

REQUEST FOR PROPOSALS

RFP NUMBER: CSP900614
INDEX NUMBER: JFS001
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 Services Provider Oversight

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 twelve (12) attachments, totaling 113 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 twelve (12) 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 Services Provider Oversight and for onsite visits for moderate or high-risk Medicaid non-waiver, non-Medicare-participating provider types who are applying for a Medicaid provider agreement or are applying to be re-enrolled (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 6/30/2015. 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 exceed 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 a statewide Provider Oversight Contractor. This Contractor must be experienced in provider oversight and/or case management with home and community-based long-term services programs. Since most people prefer to stay in their own homes and live independently for as long as they can, there is a need for programs that cover services and supports in that setting. To meet that need, federal and state government agencies have collaborated to develop several programs that will arrange for extended services and supports to be provided in home and community-based settings. Home and community-based services programs provide opportunities for individuals on Medicaid to receive services in their own home or community.

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 Office of Medical Assistance, Bureau of Long-Term Care Services & Supports, which will administer this contract, is responsible for state-level supervision and oversight of Office of Medical Assistance-administered Home and Community Based Service waiver programs, and transition to the community projects. This statewide Provider Oversight Contractor will oversee providers and manage incidents for the Ohio Home Care and Transitions II Aging Carve-Out waiver programs administered by the Office of Medical Assistance, the Integrated Care Delivery System (ICDS) or Duals Project, and the HOME Choice (**H**elping **O**hioans **M**ove, **E**xpanding **C**hoice) Demonstration Program.

In addition, the Provider Oversight Contractor will screen Medicaid non-waiver non-Medicare moderate and high risk providers as described in 2.2.5 as part of the application and re-enrollment/revalidation process.

The work of the Provider Oversight Contractor is to assist with provider compliance and effectiveness within the community-based long-term services programs listed in sub-sections 2.2.1 through 2.2.3. This work will include operating a system for reporting, investigating, and tracking incidents involving individuals in these programs, including abuse, neglect, and exploitation. 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.

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. This provider oversight RFP will be for one statewide Contractor, while the case management RFP will be awarded to two Contractors per each region of the State. The same Offeror may submit case management contract proposals for as many regions as they wish and also submit a proposal for the Provider Oversight Contract; however, the Offeror that is selected for the Provider Oversight Contract and that actually becomes the Contractor for the Provider Oversight Contract may not enter into a Case Management Contract for any region.

In keeping with the comprehensive Medicaid reforms initiated by Governor John Kasich and authorized by the Ohio General Assembly in H.B. 153, the Office of Medical Assistance is pursuing 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. One future initiative is the Single Home and Community Based Service waiver program as described in 2.2.4.

2.2.1 CURRENT HOME- AND COMMUNITY-BASED WAIVER PROGRAMS. The Office of Medical Assistance currently administers two Home and Community Based Service waiver programs directly. These are the Ohio Home Care Waiver program and the Transitions II Aging Carve-Out Waiver program. 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 and 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. The Transitions II Aging Carve-Out Waiver program provides similar services to persons who "age out" of the Ohio Home Care Waiver program when they turn 60. As of September 30, 2012, there were approximately 10,800 individuals on the Ohio Home Care waiver program and Transitions II Aging Carve-Out waiver program. After the ICDS Duals Project is fully implemented (see 2.2.3), approximately, 6,800 individuals will remain on these waiver programs in the following regions: 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. An additional 200 to 300 persons are likely to enroll on these waiver programs in each subsequent state fiscal year (SFY) of the Contract. Individuals enrolled in the Ohio Home Care Waiver program and the Transitions II Aging Carve-Out Waiver program receives waiver services from providers detailed in 2.2.6.

2.2.2 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. The program operated under this grant is known as the HOME Choice (**H**elping **O**hioans **M**ove, **E**xpanding **C**hoice) Demonstration Program. This program uses "transition coordinators" to facilitate an individuals' transition out of long-term care facilities or hospitals by helping them connect with community services and locate housing and purchase materials and supplies for community living. HOME Choice case managers provide traditional case management services and work closely with the Transition Coordinator.

Once a HOME Choice individual has moved into the community, the case manager and the individual work together closely to determine what HOME Choice and other community services will meet the individual's assessed needs.

2.2.3 INTEGRATED CARE DELIVERY SYSTEM (ICDS) or DUALS PROJECT. 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. Ohio House Bill (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. Currently, approximately 182,000 Ohioans are covered by both Medicare (because they are over age 65 or disabled) and Medicaid (because they have low income). Of the 182,000 individuals, approximately 37,000 individuals will be eligible for the ICDS project.

2.2.4 SINGLE HOME AND COMMUNITY BASED SERVICE WAIVER PROGRAM. Ohio 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, Transitions II, 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.

2.2.5 MODERATE OR HIGH RISK MEDICAID NON-WAIVER, NON-MEDICARE-PARTICIPATING PROVIDER TYPES. The Contractor shall conduct unannounced onsite visits of Medicaid non-waiver, non-Medicare-participating provider types identified as moderate or high risk in the appendix to Ohio Administrative Code rule 5101:3-1-17.8 at the time of application and re-enrollment/revalidation. Examples of these provider types, include, but are not limited to, Medicaid non-waiver non-Medicare home health agencies, Medicaid non-waiver non-Medicare durable medical equipment providers, and Medicaid non-waiver non-Medicare ambulance service providers. The Office of Medical Assistance estimates that the Contractor will have to do approximately 30-50 onsite visits per month.

2.2.6 PROVIDER TYPES FOR OHIO HOME CARE WAIVER AND TRANSITIONS II AGING CARVE-OUT WAIVER PROGRAM. Currently, more than 26,000 personal care aides, 7,100 registered nurses (RN) and 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 currently 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. For definitions of the covered services and provider requirements and specifications for the Ohio Home Care Waiver program and Transitions II Aging Carve-Out Waiver program, see Ohio Administrative Code Rules 5101:3-46-04 and 5101:3-50-04. For definitions of the covered services and provider requirements and specifications for the Ohio Department of Aging waiver programs, see Ohio Administrative Code Chapter 173-39. For definitions of the covered services and provider requirements and specifications for the HOME Choice program, see Ohio Administrative Code 5101:3-51-03 and 5101:3-51-04.

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, protocols, and laws related to the Ohio Home Care Waiver program, the Transitions II Aging Carve-Out Waiver program, the HOME Choice Demonstration Program, the Integrated Care Delivery System (ICDS), the requirements set forth in the Affordable Care Act for provider screening of the moderate or high risk Medicaid non-waiver, non-Medicare provider types, and any future initiatives related to the oversight of home and community based services providers and the management of incidents, including abuse, neglect, and exploitation. It will be the 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.

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: CSP900614 JFS001

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 "CSP900614 RFP – Technical Proposal" on the outside of each Technical Proposal package's envelope. Each Cost Proposal package must be clearly marked "CSP900614 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.

4.2 MANDATORY PROPOSAL REQUIREMENT. 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 Tab 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 Tab 1, alone, to determine whether the Proposal meets the minimum mandatory proposal requirement. If the information contained in Tab 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	510 Points
Proposal Cost	490 Points
Total	1000 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	Evidence the Offeror has incident management experience, that Offeror has capacity and vision for this specific task.	4						
4	Three (3) examples where Offeror implemented system changes that was directly responsible for improved provider quality.	4						
5	Evidence that Offeror has at least two (2) years experience with federally or state-funded programs in the past five years.	5						
6	Results of completed provider satisfaction surveys regarding Offeror's provider oversight services within the last two years.	3						
7	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						
8	Evidence that Offeror has demonstrated that all provider oversight staff have a bachelor's degree in any field and a minimum of two years paid experience working with critical care providers, public health providers, or providers that care for children, older adults, persons with traumatic brain injury, or persons with developmental disabilities. One year of the experience must have included provider monitoring, Medicaid or third party payer provider billing, or provider training. One year of the experience must have been in a home health program, community health program, hospital, private practice, publicly-funded institution, long-term care program, mental health program, community-based social service program, or any other program addressing the needs of special populations.	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
9	The Offeror's personnel profile summaries demonstrate that all provider oversight supervisors meets the same requirements of provider oversight staff (listed in 7 above) and have one additional year of paid experience working with critical care providers, public health providers, or providers that care for children, older adults, persons with traumatic brain injury, or persons with developmental disabilities.	4						
10	Evidence that Offeror has demonstrated that all Incident Management staff are either a licensed registered nurse (RN), as defined by the Ohio Board of Nursing with one year paid experience in home and community based services (HCBS); or a licensed social worker (LSW, LISW) as defined by the Ohio's Counselor, Social Worker, & Marriage & Family Therapist Board with one year paid experience in HCBS; or a licensed counselor (LPC, LPCC) in the State of Ohio with one year paid experience in HCBS. The one year of HCBS experience shall include experience with any of the following: incident investigation, assuring individual health and welfare, quality assurance, clinical risk management, the mental health system, or interfacing with law enforcement, nursing homes, children services, adult protective services, or the Department of Developmental Disabilities.	5						
11	The Offeror's personnel profile summaries demonstrate that all Incident Management Supervisors meet the same requirements of Incident Management staff (listed in 9 above) and have five additional years' paid experience in HCBS that shall include any of the following: incident investigation, assuring individual health and welfare, quality assurance, clinical risk management, the mental health system, or interfacing with law enforcement, nursing homes, children services, adult protective services, or the Department of Developmental Disabilities.	5						
12	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						
13	The Offeror's personnel profile summaries demonstrate that one (1) program management staff member has a master's degree in a business or health-related field with at least eight years of management experience.	3						
14	The Offeror's personnel profile summaries demonstrate that one (1) staff member has at least five years management experience in home and community-based services or health-related field.	4						
15	The Offeror's personnel profile summaries demonstrate that one (1) staff member has at least two years experience with quality improvement systems.	4						
16	The Offeror's personnel profile summaries demonstrate that one (1) staff member has at least two years experience in accounting or financial analysis.	3						
17	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						
18	The description of the Offeror's organizational culture, including its mission and vision statements.	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
19	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						
20	The description of the Offeror's customer service philosophy.	4						
21	The description of how the Offeror will monitor operations to assure quality.	5						
22	The description of how the Offeror will educate providers.	3						
23	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, observation.	3						
24	The description of how the Offeror will meet the record keeping policies and procedures for the Work.	4						
25	The description of how the Offeror will interface with the Case Management Contractor(s).	5						
26	The description of how the Offeror will adapt to changes in federal and state Medicaid laws, rules, and policies.	3						
27	Evidence of experience in provider disciplinary or termination proceedings.	3						

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 450 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.

4.6 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: _____

4.7 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.

4.8 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.

4.9 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 provider records, program overview and updates, training and tools, user guidance for 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, 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.

Provider Oversight is vital to program management and ensuring provider compliance and effectiveness. Provider Oversight means ensuring that providers are providing high quality care to community-based long-term care program individuals; that providers are receiving appropriate payment for providing that care; that providers are meeting eligibility requirements; and that providers are following program rules and requirements. These oversight activities include, but are not limited to:

1. Completing provider eligibility checks as part of the enrollment process.
2. Completing re-enrollment/revalidation for waiver providers.
3. Conducting site visits with moderate or high risk Medicaid non-waiver, non-Medicare providers.
4. Performing incident management and investigation.
5. Operating an alerts process.
6. Managing provider non-compliance.
7. Monitoring providers, including structural reviews of providers.
8. Making Medicaid fraud referrals.
9. Referring provider overpayments.
10. Offering education and technical assistance for providers.
11. Maintaining an up-to-date provider directory.
12. Participating in Ohio Revised Code Chapter 119 hearings process.

