGE ONE

DEPARTMENT OF ADMINISTRATIVE SERVICES

STANDARD AFFIRMATION AND DISCLOSURE FORM

EXECUTIVE ORDER 2011-12K

Governing the Expenditure of Public Funds on Offshore Services

By the signature affixed hereto, the Contractor affirms, understands and will abide by the requirements of Executive Order 2011-12K. If awarded a contract, both the Contractor and any of its subcontractors shall perform no services requested under this Contract outside of the United States.

The Contractor shall provide all the name(s) and location(s) where services under this Contract will be performed in the spaces provided below or by attachment. Failure to provide this information may subject the Contractor to sanctions. If the Contractor will not be using subcontractors, indicate "Not Applicable" in the appropriate spaces.

1. Principal location of business of Contractor:

   _____ _____
   (Address) (City, State, Zip)

   Name/Principal location of business of subcontractor(s):

   _____ _____
   (Name) (Address, City, State, Zip)

   _____ _____
   (Name) (Address, City, State, Zip)

2. Location where services will be performed by Contractor:

   _____ _____
   (Address) (City, State, Zip)

   Name/Location where services will be performed by subcontractor(s):

   _____ _____
   (Name) (Address, City, State, Zip)

   _____ _____
   (Name) (Address, City, State, Zip)

ATTACHMENT SEVEN
CONTRACTOR / SUBCONTRACTOR AFFIRMATION AND DISCLOSURE
PAGE TWO

3. Location where state data will be stored, accessed, tested, maintained or backed-up, by Contractor:

_____ _____
(Address) (Address, City, State, Zip)

Name/Location(s) where state data will be stored, accessed, tested, maintained or backed-up by subcontractor(s):

_____ _____
(Name) (Address, City, State, Zip)

_____ _____
(Name) (Address, City, State, Zip)

_____ _____
(Name) (Address, City, State, Zip)

_____ _____
(Name) (Address, City, State, Zip)

_____ _____
(Name) (Address, City, State, Zip)

Contractor also affirms, understands and agrees that Contractor and its subcontractors are under a duty to disclose to the State any change or shift in location of services performed by Contractor or its subcontractors before, during and after execution of any contract with the State. Contractor agrees it shall so notify the State immediately of any such change or shift in location of its services. The State has the right to immediately terminate the contract, unless a duly signed waiver from the State has been attained by the Contractor to perform the services outside the United States.

On behalf of the Contractor, I acknowledge that I am duly authorized to execute this Affirmation and Disclosure form and have read and understand that this form is part of any Contract that Contractor may enter into with the State and is incorporated therein.

By: _____
Contractor

Print Name: _____

Title: _____

Date: _____

ATTACHMENT EIGHT
COST SUMMARY FORM
CINCINNATI REGION

Offerors are to complete this form (or a facsimile) fully for each of the regions that they are submitting an Offer. Prices must be submitted in U.S. dollars by deliverable and for each State Fiscal Year (SFY). The State will not be responsible for any costs not identified. There will be no additional reimbursement for travel or other related expenses. No other compensation for the selected Contractor's services will be permitted.

The State fiscal year begins on July 1 and ends on June 30 of the following year. The first year will begin upon award of the Contract or July 1, 2013, whichever comes first. SFY 14 costs are required, but contract renewal for SFY 15 is contingent upon availability of necessary funding, satisfactory Contractor performance in SFY 14, all required funding and contract approvals, and is at the sole discretion of the Office of Medical Assistance. In addition, certain waiver programs may be transitioned out of the Contract during any state fiscal year.

Estimated monthly volume for the entire region has been provided for evaluation purposes only. These estimates were based on the best information available to the Office of Medical Assistance at this writing, and are not to be taken as a guarantee of actual volume that will be realized by the Contractor. The Office of Medical Assistance may award two (2) contracts per region. Offeror shall not insert a unit cost of more than three (3) digits to the right of the decimal point. Digit(s) beyond three (3) will be dropped and not used in the evaluation of the Cost Proposal.

Deliverable Description	**Estimated Monthly Volume SFY 2014**	**SFY 2014 rate (July 1, 2013 - June 30, 2014)**	**Estimated Monthly Volume SFY 2015**	**SFY 2015 rate (July 1, 2014 – June 30, 2015)**
Initial Contact	130		130	
Assessment (includes initial and annual)	305		225	
Caseload Managed	2100		1100	

FINAL DRAFT

ATTACHMENT EIGHT
COST SUMMARY FORM
CLEVELAND REGION

Offerors are to complete this form (or a facsimile) fully for each of the regions that they are submitting an Offer. Prices must be submitted in U.S. dollars by deliverable and for each State Fiscal Year (SFY). The State will not be responsible for any costs not identified. There will be no additional reimbursement for travel or other related expenses. No other compensation for the selected Contractor's services will be permitted.

The State fiscal year begins on July 1 and ends on June 30 of the following year. The first year will begin upon award of the Contract or July 1, 2013, whichever comes first. SFY 14 costs are required, but contract renewal for SFY 15 is contingent upon availability of necessary funding, satisfactory Contractor performance in SFY 14, all required funding and contract approvals, and is at the sole discretion of the Office of Medical Assistance. In addition, certain waiver programs may be transitioned out of the Contract during any state fiscal year.

Estimated monthly volume for the entire region has been provided for evaluation purposes only. These estimates were based on the best information available to the Office of Medical Assistance at this writing, and are not to be taken as a guarantee of actual volume that will be realized by the Contractor. The Office of Medical Assistance may award two (2) contracts per region. Offeror shall not insert a unit cost of more than three (3) digits to the right of the decimal point. Digit(s) beyond three (3) will be dropped and not used in the evaluation of the Cost Proposal.

Deliverable Description	**Estimated Monthly Volume SFY 2014**	**SFY 2014 rate (July 1, 2013 - June 30, 2014)**	**Estimated Monthly Volume SFY 2015**	**SFY 2015 rate (July 1, 2014 – June 30, 2015)**
Initial Contact	200		200	
Assessment (includes initial and annual)	470		320	
Caseload Managed	3235		1400	

FINAL DRAFT

ATTACHMENT EIGHT
COST SUMMARY FORM
COLUMBUS REGION

Offerors are to complete this form (or a facsimile) fully for each of the regions that they are submitting an Offer. Prices must be submitted in U.S. dollars by deliverable and for each State Fiscal Year (SFY). The State will not be responsible for any costs not identified. There will be no additional reimbursement for travel or other related expenses. No other compensation for the selected Contractor's services will be permitted.

The State fiscal year begins on July 1 and ends on June 30 of the following year. The first year will begin upon award of the Contract or July 1, 2013, whichever comes first. SFY 14 costs are required, but contract renewal for SFY 15 is contingent upon availability of necessary funding, satisfactory Contractor performance in SFY 14, all required funding and contract approvals, and is at the sole discretion of the Office of Medical Assistance. In addition, certain waiver programs may be transitioned out of the Contract during any state fiscal year.

Estimated monthly volume for the entire region has been provided for evaluation purposes only. These estimates were based on the best information available to the Office of Medical Assistance at this writing, and are not to be taken as a guarantee of actual volume that will be realized by the Contractor. The Office of Medical Assistance may award two (2) contracts per region. Offeror shall not insert a unit cost of more than three (3) digits to the right of the decimal point. Digit(s) beyond three (3) will be dropped and not used in the evaluation of the Cost Proposal.

Deliverable Description	**Estimated Monthly Volume SFY 2014**	**SFY 2014 rate (July 1, 2013 - June 30, 2014)**	**Estimated Monthly Volume SFY 2015**	**SFY 2015 rate (July 1, 2014 – June 30, 2015)**
Initial Contact	175		175	
Assessment (includes initial and annual)	460		350	
Caseload Managed	3440		2140	

FINAL DRAFT

ATTACHMENT EIGHT
COST SUMMARY FORM
MARIETTA REGION

Offerors are to complete this form (or a facsimile) fully for each of the regions that they are submitting an Offer. Prices must be submitted in U.S. dollars by deliverable and for each State Fiscal Year (SFY). The State will not be responsible for any costs not identified. There will be no additional reimbursement for travel or other related expenses. No other compensation for the selected Contractor's services will be permitted.

The State fiscal year begins on July 1 and ends on June 30 of the following year. The first year will begin upon award of the Contract or July 1, 2013, whichever comes first. SFY 14 costs are required, but contract renewal for SFY 15 is contingent upon availability of necessary funding, satisfactory Contractor performance in SFY 14, all required funding and contract approvals, and is at the sole discretion of the Office of Medical Assistance. In addition, certain waiver programs may be transitioned out of the contract during any state fiscal year.

Estimated monthly volume for the entire region has been provided for evaluation purposes only. These estimates were based on the best information available to the Office of Medical Assistance at this writing, and are not to be taken as a guarantee of actual volume that will be realized by the Contractor. The Office of Medical Assistance may award two contracts per region. Offeror shall not insert a unit cost of more than three (3) digits to the right of the decimal point. Digit(s) beyond three (3) will be dropped and not used in the evaluation of the Cost Proposal.

Deliverable Description	**Estimated Monthly Volume SFY 2014**	**SFY 2014 rate (July 1, 2013 - June 30, 2014)**	**Estimated Monthly Volume SFY 2015**	**SFY 2015 rate (July 1, 2014 – June 30, 2015)**
Initial Contact	95		95	
Assessment (includes initial and annual)	265		260	
Caseload Managed	2035		1965	

FINAL DRAFT

ATTACHMENT NINE
ADDITIONAL REQUIREMENTS FOR THE CREATION AND MAINTENANCE OF ELECTRONIC RECORDS

If a Contractor intends to create and maintain electronic records, the following requirements must be met. These requirements may be modified by OMA during the terms of this Contract.

A. Preparing Documents for Electronic Storage

Documents must be arranged and identified in a logical manner. In order to assure a clearly legible image, all staples, paper clips, rubber bands, and post-it notes should be removed before copying.

Contractor will scan both sides of every document to assure the accuracy and completeness of the digital product. Accurate images produced by Contractor are legally admissible in court in lieu of the original. Though digitizing can often provide a more legible copy than the original document, Contractor is cautioned that maximum usability, rather than maximum enhancement, is the primary criterion for Contractor imaging.

B. Indexing

An index must be created for all documents electronically stored. The indexing fields must be created in a way to allow efficient location of digitized records. List all information required to locate and access the records and specify the length/type of the information. Examples are: Medicaid provider number (7 spaces; numeric); name (up to 30 spaces, alpha); date (8 spaces, numeric). This information will build the indexing fields used for searching the project images.

C. Quality Control

Contractor will maintain quality control throughout the imaging process and must certify the accuracy of every image scanned. It is the responsibility of Contractor to review the final digitized product and identify any problems that may require re-scanning. To facilitate any necessary re-scanning, Contractor must maintain original documents until Contractor is certain that the data has been properly scanned. Contractor has the authority to delete material imaged in error, from the final product, without a re-scan.

D. Image Quality

Contractor must produce a legally acceptable image that is at least equal to the quality of the original document. Contractor will attempt to enhance an image, after which a “Best Image Possible” note will be appended to any document whose legibility is in question.

E. Disposition of Originals

Contractor will destroy all paper documents imaged (via shredding) after Contractor has assured the documents have been properly scanned

ATTACHMENT NINE
ADDITIONAL REQUIREMENTS FOR THE CREATION AND MAINTENANCE OF ELECTRONIC RECORDS
PAGE 2

F. Retrievals

If the Office of Medical Assistance requests retrieval of a document, retrievals will be sent to the Office of Medical Assistance electronically unless the Office of Medical Assistance specifically requests some other form of delivery.

G. Testing

The entire imaging process must be tested from the file room to the production document repository. This is an end-to-end technical test that will include preparation of documents, scanning, indexing, quality control, re-scanning (if applicable), and retrieval of documents. This test will be presented to the Office of Medical Assistance before the project will begin.

H. Security

Contractor must operate in a secure facility and work to safeguard all documents in its possession. The expense of any additional security requirements specified in this agreement will be the responsibility of the Contractor.

I. Preparation/Delivery of Electronic Records to OMA Records Center at End of Contract

At the end of the Contract, Contractor shall transfer to OMA any documents stored electronically. Contractor shall comply with the requirements set forth below when preparing information for transfer to OMA. The Contractor shall create two (2) copies in CD/DVD media format, one for OMA Records Center, and the additional CD/DVD will be held by Contractor until the Contract has ended. Contractor will return its copy of the CD/DVD to the Office of Medical Assistance before the last day of the active contract.

1. Description of Material

The Contractor must provide an explanation of the type of material covered by the project (*e.g.*, individual case files) and the dimensions of the typical document (*e.g.*, 8.5” x 11”, 8.5” x 14”). Specify if the original documents were white paper and printed with black ink, or other? If other than white paper with black ink, please identify.

2. Retention Schedule Title/Number

Identify the OMA retention schedule title (*e.g.*, Waiver Program Case Record Files) and number (*e.g.*, 405-86-47) for the material included in this project.

3. Dates

List the beginning and ending dates of the project documents.

4. Volume

Using the equivalent of one filled records center carton or linear foot for every 3,000 pages, list the estimated total number of pages to be included in this project.

Attachment Ten

Ohio Office of Medical Assistance

Case Management Guide

A Guide for Overseeing Case Management Services for the Ohio Home Care and Transitions II Aging Carve-Out Waiver Programs

Effective July 2013

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Purpose and Introduction

Purpose

The Office of Medical Assistance contracts with Case Management Contractors to assist with the implementation and management of Office of Medical Assistance-administered home and community-based services waiver programs throughout the state of Ohio. It also contracts with a Provider Oversight Contractor to assist with provider compliance and operate a system for investigating and tracking incidents. The Case Management Contractors and Provider Oversight Contractor must work closely and cooperatively with each other.

The federal government requires waiver programs to ensure the health and welfare of each waiver participant; it is also the fundamental goal of the relationship among the Office of Medical Assistance, Case Management Contractors, and Provider Oversight Contractor. This case management guide details the Office of Medical Assistance's standards and expectations related to the daily operations to achieve that goal. As issues and/or potential efficiencies are identified, the Office of Medicaid Assistance may modify the case management guide during the course of the Contract in order to improve performance and to better meet the needs of individuals on the home and community-based waiver programs.

Introduction

The Office of Medical Assistance administers and operates two home and community-based services waiver programs: the Ohio Home Care Waiver and the Transitions II Aging Carve-Out Waiver. These waiver programs serve individuals on Medicaid with long-term care needs that, in the absence of certain services, would require their needs to be met in a hospital or nursing facility.

The Office of Medical Assistance -administered waiver programs provide eligible individuals in need of long-term care facility services with a cost-effective home and community-based alternative that recognizes the need for autonomy and independence. Waiver programs support the individual's right to choose to live in the community, encouraging them to live as independently as possible and with self-determination, while providing the services, supports and safeguards needed to ensure their health and welfare.

The Office of Medical Assistance-administered waivers are governed by rules set forth in Chapters 5101:3-45, 5101:3-46, and 5101:3-50 of the Ohio Administrative Code. These rules provide general guidelines regarding an individual's eligibility for a waiver; provider eligibility, and reimbursement and monitoring.

The Centers for Medicare and Medicaid Services is the federal agency within the United States Department of Health and Human Services that oversees all Medicare and Medicaid programs and grants Ohio authority to operate its Medicaid waiver programs.

Medicaid waivers also allow the state to use Medicaid funds for home and community-based services that are not available through the Medicaid State Plan.

Waiver program services may include nursing, personal care aide services, home care attendant services, adult day health center services, home-delivered meals, home modifications, supplemental adaptive and assistive devices, supplemental transportation, out-of-home respite and emergency response systems.

As the single state Medicaid agency, the Office of Medical Assistance has oversight responsibility for all home and community-based services programs that use Medicaid as their primary funding source. The Ohio Office of Medical Assistance is responsible for the administration and oversight of all home and community-based services programs. The Office of Medical Assistance contracts with case management contractors for the day-to-day operations of the Office of Medical Assistance-administered waiver programs. The Case Management Contractors shall assist in the implementation and operation of the Office of Medical Assistance's waiver programs throughout the state, interfacing with individuals at the local level, and ensuring their health and welfare. The Case Management Contractor must provide case management for the waiver programs as outlined in this guide.

Case management, as described in the Contract and this case management guide, provides holistic care management to the waiver participant. The Case Management Contractors shall ensure person-centered care by including the individual on a waiver program and his/her authorized representative in all decisions about his/her care. The Case Management Contractor is the lead coordinator for the team process and care plan development and provides appropriate linkage and referral to community resources and services. Case management activities include, but are not limited to:

1. **Eligibility determination and enrollment**
    a. Level of Care Determination.
    b. Assessment to determine needs.
    c. Linkage and referral to community resources.
2. **Ensuring health and welfare**
    a. Immediate action reporting incidents and prevention from harm planning.
    b. Monitoring the waiver individual's service delivery and service quality.
    c. Monitoring the waiver individual's environment and ensuring action when needed.
    d. Linkage and referral to community services, providers, etc. to meet the needs of the individual on a waiver program.

3. Care management

a. Facilitating an interdisciplinary team and planning process.

b. Coordinating services service across all team members and providers.

c. Managing care for the individual on a waiver program.

d. Linking the individual on a waiver program to community resources and providers.

e. Developing and maintaining the waiver individual's service plan.

