

NOTICE

The following RFP is available for informational purposes and is only part of the entire contract. The entire contract is not available online.

The Contract consists of this RFP, written amendments to this RFP, the Contractor's Proposal, and written, authorized amendments to the Contractor's Proposal. It also includes any materials incorporated by reference in the above documents and any purchase orders and change orders issued under the Contract.

Purchase orders, 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.

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**AMENDMENT #1
FOR
RFP NUMBER 0A04022**

DATE AMENDMENT ISSUED: June 22, 2004

The state of Ohio, through the Department of Administrative Services, Investment and Governance Division, for the Department of Job & Family Services is requesting proposals for a Contractor to provide Case Management for all ODJFS-administered home and community-based services (HCBS) programs.

OPENING DATE:	July 15, 2004
OPENING TIME:	11:00 A.M.
OPENING LOCATION:	Department of Administrative Services IT Governance Division Bid Room 30 East Broad Street, 40th Floor Columbus, Ohio 43215

The attached pages represent the amendment for the Request for Proposal (RFP) listed above. Please use the attached pages to replace the pages previously issued by the state.

Specifications and requirements that have been revised are indicated with asterisks and/or bold type.

Calendar of Events. The schedule for the Work is given below. The State may change this schedule at anytime. If the State changes the schedule before the Proposal due date, it will do so through an alert or announcement on the State Procurement web site at the bottom of the RFP detail page. The Web site alert will be followed by an amendment to this RFP, also available through the State Procurement web site near the bottom of the RFP detail page. After the Proposal due date and before the award of the Contract, the State will make schedule changes through the RFP amendment process. And the State will make changes in the Work schedule after the Contract award through the change order provisions 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.

Dates:

Firm Dates

RFP Issued: June 4, 2004
Inquiry Period Begins: June 4, 2004
Inquiry Period Ends: July 8, 2004
Proposal Due Date: July 15, 2004 at 11:00 a.m. Eastern Standard Time

Pre-Proposal Conference. A Pre-Proposal conference will be held at 10:00 a.m., on June 14, 2004, at the Rhodes Office Tower, Lobby Hearing Room, 30 E. Broad Street, Columbus, Ohio 43215. The purpose of this conference is to discuss the RFP and the Project with prospective offerors and to allow them to ask questions arising from their initial review of this RFP.

Attendance at the pre-Proposal conference is not a prerequisite to submitting a Proposal.

***Estimated Dates**

Issuance of Purchase Order: ~~August 16, 2004~~ **September 3, 2004**
Work Begins: ~~August 23, 2004~~ **September 7, 2004**

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 that the Proposals are due and not just the date.

*Initial Assessment Fee Points = (the lowest proposed average Initial Assessment Fee/the offeror's proposed average Initial Assessment Fee) * C, where C is the total amount of Initial Assessment Fee Points available. The value of C is ~~72~~ **62.7**.

*Caseload Fee Points = (the lowest proposed average Caseload Fee/the offeror's proposed average Caseload Fee) * C, where C is the total amount of Caseload Fee Points available. The value of C is ~~72~~ **62.7**.

*Initial Quality Management Plan Points = (the lowest proposed Initial Quality Management Plan Fee/the offeror's proposed Initial Quality Management Plan Fee) * C, where C is the total amount of Initial Quality Management Plan Points available. The value of C is ~~54~~ **47**.

*Management Reports Points = (the lowest proposed Management Reports Fee/the offeror's proposed Management Reports Fee) * C, where C is the total amount of Management Reports Points available. The value of C is ~~54~~ **47**.

*Monthly Performance Reports Points = (the lowest proposed average Monthly Performance Reports Fee/the offeror's proposed average Monthly Performance Reports Fee) * C, where C is the total amount of Monthly Performance Reports Points available. The value of C is ~~408~~ **93.9**. The average Monthly Performance Reports Fee will be calculated for each offeror by averaging the proposed "Monthly Performance Reports Fee for FY05-09" and the proposed "Monthly Performance Reports Fee with Addition of the Self-Directed Care Waiver Cost".

Total evaluation points will be determined by summing the technical points and the cost points.

Total Evaluation Points = Total Technical Proposal Points
+ Initial Assessment Fee Points
+ Caseload Fee Points
+ Initial Quality Management Plan Points
+ Management Reports Points
+ Monthly Performance Points.

Based on the total "meets" points available, excluding desirable points, the technical proposal evaluation represents 60% of the total points. Cost points represent 40% of the total points available.

One or more of the Proposals will then be selected for further consideration in the next phase of the evaluation process. The Proposal(s) selected to be considered in the next phase always will be the highest-ranking Proposal(s) based on this analysis. That is, the State may not move a lower-ranking Proposal to the next phase unless all Proposals that rank above it are also moved to the next phase, excluding any Proposals that the State disqualifies because of excessive cost or other irregularities. Alternatively, if there are to be no more phases because the State feels they are unnecessary or inappropriate, the highest-ranking Proposal will be awarded the Contract.

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

This RFP 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 mandatory requirement will normally result in a rejection of that offeror's

- **Other clinical functions.** Some of the clinical functions the CMA must complete are as-needed and periodic clinical functions. Current functions include:

- **Managing Core Plus cases.** As stated in Part One of this RFP, ODJFS intends to reengineer this part of the Ohio Home Care program. Until this transformation takes place, the CMA is responsible for managing Core Plus cases as described earlier in the Scope of Work. Core Plus projections and statistical information can be found in Part One of this RFP.

Core Plus program eligibility, enrollment (as applicable), and care coordination/service planning must be completed within ten working days of the initial face-to-face assessment, including the completion of the following activities:

- Obtaining the consumer's or consumer representative's signature on the All Services Plan (ASP).
 - Notifying the applicant of program eligibility or ineligibility and due process rights.
- **Level of care desk reviews for Intermediate Care Facility for Mental Retardation and Developmental Disability (ICFMR/DD) facility placement.** The CMA may be responsible for conducting paper reviews of ICFMR/DD levels of care and making recommendations in accordance with Ohio Administrative Code rule 5101:3-3-153 (<http://onlinedocs.andersonpublishing.com>). All desk reviews must be completed by an RN, LSW, or LISW. An average of eighty-six desk reviews per month is currently performed.

Level of care desk reviews must be completed within five working days of receiving documentation.

***The CMA may be responsible for assessing individuals who have received an adverse determination as a result of the desk review process. The assessments must be performed by a Registered Nurse.**

- **In-person assessments of individuals receiving adverse determinations of Nursing Facility (NF) placement for Intermediate Care Facility for Mental Retardation and Developmental Disability (ICFMR/DD) facility placement.** The CMA may be responsible for assessing individuals for ICFMR/DD facility placement who have received an adverse determination for NF placement as required by rule 5101:3-3-151 (<http://onlinedocs.andersonpublishing.com>) of the Ohio Administrative Code. These assessments must be performed by a Registered Nurse. An average of three to five assessments per month is currently performed.

Assessments must be completed within ten working days from receipt of the assessment request.

Provider Management Functions

- **Operate an Incident Management, Investigation and Response System.** The CMA will act as the ODJFS designee in operating the Incident Management, Investigation and Response System (IMIRS) as outlined in Ohio Administrative Code rule 5101:3-12-29 (see Supplement 5). The system defines Level 1 and Level 2 incidents; the reporting, notification and response requirements; investigation requirements; the process for substantiating incidents; and recommending provider sanctions to ODJFS. The CMA must develop and implement written procedures and guidelines for operating IMIRS as well as internal processes for reviewing and analyzing all Level 1 and Level 2 incidents to identify patterns and/or trends. The guidelines must assist with the analysis of incidents and address the reduction of future actions and/or trends. Upon request by ODJFS, the CMA must provide evidence that this review has been conducted and that appropriate action has been taken.

- Methods for monitoring authorized costs and cost of services delivered for each program, including for each program and ODJFS-specified subgroups (e.g. age, geographic location) minimum, maximum, mean, and median costs for all home care-related services and changes in costs over time.

Payment for this deliverable will be based on ODJFS acceptance of the QMP.

Quarterly Management Report – Management Reports must be submitted to ODJFS quarterly, i.e. no later than 15 calendar days after December 31, March 31, June 30, and September 30. The Management Report's purpose is to summarize performance trends/patterns and their impact on the QMP components. It summarizes 1) how monthly performance results impact the QMP and 2) what actions the CMA plans for continuous improvement of the day-to-day management of the program(s). Specifically, each Management Report must include data supporting the current QMP goals and benchmarks, progress made toward goals and benchmarks, planned quality improvements or corrective actions based on analyzed data, any updated or new goals, and other updates or changes to the QMP. Information must reflect both the CMA statewide and each regional site.

While data from Monthly Performance Reports (as described later in this section) will be summarized for the Management Report, the Management Report is a separate and distinct reporting mechanism and has a broader scope than the Monthly Performance Report. Both types of reports are required to be submitted (including overlapping months of December, March, June, and September) and are paid as separate deliverables.

Payment for this deliverable will be based on ODJFS acceptance of each Management Report.

Monthly Performance Report – Performance Reports, based on an ODJFS-defined format, must be submitted to ODJFS monthly. All reports are due by the 15th calendar day of the following month; the first report must be submitted following the first full month after the Contract is initiated. Each performance report must include data about how well each regional site and the overall CMA (statewide) is meeting key waiver assurances described in the scope of work, including at minimum:

Clinical Management

- results of utilization management program reviews, when applicable during a particular month, meeting accuracy and compliance levels of at least 90% for the first year of the Contract and at least 95% for subsequent years of the Contract
- consumer health and safety – number of consumer incidents, including subcategories (e.g. type of incident, substantiated/unsubstantiated)
- ***results of level of care desk reviews**

Provider Management

- provider monitoring – number of provider occurrences/notices of operational deficiency (NODs) plans of correction, unannounced visits, results of billing reviews, etc.
- provider enrollment - BCII checks and other licensure/certification checks, number of providers enrolled, etc.

Program Management

- maintaining statewide cost neutrality for each program, including analysis of reasons for increases or decreases in median program costs
- results of activities related to upholding consumer rights and increasing consumer participation, including at minimum:
 - consumer satisfaction levels of at least 90% for the first year of the Contract and at least 95% for subsequent years of the Contract

number of adverse actions (i.e. denials and disenrollments) and corresponding percentages of hearing rights notices given for those actions, number of hearings

- o held and the corresponding percentages of decisions sustained or decisions overruled

ODJFS will monitor baseline performance standards throughout the first six months of the Contract. ODJFS reserves the right to set and/or change minimum benchmarks after the first six months of Contractor performance.

Payment for this deliverable will be based on ODJFS acceptance of each monthly performance report (including clinical management, provider management, and program management components).

The Contractor's Fee Structure. The Contractor will invoice ***(or alternately submit billing as described in this section)** and the State will pay for the following tasks/deliverables as described in the Deliverable section of this RFP:

- Initial assessments
- Caseload managed
- Initial Quality Management Plan
- Management Reports
- Monthly Performance Reports

This RFP provides only an estimate of the State's requirements. No guarantee is made of any specific amount to be purchased. The Contractor will be compensated for the actual number of initial assessments performed, the number of cases managed, and the actual number of management reports and monthly performance reports submitted.

After six months of Contractor performance, a payment holdback of 1 percent to 3 percent per region will be applied to the payment of the quarterly management report and/or monthly performance report deliverables if one or more regions are performing below the minimum performance levels. The percentage of holdback will be determined by ODJFS and based on the severity of the deficiency. The holdback amount will be paid upon successful correction of the deficient area(s) in each region.

ODJFS is exploring the possibility of utilizing performance-based rate setting as a contract management tool. This approach would provide ODJFS the ability to increase the monthly performance report rate for maintaining exceptional performance levels in one or more regions. The continuation of the increased rate would depend on the continuation of the exceptional performance. If this concept is pursued, evaluation criteria will be developed within the first year of the Contract and implemented after June 30, 2005. A formal Contract amendment will be executed prior to implementing performance-based rate setting. In addition to monthly performance report results, annual program management review results/findings may be used to evaluate performance for this purpose. An example of a scoring mechanism that might be considered is:

- Level A – region scores between 96 and 100 points – rate increases up to 10%
- Level B – region scores between 90 and 95 points – rate increases up to 5%
- Level C – region scores below 90 points – no rate increase

***For most Initial Assessments and/or all Caseload costs, the Contractor may be required to bill the Medicaid Management Information System (MMIS) following ODJFS billing instructions (<http://emanuals.odjfs.state.oh.us/emanuals/medicaid/BIN>) to receive reimbursement.**

If this alternative method of billing is required, a code will be assigned for the caseload activity and a code will be assigned for the initial assessment activity. The CMA will be informed of these codes during the initial contract implementation period.

Some persons applying for ODJFS-administered programs will not have Medicaid eligibility at the time of their assessments or may be denied Medicaid eligibility as part of the eligibility process. In these situations, the Contractor will not be able to bill MMIS for its assessment. Invoices will be submitted to ODJFS for these costs to be reimbursed.

If billing through MMIS is utilized, ODJFS will provide training and onsite technical assistance to the Contractor in the areas of Medicaid eligibility and billing as part of the initial contract implementation period.

Source of Funding; Third-Party Funding. None.

Reimbursable Expenses. None

Bill to Address. Contractor invoices ***and alternate billing, if required,** must be prepared in accordance with State of Ohio and specific ODJFS invoice ***and billing** submission requirements. ***Invoice and** billing instructions will be provided to the CMA during the initial contract implementation period.

The State will not suspend the Contract 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 Work 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.

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

~~***The Contractor's Project Manager under this Contract will be the person identified on the RFP 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. But the Project Manager may not be replaced without the approval of the State if s/he is identified in the RFP as a key individual on the Project.***~~

Work Responsibilities. The State will be responsible for providing only those things expressly identified, if any, in the RFP. If the State has agreed to provide facilities or equipment, the Contractor, by signing this Contract, warrants that the Contractor has either inspected the facilities and/or equipment or has voluntarily waived an inspection and will work with the equipment and/or facilities on an "as is" basis.

Normal working hours on State property is Monday through Friday (except for State holidays) from 8:00 a.m. to 5:00 p.m., Eastern Standard Time, with a one hour for lunch. The Contractor must plan to work within these time constraints for any Work that will be done on State property.

If the Work, or parts of it, will be performed on the State's property, the State will provide the Contractor with reasonable access to that property.

The Contractor will provide a written report to the Work Representative at least as often as the end of every other week throughout the term of this Contract, or as otherwise provided in the RFP.

Unless otherwise provided in the RFP, the Contractor will be responsible for obtaining all official permits, approvals, and similar authorizations required by any local, state, or Federal agency for the Work.

Changes. The State may make reasonable changes, within the general scope of the Project, in any one or more of the following: (I) Project tasks or subtasks; (ii) time or place of delivery; or (iii) period of performance. The State will do so by issuing a written order under this Contract describing the nature of the change ("Change Order"). Additionally, if the State provides directions or makes requests of the Contractor without a change order, and the Contractor reasonably believes the directions or requests are outside the specifications for the Project, the Contractor will have the right to request a Change Order from the State. Scope of work changes will be managed as follows: pricing will be provided from the Contractor to the State. The State

REQUEST FOR PROPOSALS

RFP NUMBER: 0A04022
DATE ISSUED: June 4, 2004

The state of Ohio, through the Department of Administrative Services, Investment and Governance Division, for the Department of Job & Family Services is requesting proposals for a Contractor to provide Case Management for all ODJFS-administered home and community-based services (HCBS) programs.

INQUIRY PERIOD BEGINS: June 4, 2004
INQUIRY PERIOD ENDS: July 8, 2004
OPENING DATE: July 15, 2004
OPENING TIME: 11:00 A.M.
OPENING LOCATION: Department of Administrative Services
Acquisition Management Bid Room
30 East Broad Street, 40th Floor
Columbus, Ohio 43215

CONFERENCE DATE: June 14, 2004
CONFERENCE TIME: 10:00 A.M.
CONFERENCE LOCATION: Lobby Hearing Room
Rhodes Office Tower
30 E. Broad Street
Columbus, Ohio 43215

This RFP consists of five (5) Parts and nine (9) Attachments, totaling 132 consecutively numbered pages. Supplements may be attached to the RFP with a beginning header page and an ending trailer page. Please verify that you have a complete copy.

PART ONE: EXECUTIVE SUMMARY

Purpose. This is a Request for Competitive Sealed Proposals (RFP) under Section 125.071 of the Ohio Revised Code (the Code) and Section 123:5-1-8 of the Ohio Administrative Code (the Administrative Code). The Ohio Department of Job & Family Services (ODJFS) has asked the Department of Administrative Services (DAS) to solicit competitive sealed proposals (Proposals) for home and community-based services case management (Work) and this RFP is in response to 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 (the Contractor) perform all or part of the Work. This RFP provides details on what is required to submit a Proposal for the Work, how the State will evaluate the Proposals and what will be required of the Contractor in performing the Work.

Except where necessary to refer specifically to the Bureau of Home and Community Services (BHCS) or Office of Ohio Health Plans (OHP) for accuracy or clarification, ODJFS will be used throughout this RFP to refer to BHCS, OHP, and ODJFS.

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

Once awarded, the term of this Contract will be in effect until June 30, 2005. The State may renew the Contract after June 30, 2005 and for two (2) optional biennia by giving written notice to the Contractor before June 30, of the second year of the current term. The State may renew all or part of this Contract subject to the satisfactory performance of the Contractor and the needs of ODJFS. The State *intends* to renew the Contract for the biennium beginning July 1, 2005 and *may* renew for the biennium beginning July 1, 2007. The Contract term including renewals may not go beyond June 30, 2009.

The continuation of federal Medicaid funding is dependent on federal approval of the State Medicaid plan and all pertinent HCBS waiver applications, as well as maintenance of cost-neutrality under all pertinent HCBS waiver programs.

Any failure to meet a deadline in the submission or evaluation phases and any objection to the dates for performance in the Work phase may result in the State refusing to consider the Proposal of the offeror.

Background. In 1998, the ODJFS, Bureau of Home and Community Services, formerly known as the Bureau of Community Long Term Care Services, initiated an integrated program of Medicaid home care services known as the Ohio Home Care Program. The program was designed to be a consumer and provider friendly way to address the specific home care needs of consumers within a continuum of services.

The Ohio Home Care Program currently consists of three benefit packages: Core, Core Plus, and ODJFS-administered waivers, each of which includes "core" services of nursing, daily living, and skilled therapy. The waiver benefit package meets the needs of consumers whose medical condition and/or functional abilities would otherwise require them to live in a nursing facility or other type of institution. The Ohio Home Care Waiver was originally intended to serve children and adults with disabilities or medically fragile conditions. However, prior to its implementation, the waiver's purpose was broadened to address capacity limitations of other delivery systems (e.g. Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) waiting list, and the Pre-Admission Screening System Providing Options and Resources Today (PASSPORT's) cost cap).

The federal Centers for Medicare and Medicaid Services (CMS) conducted its three-year waiver review of the Ohio Home Care Waiver beginning in 2001. CMS advised ODJFS that consumers

who require services for MR (Mental Retardation) or DD (Developmental Disability) needs not be served on the same waiver as those with a skilled or an intermediate level of care. In addition, an amended rule clarifying criteria for determining an ICF-MRDD (Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled) level of care became effective November 1, 2001. A new no growth waiver, the Transitions Waiver, was implemented in 2002 as a result of these two changes which affected Ohio Home Care Waiver program eligibility. Affected consumers were then transferred from the Ohio Home Care Waiver to the Transitions Waiver.

Other findings from CMS' review, coupled with unsustainable utilization growth of the Core Plus and Ohio Home Care Waiver benefit packages, have prompted additional redesign of the Ohio Home Care Program. The goals of the redesign are to:

- **Better target the needs of consumers;**
- **Control cost growth; and**
- **Meet federal cost-neutrality requirements.**

Staff from the Bureau of Home and Community Services conducted a series of Home Care Forums throughout Ohio during the summer of 2003. Several preliminary redesign proposals were discussed with consumers, providers, and other key stakeholders. As a result of many insightful comments and suggestions from the forum participants, those redesign proposals have been modified to incorporate consumer demand for greater flexibility and self-direction while pursuing the original redesign goals. ODJFS' redesign of Ohio Home Care includes several key components. Among them are:

- Renewal of the Ohio Home Care Waiver effective through June 30, 2006. This allows the program to continue as-is while other programmatic changes are developed. Additional waiver slots as approved in the State's biennial budget have been added to this waiver.
- Reengineering of Ohio's Core Plus benefit package (Medicaid state plan home health aide, nursing and skilled therapies) provided to people who need more than 14 hours of service per week. As a precursor to this, ODJFS will also work with sister agencies to determine the number of affected consumers receiving Core services, as well as services through the MR/DD and Aging systems, and how these consumers will continue to receive such services. The department will also be ready to fold adults and children with an institutional level of care into the appropriate waiver, requiring amendment of the Ohio Home Care and Transitions waivers to seek additional slots to accommodate this change.
- Creation and staggered implementation of three new waivers:
 - A Self-Directed Care Waiver to serve persons with either a nursing facility or hospital level of care. (See related information about consumer self-direction and application of a cash and counseling grant described below.)
 - A Community Resources Waiver to serve medium cost, high need consumers with either a nursing facility or a hospital level of care
 - A Subacute Community Waiver to serve high cost, high needs consumers with a hospital level of care.
- Expansion of the concept of consumer choice in ODJFS-administrated waivers, and introduction of a person-centered, self-directed care waiver. On March 31, 2004, ODJFS submitted an application to the Robert Wood Johnson Foundation for a cash and counseling grant. The cash and counseling grant, if awarded, will serve a minimum of 400 to 700 consumers in an 1115 Independence Plus waiver over a three-year period. Cash and counseling permits consumers to manage a flexible monthly allowance to pay for waiver

services and disability-related goods and services. ODJFS is exploring programmatic and technological enhancements that make Ohio unique, i.e. smartcards. If funded, the cash and counseling demonstration grant will be used in conjunction with the ODJFS self-directed care waiver, encompassing the principles of individualized budgets and supports brokerage, which will be CMA responsibilities and are described later in this RFP.

- Implementation of clinical protocols across all waivers that will strengthen and improve case management and care planning activities, enable the best use of appropriate formal consumer supports, and maximize the use of appropriate informal consumer supports. Protocols will be tailored to each ODJFS waiver, and at a minimum, will include specific case manager qualifications, caseload ratios and expectations for frequency of consumer contact.
- Implementation of an expanded quality management plan that defines continuous quality improvement activities for provider monitoring, and imposes annual criminal records checks for all independent providers of waiver services.
- Implementation of a higher standard of waiver eligibility than we currently have in the Ohio Home Care and Transitions waivers, i.e., requiring specific degrees of functional disabilities, and hands-on assistance with activities of daily living (ADLs).
- Commitment to the concept that consumers will be assigned monthly individual cost ceilings that are consistent with their needs, as identified through an individual assessment, and that assignment of the maximum monthly cost ceiling associated with their particular waiver is not automatic but rather an infrequent occurrence.

See Supplement 2 for a complete summary of the proposed Ohio Home Care Program redesign key components, including proposed implementation timeframes.

The Bureau of Home and Community Services also manages the Ohio Access Success Project. This project, funded through a combination of federal grant and state general revenue funds, expands Ohio's capacity to serve more long term care consumers in the community by identifying individuals living in a nursing facility who desire to live in a community-based setting and who can do so with linkages to community services and supports. The project provides qualified nursing facility residents with assistance in making plans for relocation from the facility to a community-based setting, assistance with linkages to needed supports and services, and one-time funding of up to \$2,000 to assist with relocation expenses. These expenses may include, but are not limited to, rental deposits, utility deposits, home modifications, and household goods.

ODJFS has contracted with Easter Seals of Central and Southeastern Ohio to develop and test the Ohio Access Success Program transition protocols. Easter Seals will design and implement a program for individuals to successfully relocate from a nursing facility to a community setting, including the support needed to assist the consumer in making informed decisions regarding care setting and services needed. Initial transition opportunities will be available in a four-county area in the state. It is anticipated that the program will move toward statewide implementation by the end of 2004.

As the project is implemented, participating individuals will be linked to needed services and supports in their community, which may include Medicaid-funded waiver services. Ohio Access Success Project participants are likely to interface with other ODJFS-administered HCBS program activities as they move from the nursing facility to a community-based setting, and if they qualify for Medicaid-funded waiver services.

ODJFS Monitoring and Oversight. ODJFS will continually monitor the quality of the Contractor's performance. A variety of monitoring and oversight methods will be utilized, including but not limited to:

- Review of Contractor deliverables
- Periodic and annual site reviews
- Quality assurance reviews
- Consumer satisfaction surveys and focus groups
- Performance standards
- Observation

When the Contractor fails to meet federal or state program requirements, Contract deliverables, or performance standards for work requirements in Part One of this RFP, ODJFS will notify the Contractor of performance deficiencies. In response to the notification, the Contractor will be required to submit a plan of correction to ODJFS describing actions that will be taken to correct deficiencies, including dates for actions to be completed. Notifications may result in the imposition of progressive corrective measures, including but not limited to:

- Meeting with ODJFS to identify problems and develop a program of additional training and technical assistance in order to meet the program requirement, contract deliverable, or performance standard.
- Referral to any regulatory agency charged with investigating specific complaints and/or situations.
- Withholding part or all of a Contractor's fees until a program requirement, contract deliverable, or performance standard is met. This may occur along with other corrective measures.
- Assigning part or all of the CMA's caseload to ODJFS or another available ODJFS contractor until a program requirement, contract deliverable, or performance standard is met. This may occur along with other measures.
- Imposing actual or liquidated damages. The State will have the option of collecting actual direct or liquidated damages from the Contractor for any default. For each instance of default, the State will provide the Contractor with estimates of the actual direct damages sustained due to the default. If the actual direct damages cannot be determined due to the nature of the default, the State may determine liquidated damages. Liquidated damages may not exceed 10 percent of the cost of the Contract for the fiscal year in which the default occurs. Events of default include, but are not limited to, the following:
 - Failure by Contractor to complete clinical and provider management functions described in the Scope of Work, including completion within specified timeframes.
 - Failure by Contractor to produce and deliver the initial Quality Management Plan, quarterly management reports, and/or monthly performance reports described in the Deliverables, including submittal within specified timeframes.
 - Failure by Contractor to adhere to all state and federal rules and program requirements.
- Termination of the contract.

During the first six months of the contract and during continuing periods of deficient performance, ODJFS will increase its frequency of monitoring and oversight as needed.

The State reserves the right to implement the Suspension and Termination language at any point in this process.

Initial Contract Implementation Period. It is ODJFS' intent to facilitate a successful transition from the existing contract to the new contract, and to 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. ODJFS will provide a variety of implementation support, including but not limited to:

- Orientation sessions for Contractor management and staff

- Expectations for transfer of current case records and case consultation
- Program redesign overview and updates
- Case management training curricula and competency testing guidelines
- User guidance for ODJFS systems
- Reporting guidelines
- Billing instructions
- Current and proposed rules and program requirements/guidelines
- Current case management tools

Beyond the initial implementation period, ODJFS staff will be available for as-needed technical assistance and will provide as-needed program guidance letters.

Contractor Limitations. The Contractor or any of its subcontractors may not provide direct home health or home and community-based waiver services to any consumers enrolled in ODJFS-administered HCBS programs throughout the entire term of the contract.

Overview of the Scope of Work. The scope of work for the Project is provided in an attachment to this RFP. This section only gives a summary of that work. If there is any inconsistency between this summary and the attachment's description of the work, the attachment will govern.

The State is releasing this RFP for the purpose of identifying an offeror to provide Case Management for all ODJFS-administered home and community-based services programs. The Contractor will manage a statewide process that affords eligible consumers access to quality services in the community as an alternative to long-term care facilities or hospitals. The case management process includes screening of referrals, intake, assessment, care coordination and individualized care planning, program eligibility determination, ongoing monitoring of the appropriateness of services and the health and safety of the consumer, consumer and caregiver education and support, and managing cost caps assigned to each individual to assure program cost neutrality. The Contractor will also recruit, screen, and coordinate the enrollment of qualified providers to furnish home and community-based services, monitor their service delivery, and manage a consumer and provider incident reporting system.

ODJFS is seeking offerors who are experienced in providing community long-term care case management services to children, adults, and seniors with disabilities, who are chronically ill or who have medically complex conditions. ODJFS will select one offeror with the documented capacity to provide statewide coverage by means of at least four locations to fulfill the requirements of this RFP and the resulting Contract.

As the single state Medicaid agency, ODJFS has oversight responsibility for all home and community-based services programs which utilize Medicaid as a source of funding. The Office of Ohio Health Plans (OHP), Bureau of Home and Community Services (BHCS), which will administer the Contract, is responsible for state level supervision and oversight of ODJFS-administered home and community-based programs. As its organizational mission, BHCS designs, implements, and manages high-quality, cost-effective and accessible home and community programs for individuals with disabilities.

The role of the Contractor (the Case Management Agency) is to assist in the implementation and management of these programs throughout the state, interfacing with consumers at the local level. The Contractor's responsibilities will include, but not be limited to clinical functions (including periodic or as-needed clinical functions), provider management functions, and program management functions.

It is anticipated that 10,000 consumers will be served by the various ODJFS-administered home and community-based service waivers in State Fiscal Year (SFY) 05. Waivers are described in Supplement 2 and in the Ohio Administrative Code Chapter 5101: 3-12

(<http://onlinedocs.andersonpublishing.com>). This total includes approximately 2,600 consumers served by the Transitions Waiver. Potentially, an additional 600 participants will be served in each subsequent SFY of the Contract. Consumers are located throughout Ohio's 88 counties, with the highest proportions in major urban counties (Cuyahoga 12%, Franklin 11%, Summit 5%, Hamilton 4%, and Montgomery 4%). Approximately 32% of consumers are under the age of 22, 59% of consumers are between the ages of 22 and 59 years old, and 9% of consumers are 60 years of age or older. Consumers have diverse conditions and a range of acuity levels. Excluding the Transitions Waiver caseload, ODJFS projects the caseload distribution to the proposed new waivers in Calendar Year (CY) 05 will be approximately 57% to either the Self-Directed Care Waiver or Community Resource Waiver, 5% to the Subacute Community Waiver, and 38% to the existing Ohio Home Care Waiver.

It is anticipated that approximately 1,500 consumers will be served by the Core Plus benefit package in SFY 05. Core Plus consumers are located throughout Ohio's 88 counties, with the highest proportions in major urban counties (Franklin 21%, Cuyahoga 16%, Summit 7%, Hamilton 4%, and Lucas 4%). Approximately 44% of consumers are under the age of 22, 42% of consumers are between the ages of 22 and 59 years old, and 14% of consumers are 60 years of age or older.

Currently, 4,200 aides/non-aides and 2,929 registered nurses (RNs)/licensed practical nurses (LPNs) are enrolled as independent providers for ODJFS-administered home and community-based programs. Of these enrolled providers, more than 3,000 aides/non-aides and 1,100 RNs/LPNs submit claims during a given quarter. Approximately 375 home health agencies and 100 ancillary providers (e.g. adult day care, emergency response service, minor home modification) serve consumers on ODJFS-administered home and community-based programs.

Objectives. States are required to provide satisfactory assurances to the CMS for approved HCBS waivers. States are also required to address assurances in new HCBS waiver requests. CMS reviews state waiver programs, confirming evidence that the assurances are present and documented. Go to <http://www.cms.hhs.gov/medicaid/waivers> for further information about CMS waiver review protocols and <http://www.gpoaccess.gov/cfr> for the Code of Federal Regulations (CFR) section 441.302, which describes state assurance requirements.

As an organization, ODJFS' mission is to help Ohioans improve the quality of their lives. Through the Office of Ohio Health Plans, this mission is supported by the coverage of high quality, cost effective, accessible health care and related services. At a bureau level, this mission is further focused toward the quality of HCBS programs. Go to <http://jfs.ohio.gov/0000AboutUs.stm> and <http://jfs.ohio.gov/ohp/aboutus.stm> for further information about ODJFS Organizational Structure and Strategic Planning. Departmental plans support Ohio's Strategic Plan to Improve Long-Term Services and Supports for People with Disabilities (<http://www.ohioaccess.ohio.gov>).

To help meet its mission, BHCS utilizes CMS' HCBS quality framework (<http://www.cms.hhs.gov/medicaid/waivers/quality.asp>) which focuses attention on the following areas and outcomes:

- **Participant Access** – Individuals have ready access to home and community-based services and supports in their communities;
- **Participant-Centered Service Planning and Delivery** – Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community;
- **Provider Capacity and Capabilities** – There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants;

- **Participant Safeguards** – Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices;
- **Participant Rights and Responsibilities** – Participants receive support to exercise their rights and in accepting personal responsibilities;
- **Participant Outcomes and Satisfaction** – Participants are satisfied with their services and achieve desired outcomes; and
- **System Performance** – The system supports participants efficiently and effectively, and constantly strives to improve quality.

Both the waiver assurances and quality framework include important elements and are fundamental to quality management efforts in BHCS. The Contractor is expected to apply these elements to its quality management activities and quality management plans.

Calendar of Events. The schedule for the Work is given below. The State may change this schedule at anytime. If the State changes the schedule before the Proposal due date, it will do so through an alert or announcement on the State Procurement web site at the bottom of the RFP detail page. The Web site alert will be followed by an amendment to this RFP, also available through the State Procurement web site near the bottom of the RFP detail page. After the Proposal due date and before the award of the Contract, the State will make schedule changes through the RFP amendment process. And the State will make changes in the Work schedule after the Contract award through the change order provisions 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.