The Scope of Work includes provider oversight functions and contract management requirements, as well as interfacing with the HCBS Waiver Program Case Management Contractor(s). 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 PROVIDER OVERSIGHT FUNCTIONS.

6.1.1 COMPLETING PROVIDER ELIGIBILITY CHECKS AS PART OF THE ENROLLMENT PROCESS FOR OHIO HOME CARE AND TRANSITIONS II AGING CARVE-OUT WAIVER PROGRAM SERVICE PROVIDERS. All Ohio Home Care Waiver program service providers must meet the eligibility requirements as set forth in Ohio Administrative Code rule 5101:3-46-04. All Transitions II Aging Carve-Out Waiver program service providers must meet eligibility requirements as set forth in Ohio Administrative Code rule 5101:3-50-04. Any person or entity who wants to provide waiver program services for these two waiver programs must complete the service provider application process as set forth in Ohio Administrative Code rule 5101:3-45-04 and receive enrollment approval from the Office of Medical Assistance.

The Contractor shall be the Office of Medical Assistance designee to implement Ohio Administrative Code rule 5101:3-45-04(C), (D) and (E), including acting as the front door of waiver program service provider enrollment by being the first reviewing entity within the provider eligibility verification process using the Office of Medical Assistance Medicaid Information Technology System (MITS), and shall recommend approval or denial of the application. The application process is paperless and initiated in a web portal. Once information is submitted by the applicant online, the "application" enters the MITS interchange where both the Contractor and the Office of Medical Assistance will have access to complete their part of the enrollment process.

The Contractor shall review all Ohio Home Care and Transitions II Aging Carve-Out waiver program provider applications and recommend approval or denial to the Office of Medical Assistance no later than ten (10) business days from receipt of a complete application. If the application is not complete (i.e., there are missing documents or verifications), the Contractor shall provide the applicant with written notification identifying the specific information or documentation that is still required. If the missing information or documentation is received within 30 calendar days of the notice, the Contractor shall have no later than ten (10) business days to complete a review and recommend approval or denial to the Office of Medical Assistance. If the missing information or documentation is not received within 30 calendar days of the notice, the Contractor shall recommend denial to the Office of Medical Assistance.

The Contractor shall provide technical assistance as needed to assist the provider applicant through the enrollment process. For more information regarding the provider eligibility check for the provider enrollment process, refer to Attachment Ten – Provider Oversight Guide.

6.1.2 COMPLETING THE RE-ENROLLMENT/REVALIDATION PROCESS FOR OHIO HOME CARE AND TRANSITIONS II AGING CARVE-OUT WAIVER PROGRAM SERVICE PROVIDERS. (The terms re-enrollment and revalidation are interchangeable for purposes of this Contract.) The re-enrollment/revalidation process is set forth in Ohio Administrative Code rule 5101:3-1-17.4. All Ohio Home Care and Transitions II Aging Carve-Out waiver program providers will have a five (5) year limited provider agreement. Providers must apply for re-enrollment/revalidation upon receipt of notice from the Office of Medical Assistance in order to continue their status as an active Medicaid provider. For all re-enrollment/revalidation applications forwarded to the Contractor by MITS, the Contractor shall review the re-enrollment/revalidation application as directed by the Office of Medical Assistance and make a recommendation to the Office of Medical Assistance for re-enrollment/revalidation or denial.

The Contractor shall review all Ohio Home Care and Transitions II Aging Carve-Out waiver program provider re-enrollment/revalidation applications and recommend approval or denial to the Office of Medical Assistance no later than ten (10) business days from receipt of a complete re-enrollment/revalidation application. If the application is not complete (i.e., there are missing documents or verifications), the Contractor shall provide the applicant with a written notification identifying the specific information or documentation that is still required. If the missing information or documentation is received within 30 calendar days of the notice, the Contractor shall have no later than ten (10) business days to complete a review and recommend approval or denial to the Office of Medical Assistance. If the missing information or documentation is not received within 30 calendar days of the notice, the Contractor shall recommend denial to the Office of Medical Assistance. The Contractor shall provide technical assistance as needed to assist the provider applicant through the enrollment process.

6.1.3 CONDUCTING SITE VISITS WITH MODERATE OR HIGH RISK MEDICAID NON-WAIVER, NON-MEDICARE-PARTICIPATING PROVIDER TYPES WHO ARE APPLYING FOR A MEDICAID PROVIDER AGREEMENT OR ARE APPLYING TO BE REVALIDATED/RE-ENROLLED. The Contractor shall conduct unannounced onsite visits of Medicaid non-waiver, non-Medicare-participating provider types identified as moderate or high risk in the appendix to Ohio Administrative Code rule 5101:3-1-17.8 at the time of application and re-enrollment/revalidation. Examples of these provider types, include, but are not limited to, Medicaid non-waiver, non-Medicare home health agencies and Medicaid non-waiver, non-Medicare durable medical equipment providers.

These visits will be completed at the site the applicant/provider identifies as their service location on their application/provider agreement.

The Contractor shall verify the information identified on an Office of Medical Assistance-approved checklist, including whether: the name of the provider's business is apparent, the business is operational, another business operates from the same location, operating policies and procedures are available for review, hours of operation are posted, if applicable, and the information submitted on the application about the nature of the business is accurate. Additionally, photographs may be required to support a determination to deny the application or the re-enrollment/revalidation. The Office of Medical Assistance will notify the Contractor of the required onsite visits. At the conclusion of the onsite visit, the Contractor will submit its results to the Office of Medical Assistance. The Office of Medical Assistance estimates that the Contractor will have to do approximately 40-60 onsite visits per month.

6.1.4 PERFORMING INCIDENT MANAGEMENT AND INVESTIGATION FOR WAIVER PROGRAMS. The Contractor will act as the Office of Medical Assistance's designee in operating an incident management and investigation system as outlined in Ohio Administrative Code rule 5101:3-45-05 and the Provider Oversight Guide for the Ohio Home Care waiver program and the Transitions II Aging Carve-Out waiver program. The rule defines incidents; the reporting, notification and response requirements; investigation requirements; the process for substantiating incidents; preparing written summaries of the investigative findings; determining when to close incidents; and recommending (but not imposing) provider sanctions to the Office of Medical Assistance.

The Case Management Contractor(s) will be responsible for developing and implementing prevention plans for individuals on the Ohio Home Care waiver program and the Transitions II Aging Carve-Out waiver program. The Provider Oversight Contractor shall be responsible for reviewing the prevention plans to assure that the plans address all causes and contributing factors to minimize the risk of reoccurrence of the incident and shall report inadequate prevention plans to the Office of Medical Assistance.

The Contractor shall review and analyze all incidents to identify patterns and/or trends, and shall report the findings to the Office of Medical Assistance monthly. Currently, approximately 800 incidents, including critical incidents and other incidents, are reported each month. For more information regarding incident management and investigation, refer to Attachment Ten – Provider Oversight Guide.

6.1.5 PERFORMING INCIDENT MANAGEMENT AND INVESTIGATION FOR INTEGRATED CARE DELIVERY SYSTEM (ICDS) WAIVER PROGRAM. The Contractor shall provide a secure data repository and tracking system where all ICDS plans will report their data on incidents for ICDS waiver program individuals. The Contractor shall provide the Office of Medical Assistance staff access to the system for reporting purposes. The system shall be designed so that the Office of Medical Assistance staff is able to query the shared system to run relevant summary and detail-level reports. The system shall be designed so that reports and applicable queries provide sufficient information for the Office of Medical Assistance to assess incident frequency by type, persons involved, incident history, investigation status and results, issues to be resolved, relevant incident dates, and follow-up.

The Contractor shall investigate the most serious incidents as specified by the Office of Medical Assistance for ICDS participants, including abuse, neglect, and death. The Contractor will track other less serious incidents that the ICDS plans will report and house the information in the secure data repository. The Contractor shall connect and communicate with the Office of Medical Assistance staff to obtain and share information relevant to the individual and the incident. The ICDS plans will be responsible for developing and implementing prevention plans for individuals on the ICDS waiver program. The Contractor shall be responsible for reviewing those prevention plans related to the subset of the most serious incidents as specified by the Office of Medical Assistance to assure that the plans address all causes and contributing factors to minimize the risk of reoccurrence of the incident, and shall report inadequate prevention plans to the Office of Medical Assistance.

In the event that the Contractor's investigation of an incident concerning an ICDS participant would involve a perceived conflict of interest (for example, Contractor has also sub-contracted to provide case management services for a managed care plan, and an incident occurs that would lead to the Contractor investigating itself), Contractor shall advise the Office of Medical Assistance which shall then lead that investigation.

6.1.6 PERFORMING INCIDENT MANAGEMENT AND INVESTIGATION FOR HOME CHOICE. The Contractor shall provide a secure data repository and tracking system for all incidents involving individuals on HOME Choice who are not on a waiver program. The Contractor shall provide the Office of Medical Assistance staff access to the system for reporting purposes and will allow data entry of individual remediation and prevention planning data by the Office of Medical Assistance staff so that outcomes can also be reported using the system. The system shall be designed so that the Office of Medical Assistance staff is able to query the shared system to run relevant summary and detail-level reports for federal-reporting requirements and for system improvement purposes. The system shall be designed so that reports and applicable queries provide enough information for the State to, at minimum, assess incident frequency by type, waiver program enrollment, persons involved, incident history, investigation status and results, issues to be resolved, relevant incident dates, and follow-up. The system shall be designed so that it is modifiable to meet changing reporting requirements by the Centers for Medicare and Medicaid Services.

The Contractor shall investigate and track all incidents involving individuals on HOME Choice who are not on a waiver program. Incidents include those defined in Ohio Administrative Code rule 5101:3-45-05 and also include specific HOME Choice incidents as specified by the Office of Medical Assistance. The Contractor shall connect and communicate with the Office of Medical Assistance staff to ensure that all necessary information is being collected and to obtain and share information relevant to the individual and the incident. Currently, for the approximately 500 individuals on HOME Choice not on a waiver program, approximately 40 incidents are reported each month.

6.1.7 OPERATING AN ALERTS PROCESS. The Contractor shall report critical incidents regarding any individual on the Ohio Home Care waiver, the Transitions II Aging Carve-Out waiver, and the ICDS waiver program to the Office of Medical Assistance within one business day of the incident submission. The Contractor shall report critical incidents regarding any individual on the HOME Choice program to the Office of Medical Assistance and the HOME Choice Operations Unit within one business day of the incident submission.

6.1.8 MANAGING PROVIDER NON-COMPLIANCE. The Contractor shall assist the Office of Medical Assistance in enforcing all provider rules. With regard to the Ohio Home Care waiver and Transitions II Aging Carve-Out waiver programs, the Office of Medical Assistance shall notify the Contractor of all provider suspensions or terminations and the Contractor shall be responsible for communicating with all case management entities when non-compliant providers need to be removed from individual service plans.

6.1.9 MONITORING PROVIDER COMPLIANCE FOR THE OHIO HOME CARE WAIVER AND TRANSITIONS II AGING CARVE-OUT WAIVER PROGRAMS. Every Ohio Home Care waiver and Transitions II Aging Carve-Out waiver program provider must submit to regularly scheduled monitoring. The Contractor shall be the designee of the Office of Medical Assistance to perform the monitoring activities outlined in Ohio Administrative Code rules 5101:3-45-05 and 5101:3-45-06. The monitoring shall include a structural review in compliance with Ohio Administrative Code rule 5101:3-45-06 and continuous monitoring of provider compliance and performance through the incident process in compliance with Ohio Administrative Code rule 5101:3-45-05.