Intake Requirements

Intake is the process by which the Case Management Contractor assesses an applicant for enrollment into an Office of Medical Assistance-administered waiver program, and the steps that follow the determination.

Application for Office of Medical Assistance-administered waivers and enrollment is made through the county department of job and family services in the county in which the applicant lives. In order to apply for the waiver program, the applicant must:

1. Apply for Medicaid and by completing an Ohio Department of Job and Family Services 07200 form, "*Request for Cash, Food and Medical Assistance.*" To apply for a waiver program, an applicant must also complete an Office of Medical Assistance 02399 form "*Request for Medicaid Home and Community-Based Services*", at the County Department of Job and Family Services. The County Department of Job and Family Services notifies the Office of Medical Assistance when it has received a waiver application.

2. The Office of Medical Assistance will notify the Case Management Contractor that a waiver application has been received and will forward the application to the Case Management Contractor.

3. After the Case Management Contractor has received notice of the application, it must make initial contact with the waiver applicant within two business days of receiving the notice to determine if one of the waiver programs could potentially meet the applicant's needs. The initial contact also confirms that the applicant is requesting waiver services. If the applicant does not wish to proceed with the waiver determination process upon initial contact, the Case Management Contractor must provide the applicant with an Office of Medical Assistance approved form and request that the applicant sign and return form to the County Department of Job and Family Services. The County Department of Job and Family Services then enters "410" into the county and state database, Client Registry Information System - Enhanced , which will show the waiver application as "denied" due to voluntary withdrawal. The Client Registry Information System - Enhanced will then generate and send hearing rights to the applicant.

4. When appropriate, the Case Management Contractor refers and/or assists the applicant to access other community resources in obtaining necessary services. This may include linking them and/or making a referral for them to the County Department of Job and Family Services, county board of developmental disabilities, Passport Administrative Agency, child or adult protective services and/or any other community resources that may be able to meet the applicant's immediate needs.

5. The initial contact must also include a discussion of the applicant's current needs and circumstances. If the applicant is residing in an institution, the Case Management Contractor is expected to discuss the HOME Choice program with the applicant.

The HOME Choice program assists with transitioning from the nursing facility to a home setting by providing goods and services. If the applicant is interested in HOME Choice, the Case Management Contractor must complete an Office of Medical Assistance #2361 form "*HOME Choice Application.*" Information about the HOME Choice program can be found at http://jfs.ohio.gov/OHP/consumers/homechoice.stm

6. The Case Management Contractor must schedule the initial assessment with the applicant within **10 business days** of the initial contact to determine the program eligibility.

   The Case Management Contractor may deny the waiver application if it has not made contact with the applicant after at least three attempts to reach the applicant by phone, at varying times, on at least three different days. The Case Management Contractor must maintain documentation of all attempts to reach the applicant.

7. If the applicant does not meet program eligibility criteria for an Office of Medical Assistance-administered waiver, it must, with the applicant's permission, refer the applicant to the appropriate agency that administers other waivers. Referrals may be made to an Ohio Department of Developmental Disabilities or an Ohio Department of Aging-administered waiver program. The Case Management Contractor must provide the applicant with the contact information for the local agency.

8. The Case Management Contractor must enter the waiver application status into Client Registry Information System - Enhanced once it has completed the eligibility determination process. The fields on the waiver (AEIWV) screen must be specified and entered as follows:

- **WAIVER STATUS:**
  - Enter A for approved.
  - Enter D for denied. A reason must be indicated (See Appendix A: Code Sheet).
- **WAIVER BEGIN DATE**:
  - Enter the beginning date for the waiver span in mm/dd/yyyy format.
- **WAIVER TYPE CODE:**
  - Ohio Home Care Redesigned Waiver -- Enter A1.
  - Transitions Carve-Out Waiver — Enter A4.
- **LEVEL OF CARE CODE**:
  - Enter IT for Intermediate Level of Care.
  - Enter SK for Skilled Level of Care.

Program Eligibility and Enrollment

To be eligible for an Office of Medical Assistance-administered waiver program, an applicant must meet all program eligibility and enrollment criteria.

Eligibility Criteria

In order to be eligible for the waiver program, the applicant:

- Must meet both the age and level of care eligibility requirements specified by the Office of Medical Assistance waiver program's benefit package.
    - Ohio Home Care Waiver: Be under the age of 60 at the time of application.
    - Transitions II Aging Carve-Out Waiver: Be 60 or more and enrolled on the Ohio Home Care Waiver.
- The applicant must meet either an intermediate or skilled Level of Care per Ohio Administrative Code 5101:3-3-08. A physician certifies the level of care by signing a Level of Care determination.
- In the absence of the waiver, the person would require hospitalization or institutionalization in a facility to meet his/her needs.
- Is informed of service alternatives, choice of qualified providers and the option of institutional or community-based care. The applicant must indicate in writing that he/she chooses to receive services on the waiver program in lieu of institutional care.
- May not be a resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or other licensed/certified facility or any facility covered by Section 1616(e) of the Social Security Act (Keys Amendment facility).
- If delivery of services does not start within 30 days of the initial assessment, the Case Management Contractor must complete a face-to-face reassessment with the applicant to ensure he or she continues to meet program eligibility and to review service needs.
- If, during the assessment process, the applicant fails to meet any of the eligibility criteria for an Office of Medical Assistance-administered waiver, the Case Management Contractor will recommend him/her for denial/disenrollment and inform him/her of hearing rights.

- The Case Management Contractor must notify applicants who are denied enrollment on a waiver, denied the provider of their choice, or permanently institutionalized and terminated from a waiver program of the reason for the denial/termination and of their appeal rights.

Enrollment Criteria

To be enrolled and to maintain enrollment on the waiver program, an applicant or the individual on a waiver program must:

- Maintain Medicaid eligibility (financial eligibility)
    - The Case Management Contractor must verify and document Medicaid eligibility via the Office of Medical Assistance Medicaid Information Technology System and/or Client Registry Information System - Enhanced system at least once per quarter.
    - If the applicant/individual on a waiver program has a patient liability, the Case Management Contractor must monitor the amount in Client Registry Information System-Enhanced. The patient liability must be assigned to a provider in the All Services Plan to ensure that the patient liability amount is paid each month. The Case Management Contractor must document the liability amount to be paid and the provider to whom it is to be paid in the All Services Plans.
- Maintain waiver program eligibility as outlined above.
- Need at least one waiver service per month that is not available through another source. This includes Medicaid State Plan services.
- Be assessed to have needs that the waiver program is able to meet.
- In addition, the waiver program must be able to ensure the applicant/waiver individual's health and welfare while he or she is enrolled on the waiver program.

Information that may be used in the enrollment determination includes, but is not limited to:

- Assessment data.
- Ongoing monitoring.
- A demonstration of the skills required of the primary caregiver(s), when necessary.
- Other information requested by or received from members of the individual's team.

The applicant/authorized representative must agree to participate in the Office of Medical Assistance-administered waiver program assessment and enrollment processes. This agreement is formally documented with the waiver individual's signatures on the Office of Medical Assistance-approved form.

The individual on a waiver program must participate in the development of an All-Services Plan and must agree to the plan by signing and dating it.

The Case Management Contractor will provide to the participant, upon enrollment and as appropriate, the phone numbers of the Case Management Contractor, case manager, Long-Term Care Ombudsman Office and the Medicaid Hotline. The Case Management Contractor must also educate the individual on a waiver program about his or her right to contact any of these entities for assistance or to notify them of concerns.

At the conclusion of the assessment, or at any point during enrollment on the waiver program, the Case Management Contractor must make a recommendation that the applicant/individual on a waiver program be enrolled or maintain enrollment on the waiver program. In determining whether or not someone meets eligibility or enrollment criteria for the waiver program, the Case Management Contractor must account for assessments, including discussions with providers and team members, in making the recommendation. The Case Management Contractor must maintain documentation of each assessment and it must be available to Office of Medical Assistance.

In all cases, the applicant/individual on a waiver program will be afforded the right to a state hearing.

If, at any time during the assessment process or while enrolled on the waiver program, the applicant/individual on a waiver program fails to meet any of the eligibility or enrollment criteria for an Ohio Home Care Waiver program, the Case Management Contractor must recommend the person for denial/disenrollment and inform him or her of hearing rights.

Assessment

The assessment process is designed to identify an applicant's needs, strengths and formal/informal supports, and to establish his/her level of care. It assesses the applicant's ability to live independently, as well as his/her ability to direct his/her own care. Assessments are completed for waiver applicants and enrolled individuals at least once per year, in addition to ongoing, as-needed assessments performed as a part of the Case Management Contractor's day-to-day operations.

The assessment process collects data, evaluates for long-term care service need, and provides linkage to programs and services for applicants/waiver individuals seeking access to waiver and non-waiver long-term care services. This section outlines expectations and standards for conducting:

1. **Initial assessments** when an applicant requests enrollment on an Office of Medical Assistance-administered waiver.
2. **Annual assessments** for a waiver individual's redetermination for waiver eligibility.
3. **Event-based assessments** for an individual on a waiver program when he/she experiences a significant change of condition.

This section will also address ongoing assessments related to the waiver individual's care needs and conditions as a standard of case management practice. All assessments are completed with input from the applicant/participant, caregivers, and internal and external support systems in accordance with program requirements.

An assessment is performed by a Registered Nurse, Licensed Social Worker, or a Licensed Independent Social Worker employed by the Case Management Contractor.

The following principles guide the assessment process:

- All assessments are conducted face-to-face with the applicant or individual on a waiver program at his/her place of residence.
- The Case Management Contractor will complete assessment components using the information gathered from the applicant and, to the extent possible, the applicant's informal caregivers and/or representative.
- With the applicant's permission, the assessment will also include information from his/her current service providers and any other sources identified by the applicant as having information that will be useful in determining his/her level of care, as well as his/her need for services.
- The assessment process must include evaluating the waiver individual's current or intended community residence.

- At the applicant/waiver individual's request, the assessment may be terminated at any time and can be rescheduled at a later date/time, within prescribed timelines.

- Assessment components will be completed using information gathered from the applicant/individual on a waiver program and, to the extent possible, his/her informal caregivers and/or representative, as well as the applicant/waiver individual's professional support team (physician, specialists, providers, etc). Additionally, the assessment will include review of the applicant/waiver individual's care needs and preferences.

- The assessment is focused on the applicant/waiver individual's current cognitive and functional ability.

- The assessment data is documented on the Office of Medical Assistance-approved assessment tools, including the eligibility assessment tool, Private Duty Nursing acuity and Norms.

- The Case Management Contractor provides the applicant/individual on a waiver program with linkage to needed services identified during the assessment process through program enrollment, referral to other long-term care support systems, and/or enrollment in other long-term care service programs.

- If, at any time during the assessment process, the applicant/individual on a waiver program fails to meet any of the eligibility or enrollment criteria for an Ohio Home Care Waiver program, the Case Management Contractor will recommend the applicant/individual on a waiver program for denial/disenrollment and inform him/her of hearing rights.

All assessments must address needs and/or changes in the following areas:

- **Physical health** - Diagnosed conditions, medication regimen and administration, special diet regimen, allergies, body systems review, listing of treatment modalities and regimen, and use of special equipment.

- **Medical history** - Frequency of hospitalization, facility placement, physician(s) names and history of recent visits, immunizations, preventive health care.

- **Medication profile** and current administration needs, including assessment of current success and supports needed to assist the applicant/individual on a waiver program in following the medication regime.

- **Medical interventions** and treatment regimens.

- **Medical supplies.**

- **Functional ability**
    - Activities of daily living - Mobility, bathing, grooming, toileting, dressing, and eating.
    - Instrumental activities of daily living - Shopping, meal preparation, house cleaning, heavy chores, yard work/maintenance, laundry, telephoning, transportation, and legal/financial maintenance.
- **Psychosocial functioning** -Cognitive function, behavior patterns, emotional well-being, relationships with others, degree of isolation.
- **Adaptive and/or assistive device(s)** use and needs.
- **Substance use** – alcohol, tobacco, caffeine, drugs and controlled substances.
- **Living conditions** - Home safety, physical barriers, privacy, cleanliness and access to all needed areas of the home, including needs for home modifications and/or adaptations.
- **Current benefits, service utilization and linkage**. Services currently utilized and/or for which the applicant/individual on a waiver program has been determined eligible, including, services from Medicaid, Medicare, and third-party insurance, local school district, Bureau of Vocational Rehabilitation, County Board of Developmental Disabilities, Alcohol and Drug Addiction Services/Mental Health/Public Health boards, Veterans Administration, Bureau of Children with Medical Handicaps, and other resources, including, but not limited to, other community resources and volunteers.
- **Informal supports** - Assistance from unpaid informal support systems, such as family, friends, neighbors; applicant's ability to self-direct care; primary and emergency contacts, strengths and weakness of applicant/waiver individual's family and or caregivers, problems, and desired outcomes for the applicant/participant. This includes the availability of informal supports to provide care when paid caregivers are not available.

The assessment process includes a summary of needs, progress and response to care and/or treatment, as well as outcomes.

Initial Assessment

Initial assessments are completed to determine program eligibility for the waiver and for the need for waiver services.

The Case Management Contractor will collect the information during the initial assessment, in conjunction with supporting documentation, on the Office of Medical Assistance-approved **eligibility assessment tool**. This tool is used to determine the applicant's level of care, as well as identify the applicant's potential service needs for the waiver program. It also serves as the supporting documentation if the applicant is determined not to meet the eligibility requirements of the waiver program.

The Case Management Contractor must complete all assessment activities, including obtaining physician verification of the level of care determination, within **30 calendar days** of conducting the face-to-face meeting with the applicant. The assessment must be summarized and sent to the physician for review. The Case Management Contractor must obtain physician verification that the applicant meets the level of care and that the physician agrees to the applicant's enrollment on the program.

Annual Assessment

Once enrolled on an Office of Medical Assistance-administered waiver program, each individual on a waiver program is required to have an annual assessment to determine his/her continued eligibility for the waiver program. Annual assessments follow the same process as previously outlined for initial assessments, except that annual assessments do not require physician verification of the level of care, unless the waiver individual's level of care has changed.

The Case Management Contractor must contact the individual on a waiver program to schedule the annual assessment at least 30 calendar days prior to the date the next assessment is due. At that time, the Case Management Contractor will also contact all participant-identified team members to invite them to participate in the annual assessment. Annual assessments are conducted no more than 365 calendar days after the previous annual assessment.

The assessment must be summarized and sent to the physician at least annually for review. At that time, the Case Management Contractor must obtain physician sign-off for the waiver individual's continued enrollment on the program.

Event-Based Assessment for a Significant Change of Condition

The Office of Medical Assistance requires an event-based assessment for any reported actual or potential significant change of condition. The Case Management Contractor must make contact with the individual on a waiver program within 24 hours of the Case Management Contractor's discovery of an actual or potential significant change of condition. The Case Management Contractor must complete a visit and assessment within **three calendar days** of the Case Management Contractor's discovery of the event.

A significant change may include, but not be limited to:

- Loss of a primary caregiver/informal support.
- An acute medical condition that results in institutionalization and/or the significant changes or deterioration of the waiver individual's condition (*e.g.*, Case Management Contractor learns that the individual on a waiver program has experienced a significant decline in the ability to perform Activities of Daily Livings or Instrumental Activities of Daily Living.

- The individual on a waiver program changes residence.
- The individual on a waiver program has three incidents within 90 days.
- The individual on a waiver program elects hospice benefits.
- The individual on a waiver program receives a new mobility device.
- The individual on a waiver program has not used waiver services for 30 days.

Ongoing Assessment

The Case Management Contractor must assess the waiver individual's changing care needs on an ongoing basis and address needs as they arise. The Case Management Contractor is not required to complete the entire Office of Medical Assistance-approved eligibility assessment tool when conducting an ongoing assessment. However, the Case Management Contractor may include communication with the participant, authorized representative, providers, and other members of the team in order to promptly and appropriately address the waiver individual's individual circumstances.

Case Management

All individuals enrolled on the Office of Medical Assistance-administered waiver program receive case management services. Case management assists individuals with linkage and authorization for services and supports necessary to remain in the least restrictive environment while maintaining the greatest amount of independence and human dignity. Case management is individual-focused and promotes/supports the waiver individual's preferences, values and right to self-determination. The case manager is also essential to ensure the waiver individual's health and welfare.

Case managers assist individuals in gaining access to approved waiver program services, Medicaid State Plan and community services, as well as the medical, social, educational and other appropriate services, regardless of the funding source. Case management includes, but is not limited to, the following core functions:

- Monitoring the waiver individual's health and welfare.
- Periodically assessing the waiver individual's needs, service goals and objectives.
- Annual assessing the waiver individual's program eligibility.
- Scheduling, coordinating and facilitating meetings with the individual on a waiver program and his/her interdisciplinary team.
- Authorizing waiver services in the amount, scope, and duration to meet the waiver individual's needs.
- Linking and referring the individual on a waiver program to needed service providers.
- Developing and reviewing the All Services Plan for Office of Medical Assistance-administered waiver services.
- Monitoring the delivery of all services identified in the waiver individual's All Services Plans.
- Transition planning for significant changes, including those changes that occur prior to enrollment on the waiver program and at significant life milestones such as entering/exiting school, work, etc.
- Identifying and reporting incidents, as well as prevention planning to reduce the risk of reoccurrence.