Dates:

Firm Dates

RFP Issued:	June 4, 2004
Inquiry Period Begins:	June 4, 2004
Inquiry Period Ends:	July 8, 2004
Proposal Due Date:	July 15, 2004 at 11:00 a.m. Eastern Standard Time

Pre-Proposal Conference. A Pre-Proposal conference will be held at 10:00 a.m., on June 14, 2004, at the Rhodes Office Tower, Lobby Hearing Room, 30 E. Broad Street, Columbus, Ohio 43215. The purpose of this conference is to discuss the RFP and the Project with prospective offerors and to allow them to ask questions arising from their initial review of this RFP.

Attendance at the pre-Proposal conference is not a prerequisite to submitting a Proposal.

Estimated Dates

Issuance of Purchase Order:	August 16, 2004
Work Begins:	August 23, 2004

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 that the Proposals are due and not just the date.

PART TWO: STRUCTURE OF THIS RFP

Organization. This RFP is organized into five (5) parts, nine (9) attachments and eight (8) supplements. The parts, attachments and supplements are listed below:

Parts:

Part 1	Executive Summary
Part 2	Structure of this RFP
Part 3	General Instructions
Part 4	Evaluation of Proposals
Part 5	Contract Award

Attachments:

Attachment 1	Work Requirements and Special Provisions
Attachment 2	Requirements for Proposals
Attachment 3	General Terms and Conditions
Attachment 4	Sample Contract
Attachment 5	Contract Performance
Attachment 6(A)	Offeror Profile
Attachment 6(B)	Organizational Experience Requirements
Attachment 7	Personnel Profile
Attachment 8	Staffing Matrix
Attachment 9	Cost Summary

Supplement:

Supplement:

Supplement 1	W-9 Form
Supplement 2	Ohio Home Care Redesign Summary
Supplement 3	BHCS Program Eligibility Assessment Tool
Supplement 4	BHCS All Services Plan
Supplement 5	Proposed Ohio Administrative Code Additions: <ul style="list-style-type: none">• 5101:3-12-25Criminal records checks involving agency-employed providers• 5101:3-12-26Criminal records checks involving independent providers• 5101:3-12-28Enrollment process for ODJFS-administered waiver service providers• 5101:3-12-29Consumer incident reporting• 5101:3-12-30Monitoring under ODJFS-administered HCBS waivers• 5101:3-12-35Non-medicaid Ohio access success project
Supplement 6	DAS Information Technology Policy F.35
Supplement 7	ODJFS Information Security Code of Responsibility Form
Supplement 8	BHCS MCATS Documents: <ul style="list-style-type: none">▪ MCATS Vision Document▪ MCATS Minimum System Specifications

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.

Contacts. The following person will represent the State during the RFP process:

Procurement Representative: Valerie Piccininni, Administrative Assistant
Department of Administrative Services
30 East Broad Street, 39th Floor
Columbus, Ohio 43215

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

Internet 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:

- Access the State Procurement Web site at <http://www.ohio.gov/procure>;
- From the Navigation Bar on the left, select "Find it Fast";
- Select "Doc/Bid/Schedule #" as the Type;
- Enter the RFP Number found on Page 1 of the document (RFP Numbers begin with zero followed by the letter "A");
- Click the "Find It Fast" button;
- On the document information page, click the "Submit Inquiry" button;
- On the document inquiry page, complete the required "Personal Information" section by providing:
 - First and last name of the prospective offeror's representative who is responsible for the inquiry,
 - Name of the prospective offeror,
 - Representative's business phone number and
 - Representative's e-mail address;
- Type the inquiry in the space provided including:
 - A reference to the relevant part of this RFP,
 - The heading for the provision under question and
 - The page number of the RFP where the provision can be found; and
- 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. 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 using the following process:

- Access the State Procurement Web site at <http://www.ohio.gov/procure>;
- From the Navigation Bar on the left, select "Find it Fast";
- Select "Doc/Bid/Schedule #" as the Type;
- Enter the RFP Number found on Page 1 of the document (RFP Numbers begin with zero followed by the letter "A");
- Click the "Find It Fast" button;
- On the document information page, click the "View Q & A" button to display all inquiries with responses submitted to date.

The State will try to respond to all inquiries within 48 hours, excluding weekends and State holidays. But the State will not respond to any inquiries received after 8:00 a.m. on the inquiry end date.

Amendments to the RFP. If the State decides to revise this RFP before the Proposal due date, amendments will be announced on the State Procurement Web site.

Offerors may view amendments using the following process:

- Access the State Procurement Web site at <http://www.ohio.gov/procure>;
- From the Navigation Bar on the left, select "Find it Fast";
- Select "Doc/Bid/Schedule #" as the Type;
- Enter the RFP Number found on Page 1 of the document (RFP Numbers begin with zero followed by the letter "A");
- Click the "Find It Fast" button;
- On the document information page, click on the amendment number to display the amendment.

After the submission of Proposals, amendments will be distributed only to those offerors whose submissions are under active consideration. When the State makes an amendment to the RFP after Proposals have been submitted, the State will permit offerors to withdraw their Proposals within ten business days after the amendment is issued. This withdrawal option will allow any offeror to remove its Proposal from active consideration should the offeror feel that the amendment changes the nature of the transaction so much that the offeror's Proposal is no longer in its interests. Alternatively, the State may allow offerors that have Proposals under active consideration to modify their Proposals in response to the amendment, as described below.

Whenever the State makes an amendment after the Proposal due date, the State will tell all offerors whose Proposals are under active consideration whether they have the option to modify their Proposals in response to the amendment. Any time the State amends the RFP after the Proposal due date, an offeror will have the option to withdraw its Proposal even if the State permits modifications to the Proposals. If the offerors are allowed to modify their Proposals, the State may limit the nature and scope of the modifications. Unless otherwise stated in the State's notice, modifications and withdrawals must be made in writing and must be submitted within ten (10) business days after the amendment 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 the State at the address and in the same manner required for the submission of the original Proposals. Any modification that is broader in scope than the State has authorized may be rejected and treated as a withdrawal of the offeror's Proposal.

When an amendment to this RFP is necessary, the State may extend the Proposal due date through an announcement on Acquisition Management's Web site question and answer area for this RFP. Amendment 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.

Proposal Submittal. Each offeror must submit 9 complete, sealed and signed copies of its Proposal and each Proposal must be clearly marked "Case Management RFP" on the outside of its envelope. The offeror must also submit 2 copies of the proposal on CD-ROM in Microsoft® Word 2000, Microsoft® Excel 2000, or MS Project, as appropriate. In the event that 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, Thursday, July 15, 2004 at 11:00 a.m., Eastern Standard Time. Proposals must be submitted to:

Acquisition Management Bid Room
30 East Broad Street, 40th Floor
Columbus, Ohio 43215

The State may reject any Proposals or unsolicited Proposal amendments that are received after the deadline. An offeror that mails its Proposal must allow for adequate mailing time to ensure its timely receipt.

Offerors must also allow for potential delays due to increased security. The State may 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.

Ohio Revised Code (ORC) Section 9.24 prohibits the State 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, offeror warrants that it is not now, and will not become subject to an “unresolved” finding for recovery under ORC 9.24, prior to the award of a Contract arising out of this RFP, without notifying DAS of such finding.

By submitting a Proposal, the offeror acknowledges that it has read this RFP, understands it and agrees to be bound by its requirements. The State 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 this RFP.

The State 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. The State may also reject any Proposal that it believes is not in its interests to accept and may decide not to do business with any of the offerors responding to this RFP.

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 Contract has been awarded.

The State will retain all Proposals, or a copy of them, as part of the contract file for at least three years. After the retention period, the State may return, destroy, or otherwise dispose of the Proposals or the copies.

Waiver of Defects. The State has the right to waive any defects in any Proposal or in the submission process followed by an offeror. But the State will only do so if it believes that is in the State’s interests and will not cause any material unfairness to other offerors.

Multiple or Alternate Proposals. The State accepts multiple Proposals from a single offeror, but the State requires each such Proposal to be submitted separately from every other Proposal the offeror makes. Additionally, the offeror must treat every Proposal submitted as a separate and distinct submission and include in each Proposal all materials, information, documentation and other items this RFP requires for a Proposal to be complete and acceptable. No alternate Proposal may incorporate materials from another Proposal made by the offeror or refer to another Proposal. The State will judge each alternate Proposal on its own merits.

Amendments to Proposals. Amendments or withdrawals of Proposals will be allowed only if the amendment or withdrawal is received before the Proposal due date. No amendment or withdrawals will be permitted after the due date, except as expressly authorized by this RFP.

Proposal Instructions. Each Proposal must be organized in an indexed binder ordered in the same manner as the response items are ordered in the applicable attachment(s) to this RFP.

The State wants clear and concise Proposals. But offerors should take care to completely answer questions and meet the RFP's requirements.

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

The State will not be liable for any costs incurred by any offeror in responding to this RFP, even if the State does not award a Contract through this process. The State may decide not to award a Contract for the Work. It may also cancel this RFP and contract for the Work through some other process or by issuing another RFP.

Protest Procedure. Offerors may file protests related to this RFP under the following guidelines:

- A. The protest shall be in writing and shall contain the following information:
 - 1. The name, address, and telephone number of the protestor;
 - 2. The name and number of the RFP being protested;
 - 3. A detailed statement of the legal and factual grounds for the protest, including copies of any relevant documents;
 - 4. A request for a ruling by the State; and
 - 5. Any other information the protestor believes to be essential to the determination of the factual and legal questions at issue in the written protest.

- B. All protests must be filed at the following location:

Deputy State Chief Information Officer
Investment and Governance Division
Office of Information Technology
Ohio Department of Administrative Services
30 East Broad Street, 39th Floor
Columbus, Ohio 43215

- C. The Deputy State Chief Information Officer shall issue written decisions on all protests.

PART FOUR: EVALUATION OF PROPOSALS

Disclosure of Proposal Contents. The State will seek to open the Proposals in a manner that avoids disclosing their contents. Additionally, the State will seek to keep the contents of all Proposals confidential until the Contract is awarded. The State will also prepare a registry of Proposals containing the name and address of each offeror. The registry will be open for public inspection after the Proposals are opened.

Rejection of Proposals. The State may reject any Proposal that is not in the required format, does not address all the requirements of this RFP, or that the State believes is excessive in price or otherwise not in its interests to consider or to accept. In addition, the State may cancel this RFP, reject all the Proposals and seek to do the Work through a new RFP or other means.

Evaluation of Proposals Generally. The evaluation process may consist of up to four distinct phases:

1. The Procurement Representative's Initial Review of all Proposals for Defects;
2. The Evaluation Committee's Evaluation of the Proposals;
3. Request for More Information (Interviews, Presentations, Demonstrations and/or Site Visits); and
4. Negotiations.

It is within the purview of the evaluation committee to decide whether phases three and four are necessary. But the committee has the right to eliminate or add phases three and/or four or add or remove sub-phases to phases two through four at anytime if the committee believes doing so will improve the evaluation process.

Clarifications & Corrections. During the evaluation process, the State may request clarifications from any offeror under active consideration and may give any offeror the opportunity to correct defects in its Proposal if the State believes doing so does not result in an unfair advantage for the offeror and it is in the State's interests.

Reference Checks. The State may conduct reference checks to verify and validate the offeror 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.

Initial Review. The Procurement Representative will review all Proposals for their format and completeness. The State will normally reject any incomplete or incorrectly formatted Proposal, though the State may elect to waive any defects or allow an offeror to submit a correction.

If the Auditor of State does not certify a proposal due to lateness, the Procurement Representative will not open it or evaluate it for format or completeness.

The Procurement Representative will forward all timely, complete and properly formatted Proposals to an evaluation committee, which the Procurement Representative will chair.

Committee Review of the Proposals. The evaluation committee will evaluate and numerically score each Proposal that the Procurement Representative has forwarded to it. 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 the committee has a right to break these criteria into components and weight any components of a criterion according to their perceived importance.

The State may also have the Proposals or portions of them reviewed and evaluated by independent third parties (e.g. Ohio’s Olmstead Task Force) or other State personnel with technical or professional experience that relates to the Work or to a criterion in the evaluation process. The State may also seek reviews of end users of the Work or the advice or evaluations of other State committees that have subject matter expertise or an interest in the Work. In seeking such reviews, evaluations and advice, the State will first decide, in writing, how to incorporate the results in the numerical scoring of the Proposals. The State may adopt or reject any recommendations it receives from such reviews and evaluations.

The evaluation will result in a point total being calculated for each Proposal. Those offerors submitting the highest rated Proposals may be scheduled for the next phase. The number of Proposals forwarded to the next phase will be within the State’s discretion, but regardless of the number of Proposals selected for the next phase, they will always be the highest rated Proposals from this phase.

At any time during this phase, the State may ask an offeror to correct, revise, or clarify any portions of its Proposal.

The State 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.

Proposal Evaluation Criteria. In the Proposal evaluation phase, the committee will rate the Proposals submitted in response to this RFP based on the following criteria and weight assigned to each criterion:

Criteria	Weight	Does Not Meet	Meets	Exceeds
Organization with at least 60 months experience serving the disability community in the past ten years OR Case management organization that has at least 60 months experience managing home and community-based services programs in the past ten years		Reject	Accept	
Offeror Profile	1	0	5	7
Organizational Experience Requirements				
Organization with at least 60 months experience serving the disability community in the past ten years OR Case management organization that has at least 60 months experience managing home and community-based services programs in the past ten years	3	0	5	7
Three examples of alliance-building activities with consumer and advocacy groups and diverse stakeholders	3	0	5	7
Description of capacity to provide a diverse and experienced workforce to meet the needs of all populations served by ODJFS-administered HCBS programs, including, but not limited to geriatrics, pediatrics, mental health and MRDD	2	0	5	7

At least 24 months experience in maintaining participant service costs within constraints set by third-party payers	3	0	5	7
Understanding of long-term care, community care and disability issues	2	0	5	7
Commitment to the CMS HCBS Quality Framework	2	0	5	7
Desirable Requirements				
Not-for-profit organization	1	0	2	3
At least 24 months experience with federally-funded waiver programs or waiver demonstration projects in the past five years	1	0	2	3
Organizational Plan				
Organizational structure description/approach chart	3	0	5	7
Communication description/approach	3	0	5	7
Staffing requirements matrix diagram	3	0	5	7
Staffing contingency plan	3	0	5	7
Facilities Plan	2	0	5	7
Work Plan				
Pre-screening and referral approach and system	3	0	5	7
Consumer handbook description and prototype	3	0	5	7
Community resource manual description and prototype	3	0	5	7
Medicaid home care provider manual description and prototype	3	0	5	7
Technology plan	3	0	5	7
Training plan	3	0	5	7
Description of record-keeping policies and procedures	3	0	5	7
Description of approach to interdisciplinary team and consumer-centered care planning	3	0	5	7
Start-up plan	3	0	5	7
Supports brokerage plan	3	0	5	7
Description of waiver cost cap monitoring	3	0	5	7

Personnel Profile Summary Form & Licensing Requirements

Some of the personnel requirements contained in the following tables require proposed candidates to be licensed in the state of Ohio. All required licenses must be in place at the time of proposal submission. It is not acceptable to propose candidates that are in the process of obtaining licensing in Ohio.

Fully Completed Personnel Profile Summary Forms must be provided for the following positions.

Clinical Functions

Clinical Managers and Supervisors

Provider Management Functions

Provider Managers

Other Provider Management Personnel

Program Management Functions

Program Managers

Other Program Management Personnel

Note: Completed Personnel Profile Summary Forms are not required for Case Managers as part of the proposal submission. After award, the successful Contactor must provide names, resumes, and Ohio licensure/certifications for Case Manager candidates demonstrating that each candidate meets or exceeds the experience requirements for the Case Manager position. All other staff proposed in the offeror's Organizational Plan must have fully completed Personnel Profile Summary Forms appropriate for their proposed positions.

Because the number of staff proposed will be determined by each offeror's Organizational Plan, the number of proposed staff for each position will not be the same for all offerors. To account for this situation during the evaluation process, the State will average the scores by position. For example, if four (4) Provider Managers are proposed by an offeror, each proposed candidate will be scored according to the evaluation criteria. The four individual scores will be totaled and averaged. The average score for each position will be used as part of the proposal evaluation score.

The example below illustrates how the State will average the scores by position for each requirement. The requirement (criteria) weighted scores are calculated by multiplying each requirement by the criteria weight listed.

Example

Criteria	Weight	Does Not Meet	Meets	Exceeds
Team Members Requirement				
Requirement #1	5	0	3	5

Scoring Range for Requirement #1:

Weighted Criteria	Possible Average Scores	Points Received
Does Not Meet	0 – 14	0
Meets	15 – 24	15
Exceeds	25 – 34	25

Example of how the average will be calculated is shown below. An offeror proposed four (4) candidates for requirement #1, the individual candidates scores are:

- Candidate A – does not meet
- Candidate B – meets
- Candidate C - exceeds
- Candidate D - meets

Proposed Candidate	Candidates Score			Score Received
Candidate A	0			
Candidate B	15			
Candidate C	25			
Candidate D	15			
		Averaging (Divide Candidate's Total Score by the number of proposed candidates)		
Totals	55	/ 4	= 13.75	0 (does not meet)

Clinical Functions				
Requirements for Clinical Managers and Supervisors				
Registered nurse (RN), or licensed social worker (LSW, LISW), or licensed counselor (LPC,LPCC) in the State of Ohio	3	0	5	7
At least 36 months experience in an HCBS environment within the last 10 years	1	0	5	7
Desirable Requirements				
Master's degree in a business or health-related field	1	0	2	3
Team Requirements				
One person with at least 36 months of pediatric specialty experience within the last 10 years	1	0	5	7
One person with at least 36 months of MRDD specialty experience within the last 10 years	1	0	5	7
One person with at least 36 months of mental health specialty experience within the last 10 years	1	0	5	7

Provider Management Functions				
Requirements for Provider Managers				
Registered nurse (RN), or licensed social worker (LSW, LISW) in the State of Ohio	3	0	5	7
At least 24 months experience in home and community-based services environment within the last 5 years	1	0	5	7
At least 24 months experience with quality improvement systems (can include experience working with the CMS HCBS Quality Framework)	1	0	5	7
At least 24 months social service management experience, including knowledge of and/or experience with community resources and service delivery system, law enforcement, etc.	1	0	5	7
Desirable Requirement				
Master's degree in a business or health-related field	1	0	2	3
At least 60 months management experience in a home and community-based environment within the past 10 years	1	0	2	3
At least 6 months professional experience with financial management or financial monitoring systems	1	0	2	3

Requirements for Other Provider Management Personnel				
Registered nurse (RN), or licensed social worker (LSW, LISW) in the State of Ohio	3	0	5	7
At least 24 months experience in home and community-based services environment	1	0	5	7
At least 24 months experience with quality improvement systems (can include experience working with the CMS HCBS Quality Framework)	1	0	5	7
At least 24 months of knowledge and/or experience with community resources and service delivery systems (MRDD, Adult Protective Services, Children Services, Community Mental Health System, law enforcement, etc.)	1	0	5	7
Desirable Requirement				
At least 12 months experience with consumer incident reporting systems or other consumer health and safety reporting systems	1	0	2	3

Program Management Functions				
Requirements for Program Managers				

Master's degree in a business or health-related field	1	0	5	7
At least 96 months of management experience	3	0	5	7
Desirable Requirements				
At least 60 months management experience in a home and community service delivery or a health-related field	1	0	2	3
At least 24 months experience with quality improvement systems (can include experience working with the CMS HCBS Quality Framework)	1	0	2	3
Requirements for Other Program Management Personnel				
Bachelor's degree in a business or health-related field	1	0	5	7
At least 60 months of program management or program analysis experience	1	0	5	7
Desirable Requirements				
At least 24 months experience in home and community service delivery or a health-related field	1	0	2	3
At least 12 months experience with quality management systems (can include experience working with the CMS HCBS Quality Framework)	1	0	2	3
Team Requirements				
One person with at least 24 months experience in data analysis and/or data trending	3	0	5	7
One person with at least 24 months experience in accounting or financial analysis	3	0	5	7

The Contractor must provide the names, resumes, and Ohio licensure/certifications for candidates meeting the following requirements within 7 working days subsequent to the award. Failure to produce candidates meeting these requirements will result in default of the Contract.

Case Managers
Registered nurse (RN) or licensed social worker (LSW, LISW) in the State of Ohio
At least 12 months experience in home and community-based service delivery within the past 5 years
At least one candidate per region with at least 12 months of acute care experience in the last 5 years

Once the technical merits of a Proposal are considered, as described above, the costs of that Proposal will be considered. But it is within the State's discretion to wait to factor in a Proposal's cost until after any interviews, presentations and discussions. Also, before evaluating the technical merits of the Proposals, the State may do an initial review of costs to determine if any Proposals should be rejected because of excessive cost. And the State may reconsider the excessiveness of any Proposal's cost at any time in the evaluation process.

Cost points are determined by the following formula:

Initial Assessment Fee Points = (the lowest proposed average Initial Assessment Fee/the offeror's proposed average Initial Assessment Fee) * C, where C is the total amount of Initial Assessment Fee Points available. The value of C is 72.

Caseload Fee Points = (the lowest proposed average Caseload Fee/the offeror's proposed average Caseload Fee) * C, where C is the total amount of Caseload Fee Points available. The value of C is 72.

Initial Quality Management Plan Points = (the lowest proposed Initial Quality Management Plan Fee/the offeror's proposed Initial Quality Management Plan Fee) * C, where C is the total amount of Initial Quality Management Plan Points available. The value of C is 54.

Management Reports Points = (the lowest proposed Management Reports Fee/the offeror's proposed Management Reports Fee) * C, where C is the total amount of Management Reports Points available. The value of C is 54.

Monthly Performance Reports Points = (the lowest proposed average Management Performance Reports Fee/the offeror's proposed average Management Performance Reports Fee) * C, where C is the total amount of Management Performance Reports Points available. The value of C is 108. The average Management Performance Reports Fee will be calculated for each offeror by averaging the proposed "Management Performance Reports Fee for FY05-09" and the proposed "Management Performance Reports Fee with Addition of the Self-Directed Care Waiver Cost".

Total evaluation points will be determined by summing the technical points and the cost points.

Total Evaluation Points = Total Technical Proposal Points
+ Initial Assessment Fee Points
+ Caseload Fee Points
+ Initial Quality Management Plan Points
+ Management Reports Points
+ Monthly Performance Points.

Based on the total "meets" points available, excluding desirable points, the technical proposal evaluation represents 60% of the total points. Cost points represent 40% of the total points available.

One or more of the Proposals will then be selected for further consideration in the next phase of the evaluation process. The Proposal(s) selected to be considered in the next phase always will be the highest-ranking Proposal(s) based on this analysis. That is, the State may not move a lower-ranking Proposal to the next phase unless all Proposals that rank above it are also moved to the next phase, excluding any Proposals that the State disqualifies because of excessive cost or other irregularities. Alternatively, if there are to be no more phases because the State feels they are unnecessary or inappropriate, the highest-ranking Proposal will be awarded the Contract.

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

This RFP 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 mandatory 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 the State received. It is not a basis for determining the importance of meeting any requirement to participate in the Proposal process.

If the State does not receive any Proposal that meets all the mandatory requirements, the State may cancel this RFP. Alternatively, if the State believes it is in the State's interest, the State may continue to consider the highest-ranking Proposals despite their failure to meet all the mandatory requirements. In doing this, the State may consider one or more of the highest-ranking Proposals. But the State may not consider any lower-ranking Proposals unless all Proposals ranked above it are also considered, except as provided below.

In any case where no Proposal meets all the mandatory requirements, it may be that an upper ranking Proposal contains a failure to meet a mandatory requirement that the State believes is critical to the success of the RFP's objectives. When this is so, the State may reject that Proposal and consider lower ranking Proposals. But before doing so, the State must notify the offeror of the situation and give the offeror an opportunity to cure the critical mandatory requirement.

If the offeror cures its failure to meet a critical mandatory requirement, its Proposal will continue to be considered. But if the offeror is unwilling or unable to cure the failure, its Proposal may be rejected. The State then may continue to consider the other remaining Proposals, including, if the State so chooses, proposals that ranked lower than the rejected Proposal.

Financial Ability. Part of the Proposal evaluation criteria is the qualifications of the offeror, which includes as a component the offeror's financial ability to perform the Contract. This RFP may expressly require the submission of audited financial statements from all offerors in the Proposal contents attachment. But if the Proposal contents attachment does not make this an express requirement, the State may still insist that an offeror submit audited financial statements for up to the past three years if the State 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 the State 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. But if the State believes the offeror's financial ability is not adequate, that decision will be a fatal one for the offeror's Proposal, and the State may reject the Proposal despite its other merits.

Interviews, Demonstrations, and Presentations. The State may require some offerors to interview with the State, make a presentation about their Proposal, and/or demonstrate their products or services. Such presentations, demonstrations, and interviews provide an offeror with an opportunity to:

- Clarify its proposal and to ensure a mutual understanding of the proposal's content;
- Show the features and functions of its proposed hardware, software or solution; or
- 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 the State. The State may record any presentations, demonstrations, and interviews.

The State normally will not numerically rank interviews, demonstrations, and presentations. Rather, the State may decide to revise its existing proposal evaluations based on the interviews, demonstrations, and/or presentations.

Determination of Responsibility. The State 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 to be not responsible. The State's determination of an offeror's responsibility may include the following factors: the offeror's and its key team members' experience, past conduct on previous Contracts, past performance on previous Contracts, ability to execute this Contract properly and management skill. The State will make such determination of responsibility based on the offeror's proposal, reference evaluations and any other information the State requests or determines to be relevant.

Contract Negotiations. The final phase of the evaluation process may be contract negotiations. Negotiations will be scheduled at the convenience of the State. The selected offeror(s) must negotiate in good faith.

Negotiations may be conducted with any offeror who submits a competitive Proposal, but the State 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. 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. But should the evaluation process have resulted in a top-ranked Proposal, the State 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, the State 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.

If the State 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, the State 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.

Auction 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.

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

If best and final Proposals are required, they may be submitted only once, unless the State makes a written determination that it is in the State's interest to conduct additional negotiations. In such cases, the State 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.

It is entirely within the discretion of the State 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. The State is free to limit negotiations to particular aspects of any Proposal, to limit the offerors with whom the State wants to negotiate, and to dispense with negotiations entirely.

The State 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, the State may negotiate with the next offeror in ranking. Alternatively, the State 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.

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 State will not be allowed to tell one offeror about the contents of another offeror's Proposal in order to gain a negotiating advantage.

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.

Negotiated changes will be reduced to writing and become a part of the contract file open to inspection to the public. The written changes will be drafted and signed by the Contractor and submitted to the State within five business days. If the State accepts the change, the State will give the offeror written notice of the State's acceptance. The negotiated changes to the successful offer will become a part of the Contract.

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, the State may terminate negotiations with that offeror and collect on the offeror's bid bond, if a bid bond was required in order to respond to this RFP.

PART FIVE: AWARD OF THE CONTRACT

Contract Award. The State plans to award the Contract, if the State decides the Contract is in its best interests and has not changed the award date.

The selected offeror will receive an executed copy of the Contract. But the Contract will not be binding on the State until the State issues a purchase order and all other prerequisites identified in the Contract have occurred.

The State expects the Contractor to commence work within 5 working days after the State issues a purchase order under the Contract.

Contract. If this RFP results in a Contract award, the Contract will consist of this RFP, written amendments to this RFP, the Contractor's Proposal, and written, authorized amendments to the Contractor's Proposal. It will also include any materials incorporated by reference in the above documents and change orders issued under the Contract. The form of the Contract is attached as a one-page attachment to this RFP, but it incorporates all the documents identified above. The general terms and conditions for the Contract are contained in another attachment to this RFP. If there are conflicting provisions between the documents that make up the Contract, the order of preference 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.

**ATTACHMENT ONE: WORK REQUIREMENTS AND SPECIAL PROVISIONS
PART ONE: WORK REQUIREMENTS**

Scope of Work

As previously stated, the role of the Contractor (Case Management Agency (CMA)) is to assist in the implementation and management of ODJFS-administered home and community-based programs throughout the state and interface with consumers at the local level. Case management is defined as a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet a consumer's community care needs through communication and utilization of available resources to promote quality, cost-effective outcomes.

The scope of work includes day-to-day and periodic/as-needed clinical functions, provider management functions, and program management functions. The requirements of this section apply to all relevant CMA staff located in central and regional locations who will be performing the scope of work, including subcontractors. The scope of work must be conducted in accordance with federal and state law, federal and state Medicaid program requirements, state administrative program rules, and other program requirements. Unless otherwise indicated, references to hours, days, weeks, months, quarters, and years are actual time designations, not business time designations.

Clinical Functions

- **Case management of Medicaid and non-Medicaid services for ODJFS-administered waiver and other ODJFS-administered and case-managed home and community service programs (e.g. Core Plus), including:**

Screening of Referrals & Intake - Requests for, and inquiries about, the Medicaid home health programs will be received from many sources, e.g. home health agencies, consumers, and discharge planners. The CMA is responsible for referring inquiries appropriately, e.g. to county departments of job and family services, county boards of mental retardation/development disability, local children's services agencies, or adult protective services agencies, to assist consumers in obtaining the services they need. CMA screening staff must be capable by education and experience to engage in health and social problem solving for all populations, including providing general information about program goals, objectives, and eligibility criteria. CMA screening staff are responsible for referring program applicants to other community resources or scheduling face-to-face assessments according to ODJFS clinical standards.

Initial application for ODJFS-administered waiver enrollment is made through county departments of job and family services. After the CMA is notified that a waiver application has been filed, the CMA will contact the waiver applicant to schedule a face-to-face interview with the applicant and any other parties that the individual requests be present, in accordance with state program rules. Sometimes a waiting list is utilized by ODJFS to manage a limited number of available waiver slots. The CMA will adhere to the waiting list process when in effect.

Program applicants must be contacted by phone within two working days of the CMA's receipt of a waiver alert or Core Plus referral. If contact cannot be made within two working days due to extenuating circumstances (e.g. incorrect phone numbers, disconnection of telephones, person's absence from the home), the CMA must document the reason and alternative means used to establish contact (e.g. contacting the CDJFS worker/discharge planner/CRIS-E authorized representative, sending a letter to the applicant, having a case manager visit the address). The CMA will not recommend denial based on inability to contact a consumer without authorization from ODJFS.

Assessment – An assessment is the process of evaluating the applicant/consumer's functional abilities, cognitive capacity, and social and psychological statuses, as well as their overall limitations, needs, strengths, and resources. Registered nurses (RNs) and licensed social workers (LSWs/LISWs) who have passed the required ODJFS clinical competency test will conduct assessments using an interdisciplinary approach, i.e. one discipline (RN or LSW/LISW) will conduct the assessment and the other discipline (RN or LSW/LISW) will review the completed assessment documentation. RNs and LSWs/LISWs will perform face-to-face assessments at the applicant's/consumer's place of residence and in other settings as appropriate.

A face-to-face assessment using the ODJFS-approved assessment tool must be completed within ten working days following the CMA's initial contact determining the need for a face-to-face interview or within the timeframe needed to accommodate the applicant's schedule. If the face-to-face assessment is not completed within ten working days of the initial contact, the CMA must fully document the reason(s) for the delay. Documentation must demonstrate that the delay is the result of an event or situation concerning the consumer or by the consumer's request. CMA staffing or administrative issues are not acceptable reasons for delay.

When necessary and at least annually, the RN and LSW/LISW will conduct a consumer assessment to ensure continued program eligibility. An adverse level of care recommendation made by an LSW/LISW will require a follow-up face-to-face visit by an RN.

Any significant change with the consumer will warrant an event-based assessment to be conducted as a face-to-face visit. A significant change may include, but not be limited to: a change in caregiver, post-hospitalization, post-facility placement, a change in location/residence, referral to a protective service agency, and/or an observed increase/decrease in the utilization of Medicaid and non-Medicaid services.

Program Eligibility – The CMA will document assessment information and program eligibility on the applicable ODJFS-approved assessment tool (see Supplement 3 for the current assessment tool). The CMA will inform the applicants/consumers of their appeal rights in accordance with state program rules.

Determination of program eligibility, program enrollment (as applicable), and initial care coordination and service planning activities (as applicable) must be completed within twenty days from the completion of the applicant's initial face-to-face assessment, including the completion of the following activities:

- Prior to the applicant's program enrollment, obtaining the physician's verbal approval that services are appropriate and that the consumer meets the level of care. A written physician approval must be obtained within thirty days of consumer enrollment.
- Obtaining the consumer's or consumer representative's signature on the All Services Plan (ASP).
- Notifying the applicant of program eligibility or ineligibility and due process rights.

When service delivery is not started within thirty days of the initial face-to-face assessment, an updated face-to-face assessment must be completed to insure eligibility.

Annual reviews must be completed no earlier than thirty calendar days before the anniversary date of the consumer's initial face-to-face assessment. The physician's verbal approval that services are appropriate and that the consumer meets the level of care must be obtained prior to the consumer's program eligibility anniversary date. The physician's signature must be obtained within thirty calendar days of the consumer's program eligibility anniversary date.

Care Coordination and Individualized Care Planning - Care coordination and care planning is an ongoing function needed to address changing circumstances and/or medical conditions of the consumer over time, including Medicaid and/or non-Medicaid needs. The CMA is responsible for the ongoing coordination of all Medicaid and non-Medicaid home and community-based services a consumer receives.

Through the use of a team process, the CMA must develop a comprehensive and participant-centered plan of care. The CMA is responsible for gathering and maintaining all documentation related to the consumer's condition and living arrangement which supports the services authorized on the ODJFS All Services Plan (see Supplement 4), the individualized goals and objectives of the care plan, and the collaborative efforts of the consumer's team. The CMA is responsible for contacting all individuals and agencies that are or will be participating in meeting the consumer's needs (including the consumer/guardian/representative), scheduling meetings, disseminating information and plan updates, maintaining documentation, mediating in the event of disagreement among team members, etc.