It is anticipated that the Office of Medical Assistance will be amending the monitoring requirements set forth in Ohio Administrative Code.

Those amendments will result in the Contractor identifying the methodology by which a randomly-selected, statistically-valid sample will be drawn for selection of records to be reviewed for all providers subject to the structural review process and having provided services to 30 or more individuals during the review period. The methodology shall specify the confidence level and margin of error. The Contractor shall review 100% of the records of providers subject to the structural review who have provided services to less than 30 individuals during the review period.

The Contractor shall not have the authority to sanction these providers, only the authority to recommend such action to the Office of Medical Assistance. For more information regarding provider monitoring and structural reviews, refer to Attachment Ten – Provider Oversight Guide.

6.1.10 MONITORING PROVIDER COMPLIANCE FOR THE ICDS WAIVER PROGRAM. The Contractor shall track and perform structural reviews of ODA-certified or OMA-approved providers who are providing services to individuals in the Integrated Care Delivery System waiver program and are not providers of services in the Ohio Home Care, Transitions II Aging Carve-Out, or any Ohio Department of Aging waiver program. For purposes of the ICDS Waiver Program the structural review will not include any unit of service verification audits. For the ICDS waiver program providers that are certified through the Ohio Department of Aging, the structural review will be the same as in Ohio Administrative Code rule 173-39-04 (excluding the unit of service verification audit portion which will not be part of the structural review). For the ICDS waiver program providers that are approved through the Office of Medical Assistance, the structural review will be the same as in Ohio Administrative Code rule 5101:3-45-06 (excluding the unit of service verification audit portion which will not be part of the structural review).

6.1.11 MAKING MEDICAID FRAUD REFERRALS. Medicaid fraud occurs when a Medicaid provider knowingly makes, or causes to be made, a false or misleading statement or representation for use in obtaining reimbursement from Medicaid. This includes, but is not limited to, billing for services not provided, charging Medicaid more than the reasonable value of the services and providing services that were medically unnecessary. The Office of Medical Assistance works with the Attorney General's Medicaid Fraud Control Unit when Medicaid fraud is suspected.

Whenever Medicaid fraud is suspected by or reported to the Contractor, the Contractor shall create an incident report with supporting documentation and submit all information regarding the incident to the Office of Medical Assistance and the Attorney General's Medicaid Fraud Control Unit. The Contractor shall provide all assistance as requested by the Office of Medical Assistance and the Ohio Attorney General's Medicaid Fraud Control Unit. For more information regarding the protocol for Medicaid fraud, refer to Attachment Ten – Provider Oversight Guide.

6.1.12 REFERRING PROVIDER OVERPAYMENTS. Provider overpayments may be discovered in a variety of ways including, but not limited to, during a structural review, an incident investigation, or by the Case Management Contractor(s). If the Contractor becomes aware of a provider overpayment, the Contractor shall refer the overpayment to the Office of Medical Assistance. The Office of Medical Assistance will forward the information to the OMA's Bureau of Audit Performance, Surveillance, Utilization, and Review Section (SURS) for collection of the overpayment. Approximately 1100 overpayment referrals were made to the Office of Medical Assistance in state fiscal year 2012. For more information regarding the protocol for provider overpayments, refer to Attachment Ten – Provider Oversight Guide.

6.1.13 OFFERING EDUCATION AND TECHNICAL ASSISTANCE FOR OHIO HOME CARE, TRANSITIONS II AGING CARVE-OUT AND ICDS WAIVER PROGRAM PROVIDERS. The Contractor shall provide monthly education sessions and technical assistance to Ohio Home Care, Transitions II Aging Carve-Out, and ICDS waiver program providers as part of the enrollment process and for purposes of remedial training. The Contractor shall assure that new providers and providers needing remedial training have completed an education session.

At a minimum, training topics shall include, provider rules, preparing plans of correction for notices of deficiency, and reporting of individual incidents. The Contractor shall provide annual notice to all Ohio Home Care and Transitions II Aging Carve-Out waiver program service providers of the rules for reporting incidents. At a minimum, this annual notice must be made in paper format and/or accessible through the Contractor's website.

In addition to the monthly education sessions and the annual notice, the Contractor may use a variety of media to perform additional education and technical assistance (e.g., newsletters, public announcements, community forums, and agency-specific training sessions). All materials developed and activities conducted must incorporate person-centered language. Any materials given to individuals or providers must be pre-approved by the Office of Medical Assistance.

6.1.14 UP-TO-DATE OHIO HOME CARE AND TRANSITIONS II AGING CARVE-OUT WAIVER PROGRAM PROVIDER DIRECTORY. The Contractor shall maintain an up-to-date Ohio Home Care and Transitions II Aging Carve-Out waiver program provider directory and shall share the directory with the Case Management Contractor(s) and the Office of Medical Assistance on a real time basis in accordance with state program requirements and rules. Provider directories shall be organized by county and provider type, and must be accessible at all times to all case managers. Provider directories shall include, at minimum: provider name, home care services provided, address, contact numbers, Medicaid provider number, and type of provider. At a minimum, provider directories shall be available in paper format and accessible through the Contractor's website.

6.1.15 PARTICIPATING IN OHIO REVISED CODE CHAPTER 119 HEARINGS PROCESS. Providers have the right to appeal any decision of a proposed action to terminate or deny their provider agreements as specified in Ohio Administrative Code Chapter 5101:6-50 (<http://codes.ohio.gov/oac>). The Attorney General's Health and Human Services Section represents the Office of Medical Assistance for all of the Chapter 119 hearings. Chapter 119 hearings are conducted by the Office of Medical Assistance hearing examiners and are held face-to-face in Columbus Ohio. The Office of Medical Assistance will lead all Chapter 119 hearings related to disenrollment or provider application denials. The Contractor shall participate in the hearings process by making recommendations for the proposed termination or denial of a provider agreement, providing supporting documentation, and offering testimony supporting proposed actions. The Contractor shall provide testimony during face-to-face Chapter 119 hearings, when requested, which means they must be available to prepare, travel and participate as requested by the Office of Medical Assistance. During calendar year 2011, the Office of Medical Assistance and its contracted designee participated in an average of 5-10 Chapter 119 hearings per month. For more information regarding the Chapter 119 Hearings process, refer to Attachment Ten – Provider Oversight Guide.

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, CONTRACTOR STANDARDS AND REPORTING REQUIREMENTS AND OFFICE OF MEDICAL ASSISTANCE MONITORING OF THE CONTRACTOR, 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 Provider Oversight Guide, and the Contractor Standards and Reporting Requirements and Office of Medical Assistance Monitoring of the Contractor 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 STAFF/WORKING HOURS. The Contractor shall provide one statewide, toll-free phone number during normal working hours, available for providers, individuals, state staff, federal staff, etc. to access Contractor staff. 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.

6.2.5 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:

Any staff member performing provider oversight functions shall have a bachelor's degree in any field and a minimum of two years paid experience working with critical care providers, public health providers, or providers that care for children, older adults, persons with traumatic brain injury, or persons with developmental disabilities. One year of the experience must have included provider monitoring, Medicaid or third party payer provider billing, or provider training. One year of the experience must have been in a home health program, community health program, hospital, private practice, publicly-funded institution, long-term care program, mental health program, community-based social service program, or any other program addressing the needs of special populations.

Any staff member performing supervision of provider oversight staff shall meet the requirements of provider oversight staff and have one additional year of paid experience working with critical care providers, public health providers, or providers that care for children, older adults, persons with traumatic brain injury, or persons with developmental disabilities.

Any staff member performing incident management functions shall either be a licensed registered nurse (RN), as defined by the Ohio Board of Nursing with one year paid experience in home and community based services (HCBS); or a licensed social worker (LSW, LISW) as defined by the Ohio's Counselor, Social Worker, & Marriage & Family Therapist Board with one year paid experience in HCBS; or a licensed counselor (LPC, LPCC) in the State of Ohio with one year paid experience in HCBS.

The one year of HCBS experience shall include experience with any of the following: incident investigation, assuring individual health and welfare, quality assurance, clinical risk management, the mental health system, or interfacing with law enforcement, nursing homes, children services, adult protective services, or the Department of Developmental Disabilities.

Any staff member performing supervision of incident management staff shall meet the requirements of incident management staff and have five additional years' paid experience in HCBS that shall include any of the following: incident investigation, assuring individual health and welfare, quality assurance, clinical risk management, the mental health system, or interfacing with law enforcement, nursing homes, children services, adult protective services, or the Department of Developmental Disabilities.

All program management staff shall 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. 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.

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 Rules 5101:3-45-07 and 5101:3-45-11. (<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 shall be kept on file by the Contractor and shall 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 its 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 STAFF 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 all provider oversight staff shall include, but not be limited to training on the following subjects:

1. Federal and state laws and program requirements.
2. Use of person-centered language in all communication.
3. Due process for providers.
4. Provider service specifications.
5. Incident management and investigation, abuse, neglect, and exploitation, and all other incident reporting.
6. Provider enrollment.
7. Provider monitoring and structural reviews.
8. HIPAA.
9. Customer service.

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. Incident management and investigation, abuse, neglect, and exploitation, and all other incident reporting.
2. Provider service specifications.
3. HIPAA.
4. 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.

6.2.7 CUSTOMER SERVICE. Customer service must be fundamental to all of the provider oversight activities outlined in this RFP. The Contractor must always aspire to customer satisfaction – that is, the sense that provider and/or individual expectations of the waiver programs have been met. The perceived success of every interaction with providers, individuals, family, and stakeholders are dependent on the staff. Customer service must be included as part of an overall approach to systematic improvement. A customer service experience can change the entire perception a provider has of the Contractor and therefore the Office of Medical Assistance-administered waiver programs.

6.2.8 COMPLAINT PROCESS. The Contractor shall set up a complaint process pursuant to the criteria set forth in Attachment Ten - Provider Oversight 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 providers, nurses, family members, friends, individuals, 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 - Provider Oversight Guide.

6.2.9 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.

6.2.10 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 issues.

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 providers, individuals, 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 PROVIDERS. In addition to paper-based methods of communication, the Contractor shall use technology in communicating with providers 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, monthly update of provider directory, and other information as required throughout this RFP (e.g., instructions on how to apply as a provider, etc.). The Contractor shall give the Office of Medical Assistance advance notice of updates and changes to any materials on the 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.

The Contractor must be able to transmit and receive information to and from all case management entities and the Office of Medical Assistance 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 PROVIDER OVERSIGHT CONTRACTOR STANDARDS AND REPORTING REQUIREMENTS AND OFFICE OF MEDICAL ASSISTANCE MONITORING OF THE CONTRACTOR. The Contractor is subject to the terms of Attachment Eleven titled Contractor Standards and Reporting Requirements and Office of Medical Assistance Monitoring of the Contractor. The Contractor shall participate and cooperate in any and all matters related to the Contractor Standards and Reporting Requirements and Office of Medical Assistance Monitoring of the Contractor. The Office of Medical Assistance reserves the right to set and/or change minimum standards after the first six months of Contractor performance and each state fiscal year thereafter throughout the duration of the Contract, and the Contractor shall be subject to all amendments.