Case Management Practice Standards

1. The maximum average staffing level for case management must be maintained in accordance with the contract.

2. The case manager must be a Licensed Social Worker, Licensed Independent Social Worker, or Registered Nurse.

3. The case manager maintains the minimum contact schedule with the individual on waiver in accordance with the specifications outlined in this section and in the Contract.

4. The case manager maintains confidentiality of individual's data in accordance with Health Insurance Portability and Accountability Act regulations.

5. The case manager reports and documents incidents in accordance with rule Ohio Administrative Code rule 5101:3-45-05 and the requirements of this case management guide.

6. The case manager informs individuals of service alternatives and choice of qualified providers and assists individuals with linkage to providers and/or with the provider selection process as needed.

7. The service planning process continually addresses the waiver individual's long-term care services and supports needs and the Case Management Contractor revises or updates the waiver individual's All Services Plan as the waiver individual's needs and resources change. The Case Management Contractor must complete plan updates within 10 calendar days of a request or identified need or within 48 hours if verbal authorization is given.

8. The Case Management Contractor must inform individuals of their rights and responsibilities while enrolled on the waiver program.

Case Management Process Requirements

The following principles and responsibilities underline case management services for Office of Medical Assistance waiver program individuals.

1. The case manager must explain the role and responsibilities of case management to the individual on a waiver program and, if applicable, his/her authorized representative. This must include the Case Management Contractor role related to the Office of Medical Assistance in the operations of the waiver program.

2. The case manager must provide current contact information to the individual on a waiver program and his/her authorized representative. The case manager must also assure that the individual on a waiver program has the Case Management Contractor information accessible to family members and emergency personnel.

3. The case manager will provide each individual on a waiver program a copy of the Office of Medical Assistance approved Waiver Handbook at enrollment and at least annually.

4. With the individual /authorized representative's permission, the case manager will contact all members of the waiver individual's team to request information about care and treatment plans in effect, and to request notification of any changes in plans of care and treatment to reduce duplication of services. The case manager must obtain permission in writing and maintain this on file.

The individual/authorized representative must be informed of the right to remove or deny permission to any person at any time within the rules and requirements of the waiver program. The case manager must provide his/her contact information to all members of the waiver individual's team.

5. For all service additions and changes, the case manager must contact the individual enrolled on a waiver within 24 hours after the service addition or change was to be initiated to confirm that it is in place and that the individual is satisfied with the service addition or change. .

6. The case manager must also contact service providers to verify delivery of waiver services in the amount, scope, and duration as identified on the waiver individual's All Services Plans no later than **three business days** after the scheduled service start date.

7. **The case manager must maintain ongoing contact with the individual enrolled on a waiver**, his/her authorized representative, and members of the team, including all service providers listed on the All Services Plans. This will identify any problems in service delivery; validate the current All Services Plan to ensure that assistance and consistency are being provided in accordance with the All Services Plans, and to request notification of any changes in the waiver individual's condition or needs. The contact will also identify any potential risks and/or monitor any known risks to the waiver individual's health and welfare.

8. The **case manager must monitor the quality of the service delivery and care** provided by all authorized Medicaid providers. This includes review of physician orders, service delivery records, incident reports, and other documentation of service delivery.

9. **Case Management Contractor supervisors must assign an individual enrolled on a waiver an acuity level for purposes of frequency for case management contacts.** The Case Management Contractor will conduct a visit at least within these guidelines and/or when there is a need or a request for visit. The Case Management Contractor must monitor any changes in the individual's circumstances, review and modify the level of case management contact/schedule, and monitor service provision. More frequent monitoring and contacts may occur depending on the individual's situation and upon consultation with the Case Management Contractor supervisor. The following individual contact and visit schedule must be maintained:

New Enrollees

Length of Individual's Enrollment on Waiver	Frequency of Contact with Individual	Timing of In-Person Visit
0-1 month	Minimum of two contacts, no more than 14 calendar days between contacts	Within 20 calendar days of the waiver effective date
2-3 months	Monthly	Monthly, maximum of 30 calendar days between visits
4-6 months	Monthly	Minimum of two visits, maximum of 45 calendar days between visits.

At six months' enrollment, the case manager must meet with the new enrollee to ensure that services are meeting his/her needs, update the All Services Plans, and ensure that the waiver individual's individual funding level is set. The case manager must also inform the individual on a waiver program of his/her level of case management.

Acuity Level 1

Level 1 case management will be provided to individuals who are able to:

- Safely direct their own care and/or;
- Live with family or friends who are able to direct their care and;
- Must have been enrolled on the waiver for more than six months.

Frequency of Individual Contact	Timing of In-Person Visit
Maximum of 90 calendar days between contacts	Maximum of 180 calendar days between visits

Acuity Level 2

Level 2 case management will be provided to individuals who do not meet the criteria for acuity 1 and/or:

- Live alone.
- Live with a paid provider.
- Do not participate in day program, school, or work.
- Receive services only from family members or non-agency providers.
- Have a restraint, seclusion, or restrictive intervention plan.
- Have an Acknowledgement of Risk Agreement (see glossary) in effect and/or;
- Have been without services, for any reason, for more than 30 days.

Frequency of Individual Contact	Timing of In-Person Visit
Maximum of 30 calendar days between contacts	Minimum of three visits in six months, Maximum of 60 calendar days between visits

Participant-to-Case Manager Ratios

The **new enrollee-to-case manager ratio** must not exceed one Full-Time Equivalent (FTE) case manager per 45 individuals. A new individual on a waiver program is one who has been enrolled on the waiver program for fewer than six months.

- **Level 1 individual on a waiver program-to-case manager ratio** must not exceed one full-time equivalent case manager per 60 individuals.
- **Level 2 waiver-individual-to-case manager ratio** must not exceed one full-time equivalent case manager per 45 individuals.

Other Case Management Process Requirements

The Case Management Contractor must:

- Monitor the waiver individual's progress with respect to the identified comprehensive goals, objectives and outcomes.
- Re-evaluate waiver individual's goals, objectives, services, and all program eligibility requirements when applicable and at least once every 12 months.
- Maintain documentation in accordance with agency policies and procedures and Office of Medical Assistance rules and regulations.
- Provide the individual, upon enrollment and as appropriate, with a copy of the Office of Medical Assistance Individual's Bill of Rights. If, at any time, the individual on a waiver program is no longer eligible for a waiver program, the Case Management Contractor will recommend him/her for disenrollment and provide state hearing rights.

Case Management Contractor Supervision of Case Managers

The Case Management Contractor must maintain a case manager-to-supervisor ratio of not more than 12:1. Supervisors must meet with each case manager at least once per month to review case load, current case assignments, critical issues, etc. Supervisors must also hold monthly team meetings with their case managers for peer review, reviewing practice standards, etc.

Service Planning and Care Coordination

The assessment provides information for the initial steps of service planning. The service planning process is intended to:

1. Identify the strengths and needs of the individual on a waiver program including on risk areas to be addressed to ensure the individual's health and welfare.
2. Develop goals to address needs.
3. Set desired outcomes for each need.
4. Identify available supports and determine the type of informal support and provider(s) to address unmet needs.
5. Set a pattern of delivery for each provider.
6. Ensure that the service plan costs are within the framework of the waiver individual's individual cost cap.

The Case Management Contractor will use these components, as well as other information outlined below, to inform and develop a comprehensive service plan for the individual on a waiver program that addresses his or her needs and outcomes.

Plan Development

Service planning and care coordination address the waiver individual's changing circumstances and/or medical conditions over time. The service planning process must be tailored and updated to address the waiver individual's changing needs. It must be revised as often as necessary to meet the waiver individual's needs.

The All Services Plan is a written outline of the waiver individual's waiver services, other Medicaid services, and all other services (formal and informal) necessary to prevent the individual on a waiver from being institutionalized. The All Services Plans identifies goals, objectives and outcomes related to the waiver individual's health and functioning and the treatments and services he or she receives. The All Services Plans also details the coordinated efforts of the waiver individual's team.

The Case Management Contractor develops the comprehensive All Services Plans in collaboration with an interdisciplinary team. The interdisciplinary team members, at a minimum, include the participant, informal caregiver(s), authorized representative, providers, physician, and the case manager. The Case Management Contractor documents communication records and/or team meeting minutes in the planning process.

The Case Management Contractor authorizes, arranges and initiates services. This includes communicating, collaborating and negotiating with the participant, formal services providers and informal caregivers.

The Case Management Contractor contacts all providers and agencies that are, or will, participate in meeting the waiver individual's needs, scheduling meetings, disseminating information, planning updates, maintaining documentation, as well as mediating disagreements among team members. The Case Management Contractor must tell the individual on a waiver that he or she has the right to request a state hearing regarding any decisions made about the waiver or Medicaid benefits. The Case Management Contractor is expected to assist the individual with identifying providers as out lined in the Provider Selection Section.

All Services Plan Contents

The Case Management Contractor is responsible for assuring that all of the waiver individual's identified needs are included in the All Services Plan. That includes all services/supports the individual on a waiver receives from sources other than the waiver program that help meet his/her needs. Service planning includes arranging for services that support and enhance, but do not replace what is already performed by informal caregivers. The All Services Plan documents that each need is being addressed.

The All Services Plans must address all of the following domains:

- Care of the participant, including medical care needs.
- Care of the home.
- Community access, including transportation.
- Mental/behavioral health, including any behavior interventions.
- School, work, or other day activities.
- Home modifications and/or adaptations.
- Medication management, including obtaining needed medications.
- Medical and personal care supplies, including equipment.

The All Services Plan results from the service planning process. It must specify the tasks and activities the service provider(s) are to carry out and include goals, objectives, and outcomes, as well as a detailed description of the interventions to be used to meet the waiver individual's needs. The All Services Plans also details the amount, frequency and duration for services. Lastly, the All Services Plans is a payment authorization and service coordination document.

The All Services Plans must also address all of the following areas, as applicable:

Individual Cost Caps

The Case Management Contractor calculates the waiver individual's individual cost cap at enrollment, and then monthly; it must not exceed $14,700. Individual cost caps include all waiver services, as well as state plan services, for purposes of prior authorization. The Case Management Contractor must enter the cost of waiver services only into the AEIWV screen in Client Registry Information System – Enhanced.

Back-Up Planning

The Case Management Contractor will work with the individual on a waiver and providers to develop a back-up plan, which meets the waiver individual's needs in the event that paid or natural supports are unavailable. The back-up plan can include other providers, family, friends or other natural supports. The All Services Plan must clearly identify the backup plan and identify the back-up person/persons and the functions to be performed by each. The back-up provider/caregiver must be available to meet the waiver individual's needs and must be trained to provide the waiver individual's care by licensed professionals, as appropriate. The individual on the waiver may be his/her own back-up if the Case Management Contractor can ensure that the individual is able to meet his/her own needs when paid or natural supports are unavailable.

Skilled Care and Medical Oversight

Physicians are an integral part of the waiver individual's interdisciplinary team. The Case Management Contractor must, at a minimum of once per year, identify the lead physician responsible for the home care of the individual on the waiver program. The lead physician may be the primary care physician or a specialist and must be identified in the All Services Plan as the lead physician. The lead physician shall either:

- Sign approval on the All Services Plan at least annually when skilled services are not needed or are provided by natural supports, or;
- If the individual on the waiver has skilled services and/or a plan of care, sign approval for the plan of care every 60 days.

If natural supports are meeting the skilled nursing care needs of the individual on the waiver, the Case Management Contractor must ensure that medical oversight of the skilled needs is outlined in the All Services Plan. This must include assessment by a licensed medical professional at least once every 60 days to ensure that the needs are being addressed and to monitor the health and welfare of the individual on the waiver program. If the lead physician delegates the assessment to a Registered Nurse, the Registered Nurse must have doctor's orders to perform this service and the service must be designated in the All Services Plan.

Disaster Planning

The Case Management Contractor must ensure every individual on a waiver has a disaster plan in place and that it is documented in the All Services Plans. This plan must address a fire, tornado, electrical outage and other potential risks that would prevent an individual on a waiver program from receiving services in his/her residence.

Acknowledgment of Responsibility Agreement

If the individual on a waiver program has known risk factors, the Case Management Contractor must complete an "Acknowledgement of Responsibility Agreement" and document it in the All Services Plans. The Acknowledgement of Responsibility Agreement is used to document and outline situations, circumstances, and/or behaviors that, without intervention, may jeopardize the waiver individual's health and welfare and potentially risk his/her enrollment the waiver program. The Acknowledgement of Responsibility Agreement must outline the risk factors, the waiver individual's rights and responsibilities on the program, action steps to be taken to mitigate them and the waiver individual's agreement to implement the action steps with assistance from the Case Management Contractor.

Services in Schools or Other Day Programs

If the family is agreeable, the Case Management Contractor must participate as a member of a waiver individual's Individual Education Plan team. The case manager must also participate in any team meetings with school and/or day programs. The case manager must not only serve as a member of the team, but be an advocate for the participant, as well. The Case Management Contractor must integrate the school or other day program services into the All Services Plans.

Medication Management

The Case Management Contractor must closely monitor a waiver program individual's use of medications in order to discover when an individual may be using medications at a frequency or amount that exceeds medical necessity, or is less than, or at a frequency that is not prescribed.
The Case Management Contractor must refer any waiver program individual suspected of prescription drug abuse or misuse to the coordinated services program described in Ohio Administrative Code Rule 5101:3-20-01. These coordinated services, formerly called "PACT" or "Lock-in" is currently known as the Coordinated Services Plan. Individuals on a Coordinated Services Plan must have a specific plan for monitoring medication use in the All Services Plan.
In addition, the Case Manager must ensure, in all circumstances, when an individual on a home and community-based services waiver program is utilizing opiates, including prescription pain medication, that there is a specific plan in place to ensure that the use of those medications is correct. Plans may include use of nursing services, implementation of medication counts, use of lock-boxes, and referrals to local drug and alcohol addiction services when necessary. The plan must include at least intermittent monitoring by a medical professional, including the lead physician as well as specific training for non-medical staff on identifying misuse or abuse of medications.

Transition Planning

Care coordination is fundamental for all transitions an individual on the waiver may experience. Case Managers are expected to take a lead role in coordinating services for individuals on the waiver program at all major transitions in their lives. This includes:

- Admissions to, and discharges from, institutions, including nursing facilities and hospitals.
- Entering and exiting school and work programs.
- Moves from one home setting to another.
- Moves to or from a home with family to living independently.
- Other transitions in living arrangement or service environment that requires care coordination.

Transition changes must be planned to ensure minimal impact on the individual. Service planning, including linkage and referral to new community and other resources and alternative service providers must be completed with the agreement of the individual on the waiver and his or her team.

The Case Manager is expected to organize and facilitate team meetings prior to the transition to identify new and ongoing needs, and ensure that a proper plan is developed for the transition. The Case Manager must also organize and facilitate at least one team meeting within 30 days after the transition to verify it occurred as planned and to identify new or ongoing needs and to develop a plan to address any needs.

Waiver and State-Plan Services

All services must be used and approved as directed in Ohio Administrative Code 5101:3-46-04, 5101:3-46-04.1, 5101:3-50-04, 5101:3-50-04.1, 5101:3-12-01 and 5101:3-12-02. Authorization of services out of the scope or limitations as directed in rule is prohibited.

Nursing: Waiver nursing services are available to individuals who have intermittent or continuous skilled nursing needs. Nursing tasks must be performed within the nurse's scope of practice and may include personal care and incidental home-making services as long as it is relevant to the care of the individual on a waiver program and does not substantially lengthen the nurse's visit. The Private Duty Nursing acuity tool may be used to guide the amount and scope of services that are needed.

When developing the All Service Plan, the Case Manager must determine when waiver services are to be used and when state plan or other community resources are available. The All Services Plan must address the need for intermittent nursing care utilizing state-plan home health nursing to the extent available. Home health nursing cannot be used as respite; however, waiver nursing can be authorized to meet a respite need.

Likewise, the All Services Plan must address the need for continuous nursing care utilizing state-plan Private Duty Nursing to the extent available.

Personal Care Aide: Personal care services are available to individuals as both an intermittent and continuous service within the service requirements. The Norms assessment tool may be used to guide the amount and scope of services that are needed.

When developing the All Service Plan, the Case Manager must determine when waiver services are to be used and when state plan or other community resources are available. The All Services Plan must address the need for intermittent home health aide services utilizing State-plan home health aide services to the extent available. Home health aide cannot be used as respite; however, waiver personal care can be authorized to meet a respite need. Aide visits that are more than four hours in length must be authorized utilizing waiver personal care.

Home Care Attendant: Health Care Attendant services are waiver services available to individuals who meet the specific requirements of Ohio Administrative Code Rule 5101:3-46-02.1 and 5101:3-50-02.1. There is no comparable service available on the state plan. Health Care Attendant services must be delivered at the direction of the individual on a waiver program or the authorized representative; therefore, this service cannot be used as respite. If respite is needed, nursing services can be authorized as identified previously.

Adult Day Health Center Services: Adult Day Services is available for both half- and full-day services. Other support services (i.e., nursing, Personal Care Aide) may not be used while the individual on a waiver program attends Adult Day Services. Adult day programs may also be available from other community resources and should be explored prior to the use of waiver services.

Home-Delivered Meals: Dietary-appropriate home-delivered meals may be used when an individual on a waiver program needs assistance with meal preparation but can eat independently. Home delivered meals may not be used at the same time as, or when a Health Care Attendant, Personal Care Aide, or nurse is in the home and can prepare a meal for the participant.