The CMA is responsible for determining and managing utilization of home and community-based services by monitoring the amounts and types of services a consumer receives.

The CMA is responsible for obtaining physician approval for the plan of care and the level of care in accordance with state program rules. All services recommended by the consumer's team and authorized by the CMA must contribute to the overall goal of preventing institutionalization, in accordance with state and federal program requirements defined in the Ohio Administrative Code (<http://onlinedocs.andersonpublishing.com>).

The CMA is responsible for coordinating activities for consumers transferring from ODJFS-administered waivers/programs to another waiver/program, being disenrolled from an ODJFS-administered program, relocating from one region to another, being temporarily institutionalized, etc. This includes notifying all affected parties, providing documentation, and maintaining contact with other case managers, etc. in accordance with state program rules and requirements.

Ongoing Monitoring of Services and Outcomes - One of the CMA's primary responsibilities is providing ongoing monitoring of the appropriateness of service delivery and outcomes identified in the care plan, using ODJFS case management protocols and clinical standards that vary by consumer need. ODJFS reserves the right to request periodic time studies to validate caseload ratios. Caseload projections and statistical information can be found in Part One: Executive Summary, Overview of the Scope of Work of this RFP.

For the first six months of the Contract or until the first new waiver is implemented, the CMA must maintain a caseload ratio of no more than 1 case manager per 60 consumers and conform to other Level 1 Case Management requirements described later in this section.

Upon the implementation of each new waiver, the CMA must follow the case management protocols and standards for each waiver as described below. While each level of case management is primarily focused on specific waivers/programs, it is possible that each level of case management may occur within the other ODJFS-administered waivers/programs based on consumer needs.

- **Level 3 Case Management (primarily for consumers served by the Sub-Acute Community Waiver)** is provided to consumers with complex, unstable medical and/or social needs that require frequent case management intervention, education, and support. The case manager to consumer ratio must not exceed 1 case manager per 30 consumers. The following consumer contact and visit schedule must be maintained:

Length of Enrollment	Frequency of Consumer Contact	Timing of In-Person Visit
0 to 3 months	Weekly during first month	Initial assessment and monthly visit (maximum of 30 days between visits)
4 to 6 months	Monthly	One visit during 5 th month after the date of enrollment
7 + months	Monthly	Quarterly (maximum of 90 days between visits)
Significant Change Episode	Telephone contact within 24 hours of episode discovery	Within 72 hours of episode discovery

- **Level 2 Case Management (primarily for consumers served by the Ohio Home Care, Transitions or Community Resource waivers, or the Core Plus Benefit Package)** is provided to consumers with chronic long-term illnesses, whose conditions are considered medically stable. The case manager to consumer ratio must not exceed 1 case manager per 50 consumers. The following consumer contact and visit schedule must be maintained:

Length of Enrollment	Frequency of Consumer Contact	Timing of In-Person Visit
0 to 3 months	Weekly during first month	Initial assessment and monthly visit (maximum of 30 days between visits)
4 + months	Monthly	Quarterly (maximum of 90 days between visits)
Significant Change Episode	Telephone contact within 24 hours of episode discovery	Within 72 hours of episode discovery

- **Level 1 Case Management (primarily for consumers served by the Self-Directed Care Waiver)** is provided to consumers with chronic long-term illnesses, whose conditions are considered medically stable and who are able to demonstrate their ability to safely direct their own care in accordance with state program rules. The case manager to consumer ratio must not exceed 1 case manager per 60 consumers. The following consumer contact and visit schedule must be maintained:

Length of Enrollment	Frequency of Consumer Contact	Timing of In-Person Visit
0 to 3 months	Weekly during first month	Initial assessment and bi-weekly visit (maximum of 14 days between visits)
4 + months	Quarterly	Every 6 months
Significant Change Episode	Telephone contact within 24 hours of episode discovery	Within 72 hours of episode discovery

- **Providing supports brokerage services.** Consumers enrolled on the self-directed care waiver must have the supports needed to make decisions regarding their

services and personal lives; must be able to exercise direct control over their individualized budgets; and must participate in the evaluation and assessment of the quality of the supports they receive.

Supports brokerage is based on the premise that persons with disabilities should be empowered to make decisions about the services he/she receives, including having choice and control over the types of support services he/she receives and who, what, when, and where the support services are delivered. Supports brokerage services emphasize that it is the individual, as opposed to the medical and social work professionals, who knows best about his/her needs and how to address them.

Supports brokerage is provided to Self-Directed Care Waiver consumers in addition to case management. It is time-limited and intended to give a boost to consumers who choose to self-direct their care.

Generally, supports brokerage provides consumers with information about processes, rights and resources and assistance with planning, budgeting and managing self-directed services. Specifically, the supports broker provides information to the consumer about:

- Person-centered planning and how it is applied;
- The range and scope of individual choices and options;
- Explaining the risks and responsibilities of self-direction;
- Practical skills training (e.g., managing workers, problem solving, conflict management and resolution, hiring and firing workers, etc.);
- Development of emergency back up plans;
- Recognizing and reporting incidents;
- Independent advocacy, to assist complaints or grievances when necessary;
- Independent advocacy, to assist with engaging other community supports or entities;
- The process for changing the plan of care and the individual budget;
- The consumer's relationship with the fiscal agent responsible for managing the consumer's employer-related tasks; and
- Monitoring and approval of the consumer's budget spending as authorized by the case manager.

The CMA must designate specific persons on staff, or a subcontractor (e.g., a Center for Independent Living), whose function is to provide brokerage services. The case manager can not serve as the supports broker nor can the supports broker provide any other waiver services to the consumer. The intensity of supports brokerage will vary by consumer or their representative. With the initial implementation of supports brokerage, the caseload ratio must not exceed 1 supports broker to 60 consumers. ODJFS expects this ratio to increase over time as the consumer/representative becomes efficient and comfortable in managing their own care.

Consumer and Caregiver Education and Support - The CMA will interact with consumers in a positive and proactive manner, uphold consumer rights, and educate consumers (and their families/caregivers) about ODJFS-administered home and community-based programs and program requirements. Support to consumers includes, but is not limited to:

- a. Using person-centered language in all communication.
- b. Adapting communication methods to meet the needs of consumers, e.g. consumers who are visually impaired or hearing impaired and consumers who have limited English proficiency.

- c. Ensuring that all consumers are informed of their rights, including but not limited to an ODJFS-developed HCBS Program Bill of Rights (**following federal requirements defined in 42 CFR 484.10**, <http://www.gpoaccess.gov/cfr>) grievance procedures, etc.
- d. Providing a call-in system that is available to all consumers twenty-four hours a day, seven days a week, and three hundred sixty-five days a year. The call-in system must enable consumers to speak to a live person rather than a recorded message and provide a method for consumers to contact clinical personnel who may assist with service-related issues.
- e. Providing an ODJFS consumer handbook and an up-to-date CMA-specific consumer guide to all consumers in accordance with state program requirements and rules. The CMA-specific guide must contain pertinent policies and procedures such as the functions and responsibilities of the CMA and key clinical personnel, information about the call-in system, how to file complaints, incidents, or other occurrences, how to access records, HIPAA Privacy requirements, and what to do in an emergency (e.g. when an aide does not show up for their work shift). CMA-specific guides must be customized to each region as needed.
- f. Providing an up-to-date community resource manual to all case management staff and consumers to access information about agencies and resources, other than Medicaid home care providers, in accordance with state program requirements and rules. Community resource manuals must be customized to each community and must be accessible at all times to all case managers. Community resource manuals must include, at minimum: resource name, services provided, address, contact numbers, funding source, and any applicable eligibility criteria. Community resource manuals must be available in paper format and accessible through the CMA's website, at minimum.
- g. Providing an up-to-date Medicaid home care provider directory to all case management staff and consumers in accordance with state program requirements and rules. Provider directories must be customized to each community and must be accessible at all times to all case managers. Provider directories must include, at minimum: provider name, home care services provided, address, contact numbers, Medicaid provider number, and type of provider. Provider directories must be available in paper format and accessible through the CMA's website, at minimum.

Managing Service Plan Cost Ceilings - Consumers will be assigned individual monthly cost caps, which align with consumer needs identified through the assessment process. The CMA is responsible for managing care plan costs and managing the cost ceiling for each program that is established by ODJFS to assure program cost effectiveness in accordance with the approved waiver(s).

- **Adhering to ODJFS case management training and competency testing requirements for staff performing clinical functions as outlined in this RFP and state program rules and regulations.** Within six months of the Contract effective date, staff listed in the Proposal or those accepted by ODJFS post-award to perform clinical functions described in the scope of work must meet ODJFS training and competency testing requirements. All new staff employed and/or subcontracted by the Contractor after the Contract effective date, must meet ODJFS training and competency testing requirements within six months of starting work on this project.

Training Curriculum – ODJFS will provide training materials for the following required topics, including but not limited to:

- Federal and State Rules/Regulations
- Screening

- Assessment
- Eligibility
- Enrollment
- Level of Care
- Care Planning (goals, objectives, outcomes and service planning)
- Community Resources and Referrals
- Due Process
- Service Specifications
- Incident Management, Investigation, and Response System
- Protection From Harm (including incident reporting)
- Provider Occurrences

ODJFS anticipates that it will take approximately 40 hours to complete the training curriculum.

Competency Testing – ODJFS will administer competency tests according to state program rules. CMA staff performing the clinical functions described in the scope of work must pass the test with a score of 90 percent. Persons who do not receive a passing score must retake the test within six months of the first testing date. The CMA must arrange for additional training in areas of deficiency. For staff unable to pass the test at the designated level within the six month period, supervision must be increased (i.e. supervisory review of 100 percent of the case manager's documentation, joint supervisor-case manager consumer visits, utilizing a mentoring program) until a passing score is achieved. Upon obtaining a passing score on the test, ODJFS will issue a formal approval notification.

- **Managing and monitoring daily case management and care coordination activities.** The CMA will manage the day to day operations of all case management and care coordination activities including, but not limited to continued consumer eligibility, case consultation, supervision, staff utilization, training, conducting chart audits, and other consumer-related functions and deliverables outlined in this RFP and in accordance with federal and state program requirements.
- **Providing specialized clinical consultation to case management staff.** The CMA must provide and ensure specialized clinical expertise to CMA case management staff in the areas of pediatrics, MRDD, and mental health.
- **Identifying and accessing appropriate resources within a consumer's community.** In addition to Medicaid home care providers, the CMA must assist the consumer in identifying and accessing community agencies and resources for each consumer's needs. In addition, the CMA must provide expertise in job placement, relocation, and independent living skills to consumers. The CMA must seek input from all members of the consumer's interdisciplinary team to identify and coordinate the community resources for the consumer. The CMA must maintain and distribute up-to-date community resource information.
- **Participating in the state hearings process.** Consumers have the right to appeal any decision regarding their Medicaid benefits, as specified in OAC Chapter 5101:6-2 (<http://onlinedocs.andersonpublishing.com>). The CMA will participate in the hearings process by preparing appeal summaries, providing supporting documentation, and offering testimony supporting proposed actions. State hearings are conducted by ODJFS hearing officers. During calendar year 2003, ODJFS and its contracted designees participated in an average of 52 hearings per month, with approximately 50 percent of these hearings requested for a level of care action. It is ODJFS' intent to completely delegate this function to the CMA over a period of six months. ODJFS will provide training and technical assistance to CMA staff in Columbus and at regional sites over the six month period to assist in the transition of this function and will provide periodic refresher training as needed.

- **Other clinical functions.** Some of the clinical functions the CMA must complete are as-needed and periodic clinical functions. Current functions include:
 - **Managing Core Plus cases.** As stated in Part One of this RFP, ODJFS intends to reengineer this part of the Ohio Home Care program. Until this transformation takes place, the CMA is responsible for managing Core Plus cases as described earlier in the Scope of Work. Core Plus projections and statistical information can be found in Part One of this RFP.

Core Plus program eligibility, enrollment (as applicable), and care coordination/service planning must be completed within ten working days of the initial face-to-face assessment, including the completion of the following activities:

- Obtaining the consumer's or consumer representative's signature on the All Services Plan (ASP).
 - Notifying the applicant of program eligibility or ineligibility and due process rights.
- **Level of care desk reviews for Intermediate Care Facility for Mental Retardation and Developmental Disability (ICFMR/DD) facility placement.** The CMA may be responsible for conducting paper reviews of ICFMR/DD levels of care and making recommendations in accordance with Ohio Administrative Code rule 5101:3-3-153 (<http://onlinedocs.andersonpublishing.com>). All desk reviews must be completed by an RN, LSW, or LISW. An average of eighty-six desk reviews per month is currently performed.

Level of care desk reviews must be completed within five working days of receiving documentation.

- **In-person assessments of individuals receiving adverse determinations of Nursing Facility (NF) placement for Intermediate Care Facility for Mental Retardation and Developmental Disability (ICFMR/DD) facility placement.** The CMA may be responsible for assessing individuals for ICFMR/DD facility placement who have received an adverse determination for NF placement as required by rule 5101:3-3-151 (<http://onlinedocs.andersonpublishing.com>) of the Ohio Administrative Code. These assessments must be performed by a Registered Nurse. An average of three to five assessments per month is currently performed.

Assessments must be completed within ten working days from receipt of the assessment request.

Provider Management Functions

- **Operate an Incident Management, Investigation and Response System.** The CMA will act as the ODJFS designee in operating the Incident Management, Investigation and Response System (IMIRS) as outlined in Ohio Administrative Code rule 5101:3-12-29 (see Supplement 5). The system defines Level 1 and Level 2 incidents; the reporting, notification and response requirements; investigation requirements; the process for substantiating incidents; and recommending provider sanctions to ODJFS. The CMA must develop and implement written procedures and guidelines for operating IMIRS as well as internal processes for reviewing and analyzing all Level 1 and Level 2 incidents to identify patterns and/or trends. The guidelines must assist with the analysis of incidents and address the reduction of future actions and/or trends. Upon request by ODJFS, the CMA must provide evidence that this review has been conducted and that appropriate action has been taken.

The CMA will not have the authority to sanction ODJFS-administered waiver service providers, only the authority to recommend such action to ODJFS.

The CMA must prepare a quarterly report identifying the number and types of incidents (Level 1/Level 2 and closed/open) that have occurred, the action taken to prevent any future harm, incident/consumer-specific outcomes, and any corrective action that occurred. The CMA must also conduct an annual review and analyze the data for the year to identify patterns and/or trends, and take corrective action where needed. This process must be identified within the CMA's quality management plan.

Within 60 days of the effective date of the Contract, CMA provider management staff must successfully complete training on the requirements set forth in the IMIRS, and the internal policy and procedures for reporting incidents. Documented evidence of the completion of this training must be made available to ODJFS upon request. New provider management staff must successfully complete training within 60 days of initial employment.

The CMA is responsible for ensuring that all ODJFS-administered waiver service providers receive notification of the internal policy and procedures for reporting incidents, and the standards outlined in the rules. Consumers and/or family members or caregivers must also receive notification of the policies and procedures for reporting incidents. Documented evidence of receipt of this notification must be made available upon request by ODJFS.

- **Completing Enrollment Process for ODJFS-administered Waiver Service Providers.** All ODJFS-administered waiver service providers must meet eligibility requirements as set forth in rule 5101:3-12-05 of the Ohio Administrative Code (<http://onlinedocs.andersonpublishing.com>). Any person or entity who wants to provide waiver services in an ODJFS-administered waiver must complete the service provider application process as set forth in the Enrollment Process for ODJFS-administered Waiver Service Providers rule 5101:3-12-28 (see Supplement 5), and receive enrollment approval from ODJFS. The CMA will be designated by ODJFS to implement this new rule, acting as the front door of provider enrollment and become the first reviewing entity within the provider eligibility verification process.
- **Monitoring Providers under ODJFS-administered Home and Community Based Service Waivers.** Every ODJFS-administered waiver provider must submit to regularly scheduled monitoring. The monitoring must include: structural review in compliance with rules 5101:3-12-06 and/or 5101:3-12-07 of the Ohio Administrative Code, as appropriate, and rules 5101:3-1-172, 5101:3-1-173 (<http://onlinedocs.andersonpublishing.com>), and 5101:3-12-25 or 5101:3-12-26 of the Ohio Administrative Code (see Supplement 5), as determined by the appropriate provider type; and continuous monitoring of provider compliance and performance through the provider occurrence process. These processes are enumerated in rule 5101:3-12-30 (see Supplement 5). The CMA will be designated by ODJFS to perform the monitoring activities outlined in the rule. The CMA will not have the authority to sanction ODJFS-administered waiver service providers, only the authority to recommend such action to ODJFS.

The CMA must develop and implement a plan to notify all ODJFS-administered waiver service providers of the CMA's internal policy and procedures, and associated Ohio Administrative Code rules as previously referenced. Documented evidence of the receipt of this notification must be made available upon ODJFS' request.

The CMA must review and analyze all occurrences to identify patterns and/or trends. The CMA must develop guidelines to assist with the analysis of provider occurrences, as well as assist in determining the reduction of future non-compliance actions and/or trends. Upon

ODJFS' request, the CMA must provide evidence that this review has been conducted and that appropriate action has been taken.

Within 60 days of the Contract effective date, the CMA must conduct training on the requirements of occurrence reporting as well as the internal CMA policy and procedures for all appropriate staff. Documented evidence of receipt of this training must be made available to ODJFS upon request. As appropriate, new personnel must receive the training within 60 days of initial employment.

Program Management Functions

- **Assuring all aspects of the Contract are met.** As a designee of ODJFS, the CMA is responsible for complying with and ensuring that all CMA staff (including regional site staff and subcontractors) comply with the Contract terms and requirements.
- **Complying with program requirements, rules, and regulations.** As a designee of ODJFS, the CMA is responsible for complying with and ensuring that all CMA staff (including regional site staff and subcontractors) comply with state and federal program requirements, rules, and regulations (e.g. Code of Federal Regulations, Ohio Revised Code, Ohio Administrative Code, approved Waivers).

Proposed rules included with this RFP are intended to provide bidders with a better understanding of the scope of work. Changes and modifications to the rules are to be expected. If a discrepancy exists between proposed rules and approved rules, final approved rules will supersede. ODJFS will share final approved rules with the selected CMA as part of the initial Contract implementation activities or when finalized, whichever comes first.

- **Implementing and managing statewide program policies, procedures, and protocols aligned with federal and state requirements.** The CMA is responsible for providing CMA staff (including subcontractors) with policies, procedures, and protocols to support federal and state program and contractual requirements, rules, and regulations. The CMA must implement new and modified policies, procedures, and protocols in a timely manner, but no later than fifteen calendar days after notification of federal and state requirement changes. The CMA must have mechanisms in place to routinely maintain and monitor policies, procedures, and protocols.
- **Assuring access to CMA management staff.** The CMA must provide a method (e.g. manager on call) for consumers, state staff, federal staff, etc. to access CMA management staff when program issues develop (e.g. issues about efficient delivery of services, responsiveness to consumers, media situations). Access to CMA management staff must be available twenty-four hours a day, seven days a week, and three hundred sixty-five days a year.
- **Utilizing technology in communicating with stakeholders.** In addition to paper-based methods of communication, the CMA must utilize technology in communicating with consumers and other stakeholders. At minimum, the CMA must utilize electronic-mail and maintain an up-to-date website which includes program information, organizational information, and other information as required throughout this RFP (e.g. community resource manual, etc.). The CMA's website must adhere to State IT Policy ITP F.35 Moratorium on the Use of Advertisements, Endorsements and Sponsorships on State-Controlled Websites (see Supplement 6).
- **Utilizing ODJFS computer systems.** The CMA will use ODJFS computer systems in the performance of their duties with the State, including but not limited to the Client Registry and

Information System-Enhanced (CRIS-E), the Medicaid Management Information System (MMIS), and any applicable ODJFS-specific system, currently the Medicaid Consumer Activity Tracking System (MCATS). The CMA must agree to comply with all ODJFS security requirements as outlined in Supplement 7. **The CMA is responsible for providing the necessary software, communication lines, etc. necessary to access ODJFS systems.**

MMIS, the Medicaid Management Information System, processes and stores data on all claims submitted for Medicaid and other health programs administered by ODJFS. The system also maintains information on Medicaid consumer eligibility, approved equipment/medications/services, reimbursement rates, Medicaid providers, and the prior authorization process.

CRIS-E, the Client Registry Information System-Enhanced, establishes eligibility for a variety of ODJFS-administered 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 consumers. Nightly data feeds from CRIS-E transfer health plan eligibility information to MMIS.

The CMA will take an active role in the development, testing, and implementation of the **Medicaid Consumer Activity Tracking System (MCATS)** or whatever alternate database/system is utilized by ODJFS, including participation in the MCATS Implementation Team, Joint Application Development (JAD) sessions, and user testing. The Implementation Team was created 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 CMA will be required to conduct user testing, based on test scripts provided by ODJFS, and provide sign-off upon completion. See Supplement 8 for further information about MCATS, including system requirements. If requirement needs change during the course of the resulting Contract, the CMA will be required to utilize whatever other database/system ODJFS stipulates. It is not required that MCATS be the sole database utilized by the CMA.

Data integrity and security are an important element of system utilization. The CMA is required to use tokens or other ODJFS-required technology needed to allow access to ODJFS systems. Tokens are used to access the systems through the Internet structure. These tokens allow access through the ODJFS firewall. The cost of these tokens (approximately fifty dollars per token for a two-year period) or any other ODJFS-required access technology is to be absorbed by the CMA. The CMA is responsible for the purchase of all software and hardware not otherwise supplied by ODJFS. The CMA is also responsible for maintaining up-to-date records of token assignments, notifying ODJFS of staff changes that impact token usage, and reconciling token assignment records with ODJFS records.

- **Hiring and maintaining qualified staff.** All staff employed by the CMA (including regional site staff and subcontractors) must complete criminal background checks in the same manner as employees of home health agencies as described in, and in accordance with, Ohio Revised Code 109.572, Ohio Revised Code 5111.95 (<http://onlinedocs.andersonpublishing.com>), and Ohio Administrative Code rule 5101:3-12-25 (Supplement 5). Results of these checks must be kept in a separate, secure file maintained by the CMA with restricted access by general personnel.

Records of staff qualifications, must be kept on file by the CMA and must be maintained in accordance with specific licensure requirements.

Staff development activities (e.g. training, workshops, conferences, peer mentoring) must be routinely offered and/or coordinated by the CMA at least quarterly for all CMA staff and for individual CMA employees as part of ongoing performance goals.

(See Replacement Personnel language in the RFP.)

- **Training, Meetings, Conference Calls.** The CMA will participate in ODJFS-sponsored training seminars, information sessions, conference calls, and management meetings. Over the past two years, training seminars and information sessions have been conducted quarterly at regional sites for all CMA staff (generally two to four hours in duration). Conference calls and management meetings have been rotated monthly (a conference call one month, a management meeting in Columbus the next month) for CMA management staff (generally two hours in duration for conference calls and generally four to six hours in duration for management meetings). Other informational meetings/trainings are convened by ODJFS when necessary. All costs (e.g. travel, phone) associated with these activities are the responsibility of the CMA. More frequent meetings, training seminars, information sessions, and conference calls may be conducted in the first year of the Contract or when needed to resolve contract or regional site issues. All CMA staff must attend orientation sessions offered by ODJFS following initiation of the Contract.
- **Community Education.** The CMA will proactively identify opportunities for community education, collaborating with other home and community-based stakeholders as needed. As the manager of ODJFS-administered home and community-based programs in local communities, the CMA will respond to community organizations (e.g., county boards of MRDD, county job and family services agencies, consumer advocacy groups) seeking technical assistance and/or education about ODJFS-administered home and community-based programs.

The CMA must use a variety of media to perform this educational function, e.g. newsletters, public announcements, community forums, agency-specific training sessions. All materials developed and activities conducted must be made accessible to persons with special needs (e.g. consumers who are visually impaired or hearing impaired, consumers who have limited English proficiency) and will incorporate person-centered language.

- **Implementing and managing a quality assurance and quality improvement system aligned with federal and state standards.** The CMA will align its quality management efforts with the approved waiver program assurances, the CMS HCBS Quality Framework areas and outcomes, other standards outlined in this RFP, and other applicable outcomes/standards outlined in state and federal program rules and requirements. See Objective Section to obtain further information about waiver program assurances and the CMS HCBS Quality Framework. Quality management activities will include, but not be limited to analysis, trending, reporting, corrective action planning, and prevention in accordance with state and federal program requirements and rules.

As part of its quality management efforts, the CMA must operate a formal utilization management program that includes at a minimum, quarterly eligibility reviews, quarterly case management reviews, quarterly structural reviews, and an annual peer review process in accordance with state and federal program requirements and rules.

The CMA must participate and cooperate in any and all program management and oversight reviews, meetings, or activities conducted by ODJFS or any other designated state or federal audit/oversight entity. Over the past two years, ODJFS has met quarterly with regional site management for contract/program management discussions (generally a two-hour duration) and has conducted one-day annual site reviews at each regional site.

- **Maintaining physical and electronic files for each consumer.** The CMA, while they may elect to use their own electronic systems, must use as their primary system the Medicaid Consumer Activity Tracking System (MCATS) or whatever other system is being utilized by ODJFS. All records, including consumer information records related to this Contract, must be kept at each applicable CMA regional office. The CMA 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 CMA's work records. The CMA will do so with all due speed, not to exceed five business days. The files must include at least the following information:

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

The CMA must have appropriate policies and procedures to maintain the confidentiality of consumer records and assure consumers have access to their own records upon request. The CMA must be able to ensure that consumer records are kept confidential, and must have a procedure which explains release of records to parties other than members of the consumer's team in compliance with any and all HIPAA and ODJFS requirements. The CMA must retain records in accordance with federal and state law.

Upon termination of the Contract by either party, the CMA is responsible for providing all consumer and provider records to ODJFS at least thirty days prior to termination date. The cost of this provision is a cost to the CMA of administering the ODJFS-administered home and community-based programs and will not be reimbursed by ODJFS.

If a subpoena is received by the CMA to testify about a consumer's case/records, the CMA must identify the parties to the subpoena. If the CMA and/or a CMA staff member are the only parties named in the subpoena, the CMA must contact their organization's attorney to handle the matter. If ODJFS is also named in the subpoena, the CMA must contact ODJFS immediately so prompt coordination with ODJFS Office of Legal Services can occur.

The CMA must inform ODJFS of legal issues (e.g. lawsuits) or receipt of legal documents (e.g. subpoenas) impacting the CMA organization, CMA employees, subcontractors, providers, consumers, etc.

- **Office Location/Environment.** The CMA must have at least one physical office location per region and a physical office location for the coordinating site to manage and administer the scope of work in this Contract. Personal residences are not acceptable regional or coordinating office locations; the CMA may utilize personal residences or other applicable environments for case managers or other personnel, however. The office locations must be accessible to consumers, providers, ODJFS, and the general public and must be fully compliant with Americans with Disabilities Act (ADA) access standards. 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 CMA's office locations must have working facsimile and copy machines, as well as computers capable of compiling data in formats compatible with all ODJFS applications. At least two on-site conference rooms to comfortably accommodate six or more people must be available for meetings with state staff, ODJFS site reviews, etc. Access to large conference or training rooms for regional training seminars, etc. must be available as well.

Deliverables. In support of the scope of work functions, the Contractor must submit specific deliverables to ODJFS in accordance with program requirements and rules:

Initial Assessment Report – Initial Assessment Reports, based on an ODJFS-defined format, must be submitted to ODJFS monthly. The Initial Assessment Report must include information about initial assessments completed during the previous month (e.g. the Initial Assessment Report submitted in August must include information about initial assessments completed in July), including periodic and as-needed assessments completed (as defined in the scope of work under the Other Clinical Functions). All reports are due by the 15th calendar day of the following

month; the first report must be submitted following the first full month after the Contract is initiated. Payment for initial assessments and the periodic/as-needed assessments will be based on ODJFS acceptance of the monthly Initial Assessment Report.

Caseload Report – Caseload Reports, based on an ODJFS-defined format, must be submitted to ODJFS monthly. The Caseload Report must include information about the number of cases managed during the previous month (e.g. the Caseload Report submitted in August must include information about the number of cases managed in July). All reports are due by the 15th calendar day of the following month; the first report must be submitted following the first full month of the initial Contract period. Payment for the numbers of cases managed will be based on ODJFS acceptance of the monthly Caseload Report. The caseload fee is a fixed fee determined by ODJFS.

Quality Management Plan (QMP) – A Quality Management Plan must be submitted to ODJFS within three months of the Contract effective date or by September 30, 2004, whichever comes first. The initial QMP must define and describe the CMA's quality management system, including at minimum: goals for the CMA organization and common goals for all regional sites, measurement benchmarks, sampling methodologies, tracking systems, and information about planned quality assurance and quality improvement activities. The QMP must be aligned with the waiver assurances, the CMS HCBS Quality Framework outcomes (see Part One: Executive Summary, Objectives, for assurances and quality framework outcomes), and other standards outlined in this RFP. While the QMP must include, at a minimum, the following components, the Contractor is encouraged to develop a plan encompassing additional components based on their previous experience and expertise.

Clinical Management

A utilization management program, which addresses, at minimum, the following components:

- quarterly eligibility reviews, i.e. activities to determine the accuracy of a consumer's program eligibility, including accuracy of level of care, etc.
- quarterly case management reviews, including comparison of care plans to assessed consumer needs, meeting age-appropriate health maintenance requirements, etc.
- quarterly structural reviews, including compliance with documentation requirements, accuracy of assessment tool completion, compliance with assessment requirements, etc.
- annual peer reviews of case manager performance, including a multidisciplinary approach between nursing and social work perspectives, inclusion of other organizational perspectives, etc.

The reviews described above must examine each CMA clinician's work annually using a minimum sample size of five consumer records per clinician.

Provider Management

In accordance with program rules and requirements (see Supplement 5), activities and benchmarks for:

- an incident management, investigation, and response system; and
- provider enrollment; and
- provider monitoring, including billing reviews.

Program Management

- Methods and activities for providing ongoing technical assistance and education to providers and CMA staff.
- A communication plan for notifying consumer, providers, and other stakeholders of ODJFS rules and CMA internal policies and procedures.
- At a minimum, annual activities and benchmarks for assessing, monitoring, and improving consumer satisfaction (including consumer feedback mechanisms).

- Methods for monitoring authorized costs and cost of services delivered for each program, including for each program and ODJFS-specified subgroups (e.g. age, geographic location) minimum, maximum, mean, and median costs for all home care-related services and changes in costs over time.

Payment for this deliverable will be based on ODJFS acceptance of the QMP.

Quarterly Management Report – Management Reports must be submitted to ODJFS quarterly, i.e. no later than 15 calendar days after December 31, March 31, June 30, and September 30. The Management Report’s purpose is to summarize performance trends/patterns and their impact on the QMP components. It summarizes 1) how monthly performance results impact the QMP and 2) what actions the CMA plans for continuous improvement of the day-to-day management of the program(s). Specifically, each Management Report must include data supporting the current QMP goals and benchmarks, progress made toward goals and benchmarks, planned quality improvements or corrective actions based on analyzed data, any updated or new goals, and other updates or changes to the QMP. Information must reflect both the CMA statewide and each regional site.

While data from Monthly Performance Reports (as described later in this section) will be summarized for the Management Report, the Management Report is a separate and distinct reporting mechanism and has a broader scope than the Monthly Performance Report. Both types of reports are required to be submitted (including overlapping months of December, March, June, and September) and are paid as separate deliverables.

Payment for this deliverable will be based on ODJFS acceptance of each Management Report.

Monthly Performance Report – Performance Reports, based on an ODJFS-defined format, must be submitted to ODJFS monthly. All reports are due by the 15th calendar day of the following month; the first report must be submitted following the first full month after the Contract is initiated. Each performance report must include data about how well each regional site and the overall CMA (statewide) is meeting key waiver assurances described in the scope of work, including at minimum:

Clinical Management

- results of utilization management program reviews, when applicable during a particular month, meeting accuracy and compliance levels of at least 90% for the first year of the Contract and at least 95% for subsequent years of the Contract
- consumer health and safety – number of consumer incidents, including subcategories (e.g. type of incident, substantiated/unsubstantiated)

Provider Management

- provider monitoring – number of provider occurrences/notices of operational deficiency (NODs) plans of correction, unannounced visits, results of billing reviews, etc.
- provider enrollment - BCII checks and other licensure/certification checks, number of providers enrolled, etc.

Program Management

- maintaining statewide cost neutrality for each program, including analysis of reasons for increases or decreases in median program costs
- results of activities related to upholding consumer rights and increasing consumer participation, including at minimum:
 - consumer satisfaction levels of at least 90% for the first year of the Contract and at least 95% for subsequent years of the Contract
 - number of adverse actions (i.e. denials and disenrollments) and corresponding percentages of hearing rights notices given for those actions, number of hearings

held and the corresponding percentages of decisions sustained or decisions overruled

ODJFS will monitor baseline performance standards throughout the first six months of the Contract. ODJFS reserves the right to set and/or change minimum benchmarks after the first six months of Contractor performance.

Payment for this deliverable will be based on ODJFS acceptance of each monthly performance report (including clinical management, provider management, and program management components).

The Contractor's Fee Structure. The Contractor will invoice and the State will pay for the following tasks/deliverables as described in the Deliverable section of this RFP:

- Initial assessments
- Caseload managed
- Initial Quality Management Plan
- Management Reports
- Monthly Performance Reports

This RFP provides only an estimate of the State's requirements. No guarantee is made of any specific amount to be purchased. The Contractor will be compensated for the actual number of initial assessments performed, the number of cases managed, and the actual number of management reports and monthly performance reports submitted.