6.2.16 MAINTAINING PHYSICAL AND ELECTRONIC FILES FOR EACH PROVIDER 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 provider and individual records and assure that providers and individuals have access to their own records upon request. The Contractor must ensure that all 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. The Contractor must have at least one physical office location for the coordinating site to manage and administer the Scope of Work in this Contract. The Contractor may also have other coordinating office locations in the State. Personal residences are not acceptable locations for coordinating offices. 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 CASE MANAGEMENT CONTRACTOR(S). Currently, provider oversight services and case management services are performed by the same Contractor. Effective with this contract period, the two services will be performed by different Contractors. The statewide Provider Oversight Contractor shall interface with the regional Case Management Contractor(s) who, among other things, will develop the service plan for individuals on waiver programs, coordinate multiple services and/or multiple providers, monitor the service plan and individual's health and welfare, address problems with service provision, and respond to and address individual crisis situations and report incidents (as currently defined and as amended in the future) to the statewide Provider Oversight Contractor for investigation. The Case Management Contractor(s) may only use eligible Medicaid service providers as identified in MITS. The Provider Oversight Contractor must provide the Case Management Contractor(s) with up-to-date Medicaid home care provider directories and alert the Case Management Contractor(s) when any providers become ineligible to provide services so that the Case Management Contractor(s) can remove the provider from the All Services Plan.

6.4 SPECIFICATION OF DELIVERABLES In addition to performing the Work, the Contractor must submit monthly performance reports based on a format defined by the Office of Medical Assistance. 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 holiday. The first report must be submitted following the first full month after the Contract is initiated.

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
Ohio Health Plans, 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 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 – Contractor Standards and Reporting Requirements and Office of Medical Assistance Monitoring of the Contractor.
 - 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 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. 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.
- d. Offerors must describe current operational capacity of the organization and the Offeror's ability to absorb the additional workload resulting from this Project.
- e. 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.
- f. The Offeror has provided evidence that Offeror has incident management experience, has capacity and vision for this specific task.
- g. The Offeror must document three examples of how the Offeror implemented system changes that were directly responsible for improved provider quality.
- h. The Offeror must document that it has at least two years' experience with federally or state-funded programs within the past five years.
- i. The Offeror must provide results of provider satisfaction surveys completed regarding provider oversight services within the last two years.

(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.

(6) Staffing Plan. 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 include 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 Offeror's customer service philosophy.
- d. Describe how Offeror's will monitor operations to assure quality.
- e. Describe how Offeror will educate providers.
- f. 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.
- g. Describe how Offeror will meet the record keeping policies and procedures for the Work.
- h. Describe how Offeror will interface with the Case Management Contractor(s).
- i. Describe how the Offeror will adapt to changes in federal and state Medicaid laws, rules and policies.

(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 CSP900614, entitled Home and Community Based Services Provider Oversight 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.

(Contractor)

Department of Administrative Services
(State of Ohio Agency)

(Signature)

(Signature)

(Printed Name)

Robert Blair
(Printed Name)

(Title)

Director, Department of Administrative Services
(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

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			

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

ATTACHMENT FIVE A
OFFEROR'S CANDIDATE REFERENCES

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.		
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	of	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	of	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	of	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

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.

- 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)

- 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)

- 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)

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

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.

Estimated monthly volume 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. 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)
Structural Reviews	400		400	
Provider Applications (including re-enrollment/revalidation)	800		800	
Onsite Visits	40		50	
Provider Oversight Monthly Fee	All other work and deliverables performed under this Contract not included above		All other work and deliverables performed under this Contract not included above	

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

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.



Ohio Office of Medical Assistance

Provider Oversight Guide

*A Guide to Overseeing Providers for
the Ohio Home Care and Transitions II
Aging Carve-Out Waiver Programs*

Effective July 2013

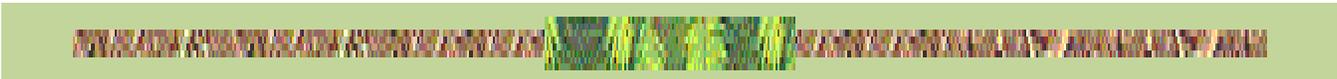


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Introduction and Background

Introduction

Welcome to the Ohio Home Care Waiver program's **Provider Oversight Guide**. Its purpose is to provide guidelines to the Ohio Office of Medical Assistance's **Provider Oversight Contractor**, which oversees providers for the Ohio Home Care Waiver program.

The Ohio Office of Medical Assistance contracts with a Provider Oversight Contractor to ensure that providers are providing high-quality care to community-based long-term care program individuals; that providers are receiving appropriate payment for providing that care; that providers are meeting eligibility requirements; and that providers are following program rules and requirements.

It also contracts with Case Management Contractors to assist with the implementation and management of the Office of Medical Assistance-administered **home and community-based service** waiver programs throughout the state of Ohio. It is imperative that the Provider Oversight Contractor and the Case Management Contractors work closely and cooperatively with each other.

The federal government requires home and community-based services waiver programs to ensure the health and welfare of each waiver individual; thus, the collective, fundamental goal of the Office of Medical Assistance, Provider Oversight Contractor and Case Management Contractors is to ensure the health and welfare of each waiver individual. This guide details the Office of Medical Assistance's standards and expectations for the Provider Oversight Contractor related to the daily operations of achieving that goal.

As issues and/or potential efficiencies are identified, the Office of Medicaid Assistance may modify the Provider Oversight 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.

Background

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. The 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 Chapter 5101:3-45 of the **Ohio Administrative Code**. These rules provide general guidelines regarding an individual's eligibility for a waiver program, and provider eligibility, reimbursement and monitoring. The Ohio Home Care Waiver is further governed by Chapter 5101:3-46 of the Ohio Administrative Code, and the Transitions II Aging Carve-Out Waiver is further governed by Chapter 5101:3-50 of the Ohio Administrative Code.

Waiver services currently include but may not be limited to 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.

The United States Department of Health and Human Services **Centers for Medicare and Medicaid Services** oversees all Medicare and Medicaid programs and grants Ohio authority to operate its Medicaid waiver programs. 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 Office of Medical Assistance is responsible for general administration and oversight of the day-to-day operation of the Office of Medical Assistance -administered waiver programs. This includes the operations of the Provider Oversight Contractor, which oversees the providers for the waiver program individuals as outlined in this guide.

Provider Enrollment

The provider enrollment process for the Office of Medical Assistance-administered waiver providers begins with the Provider Oversight Contractor. The Provider Oversight Contractor is responsible for ensuring that the Ohio home care provider enrollment requirements are met and that provider applications are completed in a timely and compliant manner.

The Office of Medical Assistance requires the Provider Oversight Contractor to verify the Office of Medical Assistance-administered waiver service provider applicant is compliant with the provider qualifications and service requirements outlined in the Ohio Administrative Code.

All steps of the provider enrollment workflow are conducted in **Medicaid Information Technology System (MITS)**, on a secure web-based system. The step-by-step enrollment and verification process is outlined in “*Provider Enrollment Desk Reference*,” which will be provided to the Provider Oversight Contractor. Potential providers must complete the enrollment process electronically.

Enrollment Process – Provider Oversight Contractor General Roles and Resources

Ohio Administrative Code 5101:3-45-04 “*ODJFS-administered waiver program: provider enrollment process*” outlines the general enrollment process and the provider-specific requirements that the Provider Oversight Contractor must verify for each provider type. The Provider Oversight Contractor’s role in the application process is to provide information to interested parties regarding provider requirements and eligibility, disseminate application-related materials, and verify that each applicant satisfactorily meets the requirements for the relevant provider type before placing the application in the Medicaid Information Technology System Final Review work queue.

The Provider Oversight Contractor must refer to the Ohio Administrative Code, the Provider Enrollment Desk Reference, utilize the Medicaid Information Technology System Enrollment Checklist and/or seek technical assistance from the Office of Medical Assistance to ensure that applications are completed in a compliant and timely manner per the requirements set forth in the Ohio Administrative Code. In addition, the Provider Oversight Contractor will consult with the Office of Medical Assistance when additional or clarifying information is needed in order to process applications and/or respond to inquiries.

The Provider Oversight Contractor must provide information to prospective and current applicants in a timely manner using various communication methods. The Provider Oversight Contractor must provide telephone, written/printed material, and electronic resources to assist applicants with the enrollment process and to document and track application-related activities.

The Provider Oversight Contractor will provide telephone access for interested parties to speak with enrollment staff in order to ask questions, seek clarification and provide information. The Provider Oversight Contractor must ensure that all incoming calls are answered and telephone messages are returned within 24 hours. The persons receiving incoming calls must have excellent customer service skills to provide accurate responses and/or referral(s) to the callers.

The Provider Oversight Contractor must respond to inquiries of any kind (written, e-mailed or calls) within three business days and ensure that the response contains contact information for next steps, or appropriate follow-up information.

The Provider Oversight Contractor must provide an interactive website for interested parties and applicants that include general information, enrollment process information, and easily navigated links to additional information.

The Provider Oversight Contractor must maintain electronic systems to receive and transmit information by secure facsimile (fax) and have in-house capability to scan documents and other information into a format that allows for ease of transmission (*e.g.*, PDF format).

Provider Oversight Contractor Activities in the Enrollment and Revalidation Processes

To be enrolled to provide Ohio Home Care Waiver services as a Registered Nurse, Licensed Practical Nurse, Home Health Agency, Non-Agency Personal Care Aide, or Home Care Attendant, or to enroll to perform services such as Home Modifications, Supplemental Transportation or Out-of-Home Respite, applicants must submit an application via the Medicaid Information Technology System portal (<https://portal.ohmits.com/public/Providers/tabid/43/Default.aspx>).

All providers must revalidate their provider agreement at least once every five years. The Provider Oversight Contractor must also complete the revalidation activities as outlined below.

The Provider Oversight Contractor will use the Provider Enrollment Desk Reference developed by the Office of Medical Assistance to process provider applications. The Office of Medical Assistance will train the Provider Oversight Contractor on how to complete the enrollment process in Medicaid Information Technology System.

Provider Oversight Contractor's Enrollment and Revalidation Workflow Process

A. Initial Placement Queue

- a. Acquire application from Office of Medical Assistance's Medicaid Information Technology System waiver work queue.
- b. Perform duplicate provider record check to determine if a current provider agreement or application is pending for the applicant and take appropriate action based on the finding.
- c. Complete Medicaid Information Technology System Application Checklist. If any required document(s) are missing, issue "Return to Provider Letter" in the Medicaid Information Technology System with list of additional items needed.
- d. Complete verification of license for nurses and/or registry for State-Tested Nurses Aides.
- e. Complete database verifications as outlined below. Indicate "reject" status if unfavorable results are received.
- f. The Provider Oversight Contractor must direct all provider applicants to have criminal background check results sent directly to the Provider Oversight Contractor by the Bureau of Criminal Identification and Investigation. Attach the applicant's criminal background check(s) results with the electronic application.
- g. Once initial review has occurred, if all required documentation is present moved application to Quality Review Queue. If all required documentation is not present move to Awaiting Document Queue.

B. Awaiting Document Queue

- a. Upon receiving missing documents, attach all documents and place in the Quality Review Queue.
- b. Reject the application if missing documents have not been received in 60 days, and issue a “Return to Provider Letter.”

C. Quality Review Queue (Must be completed by a Provider Oversight Contractor supervisor)

- a. Verify all activities completed in the Initial Placement Queue and the Awaiting Document Queue.
- b. Take appropriate action if unfavorable results are identified during the Database Verification check.
- c. Review criminal background check against the requirements outlined in Ohio Administrative Code 5101:3-45-08 for non-agency providers. If any disqualifying offenses are identified, take the appropriate action.
- d. If provider is deemed appropriate to enroll, place in the Final Review Queue.