Home Modifications: Home modifications can be approved only after an occupational therapist or physical therapist determines that the individual on a waiver program requires an adaptation to the immediate home environment in order to increase the waiver individual's independence or ability to access his/her home. The owner of the home to be modified must provide written consent to the Case Management Contractor prior to approval of any modifications. The Case Management Contractor must assist the individual on a waiver program with coordinating the job specifications and will submit a request-for-bid as directed in Ohio Administrative Code Rule 5101:3-46-04 (E). The Case Management Contractor will award the service agreement to the lowest and most responsible bidder. Price and other relevant factors will be considered as well. The Case Management Contractor must enter the completed service amount as a prior authorization into the Ohio Medicaid Management Information Technology System.

Supplemental Adaptive and Assistive Devices (including Vehicle Modifications): The Case Management Contractor can approve adaptive and assistive devices and vehicle modifications when it determines that the individual on a waiver program requires adaptation to his or her immediate living environment in order to increase his or her independence or ability to access his or her home. However, prior to the Case Management Contractor approval, an occupational therapist or physical therapist must determine that the individual on the waiver requires an adaptation to the immediate home environment in order to increase his or her independence or ability to access his or her home.

Out of Home Respite Services: Out of home respite services must include an overnight stay and can be provided only in an Intermediate Care Facility for Mentally Retarded, nursing facility or other licensed facility approved by Office of Medical Assistance.

Emergency Response Services: An Emergency Response System is available to individuals who can be left unattended for periods of time but who may need, and are able, to summon emergency assistance, if needed. The individual on a waiver program must be able to support the Emergency Response System equipment with either a phone or internet line.

Supplemental Transportation Services: Supplemental transportation services are available to help individuals access the community but they cannot be used for transportation to medical appointments. The individual on a waiver program must use community resources such as non-emergency transportation, ambulette, or ambulance services as arranged by the local county department of job and family services for medical appointments.

Case Management Services

Case management services must be outlined in the All Services Plan. The All Services Plan must indicate the acuity level and contact schedule, as well as specify that the case management services include monitoring of services, specific monitoring and/or interventions that occur for a waiver individual's needs.

Hospice Services

If an individual on a waiver elects the hospice benefit, the Case Management Contractor must update the All Services Plan to identify which services will be provided by the waiver and which will be provided by hospice. Once a an individual on a waiver program elects hospice services, the hospice provider will provide nutritional counseling, out-of-home respite, durable medical equipment, and social work, as well as home health aide and nursing, therapy, and private duty nursing related to a terminal condition.

Waiver services can remain in place and may be increased only if the need is unrelated to the condition for which hospice has been elected.

Money Follows the Person HOME Choice Demonstration Program

HOME Choice assists older adults and persons with disabilities to move from qualified institutions to home and community-based settings. It provides individuals greater choice and control over the services received in their preferred setting. It also offers services that are not available on the waiver program that further enable the individual on a waiver program to adjust to community-based living. A HOME Choice transition coordinator assists them move back into the community by helping to locate housing, set up a household and connect to community services. Once the individual has applied for the HOME Choice program with the assistance of the HOME Choice Pre-Transition Case Manager, the HOME Choice Pre-Transition Case Manager shall work in conjunction with the HOME Choice transition coordinator to ensure a successful transition to community-based living. The scope of the HOME Choice Pre-Transition Case Manager's role in this process is defined in a separate Provider Agreement.

Unless otherwise advised by the Office of Medical Assistance, the Case Management Contractor shall immediately assume HOME Choice case management responsibilities under this Contract for those individuals whom it assisted as a HOME Choice Pre-Transition Case Manager under the separate Provider Agreement. A well-developed and executed discharge plan will help ensure the individual will be successful in transitioning to community-based living. Therefore, in addition to being responsible for all care coordination outlined in this guide, the Case Management Contractor is responsible for coordinating discharge planning activities with the HOME Choice transition coordinator and other members of the individual's support team. This includes participation in discharge planning meetings, plan development, and ensuring services are ready to begin on the date of discharge. The Case Management Contractor is also responsible for integrating HOME Choice services into the All Services Plan during the 365 days the HOME Choice program is available. Services available through HOME Choice include:

- Independent living skills training.
- Community support coaching.
- Social work/counseling.
- Nutritional consultation.
- Community transition services.
- Communication aids.
- Service animals.

All Services Plan Process Requirements

The All Services Plan is updated at the waiver individual's annual assessment, at other times the Case Management Contractor determines is necessary or when events dictate the reassessment of the waiver individual's needs and re-evaluation of the All Services Plan. Goals and outcomes are updated, as well.

- The All Services Plan must include, but is not limited, to:
    - The name, phone number and service responsibilities of all paid providers and unpaid caregivers.
    - The funding sources of all paid providers and unpaid caregivers. The funding sources must include third-party benefits and Medicaid State Plan services to be used prior to the use of waiver services. Documentation of service planning costs will identify when Medicaid is the payer of last resort.
    - The total number approved units of each service and the total projected monthly cost for waiver services and Medicaid State Plan-covered services for 12 months beginning with the enrollment and/or annual date.
    - The start and stop dates of service delivery.
    - The Case Management Contractor must notify the individual on a waiver program of services and any Medicaid patient liability, if applicable. Medicaid patient liability is assigned to a provider in the All Services Plan.
- The Case Management Contractor must respond to requests for changes to the All Services Plans in writing and within 10 calendar days of a request from the individual. Approvals must be updated in the All Services Plan. All responses must include notice of the right to a state hearing.
- The Case Management Contractor must review and/or modify the All Services Plans within 24 hours of receipt of a notification of a significant change in the waiver individual's physical or mental condition.
- The Case Management Contractor must notify the individual on a waiver program and the providers of all changes in the All Services Plans.
    - The Case Management Contractor must provide written documentation prior to the expected date of service change or verbal notification prior to the expected date of delivery of the service change if written documentation is not possible prior to the expected date of service delivery.
    - The Case Management Contractor must provide an updated All Services Plan no later than 48 hours after the date of service change if verbal notification was given
- The All Services Plan is not complete until the individual on a waiver program or authorized representative signs the All Services Plan.
- The Case Management Contractor must contact the individual on a waiver program no later than 24 hours after the initiation of, or change to, services to assess the waiver individual's satisfaction with the services and/or change.

- The total amount of waiver and state plan services, excluding home modification and adaptive/assistive devices, must not exceed the individual cost cap. The Case Management Contractor must document all contacts or visits with the participant, authorized representative, providers, or other team members in the case record within one business day of the contact and/or visit.

All Services Plan Prior Authorization

Office of Medical Assistance ensures state-wide consistency and monitors costs by using All Services Plan prior authorization, which is a process to review requests for increases in waiver services.

The prior authorization is used whenever an individual on a waiver program requests an increase in service or the Case Management Contractor determines an increase in services is needed, which causes the service authorization to exceed the waiver individual's current individual cost cap, as directed below.

Prior authorization must be obtained for service increases as outlined below *unless the service need meets the criteria for emergency or post-hospital benefits.*

Service Authorizations Requiring Prior Authorization

Service authorizations that meet any of the following criteria require the Case Management Contractor to submit a prior authorization to the Office of Medical Assistance:

- Increase in monthly cost of service authorization of more than $1000 over the current individual cost cap.

- Increase in service authorization accumulating to $1000 more than the previously authorized amount of Private Duty Nursing or, if applicable, a combination of Private Duty Nursing and home health services for newly enrolled waiver individuals (applies to any increases within first six months of enrollment). Information about the current Private Duty Nursing authorization can be requested by e-mail to PDN_BCSP@jfs.ohio.gov .

- Any service authorization of $14,000 or more in a month.

- Service plans including 112 paid hours or more per week of personal care aide, nursing or health care aide, adult day health, or any combination of these or other like services, including work, day programs, and school services, regardless of funding source.

Review Expectations

Both the Case Management Contractor and Office of Medical Assistance will review prior authorization plans and evaluate the following needs:

- Health and welfare.
- Cognitive.
- Physical.
- Environmental.

The Case Management Contractor must submit the request for increase within five business days of the waiver individual's request or the determination of need. The Office of Medical Assistance will review submitted prior authorization and respond to the Case Management Contractor within 10 business days of submission. The Case Management Contractor has up to five business days to respond to a request for more information or withdraw the request.

The Office of Medical Assistance reviews prior authorizations in order of receipt unless the Case Management Contractor requests a priority review.

Priority Reviews

Office of Medical Assistance will expedite the review of a prior authorization as a priority only in these circumstances:

- The requested services meet the criteria for an emergency over $12,000 as described below, or;

- The need for the increased services that meet the other criteria for a prior authorization when there are extenuating circumstances relating to a significant change of condition. An event-based assessment must accompany the prior authorization request.

The Case Management Contractor designated managers must submit all requests for priority review by e-mail to BHCS-CMA-PA-Requests@jfs.ohio.gov. The Office of Medical Assistance will determine if the request meets the criteria for a priority review.

Emergency Authorization

The emergency authorization is to be used only for true individual emergencies and may not bypass the prior authorization process.

The Case Management Contractor can approve temporary increases in services up to $12,000 for no more than 21 calendar days.

Office of Medical Assistance will not repeat, extend or renew an emergency authorization. If the individual on a waiver program is expected to need the increase in services beyond 21 days, the Case Management Contractor will submit a prior authorization request to the Office of Medical Assistance.

Office of Medical Assistance must prior authorize any emergency request over $12,000.

Post-Hospital Benefits

Post-hospital benefits are available to all Medicaid state-plan recipients. To be eligible, the individual on a waiver program must have had three consecutive overnight in-patient stays in a hospital and meet the eligibility requirements as defined in Ohio Administrative Code rules 5101:3-12-01 and 5101:3-12-02.
When an individual on a waiver program qualifies for and requires post-hospital home health and/or post-hospital Private Duty Nursing services, due to the temporary availability of the service, a prior authorization is not required. If the need for the increased services is ongoing or does not meet the criteria for post-hospital, the Case Management Contractor can approve an emergency authorization, if appropriate, or request a prior authorization. However, the Case Management Contractor cannot authorize continuance of post-hospital services beyond 60 days.

Anticipated Increased Services

The Case Management Contractor must anticipate increased services during the service planning process. The Case Management Contractor and individual on a waiver program must discuss future service needs and plan for those events in the individual's All Services Plans. Examples of events that must be anticipated are:

- Vacations and respite of informal caregivers.
- Scheduled school or workshop breaks and closings.
- Planned hospitalizations of individuals or informal caregivers.
- Estimated snow days.
- Scheduled and estimated late start days at school or workshop.
- Camp.
- Holidays.
- Informal caregiver schedule fluctuations.

Authorizations of services for anticipated events are time-limited as appropriate.

A prior authorization is not required for planning to replace home care attendant services with nursing when the home care attendant is unavailable. Case managers do not need to use the prior authorization to develop a back-up plan for an individual using Health Care Attendant. The back-up plan using nursing is considered anticipated services to replace Health Care Attendant services.

Increasing the Individual Cost Cap

When Office of Medical Assistance determines it is appropriate, a waiver individual's Individual Cost Cap may be increased to accommodate a significant change of condition. The Case Management Contractor can increase the Individual Cost Cap by up to $1000 a month but only the Office of Medical Assistance can increase the Individual Cost Cap by more than $1000.

Home and Vehicle Modifications/Durable Medical Equipment/Supplemental and Adaptive Assistance Devices

The Office of Medical Assistance–administered home and community-based services programs provide medically necessary home and vehicle modifications, durable medical equipment and adapt assistance devices. When an individual on a waiver program requests one or more of these, the Case Management Contractor must schedule, within five calendar days, a physical or occupational evaluation to determine the medical necessity and initiate the process for obtaining an device or modification if medically necessary.

Upon completion of a physical or occupational therapy evaluation, the Case Management Contractor must seek a minimum of three vendor or contractor bids for modification. It must ensure that the device or modification is requested through a prior authorization process within 30 days or a vehicle or home modification vendor is selected and begins work within 45 days. The Case Management Contractor must keep the individual on a waiver program updated on the status of his or her request throughout the procurement process.

The Case Management Contractor must first obtain a denial from any third-party insurance available and Medicaid fee-for-service, including prior authorization, before authorizing the device or modification through the waiver program. The Case Management Contractor will approve the lowest cost alternative that meets the individual's needs as determined during the assessment process.

For more details about home and vehicle modifications, durable medical equipment and adaptive assistance devices, please see Ohio Administrative Code Rule 5101:3-46-04 Ohio home care waiver: definitions of the covered services and provider requirements and specifications at http://codes.ohio.gov/oac/5101%3A3-46-04 .

Home Modification Services

Home modification services" are environmental accessibility adaptations to structural elements of the interior or exterior of a consumer's home that enable the consumer to function with greater independence in the home and remain in the community. Home modification services are not otherwise available through any other funding source and must be suitable to enable the consumer to function with greater independence, avoid institutionalization and reduce the need for human assistance.

They cannot exceed a total of $10,000 within a 12- month calendar year per individual. The Office of Medical Assistance will approve the lowest cost alternative that meets the consumer's needs as determined during the assessment process.

Home modification services do not include changes to a home that are of general utility and are not directly related to the environmental accessibility needs of the consumer (i.e., carpeting, roof repair, central air conditioning, etc.); adaptations that add to the total square footage of the home; services performed in excess of what is approved pursuant to, and specified on, the individual's All Services Plan; the same type of home modification for the same individual during the same 12-month calendar year, unless there is a documented need for the home modification or a documented change in the individual's medical and/or physical condition that requires the replacement; new home modifications or repair of previously approved home modifications that have been damaged as a result of confirmed misuse, abuse or negligence.

Supplemental Adaptive and Assistive Device Services

"Supplemental adaptive and assistive device services" are medical equipment, supplies and devices, and vehicle modifications to a vehicle owned by the individual, or a family member, or someone who resides in the same household as the individual, that are not otherwise available through any other funding source and that are suitable to enable the consumer to function with greater independence, avoid institutionalization, and reduce the need for human assistance.

Vehicle Modifications

Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, wheelchair tie-downs, scooter/wheelchair handling devices, transfer seats, remote devices, lifts, equipment repairs and/or replacements, and transfers of equipment from one vehicle to another for use by the same consumer. Vehicle modifications may also include the itemized cost, and separate invoicing of vehicle adaptations associated with the purchase of a vehicle that has not been pre-owned or pre-leased.

Implementation Expectations

1. **The Case Management Contractor must provides weekly status reports** to the assigned Case Manager listing all individuals who have requested a supplemental adaptive or assistive device, or a vehicle or home modification with the status of those requests in the procurement process.
   Case Managers must update individuals awaiting adaptive or assistive devices or modifications **at least bi-weekly** and document the communication in the individual's record.
2. **Use standard template language on all bid forms**. The standard language on all bid templates must include Americans with Disabilities Act compliance information, require the provider to have proof of insurance, bonding, and all permits required for the job; and require a warranty to be included in bid.
3. **Send bid requests to all providers within the individual's county and all contiguous counties with a deadline.**

4. **The Case Management Contractor must correctly define devices and modifications and categorize them as billing code T2029 or billing code S5165**. Each requested device or modification must be separate.

Provider Selection

Free Choice of Provider: Individuals enrolled on a home and community-based waiver program have the right to select the provider of his or her choice for any Medicaid and/or waiver service. The Case Management Contractor is responsible for ensuring that individuals are afforded this right and assisted, to the extent needed, in the selection process.

Provider search options include:

- Ohio Department of Job and Family Services consumer website (http://jfs.ohio.gov/OHP/consumer.stm).
- Office of Medical Assistance approved system.
- Medicaid Consumer Hotline (1-800-324-8680).

Individuals can select any combination of agency and/or non-agency providers. The Case Management Contractor is responsible for ensuring that the individual has selected an adequate number of providers to ensure full coverage of services authorized in the All Services Plan. This includes, but is not limited to, assisting individuals with identifying potential providers, contacting the providers to determine interest, and linking individuals to interested providers.

Managing Non-Agency Providers: Individuals who elect to use non-agency providers are expected to manage these providers in accordance with Ohio Administrative Code rule 5101:3-45-04 and have the right to use non-agency providers unless it has been assessed that the individual is unable to manage the non-agency provider option. Individuals are to be allowed the opportunity to utilize and manage non-agency providers until such time as they are assessed as unable to do so in accordance with the rule previously noted.

Ensuring Individual's Health and Welfare

"Health and welfare" is an assurance required by the Centers for Medicare and Medicaid Services whereby the Office of Medical Assistance must ensure that safeguards are taken to protect the health and welfare of Office of Medical Assistance-administered waiver individuals, Centers for Medicare and Medicaid Services will not grant an Office of Medical Assistance-administered waiver, and may terminate an existing Office of Medical Assistance-administered waiver, if the Office of Medical Assistance fails to ensure compliance with this requirement. The Office of Medical Assistance meets this requirement, at a minimum, by implementing policies and procedures regarding the following:

- Individual risk and safety planning and evaluations.
- Individual critical incident management.
- Housing and environmental safety evaluations.
- Individual behavioral interventions (see below).
- Individual medication management.
- Natural disaster and public emergency response planning.

The Office of Medical Assistance requires the Case Management Contractor to assess, identify, and care plan for risk and/or safety factors that may impact the waiver individual's health and/or welfare. When the Case Management Contractor identifies risk factors it must put services and supports in place to mitigate the risk. Risks can be identified through formal and ongoing assessment, incident reports, reports from providers, documentation reviews, and other means.
All Services Plans must address health and welfare concerns when risk factors exist. Services and supports must be put in place to address the risk.