After six months of Contractor performance, a payment holdback of 1 percent to 3 percent per region will be applied to the payment of the quarterly management report and/or monthly performance report deliverables if one or more regions are performing below the minimum performance levels. The percentage of holdback will be determined by ODJFS and based on the severity of the deficiency. The holdback amount will be paid upon successful correction of the deficient area(s) in each region.

ODJFS is exploring the possibility of utilizing performance-based rate setting as a contract management tool. This approach would provide ODJFS the ability to increase the monthly performance report rate for maintaining exceptional performance levels in one or more regions. The continuation of the increased rate would depend on the continuation of the exceptional performance. If this concept is pursued, evaluation criteria will be developed within the first year of the Contract and implemented after June 30, 2005. A formal Contract amendment will be executed prior to implementing performance-based rate setting. In addition to monthly performance report results, annual program management review results/findings may be used to evaluate performance for this purpose. An example of a scoring mechanism that might be considered is:

- Level A – region scores between 96 and 100 points – rate increases up to 10%
- Level B – region scores between 90 and 95 points – rate increases up to 5%
- Level C – region scores below 90 points – no rate increase

Source of Funding; Third-Party Funding. None.

Reimbursable Expenses. None

Bill to Address. Contractor invoices must be prepared in accordance with State of Ohio and specific ODJFS invoice submission requirements. Billing instructions will be provided to the CMA during the initial contract implementation period.

ATTACHMENT TWO: REQUIREMENTS FOR PROPOSALS

Proposal Format. Each Proposal must include sufficient data to allow the State to verify the total cost to do the Work 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.

The offeror must provide a well-documented proposal that meets the requirements of this RFP, and must demonstrate the capability and experience of having successfully completed projects of similar size, scope and importance in a comparable time frame. Proposals may also include the use of subcontractors.

The offeror must give clear, full, detailed descriptions in response to all requirements. The offeror must not assume that the State or evaluation committee is familiar with the offeror's capabilities.

Any material deviation from the format outlined below may result in a rejection of the non-conforming Proposal.

Each Proposal must contain the following:

- Cover Letter
- Offeror Profile
- Organizational Experience Requirements
- Contract Performance
- Organizational Plan
- Personnel Profile Summaries
- Work Plan
- Support Requirements
- Cost Summary
- Conflict of Interest
- Payment Address
- Proof of Insurance
- Performance Bond Letter
- W-9 Form

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 must include an executive summary of the solution the offeror plans to provide. The letter must also have the following:

- a. A statement regarding the offeror's legal structure (e.g., an Ohio corporation), Federal tax identification number, and principal place of business;
- b. A list of the people who prepared the Proposal, including their titles;
- c. The name, phone number, and fax number of a contact person who has authority to answer questions regarding the Proposal;
- d. A list of all subcontractors, if any, that the offeror will use on the Project if the offeror is selected to do the work;

- e. 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:
 - 1. The subcontractor's legal status, tax identification number, and principal place of business address;
 - 2. The name and phone number of someone who is authorized to legally bind the subcontractor to contractual obligations;
 - 3. A description of the work the subcontractor will do;
 - 4. A commitment to do the work if the offeror is selected;
 - 5. A statement that the subcontractor has read and understood the RFP and will comply with the requirements of the RFP; and
- f. A statement that the offeror's Proposal meets all the requirements of this RFP.
- g. A statement that the offeror is not now, and will not become subject to an "unresolved" finding for recovery under ORC 9.24, prior to the award of a Contract arising out of this RFP, without notifying DAS of such finding.
- h. A statement that the offeror has not submitted its Proposal assuming that there will be an opportunity to negotiate any aspect of the Proposal.

Offeror Profile. Each Proposal must include a profile of the offeror's relevant experience working on projects similar to this Work. The profile must also include the offeror's legal name, address, and telephone number; 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 evaluation committee gauge the ability of the offeror to fulfill the obligations of the Contract.

The offeror must also include three (3) projects for which 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 a reference form as Attachment 6(A). The offeror must use this form and fill it out completely for each reference. 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.

Each reference must be willing to discuss the offeror's performance with the evaluation committee.

Offeror must submit letters of support from community/disability organizations and consumers supporting the offeror's organization and approach.

Organizational Experience Requirements. The offeror must provide projects that clearly demonstrate how the offeror or subcontractor meets the following experience requirements:

Organization with at least 60 months experience serving the disability community in the past ten years **OR** Case management organization that has at least 60 months experience managing home and community-based services programs in the past ten years

This RFP includes an Experience Requirement form as an Attachment Six (B). The offeror must use this form and fill it out completely for each project. The offeror is required to list the company that has performed work that is similar to the requirement. 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.

Each reference must be willing to discuss the offeror's performance with the State.

The offeror must describe in detail the following items on the forms provided in Attachment 6(B):

Requirements

1. At least three examples of alliance-building activities with consumer and advocacy groups and diverse stakeholders.
2. The offeror's capacity to provide a diverse and experienced workforce to meet the needs of all populations served by ODJFS-administered HCBS programs, including, but not limited to geriatrics, pediatrics, and mental health and MRDD.
3. At least 24 months experience in maintaining participant service costs within constraints set by third party payers.
4. A description or other demonstration of the offeror's understanding of long-term care, community care and disability issues.
5. The offeror's commitment to the CMS HCBS Quality Framework (see RFP Objective Section for further information). The description must include demonstrated value and commitment, such as the offeror's vision/mission statements, strategic management activities, specific quality improvement projects/activities/tools, organizational policies, etc.

Desirable

1. Not-for-profit organization
2. At least 24 months experience with federally-funded waiver programs or waiver demonstration projects in the past five years

Contract Performance. The offeror must complete Attachment 5.

Organizational Plan. The offeror must provide an organizational plan that describes the organization's capacity to manage all scope of work requirements stated in this RFP across the state and identifies all key personnel required to do the work. The organizational plan must indicate the key personnel's roles and responsibilities on the Project and the percentage of time each person will be devoted to the scope of work outlined in this RFP. The State is seeking an organizational plan that matches the proposed key personnel's experience and qualifications to the activities and tasks that will be completed on the Project. ODJFS is looking for creativity in approach and design. The plan must have the following information:

- A description of the organizational structure, including the identification of a minimum of four regional sites to support the demographics of the ODJFS-administered HCBS programs as described in the RFP.
- An organizational chart (including any subcontractors), specifying all personnel to meet the offeror qualifications and the percentage of time each person will be devoted to the scope of work outlined in this RFP. The evaluation committee may reject any Proposal that commits the proposed candidates to other projects during the term of the Project if the committee believes that doing so will be detrimental to the offeror's performance.
- A description of the communication flow between the regional sites, the coordinating site, and ODJFS.
- A matrix diagram matching key personnel to the staffing requirements in this RFP. The offeror must complete Attachment 8. Attachment 8 can be duplicated, as needed.
- A contingency plan that shows the ability to add more staff if needed to meet the requirements of this RFP. The contingency plan must include a description of the offeror's ability to provide qualified replacement personnel and a description of how it will ensure that sufficient staff are available to meet staffing requirements by the initial

Contract effective date and subsequent waiver implementation timeframes, address emergencies, leaves of absences, full/part time work status, and other absences.

- A facilities plan that addresses the capacity to meet the scope of work requirements, primarily outlined under the Program Management Functions section, and including at minimum:
 - Evidence (e.g. photos, written documentation/letters confirming compliance) that the offeror's proposed regional facilities are ADA compliant, at minimum providing access to the building, access to restrooms, and access to conference rooms.
 - A description of the public transportation options available in the community and near the CMA facility.
 - A description of the facility layout, including reception areas and available conference rooms.

Personnel Profile Summaries. Each Proposal must include a profile for each key member of the proposed Work team. This RFP includes a reference form as an attachment. The offeror must use this form and fill it out completely for each project. 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.

NOTE: The personnel profile summary forms contained in the Attachment Seven have been customized for each personnel requirement.

Each page of the form may contain minor variations. If an offeror elects to re-create the forms instead of typing in the forms using a typewriter, **please carefully review each form** to ensure that the forms have been created accurately, as failure to recreate the forms accurately may lead to the rejection of the offeror's proposal.

One of the criteria on which the State may base the award of the Contract is the quality of the offeror's project team. Switching personnel after the award will not be accepted without due consideration.

The offeror must propose a Project team that collectively meets all the requirements in this RFP, as demonstrated through the Personnel Profile Summary Forms. Additionally, each team member may have mandatory requirements listed in this RFP that the team member must individually meet.

Some of the personnel requirements contained in the following tables require proposed candidates to be licensed in the state of Ohio. All required licenses must be in place and a copy included in the offeror's proposal at the time of proposal submittal. It is not acceptable to proposed candidates that are in the process of obtaining licensing in Ohio.

Fully Completed Personnel Profile Summary Forms must be provided for the following positions.

Clinical Functions

Clinical Managers and Supervisors

Provider Management Functions

Provider Managers

Other Provider Management Personnel

Program Management Functions

Program Managers

Other Program Management Personnel

Because the number of staff proposed will be determined by each offeror's Organizational Plan, the number of proposed staff for each position will not be the same for all offerors. To account for this situation during the evaluation process, the State will average the scores by position. For example, if four (4) Provider Managers are proposed by an offeror, each proposed candidate will be scored according to the evaluation criteria. The four individual scores will be totaled and averaged. The average score for each position will be used as part of the proposal evaluation score.

All candidates proposed must meet the technical experience for the candidate's position and be identified by name. If any candidate does not meet the minimum requirements for the position the candidate has been proposed to fill, the offeror's Proposal may be rejected as non-responsive. The various sections of the form are described below.

- a) References. Provide 3 projects for which the proposed candidate has successfully provided services similar to those required for this RFP. These projects must be of similar size and scope and have occurred within the past 5 years. The name of the client contact, phone number, client company, address, brief description of project size and complexity, and dates (month and year) of experience must be given for each project. The candidate must provide a list of professional references that can attest to his/her specific qualifications. The references given should be a client contact person to whom the candidate reported and not a co-worker.

If less than three projects are provided, the offeror must include information as to why less than three projects were provided. The State may disqualify the proposal if less than three projects are given.

- b) 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.
- c) Mandatory Experience and Qualifications. This section must be completed to show how the candidate meets the required experience. For each project the following information must be provided:

Candidate Name.

Contact Information. The contact name, phone number, company name, and address must be completely filled out. If the primary contact cannot be reached, an alternate contact name in the company, address, and phone number must be provided in lieu of the primary contact.

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. These dates must be completed by giving a beginning month and year and an ending month and year.

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 project. It is the Contractors' responsibility to customize the description to clearly substantiate the candidate's qualification.

- d) Project Experience. 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.
- e) Resume. The candidate's resume must follow the completed form and show how the candidate meets the qualifications listed for the position in the RFP.

Note: Completed Personnel Profile Summary Forms are not required for Case Managers as part of the proposal submission. After award, the successful Contactor must provide names, resumes, and Ohio licensure/certifications for Case Manager candidates demonstrating that each candidate meets or exceeds the experience requirements for the Case Manager position. All other staff proposed in the offeror's Organizational Plan must have a fully completed Personnel Profile Summary Forms appropriate for their proposed position.

Work Plan. The offeror must fully describe its approach, methods, and specific work steps for doing the work and producing the Deliverables. The State encourages responses that demonstrate a thorough understanding of the nature of the work and what the Contractors must do to get the work done well. The offeror must also provide a complete and detailed description of the way it will do the work that addresses the areas of concern identified below.

The State seeks insightful responses that describe proven state-of-the-art methods. Recommended solutions should demonstrate that the offeror would be prepared to quickly undertake and successfully complete the required tasks. The offeror's work plan should clearly and specifically identify key personnel assignments and the number of hours by individual for each task.

ODJFS is looking for creativity in approach and design. The offeror must, at a minimum, provide the following elements:

- A description of the offeror's pre-screening and referral approach and system, including:
 - the referral of consumers to other entities
 - answering calls after regular office hours
 - addressing consumer emergencies
 - addressing the concerns of angry consumers and families
 - addressing inquiries from legislators or other governmental representatives
 - how it will inform consumers about the call-in system and its purpose
 - how the system will be monitored, how calls will be tracked and logged, and how logs will be maintained
 - how the calls will be monitored to ensure that calls are being answered and referred properly by call-in staff
- A prototype of a consumer handbook, an indication of how it will be made available to all ODJFS home and community-based program participants, how it will be available in various media, and how it will distribute the handbook to consumers with various needs, e.g. Braille, audio, multi-lingual, etc.
- A prototype of a community resource manual that the case management staff and consumers can access in order to obtain information about agencies and resources, other than Medicaid home care providers, by region. The offeror must describe how it will ensure that the manual is up to date with current information specific to each region where it provides Case Management and how it will be available in various media.
- A prototype of a Medicaid home care provider directory. RFP responses must include a description of how the provider directory will be made available to consumers upon request, maintained, and how it will be available in various media.

- A Technology Plan. The Technology Plan must describe how the CMA will utilize technology in carrying out the requirements of this RFP, including how it will make resource handbooks and manuals available online, how it will use technology in physical office locations and with any remote staff, how it will use technology to communicate with consumers and gather consumer feedback, etc.
- A Training Plan. The Training Plan must describe what sources of training will be used (hospitals, DHS, community colleges, CBMRDDs, etc.) with CMA staff, how pertinent topics will be selected, and how training will be delivered and documented.
- The offeror must describe its record-keeping policies and procedures, including maintaining the confidentiality of consumer records, assuring consumers have access to their own records upon request, and retention of records in accordance with federal and state law.
- The procedures and standards that will be used to ensure successful team meetings/collaborations, including how documentation will be maintained, and how information will be shared among team members.
- A Start Up Plan. The Start Up Plan must describe how the offeror will collaborate with ODJFS in effectively initiating the Contract, including but not limited to orienting staff to the scope of work described in this RFP and work with existing Contractors in transferring consumer cases and records.
- A Supports Brokerage Plan. The offeror must describe how it would meet the supports brokerage scope of work described in this RFP.
- The offeror must describe the procedures it will use to assure that consumer Medicaid expenditures for covered services fall within each individual's cost cap, including a description of reports to be submitted to ODJFS summarizing the results of such monitoring. Under the Support Requirements section described in this RFP, the offeror must describe the type(s) of information that would be required from the State for this process.

Support Requirements. The offeror must describe the support it wants from the State other than what the State has offered elsewhere in this RFP. Specifically, the offeror should address the following:

- Nature and extent of State support required;
- Assistance from State staff and the experience/qualification level required; and
- Other support requirements.

The State may not be able or willing to provide the additional support the offeror lists in this part of its Proposal. The offeror must therefore indicate whether its request for additional support is a requirement for its performance. If any part of the list is a requirement, the State may reject the offeror's Proposal if the State is unwilling or unable to meet the requirements.

Cost Summary. This RFP includes a Cost Summary Form provided as an attachment. Offerors may not reformat this form. Each offeror must complete the cost summary sheet in the exact format provided. Any reformatting may cause the State to reject the offeror's Proposal.

A greater proportion of cost is anticipated for qualitative deliverables (QMP, Management Reports, Monthly Performance Reports) than quantitative deliverables. In addition, a greater proportion of cost is anticipated for Monthly Performance Reports than the other qualitative deliverables.

The State will not be liable for any costs the offeror does not identify in its Proposal.

Conflict of Interest. Each Proposal must include a statement indicating whether the offeror or any people that may do the Work 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.

Payment Address. The offeror must give the address to which payments to the offeror will be sent.

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

Performance Bond. The Contractor must provide a performance bond. The amount of the performance bond must be equal to at least 5% of the total annual 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.

W-9 Form. The offeror must complete the attached W-9 form in its entirety. At least one original W-9 form must be submitted. All other copies of a Proposal may contain copies of the W-9 form. Please indicate on the outside of the binder which Proposal contains the original signature.

ATTACHMENT THREE: GENERAL TERMS AND CONDITIONS
PART ONE: PERFORMANCE AND PAYMENT

Statement of Work. The RFP and the Contractor's Proposal (Collectively referred to as the "RFP") are a part of this Contract and describe the work (the "Work") the Contractor will do and any materials or services (including all work product) the Contractor will deliver (the "Deliverables") under this Contract. The Contractor will do the Work in a professional, timely, and efficient manner and will provide the Deliverables in a proper fashion.

The Contractor will consult with the appropriate State representatives and others necessary to ensure a thorough understanding of the Work and satisfactory performance. The State may give instructions to or make requests of the Contractor relating to the Work, and 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 Work and will not amend or alter the scope of the Work.

Bond. If the RFP provides a dollar amount for a performance bond, the Contractor will provide the State with a performance bond in that amount within 5 business days after execution of this Contract. The performance bond will serve as an assurance that the Contractor and all of its subcontractors will comply with all requirements of this Contract. The performance bond will indemnify the State against all direct damages it suffers from any failure of the Contractor to perform. The bond must be issued by a company authorized by Ohio's Department of Insurance to do business in Ohio. Failure of the Contractor to provide the performance bond on or before the date it is required to be delivered to the State will result in a breach of this Contract without a cure period and termination or suspension (or ultimately both) of this Contract for cause.

The terms of the bond must reflect the terms of this section, or the State will reject it and treat the failure of conformance as a failure by the Contractor to deliver the bond in a timely fashion.

Term. Unless this Contract is terminated or expires without renewal, it will remain in effect until June 30 2009. But the current General Assembly cannot commit a future General Assembly to an expenditure. Therefore, this Contract will automatically expire at the end of the current biennium, which is June 30, 2005. The State may renew the Contract after June 30, 2005 and for two (2) optional biennia by giving written notice to the Contractor before June 30, of the second year of the current term. The State *intends* to renew the Contract for the biennium beginning July 1, 2005 and *may* renew for the biennium beginning July 1, 2007. Termination or expiration of this Contract will not limit the Contractor's continuing obligations with respect to Deliverables that the State paid for before termination or limit the State's rights in such.

It is understood that the State's funds are contingent upon the availability of lawful appropriations by the Ohio General Assembly. If the General Assembly fails at any time to continue funding for the payments and other obligations due as a 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 Contractor must comply with all its obligations under this Contract within the specified time. If the Contractor does not meet those times, the Contractor will be in default, and the State may terminate this Contract under the termination provision contained below. But 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 effected 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 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 State Project Representative and the State Procurement Representative. The extension of the Contractor's performance time will be, at the State's discretion, the Contractor's only remedy for the State's delay.

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"), plus any other expenses identified as reimbursable in the RFP. But 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 all relevant parts of the Work tied to the payment. 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 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 "Code"). That section of the Code currently requires monthly interest payments equal to one 12th of the rate per annum prescribed by Section 5703.47 of the 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. In addition, the State will consult with the Contractor as early as reasonably possible about the nature of the dispute and the amount of payment affected. When the Contractor has resolved the disputed matter to the State's satisfaction, the State will pay the disputed amount within 30 business days after 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. On written request from the Contractor, the State will provide reasonable assistance in determining the nature of the problem by giving the Contractor reasonable access to the State's facilities and any information the State has regarding the problem.

Reimbursable Expenses. The State will pay all reimbursable expenses identified in the RFP, if any, in accordance with the terms in the RFP and, where applicable, Section 126.31 of the Code. The Contractor will assume all expenses that it incurs in the performance of this Contract that are not identified as reimbursable in the RFP.

In making any reimbursable expenditure, the Contractor will always comply with the more restrictive of its own, then-current internal policies for making such expenditures or with the State's then-current policies. All reimbursable travel will require the advance written approval of the State's Representative. All reimbursable expenses will be billed monthly and paid by the State within 30 business days of receiving the Contractor's invoice.

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:

- (a) All statutory provisions under the Code, including Section 126.07, have been met;

- (b) All necessary funds are made available by the appropriate state agencies;
- (c) If required, approval of this Contract is given by the Controlling Board of Ohio; and
- (d) 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.

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.

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 Work, such will be the sole and exclusive responsibility of the Contractor, and 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 a later time.

PART TWO: WORK & CONTRACT ADMINISTRATION

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 Work duplicates the work done or to be done under the other contracts.

Subcontracting. The Contractor may not enter into subcontracts for the Work after award without written approval from the State. But 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 Work. 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 Work 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. And 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 Replacement Personnel and Subcontractors, 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. But this exception is applicable only to sections that expressly provide an exclusion 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.

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. And the Contractor will keep all Work-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 Work (the "Work Account"). All payments made from the Work 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 Work 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 Work Account.

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

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 need 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 Work records. The Contractor will do so with all due speed, not to exceed five business days.

If any audit reveals any material deviation from the Work'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 \$25,000.00, 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. But the Contractor may not artificially break up contracts with its subcontractors to take advantage of this exclusion.

Equal Employment Opportunity. During the Work, the Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, disability, age, or Vietnam-era veteran status ("Protected Status"). The Contractor will ensure that applicants for employment and employees are treated without regard to their Protected Status.

The Contractor agrees to post notices with the provisions of this section in conspicuous places that are available to employees and applicants and to state in all solicitations and advertisements for employees that it is an equal opportunity employer.

Insurance. The Contractor will provide the following insurance coverage at its own expense throughout the term of this Contract:

- (a) 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 will also maintain employer's liability insurance with at least a \$1,000,000.00 limit.

- (b) 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 will also be endorsed to include a blanket waiver of subrogation. 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.

- (c) Commercial Automobile Liability insurance with a combined single limit of \$500,000.
- (d) Professional Liability insurance covering all staff with a minimum limit of \$1,000,000 per incident and \$3,000,000 aggregate. If the offeror's policy is written on a "claims made" basis, the offeror 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 offeror must purchase and maintain "tail" coverage through the applicable statute of limitations.

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.

State Personnel. During the term of this Contract and for one year after completion of the Work, the Contractor will not hire or otherwise contract for the services of any state employee involved with the Work.

Replacement Personnel. The quality and professional credentials of the people the Contractor submitted in its proposal to do the Work 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 Work without the prior, written consent of the State, except as provided below.

The Contractor may remove a person listed in the RFP from the Work if doing so is necessary for legal or disciplinary reasons, provided that the Contractor makes a reasonable effort to give the State 30 calendar days' prior, written notice of the removal.

The Contractor must have qualified replacement people available to replace any people listed by name in the RFP. When the removal of a listed person is permitted under this Section, or if a person becomes unavailable, the Contractor will submit the resumes for two replacement people for each person removed or who otherwise becomes unavailable. The Contractor will submit the two resumes, along with such other information as the State may reasonably request, within five business days after the decision to remove a person is made or the unavailability of a listed person becomes known to the Contractor.

The State will select one of the two proposed replacements or will reject both of them within ten business days after the Contractor has submitted the proposed replacements to the State. The

State may reject the proposed replacements for any legal reason(s). Should the State reject both replacement candidates due to their failure to meet the minimum qualifications identified in the RFP, or should the Contractor fail to provide the notice required under this Section or fail to provide two qualified replacement candidates for each removed or unavailable person, the Contractor will be in default and the cure period for default specified elsewhere in this Contract will not apply. In the event of such a default, the State will have the right to terminate this Contract and to have the damages specified elsewhere in this Contract for termination due to default.

The State may determine that proposed replacement candidates meet the minimum qualifications of this Contract and still substantially reduce the value the State perceived it would receive through the work of the original individual(s) the Contractor proposed and on whose credentials the State decided to enter into this Contract. Therefore, the State will have the right to reject any candidate that the State determines will provide it with diminished value.

Should the State reject both proposed candidates for any legal reason other than their failure to meet the minimum qualifications identified in the RFP, then such rejection will be deemed a termination for convenience.

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 doing any part of the Work 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 on the RFP.

Suspension and Termination. The State may terminate this Contract if the Contractor defaults in meeting its obligations under this Contract and fails to cure its default within the time allowed by this Contract, or if a petition in bankruptcy (or similar proceeding) has been filed by or against the Contractor. The State may also terminate this Contract if the Contractor violates any law or regulation in doing the Work, 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.

On written notice, the Contractor will have 30 calendar days to 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. The State may also terminate this Contract in the case of breaches that are cured within 30 calendar days but are persistent. "Persistent" in this context means that the State has notified the Contractor in writing of the Contractor's failure to meet any of its obligations three times. After the third notice, the State may terminate this Contract without a cure period if the Contractor again fails to meet any obligation. The three notices do not have to relate to the same obligation or type of failure. 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 Work. If a third party is providing funding for the Work, the State may also terminate this Contract should that third party fail to release any Work funds. The RFP identifies any third party source of funds for the Work.

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 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 detail 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. But, 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 Work 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 Work to the extent that such costs, when combined with payments already made to the Contractor for the Work before termination, exceed the costs that the State would have incurred under this Contract. The Contractor will also be liable for any other direct 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 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 applicable unit(s) of Work 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 Contract 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 Work rather than termination for cause, the Contractor will not be entitled to any compensation for any part of the Work performed. If the State reinstates the Contract 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 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 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 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. And the Contractor will prepare a report concerning the Work just as is required by this Section in the case of termination. After suspension of the Contract, the Contractor will perform no Work without the consent of the State and will resume the 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 Contract. 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 Contract 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 Work 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.

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

The Contractor's Project Manager under this Contract will be the person identified on the RFP 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. But the Project Manager may not be replaced without the approval of the State if s/he is identified in the RFP as a key individual on the Project.

Work Responsibilities. The State will be responsible for providing only those things expressly identified, if any, in the RFP. If the State has agreed to provide facilities or equipment, the Contractor, by signing this Contract, warrants that the Contractor has either inspected the facilities and/or equipment or has voluntarily waived an inspection and will work with the equipment and/or facilities on an "as is" basis.

Normal working hours on State property is Monday through Friday (except for State holidays) from 8:00 a.m. to 5:00 p.m., Eastern Standard Time, with a one hour for lunch. The Contractor must plan to work within these time constraints for any Work that will be done on State property.

If the Work, or parts of it, will be performed on the State's property, the State will provide the Contractor with reasonable access to that property.

The Contractor will provide a written report to the Work Representative at least as often as the end of every other week throughout the term of this Contract, or as otherwise provided in the RFP.

Unless otherwise provided in the RFP, the Contractor will be responsible for obtaining all official permits, approvals, and similar authorizations required by any local, state, or Federal agency for the Work.

Changes. The State may make reasonable changes, within the general scope of the Project, in any one or more of the following: (I) Project tasks or subtasks; (ii) time or place of delivery; or (iii) period of performance. The State will do so by issuing a written order under this Contract describing the nature of the change ("Change Order"). Additionally, if the State provides directions or makes requests of the Contractor without a change order, and the Contractor reasonably believes the directions or requests are outside the specifications for the Project, the Contractor will have the right to request a Change Order from the State. Scope of work changes will be managed as follows: pricing will be provided from the Contractor to the State. The State

will execute a Change Order once it and the Contractor have agreed on the description of and specifications for the change as well as any equitable adjustments that need to be made in the Contractor's Fee or the performance schedule for the Work. Within five business days after receiving the Change Order, the Contractor will sign it to signify agreement with it.

If a change causes an increase in the cost of, or the time required for, the performance of the Work, the Contractor will notify the State in writing and request an equitable adjustment in the Contractor's Fee, the delivery schedule, or both before the Contractor signs the Change Order. If the Contractor claims an adjustment under this section in connection with a change to the Work not described in a written Change Order, the Contractor must notify the State of such claim within five business days after the Contractor is notified of the change and before work on the change begins. Otherwise, the Contractor will have waived the claim. In no event will the State be responsible for any increase in the Fee or revision in any delivery schedule unless the relevant change was specifically ordered in writing by the State and the Contractor has complied with the requirements of this section. Provided the State has complied with the procedure for Change Orders in this section, nothing in this clause will excuse the Contractor from proceeding with performance of the Work as changed.

Where an equitable adjustment to the Contractor's fee is appropriate, the State and the Contractor may agree upon such an adjustment. If the State and the Contractor are unable to agree, and the Contractor seeks an equitable adjustment in its Fee, the Contractor must submit its actual costs for materials needed for the change (or estimated amount if the precise amount of materials cannot be determined) and an estimate of the hours of labor required to do the Work under the Change Order. The hours of labor will be broken down by employee position, and the actual hourly pay rate for each employee involved in the change must be provided. The total amount of the equitable adjustment for the Change Order will then be made based on the actual cost of materials (or estimated materials) and actual rate for each person doing the labor (based on the estimated hours of work required to do the change). Labor rates will be increased by 25% to cover benefits and taxes. The equitable adjustment for the Change Order will then be set based on this amount, plus 15% to cover overhead and profit. Alternatively, if the Contractor's proposal provides for hourly rates for each position involved in the Change Order, then those rates will apply rather than the actual rates, and there will be no adjustment for benefits, taxes, overhead, or profit. This amount will be the not-to-exceed amount of the Change Order. However, if the change involves removing a requirement from the Work or replacing one part of the Work with the change, the State will get a credit for the Work no longer required under the original scope of the Work. The credit will be calculated in the same manner as the Contractor's Fee for the change, and the not-to-exceed amount will be reduced by this credit.

The Contractor will be responsible for coordinating changes with its subcontractors and adjusting their compensation and performance schedule. The State will not pay any subcontractor for the Change Order. If a subcontractor will perform any Work under a Change Order, that Work must be included in the Contractor's not-to-exceed amount and calculated in the same manner as the Contractor's equitable adjustment for the portion of the Work the Contractor will perform. The Contractor will not receive an overhead percentage for anything a subcontractor will do under a Change Order.

Excusable Delay. Neither party will be liable for any delay in its performance that arises from causes beyond its control and without its negligence or fault. The delayed party will notify the other promptly of any material delay in performance and will specify in writing the proposed revised performance date or dates as soon as practicable after notice of delay. In the event of any such excusable delay, the dates of performance or of delivery affected by the delay will be extended for a period equal to the time lost by reason of the excusable delay. The delayed party must also describe the cause of the delay and what steps it is taking to remove the cause. The delayed party may not rely on a claim of excusable delay to avoid liability for a delay if the delayed party has not taken commercially reasonable steps to mitigate or avoid the delay. Things that are controllable by the Contractor's subcontractors will be considered controllable by the

Contractor, except for third-party manufacturers supplying commercial items and over whom Contractor has no legal control.

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.

PART THREE: OWNERSHIP & HANDLING OF INTELLECTUAL PROPERTY & CONFIDENTIAL INFORMATION

Confidentiality. 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 agrees to 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 and by no means by way of limitation, information should be treated as confidential if it includes 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 agrees not to disclose any Confidential Information to third parties and to use it solely to do the Work. 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 Work. 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 be liable for any unintentional disclosure of Confidential Information that results despite the Contractor's exercise of at least the same degree of care as it normally takes to preserve and safeguard its own secrets, except when the Contractor's procedures are not reasonable given the nature of the Confidential Information or where the disclosure nevertheless results in liability to the State.

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

The Contractor's obligation to maintain the confidentiality of the Confidential Information will not apply where such: (1) was already in the Contractor's possession before disclosure by the State, and such was received by the Contractor without obligation of confidence; (2) is independently developed by the Contractor; (3) is or becomes publicly available without breach of this Contract; (4) is rightfully received by the Contractor from a third party without an obligation of confidence; (5) is disclosed by the Contractor with the written consent of the State; or (6) is released in

accordance with a valid order of a court or governmental agency, provided that the Contractor (a) notifies the State of such order immediately upon receipt of the order and (b) makes a reasonable effort to obtain a protective order from the issuing court or agency limiting disclosure and use of the Confidential Information solely for the purposes intended to be served by the original order of production. The Contractor will return all originals of any Confidential Information and destroy any copies it has made on termination or expiration of this Contract.

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

Ownership of Deliverables. All custom Work done by the Contractor and covered by this Contract will 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. Additionally, the Contractor waives any author rights and similar retained interests in custom-developed material. The Contractor will provide the State with all assistance reasonably needed to vest such rights of ownership in the State.

PART FOUR: REPRESENTATIONS, WARRANTIES AND LIABILITIES

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 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 and regulations, including those of the State regarding conduct on any premises under the State's control; and (4) the Contractor has good and marketable title to any goods delivered under this Contract and in which title passes to the State.

The warranty regarding professionalism and material defects is a one-year warranty. All other warranties will be continuing warranties. If any portion of the Work or a Deliverable fails to comply with these warranties, and the Contractor is so notified in writing, the Contractor will correct such failure with all due speed or will refund the amount of the compensation paid for such portion of the Work or the applicable Deliverable. The Contractor will also indemnify the State for any direct damages and claims by third parties based on a breach of these warranties. This obligation of indemnification will not apply where the State has modified or misused the Deliverable and the claim is based on the modification or misuse. The State agrees to give the Contractor notice of any such claim as soon as reasonably practicable. 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 of the following four things: (1) modify the Deliverable so that it is no longer infringing; (2) replace the Deliverable with an equivalent or better item; (3) acquire the right for the State to use the infringing Deliverable as it was intended for the State to use under this Contract; or (4) remove the Deliverable and refund the amount the State paid for the Deliverable and the amount of any other Deliverable or item that requires the availability of the infringing Deliverable for it to be useful to the State.

General Exclusion of Warranties. THE CONTRACTOR 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 WILL MEET THE STATED PURPOSE FOR THAT WORK.

Indemnity for Property Damage and Bodily Injury. The Contractor will indemnify the State for all liability and expense resulting from bodily injury to any person (including injury resulting in death) and damage to property arising out of the performance of this Contract, providing such bodily injury or property damage is due to the fault of the Contractor, its employees, agents, or subcontractors.