Database Verifications

In addition to the provider-specific requirements and verifications described here, the Enrollment Desk Reference and in Medicaid Information Technology System, the Ohio Administrative Code requires review and confirmation of an individual or agency’s eligibility through research of other state and federal agencies. The Provider Oversight Contractor must conduct searches of the online databases for the following entities and note the results in the Medicaid Information Technology System. The Provider Oversight Contractor must search on the name of the individual provider or search on the names of the agency owners listed on the application for an organizational provider. The internet-based checks include:

- The “Excluded Parties List System” maintained by the United States General Services Administration, available at <https://www.epls.gov/>;
- The list of excluded individuals and entities maintained by the United States General Services Administration at <https://www.sam.gov/portal/public/SAM/>;
- The registry of employees guilty of abuse, neglect, or misappropriation maintained by the Ohio Department of Developmental Disabilities, available at https://its.prodapps.dodd.ohio.gov/ABR_Default.aspx;
- The sex offender and child-victim database maintained by the Ohio Attorney General, available at <http://www.icrimewatch.net/index.php?AgencyID=55149&disc=>;
- The database of inmates maintained by the Ohio Department of Rehabilitation and Correction, available at <http://www.icrimewatch.net/index.php?AgencyID=55149&disc=>; and
- The Ohio nurse aide registry, maintained by the Ohio Department of Health, available at https://odhgateway.odh.ohio.gov/nar/nar_registry_search.aspx.

The Ohio Administrative Code also allows Office of Medical Assistance to add additional checks that it considers useful in determining a provider’s eligibility.

Information Regarding Required Documentation or Processes

Social Security Card

In accordance with OAC 5101:3-46-04 “*Ohio home care waiver: definitions of the covered services and provider requirements and specifications,*” applicants must present their Social Security number card to be copied and included with the application packet. The Social Security number must be compared to and confirmed to match the Social Security number entered elsewhere on the application and other accompanying documents, such as the background check. The application must not be processed if discrepancies with the Social Security number are identified. The Office of Medical Assistance must be alerted if discrepancies appear to be an applicant’s attempt to present false or misleading information.

Identification/Government-Issued Identification

Individual applicants must provide a form of identification, which may include an alien identification card, a valid State of Ohio identification card, a valid driver’s license, or other government-issued photo identification. The identification item must be clearly photocopied and included with the application.

The Provider Oversight Contractor must not process an application if any identification is expired or not legitimate. Applicants may be provided an opportunity to renew the identification item (such as a driver’s license) if they are able to do so within 30 days of being notified their application cannot be processed.

National Provider Identifier

The Health Insurance Portability and Accountability Act of 1996 require providers to have a **National Provider Identifier** so there is a standard unique identifier for health care providers. Registered Nurses and Licensed Practical Nurses and home health agencies **are** required to obtain a National Provider Identifier.

Non-agency personal care aides, supplemental transportation services, home delivered meal and home modification providers **are exempt** from having a National Provider Identifier.

In addition to completing the National Provider Identifier portion of the application, applicants must attach a copy of the notice from the National Provider Identifier Enumerator to verify the National Provider Identifier number.

W-9 Request for Taxpayer Identification Number and Certification

Individual applicants must complete and submit a W-9 form that contains their name, address, Social Security number, original signature and date. Individual applicants may not use a group tax identification number. The Social Security number entered on the W-9 must match the Social Security number entered elsewhere on the application and must match the Social Security number on the Social Security card provided by the applicant.

Agency/organization applicants must also complete and submit a signed W-9 form. The W-9 should contain the proprietor’s Social Security number and/or the Employer Identification Number. Only page one of the W-9 form needs to be included as a part of the application.

Signed Medicaid Provider Agreement

The Provider Oversight Contractor must have an original signature as a part of the enrollment process. Therefore, the applicant must print out, sign and upload a copy of the provider-signed agreement.

Confirmation from an Individual on a Waiver Program

Persons applying to become a personal care aide who are not registered State-Tested Nurse Aides or have equivalent training, and/or a home care attendant must submit documentation from an individual currently enrolled on a waiver program who intends to use the applicant as a provider. This confirmation can be a letter from the individual on a waiver program or JFS Form 06724 “Consumer Service Request for Provider.” This document must be uploaded to the electronic application.

Licensure /Certification/Competency

Non-Agency Personal Care Aide

Personal care aide services and eligibility requirements are defined in Ohio Administrative Code 5101:3-46-04 and 5101:3-50-04. Individuals seeking to apply as a non-agency personal care aide must meet the requirements set forth in the Ohio Administrative Code and must provide accurate and appropriate documentation to verify their eligibility. There are three options for how an applicant may qualify as a non-agency personal care aide: Nurse Aide Competency Training, Other Equivalent Training, or Consumer-Specific Training Option.

Nurse Aide Competency Evaluation Program

The applicant may have obtained training from either a nurse aide competency evaluation program through the Ohio Department of Health or a Medicare competency evaluation program for home health aides. The provider applicant must submit a certificate of completion dated within the last 24 months of the date of application as part of the provider application. If an applicant completed the nurse aide competency evaluation program and achieved State Tested Nurse Aide status, his or her training is considered current if he or she is listed as “In Good Standing” on the Ohio Department of Health Nurse Aide Registry. Applicants that are State-Tested Nurse Aides must submit a copy of his or her State-Tested Nurse Aide card issued by the Ohio Department of Health.

Other Equivalent Community Program

The applicant may obtain training from an equivalent community program. Equivalent training may be provided by existing training programs or by the individual, the individual’s authorized representative (such as a parent or other family member), or other qualified person.

If the training is provided by an established program, the provider applicant must submit a certificate of completion and the syllabus for the community program as part of the provider application packet. The Provider Oversight Contractor must determine if the applicant meets the training requirements that are detailed below.

If the training is provided by the consumer, authorized representative or other qualified person, the training must include the items listed below as well as instruction about the specific care needs of the consumer. The training must include instruction about:

- Personal care aide services that assist the individual on a waiver program with activities of daily living and instrumental activities of daily living impairments;
- Basic home safety; and
- Universal precautions for infection control, including hand-washing and proper disposal of bodily waste and medical instruments that are sharp or may produce sharp pieces if broken.

If the training is provided by the waiver individual, authorized representative or other qualified person, the provider applicant must submit JFS Form 06722 “Other Equivalent Training Program - Consumer, Consumer’s Representative or Qualified Trainer Verification and Provider Enrollment Addendum Non-Agency Personal Care Aide.”

A provider who is approved based on this level of training is limited to the specific individual on a waiver program listed on the form. If the provider wishes to provide services to another waiver individual, he or she must submit a new JFS Form 06722 to the Provider Oversight Contractor. The Provider Oversight Contractor must develop a system to ensure that providers trained through the individual -specific process are restricted to the individuals where the training has been documented.

All non-agency personal care aide applicants must submit evidence of having obtained first aid certification, which includes hands-on training by a certified first aid instructor. A copy of the current and valid first aid card or certificate must be included with the application. The first aid class cannot be solely Internet-based.

Licensed Practical Nurse

The Provider Oversight Contractor must conduct a licensure verification of the Licensed Practical Nurse’s eligibility on Ohio Board of Nursing website (<http://www.nursing.ohio.gov/Verification.htm>).

Licensed Practical Nurse applicants must identify the Registered Nurse under whose direction the Licensed Practical Nurse will work on their application. The Provider Oversight Contractor can find this information by reviewing the electronic application attached to the applicant’s file. The Provider Oversight Contractor must also verify the Registered Nurse’s license on the Ohio Board of Nursing website.

Registered Nurse

The Provider Oversight Contractor must conduct licensure verification of the Registered Nurse’s eligibility on the Ohio Board of Nursing website (<http://www.nursing.ohio.gov/Verification.htm>).

Incident Management

Protection from Harm

Protection from harm involves activities and processes that mitigate potential risks and respond when individuals experience an incident or event that impacts the individual's health, safety, welfare, or service delivery. The Office of Medical Assistance, the Provider Oversight Contractor and the Case Management Contractor all are responsible for ensuring the health and welfare of individuals by using proper reporting procedures.

Incident Discovery and Reporting

The Provider Oversight Contractor must initiate incident reports when an incident is identified during any oversight process or upon a complaint or report from any party.

Reportable incidents are outlined in Ohio Administrative Code 5101:3-45-05.

The Provider Oversight Contractor must ensure all of the follow have occurred when an incident report is identified or reported.

1. Review to Ensure Health and Welfare of Individual:

The Provider Oversight Contractor must review all reported incidents within one (1) business day. The review must include the following:

- a. **Immediate Action.** Proper immediate action has been taken to ensure the health and welfare of the individual on a waiver program if the Case Management Contractor or another entity initiates the incident report. In the event of a death of an individual on a waiver program, the Provider Oversight Contractor must ensure that the county coroner was notified 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.
- b. **Reporting to protective agencies.** Local law enforcement, county children's services, adult protective units, county board of developmental disabilities or other regulatory entity, have been notified, as appropriate and required by law.
- c. **Incident Reporting.** All incidents must be reported within 24 hours, as directed by the Office of Medical Assistance.

2. Identify Incident Alerts

The Provider Oversight Contractor must ensure that incidents that rise to the level of an alert are reported to the Office of Medical Assistance within one business day of the incident report submission.

The Office of Medical Assistance monitors each incident to ensure that investigation and remediation are timely and effective. Alerts are closed after the health and safety of the individual on a waiver program and other affected individuals have been addressed.

The Office of Medical Assistance does not close an alert until it has reviewed all pertinent information, including investigation outcomes, recommendations, final reports, approved prevention plans, and verification of implementation.

The following are cause for an Incident Alert:

- Suspicious death (see below);
- Abuse/neglect that result in the individual requiring hospital admission, emergency removal from home, or emergency room treatment;
- Allegations implicating any Case Management Contractor or Provider Oversight Contractor staff ;
- Incidents generated from correspondence received from the Ohio Attorney General, Governor's Office, Centers for Medicare and Medicaid Services, or Ohio Civil Rights;
- Injury of an individual 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 by a public media source; and
- Any other situation the Office of Medical Assistance considers an incident.

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

- i. 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; and/or
- ii. There is indication that someone's action or inaction may have caused or contributed to the death. When a suspicious death is identified, the Provider Oversight Contractor must immediately notify er or not to accept the case.

3. Identify Conflict of Interest

If, at any time, during the discovery or investigation stages, information surfaces that indicates that a Case Management Contractor or Provider Oversight Contractor employee is, or may be, directly or indirectly responsible for the death, abuse or neglect of an individual, the Case Management Contractor or Provider Oversight Contractor must immediately notify the Office of Medical Assistance regarding who will determine if the Office of Medical Assistance will assume control of the investigation.

Investigation Responsibilities

The Provider Oversight Contractor must initiate a full investigation within two (2) business days of the incident date of notification. The investigation must include:

1. Verification that immediate action was taken to protect the individual on the waiver program and others potentially impacted and to ensure the health and welfare of the individual. If immediate action was not taken to protect the individual, initiate immediate action to do so.

2. Verification that proper reporting was made to protective agencies, including law enforcement, county children's services, adult protective units, county board of developmental disabilities or any other entity, as needed. If proper reporting was not made to protective agencies, proper reporting must be initiated.