When the individual on a waiver program poses or continues to pose a risk to his/her health and welfare, the Case Management Contractor must develop and implement an Acknowledgment of Responsibility Agreement. The Acknowledgement of Responsibility Agreement is created between the Case Management Contractor and the individual on a waiver program identifying the risks and setting forth interventions recommended by the Case Management Contractor to remedy risks to the waiver individual's health and welfare.

The individual on a waiver program must sign the Acknowledgement of Responsibility Agreement. If she or he does not, the Case Management Contractor must document the waiver individual's refusal to sign.

The Acknowledgement of Responsibility Agreement must be identified in the All Services Plan, and it must be monitored monthly to ensure the individual on a waiver program is adhering to the agreed-upon interventions, as well as for follow up on recommendations for service linkage, etc.
If the individual on a waiver program does not adhere to the agreed-upon interventions, the Case Management Contractor must disenroll the individual on a waiver program from the waiver program for inability to ensure his/her health and welfare. This must be done as soon as a continued risk is identified or after intervention attempts have failed.

Behavioral Interventions: Restraint, Seclusion or Restrictive Interventions

Restraint and seclusion are used for behaviors that pose a serious risk of harm to the individual on a waiver program or others. They include aggression to others, objects, or self. Please see Appendix C for definitions of restrictive interventions, seclusion or "time out,' and time away.

If such behaviors occur, the Case Management Contractor must identify and engage an authorizing entity. The use of restraint or restrictive intervention is permitted only if authorized by a physician, county board of developmental disabilities, a licensed psychologist, or other behavioral health professional. Only physicians can authorize chemical restraints. Only a county board of developmental disabilities can authorize the use of seclusion.

The following are *not* considered restraints:

- Any device that an individual can remove or is used for positioning and/or alignment.
- Age-appropriate devices such as a crib, playpen, or child-gate to safeguard babies/toddler or age-appropriate child safety seats used in a vehicles.
- Physical guidance or assistance to complete Activities of Daily Living or medical procedures, or for safety, such as holding hands when crossing the street if not age-appropriate.
- Medication ordered to be used in preparation for a medically necessary medical procedure.

Prohibitions:

- Use of seclusion that is not a part of a plan authorized and overseen by a county board of developmental disabilities is specifically prohibited.
- The use of prone (face-down) restraint if prohibited by an authorizing entity.

The Case Management Contractor must identify and develop a plan that addresses behaviors that include the use of restraint, seclusion and restrictive interventions. Case managers must ensure the following are addressed for the use of restraint, seclusion, or restrictive interventions:

- Ensuring agreement from the team that the use of use of restraint, seclusion, or restrictive intervention is appropriate.
- Obtaining consent from the individual on a waiver program or authorized representative for the plan and the interventions.
- Building safety and well-being measures into the All Services Plan as well as measures to mitigate or prevent risk.

- Obtaining written verification of authorization of the use of restraint, seclusion, or restrictive intervention by the authorizing entity.
- Identifying an oversight entity for ongoing monitoring the use of the restraint, seclusion, or restrictive intervention. The person implementing the restraint, seclusion, or restrictive intervention cannot be person responsible for monitoring the use of the restraint, seclusion, or restrictive intervention.
- Identifying and directing the party responsible to train staff that implement the restraint, seclusion, or restrictive intervention.
- Documenting the planned use of restraint, seclusion, restrictive interventions in the All Services Plan, Program Eligibility and Assessment Tool, and communication record.

Individuals with developmental disabilities who are served by a County Board of Developmental Disabilities are eligible to access support with behavior plan development. This includes the county board of developmental disabilities oversight committees and processes. Case managers are expected to collaborate with local county boards of developmental disabilities staff to access this service on behalf of the participant.

Reporting expectations: Any use, whether approved or unapproved, of restraint, seclusion or restrictive intervention must be reported as an incident via the Office of Medical Assistance approved system. Additionally, the use of any prohibited restraint or seclusion or any unauthorized use of a restrictive intervention must be reported as an incident. The Case Management Contractor must review reporting requirements with all persons authorizing or implementing a restraint, seclusion, or restrictive intervention.

The Case Management Contractor must develop and send an annual report to the physician who certified the restraint, seclusion plan or restrictive intervention plan. The report must include identification of the restraint, seclusion or restrictive intervention used, frequency of use per month, and information on the outcome or response to the use of the restraint, seclusion, or restrictive intervention. The Case Management Contractor must ensure the physician evaluates the need for, and re-authorizes if necessary, the use of the restraint, seclusion, or restrictive intervention at least annually.

Review: The Case Management Contractor must review and discuss the use of restraint, seclusion, or restrictive intervention with the team at least every 90 days. Additionally, the Case Management Contractor must review all incident reports related to the use of restraint, seclusion, or restrictive intervention. The Case Management Contractor is required to review the use of restrictive interventions to ensure the use was appropriate and within prescribed guidelines.

Service Monitoring

The Case Management Contractor must monitor service delivery continuously. Monitoring services is not a compliance review process, but rather a quality check to ensure the health and welfare of the participant, as well as to ensure all needs are being met.

At any time, if there are concerns about the waiver individual's well-being, including incident identification, or about the performance of the provider, the Case Management Contractor must file incident reports.
Monitoring services includes:

1. Confirming the start of services within one business day of a new service or a new provider being added to an All Services Plan.

2. Monitoring provider service delivery by reviewing notes, plans of care, and other documentation at each home visit and when documentation is submitted to the Case Management Contractor. This includes comparing plans of care to the All Services Plan to identify changes and consistency. Any changes that were made to the All Services Plan that were not previously reported to the Case Management Contractor must be addressed with an event-based assessment or incident report.

Incident Discovery, Reporting and Prevention Planning

Incidents are listed in Ohio Administrative Code Rule 5101:3:45-05. The Case Management Contractor must follow the protocol below when an incident occurs:

1. **Take Immediate Action:** Upon discovery of an incident or allegation, the Case Management Contractor must take immediate action(s) to ensure the health and welfare of the participant. In the event of a death of an individual on a waiver program, the Case Management Contractor must notify the local county coroner when the Case Management Contractor is aware that the disability of the individual on the waiver program was a result of an accident, injury, or trauma.

   In addition, in the event of a death, the Case Management Contractor must contact the individual's natural supports and offer linkage and referral to local grief and counseling services.

2. **Report to protective agencies:** Immediately after securing the waiver individual's safety, the Case Management Contractor must notify law enforcement, county children's services, adult protective services, county board of developmental disabilities or other entity, as needed. The Office of Medical Assistance also expects the Case Management Contractor to cooperate with these entities, as needed, in an investigation.

3. **Report Incident to Provider Oversight Contractor:** The Case Management Contractor must report incidents in the Office of Medical Assistance-approved system within 24 hours of the Case Management Contractor discovery, as directed by Office of Medical Assistance. In addition to filing the incident report, all of the following must be reported to Office of Medical Assistance:

Incidents Alerts: Incident alerts are incidents (see below) that must be reported to the Office of Medical Assistance within one business day of discovery due to the severity and/or impact of the incident on the individual on the waiver or the need for Office of Medical Assistance involvement in the incident. The Office of Medical Assistance monitors each incident alert to ensure that the investigation, remediation, and prevention planning are timely and effective. The Case Management Contractor must report incident alerts within one business day of discovering the incident to both the Provider Oversight Contractor and Office of Medical Assistance. The notification must include the incident number assigned by the incident database. The Office of Medical Assistance does not close the incident alert until after the health and safety of the individual on a waiver program has been ensured. Prior to closing the incident alert, the Office of Medical Assistance will have reviewed all pertinent information, including investigation outcomes, recommendations, final reports, approved prevention plans and verification of implementation of the approved prevention plans.

Incident alerts include the following:

- Suspicious death.
- Abuse/neglect that result in the individual on a waiver program requiring hospital admission, emergency removal from home, or emergency room treatment.
- Allegations implicating any Case Management Contractor staff.
- Incidents generated from correspondence received from Ohio Attorney General, Governor's Office, Center for Medicare and Medicaid Services, or Ohio Civil Rights.
- Serious injury of an individual on a waiver program with an unknown cause resulting in a hospital admission.
- Harm to multiple individuals as a result of an incident.
- Injury resulting from the use of a restraint, seclusion or restrictive intervention.
- Alleged theft or misappropriation by a Medicaid provider or guardian that is valued at $500 or more.
- Incidents identified in a public media source.
- Other incidents the Office of Medical Assistance deems appropriate.

- **Suspicious deaths**: If an incident meets the criteria for a **Suspicious Death,** the Case Management Contractor must notify the Office of Medical Assistance within one business day of the Case Management Contractor's date of discovery. A suspicious death is one in which:

  - There is no reasonable explanation for the death because the circumstances or the cause of the death are not related to any known medical condition.

  - There is indication that someone's action or inaction may have caused or contributed to the death.

- **Potential Case Management Contractor involvement/Conflict of Interest**: If, at any time, during the discovery or investigation stages, information surfaces that indicates that a Case Management Contractor employee is directly or indirectly responsible for the death, abuse or neglect of a participant, the Case Management Contractor must immediately notify Office of Medical Assistance, which will assume the investigation.

4. **Incident Prevention Planning:** After the investigation concludes, the Case Management Contractor must create a prevention plan to prevent the same or similar incident from reoccurring and submit to the Provider Oversight Contractor.

   Prevention planning should include an evaluation to determine how to mitigate the effects of the occurrence, how to eliminate the risk to the individual on a waiver program from the cause(s) and contributing factors, and/or how to eradicate those cause(s) and contributing factors that pose a continued risk to the individual on a waiver program and others.

   The prevention plan should:

   - Be objective, measurable, attainable, reasonable (include timelines), realistic, enforceable, verifiable, and sustainable.
   - Consider/address all cause(s) and contributing factors and effects of the occurrence.
   - Be comprehensive and meet appropriate, legal, ethical, industry/profession standards, and be an acceptable practice.

   Some plan elements may require multiple actions, including but not limited to:

   - Training for other provider/agency staff members.
   - Revising All Services Plans .
   - Disciplining employees.
   - Taking administrative actions (i.e., changing policy or procedure, reassigning staff, increasing staff ratios).

Individual's Due Process Rights

The Case Management Contractor must issue hearing rights for all service changes, including increases and decreases of services, as well as any denial of a requested waiver service. It must review and evaluate all information to make a determination about requested services and be prepared to defend the action in a state hearing, if the individual on a waiver program requests one. More information on the state hearings process can be found in Ohio Administrative Code 5101:6. All actions must include an explanation of the decision, as well as rule citations and language to support the action.

The Case Management Contractor must lead all hearings in which it recommended the service denial or when the Case Management Contractor recommended denial or modification to requested services and the Office of Medical Assistance concurred with the Case Management Contractor's recommendation. The Office of Medical Assistance will lead all hearings for which Office of Medical Assistance determines the outcome of the All Services Review Plan Process (prior authorization) against the recommendation of the Case Management Contractor. When the Office of Medical Assistance is the lead on a hearing, the Case Management Contractor must provide a knowledgeable staff member to participate in the hearing.

The Case Management Contractor must produce and provide copies of an appeal summary to the hearing officer and to the individual on a waiver program and his/her authorized representative(s) at least three business days prior to the hearing date.

Requesting an Assistant Attorney General for a Hearing

When the Case Management Contractor is notified that the individual on a waiver program will have legal representation, the Case Management Contractor can request an Assistant Attorney General to represent the Case Management Contractor at the hearing. However, the Attorney General's office will provide an Assistant Attorney General only if the Case Management Contractor can confirm that the appellant has legal representation.

- All requests for Attorney General representation must be made as directed by the Office of Medical Assistance. If the request is received fewer than 24 hours before the hearing is scheduled, but at least 30 minutes before the hearing, the Case Management Contractor can e-mail a request for an Assistant Attorney General to attend the hearing. An Assistant Attorney General cannot be requested with a phone call.

- The Case Management Contractor will be notified of the name of the Assistant Attorney General assigned to the hearing.

- If the Assistant Attorney General is requested fewer than 30 minutes prior to the start of a hearing, the Case Management Contractor must proceed without Assistant Attorney General representation.

Hearings Process

- If an Assistant Attorney General is attending the hearing, the Office of Medical Assistance or Case Management Contractor must forward all documents pertaining to the hearing to the assigned Assistant Attorney General. If a hearing has been canceled, the Office of Medical Assistance or Case Management Contractor must notify the Attorney General's office by e-mail as soon as it learns this.

- If the appellant appears with an attorney without advance notice and the attorney admits new written information or elicits new testimony not previously seen or heard by the Office of Medical Assistance, the Case Management Contractor or the Assistant Attorney General and they need time to review and consider new information, they can request that the hearing be reconvened or the record left open for the submission of additional documentation. State hearing officers will make the final ruling.

- If an appellant has no attorney or paralegal and submits new evidence/documentation, the Office of Medical Assistance or Case Management Contractor may request that the hearing officer reconvene the hearing or leave the record open to allow them to review and respond to the new evidence or documentation.

- If the appellant has requested a state hearing within 10 days of receiving hearing rights, the Case Management Contractor must continue the appellant's services at their current level until the outcome of the state hearing. When the hearing decision is rendered, the Case Management Contractor must follow the decision as directed and submit a compliance form to the Bureau of State Hearings validating compliance.

- If the appellant disagrees with the state hearing decision, he or she may make a written request for an administrative appeal to the Ohio Department of Job and Family Services, Bureau of State Hearings, PO Box 182825, Columbus OH 43218-2825 or fax (614) 728-0874. Their written request must be received by the Bureau of State Hearings within 15 calendar days of the date the decision was issued.

- Unlike a state hearing request, however, during an administrative appeal, the Case Management Contractor must proceed with enacting the state hearing decision *unless* instructed by the Bureau of State Hearings to do otherwise.

Complaint Process

The Office of Medical Assistance-administered waiver individuals, service providers, family members, individual advocates, or others involved in the care of the individual have the right to make form complaints to, or about, the Case Management Contractor. Complaints can be made to the Case Management Contractor, Provider Oversight Contractor, or to the Office of Medical Assistance and they can originate from a face-to-face conversation, phone call, e-mail, Office of Medical Assistance legislative inquiry, or regular mail.

The Case Management Contractor must share an OMA approved web-based complaint system so that the Office of Medical Assistance, the Case Management Contractor, and the Provider Oversight Contractor will have access to all of the complaint processes.

The Case Management Contractor must enter all complaints it receives into the complaint system. If the Case Management Contractor receives a complaint about a provider, the complaint must be forwarded to the Provider Oversight Contractor. The Case Management Contractor must use the following protocol for complaints:

1. Categorize complaints, reference a department, and determine a resolution type.

2. Send a complaint acknowledgment letter to the complainant within one business day of the complaint. If the Case Management Contractor takes the complaint, it will be responsible for sending the form letter on its letterhead. If the Office of Medical Assistance takes the complaint, it will send the form letter on Office of Medical Assistance letterhead. The form letter will acknowledge the complaint and offer an apology.

3. Investigate all complaints within three business days of the date of receiving the complaint. Record all investigatory notes on the complaint form.

4. Submit an action plan to the Office of Medical Assistance contract manager via e-mail within seven days of receiving the complaint.

5. Address and attempt to resolve all complaints within 15 calendar days and the record resolution on the complaint form.

6. The Office of Medical Assistance will send a follow-up letter to each complainant to confirm that resolution has taken place.

7. If a complainant indicates to the Office of Medical Assistance that a satisfactory resolution was not obtained and the Office of Medical Assistance agrees, it will re-open the complaint and return it to the Case Management Contractor for re-investigation (Step 3) and to proceed through the complaint process again.

Accessing Office of Medical Assistance's Information Management Systems

In order to fulfill case management functions, the Case Management Contractor must have access to state data systems, which requires it to implement a secure **virtual private network connection**. This must be done in cooperation with Office of Medical Assistance.

The Office of Medical Assistance will provide the Case Management Contractor access to three Office of Medical Assistance data systems:

1. Medicaid Information Technology System (the Office of Medical Assistance database that contains Medicaid information).

2. Client Registry Information System - Enhanced (the statewide eligibility system used by Office of Medical Assistance and county departments of job and family services).

3. The Office of Medical Assistance approved case management system.

The Case Management Contractor must request individual Case Management Contractor staff access through Office of Medical Assistance by submitting the appropriate access request documentation. The request is made by completing a *Code of Responsibility Form* (Office of Medical Assistance #7078), which can be requested by e-mail to BHCS@jfs.ohio.gov. Submit completed forms to the same e-mail address.

Terminating a User's Access

The Case Management Contractor must request termination of the Office of Medical Assistance system access within ***one*** business day of the last date of employment for any user with access to any Office of Medical Assistance system. Requests for terminations may be made in advance. E-mail termination requests to BHCS@jfs.ohio.gov.