Limitation of Liability. The parties agree as follows:

- 1) The parties are not 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.
- 2) The Contractor further agrees that the Contractor shall be liable for all direct damages due to the fault or negligence of the Contractor.

Passage of Title. Title to any Deliverable will pass to the State only on acceptance of the Deliverable. All risk of loss, regardless of the cause, will remain with the Contractor until title to the Deliverable passes to the State.

PART FIVE: CONSTRUCTION

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.

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.

Amendments - Waiver. No amendment or modification of 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 construed as a waiver or relinquishment of any such term and either party may at any later time demand strict and complete performance by the other party of such a term.

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.

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

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

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.

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

PART SIX: LAW & COURTS

Compliance with Law. The Contractor agrees to comply with all applicable Federal, state, and local laws in the conduct of the Work.

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.

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 Work 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 all legal steps to ensure that such a person does not participate in any action affecting the Work under this Contract, unless the State has determined that, in the light of the personal interest disclosed, that person's participation in any such action would not be contrary to the public interest.

Ohio Ethics and Elections Law. The Contractor certifies that it is currently in compliance and will continue to adhere to the requirements of the Ohio ethics law, O.R.C. §102.04. The Contractor affirms that, as applicable to the Contractor, no party listed in Division (I) or (J) of Section 3517.13 of the Ohio Revised Code or spouse of such party has made, as an individual, within the two previous calendar years, one or more contributions totaling in excess of \$1,000.00 to the Governor or to his campaign committees.

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.

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.

Governing Law. This Contract will be governed by the laws of Ohio, and venue for any disputes will lie exclusively with the appropriate court in Franklin County, Ohio.

Health Insurance Portability & Accessibility Act (HIPAA) Requirements. As a condition of receiving a contract from the State, the Contractor, and any subcontractor(s), will be required to 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 ODJFS 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 CFR164.501 and any amendments thereto.

HIPAA compliance requires, at minimum, that the Contractor:

- shall not use or disclose PHI except as specifically required under the terms of the Contract with the State, or as otherwise required under the HIPAA regulations or other applicable law.
- shall use appropriate safeguards to protect against use or disclosure not provided for by this Agreement.

- shall promptly report to the State any knowledge of uses or disclosures of PHI that are not in accordance with the contract or applicable law. In addition, the Contractor shall mitigate any adverse effects of such a breach to the extent possible.
- shall ensure that all its agents and subcontractors that receive PHI from or on behalf of the Contractor and/or the State agree to the same restrictions and conditions that apply to Contractor with respect to the use or disclosure of PHI.
- shall make available to the State such information as the State may require to fulfill its obligations to provide access to, provide a copy of, and account for disclosures with respect to PHI pursuant to HIPAA and related regulations.
- shall make PHI available to the State in order for the State to fulfill its obligations pursuant to HIPAA to amend the information and shall, as directed by the State, incorporate any amendments into the information held by the Contractor and ensure incorporation of any such amendments into information held by its agents or subcontractors.
- shall make available its internal practices, books and records relating to the use and disclosure of PHI received from the State, or created and received by the contractor on behalf of the State, to the State and to the Secretary of the U.S. Department of Health and Human Services for the purpose of determining the State compliance with HIPAA and the regulations promulgated by the United States Department of Health & Human Services and any amendment thereto.
- shall, upon termination of this Agreement, at the option of the State, return to the State, or destroy, all PHI in its possession, and keep no copies of the information except as requested by the State or required by law. If the Contractor or its agent or subcontractor destroys any PHI, then the Contractor will provide the State with documentation evidencing such destruction. Any PHI maintained by the Contractor shall continue to be extended the same as required by HIPAA and the State for as long as it is maintained.

In the event of a material breach of Contractor obligations under this section, the State may at its option terminate the Contract according to provisions within the contract for termination.

SAMPLE

ATTACHMENT FOUR

**A CONTRACT BETWEEN
THE OHIO DEPARTMENT OF ADMINISTRATIVE SERVICES
ON BEHALF OF THE DEPARTMENT OF JOB & FAMILY SERVICES
AND**

(CONTRACTOR)

THIS CONTRACT, which results from CSP#0A04022, entitled Case Management RFP, is between the state of Ohio, through the Department of Administrative Services, Investment and Governance Division, on behalf of the Ohio Department of Job & Family Services (the "State") and (the "Contractor").

The Contract consists of this RFP including all attachments, written amendments to this RFP, the Contractor's proposal, and written, authorized amendments to the Contractor's proposal. It will also include any materials incorporated by reference in the above documents and any change orders issued under the Contract. The form of the Contract is this one page, 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 preference 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 _____, 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

STATE OF OHIO
DEPARTMENT OF ADMINISTRATIVE SERVICES

By: _____

By: _____

Title:

Title: DAS Director

Date:

Date:

**ATTACHMENT FIVE
CONTRACT PERFORMANCE**

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

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.
	Trading in the stock of the company has ever been suspended with 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 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 evaluation committee, such an answer and a review of the background details may result in a rejection of the offeror's proposal. The committee 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 contract, and the best interests of the State.

**ATTACHMENT SIX (A)
OFFEROR'S REFERENCES**

The offeror must also include three (3) projects for which 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.

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe how project was similar in size and scope:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe how project was similar in size and scope:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe how project was similar in size and scope:		

**ATTACHMENT SIX (B)
EXPERIENCE REQUIREMENTS**

Organization with at least 60 months experience serving the disability community in the past ten years **OR** Case management organization that has at least 60 months experience managing home and community-based services programs in the past ten years

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe how the organization served the disability community or managed home and community-based services:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe how the organization served the disability community or managed home and community-based services:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe how the organization served the disability community or managed home and community-based services:		

**ATTACHMENT SIX (B)
EXPERIENCE REQUIREMENTS**

At least 24 months experience in maintaining participant service costs within constraints set by third-party payers

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe the process for maintaining participant service costs within constraints set by third-party payers:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe the process for maintaining participant service costs within constraints set by third-party payers:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe the process for maintaining participant service costs within constraints set by third-party payers:		

**ATTACHMENT SIX (B)
DESIRABLE EXPERIENCE REQUIREMENTS**

At least 24 months experience with federally-funded waiver programs or waiver demonstration projects in the past five years

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe the federally-funded waiver program or waiver demonstration project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe the federally-funded waiver program or waiver demonstration project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe the federally-funded waiver program or waiver demonstration project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE SUMMARY**

Candidate's Name:

The offeror must include three references for which the candidate has successfully provided services on projects that are similar in nature, size and scope to the project proposed. These references must relate to work that was completed within the past five (5) years.

Company:		Contact:	
Address:		Phone Number:	
Project Name:	Beginning Date of Employment Month/Year:	Ending Date of Employment Month/Year:	
Description of related services provided:			

Company:		Contact:	
Address:		Phone Number:	
Project Name:	Beginning Date of Employment Month/Year:	Ending Date of Employment Month/Year:	
Description of related services provided:			

Company:		Contact:	
Address:		Phone Number:	
Project Name:	Beginning Date of Employment Month/Year:	Ending Date of Employment Month/Year:	
Description of related services provided:			

**ATTACHMENT SEVEN
PERSONNEL PROFILE SUMMARY**

Candidate's Name _____

Position/Role _____

This form must be completed for each candidate proposed.

(Note: Please attach a copy of your resume to this document)

The candidate's name and education & training information must be provided below:

Education and Training

	Months/Years Training	Where Obtained	Degree/Major/Year Earned
College	_____	_____	_____
Technical School	_____	_____	_____
Other Training	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Clinical Functions
Clinical Manager or Supervisor**

At least 36 months experience in HCBS environment within the last 10 years

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe how project was similar in size and scope as defined in the RFP:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe how project was similar in size and scope as defined in the RFP:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe how project was similar in size and scope as defined in the RFP:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Clinical Functions
Clinical Manager or Supervisor Team Requirement**

One person with at least 36 months of pediatric specialty experience within the last 10 years

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Clinical Functions
Clinical Manager or Supervisor Team Requirement**

One person with at least 36 months of MRDD specialty experience within the last 10 years

Candidate's Name _____

Company:	Contact Name:	Contact Title:	
Address:		Contact Phone Number:	
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year	
Description of Related Services Provided:			
Describe candidate's role on this project:			

Company:	Contact Name:	Contact Title:	
Address:		Contact Phone Number:	
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year	
Description of Related Services Provided:			
Describe candidate's role on this project:			

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Clinical Functions
Clinical Manager or Supervisor Team Requirement**

One person with at least 36 months of mental health specialty experience within the last 10 years

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Provider Management Functions
Provider Manager**

At least 24 months experience in home and community-based services environment within the last 5 years

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Provider Management Functions
Provider Manager**

At least 24 months experience with quality improvement systems (can include experience working with the CMS HCBS Quality Framework)

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Provider Management Functions
Provider Manager**

At least 24 months social service management experience, including knowledge of and/or experience with community resources and service delivery system, law enforcement, etc.

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Provider Management Functions
PROVIDER MANAGER
DESIRABLE REQUIREMENT**

At least 60 months management experience in a home and community-based environment within the past 10 years

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Provider Management Functions
PROVIDER MANAGER
DESIRABLE REQUIREMENT**

At least 6 months professional experience with financial management or financial monitoring systems

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Provider Management Functions
OTHER PROVIDER MANAGEMENT PERSONNEL**

At least 24 months experience in home and community-based services environment

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Provider Management Functions
OTHER PROVIDER MANAGEMENT PERSONNEL**

At least 24 months experience with quality improvement systems (can include experience working with the CMS HCBS Quality Framework)

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Provider Management Functions
OTHER PROVIDER MANAGEMENT PERSONNEL**

At least 24 months of knowledge and/or experience with community resources and service delivery systems (MRDD, Adult Protective Services, Children Services, Community Mental Health System, law enforcement, etc.)

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Provider Management Functions
OTHER PROVIDER MANAGEMENT PERSONNEL
DESIRABLE REQUIREMENT**

At least 12 months experience with consumer incident reporting systems or other consumer health and safety reporting systems

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Program Management Functions
PROGRAM MANAGER**

At least 96 months of management experience

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Program Management Functions
PROGRAM MANAGERS
DESIRABLE REQUIREMENT**

At least 60 months management experience in a home and community service delivery or a health-related field

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Program Management Functions
PROGRAM MANAGERS
DESIRABLE REQUIREMENT**

At least 24 months experience with quality improvement systems (can include experience working with the CMS HCBS Quality Framework)

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Program Management Functions
OTHER PROGRAM MANAGEMENT PERSONNEL**

At least 60 months of program management or program analysis experience

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Program Management Functions
OTHER PROGRAM MANAGEMENT PERSONNEL
DESIRABLE REQUIREMENT**

At least 24 months experience in home in home and community service delivery or health-related field

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Program Management Functions
OTHER PROGRAM MANAGEMENT PERSONNEL
DESIRABLE REQUIREMENT**

At least 12 months experience with quality management systems (can include experience working with the CMS HCBS Quality Framework)

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Program Management Functions
OTHER PROGRAM MANAGEMENT PERSONNEL
TEAM REQUIREMENT**

One person with at least 24 months experience in data analysis and/or data trending

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT SEVEN
PERSONNEL PROFILE
Program Management Functions
OTHER PROGRAM MANAGEMENT PERSONNEL
TEAM REQUIREMENT**

One person with at least 24 months experience in accounting and/or financial analysis

Candidate's Name _____

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

Company:	Contact Name:	Contact Title:
Address:		Contact Phone Number:
Project Name:	Beginning Date of Employment: Month/Year	Ending Date of Employment: Month/Year
Description of Related Services Provided:		
Describe candidate's role on this project:		

**ATTACHMENT EIGHT
TEAM PERSONNEL GRID**

Mandatory Experience Requirements	Team Member A	Team Member B	Team Member C	Team Member D
<i>Clinical Functions</i>				
Requirements for Clinical Managers and Supervisors				
Registered nurse (RN), or licensed social worker (LSW, LISW), or licensed counselor (LPC,LPCC) in the State of Ohio				
At least 36 months experience in an HCBS environment within the last 10 years				
Desirable Requirement				
Master's degree in a business or health-related field				
Team Requirements				
One person with at least 36 months of pediatric specialty experience within the last 10 years				
One person with at least 36 months of MRDD specialty experience within the last 10 years				
One person with at least 36 months of mental health specialty experience within the last 10 years				
<i>Program Management Functions</i>				
Requirements for Provider Managers				
Registered nurse (RN), or licensed social worker (LSW, LISW) in the State of Ohio				
At least 24 months experience in home and community-based services environment within the last 5 years				
At least 24 months experience with quality improvement systems (can include experience working with the CMS HCBS Quality Framework)				
At least 24 months social service management experience, including knowledge of and/or experience with community resources and service delivery system, law enforcement, etc.				
Desirable Requirement				
Master's degree in a business or health-related field				
At least 60 months management experience in a home and community-based environment within the past 10 years				
At least 6 months professional experience with financial management or financial monitoring systems				
Requirements for Other Provider Management Personnel				
Registered nurse (RN), or licensed social worker (LSW, LISW) in the State of Ohio				
At least 24 months experience in home and community-based services environment				
At least 24 months experience with quality improvement systems (can include experience				

working with the CMS HCBS Quality Framework)				
Desirable Requirement				
At least 12 months experience with consumer incident reporting systems or other consumer health and safety reporting systems				
Program Management Functions				
Requirements for Program Managers				
Master's degree in a business or health-related field				
At least 96 months of management experience				
Desirable Requirements				
At least 60 months management experience in a home and community service delivery or a health-related field				
At least 24 months experience with quality improvement systems (can include experience working with the CMS HCBS Quality Framework)				
Requirements for Other Program Management Personnel				
Bachelor's degree in a business or health-related field				
At least 60 months of program management or program analysis experience				
Desirable Requirements				
At least 24 months experience in home and community service delivery or a health-related field				
At least 12 months experience with quality management systems (can include experience working with the CMS HCBS Quality Framework)				
Team Requirements				
One person with at least 24 months experience in data analysis and/or data trending				
One person with at least 24 months experience in accounting or financial analysis				

Note: Because the number of staff proposed will be determined by each offeror's Organizational Plan, the number of proposed staff for each position will not be the same for all offerors. To account for this situation during the evaluation process, the State will average the scores by position. For example, if four (4) Provider Managers are proposed by an offeror, each proposed candidate will be scored according to the evaluation criteria. The four individual scores will be totaled and averaged. The average score for each position will be used as part of the proposal evaluation score.

**ATTACHMENT NINE
COST SUMMARY**

This RFP provides only an estimate of the State's requirements. No guarantee is made of any specific amount to be purchased. The Contractor will be compensated for the actual number of initial assessments performed, the number of cases managed, and the actual number of management reports and monthly performance reports submitted. Offerors must complete the required pricing information below.

A greater proportion of cost is anticipated for qualitative deliverables (Initial QMP, Management Reports, Monthly Performance Reports) than quantitative deliverables (Initial Assessment and Caseload Management). In addition, a greater proportion of cost is anticipated for Monthly Performance Reports than the other qualitative deliverables.

INITIAL ASSESSMENT FEE	COST PER ASSESSMENT	ESTIMATED NUMBER OF ASSESSMENTS	TOTAL COST OF ASSESSMENTS FOR EACH FISCAL YEAR (FY)
FY 05	\$	5700	\$
FY 06	\$	5700	\$
FY 07	\$	5700	\$
FY 08	\$	5700	\$
FY 09	\$	5700	\$
AVERAGE COST PER ASSESSMENT	\$	TOTAL COST OF INITIAL ASSESSMENTS (FY05-09)	

CASELOAD FEE	COST PER CASE	ESTIMATED NUMBER OF CASES	NUMBER OF MONTHS	TOTAL COST OF CASELOADS PER FISCAL YEAR
FY 05	\$	11500	12	\$
FY 06	\$	12100	12	\$
FY 07	\$	12700	12	\$
FY 08	\$	13300	12	\$
FY 09	\$	13900	12	\$
AVERAGE COST PER CASE	\$		TOTAL COST OF CASELOADS (FY05-09)	\$

Note: The total costs of the Initial Assessment Fees and the Caseload Fees must not exceed 40% of the total cost of the Contract. The State may reject proposals that propose total Initial Assessment Fees and Caseload Fees in excess of 40% of the total cost of the Contact.

INITIAL QUALITY MANAGEMENT PLAN (FY 05 ONLY)	\$
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Offerors must propose a single rate for Management Reports for FY05 through FY09.

MANAGEMENT REPORTS	COST PER QUARTERLY REPORT	NUMBER OF QUARTERS PER YEAR	NUMBER OF YEARS	TOTAL COST OF MANAGEMENT REPORTS (FY05-09)
FY05-FY09	\$	4	5	\$

Offerors must propose a single rate for Monthly Performance Reports for FY05 through FY09.

MONTHLY PERFORMANCE REPORTS	COST PER PERFORMANCE REPORT	NUMBER OF MONTHS	NUMBER OF YEARS	TOTAL COST OF MONTHLY PERFORMANCE REPORTS (FY05-09)
FY 05-FY09	\$	12	5	\$

Offerors may propose a new Monthly Performance Report rate to be effective with the addition of the Self-Directed Waiver. Offerors must provide the monthly rate for the Monthly Performance Report, including the Self-Directed Waiver in the table below. This proposed rate should not be used when completing the Summary of Proposed Costs by Fiscal Year tables include in this Cost Summary Form.

COST PER MONTHLY PERFORMANCE REPORT WITH ADDITION ON THE SELF-DIRECTED CARE WAIVER	\$
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The Costs of the Initial Quality Management Plan, Management Reports and the Monthly Performance Reports must not be less than 60% of the total cost of the Contract. The State may reject proposals that propose total Initial Quality Management Plan, Management Reports and Monthly Performance Reports costs less than 60% of the total cost of the Contact.

SUMMARY OF PROPOSED COSTS BY FISCAL YEAR

Note: A greater proportion of cost is anticipated for qualitative deliverables (Initial QMP, Management Reports, Monthly Performance Reports) than quantitative deliverables (Initial Assessment and Caseload Management). In addition, a greater proportion of cost is anticipated for Monthly Performance Reports than the other qualitative deliverables.

The Costs of the Initial Quality Management Plan, Management Reports and the Monthly Performance Reports must not be less than 60% of the total cost of the Contract. The State may reject proposals that propose total Initial Quality Management Plan, Management Reports and Monthly Performance Reports costs less than 60% of the total cost of the Contract.

The total costs of the Initial Assessment Fees and the Caseload Fees must not exceed 40% of the total cost of the Contract. The State may reject proposals that propose total Initial Assessment Fees and Caseload Fees in excess of 40% of the total cost of the Contract.

Fiscal Year 2005 Summary

TOTAL COST OF INITIAL ASSESSMENTS (FY05)	\$
TOTAL COST OF CASELOADS (FY05)	\$
Total FY05 Quantitative Costs	\$

INITIAL QUALITY MANAGEMENT PLAN (FY05 ONLY)	\$
TOTAL COST OF QUARTERLY MANAGEMENT REPORTS FOR FY05 = (COST PER QUARTERLY MANAGEMENT REPORT) "MULTIPLIED BY" (4)	\$
TOTAL COST OF MONTHLY PERFORMANCE REPORTS FOR FY05 = (COST PER MONTHLY PERFORMANCE REPORT) "MULTIPLIED BY" (12)	\$
Total FY05 Qualitative Costs	\$

FY05 Percentage Calculations

Total FY05 Cost = Total FY05 Quantitative Costs + Total FY05 Qualitative Costs

Total FY05 Cost =	\$
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Percentage of FY05 Quantitative Costs = Total FY05 Quantitative Costs / Total FY05 Cost

Percentage of FY05 Quantitative Costs =	%
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Percentage of FY05 Qualitative Costs = Total FY05 Qualitative Costs / Total FY05 Cost

Percentage of FY05 Qualitative Costs =	%
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Fiscal Year 2006 Summary

TOTAL COST OF INITIAL ASSESSMENTS (FY06)	\$
TOTAL COST OF CASELOADS (FY06)	\$
Total FY06 Quantitative Costs	\$

TOTAL COST OF QUARTERLY MANAGEMENT REPORTS FOR FY06 = (COST PER QUARTERLY MANAGEMENT REPORT) "MULTIPLIED BY" (4)	\$
TOTAL COST OF MONTHLY PERFORMANCE REPORTS FOR FY06 = (COST PER MONTHLY PERFORMANCE REPORT) "MULTIPLIED BY" (12)	\$
Total FY06 Qualitative Costs	\$

FY06 Percentage Calculations

Total FY06 Cost = Total FY06 Quantitative Costs + Total FY06 Qualitative Costs

Total FY06 Cost =	\$
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Percentage of FY06 Quantitative Costs = Total FY06 Quantitative Costs / Total FY06 Cost

Percentage of FY06 Quantitative Costs =	%
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Percentage of FY06 Qualitative Costs = Total FY06 Qualitative Costs / Total FY06 Cost

Percentage of FY06 Qualitative Costs =	%
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Fiscal Year 2007 Summary

TOTAL COST OF INITIAL ASSESSMENTS (FY07)	\$
TOTAL COST OF CASELOADS (FY07)	\$
Total FY07 Quantitative Costs	\$

TOTAL COST OF QUARTERLY MANAGEMENT REPORTS FOR FY07 = (COST PER QUARTERLY MANAGEMENT REPORT) "MULTIPLIED BY" (4)	\$
TOTAL COST OF MONTHLY PERFORMANCE REPORTS FOR FY07 = (COST PER MONTHLY PERFORMANCE REPORT) "MULTIPLIED BY" (12)	\$
Total FY07 Qualitative Costs	\$

FY07 Percentage Calculations

Total FY07 Cost = Total FY07 Quantitative Costs + Total FY07 Qualitative Costs

Total FY07 Cost =	\$
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Percentage of FY07 Quantitative Costs = Total FY07 Quantitative Costs / Total FY07 Cost

Percentage of FY07 Quantitative Costs =	%
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Percentage of FY07 Qualitative Costs = Total FY07 Qualitative Costs / Total FY07 Cost

Percentage of FY07 Qualitative Costs =	%
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Fiscal Year 2008 Summary

TOTAL COST OF INITIAL ASSESSMENTS (FY08)	\$
TOTAL COST OF CASELOADS (FY08)	\$
Total FY08 Quantitative Costs	\$

TOTAL COST OF QUARTERLY MANAGEMENT REPORTS FOR FY08 = (COST PER QUARTERLY MANAGEMENT REPORT) "MULTIPLIED BY" (4)	\$
TOTAL COST OF MONTHLY PERFORMANCE REPORTS FOR FY08 = (COST PER MONTHLY PERFORMANCE REPORT) "MULTIPLIED BY" (12)	\$
Total FY08 Qualitative Costs	\$

FY08 Percentage Calculations

Total FY08 Cost = Total FY08 Quantitative Costs + Total FY08 Qualitative Costs

Total FY08 Cost =	\$
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Percentage of FY08 Quantitative Costs = Total FY08 Quantitative Costs / Total FY08 Cost

Percentage of FY08 Quantitative Costs =	%
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Percentage of FY08 Qualitative Costs = Total FY08 Qualitative Costs / Total FY08 Cost

Percentage of FY08 Qualitative Costs =	%
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Fiscal Year 2009 Summary

TOTAL COST OF INITIAL ASSESSMENTS (FY09)	\$
TOTAL COST OF CASELOADS (FY09)	\$
Total FY09 Quantitative Costs	\$

TOTAL COST OF QUARTERLY MANAGEMENT REPORTS FOR FY09 = (COST PER QUARTERLY MANAGEMENT REPORT) "MULTIPLIED BY" (4)	\$
TOTAL COST OF MONTHLY PERFORMANCE REPORTS FOR FY09 = (COST PER MONTHLY PERFORMANCE REPORT) "MULTIPLIED BY" (12)	\$
Total FY09 Qualitative Costs	\$

FY09 Percentage Calculations

Total FY09 Cost = Total FY09 Quantitative Costs + Total FY09 Qualitative Costs

Total FY09 Cost =	\$
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Percentage of FY09 Quantitative Costs = Total FY09 Quantitative Costs / Total FY09 Cost

Percentage of FY09 Quantitative Costs =	%
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Percentage of FY09 Qualitative Costs = Total FY09 Qualitative Costs / Total FY09 Cost

Percentage of FY09 Qualitative Costs =	%
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SUPPLEMENTAL INFORMATION HEADER

The following pages contain supplemental information for this competitive document. The supplemental information is contained between this header and a trailer page. If you receive the trailer page, all supplemental information has been received.

If you do not receive the trailer page of this supplement, use the inquiry process described in the document to notify the Procurement Representative.

Note: portions of the supplemental information provided may or may not contain page numbers. The total number of pages indicated on the cover page does not include the pages contained in this supplement.

SUPPLEMENT 1

W-9 FORM

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do NOT send to the IRS.

Please print or type

Name (If joint names, list first and circle the name of the person or entity whose number you enter in Part I below. See instructions on page 2 if your name has changed.) _____

Business name (Sole proprietors see instructions on page 2.) _____

Please check appropriate box: Individual/Sole proprietor Corporation Partnership Other ▶ _____

Address (number, street, and apt. or suite no.) _____

City, state, and ZIP code _____

Requester's name and address (optional) _____

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). For sole proprietors, see the instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see **How To Get a TIN** below.

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Social security number								
OR								
Employer identification number								

List account number(s) here (optional) _____

Part II For Payees Exempt From Backup Withholding (See Part II instructions on page 2)

▶

Part III Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
- I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions.—You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, the acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (Also see **Part III instructions** on page 2.)

Sign Here Signature ▶ _____ Date ▶ _____

Section references are to the Internal Revenue Code.

Purpose of Form.—A person who is required to file an information return with the IRS must get your correct TIN to report income paid to you, real estate transactions, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA. Use Form W-9 to give your correct TIN to the requester (the person requesting your TIN) and, when applicable, (1) to certify the TIN you are giving is correct (or you are waiting for a number to be issued), (2) to certify you are not subject to backup withholding, or (3) to claim exemption from backup withholding if you are an exempt payee. Giving your correct TIN and making the appropriate certifications will prevent certain payments from being subject to backup withholding.

Note: If a requester gives you a form other than a W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

What Is Backup Withholding?—Persons making certain payments to you must withhold and pay to the IRS 31% of such

payments under certain conditions. This is called "backup withholding." Payments that could be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, your payments will not be subject to backup withholding. Payments you receive will be subject to backup withholding if:

- You do not furnish your TIN to the requester, or
- The IRS tells the requester that you furnished an incorrect TIN, or
- The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
- You do not certify to the requester that you are not subject to backup withholding under 3 above (for reportable

interest and dividend accounts opened after 1983 only), or

- You do not certify your TIN. See the Part III instructions for exceptions.

Certain payees and payments are exempt from backup withholding and information reporting. See the Part II instructions and the separate **Instructions for the Requester of Form W-9.**

How To Get a TIN.—If you do not have a TIN, apply for one immediately. To apply, get **Form SS-5**, Application for a Social Security Number Card (for individuals), from your local office of the Social Security Administration, or **Form SS-4**, Application for Employer Identification Number (for businesses and all other entities), from your local IRS office.

If you do not have a TIN, write "Applied For" in the space for the TIN in Part I, sign and date the form, and give it to the requester. Generally, you will then have 60 days to get a TIN and give it to the requester. If the requester does not receive your TIN within 60 days, backup withholding, if applicable, will begin and continue until you furnish your TIN.

Note: Writing "Applied For" on the form means that you have already applied for a TIN **OR** that you intend to apply for one soon.

As soon as you receive your TIN, complete another Form W-9, include your TIN, sign and date the form, and give it to the requester.

Penalties

Failure To Furnish TIN.—If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil Penalty for False Information With Respect to Withholding.—If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal Penalty for Falsifying Information.— Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs.—If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name.—If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage, without informing the Social Security Administration of the name change, please enter your first name, the last name shown on your social security card, and your new last name.

Sole Proprietor.—You must enter your individual name. (Enter either your SSN or EIN in Part I.) You may also enter your business name or "doing business as" name on the business name line. Enter your name as shown on your social security card and business name as it was used to apply for your EIN on Form SS-4.

Part I—Taxpayer Identification Number (TIN)

You must enter your TIN in the appropriate box. If you are a sole proprietor, you may enter your SSN or EIN. Also see the chart on this page for further clarification of name and TIN combinations. If you do not have a TIN, follow the instructions under **How To Get a TIN** on page 1.

Part II—For Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are **not** exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For a complete list of exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form. If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester a completed **Form W-8, Certificate of Foreign Status**.

Part III—Certification

For a joint account, only the person whose TIN is shown in Part I should sign.

1. Interest, Dividend, and Barter Exchange Accounts Opened Before 1984 and Broker Accounts Considered Active During 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, Dividend, Broker, and Barter Exchange Accounts Opened After 1983 and Broker Accounts Considered Inactive During 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real Estate Transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other Payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified of an incorrect TIN. Other payments include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services, payments to a nonemployee for services (including attorney and accounting fees), and payments to certain fishing boat crew members.

5. Mortgage Interest Paid by You, Acquisition or Abandonment of Secured Property, Cancellation of Debt, or IRA Contributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. You must provide your

TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship	The owner ³
For this type of account:	Give name and EIN of:
6. Sole proprietorship	The owner ³
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name, but you may also enter your business or "doing business as" name. You may use either your SSN or EIN.

⁴ List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

SUPPLEMENT 2
Ohio Home Care Redesign Summary

Ohio Department of Job and Family Services
Proposed Redesign of the Ohio Home Care Program
January 28, 2004

The Ohio Department of Job and Family Services (ODJFS) is committed to a redesign of the Ohio Home Care Program. *Our goals are to:*

- *Better target the needs of consumers;*
- *Control cost growth; and*
- *Meet federal cost-effectiveness requirements.*

To accomplish these ends, ODJFS conducted a series of Home Care Forums around Ohio last summer. We discussed several preliminary proposals with consumers, providers and other key stakeholders, and received many insightful comments and suggestions. As a result, we concluded that essential to any proposal is our commitment to honor consumer demand for greater flexibility and self-direction, while at the same time pursuing our previously stated goals.

ODJFS' redesign of Ohio Home Care includes several key components. Among them are:

- Renewal of the Ohio Home Care Waiver effective through June 30, 2006. This will allow the program to continue with no programmatic changes at this time, but with additional waiver slots as approved in the state's biennial budget. It will also allow ample time to develop our proposed redesign of the Ohio Home Care Program.
- Reengineering of Ohio's Core Plus benefit package (Medicaid state plan home health aide, nursing and skilled therapies) to serve only children and adults who are not eligible for, or cannot be enrolled in a home and community-based services waiver. As a precursor to this, ODJFS will also work with sister agencies to determine the number of affected consumers receiving Core services, as well as services through the MR/DD and Aging systems, and how these consumers will continue to receive such services. The department will also be ready to fold adults and children with an institutional level of care into the appropriate waiver, requiring amendment of the Ohio Home Care (0337) and Transitions (0383) waivers to seek additional slots to accommodate this change.
- Creation and staggered implementation of three new waivers:
 - Self-Directed Care Waiver for persons with either a NF or hospital level of care
 - Community Resources Waiver to serve medium cost, high need consumers with either a NF or a hospital level of care

- Subacute Waiver to serve high cost, high needs consumers with a hospital level of care.
- Expansion of the concept of consumer choice in ODJFS-administrated waivers, and introduction of a person-centered, self-directed care waiver.
 - Consumers in all ODJFS waivers will have access to all Medicaid state plan and optional state plan services, and will be able to participate in the development of their all services plan.
 - Consumers in the Community Resource and Subacute waivers will have their choice of providers, as well as the responsibility to approve provider timesheets; choose, train, direct and change providers; and establish a workable back-up plan for situations when the primary provider is unable to render services.
 - Specific to the Self-Directed Care waiver, Ohio will also:
 - allow consumers to be the employer of record (i.e., the consumer or his or her legally responsible relative assumes responsibility for the recruitment, training and dismissal of providers, day-to-day personnel management, and work scheduling), and establish provider rates up to the Medicaid ceiling;
 - offer supports brokerage as a means to empower consumers to develop, implement and manage their own services and supports, and ultimately, their own lives. Supports brokerage offers practical skills training to enable families and consumers to remain independent. Examples of training include providing information on recruiting and hiring home care attendants, managing home care attendants, and providing information on effective communication and problem solving. The function provides sufficient information to assure that consumers and their families understand the responsibilities involved with self-direction and assist in the development of effective back-up and emergency plans.
 - As an alternative to the Self-Directed Care waiver, make application to the Robert Wood Johnson Foundation for a Cash and Counseling demonstration grant to serve approximately 400 consumers in an *1115 Independence Plus* waiver over a three-year period. Cash and Counseling would permit consumers to manage a flexible monthly allowance to pay for waiver services and disability-related goods and services. ODJFS needs to explore programmatic and technological enhancements that will make Ohio unique and attractive for funding as compared to the existing Cash and Counseling demonstration states (Florida, New Jersey and Arkansas), i.e., vouchers, smartcard, etc.