During the investigation, the Provider Oversight Contractor must:

- a. Coordinate with law enforcement, county children's services, adult protective units, county board of developmental disabilities, or any other entity as needed.
- b. Review all relevant documents. These may include, but are not limited to, the All Services Plans, Program Eligibility Assessment Tool, clinical notes, communication notes, coroner's report, nurse's notes, provider billing, medical reports, police or fire department reports, etc.
- c. Document all investigative activities. The documentation must include discovery of all elements of the incident, including answering who, what where, when, and how the incident occurred.
- d. Conduct and document interviews with individuals who may have relevant information. For incidents involving abuse, neglect, exploitation or suspicious death, attempt to complete face-to-face (in person or via web technology) interviews to evaluate the credibility of the witnesses.
- e. At the conclusion of the investigation, make the appropriate referrals to other agencies or licensing boards.
- f. If it is not possible or relevant to the investigation to complete one of the investigation activities listed in this section, document the reason in the incident reporting system.
- g. Use the "Death Investigation Protocol" following the death of an individual.

Death Investigation Protocol

In addition to the investigation steps outlined previously, the Provider Oversight Contractor must gather the following information in all death cases:

- Time and date of death.
- Location of death.
- Circumstances of death (*e.g.*, events, activities, during and preceding death).
- Person who discovered the death.
- Witnesses.
- Individual's diagnoses.
- Whether the death was expected.
- Whether the death was a result of a crime and if any criminal charges were filed.
- Whether an autopsy was performed.
- Whether the individual on a waiver program had "Do Not Resuscitate" status.
- Copy of death certificate.

- Copy of autopsy, if applicable.
- Nurse's and personal care aide's documentation.
- Any other salient information (such as phone conversations, case manager notes, law enforcement investigation reports, known health risks, individual's mental health status).
- If it is not possible or relevant to the investigation to meet all of the activities listed in this section, the Case Management Contractor must document the reason in the incident reporting system.

Concluding the Investigation

All investigations must be completed within 45 calendar days of the report of the incident. The Provider Oversight Contractor may request an extension from the Office of Medical Assistance, if needed. The Office of Medical Assistance has the authority to determine when an investigation will have a delayed conclusion

The Provider Oversight Contractor must write an investigation summary report and develop a prevention plan at the conclusion of any investigation. The summary report must include:

- a. Clear statement of the allegation.
- b. Witnesses and clear, complete documenting evidence.
- c. A concise analysis of the evidence. The results of the investigation should identify the effects of the incident and the cause(s) and contributing factor(s), which resulted in the occurrence.
- d. A clearly stated conclusion that identifies which allegations were substantiated based upon whether credible evidence indicates that it is more probable than not that the incident occurred.
- e. If an allegation is substantiated, the Provider Oversight Contractor must require a prevention plan from the Case Management Contractor. The prevention plan must be objective, measurable and include timelines. It must address all causes, contributing factors and effects of the occurrence.
- f. When warranted, the Provider Oversight Contractor must take further action related to the provider when the allegation is substantiated or other performance issues are identified (*see Provider Compliance section, page 28*).
- g. Prevention plans and plans of correction must both 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 Provider Oversight Contractor must refer all situations in which the provider or Case Management Contractor fail to provide a timely or adequate plan to Office of Medical Assistance for review.

Office of Medical Assistance-Led Investigations

The Ohio Administrative Code requires the Office of Medical Assistance to lead all investigations in which the circumstances of the death is suspicious and when a reportable incident includes an allegation in which a Case Management Contractor or Provider Oversight Contractor employee may be directly or indirectly responsible, for the death or abuse or neglect of an individual on the waiver. There may be other occasions when the Office of Medical Assistance will elect to lead an investigation. When the Office of Medical Assistance does, it will notify the Provider Oversight Contractor not to monitor the investigation until the Office of Medical Assistance has concluded its investigation.

Joint Investigations with the Ohio Department of Developmental Disabilities and/or County Boards of Developmental Disabilities

The Ohio Department of Developmental Disabilities' Major Unusual Incident Unit and Office of Medical Assistance have agreed to the following investigation protocol when the case involves an open investigation by the county board of developmental disabilities.

A "major unusual incident" means the alleged, suspected, or actual occurrence of an incident when there is reason to believe the health or safety of an individual may be adversely affected or an individual may be placed at a reasonable risk of harm, if such individual is receiving services through the developmental disabilities service delivery system or will receive such services as a result of the incident.

- The Case Management Contractor must immediately report all incidents involving individuals receiving services through the county board of developmental disabilities or who are identified as having a developmental disability.
- County boards of developmental disabilities will concurrently report all Major Unusual Incidents involving an individual on a waiver program enrolled on an Office of Medical Assistance - administered waiver to the Provider Oversight Contractor.
- The Provider Oversight Contractor and the county boards of developmental disabilities will make separate determinations regarding whether the reported incident require an investigation according to statute, rule or policy by application of their own agency's standards. Incidents will be recorded, opened and/or closed according to each agency's standards.
- If only one agency is required by statute, rule or internal policy to investigate, that agency will proceed with the investigation according to its standards and requirements. The investigating agency will share its investigation outcome with the other agency.
- If both the Provider Oversight Contractor and the county board of developmental disabilities are required to investigate, the following criteria will be used to determine the lead agency on the investigation:
 - The agency that holds direct or indirect programmatic and/or contractual responsibility for the actions of the provider involved in the incident; or

- In the absence of alleged or apparent programmatic responsibility or cause, the agency that observed the incident or received the initial report of the incident will serve as the lead investigative agency.
- If neither of the preceding applies, the lead agency designation may be mutually agreed upon by the Provider Oversight Contractor and the county board of developmental disabilities.
- The agency that does not lead will participate as requested in the processes of the investigation, such as helping to obtain documents, arranging for and/or participating in interviews.
- The lead investigative agency will provide regular and timely updates regarding immediate health and safety measures, investigative process, prevention planning, findings and outcomes upon request to the secondary agency for purposes of compliance with statute, rule or internal timeframes.

Immediately upon completion of the investigation, the lead agency will provide a written **investigation report** to the Office of Medical Assistance.

- If during the course of an investigation, either investigator has concerns about how activities are being conducted or if conflicts arise, investigators must discuss their issues with the other agency. If discussion does not resolve the concerns, the following procedures will be used:
 - The Major Unusual Incident investigator must report concerns to his or her supervisor. If the supervisor is unable to resolve the issue, he or she must report the issue to the Ohio Department of Developmental Disabilities' Major Unusual Incident Unit.
 - The Provider Oversight Contractor investigator must report concerns to his/her supervisor. If the supervisor is unable to resolve the issue, he or she must report the issue to Office of Medical Assistance.

Death Reviews and Mortality Review Committee

The Office of Medical Assistance reviews all reported death cases. If the Office of Medical Assistance determines the death to be suspicious, it will lead the investigation. When the Office of Medical Assistance determines that it does not need to lead the investigation, it may determine that the death will be monitored as an Incident Alert.

The Office of Medical Assistance Mortality Review Committee reviews all investigations into the deaths of individuals enrolled on Office of Medical Assistance -administered waiver programs when the Office of Medical Assistance has led the investigation. The committee reviews the circumstances of a death and identifies and addresses case-specific or system-wide issue that could improve the quality of care provided to individuals. The outcome of these reviews may result in further actions against a provider, referrals to other agencies, or changes in policy, procedures and/or monitoring.

Structural Reviews

Ohio Administrative Code Rule 5101:3-46-06 requires every Office of Medical Assistance-administered waiver provider to be subject to ongoing monitoring activities by the Office of Medical Assistance or its designee. A structural review evaluates a provider's compliance with applicable rules in chapters 5101:3-45, 5101:3-46 and 5101:3-50 of the Ohio Administrative Code.

All Office of Medical Assistance-administered waiver agency providers that are not certified by Medicare or another accrediting organization must have a biennial structural review. This includes all providers that perform specialty services (out of home respite, respite, home modifications, home-delivered meals, etc.) would be reviewed every other year. The first biennial structural review must occur no later than one year after the date on which the provider first furnishes billable waiver services.

All Office of Medical Assistance-administered waiver providers must participate in a structural review when there are health or welfare issues involving the provider and an Office of Medical-Assistance-administered individual on a waiver program or for any other provider performance issue.

All Office of Medical Assistance-administered waiver non-agency providers must participate in structural reviews annually.

All Office of Medical Assistance-administered waiver providers are subject to an announced or unannounced structural review.

Purpose of the Structural Review

The Provider Oversight Contractor must conduct a face-to-face meeting with the provider, which will include review of the provider's documentation and supporting evidence to ensure:

1. The provider's compliance with the Ohio Administrative Rules for provider performance for the delivery of the services.
2. The provider's adherence to providing and billing for services authorized according to each waiver individual's All Services Plan.
3. Review of the clinical documentation to support reimbursement of services.
4. The provider is educated about the rule violations found during the face-to-face review and about any rules changes.

The Structural Review is also a form of provider oversight to ensure the provider has billed according to the services authorized on the individual's All Services Plan, and maintained documentation to support the appropriate reimbursement of services. The Provider Oversight Contractor uses the structural review as an opportunity to identify and review violations of rules and to help gain compliance by requiring the provider to submit a correction plan.

Prior to notifying a provider of a pending review, the Provider Oversight Contractor must:

- Verify with the Attorney General’s Medicaid Fraud Control Unit that there is not an open investigation of the provider that is scheduled for review. To determine this, the Provider Oversight Contractor must send a list to the Attorney General’s Medicaid Fraud Control Unit one month prior to contacting the providers about conducting structural review. The Attorney General’s Medicaid Fraud Control Unit will let the Provider Oversight Contractor know of any providers that will not have their structural reviews of because of pending or open investigations. The Provider Oversight Contractor will note the “hold” recommendation in the providers’ file.”
- After the Attorney General’s Medicaid Fraud Control Unit verifies the list, the Provider Oversight Contractor will contact the Case Management Contractor(s) to share the list of providers being reviewed. The Provider Oversight Contractor must ask that the case manager to document any issues in the provider’s structural review file. The Provider Oversight Contractor will need to contact more than one Case Management Contractor if the non-agency provider is providing services to multiple individuals.

Conducting the Structural Review

The Provider Oversight Contractor and Case Management Contractor must work together if questions arise during the structural review that require clarification or information about the All Services Plan, individuals, or issues of health and safety discovered during the review.

Structural reviews must be conducted face-to-face with the provider and the Provider Oversight Contractor. The Provider Oversight Contractor must complete all structural reviews using an Office of Medical Assistance-developed structural review tool. Each provider type is reviewed to determine the provider’s compliance with the requirements outlined in rules 5101:3-45-10, 5101:3-45-06, 5101:3-46-04, and 5101:3-50-04 of the Ohio Administrative Code.

Except for unannounced structural reviews or reviews due to health and welfare issues involving the provider, the provider must be notified at least 14 days in advance of the review. The confirmation of the structural review must be sent to the provider in writing and include a list of documents the provider is required to bring to the structural review.

1. Confirmation must include a mutually acceptable date, time and location for the face-to-face review. The Provider Oversight Contractor must inform the non-agency provider that lack of compliance will lead to his or her removal from the All Services Plans until he or she participates in the structural review process.
2. The Provider Oversight Contractor must contact the non-agency provider by telephone or e-mail to schedule and arrange for the structural review.
3. The Provider Oversight Contractor must then confirm by letter the location, date, time, contact number for the reviewer and include a checklist of items the non-agency provider needs to bring to the structural review. These include:
 - Photo identification such as a driver’s license or a state identification card if the provider does not have a driver’s license.
 - Clinical records for the following individual(s) with review time periods and doctor’s orders (for nursing) with the specified time period requested.

- Billing records/time sheets for the specified time periods.
- All Services Plan for the specified time period.
- Notarized affidavit of tax payment for federal, state, local and employment taxes.
- ***For personal care aides only:*** proof of continuing education that occurred during the required time period.
- ***For Registered Nurses and Licensed Practical Nurses only:*** proof of nursing licensure.