Appendix A: Code Sheet

Waiver Denial and Disenrollment Codes and Descriptions

509	You Refused To Cooperate With an Assessment
510	Deceased
511	You Voluntarily Withdrew From the Program
512	You Are In a Hospital and There Is No Discharge Date
743	You Have an Inappropriate Level of Care
762	Your Level of Care Has Been Denied
790	All Slots Are Reserved
797	Ohio Home Care Waiver eligibility is for individuals under 60 years of age
410	Voluntary Withdrawal of Initial Application
502	There Are No Waiver Openings Available
504	The Cost of Required Services Exceeds the Maximum
505	Your Needs Can Be Met By Community Resources
506	Your Doctor Did Not Approve the Plan of Services
507	Your Health and Safety Cannot Be Assured By the Program
508	You Are In A Nursing Facility and Have No Plans to Leave

Appendix B:
Ohio Administrative Code Rules

Ohio Department of Job and Family Services- Administered Waiver Rules:

- 5101:3-45- 01 ODJFS-administered waiver program definitions.
- 5101:3-45-03 ODJFS-administered waiver programs: consumer choice and control.
- 5101:3-45-04 ODJFS-administered waiver programs: provider-enrollment process.
- 5101:3-45-05 ODJFS-administered waiver program: consumer-incident management, investigation and response system.
- 5101:3-45-06 ODJFS-administered waiver program: structural reviews of providers and investigation of alleged provider occurrences and overpayments.
- 5101:3-45-07 ODJFS-administered waiver program: Criminal records checks involving agency providers.
- 5101:3-45-08 ODJFS-administered waiver program: Criminal records checks involving non-agency providers.
- 5101:3-45-09 ODJFS-administered waivers: quality assurance monitoring and oversight of ODJFS-administered waver service providers and the contracted case management agency.
- 5101:3-45-10 Conditions of participation for Ohio department of job and family services (ODJFS) administered waiver service providers.
- 5101:3-46 Ohio home care waiver.
- 5101:3-46-02 Ohio home care waiver: consumer eligibility for enrollment.
- 5101:3-46-04 Ohio home care waiver: definitions of the covered services and provider requirements and specifications.
- 5101:3-46-04.1 Ohio home care waiver program: home care attendant services.
- 5101:3-46-06 Ohio home care waiver: reimbursement rates and billing procedures.
- 5101:3-46-06.1 Ohio home care waiver program: home care attendant services reimbursement rates and billing procedures.
- 5101:3-46-07 Ohio home care waiver: enrollment and waiting list process.
- 5101:3-50 Transitions carve-out waiver.
- 5101:3-50-02 Transitions carve-out waiver: consumer eligibility for enrollment.
- 5101:3-50-04 Transitions carve-out waiver: definitions of the covered services and provider requirements and specifications.
- 5101:3-50-04.1 Transitions carve-out waiver program: home care attendant services.
- 5101:3-50-06 Transitions carve-out waiver program: reimbursement rates and billing procedures.
- 5101:3-50-06.1 Transitions carve-out waiver program: home care attendant services reimbursement rates and billing procedures.

Home Health Rules: Ohio Administrative Code 5101:3-12

- 5101:3-12-01 Home Health Services; provision requirements, coverage and service specification.
- 5101:3-12-03 MCRHHAs: qualifications and requirements.
- 5101:3-12-04 Home health and Private duty Nursing: Visit Policy.
- 5101:3-12-05 Reimbursement: Home Health Services.
- 5101: 3-12-07 Reimbursement: exceptions.

Private Duty Nursing Rules:

- 5101:3-12-02 Private Duty Nursing: services, Provision requirements, coverage and service specification.
- 5101:3-12-02.3 Private Duty Nursing: Procedure for service authorization.
- 5101:3-12-03.1 Non-agency nurses and otherwise-accredited agencies: qualifications and requirements.
- 5101:3-12-04 Home health and Private Duty Nursing: visit policy.
- 5101:3-12-06 Reimbursement: Private Duty Nursing services.
- 5101:3-12-07 Reimbursement: Exceptions.

Hospice Rules:

- 5101:3-56-01 Hospice services: definitions.
- 5101:3-56-02 Hospice services: eligibility and election requirements.
- 5101:3-56-03 Hospice services: discharge requirements.
- 5101:3-56-03.3 Hospice services: reporting requirements.
- 5101:3-56-04 Hospice services: provider requirement.
- 5101:3-56-05 Hospice services: covered services.
- 5101:3-56-06 Hospice services: reimbursement.

Medicaid Eligibility for Home and Community Based Services Rule

- 5101:1-38-01.6 Medicaid: application for home and community-based (HCB) services.

HOME Choice Rules

- Chapter 5101:3-51 HOME choice ("Helping Ohioans Move, Expanding Choice") demonstration program.
- 5101:3-51-01 HOME choice ("Helping Ohioans Move, Expanding Choice") demonstration program: definitions.
- 5101:3-51-01 HOME choice ("Helping Ohioans Move, Expanding Choice") demonstration program: definitions.
- 5101:3-51-02 HOME choice ("Helping Ohioans Move, Expanding Choice") demonstration program: individual eligibility for services and participant hearing rights.
- 5101:3-51-03 HOME choice ("Helping Ohioans Move, Expanding Choice") demonstration program: conditions of participation for providers.

- 5101:3-51-04 HOME choice ("Helping Ohioans Move, Expanding Choice") demonstration program: definitions of the covered services and program service limitations, provider qualifications and specifications.
- 5101:3-51-05 HOME choice ("Helping Ohioans Move, Expanding Choice") demonstration program: process for enrolling service providers.
- 5101:3-51-06 HOME choice ("Helping Ohioans Move, Expanding Choice") demonstration program: reimbursement rates and billing procedures.

Level of Care Rules

- 5101:3-3-05 Level of Care Definitions.
- 5101:3-3-06 Protective Level of Care.
- 5101:3-3-07 Intermediate Level of Care for Persons with Mental Retardation.
- 5101:3-3-08 Criteria for Nursing Facility-Based Level of Care.
- 5101:3-3-15 Process and timeframes for a level of care determination for nursing facility-based level of care programs.
- 5101:3-3-15.3 Level of Care Review Process for Intermediate Care Facilities for the Mentally Retarded.

Other Medicaid Rules

- 5101:3-1-01 Medicaid medical necessity.
- 5101:3-20-01 Coordinated services program.

Appendix C: Definitions

Acknowledgement of Responsibility Agreement is the document created between the Case Management Contractor and the individual on a waiver program identifying and setting forth the interventions recommended by the Case Management Contractor to remedy risks to the waiver individual's health and welfare.

All-Services Plan is the service coordination and payment authorization document that identifies specific goals, objectives and measurable outcomes for waiver individual's health and functioning expected as a result of services provided by both formal and informal caregivers, and that addresses the physical and medical conditions of the waiver individual.

All Services Plan Prior Authorization is the process by which the Case Management Contractor obtains prior authorization for specified service amounts or increases. This prior authorization will be given by Office of Medical Assistance or the Case Management Contractor clinical management team, as designated.

Authorized Representative: When the individual on a waiver program has an authorized representative, the scope of that representative's decision-making authority, as established by the probate court or legal documentation, must be documented in the waiver individual's file.

Contact is a phone conversation, e-mail exchange, or other electronic communication with a participant, authorized representative, or provider, which includes information shared between parties. Voice mail messages and e-mails without response are **not** considered contact.

Continuous, as defined in Ohio Administrative Code 5101:3-12-02, means a service visit that lasts more than four hours.

Client Registry Information System - Enhanced is the statewide eligibility system used by Office of Medical Assistance and county departments of job and family services.

HOME Choice is Ohio's Money Follows the Person Demonstration project that assists individuals with transferring from the institution into a home setting.

"Individual cost cap," as defined in Ohio Administrative Code 5101:3-45-01 is the monthly cost of services that is approved by Office of Medical Assistance for an individual enrolled in the "Ohio Home Care Waiver," or "Transitions Carve-Out Waiver." The Office of Medical Assistance or its designee oversees that the cost of covered services does not exceed the individual cost cap, determines when an increase or decrease in the cap is required, and makes a recommendation with justification to Office of Medical Assistance for approval for increasing or decreasing the individual cost cap.

Intermittent, as defined in Ohio Administrative Code 5101:3-12-01, means service visits that last four or fewer hours.

Lead Physician. On a waiver individual's interdisciplinary team, the lead physician is the primary care physician or specialist identified in the All Services Plan. The lead physician signs approval on the All Services Plan at least annually when skilled services are not needed or are provided by natural supports, or, if the individual on the waiver has skilled services and/or a plan of care, signs approval for the plan of care every 60 days.

Natural supports are non-paid caregivers who provide care to the individual on a waiver. The Case Management Contractor must ensure all natural supports are documented in the individual's All Services Plans.

Norms is a tool used in Ohio that is an adaptation of the Colorado Norms Assessment tool. It is used to guide, but not prescribe service scope and amount for service plan development. It is *not* a fiscal or cost-projection instrument.

New individual on a waiver program is one who has been enrolled for fewer than six months.

Restraint means:

Physical restraint: Any hands-on or physical method that is used to restrict the movement or function of the individual's head, neck, torso, one or more limbs or entire body; **or**

Chemical restraint: The use of any sedative psychotropic drug exclusively to manage or control behavior; **or**

Mechanical restraint: The use of any device to restrict an individual's movement or function and is used for any purpose other than positioning and/or alignment.

Restrictive interventions are any actions or activities limiting a waiver individual's rights for a brief period of time to assure an individual's health, safety, or welfare. Restrictive interventions may only be used to safeguard individuals from accidents or injuries, or to help promote optimal health and welfare. Some examples of restrictive interventions include, but are not limited to, locking cabinets, using door alarms, or limiting access to a desired item contingent on a behavior/activity.

"Time away" is a restrictive intervention during which the individual on a waiver program is directed away from a location or activity using verbal prompting only to address a specified behavior. The individual is able to return to the location or activity at his/her choosing. Time away may never include the use of a physical prompt or escort. The use of any physical prompt or required timeline for re-engaging in an activity will elevate the intervention to "seclusion."

Seclusion or "Time Out" is any restriction that is used to address a specified behavior and that prevents the individual from leaving a location for any period of time. Seclusion may include preventing the individual from leaving the area until he/she is calm. Seclusion may never include the use of locked doors and must always include constant visual supervision of the individual, and must be used only for behaviors that are physically harmful to the individual or other persons.

Significant change of condition is a change of condition in one or more of the following events that results in a change to the *type, amount, or scope* of service provided to an individual for which the service need is expected to be sustained for more than one year.

This includes both increases and decreases in service needs, and includes the following:

- Change in health status.
- Loss or addition of a voluntary caregiver.
- A change in location or residence.
- Transition to/from school-aged services (i.e., school programs).
- Loss or addition of another person with whom the individual shares services.
- Change of funding source to Medicaid (i.e., from Medicare or private insurance).

Visit means a face-to-face encounter with an individual in his/her home. Meetings and encounters at locations other than the individual's home or when the individual is not present are *not* considered visits. Case managers *must* interact (converse, make visual contact, and otherwise engage the individual at his/her functional ability) during every visit.

ATTACHMENT ELEVEN

THE OFFICE OF MEDICAL ASSISTANCE

THE BUREAU OF LONG-TERM CARE SERVICES & SUPPORT

QUALITY MANAGEMENT PLAN

REQUIREMENTS FOR THE

CASE MANAGEMENT CONTRACTOR

(A) Introduction

The Office of Medical Assistance must comply with six federal waiver program assurances in order to maintain approval from the Centers for Medicare and Medicaid Services to operate the waiver programs. This Quality Management Plan, that may be amended each state fiscal year, sets forth requirements imposed on the Contractor in order to guarantee that these assurances are met. The Bureau of Long-Term Care Services & Support is responsible for the oversight of the Quality Management Plan. The six waiver program assurances are:

(1) Waiver Assurance I: State Conducts Level of Care Need Determinations Consistent with the Need for Institutionalization

The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for waivers, when there is a reasonable indication that an individual might need such services in the near future and that the individual would require placement in a hospital, NF or ICF/MR but for the receipt of home and community based services available under waivers.

(2) Waiver Assurance II: Plans of Care Responsive to Waiver Individual Needs

The State must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of plans of care for waiver individuals.

(3) Waiver Assurance III: Qualified Providers Serve Waiver Individuals

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

(4) Waiver Assurance IV: Health and Welfare of Waiver Individuals

The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

(5) Waiver Assurance V: Administrative Authority

The State must demonstrate that it retains administrative authority over the waiver program and that its administration of the waiver program is consistent with its approved waiver application.

(6) Waiver Assurance VI: Financial Accountability

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.

(B) Contractor Requirements for Waiver Assurance I

(1) The Contractor shall assure that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for waiver programs, when there is a reasonable indication that an individual might need such services in the near future and that the individual would require placement in a hospital, NF or ICF/MR but for the receipt of home and community based services available under waiver programs.

(2) The Contractor must use an OMA-approved information and referral tracking system that collects the following data for each waiver program:

a) The total number of individual inquiries/phone contacts during normal business hours.
b) The total number of individual inquiries/phone contacts during non-business hours.
c) The number of individual referrals to other community resources and what referrals were made.
d) The number of individuals referred for State Plan Benefits.
e) The number of individual referrals coming from institutional settings.

Quarterly Reporting Requirement: The Contractor must summarize the data in the quarterly management report completing an analysis highlighting patterns and/or trends of the data.

(3) The Contractor must collect the following data on intake and eligibility activities for each waiver program:

a) The number of alerts received from the State.
b) The number and percentage of alerts that resulted in applicant contact within two (2) business days (Standard is 90%).
c) The number of individuals scheduled for assessment after initial contact.
d) The number of individuals who voluntarily withdrew after initial contact.
e) The number and percentage of individuals who had a face-to-face initial assessment within ten (10) business days of their initial contact **(Standard is 90%).**
f) The number of individuals assessed.
g) The number of individuals pending face-to-face initial assessment.
h) The number of individuals that were approved for a waiver program.
i) The number and percentage of approved individuals receiving services within 30 calendar days from the face-to-face initial assessment completion date **(Standard is 95%)**.
j) The reasons the individuals identified in (i) above did not receive services within 30 calendar days.
k) The number of individuals that were reassessed due to delayed service initiation.
l) The number of annual assessments due.
m) The number and percentage of annual assessments completed **(Standard is 100%).**
n) For any annual assessment not completed, provide the reason the annual assessment was not completed.
o) The number of times a registered nurse completed a level of care determination after a social worker gave an adverse level of care determination during either an initial or annual assessment.
p) The number and percentage of individuals contacted within one calendar day after the Contractor was notified of the individual's significant change of condition **(Standard is 95%).**
q) The number and percentage of individuals visited by Contractor within three calendar days after the Contractor was notified of the individual's significant change of condition **(Standard is 90%).**
r) The number of evaluations for increased home health services (HealthChek).

Monthly Reporting Requirement: The Contractor must summarize the data in the monthly performance report. The Contractor will explain the reason for non-compliance with any Standard and explain how Contractor intends to remedy the non-compliance.

(4) The Contractor must collect and report the following data for each waiver program:

(a) The number of level of care physician approvals requested.
(b) The number of approvals and percentage of approvals received back from the physicians within 30 calendar days.

Quarterly Reporting Requirement: The Contractor must summarize the data in the quarterly management report completing an analysis highlighting patterns and/or trends of the data. The Contractor must explain the reason for non-compliance with the thirty-day requirement and explain how Contractor intends to remedy the non-compliance.

NOTE: As part of the State's ongoing review of the Contractor, the State will review a sample of waiver program individuals to verify that the level of care eligibility requirements were met.

(C) Contractor Requirements for Waiver Assurance II

(1) The Contractor must review the adequacy of plans of care for waiver program individuals.

(2) The Contractor must collect the following data on individual phone contacts and face-to-face visits for each waiver program:

(a) The number and percentage of individuals with a minimum of two phone contacts with no more than 14 calendar days between contacts, and one face-to-face visit conducted no later than 20 calendar days following the individual's effective date on the waiver program. **(Standard is 95%).**
(b) The number and percentage of individuals who during their second and third months of enrollment had monthly phone contact with no more than 30 calendar days between phone contacts, and a minimum of two face-to-face visits with no more than 30 calendar days between visits. **(Standard is 95%).**
(c) The number and percentage of individuals who during months four through six of enrollment had monthly phone contact with no more than 30 calendar days between phone contacts, and a minimum of two face-to-face visits with no more than 45 calendar days between visits. **(Standard is 95%).**
(d) The number and percentage of Level One acuity waiver program individuals enrolled for more than six months with quarterly phone contact with no more than 90 calendar days between contacts, and a minimum of one face-to-face visit every six months with no more than 180 calendar days between face-to-face visits. **(Standard is 95%).**
(e) The number and percentage of Level Two acuity waiver program individuals enrolled for more than six months with monthly phone contact with no more than 30 calendar days between contacts, and a face-to-face visit every other month with no more than 60 calendar days between face-to-face visits. **(Standard is 95%).**

Quarterly Reporting Requirement: The Contractor must summarize the data in the quarterly management report completing an analysis highlighting patterns and/or trends of the data. The Contractor must explain the reasons for any non-compliance and explain how Contractor intends to remedy the non-compliance.

(3) The Contractor shall assure that waiver program individuals are receiving safe, effective, and adequate care.

(4) The Contractor must identify all of the waiver program individuals' needs in their individual service plans.

(5) The Contractor must review, and if appropriate revise, waiver program individuals' service plans at least once every six months.

(6) The Contractor shall assure that waiver program individuals are receiving services in the type, amount, frequency, and duration as specified in their service plans.

(7) The Contractor shall assure that waiver program individuals are aware that they can choose their providers.

(8) The Contractor shall assure that waiver program individuals have input regarding the services they are receiving.

NOTE: As part of the State's ongoing review, the State will periodically review the Contractor's compliance with the above requirements.