- Amendment of the Ohio Home Care waiver to continue serving consumers who do not meet the eligibility requirements of the other waivers (i.e., they are age 60 and over, or of any age and their service needs exceed that which is provided by the other waivers). It will allow eligible consumers access to needed waiver services until they can be transferred into more appropriate, more cost-effective waivers.
- Development of new and/or amended statutes, policies and procedures, as appropriate, including, but not limited to delegated health-related activities (i.e., delegated nursing), and allowing the consumer to establish provider rates of payment up to the Medicaid ceiling.
- Relaxation of the prohibition against the provision of services by certain family members as a result of the current Ohio Home Care program definition of “family”. Specifically, ODJFS will develop a definition for the term “legally responsible family member” (i.e., a consumer’s spouse; mother or father; stepmother or stepfather; or legal guardian, as adjudicated in a court of law), and will propose that he or she be permitted to provide home care attendant services as an “independent home care attendant” under the Self-Directed Care Waiver.
- Replacement of the independent daily living aide and non-aide provider types with a single “independent home care attendant” provider type. This provider will deliver home care attendant services, and will be able to perform delegated health-related activities under the Self-Directed Care Waiver if all appropriate requirements are met. This provider will also be able to provide personal care services under the Community Resource Waiver and Subacute Waiver, but will exclude legally responsible family members.
- Utilization of relocation services (that are part of Ohio’s Success Project) in the new waivers in order to facilitate the transition of consumers out of nursing facilities and into home and community-based service waivers. Services will include provision of payment for such things as first and last month’s rent, utility deposits, housewares, furniture, transportation to locate housing, assistive technology, home modifications, linens, etc. The addition of these services to the waivers will allow for increased federal financial participation, and will also increase the number of people served through the Success Project.
- Implementation of clinical protocols across all waivers that will strengthen and improve case management and care planning activities, and maximize the use of appropriate formal and informal consumer supports. Protocols will be tailored to each ODJFS waiver, as appropriate, and at a minimum, will include specific case manager qualifications, caseload ratios and expectations for frequency of consumer contact. Additionally, new contractual requirements will support the implementation of the improved protocols. Specifically, a case management RFP will be released in early 2004 which will require increased program oversight in the areas of provider monitoring, case management and care planning practice,

and program quality assurance and quality improvement. The new contract will be effective July 1, 2004.

- Implementation of an expanded quality management plan that defines continuous quality improvement activities for provider monitoring, and imposes annual criminal records checks for all independent providers of waiver services.
- Implementation of a higher standard of waiver eligibility than we currently have in the Ohio Home Care and Transitions waivers, i.e., requiring specific degrees of functional disabilities, and hands-on assistance with activities of daily living (ADLs).
- Creation of a short-term, acute home care Medicaid state plan benefit for waiver and nonwaiver consumers that experience acute episodes. Specifically, 14 or more hours/week of nursing/PDN will be made available to consumers, as needed, after discharge from a hospital or NF, or when their condition changes. Waiver consumers, including those on waivers administered by sister agencies, will be able to access a maximum of 60 days of this service per year.
- Commitment to the concept that consumers will be assigned individual cost caps that are consistent with their needs, as identified through an individual assessment, and that assignment of the maximum cost ceiling associated with their particular waiver is not automatic. To accomplish this, a methodology will be developed to predict and authorize individual cost caps within the maximum cost ceiling for each waiver. The methodology may include a review of actual claims paid and assessment information.
- Provision of home care attendant services and delegated health-related activities by legally responsible family members (i.e., a consumers' spouse; mother or father; step-mother or step-father; or legal guardian as adjudicated in a court of law). For this to be permissible,
 - the legally responsible family members must:
 - be an independent home care attendant, as approved by ODJFS, and
 - meet all training and continuing education, reporting and accountability, and cost-effectiveness requirements;
 - the service must not be a function which the legally responsible family members would normally provide for the consumer without charge as a matter of course in the usual relationship among members of the nuclear family; and
 - The results of the person-centered planning process must be taken into account (i.e., when the needs and preferences of the consumer and his or her family are taken into account in developing the all services plan).

ODJFS' proposed implementation timeline is as follows:

- *Ohio Home Care Waiver (renewal application currently pending)*
- *Cash and Counseling Demonstration Grant Application (date due 3/31/04)*
- *Contracted Case Management (target date for implementation of new contract 7/04)*
- *Transitions Waiver (target date for renewal submission 9/04)*
- *Reengineering of the Core Plus benefit (target date for implementation 1/05)*
- *Community Resource Waiver (target date for implementation 1/05)*
- *Sub-Acute Waiver (target date for implementation 1/05)*
- *Self-Directed Care Waiver (target date for implementation 1/06)*
- *Ohio Home Care Waiver (target date for implementation of amended waiver 7/06)*

Self-Directed Care Waiver

Eligibility

This waiver is intended to serve consumers who are age 59 and younger with a NF or hospital level of care, and who:

- Have functional disabilities and require hands-on assistance with completion of at least one age-appropriate ADL. Hands-on assistance must be required whenever this activity is completed.
- Are at risk of nursing facility placement or long-term hospitalization.
- Have a need for formal/informal services in order to maintain safety and prevent harm.
- Have a need for at least a minimum of two waiver services, one of which must be home care attendant services. The establishment of this level of need is relevant for waiver eligibility.

Services

The primary service available under the Self-Directed Care Waiver is home care attendant services (HCAS).

HCAS consists of supportive activities specific to the needs of the consumer which are designed to address ADL and IADL impairments. It substitutes for the absence, loss, diminution or impairment of physical or cognitive function and may include one or more of the following activities:

- Assistance with bathing, dressing, grooming, caring for nails, hair and oral hygiene, shaving, deodorant application, skin care with lotions and/or powders; foot care, ear care, feeding, toileting, assistance with ambulation, changing position in bed, assistance with transfers, normal range of motion, and nutrition and fluid intake;
- General household activities, including but not limited to planning, preparation and clean-up of meals, laundry, bed making, dusting, vacuuming, shopping and other errands, replacing furnace filters, waste disposal, seasonal yard care and snow removal;
- Heavy household chores, including but not limited to washing floors, windows and walls; tacking down loose rugs and tiles; moving heavy items of furniture to provide safe access and egress;

- Assistance with money management and correspondence as directed by the consumer;
- Escort services and transportation to enable consumers to gain access to the waiver and other community services, activities and resources (This activity is offered in addition to medical transportation available under the Medicaid state plan, and shall not replace it. Whenever possible, other sources which can provide this service without charge shall be utilized.);
- Delegated health-related activities within a health care professional's scope of practice pursuant to the provisions of the Ohio Revised Code under which the professional is authorized to practice, and which are delegated by the professional to an independent home care attendant. Examples of delegated health-related activities include, but are not limited to: care and suctioning of tracheotomies, set-up and assistance with medications, g-tube feedings for persons with uncomplicated conditions, catheter care, stage 1 wound care, and insulin coverage, etc.

HCAS can be provided by:

- A Medicare-certified agency
- A JCAHO-accredited or CHAP-accredited agency
- An independent home care attendant*

*Independent home care attendants may include legally responsible family members (i.e., a parent, spouse or guardian). They are required to meet all training and continuing education requirements. Those independent home care attendants who provide delegated health-related activities must also successfully complete additional training and demonstrate competency as prescribed by ODJFS and the Ohio Board of Nursing.

Additional waiver services include:

- Waiver Nursing and/or Nursing Respite
- Specialized medical equipment and supplies/adaptive and assistive devices/assistive technologies, including vehicle modifications
- Home modifications
- Home delivered meals or nutritional consultation
- Adult day health and specialized child care services
- Emergency Response Systems
- Social work/counseling
- Relocation services
- Supplemental transportation

Consumers enrolled in the Self-Directed Care waiver will also:

- Have access to all Medicaid state plan and optional state plan services
- Participate in the development of the all services plan
- Approve provider timesheets
- Have the ability to hire, train, direct, and dismiss providers
- Have their choice of providers, i.e., agency or independent provider
- Establish a workable back-up plan for situations when the primary provider is unable to render services.
- Be the employer of record
- Have the ability to establish provider rates up to the Medicaid ceiling
- Have the ability to utilize financial management services via a fiscal/employer agent

Financial Management Services

Financial management services will be conducted as a Medicaid-reimbursable administrative activity and will be funded through a contract that is bid separately from that of case management services. Waiver case management contractors cannot bid for financial management service contracts.

These services are intended to assist the family or consumer to manage and distribute funds contained in the individual budget, including but not limited to, the facilitation of the employment of service workers by the family or consumer, including Federal, state and local tax withholdings/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, etc. These services would also include acting as a repository for independent provider service delivery records, collection and application of consumer liability payments, providing an accounting mechanism and assurance for monitoring the rate of Medicaid payment, cutting checks to independent providers, and producing reports/utilization data and unit of verification audits. ODJFS will need to provide an initial prospective payment to the contractor equal to that of the consumer's individual budget.

Supports Brokerage Services

Supports brokerage offers practical skills training to enable families and consumers to remain independent. Examples of training include providing information on recruiting and hiring home care attendants, managing home care attendants, and providing information on effective communication and problem solving. The function provides sufficient information to assure that participants and their families understand the responsibilities involved with self-direction and assist in the development of effective back-up and emergency plans.

Supports brokerage services will be an additional Medicaid-reimbursable administrative activity conducted by the contracted case management agency. However, the actual case manager cannot serve as the support broker. The case management agency must

designate specific persons on staff, or a subcontractor such as a center for independent living, whose function is to provide brokerage services. Additionally, the support broker cannot provide any other waiver services to the consumer.

Individualized Budgeting

Each consumer will receive an individualized budget good for six months. That budget will be no greater than six times the consumer's monthly cost cap for the Self-Directed Care Waiver. It will be used to purchase waiver services for which a need has been identified during the assessment process, and which are included on the consumer's all services plan. If a service has not been identified during the assessment and/or on the all services plan, and the consumer believes such a need exists, then it is the responsibility of the contracted case manager to assess that need.

Consumers, by virtue of their ability to establish provider rates up to the Medicaid ceilings, can accrue savings over the six-month budget period. During that time they can spend accrued savings on approved waiver services, and/or disability-related goods and services. Any accrued savings that are not spent by the end of the six-month period shall be returned to ODJFS by the financial management service contractor.

ODJFS will be able to monitor consumer spending on a monthly basis from monthly financial management service contractor reconciliation statements.

Cost Ceiling

At \$3,000/month, the cost ceiling for the Self-Directed Care Waiver is proposed to be the lowest of all of the ODJFS-administered waivers. The cost ceiling will include all waiver services, state plan nursing/home health aide, and private duty nursing for children (as PDN will not be offered as an optional state plan service for adults).

Control Group

The control group for the cost-effectiveness calculation for this waiver will be people 59 years of age and younger in a NF or hospital.

Cash and Counseling Demonstration Waiver

ODJFS intends to apply for a Robert Wood Johnson Foundation Cash and Counseling Demonstration Grant, and upon successful receipt of that grant, an *1115 Independence Plus* waiver to serve as our Self-Directed Care Waiver.

Under Ohio's cash and counseling waiver, consumers will be able to:

- Manage a flexible monthly allowance to purchase their own waiver services, and disability-related goods and services, instead of receiving them through an agency, existing independent provider or an enrolled Medicaid provider.
- Hire, train, direct and dismiss providers of their choice to provide services authorized on the All Services Plan.
- Hire friends and family members, including those who are legally responsible for their well-being.
- Be the employer of record.
- Establish provider rates up to the Medicaid ceiling.
- Utilize financial management services that are conducted as a Medicaid-reimbursable administrative activity and funded through a contract that is bid separately from that of case management services. These services are intended to assist the family and/or consumer to manage and distribute funds contained in the individual budget, including but not limited to the facilitation of the employment of service workers, including Federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, etc.
- Utilize supports brokerage services, an additional Medicaid-reimbursable administrative activity conducted by the contracted case management entity, as a means to empower consumers to develop, implement and manage their own services and supports.

Participation in the cash and counseling demonstration waiver is limited to consumers who:

- Are age 60 and over, currently enrolled on the Ohio Home Care Waiver; and
 - Have a NF or hospital level of care;
 - Are at risk of NF/long term hospitalization, and need ongoing professional monitoring in order to remain in the home setting;
 - Have a need for formal/informal services in order to maintain safety and prevent harm.

- Age 59 and younger: and
 - Have a NF or hospital level of care;
 - Have functional disabilities and require hands-on assistance with the completion of at least one ADL (hands-on assistance must be required whenever this activity is completed);
 - Are at risk of nursing home placement or long-term hospitalization;
 - Have a need for formal/informal services in order to maintain safety and prevent harm;
 - Have a need for at least a minimum of two waiver services, one of which must be home care attendant services (The establishment of this level of need is relevant for waiver eligibility. Continued waiver enrollment is not contingent upon these services being delivered and paid for through the waiver).

Treatment Group

- The demonstration will serve no more than 400 treatment group consumers over a three-year period.
- The eligibility pool will be limited to those consumers who both meet the eligibility requirements for the demonstration and successfully complete a readiness evaluation conducted by a supports broker.

Evaluation Component

It is recommended that ODJFS collaborate with the Scripps Gerontological Center at Miami University. We would subcontract with them to conduct the evaluation component of the demonstration. Scripps has experience with the Choices self-directed care waiver administered by the Ohio Department of Aging. Additionally, they have already developed evaluation tools regarding consumer satisfaction, service accessibility, and health and safety.

Community Resource Waiver

Eligibility

This waiver is intended to serve medium cost, high need consumers who are age 59 and younger with a NF level of care or hospital level of care, and who:

- Have functional disabilities and require hands-on assistance with completion of at least two age-appropriate ADLs. Hands-on assistance must be required whenever these activities are completed.
- Are at risk of NF/long term hospitalization.
- Have a need for formal/informal services in order to maintain safety and prevent harm.
- Have a need for a minimum of two waiver services, one of which must be personal care services. The establishment of this level of need is relevant for waiver eligibility.

Services

The primary service available under the Community Resource Waiver is personal care. Personal care consists of supportive activities specific to the needs of the consumer which are designed to address ADL and IADL impairments. It substitutes for the absence, loss, diminution or impairment of physical or cognitive function and may include one or more of the following activities:

- Assistance with bathing, dressing, grooming, caring for nails, hair and oral hygiene, shaving, deodorant application, skin care with lotions and/or powders; foot care, ear care, feeding, toileting, assistance with ambulation, changing position in bed, assistance with transfers, normal range of motion, and nutrition and fluid intake;
- General household activities, including but not limited to planning, preparation and clean-up of meals, laundry, bed making, dusting, vacuuming, shopping and other errands, replacing furnace filters, waste disposal, seasonal yard care and snow removal;
- Heavy household chores, including but not limited to washing floors, windows and walls; tacking down loose rugs and tiles; moving heavy items of furniture to provide safe access and egress;
- Assistance with money management and correspondence as directed by the consumer;

- Escort services and transportation to enable consumers to gain access to the waiver and other community services, activities and resources (This activity is offered in addition to medical transportation available under the Medicaid state plan, and shall not replace it. Whenever possible, other sources, which can provide this service without charge, shall be utilized.).

Personal care services can be provided by:

- A Medicare-certified agency
- A JCAHO-accredited or CHAP-accredited agency
- An independent home care attendant**

Independent home care attendants **shall not include legally responsible family members (i.e., a parent, spouse or guardian). However, attendants are still required to meet all training and continuing education requirements.

Additional waiver services include:

- Waiver nursing and/or nursing respite
- out-of-home respite
- Specialized medical equipment and supplies/adaptive and assistive devices/assistive technologies, including vehicle modifications
- Home modifications
- Home delivered meals or nutritional consultation
- Adult day health and specialized child care services
- Social work/counseling
- Emergency Response Systems
- Supplemental transportation
- Relocation services

Consumers enrolled in the Community Resource Waiver will also:

- Have access to all Medicaid state-plan and optional state-plan services
- Participate in the development of the all services plan
- Verify delivery of services
- Have their choice of providers, i.e., agency or independent provider
- Have the ability to choose, train, direct, and change providers
- Establish a workable back-up plan for situations when the primary provider is unable to render services

Cost Ceiling

At \$4,000/month, the cost ceiling for the Community Resource Waiver is proposed to be greater than that of the Self-Directed Care Waiver and less than the other ODJFS-administered waivers. The cost ceiling will include all waiver services, state plan

nursing/home health aide, and private duty nursing for children (as PDN will not be offered as an optional state plan service for adults).

Control Group

The control group for the cost-effectiveness calculation for this waiver will be people 59 years of age and younger in a NF or hospital.

Subacute Waiver

Eligibility

This waiver is intended to serve high-cost, high-need consumers who are age 59 and younger with a hospital level of care, and who:

- Have functional disabilities and require hands-on assistance with completion of at least two age-appropriate ADLs. Hands-on assistance must be required whenever those activities are completed.
- Are at risk of long-term hospitalization, and need ongoing professional monitoring in order to remain in the home setting.
- Have a need for formal/informal services in order to maintain safety and prevent harm.
- Have a need for a minimum of two waiver services, one of which must be nursing or nursing respite. The establishment of this level of need is relevant for waiver eligibility.

Services

Individuals served by this waiver are expected to use waiver nursing and/or nursing respite. They can be provided by Medicare-certified, or JCAHO- or CHAP-accredited agencies, or by independent RNs, or LPNs under the supervision of RNs.

Additional waiver services include:

- Personal care as fully defined in the Community Resource Waiver
- Out-of-home respite
- Specialized medical equipment and supplies/adaptive and assistive devices/assistive technologies, excluding vehicle modifications
- Home modifications
- Relocation services

Consumers enrolled in the Subacute Waiver will also:

- Have access to all Medicaid state plan and optional state plan services
- Participate in the development of the all services plan
- Verify delivery of services
- Have their choice of providers, i.e., agency or independent provider
- Have the ability to choose, train, direct, and change providers
- Establish a workable back-up plan for situations when the primary provider is unable to render services

Cost Ceiling

At \$12,000, the monthly cost ceiling for the Sub-Acute Waiver is proposed to be greater than the Self-Directed Care Waiver and the Community Resource Waiver, yet less than the Ohio Home Care Waiver and the Transitions Waiver. The cost ceiling will include all waiver services, state plan nursing/home health aide, and private duty nursing for children (as PDN will not be offered as an optional state plan service for adults).

Control Group

The control group for the cost-effectiveness calculation for this waiver will be people 59 years of age and younger in a hospital.

Ohio Home Care Waiver

Eligibility

This is a “no open enrollment, no-growth” waiver. Participants in this waiver are those current waiver consumers who remain after implementation of the Self-Directed Care Waiver, Community Resource Waiver, and Subacute Waiver (i.e., they are either age 60 or over, they are of any age and their service needs exceed what is provided by the other waivers, or their functional limitations do not qualify them for another ODJFS-administered waiver). It will serve as a means to access needed home and community-based services until consumers can be transferred into more appropriate, more cost-effective waivers. Consumers in this waiver:

- Have a NF or hospital level of care.
- Are at risk of NF/long term hospitalization, and need ongoing professional monitoring in order to remain in the home setting.
- Have a need for formal/informal services in order to maintain safety and prevent harm.

Services

The services available under this waiver will include:

- Personal care services as fully defined in the Community Resource Waiver
- Waiver nursing and/or nursing respite provided by Medicare-certified, or JCAHO- or CHAP-accredited agencies, or by independent RNs, or LPNs under the supervision of RNs
- Out-of-home respite
- Specialized medical equipment and supplies/adaptive and assistive devices/assistive technologies, including vehicle modifications
- Home modifications
- Home delivered meals
- Emergency Response Systems
- Adult day health and specialized child care services
- Supplemental transportation

Consumers will have access to all Medicaid state-plan and optional state-plan services, and will participate in the development of the all services plan.

Cost Ceiling

The maximum monthly cost ceiling is \$14,700. It will include all waiver services, state plan nursing/home health aide, and private duty nursing for children (as PDN will not be offered as an optional state-plan service for adults).

Control Group

The control group for the cost-effectiveness calculation for this waiver will be people of any age in a NF or hospital. (See Attachment 1 for a list of DRGs used for the hospital control group.)

Attachment 1**DRG List Used for Hospital Control Group in the Ohio Home Care Waiver**

DRG 9	Spinal Disorders & Injuries
DRG 13	Multiple Sclerosis & Cerebellar Ataxia
DRG 27	Traumatic Stupor & Coma
DRG 31	Concussion age >17 w cc
DRG 32	Concussion age > 17 w/o cc
DRG 33	Concussion 0 - 17
DRG 34	Other Disorders of Nervous system w cc
DRG 35	Other Disorders of nervous system w/o cc
DRG 88	Chronic Obstructive Pulmonary Disease
DRG 101	Other Respiratory System Diagnosis w cc
DRG 102	Other Respiratory System Diagnosis w/o cc
DRG 385	Neonates transferred to another facility
DRG 386	Extreme immaturity/respiratory distress
DRG 388	Prematurity w/o major problems
DRG 389	Full term neonate w/ major problems
DRG 467	Other factors influencing health status
DRG 475	Respiratory system diagnosis w/ vent. support
DRG 492	Extreme immaturity etc., ICD code 7650
DRG 493	Extreme immaturity w/o ICD 7650 - Level II
DRG 494	Extreme immaturity w/o ICD 7650 - Level III
DRG 495	Prematurity, maj. probs., BW < 1750 - Level I/II
DRG 496	Prematurity, maj. probs., BW < 1750 - Level III
DRG 497	Prematurity, maj. probs., BW > 1750 - Level I/II
DRG 498	Prematurity, maj. probs., BW > 1750 - Level III

Transitions Waiver

The Transitions Waiver is a no-growth waiver created for Ohio Home Care Waiver consumers affected by Ohio's revised ICF-MR level of care that was implemented in November 2001. Participants in this waiver are those consumers of any age with an ICF-MR level of care who would otherwise be eligible for placement in an ICF-MR facility. The only changes ODJFS will make to this waiver are an amendment to allow for the creation of additional slots to accommodate the transfer of eligible adults and children now receiving services through Ohio's Core Plus benefit, and who would not be transferred to an ODMR/DD-administered waiver as a result of Core Plus reengineering negotiations; and any changes required by CMS as a result of their December 2003 program review. Additionally, the Transitions Waiver must be renewed by January 1, 2005.

Cost Ceiling

The maximum monthly cost ceiling is \$14,700. It will include all waiver services, state-plan nursing/home health aide, and private duty nursing for children (as PDN will not be offered as an optional state-plan service for adults).

Control Group

The control group for the cost effectiveness calculation for this waiver will be people of any age in an ICF-MR.

SUPPLEMENT 3
BHCS Program Eligibility Assessment Tool

COMPREHENSIVE - PROGRAM ELIGIBILITY ASSESSMENT TOOL
 PLEASE TYPE OR PRINT ALL INFORMATION

Attach additional pages
 **MCATS data entry requirement

SECTION A** : REFERRAL INFORMATION					
2399 Signature Date: (if applicable)			Date Alert/Referral Received:		
Date of Face to Face Assessment Initial Annual Update			Place of Assessment Home Hospital NF Other:		
Reason for Request: Ohio Home Care Waiver Transition Core Plus Other (explain):					
Name(s) of persons present at assessment:					
Source(s) of assessment Information: Individual Primary Caregiver Legal Guardian Physician Other:					
SECTION B** : CONSUMER INFORMATION					
Last Name		First Name		Middle Initial	
Street Address City		State		Zip	
Phone Number ()			Communication Barrier: Y N Language Spoken:		
Alias Name: N/A		Directions:			
PETS					
Date of Birth:		Age:		Gender: Male Female	
Marital Status: N/A Married Divorced Separated Widow Never Married					
Race: White, not of Hispanic Origin Asian/Pacific Islander Other		African American/Black, not of Hispanic Origin American Indian or Alaskan Native		Hispanic Origin Southeast Asian	
Social Security Number	CRISE Case Number	MMIS Billing Number	CRIS-E Recipient #	County	
Current Medicaid Recipient Y N	Medicaid Eligible Y N	Pending Medicaid Y N	Eligible w/ Spend down Y N Amount \$		
			Liability Amount \$		
Medicaid HMO Y (List Name)			N		
Medicare Number: N/A					
Part A: Hospital Benefits Y N			Part B: Supplemental Medical Insurance Benefits Y N		
Other Insurance N/A					
Company Name:					
			Policy Number:		
Billing Address:			Company Phone Number:		
Emergency Contact(s)					
Name:		Phone:		Relationship:	
Legal Guardian Y N POA Y N					
Name:		Phone:		Relationship:	
Legal Guardian Y N POA Y N					

SECTION C: LIVING ARRANGEMENTS / HOUSEHOLD COMPOSITION					
Living Arrangement					
Usual	Current	Living Arrangement	Usual	Current	Living Arrangement
		Own/Rent: Home/Apartment			w/ Relative/Friend
		Congregate Housing			ICF-MR
		Group Home /Foster Home/Rest Home			Assisted or Supportive Living
		Other (list)			Other (list)

Household Composition List all persons residing in household			
Name	Relationship	Age	Receiving Community Services? Type?

SECTION D:** MEDICAL INFORMATION		
Diagnosis	ICD9 Code	Date of Onset
*Primary::		
Secondary:		
Secondary:		
Secondary:		

Physicians and Specialists

Primary/Treating Physician **

Name: _____ Specialty: _____

Address: _____

Phone: _____ Email: _____ Fax: _____

Date last seen: _____ Office contact Name: _____

SECTION E: REVIEW OF SYSTEMS

Check all resources that apply: Physician Medical Record Individual Primary C/G Other:
 Specify all medical interventions and treatment regimens, indicating tasks that must be performed (and at what frequency) by licensed professionals. **For the tasks that cannot be delegated, indicate reason:** e.g. -- unstable condition, complexity of service, medical complication, and other (REFER TO OAC 5101:3-3-05). Note that last examination date is exam done by any medical professional.

1) EYES	Last examination date:	No Abnormalities reported/detected					
Prosthesis Lt Rt	Swelling	Jaundice	Redness	Pain			
Loss of vision Lt Rt	Discharge	Blurring	Diplopia				
Difficulty Reading	Glasses	Contacts	History of Glaucoma/Cataracts				
Other (list):							
Interventions:							
Performed by (check and list frequency)		SN (RN/LPN)	PT	ST	OT	Parent/Guardian	Other (specify):
Specify Equipment/Supplies:				Provider:			

2) EARS	Last examination date:	No Abnormalities reported/detected					
Hearing Aide Lt Rt	Deafness	Diminished Hearing Lt Rt		Tinnitus	Discharge		
Pain							
Other (list):							
Interventions:							
Performed by (check and list frequency)		SN (RN/LPN)	PT	ST	OT	Parent/Guardian	Other (specify):
Specify Equipment/Supplies:				Provider:			

3) MOUTH & THROAT	Last examination date:	No Abnormalities reported/detected				
Teeth: missing broken (Location _____)			Difficulty: chewing		swallowing	
Gums: swollen bleeding receding			Dentures / Partial			
Lesions			Dry Mouth			
Halitosis	Dysphagia	Loss of sense of taste		Other (list):		
Interventions:						
Performed by (check and list frequency)		SN (RN/LPN)	PT	ST	OT	Parent/Guardian
Other (specify):						
Specify Equipment/Supplies:				Provider:		

4) PULMONARY/RESPIRATORY/SINUS	Last examination date:	No Abnormalities reported/detected				
Abnormalities with sinus	Abnormalities with sense of smell	Dyspnea: at rest with exertion				
Persistent Cough	Audible wheezing	Tracheotomy				
Expectorates: blood sputum	Cyanosis	Nosebleeds				
Therapy: oxygen cannula	oxygen mask	ventilator	IPPB	BPAP	CPAP	
Other (list):						
Interventions:						
Performed by (check and list frequency)		SN (RN/LPN)	PT	ST	OT	RT
Specify Equipment/Supplies:				Parent/Guardian Other (specify):		
				Provider:		

5) CARDIOVASCULAR AND CIRCULATORY	Last examination date:	No Abnormalities reported/detected				
Pain: chest jaws neck arms	Irregular Heartbeat	Fainting				
Pressure: chest neck arms	High Blood Pressure	Blackouts				
Tightness: chest neck arms	Vertigo	Convulsions				
Edema: hands ankles feet other	Shortness of Breath: at rest with exertion					
Other (list):						
Interventions:						
Performed by (check and list frequency)		SN (RN/LPN)	PT	ST	OT	
Specify Equipment/Supplies:				Parent/Guardian Other (specify):		
				Provider:		

6) MUSCULOSKELETAL Joints: swollen stiffness Gait: unsteady shuffling wh/ch bound Deformity: Interventions: Performed by (check and list frequency)	Last examination date: Pain: joint muscle Frequent Falls bedbound Other (list): SN (RN/LPN) PT Parent/Guardian Other (specify):	No Abnormalities reported/detected Prosthesis: List Standing: limited unable Immobility: Contracture ST OT Provider:
7) GASTROINTESTINAL Indigestion Vomiting Constipation: laxative use enema use Recent Weight: gain loss Interventions: Performed by (check and list frequency)	Last examination date: Nausea Fecal Incontinence Ostomy - Type: Other (list): SN (RN/LPN) PT Parent/Guardian Other (specify):	No Abnormalities reported/detected Abdominal Pain Recent change in bowel habits ST OT Provider:
8) NUTRITIONAL STATUS Height _____ report actual Appetite good fair poor Prescribed Diet: Number of Meals per day [] History of eating disorder: Specify Equipment/Supplies:	Last examination date: Weight _____ report actual Supplemental Feeding enteral parental List type: Restrictions: Fluid Intake: usual amount per 24 hr. [] limited to [] per 24 hr. type [] SN (RN/LPN) PT Parent/Guardian Other (specify):	No Abnormalities reported/detected Provider:
9) GENITOURINARY/ GYNECOLOGICAL Incontinence: recent onset chronic Dribbling: frequency urgency hesitation Breast: lumps pain tenderness discharge Urine Monitoring for Glucose Interventions: Performed by (check and list frequency)	Last examination date: Painful Urination Nocturia Bleeding: vaginal rectal urethral Other (list): SN (RN/LPN) PT ST OT Parent/Guardian Other (specify):	No Abnormalities reported/detected Hematuria Catheter: foley straight external Provider:
10) NEUROLOGICAL Paraplegic Grasp: tremors weakness Blackouts Sleep Pattern Disturbance Aphasia: expressive receptive Interventions: Performed by (check and list frequency)	Last examination date: Quadriplegic Headache: Frequency _____ Vertigo Loss of Tactile Sensation Other (list): SN (RN/LPN) PT Parent/Guardian Other (specify):	No Abnormalities reported/detected Hemiplegia: Lt Rt Fainting Convulsions ST OT Provider:

<p>11)SKIN</p> <p>Oily Jaundice Rash Ulcers Lumps Abnormalities of Toes Other (list): Interventions:</p>	<p>Last examination date:</p> <p>Dry Bruises Itching Skin Tears Problem w/ Abnormalities of: hair scalp</p>	<p>No Abnormalities reported/detected</p> <p>Discoloration Abrasion Sores Poor Turgor Abnormalities of Fingers Open Wounds: Location</p>
<p>Performed by (check and list frequency)</p> <p>Specify Equipment/Supplies:</p>	<p>SN (RN/LPN) Parent/Guardian</p> <p>PT Other (specify):</p>	<p>ST OT</p> <p>Provider:</p>
<p>12)BLOOD DISORDER/ENDOCRINE/OTHER</p> <p>History of Iron Deficiency History of Autoimmune Disorders Bloodwork Monitoring: self/Caregiver Other (list): Interventions:</p>	<p>Last examination date:</p> <p>History of Bleeding Disorders Blood Transfusions: Frequency _____ physician office skilled nurse</p>	<p>No Abnormalities reported/detected</p> <p>History of Clotting Disorders</p> <p>Frequency _____</p>
<p>Performed by (check and list frequency)</p> <p>Specify Equipment/Supplies:</p>	<p>SN (RN/LPN) Parent/Guardian</p> <p>PT Other (specify):</p>	<p>ST OT</p> <p>Provider:</p>
<p>13) HEALTH PROMOTION</p> <p>Immunizations up-to-date (for children ages 0-16 years of age): Y N</p> <p>Date of last influenza vaccine: _____ Date of Last pneumococcal vaccine: _____</p> <p>Date of last Pap/Prostate exam: _____ Date of last mammogram: _____</p> <p>Other (list): _____</p> <p>Interventions: _____</p> <p>Specify Equipment/Supplies: _____ Provider: _____</p>		

SECTION F: MEDICATION PROFILE (Supervision, set-up, and assistance with oral medications and multi-dose inhalers is age-appropriate for consumers 0-11 years of age). These activities do not qualify as a need for skilled nursing services. **Taking oral medications (for consumers of any age) does not mean a consumer requires skilled nursing.**
I=Independent S=Supervision A=Hands-on Assistance AA=Age Appropriate

MEDICATIONS	R X	O T C	DOSE AND FREQ	R O U T E	Assistance Needed						A A	WHO ASSIST
					SET - UP			ADMINISTER				
					I	S	A	I	S	A		
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												

ADDITIONAL PAGE INCLUDED

Describe any specialized skilled interventions with medications: N/A
 Who provides intervention at this time:

Frequency of medication changes: _____ Has multiple physicians prescribing meds: Y# N

Allergies: (Medical and Environmental - Include medications, insects, foods, animals, etc.) No known allergies

Pharmacy:
 1) Name _____ Address _____
 Phone _____ Fax _____
 2) Name _____ Address _____ Phone _____ Fax _____

Chemicals: (frequency/amount) Alcohol _____ Caffeine _____ Nicotine _____ Other (list) _____

SECTION G: FUNCTIONAL ABILITY**

Activities of Daily Living (ADL'S) - Independent means ability to do activity with or without the use of assistive devices.
 Supervision and assistance with ADL's of bathing and grooming are age appropriate for consumers from 0-5 years of age.
 Assistance for this age group is not considered a deficit. **I=Independent S=Supervision A=Hands-on Assistance**

AA=Age Appropriate **Developmental Scale Referenced**

ADL Activity	I	S	A	AA	Performed By	Assessment determines more assistance necessary
1. Mobility (incl any a-c)						
a. Bed mobility						
b. Transfer						
c. Locomotion						
2. Bathing						
3. Grooming (incl a-c)						
a. Hair Care						
b. Nail Care						
c. Oral Hygiene						
4. Toileting						
5. Dressing						
6. Eating						

Instrumental Activities of Daily Living (IADL's) - Supervision and assistance with IADL's are age appropriate for consumers - 0-15 years of age. Assistance for this age group is not considered a deficit.