The structural review must include an educational component for the non-agency provider. The Provider Oversight Contractor must share information about violations, changes in the rules, and other timely, important educational items. The non-agency provider must acknowledge the education in writing at the structural review.

The Provider Oversight Contractor must give the provider a copy of this acknowledgement for his or her files and the Provider Oversight Contractor must also file a copy in the non-agency provider's electronic record.

The Provider Oversight Contractor must conduct a unit of service verification to ensure that all waiver services are authorized, delivered and reimbursed in accordance with the individual's approved All Services Plan. The Provider Oversight Contractor reviewer will compare what has been reimbursed to the non-agency provider to validate:

- Services were billed in base and subsequent units according to the All Services Plan; and
- Time sheets and daily clinical documents support the reimbursement of the services.

The Provider Oversight Contractor must address any suspected inappropriate provider payment, including alleged overpayments, in accordance with paragraph (D) of rule 5101:3-46-06. The protocol for suspected inappropriate provider payment referral to Office of Medical Assistance are addressed later in this guide.

The Provider Oversight Contractor reviewer must examine, at least three months of clinical records and supporting documentation per individual on a waiver program for all non-agency providers. The sample percentages for the structural reviews of agency providers must be developed as agreed upon in the contract between the Provider Oversight Contractor and the Office of Medical Assistance. Any records reviewed for the structural review process must be maintained electronically.

The findings of the unit of service verification could result in an expanded review of records. If fraud or overpayment is alleged or suspected, the Provider Oversight Contractor must provide information to the Office of Medical Assistance.

The Provider Oversight Contractor must:

- Determine whether the provider has implemented all actions in their plans of correction. Documentation of this evaluation must be maintained electronically.

- Conduct an exit conference with the non-agency provider, or the agency administrator, to discuss its preliminary findings from the structural review and any follow-up they are required to do. Documentation of the exit conference must be maintained electronically. If the Provider Oversight Contractor determines that the provider has significant program integrity and financial integrity issues, it can recommend Office of Medical Assistance to take further action with the provider.

Protocol for the Suspected Inappropriate Provider Payment

If a provider has been reimbursed for services for which the provider may not have been entitled, the Provider Oversight Contractor must complete an incident report and refer the provider to the proper authority, as follows:

- When found non compliant with the rules and an overpayment is suspected, refer the provider to the Office of Medical Assistance Surveillance, Utilization Review Section.
- When there is an allegation or substantiation that a provider has billed for services not rendered, refer the provider to the Ohio Attorney General's Medicaid Fraud Control Unit.
- Any circumstance in which a provider may have been paid for services without proper authorization from the Case Management Contractor, whether that was a result of the provider's or the Case Management Contractor's failure to ensure proper authorization, refer to the Office of Medical Assistance.
- In any other circumstance in which the provider is suspected to have been reimbursed inappropriately for services, refer the provider to the Office of Medical Assistance: Examples may include, but are not limited to:
 1. Reviewing the All Services Plan for services authorized. If the group modifier is to be used, the All Services Plans of all individuals who are part of the group must be reviewed.
 2. Reviewing billing in the Medicaid Information Technology System to determine dates of services involved.
 3. Obtaining documentation from the provider(s), if possible, about services provided. Compare time sheets with services billed and the All Services Plans.
 4. Determining dates of service and time spans that appear to have been billed in error. This information must include the number of units and amount of services for each date of service and the amount.
 5. Determining the date that the service was last billed for the time spans that have been billed in error. This is the date found on the Medicaid Information Technology System screen for the last date of service billed.
 6. Forwarding documentation to Office of Medical Assistance:

- a. Office of Medical Assistance Referral Summary Sheet (Appendix A, indicating the findings and the amount the provider has potentially overbilled.
- b. Medicaid Information Technology System print-outs, provider documentation, calendars, and any other information that would assist in understanding how the Provider Oversight Contractor determined the amount of the overpayment.

Potential indicators of Medicaid fraud include:

- The individual on a waiver program does not appear to be receiving appropriate care.
- The provider is scheduled to be in the home and is not there.
- The individual on a waiver program, caregiver or the provider, request a significant increase in services when there does not appear to be justifiable changes in the condition or situation of the individual on a waiver.
- The individual on a waiver program is in the hospital or nursing home and it appears the provider billed for services.
- The individual on a waiver program or provider is on vacation and the provider billed when services were not provided.
- An anonymous caller provides a tip.

Provider Non-Compliance

The Provider Oversight Contractor issues a notice to the provider outlining the program compliance violations when the provider:

- Is out of compliance with the program rules and/or policies and procedures; or
- Has an allegation substantiated during an incident investigation.

The notice must:

1. Outline the program rules and/or policies and procedures violated, including the findings from any investigation or structural review;
2. State that the Plan of Correction does not, however, prevent the Office of Medical Assistance from taking further action against the provider, including recouping any overpayment and/or terminating the provider agreement, if warranted;
3. Require the provider to submit a Plan of Correction that addresses all of the violations within 45 calendar days; and
4. Inform the provider that lack of compliance can lead to removal from the individuals' All Services Plan or termination of the provider agreement.

Plans of Correction and Further Sanctions

Accepting a Plan of Correction: If the Provider Oversight Contractor finds the provider's plan of correction has been submitted timely and satisfactorily addresses the findings outlined in the notice of program violations, it will notify the provider in writing that the plan was accepted and must be implemented immediately.

Failing to Submit the Plan of Correction: If the provider fails to submit a plan of correction within the notification's stated time frame, it must notify the provider in writing a second time and direct the provider to submit an original plan of correction within 10 calendar days.

Rejecting the Plan of Correction: If the Provider Oversight Contractor determines that the provider has not satisfactorily addressed the findings outlined in the notice of program violations, it must notify the provider in writing, and require the provider to submit a revised plan of correction within 10 calendar days. The Provider Oversight Contractor must identify the actions that must be included in the revised plan of correction.

When to Refer the Provider to the Office of Medical Assistance

The Provider Oversight Contractor must refer the provider to Office of Medical Assistance in the following circumstances, if the provider:

- Had rule or program violations identified in three or more structural reviews.
- Failed to submit an acceptable plan of correction.
- Failed to follow an accepted plan of correction.
- Failed to obtain physician orders.
- Had an incident substantiated.

The Office of Medical Assistance will determine what, if any, further action will be taken against the provider.

If the Office of Medical Assistance seeks to terminate a provider's Medicaid provider agreement, it will keep the Provider Oversight Contractor informed throughout the process, including provider termination or further action. The Provider Oversight Contractor may be requested to assist with the 119 hearing process when warranted.

Complaint Process

Individuals enrolled on the Office of Medical Assistance-administered waiver programs, service providers, family members, individual advocates, or others involved in the care of the individual, have the right to make formal complaints to, or about, the Provider Oversight Contractor. Individuals can make complaints to the Provider Oversight Contractor itself, the Office of Medical Assistance or to the Case Management Contractor. If a complaint about a case manager is made to the Provider Oversight Contractor, the Provider Oversight Contractor must report it to the Case Management Contractor.

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

Complaints can originate from a face-to-face conversation, phone call, e-mail, Office of Medical Assistance legislative inquiry, the Centers for Medicaid and Medicare Services or other federal office, or regular mail. If the Provider Oversight Contractor is notified by a Case Management Contractor, the Office of Medical Assistance or an Office of Medical Assistance-administered waiver individual, it is required to investigate the complaint and respond to the complainant with resolution.

The Provider Oversight Contractor must use the following protocol for complaints:

1. Categorize complaints, reference the Provider Oversight Contractor department, and determine a resolution type.
2. Send a complaint acknowledgment letter to the complainant within one business day of receiving the complaint. If the Provider Oversight Contractor receives the complaint directly or receives it from the Case Management Contractor, the Provider Oversight Contractor must send an acknowledgement letter on its letterhead. If the Office of Medical Assistance takes the complaint, it will send an acknowledgement letter on the Office of Medical Assistance letterhead. Both letters will acknowledge the complaint, confirm that it will be addressed and state that a resolution is forthcoming.
3. Investigate all complaints within three business days of receipt and record all investigatory notes on the complaint form.
4. Record an action plan in the complaint system and submit it to the Office of Medical Assistance contract manager via email within seven business days of receiving the complaint.
5. Attempt to resolve complaints within 15 calendar days of receipt. Record the resolution on the complaint system.
6. Notify the Office of Medical Assistance of the resolution so that the Office of Medical Assistance can send a follow-up letter to confirm that resolution has taken place within one business day of resolution.
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, the Office of Medical Assistance will re-open the complaint return it to the Provider Oversight Contractor for re-investigation (Step 3) and to proceed through the complaint process again.

Accessing the Office of Medical Assistance's Information Management Systems

In order to fulfill provider oversight functions, the Provider Oversight Contractor must implement a secure **virtual private network connection** in order to have access to state data systems. This must be done in cooperation with Office of Medical Assistance.

The Office of Medical Assistance will provide the Provider Oversight 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 provider oversight/case management system.

The Provider Oversight Contractor must request individual Provider Oversight Contractor staff access through the 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 Provider Oversight 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 must be made in advance. E-mail termination requests to BHCS@jfs.ohio.gov.

Appendix A: Referral Summary Sheet

Office of Medical Assistance Referral Summary Sheet

To: _____
From: _____
Region: 1 2 3 4
Date: _____
RE: Recommendation of Disenrollment of Provider
 Overpayment Referral
 Request for Notice of Operational Deficiency
 Allegation of Medicaid Fraud for Interagency Committee

Summary of Allegation

Name of Provider: _____
Provider #: _____
Provider Address: _____
OAC Rule Violations: _____
Occurrence #: _____
SR Review #: _____
Consumer Name: _____ Billing

Attachments Included for Supporting Documentation

<input type="checkbox"/> ORF	<input type="checkbox"/> All Services Plan
<input type="checkbox"/> MITs Print-outs	<input type="checkbox"/> SR Reports and Plans of Corrections
<input type="checkbox"/> CDL	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Provider Documentation	<input type="checkbox"/> Other: _____

Summary of Evidence to Substantiate Violation

Summary of Billing Information

Does the provider provide services to more than one consumer? Y N
If Y, has provider's billing been reviewed for all consumers? Y N
Amount of money that the provider appears to have been overpaid: \$ _____
Other Billing Information: _____

Other Pertinent Information

Appendix B: 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 an individual, 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.

Major Unusual Incident means the alleged, suspected, or actual occurrence of an incident when there is reason to believe the health or safety of an individual may be adversely affected or an individual may be placed at a reasonable risk of harm as listed in this paragraph, if such individual is receiving services through the developmental disabilities service delivery system or will be receiving such services as a result of the incident. For more details on major unusual incidents, please see Ohio Administrative Code Rule 5123:2-17-02 Incidents adversely affecting health and safety.

Medicaid fraud occurs when a Medicaid provider knowingly makes, or causes to be made, a false or misleading statement or representation for use in obtaining reimbursement from Medicaid. This includes, but is not limited to, billing for services not provided, charging Medicaid more than the reasonable value of the services and providing services that were medically unnecessary.

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

- Contractor Standards and Reporting Requirements
 - Exemplary Performance Awards
 - Office of Medical Assistance Monitoring of Contractor
 - Actual and Liquidated Damages
-

(A) Introduction

This Attachment sets forth standards the Contractor must meet in the provision of the work, the monthly reporting requirements, the exemplary performance awards, the Office of Medical Assistance monitoring of the Contractor, and the actual and liquidated damages that will be assessed for Contractor defaults.