(D) Contractor Requirements for Waiver Assurance III

(1) With guidance from the Office of Medical Assistance, the Contractor shall monitor provider availability and report the results of the monitoring to the Office of Medical Assistance. The monitoring shall be by region and by waiver program and include, at a minimum, potential provider availability issues due to location, potential provider availability issues related to the multi-lingual needs of a particular community, and potential provider availability issues related to the need for a particular specialty in a community, *e.g.,* nurses with pediatric care skills.

Monthly Reporting Requirement: The Contractor shall report its monitoring of potential provider availability issues to the Office of Medical Assistance, or immediately if the situation merits immediate action.

(E) Contractor Requirements for Waiver Assurance IV

(1) The Contractor shall identify, address and seek to prevent instances of abuse, neglect and exploitation of waiver program individuals.

(2) The Contractor must review each implemented "Acknowledgement of Responsibility Agreement" (ARA) on an ongoing basis.

Quarterly Reporting Requirement: - Contractor will report all ARAs that have been initiated and are all ARAs that are in place by waiver program each quarter. All active ARAs must be categorized as to the issues that were addressed with individuals and listed in the report.

(3) The Contractor must document and report the authorized and unauthorized use of restraints and/or seclusion and the unauthorized use of restrictive interventions with waiver program individuals, and include the following:

(a) Number of reported incidents of authorized use of restraints and/or seclusion.
(b) Number of reported incidents of unauthorized use of restraints and/or seclusion.
(c) Number of reported incidents of unauthorized use of restrictive interventions.
(d) Number of individuals with approved behavior support plans, identifying the authorizing entities.
(e) Of those individuals with approved behavior support plans, the number with approved restraints (mechanical, chemical, and physical), the number with approved seclusion, and the number with approved restrictive interventions (as defined in the Case Management Guide).

Quarterly Reporting Requirement: The Contractor must summarize the data in the quarterly management report.

(4) The Contractor must submit updates on its detailed Emergency Response Plan for natural disasters and other public emergencies (*e.g.,* floods, extreme heat, extreme cold, etc.) on a quarterly basis. Coordination with other appropriate systems is recommended (*e.g.,* American Red Cross, Area Agencies on Aging, etc.).
Quarterly Reporting Requirement: The Contractor must report when and where the Emergency Response Plan was activated, if the plan was effective, and if not, what improvement activities are needed.

The Office of Medical Assistance will review the Contractor's Emergency Response Plan annually to provide suggestions for improvement.

(5) The Contractor must develop and implement due process policies, procedures and activities in accordance with the Ohio Administrative Code. The Contractor will collect the following minimum information, by waiver program:

(a) The number of hearing rights mailed to individuals each month. The report must include a itemization of the appealable events.
(b) The number of state hearing requests.
(c) The number of hearings that were abandoned, overruled, rescheduled, sustained, withdrawn, or pending (**Standard for sustained hearings to total hearings is less than 8% per year)**.

Monthly Reporting Requirement: The Contractor must summarize the data collected in the monthly performance report, by waiver program. The Contractor must supply a copy all sustained state hearing decisions with an explanation of why the appeal was sustained.

(6) The Contractor must implement a process pursuant to the directions in the Case Management Guide for the resolution of complaints by individuals, providers and stakeholders. The Contractor must collect, at a minimum, the following information by waiver program:

(a) The number of complaints received in each complaint category.
(b) The number of complaints that for which the investigations were not started within three business days, and provide the reason for noncompliance (**Standard is 100%).**
(c) The number of complaints that were not resolved within 15 calendar days, and provide the reason for noncompliance **(Standard is 95%).**

Quarterly Reporting Requirement: The Contractor must summarize the data above in the quarterly management report, noting any patterns and/or trends and any actions taken to prevent future noncompliance.

(F) Contractor requirements for Waiver Assurance V

(1) The State must demonstrate to the Centers for Medicare and Medicaid Services that it retains administrative authority over the waiver program and that its administration of the waiver program is consistent with its approved waiver program application. In furtherance of this assurance, the Contractor must do the following:

(a) The Contractor must implement a peer review/consultation program.

Semi-Annual Reporting Requirement: The Contractor must report the results of the Peer Review/Consultation program at the semi-annual quality briefings.

(b) The Contractor must complete semi-annual clinical practice reviews of individuals' charts according to the following schedule: 100% of the charts of new case manager's during their first six months of employment; 100% of the charts of each case manager who has been identified as having performance issues; for all other case managers, the State will semi-annually identify a sample of the total census (95% confidence level/margin of error 6%) and the Contractor must review those charts.

The reviews of the charts must include at a minimum the following:

(i) Verification that the documentation supports the assigned level of care.
(ii) If there was a guardianship, evidence that the guardianship was verified and documented. The guardianship may be verified either by the case manager indicating the guardianship papers were viewed, or by a copy of the guardianship papers in the chart, or a notation that guardianship was verified with the probate court, either by phone or online.
(iii) Verification that the charts contained the form signed by the individual indicating the individual's choice to receive community based long term care instead of facility based long term care.
(iv) Verification that the assessment tool was complete.
(v) Verification that the correct billing procedure codes were identified on the All Services Plan.
(vi) Verification that if the need for home modifications and/or supplemental/adaptive equipment was identified in the assessment tool, that the service was requested and/or provided.
(vii) If the individual needs assistance with medication administration, verification that the name of the person responsible for providing the assistance is identified on the assessment tool and in the All Services Plan.
(viii) Verification that the All Services Plan includes a back-up plan for the individual.
(ix) Verification that the prior authorization process for additional services was followed correctly.
(x) Documentation that individual was informed of right to free choice of eligible providers.
(xi) Verification that the chart contains documentation that the case manager is monitoring medications adequately and is consulting with other team members when issues are identified.
(xii) Verification that all paid and unpaid supports are identified on the All Services Plan.
(xiii) Verification of documentation in the chart of inter-disciplinary team meetings.
(xiv) Verification that the All Services Plan is complete, including identification of goals, objectives and methods to achieve the goals
(xv) Verification that the All Services Plan goals, objectives, and methods are clearly supported by clinical documentation.
(xvi) Verification that all needs identified in the assessment are addressed in the All Services Plan or documented elsewhere as appropriate.
(xvii) Verification that the services are being delivered according to the individual's goals and objectives as described in the All Services Plan.
(xviii) Verification that the case manager is applying sound clinical judgment in the performance of the case management duties.
(xix) Verification that any known or perceived risks and/or safety considerations that could impact individual's health and welfare are identified and addressed in the All Services Plan and/or other clinical documentation.
(xx) Verification that the case manager made changes to the All Services Plan as individual's needs change.
(xxi) Verification that any follow up on identified issues and/or concerns is documented.
(xxii) Verification that clinical documentation is complete and follows general practice standards.
(xxiii) Verification that all incidents have been reported as required.

Semi-Annual Reporting Requirement: Results of these reviews must be reported at the semi-annual quality briefings.

(2) The Contractor must send its current staff roster to the Office of Medical Assistance contract manager on the first business day of the month.

(3) The Contractor must send its calendar of educational/marketing opportunities regarding the Office of Medical Assistance administered waiver programs to the Office of Medical Assistance contract manager on the first business day of the month.

This calendar will outline who will be providing the education/marketing, where the education/marketing is taking place, and to whom the education/marketing is being given.

(4) The Contractor must demonstrate that it conducts regularly scheduled meetings with individuals, individual supports, and other stakeholders.

The meetings shall address, if appropriate, the following:

- Individual's involvement in their All Services Plan.
- Family and individual supports' involvement in individual's All Services Plan.
- Interdisciplinary team structure and involvement in individual's All Services Plan.
- Quality committees, which include individuals, individuals' supports and other stakeholders.

Quarterly Reporting Requirement: A description of the meetings must be contained in the Quarterly Management Report.

(G) Contractor requirements for Waiver Assurance VI

(1) The Contractor must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.

(a) The Contractor must promptly and accurately enter individual information into the eligibility and service payment systems (*e.g.*, MITS and CRIS-E).

(b) The Contractor must cooperate with the Office of Medical Assistance program integrity activities (*e.g.*, Unit of Service Verification reviews, financial services and the Ohio Attorney General's Medicaid Fraud Control Unit).

(c) The Contractor shall collaborate with the Office of Medical Assistance's efforts to manage cost growth in the waiver programs. The Contractor shall analyze data from the Office of Medical Assistance's quarterly individual-specific and provider reports of incurred costs of program services and use it to manage cost growth in the waiver programs.

Quarterly Reporting Requirement: The Contractor must describe how it is managing cost growth in the waiver programs.

(H) Monitoring of the Case Management Contractor:

(1) Ongoing Waiver Program Review – The Office of Medical Assistance conducts an ongoing review process that relies on a universal survey instrument that can be applied to all home and community based Medicaid waiver programs, including Medicaid waiver programs administered by the Ohio Department of Developmental Disabilities and the Ohio Department of Aging. These reviews are intended to generate performance data related to the six core waiver program assurances, as well as data related to individual free choice of provider and individual satisfaction.

The Office of Medical Assistance intends to conduct biannual reviews of each waiver program, which will include face-to-face interviews with individuals and record reviews, with approximately 150 randomly selected individuals on each waiver program. Samples of this size will produce findings that can be reported with a 95% confidence level within a margin of error of +/-8%.

Findings from this ongoing review process will become the basis for annual quality reporting to the Centers for Medicare and Medicaid Services (CMS) on the 372 report. Data compiled from these reviews will be discussed with the Contractor at a semi-annual quality briefing.

(2) Targeted Reviews – The Office of Medical Assistance may at any time conduct specific targeted reviews of the Contractor for any purpose, including without limitation for the purpose of assuring health and welfare and/or reviews of individual deaths, and the Contractor will cooperate with any request made by the Office of Medical Assistance.

(3) Notice of Adverse Outcomes – If the ongoing or targeted review by the Office of Medical Assistance identifies Contractor deficiencies, the Office of Medical Assistance staff will follow the Office's adverse outcome protocol. As part of the protocol, the Office of Medical Assistance will communicate any adverse findings to the Contractor and require immediate action and/or a plan of correction. The Contractor shall submit a plan of correction within the required timeframes. If the Office of Medical Assistance approves the plan of correction, the Contractor shall implement the plan of correction immediately.

(4) Monitoring of Alerts Process – The Office of Medical Assistance monitors critical incidents as part of the alerts process to assure that investigation and remediation are timely and effective. Critical incidents requiring an alert are defined in Attachment Ten – Case Management Guide.

(5) Review of Monthly and Quarterly Reports – After the Office of Medical Assistance reviews reports submitted by the Contractor, the Office of Medical Assistance will follow-up with the Contractor as needed.

(6) Semi-Annual Quality Briefings – The Contractor must participate with the Office of Medical Assistance in semi-annual quality briefings. These briefings serve as the forum for the Office of Medical Assistance and the Contractor to share and review performance data which has been collected by either party. This performance data may include performance metrics, results of any reviews, information on any compliance or performance issues or concerns, along with actions taken to remedy those issues or concerns, and whether those actions were effective.

(7) Quarterly Multi-Agency Quality Forums – The Contractor shall participate in the Quarterly Multi-Agency Quality Forums convened by the Office of Medical Assistance. The forum is attended by multiple agencies and contractors involved in home and community based waiver programs and the group is referred to as the Quality Steering Committee (QSC). The committee collects, compiles, and reports aggregate waiver-specific performance data. The committee uses this data, and conducts additional analysis, as a means to assess and compare performance across Ohio's Medicaid waiver program systems, to identify cross-waiver structural weaknesses, to support collaborative efforts to improve waiver program systems, and to help move Ohio toward a more unified quality management system. The Office of Medical Assistance uses this forum to monitor and oversee the Contractor.

(8) Notice of Quality Assurance and Monitoring Oversight Reviews (NQAMOR) and Plans of Correction (POC) – Pursuant to Ohio Administrative Code rule 5101:3-45-09, the Office of Medical Assistance will identify operational deficiencies and give the Contractor a NQAMOR. The NQAMOR will require the Contractor to develop a POC for any instance of noncompliance. A POC is a document that is part of the process to improve identified operational quality deficiencies. In addition to the requirement of a POC by the Contractor, actual and liquidated damages may be assessed.

(9) Annual Contractor Review – The Office of Medical Assistance will conduct an annual review of the Contractor in order to assure compliance with all contract terms. The annual review includes desk reviews and an on-site visit.

The Office of Medical Assistance will issue an annual review report and the Contractor will be required to develop and submit a plan of correction related to all identified deficiencies. The Office of Medical Assistance will continue to monitor the Contractor's compliance with that plan of correction.

(I) Actual and Liquidated Damages

Pursuant to the monitoring set forth in (H) above, the Office of Medical Assistance may assess actual and liquidated damages for Contractor defaults. Liquidated damages shall be assessed as follows for each of the Contractor defaults irrespective of whether or not the defaults arise out of a single event:

Category One Liquidated Damages: $250.00 per failure

a) A failure to timely provide an individual with their All Services Plan and a copy of the individual handbook.
b) A failure to obtain the Office of Medical Assistance pre-approval of marketing materials and/or external forms or documents used in performance of the Contract.
c) A failure to timely submit a report, invoice, or plan of correction.
d) A failure to submit an annual audit to the Office of Medical Assistance.
e) A failure to use person-centered language.
f) A failure to maintain normal working hours as required.
g) A failure to comply with HIPAA requirements regarding Protected Health Information or other laws governing the confidentiality of Medicaid records resulting in minimal harm.
h) A first-time failure, or subsequent but nonconsecutive failure, to meet a Quality Management Plan Standard.

Category Two Liquidated Damages: $500.00 per failure

a) A failure to notify an individual of their right to a state hearing when the Contractor proposes to deny, reduce, suspend, or terminate a Medicaid–covered service.
b) A failure to comply with a state hearing and/or administrative appeal decision.
c) A failure to comply with the resolution of a complaint or adverse outcome.
d) A failure to coordinate an individual's care across all providers and interdisciplinary team members.
e) A failure to monitor an individual's care.
f) A failure to implement a plan of correction.
g) A failure to adequately assess an individual's needs.
h) A failure to authorize a provider on an all services plan in compliance with the rules.
i) A failure to submit a prior authorization to the Office of Medical Assistance within the prescribed time frames, and resulting in delivery of unauthorized waiver program services.
j) A failure to assist an individual in accessing needed services by providing linkage and referral.
k) A failure to assist an individual in accessing needed services by updating the All Services Plan within the required timeframes as outlined in the Case Management Guide.
l) A failure to conduct required orientation trainings with staff and/or a failure to conduct required annual staff trainings.
m) A failure to adapt or accommodate communication methods to meet the needs of individuals.
n) A failure to follow the emergency disaster plan.
o) A failure to accommodate an individual's preferences regarding contacts or visits.
p) A failure to comply with HIPAA requirements or other laws governing the confidentiality of Medicaid records regarding Protected Health Information resulting in material harm.
q) A second consecutive failure to meet a Quality Management Plan Standard.

Category Three Liquidated Damages: $1,000.00 per failure

a) A failure to maintain the required staff.
b) A failure to remove a provider from an all services plan and/or notify the individual when the Contractor is notified by the Office of Medical Assistance that the provider no longer has a provider agreement.
c) A failure to report an incident in compliance with the rules.
d) A failure to implement the individual prevention plan that resulted from an incident.
e) A failure to develop an All Services Plan that appropriately meets the assessed needs of an individual.
f) A failure to appropriately assess the acuity level of an individual.
g) A failure to follow the contact/visit schedule based on the acuity level of individual.
h) A failure to cooperate with incident investigations.
i) A provision of false, inaccurate, or materially misleading information to a health care provider, an individual, or a waiver program applicant.
j) A misrepresentation or submission of false information to the Office of Medical Assistance.
k) A failure to comply with HIPAA requirements or other laws governing the confidentiality of Medicaid records regarding Protected Health Information resulting in substantial harm.
l) A failure to meet a Quality Management Plan Standard three or more consecutive times.

Category Four Liquidated Damages:

a. Any failure or default not captured in Category One, Two or Three that placed an individual at risk of harm. $1,000.00
b. Any Category One, Two or Three default that result in material harm, or any other failure to assure the health and welfare of an individual that results in material harm. $50,000.00
c. Any Category One, Two or Three default that result in irreparable harm, or any other failure to assure the health and welfare of an individual that results in irreparable harm. $100,000.00

(J) EXEMPLARY PERFORMANCE AWARD

The Office of Medical Assistance is establishing an incentive system for the Contractor to achieve exemplary performance in two specific areas. If the Contractor achieves exemplary performance in both areas, the Contractor could receive an additional $20,000 in each state fiscal year of the Contract. However, to qualify for the exemplary performance payment, the Contractor must first meet or exceed all of the Quality Management Plan Standards.

1) Avoidable Emergency Department Usage: Ohio is striving to excel and be a trend-setter in reducing unnecessary emergency department usage. To achieve this goal in partnership with the Contractor, the State will reward the Contractor for exemplary performance demonstrated in this area according to the following formula:

Numerator*:* Total number of emergency department visits by waiver program individuals per quarter, per Contractor. A visit is defined as a unique recipient and date of service. Emergency department visits will be identified using the following method: CPT codes 99281-99285 with revenue center code of 450, 451, 452, 459, and 981 with Claim Type of “O” or “W” with Bill Type of “131” or “135”.

Denominator*:* An unduplicated count of the number of waiver program individuals served by the Contractor in the quarter.