IADL Activity	I	S	A	AA	Performed By	More Help Indicated
1. Shopping						
2. Meal Preparation						
3. Environmental Management (incl a-c)						
a. House Cleaning						
b. Heavy Chores						
c. Yard work/ Maintenance						
4. Personal Laundry						
5. Accessing Community						
6. Telephoning						
7. Transportation						
8. Legal/Financial						

YES	NO	Developmental Scale Worksheet
		Does the consumer have a sole diagnosis of mental illness?
		Does the consumer have a diagnosis of any other diagnosed condition (other than MI) that results in substantial functional limitations. (For initial submissions of the assessment tool documentation by a licensed physician and or psychologist must accompany this form or filed in the consumer record).
		Documentation attached? [] yes [] no Diagnosis on file? [] yes [] no
		Did the disability resulting from the diagnosed condition manifest before the consumers 22 nd birthday?
		Is the disability resulting from the consumers condition expected to continue indefinitely?
		Could the consumer benefit from services and supports specifically designed to promote the acquisition of skills or to decrease or prevent the regression of skills in the areas of substantial functional limitations were identified (specialized habilitative services e.g. CAFS, early intervention, behavioral modification (ABA), Occupation therapy, Physical therapy, Speech therapy, and day programming)?

If you have answered yes to questions 2 through 5. Please obtain the information requested and complete the following age appropriate check list:

1. Consumers ages birth through 5 years of age a developmental scale that indicated the consumers diagnosed condition has resulted in at least three developmental delays in the following six major life areas? Check the areas below:

	Adaptive Behavior
	Physical Development and Maturation, Fine and Gross Motor Skills, Growth
	Cognition
	Communication
	Sensory Development

2. Consumer ages 6 through 15 years of age complete the age specific worksheet: Worksheet A for ages 6 through 8; Worksheet B for ages 9 through 11; Worksheet C for ages 12 through 15. Check the areas below:

	Capacity for independent living
	Communication
	Learning
	Mobility
	Personal Care
	Self Direction

3. Consumers ages 16 and older: Complete Worksheet D for ages 16 and older. Check the areas below:

	Communication
	Economic self-sufficiency
	Learning
	Mobility
	Personal Care
	Self Direction

SECTION H: PSYCHO-SOCIAL STATUS: Explain how deficits/identified concerns interfere with functioning. Describe behavior(s) and when applicable, describe the level of supervision necessary to prevent harm.

Name:

P.E.A.T.

Page 10

Disoriented to person/place/time		Confusion		Sleep Difficulties	
Social Isolation		Exhibits Bizarre Behavior		Depression	
Restlessness		Psycho-motor retardation		Hallucinations	
Hyperactive		Indications of Verbal/Physical Abuse		Paranoia	
Inappropriate fears, suspicions		Delusions		Obsessions	
Compulsions		Rages		Agitation	
Mood Swings		Wanders: Mentally / Physically		Suicidal Ideation/past attempts	
Forgetfulness: Long Term/ Short Term		Self-Abuse/Self-Neglect		Feels extremely sad	
Speech deficit		Hearing deficit		Unable to read/write	
Has difficulty concentrating		Inability to make Decisions		Feels irritable with people	
Feels impatient with people		Careless Smoking		Other:	

SECTION I: SAFETY AND COGNITION**

Yes	No	
		Can the consumer make his wants and needs known?
		Do any of the psycho-social behaviors identified above interfere with the consumers ability to participate in the development of a plan of care?
		Does the consumer require 24 hour awake direct supervision to prevent harm due to a cognitive impairment? If yes, explain:
		Does the consumer require less than 24 hour awake direct supervision to prevent harm due to a cognitive impairment? If yes, explain:
		Can the consumer remain alone safely without a caregiver? If yes, for how many hours:

SECTION J: ENVIRONMENTAL

House: 1 story 2 story 3 story Trailer Apartment Duplex

Own Rent List Name of Property owner/contact:

Wheelchair access: N/A doorways kitchen bathroom bedroom enter/exit home

Internal Environment	Acceptable	Needs Repair	Unable to Access	Comments
Kitchen				
Bathroom(s)				
Bedroom				
Living Room				
Electrical				
Plumbing				
Floors				
Stairs				
Heating/Cooling				
Windows				
Cleanliness				
Safety Factors/Issues				
a. Cords/plugs/ outlets				
b. Back-up plan/ caregiver				
c. Power loss				
d. Adequate lighting				
f. Smoke alarm				
e. Fire plan/exit				
g. Knowledge of infection control technique				
Medication Safety				
a. Storage/labeling				
b. Secure from children				
c. Oxygen use				
Smoking				
Other: list				

SECTION K: CURRENT ADAPTIVE/ASSISTIVE EQUIPMENT List Company and note if lease or own. Check if not applicable

Bed:	H2O	Hospital	Electric	Flotation	Other:
Lift:	Hoyer Van		Stair	Tub	
Bathroom:	Grab rails	Shower or Tub Chair	Hand-held shower	Adapted Toilet Seat	Other:
Ambulation-related:	Cane	Crutches	Walker	Scooter	
	Wheelchair (electric) or (conventional)		Adapted	Ramp	
	Other:				
Other:					
Equipment Needed:			Comments And/or Identify Available Resources:		

SECTION L: INFORMAL SUPPORTS Check if not applicable

Primary Caregiver Information	N/A	Present	Not Present
NAME:			
Address: same as individual			
Phone: same	Legal Guardian		Y N POA Y N
Relationship	Age	Gender: male female	Average hours/week
Employment: Employed	Part-time	Full-time	Unemployed Retired
Special caregiver education/training: N/A Received Needed: list			
Caregiver's self report of emotional well-being: Excellent Good Fair Poor			
Caregiver's self report of physical health: Excellent Good Fair Poor			
Length of time as primary caregiver:			
Ability to continue caregiving: same more less			

Comments:

Secondary Caregiver Information N/A		Present	Not Present
NAME:			
Address: same as individual			
Phone: same		Legal Guardian	Y N
		POA	Y N
Relationship	Age	Gender: male female	Average hours/week
Employment:	Employed Part-time Full-time	Unemployed	Retired
Special caregiver education/training: N/A Received Needed: list			
Caregiver's self report of emotional well-being: Excellent Good Fair Poor			
Caregiver's self report of physical health Excellent Good Fair Poor			
Length of time as secondary caregiver:			
Ability to continue caregiving: same more less			
Comments:			

TYPE AND FREQUENCY OF SERVICES BEING PROVIDED BY ALL VOLUNTARY CAREGIVERS / INFORMAL SUPPORTS COMBINED (Complete for consumers 16 years and older)

Current Services	Days	Frequency/ Duration	By Whom	Current Services	Days	Frequency/ Duration	By Whom
Personal Care				Transportation			
Meal Preparation				Shopping			
Laundry				Money Management			
Homemaking				Skilled Services			
Other (list)							
Other (list)							
Comments:							

FORMAL SUPPORT SERVICES: Services currently being provided by paid Caregiver(s).
This includes consumers of all ages.

Check if not applicable

Name and type of service(s) provided list agency or individual name(s)	Frequency/Duration/Days	Funding Source (Private Pay, Medicaid, Medicare, Insurance, etc.)

SECTION M: RECOMMENDATION/DETERMINATION **

Based on review of the LOC assessment, it is recommended that the Level of Care indicated below is appropriate:

Skilled Intermediate ICF-MR Protective None

Core Plus Benefit: Approved ___/___/___ Continue Service
Denial ___/___/___ Reason _____; Termination ___/___/___ Reason _____

Waiver Benefit: Approved ___/___/___ Continue Service
Denial ___/___/___ Reason _____; Termination ___/___/___ Reason _____

Case Manager Name(print):

Signature/Title:

Date:

SUMMARY / CARE PLAN IMPLICATIONS: Summarize all information obtained on the P.E.A.T and address consumer needs and how needs are currently being met. Include formal and informal caregivers and how they are currently meeting consumer needs. Include needs identified and care plan implications, if relevant.

Would the consumer require institutionalization in a hospital or nursing facility if services were no longer available in the home and/or community? If yes, give a brief explanation:

ADDITIONAL PAGE
SECTION F: MEDICATION PROFILE

MEDICATIONS	RX	OT C	DOSE AND FREQ	R O U T E	Assistance Needed						A A	WHO ASSIST
					Set-Up			Administer				
					I	S	A	I	S	A		
14												
15												
16												
17												
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SUPPLEMENT 4
BHCS All Services Plan

SUPPLEMENT 5

Proposed Ohio Administrative Code Additions

- **5101:3-12-25 Criminal records checks involving agency-employed providers**
- **5101:3-12-26 Criminal records checks involving independent providers**
- **5101:3-12-28 Enrollment process for ODJFS-administered waiver service providers**
- **5101:3-12-29 Consumer incident reporting**
- **5101:3-12-30 Monitoring under ODJFS-administered HCBS waivers**
- **5101:3-12-35 Non-medicaid Ohio access success project**

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5101:3-12-25

Criminal records checks involving agency-employed providers of ODJFS-administered waiver services.

(A) This rule sets forth the process and requirements for the criminal records checks of persons under final consideration for employment with a waiver agency, and existing employees with a waiver agency in a full-time, part-time or temporary position, and who are providing home and community-based services (HCBS) in an ODJFS-administered waiver.

(B) For the purposes of this rule,

(1) "Applicant" means a person who is under final consideration for employment or, after the effective date of section 5111.95 of the Revised Code, an existing employee, with a waiver agency in a full-time, part-time or temporary position, that involves providing HCBS to a person with disabilities.

(2) "Chief Administrator" means the head of a waiver agency, or his or her designee.

(3) "Criminal Records Check" means any criminal records check conducted by the superintendent of the bureau of criminal identification and investigation (BCII) in accordance with section 109.572 of the Revised Code.

(4) "Disqualifying Offense" means any of the following:

(a) A violation of sections 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.12, 2919.24, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2925.11, 2925.13, 2925.22, 2925.23 or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date; or

(b) An existing or former law of the state of Ohio, any other state, or the United States that is substantially equivalent to any of the disqualifying offenses listed in subparagraph (B)(4)(a).

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(5) "Home and Community-Based Services" (HCBS) refers to the services defined in division (A) (4) of section 5111.95 of the Revised Code.

(6) "Superintendent" means superintendent of BCII.

(7) "Waiver Agency" means a person or government entity that is not certified under the medicare program and is accredited by the community health accreditation program (CHAP) or the joint commission on accreditation of health care organizations (JCAHO), or a company that provides HCBS to persons with disabilities through ODJFS-administered waiver programs.

(C) Process for conducting criminal records checks

(1) The chief administrator of a waiver agency shall require each person, at the time of initial application for a position that involves providing HCBS to a person with a disability, that the applicant must provide a set of fingerprint impressions and that a criminal records check must be conducted if the person comes under final consideration for employment.

(2) An employee of a waiver agency in a full-time, part-time, or temporary position that involves providing HCBS to a person with disabilities shall comply with this rule within sixty days after the effective date of this rule unless he or she:

(a) Previously was the subject of a criminal records check relating to that position; and

(b) Has been continuously employed in that position since that criminal records check was conducted.

(3) Except as otherwise noted in paragraph (C) (2) of this rule, the chief administrator of a waiver agency shall request that the BCII superintendent conduct a criminal records check with respect to each ODJFS-waiver agency provider applicant, and pursuant to sections 5111.95, 5111.96 and 109.572 of the Revised Code.

(a) If an applicant does not present proof of having been a resident of the state of Ohio for the five-year period immediately prior to the date the criminal records check is requested, or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation (FBI), the chief administrator shall request that the superintendent obtain a criminal records check from the FBI.

(b) Even if an applicant presents proof of having been a resident of the state of Ohio for the five-year period, the chief administrator may request that the

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superintendent obtain information from the FBI in the criminal records check.

(4) The chief administrator of a waiver agency shall:

(a) Provide information to each applicant about requesting a copy of the form prescribed pursuant to division (C) (1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet presented pursuant to division (C) (2) of that section, and obtain the completed form and impression sheet from the applicant; and

(b) Forward the completed form and impression sheet to the BCII superintendent.

(5) If an applicant fails to complete the form or provide the fingerprint impressions, then he or she shall not be employed in any position in a waiver agency for which a criminal records check is required by this rule.

(6) A waiver agency may conditionally employ an applicant for whom a criminal records check is required by this rule prior to obtaining the results of that check, provided that the request is made no later than five business days after he or she begins conditional employment.

(7) The waiver agency shall terminate employment if the results of the criminal records check, other than the results of any request for information from the FBI, are not obtained within the period ending sixty days after the date the request is made.

(8) Regardless of when they are obtained, if the results indicate that the employee has been convicted of or pleaded guilty to any of the offenses listed in paragraph (B) (4) of this rule, then the waiver agency:

(a) Shall terminate his or her employment, or

(b) May choose to employ him or her because he or she meets personal character standards set by the department and enumerated in paragraph (D) of this rule.

(9) Termination of employment shall be considered just cause for discharge for the purposes of division (D) (2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the waiver agency about his or her criminal record.

(10) Waiver agencies shall pay to BCII the fee prescribed pursuant to division (C) (3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to their request. Waiver agencies may:

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- (a) Charge an applicant a fee not to exceed the amount the waiver agency pays in accordance with this paragraph;
 - (b) Only collect fees if the waiver agency notifies the person at the time of the initial application for employment of the amount of the fee and that, unless the fee is paid, he or she will not be considered for employment.
- (11) Reports of any criminal records checks conducted by BCII in accordance with this rule are not public records for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:
 - (a) The person who is the subject of the criminal records check or the individual's representative;
 - (b) The chief administrator of the waiver agency requesting the criminal records check or the administrator's representative;
 - (c) Any court, hearing officer, or other necessary individual involved in a case dealing with a denial of employment of the applicant, or dealing with employment or unemployment benefits of the applicant.
- (D) Personal character standards
 - (1) A waiver agency may employ an applicant who has been convicted of or pleaded guilty to an offense listed in paragraph (B) (4) of this rule in a position that involves providing HCBS to disabled consumers if all of the following personal character standards are met for each offense:
 - (a) The applicant is not a repeat violent offender;
 - (b) The offense is not sexually-oriented;
 - (c) The offense is not one of abuse or neglect as described in section 2903.34 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.34 of the Revised Code;
 - (d) The offense is not a repeat theft-related offense or a violation of any two, or a combination of any two existing or former laws of the state of Ohio, any other state, or the United States, if the theft-related offenses are substantially equivalent to any of the offenses described in paragraph (B) (4) of this rule;
 - (e) The offense is not one of aggravated murder as described in section 2903.01 of the Revised Code or a violation of an existing or former law of the state

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of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.01 of the Revised Code;

- (f) The offense is not one of murder as described in section 2903.02 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.02 of the Revised Code;
 - (g) The offense is not one of voluntary manslaughter as described in section 2903.03 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.03 of the Revised Code;
 - (h) The offense is not a disqualifying offense as defined in paragraph (B) (4) of this rule; and the applicant is discharged from imprisonment, sentenced to probation in lieu of imprisonment, or is on parole and is meeting all conditions subject to that conviction;
 - (i) A waiver agency may employ an applicant who has been convicted of or pleaded guilty to a disqualifying offense as defined in paragraph (B) (4) of this rule if, and only if, at least five years have elapsed since the applicant was fully discharged from imprisonment, probation and parole; and
 - (j) A waiver agency may not employ an applicant who has been convicted of or pleaded guilty to a disqualifying offense as defined in paragraph (B) (4) of this rule if the victim was a child.
- (2) When the conditions enumerated in paragraph (D) (1) of this rule are met, the waiver agency shall consider each of the following factors in determining whether it is not likely that the applicant will commit another disqualifying offense:
- (a) The duties and responsibilities of the position;
 - (b) The nature and seriousness of the offense;
 - (c) Whether or not the applicant had committed a disqualifying offense as described in paragraph (B) (4) of this rule
 - (d) The circumstances under which the offense was committed, including but not limited to:

 - (i) The applicant's age at the time of the offense;
 - (ii) The degree to which the applicant participated in the offense;

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- (iii) The age and ability of the victim, including whether the victim was an individual with a disability;
 - (e) The extent to which the position being filled provides an opportunity for the commission of the same or similar offenses;
 - (f) The time elapsed since the applicant was fully discharged from imprisonment, probation and parole;
 - (g) The applicant's efforts at rehabilitation and the results of those efforts;
 - (h) Whether any criminal proceedings are pending against the applicant;
 - (i) A conviction listed on the report of the criminal records check which identifies any offenses contained in the Revised Code that are not listed in paragraph (B) (4) of this rule, if the crime bears a direct and substantial relationship to the duties and responsibilities of the position being filled; and
 - (j) Any other factors which are relevant to the performance of the job duties.
- (3) It is the duty of the applicant to provide proof that the standards in regard to personal character specified in paragraphs (D) (1) and (D) (2) of this rule are met. If the applicant fails to provide such proof or if the waiver agency determines that the proof offered by the applicant is inconclusive, the applicant shall not be placed in a position that requires direct care to ODJFS-administered waiver consumers with disabilities.

(E) Pardons

A conviction of, or a plea of guilty to, an offense listed or described in paragraph (B) (4) of this rule shall not prevent an applicant's employment under any of the following circumstances:

- (1) The applicant has been granted an unconditional pardon for the offense pursuant to Chapter 2967. of the Revised Code;
- (2) The applicant has been granted an unconditional pardon for the offense pursuant to an existing or former law of the state of Ohio, any other state, or the United States, if the law is substantially equivalent to Chapter 2967. of the Revised Code;
- (3) The applicant has been granted a conditional pardon for the offense pursuant to Chapter 2967. of the Revised Code, and the condition(s) under which the pardon was granted have been satisfied; or

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(4) The conviction or guilty plea has been set aside pursuant to law.

(F) Documentation - applicant log

The chief administrator of a waiver agency shall maintain an applicant log separate from the personnel record. It shall contain the following information:

(1) Names of all applicants;

(2) The date of application;

(3) The date the applicant started work;

(4) The date the criminal records check request was submitted to BCII;

(5) The type(s) of criminal records checks requested (BCII, FBI or both);

(6) The date the BCII and FBI checks were received;

(7) Whether or not the results of the check revealed that the applicant committed a disqualifying offense(s), and the specific offense(s) and date(s) committed;

(8) The number of references received on behalf of the applicant, the dates that the references were received, and how the references were verified;

(9) Whether the personal character standards were applied as a condition for employment;

(10) Whether or not the applicant was conditionally hired, hired and/or terminated;

(11) The date of the fingerprint check by BCII, the FBI or both;

(12) The chief administrator of a waiver agency shall certify in the applicant log that it has used each and every personal character standard as described in paragraph (D) of this rule when hiring an applicant whose background check results revealed the commission of a disqualifying offense as described in paragraph (B) of this rule.

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5101:3-12-26

Criminal records checks involving independent providers of ODJFS-administered waiver services.

(A) This rule sets forth the process and requirements for the criminal records checks of independent providers of home and community-based waiver services (HCBS) in an ODJFS-administered waiver.

(B) For the purposes of this rule,

(1) "Anniversary Date" means the later of the effective date of the provider agreement relating to the independent provider or sixty days after the effective date of section 5111.96 of the Revised Code.

(2) "Criminal records check" means any criminal records check conducted by the superintendent of the bureau of criminal identification and investigation (BCII) in accordance with section 109.572 of the Revised Code.

(3) "Department" means the Ohio department of job and family services.

(4) "Disqualifying Offense" means any of the following:

(a) A violation of Sections 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.12, 2919.24, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date; or

(b) An existing or former law of the state of Ohio, any other state, or the United States that is substantially equivalent to any of the disqualifying offenses listed in subparagraph (B)(4)(a) of this rule.

(5) "Effective Date of Provider Agreement" means the next occurrence of the month in which the initial provider agreement was entered into between the department and the provider. If, in the first year of application of the requirement contained in this rule, the effective date of the provider agreement is less than sixty days

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after the effective date of this rule, the effective date of the provider agreement is extended by seventy-five days from the date otherwise determined in this sentence.

(6) "Home and Community-Based Services" (HCBS) means services as defined in division (A) (4) of section 5111.95 of the Revised Code.

(7) "Independent Provider" means a person who is submitting an application for a provider agreement or who has a provider agreement as an independent provider of HCBS services in an ODJFS-administered waiver.

(8) "Superintendent" means superintendent of BCII.

(C) Process for Conducting Criminal Records Checks

(1) ODJFS shall inform:

(a) Each prospective independent provider, at the time of initial application for a medicaid provider agreement that involves providing HCBS to persons with disabilities, that he or she must provide a set of fingerprint impressions, and a criminal record check must be conducted.

(b) Each currently-enrolled independent provider, on or before the time of the anniversary date of their medicaid provider agreement that involves providing HCBS to consumers with disabilities, that he or she must provide a set of fingerprint impressions and that a criminal records check must be conducted.

(2) ODJFS shall require the independent provider to complete a criminal records check prior to entering into a medicaid provider agreement with the independent provider, and at least annually thereafter.

(a) If the independent provider does not present proof of having been a resident of the state of Ohio for the five-year period immediately prior to the date the criminal records check is requested, or provide evidence that within that five-year period the superintendent has requested information about the independent provider from the Federal Bureau of Investigation (FBI), ODJFS shall request the independent provider obtain through the superintendent a criminal records check from the FBI.

(b) Even if an independent provider presents proof of having been a resident of the state of Ohio for the five-year period, ODJFS may request that he or she obtain information through the superintendent from the FBI in the criminal records check.

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- (3) ODJFS shall provide information to each independent provider about requesting a copy of the form prescribed pursuant to division (C) (1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet prescribed pursuant to division (C) (2) of that section, and instructions regarding submission procedures to BCII.
- (4) Each independent provider shall forward the completed form, impression sheet, and fee to the BCII superintendent. The BCII fee shall be the fee prescribed pursuant to division (C) (3) of section 109.572 of the Revised Code for each criminal records check conducted on his or her behalf pursuant to this rule.
- (5) An independent provider who fails to complete the form or provide fingerprint impressions shall not be approved as an independent provider.
- (6) Except as provided by paragraph (D) of this rule, ODJFS shall not issue a new provider agreement to, and shall terminate an existing provider agreement of an independent provider if he or she has been convicted of or pleaded guilty to any of the disqualifying offenses enumerated in paragraph (B) (4) of this rule.
- (7) Reports of any criminal records checks conducted by BCII in accordance with section 109.572 of the Revised Code and this rule are not public records for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:

 - (a) The person who is the subject of the criminal records check, or the person's representative;
 - (b) The administrator at ODFJS who is requesting the criminal records check or the administrator's representative;
 - (c) Any court, hearing officer, or other necessary individual involved in a case dealing with a denial or termination of a Medicaid provider agreement related to the criminal records check.
- (8) Failure on the part of the independent provider to submit to a criminal records check within ninety days of notification by ODJFS of his or her need to do so shall render the independent provider immediately ineligible to provide services to all ODJFS-administered waiver consumers. ODJFS or its designated contracted case management entity shall take immediate steps to remove the independent provider from all all services plans until such time as the independent provider has satisfactorily completed all requirements of this rule.
- (9) If the independent provider continues to be noncompliant with the provisions of this rule, ODJFS shall initiate termination of the medicaid provider agreement.

(D) Personal character standards

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- (1) A consumer may choose to enter into a provider agreement with an independent provider who has been convicted of or pleaded guilty to an offense listed in paragraph (B) (4) of this rule in a position that involves providing HCBS to disabled consumers if all of the following personal character standards are met for each offense:
- (a) The independent provider is not a repeat violent offender;
 - (b) The offense is not sexually-oriented;
 - (c) The offense is not one of abuse or neglect as described in section 2903.34 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.34 of the Revised Code;
 - (d) The offense is not a repeat theft-related offense or a violation of any two, or a combination of any two existing or former laws of the state of Ohio, any other state, or the United States, if the theft-related offenses are substantially equivalent to any of the offenses described in paragraph (B) (4) of this rule;
 - (e) The offense is not one of aggravated murder as described in section 2903.01 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.01 of the Revised Code;
 - (f) The offense is not one of murder as described in section 2903.02 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.02 of the Revised Code;
 - (g) The offense is not one of voluntary manslaughter as described in section 2903.03 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.03 of the Revised Code;
 - (h) The offense is not a disqualifying offense as defined in paragraph (B) (4) of this rule; and the independent provider is discharged from imprisonment, sentenced to probation in lieu of imprisonment, or is on parole and is meeting all conditions subject to that conviction;
 - (i) A consumer may employ an independent provider who has been convicted of or pleaded guilty to a disqualifying offense as defined in paragraph (B) (4) of this rule if, and only if, at least five years have elapsed since the

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independent provider was fully discharged from imprisonment, probation and parole; and

(j) A consumer may not employ an independent provider who has been convicted of or pleaded guilty to a disqualifying offense as defined in paragraph (B) (4) of this rule if the victim was a child.

(2) When the conditions enumerated in paragraph (D) (1) of this rule are met, the consumer shall consider each of the following factors in determining whether or not it is likely that the independent provider will commit another disqualifying offense:

(a) The duties and responsibilities of the position;

(b) The nature and seriousness of the offense;

(c) Whether or not the independent provider had committed a disqualifying offense as described in paragraph (B) (4) of this rule;

(d) The circumstances under which the offense was committed, including but not limited to:

(i) The independent provider's age at the time of the offense;

(ii) The degree to which the independent provider participated in the offense;

(iii) The age and ability of the victim, including whether the victim was an individual with a disability;

(e) The extent to which the position being filled provides an opportunity for the commission of the same or similar offenses

(f) The time elapsed since the independent provider was fully discharged from imprisonment, probation and parole;

(g) The independent provider's efforts at rehabilitation and the results of those efforts;

(h) Whether any criminal proceedings are pending against the independent provider;

(i) A conviction listed on the report of the criminal records check which identifies any offenses contained in the Revised Code that are not listed in paragraph (B) (4) of this rule, if the crime bears a direct and substantial

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relationship to the duties and responsibilities of the position being filled;
and

(j) Any other factors which are relevant to the performance of the job duties.

(3) It is the duty of the independent provider to provide proof that the standards in regard to personal character specified in paragraphs (D) (1) and (D) (2) of this rule are met. If the independent provider fails to provide such proof or if the consumer determines that the proof offered by the independent provider is inconclusive, the independent provider shall not be placed in a position that requires directed care to ODJFS-administered waiver consumers with disabilities.

(E) Pardons

A conviction of, or a plea of guilty to, an offense listed or described in paragraph (B) (4) of this rule shall not prevent an independent provider's employment under any of the following circumstances:

(1) The independent provider has been granted an unconditional pardon for the offense pursuant to Chapter 2967. of the Revised Code;

(2) The independent provider has been granted an unconditional pardon for the offense pursuant to an existing or former law of the state of Ohio, any other state, or the United States, if the law is substantially equivalent to Chapter 2967. of the Revised Code;

(3) The independent provider has been granted a conditional pardon for the offense pursuant to Chapter 2967. of the Revised Code, and the condition(s) under which the pardon was granted have been satisfied; or

(4) The conviction or guilty plea has been set aside pursuant to law.

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5101:3-12-28 Enrollment process for ODJFS-administered waiver service providers.

- (A) All ODJFS-administered waiver service providers must meet the eligibility requirements set forth in rule 5101:3-12-05 of the Administrative Code. Any person who wants to provide waiver services in an ODJFS-administered waiver must complete the service provider application process set forth in this rule and receive enrollment approval from ODJFS.
- (B) All applicants must submit a complete and accurate provider enrollment packet to ODJFS or to the entity designated by ODJFS to receive and process enrollment packets. Each applicant must submit with their enrollment packet a signed statement affirming that the applicant received and read all Administrative Code provisions governing the Ohio home care program.
- (C) ODJFS will review the provider enrollment packet to verify the following information for each provider type.
- (1) For each medicare-certified home health agency, ODJFS will verify the agency's current medicare certification status, and that the agency and/or the agency's primary officer, director, or owner is not on the U.S. department of health and human services' exclusionary participant list.
- (2) For each other accredited home health agency, ODJFS will verify the agency's current accreditation status, and that the agency and/or the agency's primary officer, director, or owner is not on the U.S. department of health and human services' exclusionary participant list.
- (3) For each waiver independent daily living aide, ODJFS will verify the following:
- (a) The aide has successfully completed the nurse aide competency evaluation conducted by the Ohio department of health under section 3721.31 of the Revised Code, or has successfully completed and passed the home health aide competency evaluation as specified in 42 CFR Part 484 (as effective on July 1, 2004);
- (b) The aide is not listed on the U.S. department of health and human services' exclusionary participant list;
- (c) The aide has successfully completed a criminal records check as enumerated in rule 5101:3-12-26 of the Administrative Code and, if applicable, the consumer has implemented the personal character standards enumerated in paragraph (D) of rule 5101:3-12-26 of the Administrative Code; and

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- (d) The aide is not listed on the Ohio department of mental retardation and developmental disabilities' (ODMR/DD) abuser registry or STNA registry.
- (4) For each waiver independent daily living non-aide, ODJFS will verify the following:
 - (a) The non-aide has successfully completed a criminal records check as enumerated in rule 5101:3-12-26 of the Administrative Code, and if applicable, the consumer has implemented the personal character standards enumerated in paragraph (D) of rule 5101:3-12-26 of the Administrative Code;
 - (b) The non-aide is not listed on the U.S. department of health and human services' exclusionary participant list; and
 - (c) The non-aide is not listed on the ODMR/DD abuser registry.
- (5) For each independent home care nurse, ODJFS will verify the following:
 - (a) The nurse has a valid and active RN or LPN license in the state of Ohio;
 - (b) An appropriate license is held by an LPN supervisor;
 - (c) There are no pending actions or sanctions against the nurse by the Ohio board of nursing;
 - (d) The nurse has successfully completed a criminal records check as enumerated in rule 5101:3-12-26 of the Administrative Code and, if applicable, the consumer has implemented the personal character standards enumerated in paragraph (D) of rule 5101:3-12-26 of the Administrative Code;
 - (e) The nurse is not listed on the U.S. department of health and human services' exclusionary participant list; and
 - (f) The nurse is not listed on the ODMR/DD abuser registry.
- (6) For each ODJFS-administered HCBS waiver provider of other waiver services, ODJFS will verify that the entity or organization meets the requirements specified in paragraphs (I) (2) and (I) (3) or (J) of rule 5101:3-12-05 of the Administrative Code.
- (D) ODJFS will not process an enrollment packet if the packet does not contain information necessary to complete the required verifications. ODJFS will not process an enrollment packet if the applicant does not submit the signed statement as required by section (B) of this rule. ODJFS will notify the applicant in writing of

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any missing information, and will provide the applicant thirty calendar days to provide the required documentation. If the applicant does not submit the required documentation within thirty calendar days, the enrollment process will be terminated.

(E) ODJFS will review all information and make a determination regarding the applicant's eligibility for enrollment. If ODJFS determines the applicant is ineligible for enrollment, the applicant is entitled to appeal rights in accordance with rule 5101:3-1-17.6 of the Administrative Code.

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5101:3-12-29

Consumer incident reporting.

- (A) ODJFS will operate an incident management, investigation and response system (IMIRS). This rule sets forth the standards and procedures for operating the IMIRS. This rule applies to ODJFS and providers of waiver services for ODJFS-administered waivers. ODJFS may contract with other agencies or entities to perform one or more investigatory functions under this rule.
- (B) ODJFS will maintain the secure and confidential storage of ODJFS-approved occurrence reporting forms, and ODJFS-approved incident narrative forms, and any associated investigation reports and related documents. All such documents will be filed according to the name of the consumer, and in an area separate from the involved consumer's clinical record.
- (C) "Level 1" incidents will include, but not be limited to:
- (1) Physical, emotional, mental and/or sexual abuse of a consumer;
 - (2) Neglect of a consumer;
 - (3) Abandonment of a consumer;
 - (4) Exploitation of a consumer;
 - (5) Death of a consumer;
 - (6) Accident or injury of a consumer which may or may not result in hospitalization or emergency room visit;
 - (7) Inappropriate delivery of services to a consumer, with health and safety implications;
 - (8) Services provided to a consumer that are beyond the provider's scope of practice, with health and safety implications;
 - (9) Services delivered to a consumer without physician's orders, that may have health and safety implications;
 - (10) Errors in the administration of medication to the consumer, with health and safety implications;
 - (11) Alleged illegal activity by the consumer resulting in documented police intervention;

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(12) Consumer's inappropriate use or abuse of substances which may result in health and safety implications; and

(13) Theft of consumer's medication.

(D) Reporting, notification and response requirements of "Level 1" incidents

(1) If an ODJFS-administered waiver provider learns of a "Level 1" incident, the provider must report the incident to ODJFS within twenty-four hours.

(2) If ODJFS receives a report of an incident, ODJFS will contact the appropriate investigatory or law enforcement authority which may include one or more of the following:

(a) The law enforcement agency having jurisdiction over the location at which the incident occurred, if the "Level 1" incident includes conduct that would constitute a possible criminal act, including abuse or neglect.

(b) The public children services agency (PCSA) and/or the public adult protective services units having jurisdiction over the location where the consumer resides, if applicable.

(c) The county board of mental retardation and developmental disabilities (CBMR/DD) for all allegations of abuse, neglect and other major unusual incidents as specified in section 5123.61 of the Revised Code. This notification must be made following all reporting mandates as outlined by ODMR/DD.