(B) Standards and Reporting Requirements for Structural Reviews, Incident Management and Investigation, Enrollment Process, and the Complaint Process

(1) **Structural Reviews.** The Contractor shall be the Office of Medical Assistance designee to perform provider structural reviews in accordance with Ohio Administrative Code Rule 5101:3-45-06.

(a) **Monthly Monitoring, Data Collection and Reporting.** The Contractor shall monitor, collect data, and report *monthly* on the following provider structural review activities:

- (i) The number of structural reviews due to be completed.
- (ii) The number and percentage of structural reviews that were not completed timely.
- (iii) For each structural review not completed timely, the number of days it was late and the reason it was late.
- (iv) A breakdown of the categories of provider non-compliance and the number of providers that fell under each category.
- (v) The number of sanction requests the Contractor made to the Office of Medical Assistance.
- (vi) The number of plans of correction received from providers.
- (vii) The number of plans of correction that were accepted.
- (viii) The number of plans of correction that were rejected.
- (ix) The training issues identified as a result of structural reviews.

(b) **Additional Data to be Included in the Last Monthly Report of Each Fiscal Year.** The Contractor shall collect the following data and report it to the Office of Medical Assistance:

- (i) The number and percentage of structural reviews for licensed and/or certified providers due for completion during the year that were actually completed. **(The standard is 90 %.)**
- (ii) The number and percentage of structural reviews for non-licensed and/or non-certified providers due for completion during the year that were actually completed. **(The standard is 90 %.)**
- (iii) The number and percentage of providers receiving a structural review who met training standards.
- (iv) The number of providers that were found to be in non-compliance for the same reason as was identified in their prior structural review.

(v) For each of the providers identified in (iv), report the actions taken to address the non-compliance.

Monthly Reporting Requirement. The Contractor shall collect the monthly data regarding structural reviews and report it to the Office of Medical Assistance. The Contractor shall analyze the data to identify any patterns and trends requiring additional technical assistance and/or training of providers and report the results of the analysis to the Office of Medical Assistance. The Contractor shall report to the Office of Medical Assistance its plan for providing the additional technical assistance and training of the providers it determines necessary. In the last monthly report for each fiscal year, the Contractor shall report on the additional data collected pursuant to (b).

(2) **Incident Management and Investigation.** The Contractor shall be the Office of Medical Assistance designee to operate a consumer incident management, investigation and response system (IMIRS) in accordance with Ohio Administrative Code Rule 5101:3-45-05. The Contractor shall monitor, collect data, and report *monthly* on the following activities for each of the waiver programs:

- (a) The number of reportable incidents by incident type.
- (b) The number and percentage of the incidents captured in (i) that were reported within 24 hours.
- (c) For those incidents not reported within 24 hours by case managers, provide the names of the case managers that failed to timely report.
- (d) The number of reportable incidents that were substantiated.
- (e) The number of reportable incidents that were unsubstantiated.
- (f) The number of incidents “yet to be determined.” This number shall be reported in a rolling month-to-month manner.
- (g) The number of investigations conducted in collaboration with other entities.
- (h) The number of certified letter notices sent to providers.
- (i) The number of referrals to other entities.
- (j) The number of sanction requests made by the Contractor to the Office of Medical Assistance.
- (k) The incident rate per 1000 enrolled individuals.

Monthly Reporting Requirement. The Contractor shall collect the monthly data regarding incidents and report it to the Office of Medical Assistance. The Contractor shall analyze the data to identify any patterns and trends regarding incidents and incident reporting and report the results of the analysis to the Office of Medical Assistance. The Contractor shall identify case manager training issues and report those to the Office of Medical Assistance. The Contractor shall identify provider training issues and report them to the Office of Medical Assistance. In regards to provider training issues, the Contractor shall provide a summary of the technical assistance and training that occurred as a result of the identified provider training issues.

(3) **Provider Eligibility Check for Enrollment Process and Re-Enrollment/Revalidation Activities.**

The Contractor shall perform all provider eligibility checks for the enrollment process and re-enrollment/revalidation activities required by Part Six Scope of Work (6.1.1 and 6.1.2) and Attachment Ten – Provider Oversight Guide. The Contractor shall collect the following enrollment and re-enrollment/revalidation-related data and report it *monthly*:

- (a) The number of initial applications completed that were recommended for enrollment.
- (b) The number of initial applications completed that were recommended for denial.
- (c) The number of initial applications incomplete (return to provider (RTP) status) and not processed.
- (d) The number of initial applications that had been placed in RTP status that were never completed.
- (e) The number of initial applications and what percentage was found to be non-compliant with specific reasons for non-compliance.
- (f) The number of re-enrollment/revalidation applications completed.
- (g) The number and percent of initial applications completed within 10 business days from receipt of a complete application. **(The Standard is 90 %.)**
- (h) The number and percent of re-enrollment/revalidation applications completed within 10 business days from receipt of a complete revalidation. **(The Standard is 90 %.)**

Monthly Reporting Requirement: The Contractor shall collect the monthly data regarding enrollment and re-enrollment/revalidation activities and report it to the Office of Medical Assistance. The Contractor shall analyze the data to identify any patterns and trends regarding the types of non-compliance and report the results of the analysis to the Office of Medical Assistance. The Contractor shall report any performance improvement actions taken or technical assistance offered to its staff or providers as a result of the analysis.

(4) **Onsite Visits for Moderate Or High Risk Medicaid Non-Waiver, Non-Medicare-Participating Provider Types Who Are Applying For A Medicaid Provider Agreement Or Are Applying To Be Re-Enrolled.**

The Contractor shall perform all onsite visit activities required by Part Six Scope of Work (6.1.3) and Attachment Ten – Provider Oversight Guide. The Contractor shall collect the following onsite visit-related data and report it *monthly*:

- (a) The number of onsite visits completed by provider type.
- (b) The number and percentage of providers who, as the result of the onsite visit, were determined to have met all requirements.
- (c) The number of onsite visits that resulted in provider non-compliance.

Monthly Reporting Requirement: The Contractor shall collect the monthly data regarding onsite visits and report it to the Office of Medical Assistance. The Contractor shall analyze the data to identify any patterns and trends regarding the reasons for non-compliance based on the onsite visits and report the results of the analysis to the Office of Medical Assistance. The Contractor shall report any performance improvement actions taken or technical assistance offered to its staff or providers as a result of the analysis.

(5) **Complaints Process.** The Contractor shall perform all complaint activities required by Part Six Scope of Work (6.2.8) and Attachment Ten – Provider Oversight Guide.

The Contractor shall collect the following complaint-related data and report it *monthly* for each waiver program:

- (a) The number of complaints received in each complaint category.
- (b) The number of complaints for which the investigations were not started within three business days, and provide the reason for noncompliance. **(The Standard is 90 %.)**

- (c) The number of complaints that were not resolved within 15 calendar days, and provide the reason for noncompliance. **(The Standard is 90 %.)**

Monthly Reporting Requirement: The Contractor shall collect the monthly data regarding complaints and report it to the Office of Medical Assistance. The Contractor shall analyze the data to identify any patterns and trends regarding the types of complaints and report the results of the analysis to the Office of Medical Assistance. The Contractor shall report any performance improvement actions taken or technical assistance offered to its staff or providers as a result of the analysis.

(6) **Staff Roster.** The Contractor must report its current staff roster to the Office of Medical Assistance contract manager on the first business day of the month.

(C) EXEMPLARY PERFORMANCE AWARDS

The Office of Medical Assistance is establishing an exemplary performance award of \$100,000.00 to be paid if the Contractor designs a performance report card program for the non-agency waiver program provider that is approved by the Office of Medical Assistance. An additional exemplary performance award of \$100,000 will be awarded if the Contractor successfully completes implementation of the approved performance report card program for non-agency waiver program providers to the satisfaction of the Office of Medical Assistance. In order to qualify for either of the exemplary performance awards, the Contractor must have met or exceeded all of the Contractor Standards during the three months preceding the award payment.

The Office of Medical Assistance's goal for the performance report card program for non-agency waiver program providers is to create something similar in concept to the Medicare "Nursing Home Compare" and "Physician Compare" programs. More information about those programs can be found using links on the Ohio Department of Aging website. The performance report card program for non-agency waiver program providers should provide information that allows individuals to compare the non-agency waiver program providers' performance in order to assist individuals in selecting a particular non-agency provider. In addition, the program should be designed in a manner that would motivate the non-agency waiver program providers to improve the quality of care they provide, through healthy competition. An element that could be incorporated that could foster healthy competition would be including program participant satisfaction data.

The Office of Medical Assistance is interested in a model that would compare non-agency waiver program providers within a specific geographic region. At a minimum, the non-agency waiver program providers should be identified by name, address, languages spoken, and specialty licenses or certifications achieved. The information needs to be presented in a written format for individuals without access to the internet and in an internet accessible manner.

If any aspects of the designed program require actions by waiver program participants or providers that are not required by existing Ohio Administrative Code rules, the waiver program participants and providers should be asked to voluntarily participate until the Office of Medical Assistance implements Ohio Administrative Code rules requiring the participation.

In the event the Office of Medical Assistance, or the Contractor, gives notice of intent to terminate or not renew this contract, no exemplary performance award monies are available for partially completed work.

(D) Monitoring of the Provider Oversight Contractor:

(1) Targeted Reviews and Notice of Adverse Outcomes – The Office of Medical Assistance may at any time conduct specific targeted reviews of the Contractor for any purpose, and the Contractor will cooperate with any request made by the Office of Medical Assistance. If any 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.

(3) Monitoring of Alerts Process – The Office of Medical Assistance will monitor the Contractor's handling of 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 – Provider Oversight Guide.

(4) Review of Monthly 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.

(5) 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.

(6) 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.

(7) 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.

(8) 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.

(E) Actual and Liquidated Damages

As a result of the monitoring set forth in (D) above, the Office of Medical Assistance may assess actual and liquidated damages for Contractor defaults. Liquidated damages shall be assessed as follows for each Contractor default 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 furnish provider materials to new providers in a timely manner.
- b. A failure to obtain 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 Contractor Standard as set forth in this attachment.

Category Two Liquidated Damages: \$500.00 per failure

- a. A failure to comply with a state hearing and/or administrative appeal decision.
- b. A failure to comply with the resolution of a complaint or adverse outcome.
- c. A failure to assist a provider in a timely manner after request from provider.
- d. A failure to implement a plan of correction.
- e. A failure to conduct required orientation trainings with staff and/or a failure to conduct required annual staff trainings.
- f. A failure to update website provider directories as required monthly.
- g. A failure to comply with HIPAA requirements regarding Protected Health Information or other laws governing the confidentiality of Medicaid records resulting in material harm.
- h. A second consecutive failure to meet a Contractor Standard as set forth in this attachment.

Category Three Liquidated Damages: \$1,000.00 per failure

- a. A failure to maintain the required staff.
- b. A provision of false, inaccurate, or materially misleading information to a health care provider, an individual, or a waiver program applicant.
- c. A misrepresentation or submission of false information to the Office of Medical Assistance.
- d. A failure to promptly communicate with case management agencies to remove providers from all services plans when notified by the Office of Medical Assistance to do so.
- e. A failure to investigate a reportable incident in compliance with the rules.
- f. A failure to initiate investigations of incidents within the prescribed time frames.
- g. A failure to comply with HIPAA requirements regarding Protected Health Information or other laws governing the confidentiality of Medicaid records resulting in substantial harm.
- h. A failure to meet a Contractor Standard as set forth in this attachment 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

ATTACHMENT TWELVE
FOUR REGIONAL AREAS FOR CASE MANAGEMENT CONTRACTOR