Quarterly Exemplary Performance Award: $2,500 each quarter that the overall rate of emergency department usage is reduced by at least 5%.
Data Source: DSS (taking into account claims lag)

Who Will Calculate: Office of Medical Assistance Staff

2) **Encouraging Case Manager Retention:** Ohio is striving to excel and be a trend-setter in promoting case manager retention in the area of long term care services and support. To achieve this goal in partnership with the Contractor, the State will reward the Contractor for exemplary performance demonstrated in this area according to the following formula

Numerator: The case managers included in the denominator that are still employed with the Contractor at the end of the state fiscal year.

Denominator: Total number of case managers employed with the Contractor at the beginning of the State fiscal year.

For example, if the Contractor had 100 case managers at the beginning of the state fiscal year and 85 of those individuals remained at the end of the state fiscal year, the case manager retention rate would be 85%.

Exclusions: Case managers who were terminated by the Contractor, retired, or died should be excluded from both the numerator and the denominator.

Annual Exemplary Performance Award: $10,000 if at least 85% retention

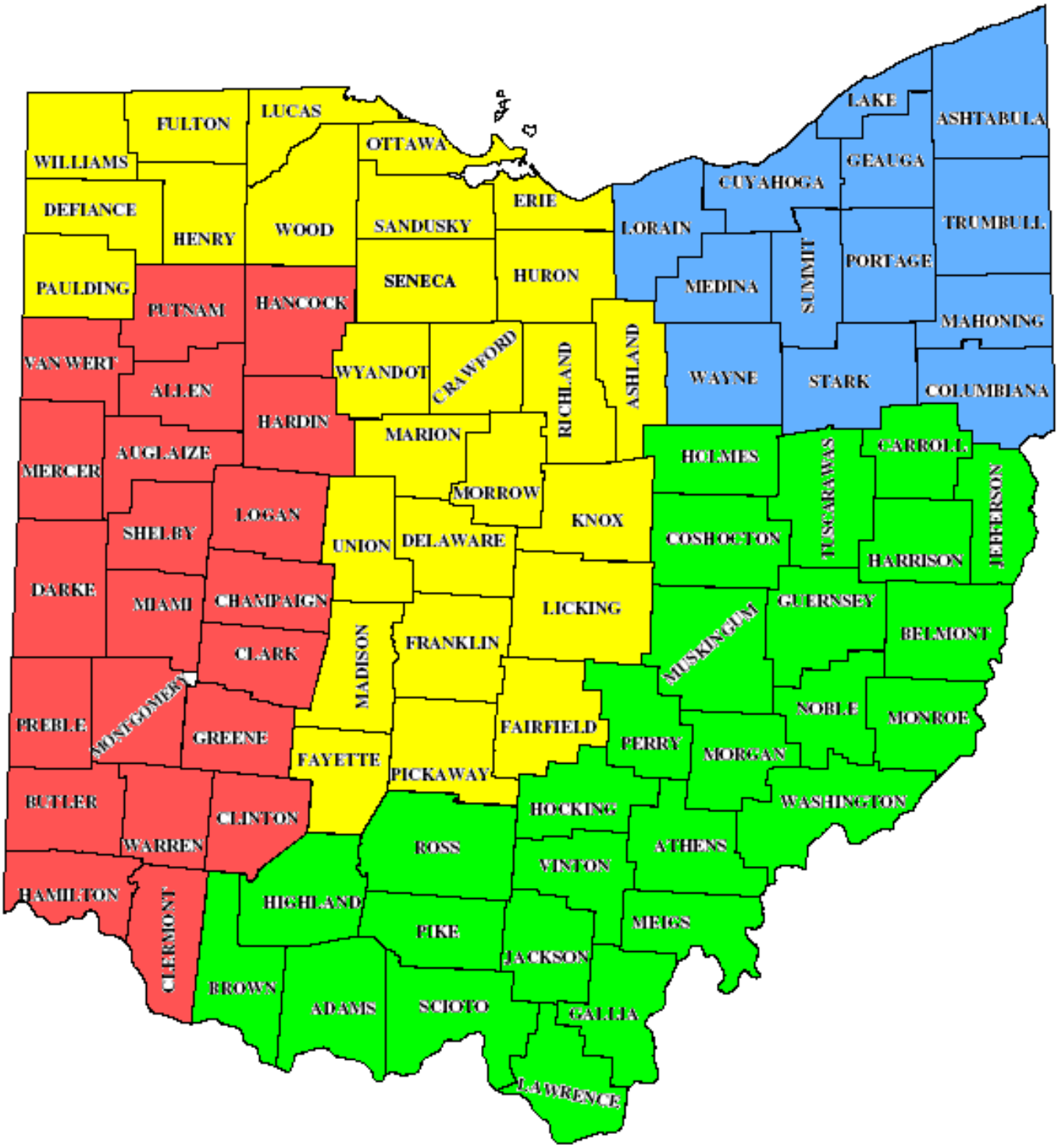
Data Source: Contractor

Who Will Calculate: Contractor, verified by Office of Medical Assistance

Contract Termination or Nonrenewal

Upon termination or nonrenewal of the Contractor contract, the exemplary performance awards will be retained by the Office of Medical Assistance.

ATTACHMENT TWELVE
MAP OF OHIO- FOUR REGIONAL AREAS



Coral – Cincinnati
Yellow – Columbus
Blue – Cleveland
Green – Marietta

ATTACHMENT THIRTEEN
OFFICE OF MEDICAL ASSISTANCE
OHIO HOME CHOICE DEMONSTRATION PROGRAM
PROVIDER ENROLLMENT APPLICATION/TIME LIMITED AGREEMENT
PRE-TRANSITION CASE MANAGEMENT AGENCY

Submit completed signed application/agreement to:

HOME Choice Operations Unit
P.O. Box 182709, 5th Floor
Columbus, Ohio 43218

(For State Use Only)

Provider Identification *(Please print or type entries)*

Agency Name					
Social Security or EIN Number *	Current or previous Medicaid Number(s) (if applicable)				

*You must attach a completed and signed W-9 form. Do not use GROUP tax ID number.

Service Location of Practice/Business
(Please complete an application for each physical location of practice or business. Non-agency providers can use home address if applicable)

Name/ Building Name/ or Department/ or In care of			
Physical Address *(Number, Street, Avenue or Route) (P.O. and Drop Boxes are not acceptable)*			Suite Number
City	County	State	Zip Code *(Zip +4, if possible)*
Telephone Number	Cell Phone Number	Email Address	

"Pay to" Address (Name & Address to which payment is to be mailed)
Leave blank if address is the same as "Service Location of Practice/Business"

Name		
Address		Suite Number
City	State	Zip Code *(Zip +4, if possible)*

Mailing/Correspondence Address (Name & Address to which all other material is to be mailed)
Leave blank if address is the same as "Service Location of Practice/Business"

Name			
Address		Suite Number	
City	County	State	Zip Code *(Zip +4, if possible)*

Disclosure and Ownership/Control Interest Statement

Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations in spaces provided.

1. List names, addresses, AND SSNs for individuals serving in a leadership role (paid or volunteer).

Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN

2. Are any individuals serving in a leadership role (paid or volunteer) also the owner of other Medicare/Medicaid Agency?
If yes, list names, addresses of individuals, and provider numbers. If under Title XIX, list vendor number. ☐ YES ☐ NO

Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number

3. Have you or any individuals or organizations having a direct or indirect ownership or control interest of five (5) percent or more in the institution, organization, agency, or professional association been indicted or convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX, or XX? ☐ YES ☐ NO

Name (who was it?)	Type of Offense and Disposition	When?	SSN/EIN
Name (who was it?)	Type of Offense and Disposition	When?	SSN/EIN

4. **Have you or the Agency ever been sanctioned by the Medicare or Medicaid Program?** ☐ YES ☐ NO

If "YES", when? *(mm/dd/yyyy)* How long? *(mm/dd/yyyy)* **IF YES, ATTACH EXPLANATION**

Who was it? Give name(s)	When? Give date *(mm/dd/yyyy)*	SSN/EIN
Who was it? Give name(s)	When? Give date *(mm/dd/yyyy)*	SSN/EIN

5. Have you or any Directors, Officers, Agents, or Managing Employees of This Agency ever been indicted or convicted of a violation of State or Federal Law? ☐ YES ☐ NO

Name	Type of Offense and Disposition	When, give date? *(mm/dd/yyyy)*	SSN/EIN
Name	Type of Offense and Disposition	When, give date? *(mm/dd/yyyy)*	SSN/EIN

This provider agreement is a contract between the Office of Medical Assistance (OMA) and the undersigned Pre-Transition Case Management Agency to provide pre-transition case management ("PTCM") services under the HOME Choice Demonstration Program. Under this provider agreement, the HOME Choice PTCM Agency will be responsible for assessing whether a HOME Choice applicant is eligible to participate in the HOME Choice program, and for providing pre-transition services and oversight to ensure a successful transition to the community.

HOME Choice PTCM services are available to all HOME Choice applicants. The PTCM agency may or may not be the same agency providing HOME Choice case management post-discharge once a successful transition to the community has occurred.

Upon receiving a referral from OMA's HOME Choice Operations Unit, the PTCM Agency shall:

1. Contact the facility and/or the applicant to schedule a face-to-face visit. This contact shall take place within 3 – 5 business days of receipt of the HOME Choice referral.
2. Determine if the applicant has a guardian. If the applicant has a guardian, the Pre-Transition Case Manager shall also contact the guardian prior to scheduling the face-to face-meeting.
3. Schedule and facilitate the face-to-face meeting with the applicant and/or guardian within 10 business days of receipt of the HOME Choice referral.

During the face-to-face meeting, the Pre-Transition Case Manager shall:

1. Complete the HOME Choice Readiness Assessment Tool.
2. Based on the assessment, dialogue, observations and any other information shared, provide comments on the Eligibility Checklist that reflect the Pre-Transition Case Manager's assessment of whether the applicant may be eligible to participate in a waiver program, not as a determination but as an observation. (For example: "Your health and safety cannot be assured by the program"; "Your needs can be met by community resources".)
3. Provide waiver information to the individual/guardian and have the individual/guardian sign the Request for Medicaid Home and Community Based Services (HCBS) – JFS form 02399 if applicable. The completed form shall be submitted by the PTCM Agency to the local JFS office for processing.
4. Review the HOME Choice Informed Consent form with the applicant/guardian and obtain the applicant/guardian's signature.
5. Complete the HOME Choice Eligibility Checklist:
    a. Based on the readiness assessment tool, dialogue, observations and other information shared, provide comments on this form that reflect your professional opinion of whether the participant should proceed with the HOME Choice process/program, not as a determination but as an observation.
    b. Identify whether you recommend approval for HOME Choice or not by selecting the appropriate check box. (Please note that OMA's HOME Choice Operations Unit will make the final determination).
6. Review the list of Transition Coordinators with the applicant/guardian, taking into account the applicant's disabilities and needs, and enter the applicant's "preferred" choice of a Transition Coordinator onto the HOME Choice Demonstration and Supplemental Service Plan with the Transition Coordinator agency and Community Transition Services entered.
7. Provide information regarding HOME Choice Demonstration and Supplemental Services to the applicant, guardian, family, facility, and other appropriate individuals.

8. Submit the HOME Choice Eligibility Checklist, Informed Consent form, Readiness Assessment Tool and HOME Choice Demonstration & Supplemental Service Plan to the HOME Choice Operations Unit; provide copies to the applicant and/or guardian, and maintain a copy in the applicant's file.

During the Pre-Transition period, the Pre-Transition Case Manager shall:

1. Obtain regular status updates from the Transition Coordinator during the pre-transition process.
2. Participate in discharge planning meetings with the participant, guardian (if applicable), Transition Coordinator and nursing facility staff.
3. Assist with linkages to service providers and community resources.
4. Fill out and submit a HOME Choice Change in Status Form to notify the HOME Choice Operations Unit of a change in a participant's status that would affect their ability and/or willingness to participate in the program.
5. Work with the Transition Coordinator, based on information obtained during the initial face-to-face meeting, to ensure that the appropriate MH and/or Substance Abuse community referrals are made prior to discharge.
6. With the discharge planning team, assess what HOME Choice services should be added to the participant's HOME Choice Demonstration & Supplemental Service Plan at time of discharge, contact service providers, coordinate service provision and submit updated HOME Choice Demonstration & Supplemental Service Plans to the HOME Choice Operations Unit as necessary.
7. Assist participants with developing post-discharge back-up plans in the event of a failure of an authorized service to be provided.
8. Coordinate the date of discharge to coincide with the start of HCBS services (Medicaid waiver and/or state plan) and HOME Choice services.
9. Ensure that HOME Choice services are in place if waiver or state plan services cannot start at time of discharge.

At the time of participant discharge, the Pre-Transition Case Manager will:

1. Transfer all pertinent information about the participant to the HOME Choice Case Manager.
2. Communicate and coordinate with the Transition Coordinator, the participant and the HOME Choice Case Manager to ensure services and supports are in place and housing is "move-in" ready.
3. Complete the HOME Choice Enrollment Form and submit to the HOME Choice Operations Unit.

The PTCM Agency will be paid for authorized services provided pursuant to this Provider Agreement through a designee of OMA. Full and complete payment for services provided under this Provider Agreement shall be made as follows:

1. $1,000 for each HOME Choice referral from OMA's HOME Choice Operations Unit that results in the face-to-face meeting occurring (as described above). If the applicant is not approved for the HOME Choice Program by the HOME Choice Operations Unit, there will not be a second payment made to the PTCM agency.
2. $1,000 upon the OMA's HOME Choice Operations Unit's receipt of either the completed enrollment form after the participant has successfully relocated to the community or a Change in Status form regarding the need for pre-enrollment termination.

The PTCM Agency agrees to comply with the terms of this provider agreement, along with federal and state laws, federal and state program requirements, and other requirements as required by OMA. The PTCM Agency also specifically agrees to:

1. Follow all OMA-approved policies and procedures established for the HOME Choice Demonstration Program.
2. Accept the allowable payment for Pre-Transition Case Management services as payment-in-full and not seek payment for the services from the resident, authorized representative, any member of the family, or any other person or entity.
3. Maintain all applicant/participant records necessary and in such form so as to fully disclose the extent of services provided. The PTCM agency shall maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer. At a minimum, each applicant/participant's record must contain:
    a. A cover sheet that includes: name, address, and telephone number of the facility where the applicant resided, emergency contacts, guardianship information (if applicable), and name, address and phone number of the pre-transition case manager.
    b. Case notes that include documentation of applicant/participant contacts and activities of the HOME Choice Pre-Transition Case Management agency on applicant's/participant's behalf. Nothing shall prohibit the use of technology-based systems in collecting and maintaining case note documentation. All case notes must be signed and dated.
    c. Releases of information on HIPAA-compliant forms signed by the applicant/guardian.
    d. Copies of HOME Choice participant's service plans, forms, and any other documents related to the pre-transition process.
4. Furnish to OMA, the secretary of the Department of Health and Human Services, or the Health Care Fraud Section of the Ohio Attorney General, or their designees, any information maintained under paragraph 3 above for audit or any other purpose within 30 days of the request for such information. Audits may use statistical sampling. Failure to comply shall result in withholding of HOME Choice Demonstration Program payments and may result in termination from the HOME Choice Demonstration Program.
5. Inform the HOME Choice Provider Administrator within thirty days of any changes to information provided in the application and/or provider agreement (*e.g.*, change in ownership; change in Medicaid number; change in address; new phone number; etc.).
6. Disclose ownership and control information, and disclose the identity of any person (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5101:3-51-03 of the Administrative Code) who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX Services.
7. Comply with the criminal record check requirements set forth in Rule 5101:3-51-03 of the Administrative Code.
8. Ensure that staff providing direct participant contact:
    a. Have knowledge about and experience with local community resources and applicable disability laws and regulations.
    b. Embrace participant self-determination and possess experience advocating on behalf of individuals with disabilities.
    c. Are eighteen years of age or older.
9. Comply with the policies and procedures governing HOME Choice and the conditions of participation as set forth in Chapter 5101:3-51 of the Ohio Administrative Code.

10. Ensure that neither the provider, nor the organization, nor any owner, director, officer, employer of the organization, or any provider retained by the organization or any of the aforementioned persons, currently is subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title XX beneficiaries.

The HOME Choice Demonstration Program is not a Medicaid program. This agreement does not permit the Provider to furnish medical assistance services through the Ohio Medicaid Program.

This agreement supersedes any and all previous provider agreements for this service, whether written or oral, between the parties.

This agreement is intended to remain in effect for the duration of the HOME Choice Demonstration Program; however, the agreement may be terminated by either party upon written notice to the other party no less than 30 days prior to the termination date. The PTCM Agency, upon receipt of written notice of termination, shall cease provision of services under this Provider Agreement unless otherwise directed by the Office of Medical Assistance.

Applicant, including any officer, member, employee or agent of Applicant, understands and agrees to take no action, or cause OMA to take any action, which is inconsistent with the applicable Ohio ethics and conflict of interest laws, including those provisions found in Chapter 102 and Chapter 2921 of the Ohio Revised Code.

The undersigned certifies that he/she is the officer, chief executive officer, or general partner of the organization that is applying to provide pre-transition case management services as part of the HOME Choice Demonstration Program. The undersigned agrees to be bound by this provider agreement, and confirms that the information he/she has provided is true and accurate.

Name and Title *(Please Print)*	
Signature	Date