(d) The consumer's local mental health case manager, if such services are identified on the all services plan. This notification must be made following reporting mandates as outlined by the Ohio department of mental health.

(e) The Ohio department of health or Ohio board of nursing, if appropriate.

(E) Investigation requirements for "Level 1" incidents

ODJFS will conduct investigations of "Level 1" incidents as follows:

(1) ODJFS will review all available information to determine if there are adequate safeguards to protect the consumer's health and welfare.

(2) ODJFS will not delegate the investigation of the following types of incidents to a contractor:

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- (a) "Level 1" incidents that include an allegation that an employee of the contractor is responsible for the death, or abuse, or neglect of a consumer; or
 - (b) "Level 1" incidents of a consumer's death where the circumstances of the death are suspicious in nature.
 - (3) ODJFS will review the information gathered in the investigation, and may consider the recommendations of any contractor, to determine if the reported incident is substantiated.
- (F) Substantiated "Level 1" incidents involving ODJFS-administered waiver service providers
- (1) Upon substantiation of "Level 1" incident(s), the ODJFS-administered waiver service provider will be notified by ODJFS via certified mail with a cease and desist letter. The letter will:
 - (a) Outline the alleged behavior or practice to be stopped;
 - (b) Specify the Administrative Code rule that supports the noncompliance finding(s);
 - (c) Specify what the provider must do to correct the finding(s); and
 - (d) Specify the date a plan of correction must be submitted to ODJFS, not to exceed fifteen calendar days after the date the letter was mailed.
 - (2) If ODJFS finds the provider's plan of correction acceptable, it shall approve the plan and confirm to the provider in writing that the plan addresses the issues of noncompliance outlined in the cease and desist order. If ODJFS determines that it cannot approve the provider's plan of correction, it will inform the provider of this determination in writing, require the provider to submit a new plan of correction, and specify the required actions that must be included in the new plan of correction. The provider must submit the new plan of correction by the date specified by ODJFS.
 - (3) ODJFS will impose sanctions upon the provider in accordance with rule 5101:3-12-08 of the Administrative Code if the provider:
 - (a) Has not followed the plan of correction and/or successfully achieved the plan's desired results;
 - (b) Has not submitted a plan of correction or has not had a plan of correction approved;

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(c) Has not complied with the time frames outlined in this rule;

(d) Has failed to protect consumers from repeated and substantiated "Level 1" incidents; and/or

(e) Has created a serious and immediate threat to the health and/or safety of the consumer.

(G) At its discretion, for technical assistance or oversight, ODJFS will conduct a separate, independent review or investigation of a "Level 1" incident investigated by a contractor.

(H) "Level 2" incidents will include, but not be limited to:

(1) Theft of a consumer's money;

(2) Theft of a consumer's personal property;

(3) Errors in the administration of medication to the consumer, without health and safety implications;

(4) Alleged illegal activity occurring in the consumer's environment without law enforcement intervention;

(5) A consumer's exposure to or diagnosis of communicable disease;

(6) A consumer's family or environmental crisis;

(7) Loss of a consumer's informal (unpaid) caregiver or family member; and/or

(8) A consumer's unplanned hospital or nursing home stay.

(I) Reporting, notification and response requirements for "Level 2" incidents.

(1) If an ODJFS-administered waiver provider learns of a "Level 2" incident, the provider must report the incident to ODJFS within twenty-four hours.

(2) If ODJFS receives a report of an incident, ODJFS will contact the appropriate investigatory or law enforcement authority which may include one or more of the following:

(a) The law enforcement agency having jurisdiction over the location at which the incident occurred, if the "Level 2" incident includes conduct that would constitute a possible criminal act, including abuse or neglect.

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(b) The PCSA and/or the public adult protective services units having jurisdiction over the location where the consumer resides, if applicable.

(c) Contact the CBMR/DD for all allegations of major unusual incidents as specified in section 5123.61 of the Revised Code. This notification must be made in accordance with all reporting mandates as outlined by ODMR/DD.

(d) The consumer's local mental health case manager, if such services are identified on the all services plan. This notification must be made following reporting mandates as outlined by the Ohio department of mental health.

(e) The Ohio department of health or Ohio board of nursing, as appropriate.

(J) Investigatory requirements for "Level 2" incidents

ODJFS will conduct investigations of "Level 2" incidents as follows:

(1) ODJFS will review all available information to determine if there are adequate safeguards for the consumers health and welfare.

(2) ODJFS will review the information gathered in the investigation, and may consider recommendations of any contractor, to determine if the "Level 2" incident is substantiated.

(K) Substantiated "Level 2" incidents involving ODJFS-administered waiver service providers

(1) Upon substantiation of a "Level 2" incident, the ODJFS-administered waiver service provider will be notified by ODJFS via certified mail with a cease and desist letter. The letter will:

(a) Outline the alleged behavior or practice to be stopped;

(b) Specify the Administrative Code rule that supports the noncompliance finding;

(c) Specify what the provider must do to correct the finding; and

(d) The date a plan of correction must be submitted to ODJFS, not to exceed thirty calendar days after the date the letter was mailed.

(2) If ODJFS finds the provider's plan of correction acceptable, it shall approve the plan and confirm to the provider in writing that the plan addresses the issues of noncompliance outlined in the cease and desist order. If ODJFS determines that it cannot approve the provider's plan of correction, it will inform the provider of this determination in writing, require the provider to submit a new plan of

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correction, and specify the required actions that must be included in the new plan of correction. The provider must submit the new plan of correction by the date specified by ODJFS.

- (3) ODJFS will impose sanctions upon the provider in accordance with rule 5101:3-12-08 of the Administrative Code if the provider:
- (a) Has not followed the plan of correction and/or successfully achieved the plan's desired results;
 - (b) Has not submitted a plan of correction or has not had a plan of correction approved;
 - (c) Has not complied with the time frames outlined in this rule;
 - (d) Has failed to protect consumers from repeated and substantiated "Level 2" incidents; and/or
 - (e) Has created a serious and immediate threat to the health and/or safety of the consumer.
- (L) At its discretion, and for technical assistance or oversight, ODJFS will conduct a separate, independent review or investigation of a "Level 2" incident investigated by a contractor.
- (M) ODJFS will provide a written summary of the investigative findings to the reporter of a "Level 1" or "Level 2" incident, unless it may jeopardize the health and safety of the consumer. Adherence to all consumer confidentiality and HIPAA regulations shall be assured.
- (N) ODJFS will determine when to close cases of suspected abuse, neglect, death and exploitation as well as any other "Level 1" incident investigated by the department.
- (O) ODJFS will be responsible for ensuring that all cases have been properly closed and may request further review if necessary.

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5101:3-12-30 **Monitoring under ODJFS-administered home and community-based service waivers.**

(A) Every ODJFS-administered waiver provider will submit to regularly scheduled monitoring. The monitoring will include:

(1) Structural review of compliance with rules 5101:3-12-05, 5101:3-12-06, 5101:3-12-07, 5101:3-1-172, 5101:3-1-173, and 5101:3-12-25 or 5101:3-12-26 of the Administrative Code, as determined by the appropriate provider type; and

(2) Continuous monitoring of provider compliance and performance through the provider occurrence process enumerated in paragraph (D) of this rule.

(B) ODJFS may contract with other agencies or entities to perform one or more functions enumerated in this rule.

(C) Structural reviews

(1) ODJFS will conduct an annual face-to-face structural review of all ODJFS-administered waiver providers using the ODJFS structural compliance review tool, beginning from the first date of service delivery, with the exception of the following:

(a) For medicare certified home health agencies and JCAHO or CHAP accredited agencies, the results of the respective certifying or accrediting body will serve as the required structural review.

(b) For home modifications, vehicle modifications, equipment and supplies and emergency response system providers, the structural review will occur annually through the second year of service delivery, and biennially thereafter.

(2) ODJFS may conduct a structural review as a result of reported provider occurrences as defined in paragraph (D) of this rule.

(3) The structural review will include no less than the following:

(a) A telephone call or a written announcement establishing the date, time and location of the review.

(b) An evaluation of compliance in accordance with paragraph (A) of this rule.

(c) A unit of service verification audit assuring that services authorized and delivered are billed for correctly.

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- (d) An evaluation of the ODJFS-administered waiver provider's implementation of any/all plans of correction.
- (e) An exit conference with agency/provider staff or with the independent provider.
- (4) For the structural review, ODJFS will gather unit of service verification samples. These will consist of:

 - (a) Ten per cent of the agency-based provider's current ODJFS-administered waiver service delivery records for each service, with a minimum of three and a maximum of thirty records per service/per provider.
 - (b) Three months of clinical records and supporting documentation per consumer for all independent providers. In cases where the independent provider services more than one ODJFS-administered waiver consumer, the structural review will examine three months of clinical records and supporting documentation up to a maximum of six consumers. The findings of this limited review may result in an expanded review of records.
- (5) The unit of service verification audit described in paragraph (C) (3) (c) of this rule will include a comparison of services authorized, delivered and billed as it relates to the consumer's all services plan. ODJFS will report any/all provider overpayments to the department's surveillance and utilization review section. Providers will return any overpayment of funds to ODJFS.
- (6) ODJFS will conduct a combined structural review for all agency-based ODFJS-administered waiver providers that provide both daily living and nursing services. The total sample will equal the required sample as set forth in paragraphs (C) (4) (a) and (C) (4) (b) of this rule.
- (7) ODJFS reserves the right to conduct unannounced structural reviews at any time to evaluate alleged health and/or safety issues, provider occurrences and/or performance concerns. The provider will cooperate by accommodating ODJFS, meeting, making available appropriate meeting space, records and/or other documents requested as part of the review.
- (8) ODJFS will complete one structural review tool per service for each consumer record contained in the review sample, as described in paragraphs (C) (4) (a) and (C) (4) (b) of his rule.
- (9) After the structural review has been conducted, ODJFS will issue a written report to the provider. The report will summarize the overall outcome of the compliance review, list specific rule citations where noncompliance has been determined, and outline specific requirements or actions that must be addressed

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in a plan of correction. ODJFS may issue an abbreviated written report when identifying consumer health and/or safety issues.

- (10) No later than forty-five calendar days after ODJFS mails the written report described in paragraph (C) (9) of this rule, the provider must submit to ODJFS a plan of correction for all identified noncompliance findings. If ODJFS issues an abbreviated written report identifying consumer health and/or safety issues, the provider's plan of correction must be submitted to ODJFS within five working days after it was mailed.
- (11) If ODJFS finds the provider's plan of correction acceptable, it shall approve the plan and confirm to the provider that the plan addresses the issues of noncompliance outlined in ODJFS' written report. If ODJFS determines that it cannot approve the provider's plan of correction, it will inform the provider of this determination in writing, require the provider to submit a new plan of correction, and specify the required actions that must be included in the new plan of correction. The provider must submit the new plan of correction by the date specified by ODJFS.
- (12) ODJFS may impose sanctions upon the provider in accordance with rule 5101:3-12-08 of the Administrative Code in the event the provider:
- (a) Has not followed the plan of correction and/or successfully achieved the plan's desired results.
 - (b) Has not complied with the timeframes enumerated in this rule.
 - (c) Has created a serious and immediate threat to the health and/or safety of any ODJFS-administered waiver consumer.
 - (d) Did not cooperate in meeting face-to-face for the structural review.
 - (e) Did not make service delivery and/or clinical records available.
 - (f) Did not submit a satisfactory plan of correction, or upon request, resubmit a satisfactory plan of correction.

(D) Provider occurrence process

(1) Provider occurrence means:

- (a) Consumer care violations;
- (b) Provider billing violations;
- (c) Medicaid fraud; and/or

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- (d) Substandard provider performance.
- (2) ODJFS will investigate provider occurrences and gather supporting documentation upon discovery of any such occurrence.
- (3) ODJFS may gather any of the following information as part of the investigation:

 - (a) Clinical and/or progress notes from the provider;
 - (b) Case management documentation from the consumer's file;
 - (c) Assessment information;
 - (d) The all services plan;
 - (e) MMIS billing information;
 - (f) Doctor's orders;
 - (g) Prior occurrence reports;
 - (h) Consumer/family documentation;
 - (i) Any other relevant supporting documentation.
- (4) If ODJFS decides to substantiate the occurrence, it will notify the provider via certified mail with a cease and desist letter. The letter will:

 - (a) Outline the alleged behavior or practice which must be stopped by the provider;
 - (b) Specify the Administrative Code rule cites that support the noncompliance finding;
 - (c) Specify what the provider must do to correct the finding; and
 - (d) Specify the date on which the provider must submit a plan of correction to ODJFS, not to exceed thirty calendar days after the date the letter was mailed.
- (5) If ODJFS finds the provider's plan of correction acceptable, it shall approve the plan and confirm to the provider that the plan addresses the issues of noncompliance outlined in the cease and desist order. If ODJFS determines that it cannot approve the provider's plan of correction, it will inform the provider of this determination in writing, require the provider to submit a new plan of

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correction, and specify the required actions that must be included in the new plan of correction. The provider must submit the new plan of correction by the date specified by ODJFS..

- (6) The provider may request technical assistance from ODJFS to correct deficiencies or findings of noncompliance at any time.
- (7) ODJFS may conduct a structural review as outlined in paragraph (C) of this rule to evaluate the provider's implementation of the plan of correction.
- (8) ODJFS reserves the right to conduct unannounced provider structural reviews at any time to evaluate provider occurrences. The provider will cooperate by accommodating ODJFS, meeting, making available appropriate meeting space, records, and/or other documents that may be requested as a part of the review.
- (9) ODJFS may impose sanctions upon the provider in accordance with rule 5101:3-12-08 of the Administrative Code in the event the provider:
 - (a) Has not followed the plan of correction and/or successfully achieved the plan's desired results;
 - (b) Has not complied with the time frames outlined in paragraph (D) of this rule;
 - (c) Has repeated substantiated occurrences;
 - (d) Has created a serious and immediate threat to the health and/or safety of the consumer.
- (10) All allegations of Medicaid fraud will be processed by ODJFS using supporting documentation enumerated in subparagraph (D) (3) of this rule.
- (11) All allegations of provider overpayment will be processed by ODJFS. The occurrence reporting form, along with the supporting documentation as enumerated in subparagraph (D) (3) of this rule will be forwarded to the surveillance and utilization review section. Overpayments will be returned to ODJFS.
- (12) ODJFS will review a provider's occurrence reports prior to conducting a structural compliance review. Documented noncompliance will be addressed during the review.

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5101:3-12-35

Non-medicaid Ohio access success project.

(A) This rule sets forth the eligibility requirements and benefit limitations for the non-medicaid funded Ohio access success project.

(B) Definitions:

(1) "Fiscal Year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.

(2) "Individual" means a NF resident who is seeking non-medicaid Ohio access success project benefits.

(3) "Nursing Facility (NF)" means a facility or a distinct part of a facility as defined in division (M) of section 5111.20 of the Revised Code.

(4) "Ohio access success project non-medicaid funded project" means the portion of the Ohio access success project that is authorized to be paid for with non-medicaid program funds. The benefits provided under the Ohio access success project non-medicaid project shall not exceed a once in a lifetime two thousand dollar benefit.

(5) "ODJFS" means the Ohio department of job and family services.

(6) "ODA" means the Ohio department of aging.

(7) "Resided continuously" means all consecutive days during which an individual, regardless of payment source, occupies a bed in a NF that is included in a facility's certified capacity under medicaid. Coverage of bed-hold days for medically necessary and other limited absences in a NF covered under the provisions of rule 5101:3-3-59 of the Administrative Code are considered days during which an individual occupies a bed in a NF.

(8) "Transition" means the same as relocation to the community from the NF.

(C) The application process for the Ohio success project non-medicaid project benefit includes:

(1) Completion by ODJFS or its designee of the "non-medicaid Ohio access success project referral"; and

(2) A face-to-face interview with the individual and ODJFS or its designee.

(D) An individual must meet all of the following to qualify for the Ohio access success project non-medicaid project benefits:

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- (1) The individual must be a recipient of medicaid-funded NF services at the time of application;
 - (2) The individual must have resided continuously in a NF for not less than eighteen months immediately preceding the individual's application for the Ohio access success project non-medicaid project;
 - (3) The individual must need the level of care provided by the NF;
 - (4) The individual must not meet ICF-MR level of care as defined in rule 5101:3-3-07 of the Administrative Code;
 - (5) The individual must have a determination by ODJFS or its designee that the projected monthly cost of services for the individual in the community as defined in paragraph (E) of this rule will not exceed eighty per cent of the average monthly medicaid costs of a medicaid recipient residing in the NF as described in paragraph (F) of this rule; and
 - (6) The individual does not qualify for benefits funded by medicaid Ohio access success project.
- (E) The calculation of the projected monthly costs of services for the individual in the community shall include:
- (1) The average medicaid per member per month costs for hospital and physician services as determined by ODJFS;
 - (2) The average medicaid per member per month costs for pharmacy services as determined by ODJFS; and
 - (3) The individual's assessed monthly need for medicaid covered services including, but not limited to:
 - (a) Home health services;
 - (b) Transportation;
 - (c) Adaptive equipment;
 - (d) Durable medical equipment.
- (F) The calculation of the average monthly cost of an individual residing in a NF shall be the sum of:

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- (1) The average medicaid per diem paid to all NF's as of July 1 of the fiscal year in which eligibility is being determined under this section; and
- (2) The average per member per month medicaid costs for medicaid services not covered in paragraph (E)(1) of this rule for a NF resident.
- (G) Non-medicaid Ohio access success project benefit funds shall be used to purchase goods and services to assist in the transition of the consumer from the NF to a community setting. Goods and services include, but are not limited to:

 - (1) Rental deposits;
 - (2) Utility deposits;
 - (3) Moving expenses;
 - (4) Home modifications; and/or
 - (5) Debts to facilitate securing a community setting.
- (H) An individual applying for or receiving benefits under the non-medicaid success project shall retain the right to appropriate notice for a hearing in accordance with division-level 5101:6 of the Administrative Code.
- (I) ODJFS has the authority to limit the number of individuals for the non-medicaid Ohio access success project to he extent funds are available.

SUPPLEMENT 6
DAS Information Technology Policy F.35



Moratorium on the Use of Advertisements, Endorsements, And Sponsorships on State-Controlled Web sites	NO: ITP F.35
	Effective: 10/23/2000
	Issued By: Gregory S. Jackson Assistant Director Department of Administrative Services Chief Information Officer, State of Ohio Published By: Office of Statewide IT Policy

1.0 Purpose

As the state makes services and information more available via the Internet, new challenges emerge. One of these challenges is advertising on state-controlled websites or creating partnerships with advertising companies to host an agency's website. From a funding aspect, this opportunity looks very attractive. However, there are numerous legal and policy issues that surface when considering advertising on state-controlled websites. Until the issues surrounding *web advertisements* on state-controlled websites have been fully studied and presented to the Governor's Council on Electronic Commerce for review, agencies shall not allow advertisements, *sponsorships* or *endorsements* on state-controlled websites including vendor-hosted websites. The details of this moratorium are stated below in the Policy section.

2.0 Scope

All Agency Directors, Agency Information Technology (IT) Managers and Agency Chief Legal Counsels.

3.0 Background

The Internet has become one of the state's most important resources for providing easy access to information, both internally and to our citizens and customers. There are many challenges such as funding of web-based initiatives, appropriate use of the Internet, security and privacy that need to be addressed as the state moves toward providing an increasing number of services on the Internet. One such challenge is the issue of placing advertisements on state-controlled websites in order to ease funding pressures. However, there are complex legal and policy issues that arise regarding advertising on state-controlled websites. Because of their importance, the chief information officer in consultation with the Governor's Council on Electronic Commerce must carefully research and consider these issues in order for the state to progress in a uniform manner in this area since the actions of individual agencies may set a precedence that impacts the entire state. Examples of these issues include:

- 3.1 Legal implications such as the legal authority under Ohio law including the Ohio Constitutional Lending Aid and Credit Clause, the potential for legal liability and U.S. First Amendment implications for agency control and content guidelines;
- 3.2 Potential privacy abuses when a user accesses web advertisements – since advertisers may track the visitors linking to their site, there is a loss of a level of privacy control, and while some privacy requirements could be placed on advertisers, those requirements need to be clearly and comprehensively defined;
- 3.3 Lack of accepted public-sector standards and guidelines regarding "best practices" in web advertising – few states, if any, have adopted policies on advertising on state websites.
- 3.4 Impact on performance – without clear standards, there is a danger that advertisements will degrade website performance or create confusing websites, and as such, those standards need to be comprehensively defined;
- 3.5 Impact on public perception and customer confidence – website visitors may perceive that the state service or information delivered is controlled by or associated with the advertiser either directly or indirectly;
- 3.6 Appearance of endorsement by the state of Ohio – potential consequences are the appearance of favoritism, public or media scrutiny of a state agency promoting a certain businesses, products, etc., as well as potentially implicating liability issues;
- 3.7 Control of downstream navigation and content – with the ability of websites to re-direct their visitors to other websites, the state may lose control of providing a means for visitors to return to the state website, and, furthermore, there is a danger that the visitors may very quickly be directed to problematic websites;
- 3.8 Impact on revenue allocation – this new funding source needs to be carefully examined for its impact on funding overall, including the implications to agencies receiving federal funds; and
- 3.9 Risk of litigation – apart from any of the legal implications described above, web advertisements may entail a high-risk of litigation, the cost of which must be considered.

4.0 References

- 4.1 This moratorium replaces all previously released memoranda regarding this topic.
- 4.2 A glossary of terms found in this policy is located in Section 8.0 – Definitions. The first occurrence of a defined term is italicized.

5.0 Policy

Until the issues surrounding web advertisements on state-controlled websites have been fully studied and presented to the Governor's Council on Electronic Commerce for review, agencies shall not allow advertisements, sponsorships or endorsements on state-controlled websites including vendor-hosted websites. This moratorium is effective

immediately and will remain in effect until the Department of Administrative Services in consultation with the Governor’s Council on Electronic Commerce issues a final statewide policy. Agencies with explicit statutory authority regarding advertisements may request a waiver of this moratorium through Mary Carroll, deputy director of IT policy, at 614.995.1057 or mary.carroll@das.state.oh.us.

5.1 Acknowledgements

State agencies may include *acknowledgements* on their websites as long as the acknowledgement is:

- 5.1.1 Made discreetly and subtly;
- 5.1.2 Not linked to any external websites; and
- 5.1.3 Accompanied by a disclaimer that the acknowledgement does not constitute endorsement.

5.2 Directories

A web directory is a listing of external websites that might serve as a source of additional information for website visitors. An agency who offers a web directory with links to external websites on a state-controlled website, must define a class of entities that may be listed in the directory, allow anyone within that class to be linked, disclose on the website the criteria and procedures for requesting a link and disclaim endorsement. The criteria that the agency uses for determining if an entity to be linked via a directory falls within the class must be approved by the agency’s director and then submitted to the Department of Administrative Services along with the director’s approval. The criteria should be sent to Mary Carroll, deputy director of IT policy, at mary.carroll@das.state.oh.us.

5.3 Required Software

Whenever an agency website requires the use of particular software that the website visitor may need to download (e.g., .PDF formatted files require the Adobe Acrobat Reader software), the link to the download site may be included. The link should be accompanied by a statement that the particular software is required.

6.0 Procedures

None.

7.0 Revision History

Date	Description of Change
10/23/2000	Original Policy. This Policy replaces all previously released memoranda regarding this topic.
09/26/2001	ITP policy ITP F.35 supersedes ITP policy OPP-035: A new numbering system and a new policy format have been introduced.
10/03/2001	Updated policy to reflect office name change from the Office of IT Policy and Planning (OPP) to the Office of Statewide IT Policy (ITP).

Date	Description of Change
10/31/2001	Modified URL references to reflect the new address for the IT Policy home page.
01/31/2002	Completed minor modifications to the policy template.

8.0 Definitions

- 8.1 Acknowledgement. A statement, which may include a logo, graphic or text, that identifies but does not promote an individual business, person or any other non-governmental entity as the source of work, material, equipment or services for a project.
- 8.2 Advertisements. A logo, graphic, text, sound, video or any other means of promoting the commercial, political or other activities of an individual business, person or non-governmental entity.
- 8.3 Endorsement. A statement of approval of a product, service or individual business, person or any other non-governmental entity.
- 8.4 Sponsorship. A logo, graphic, text, sound, video, or any other means of recognizing an individual business, person or any other non-governmental entity in exchange for underwriting a project.

9.0 Related Resources

None.

10.0 Inquiries

Direct inquiries about this policy to:

Office of Statewide IT Policy
 Computer Services Division
 Department of Administrative Services
 30 E. Broad Street, 39th Floor
 Columbus, Ohio 43215

Voice: 614-644-9352
 FAX: 614-644-9152
 Email: OPP.policy_mgr@das.state.oh.us

ITP policies can be found on the Internet at:
<http://www.state.oh.us/ITP/>

11.0 Attachments

None.

SUPPLEMENT 7
ODJFS Information Security Code of
Responsibility Form

**OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
CODE OF RESPONSIBILITY**

* PLEASE PRINT *

NAME: First, MI, Last _____ **Agency** _____
Work Phone _____ **County** _____
Date of Birth _____ **Work Unit** _____
Social Security No. _____ **Supervisor** _____

AGENCY TYPE: ODJFS Non-ODJFS State County Local Govt. Private/non-profit Federal
 Contract Employee Contract Company Name & Telephone No. _____

ACCESS REQUESTED: (Local Security Coordinator/Supervisor use only)

<input type="checkbox"/> ODJFS network / email access	<input type="checkbox"/> CRISE	<input type="checkbox"/> SETS	<input type="checkbox"/> FACSIS	<input type="checkbox"/> MMIS
OTHER access:				
Novell Container:		Existing RACF / Novell ID's:		

PLEASE READ CAREFULLY

Security and confidentiality are a matter of concern for all users of the Ohio Department of Job and Family Services (ODJFS) information systems and all other persons who have access to ODJFS confidential data. Each person that is entrusted with an authorized ID to access ODJFS systems, holds a position of trust relative to this information and must recognize the responsibilities entrusted to him/her in preserving the security and confidentiality of this information. Confidentiality requirements contained in law include, but are not limited to: 45 CFR 164.501 et al HIPAA; ORC sections 2301.35, 5101.26, 5101.27, 5101.28, 5101.29, 5101.30; and OAC rules 5101:1-1-03 and 5101:1-29-071.

An authorized user's conduct either on or off the job may threaten the security and confidentiality of this information. It is the responsibility of every user to know, understand and comply with the following:

1. I will not make or permit unauthorized uses of any information in hard copy or computer files maintained by ODJFS.
2. I will not seek to benefit personally or permit others to benefit personally by any confidential information to which has come to me by virtue of my work assignment.
3. I will not exhibit or divulge the contents of any record to any person except in the conduct of my work assignment or in accordance with the policies of ODJFS.
4. I will not knowingly include or cause to be included in any record or report false, inaccurate or misleading information.
5. I will not remove or cause to be removed copies of any official record or report from any file from the office where it is kept, except in the normal conduct of my work assignment and in accordance with the policies of ODJFS.
6. I will not operate or request others to operate any ODJFS or Ohio Data Network equipment on personal business.
7. I will not violate rules and/or regulations concerning access and/or improperly use Security entry cards or codes for controlled areas.
8. I will not divulge or share any security codes (e.g., sign-ons, passwords, key card PIN, etc.) used to access any secured files.
9. I will report any violation of this code by anyone to my supervisor and / or the Information Security Unit immediately.
10. I will not aid, abet or act in conspiracy with another or others to violate any part of this code.
11. I will not load any personally owned software or software not licensed to ODJFS on any ODJFS-owned equipment without proper authorization.
12. I will treat all case record material as confidential, and will handle Income and Eligibility Verification System (IEVS) material with extra care. I understand that Internal Revenue Code Sections 7213(a), 7213A and 7431 provide civil and criminal penalties for unauthorized inspection or disclosure. These penalties include a fine of up to \$5000 and/or imprisonment of up to 5 years.

Any violation of this policy may result in disciplinary action pursuant to the agency work rules.

I have read, understand and will comply with the ODJFS Code of Responsibility for Security and Confidentiality of Data:

Applicant Signature _____ **Date** _____

Supervisor Signature _____ **Date** _____

1. Form Instructions: <http://innerweb/Omis/InfoSecurity/InfoSecindex.shtml>
2. Fax or Mail with cover memo detailing system access requested.
To: ODJFS / BISS / Information Security Unit
4200 E. Fifth Ave. Columbus, Ohio 43219-2551
Fax #: (614) 995-0118

FOR INFOSEC USE ONLY

SUPPLEMENT 8

BHCS MCATS Documents

- **MCATS Vision Document**
- **MCATS Minimum System Specifications**



Ohio Department of Job & Family Services

Medicaid Consumer Activity Tracking System (MCATS) Global Vision

Revision 2.5

Medicaid Consumer Activity Tracking System (MCATS)	Revision: 2.5
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Revision History

Date	Revision	Description	Author
10/01/03	2.0	Revisions from revision 1.12 to reflect changes in BHCS organization and updated system requirements.	Harold D. Thomas
10/17/03	2.1	Correction of errors in user names.	Harold D. Thomas
12/12/03	2.2	Addition of linkages to mainframe systems and reprioritization according to MCATS Project Timeline, dated 12/1/2003.	Harold D. Thomas
12/19/03	2.3	Document review with Lesli Anderson.	Harold D. Thomas
12/19/03	2.4	Technical review of document.	Harold D. Thomas
1/22/04	2.5	Clarification of plans to hand off MCATS to the Medical Systems Section.	Harold D. Thomas

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Global Vision

1. Introduction

1.1 Purpose

The purpose of this Global Vision document is to create a common vision between the Bureau of Home and Community Services (BHCS), the Home Service Facilitation Agencies (HSFAs), and Management Information Systems (MIS) for the enhancement of the Medicaid Consumer Activity Tracking System (MCATS) to be implemented in the remaining releases in Version 2; and to outline features desired in later versions. This document is called a "Global Vision" document, because the system is expected to evolve over many versions, some of which are likely to require separate Vision documents. Many sections of the Vision document apply to all versions, however.

1.2 Scope

This Vision is limited in scope to the existing MCATS, with the following additions:

- Addition of the Disenrollment form.
- Addition of Workflow functionality for BHCS.
- Additional functionality is envisioned for later versions (see section 4.2).

Priorities are discussed in section 8 of this document.

Legal and business requirements may dictate other changes, particularly to the Data Collection Checklist. These will be written into the system as needed to meet those requirements.

1.3 Definitions, Acronyms, and Abbreviations

See the IAS Process Glossary and the MCATS Glossary.

1.4 References

References are available on the MCATS Documentation Website:

<http://innerweb/Omis/bsd/ia/iss/document/bcs>

MCATS Glossary.

MCATS Business Rules.

MCATS System Requirements Document, Document Version 1.3.

MCATS paper documents and instructions to DCC and Level of Care Worksheet.

1.5 Overview

These releases are intended to update the system to encompass changes to the business rules since they were originally written, and to eliminate the need for BHCS and the HSFAs to maintain data in multiple systems.

2. Positioning

2.1 Business Opportunity

The opportunity lies in being able to encompass all existing systems into one, with future opportunities to link to the Medicaid Management Information System (MMIS) and the Client Registry Information System, Enhanced (CRIS-E), and the Hearing Appeals Tracking System (HATS).

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2.2 Problem Statement

The problem of	Multiple systems with limited access in MCATS
Affects	BHCS, the HSFAs, and consumers,
the impact of which is	Efficiency is compromised
a successful solution would be	The integration of these systems.

2.3 Product Position Statement

For	BHCS and the HSFAs
Who	Require an integrated system
The MCATS	Is a database
That	Integrates existing desktop systems and enables access to relevant mainframe data
Unlike	Manual systems
Our product	Enables easy access and usage throughout the business process.

3. Stakeholder and User Descriptions

3.1 Stakeholder Summary

Name	Description	Responsibilities
BHCS user	Internal user of the system	Accurately documents the eligibility process according to law and regulations
HSF, HSFA user	Contractor performing eligibility tasks and locating appropriate providers to consumers	Collects required data to determine eligibility and locate appropriate providers with an easy to input interface.
Consumer	Individual receiving benefits from the Ohio Home Care program	None.
Provider	Persons providing services	Accurately records services to substantiate billing.
MIS Internet Support Services Unit	Developer of the system : including analysts, implementers, and testers.	Ensure that a robust system is completed on time according to both BHCS and HSFA specifications.
Bureau of State Hearings	ODJFS in administrative hearings related to disputed eligibility.	Supply accurate data on BHCS-related hearings.
CRIS-E, MMIS, and DSS	Major mainframe systems containing recipient and provider data needed by MCATS.	Supply accurate client and provider data.

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3.2 User Summary

The Customer for this system is the Bureau of Home and Community Services (BHCS). Users for this system are BHCS and the HSFAs. The BHCS user stakeholder can be subdivided into three user groups: BHCS Analysis, who are users of management reports and creators of analyses; BHCS Client Coordination, who review input of HSFAs according to eligibility considerations; and BHCS Program Management, who use management reports to determine effectiveness of the program. The HSFAs are independent contractors who process requests for service from consumers and County Departments of Job & Family Services (CDJFSs), and secure providers for those consumers.

3.3 User Environment

Number of people involved in completing the task: Approximately 200, subject to change if realignment occurs following possible changes of HSFAs or restructuring of region boundaries; as services expand (requiring more HSFs); and as individual HSFs are added to the system.

A task cycle is widely variable, generally 7-10 days for an HSFA, 3-5 days for BHCS approval. These estimates are not likely to change. A task cycle begins when an HSFA receives an Alert/Referral or JFS Form 2399 from the CDJFS, and ends when enrollment has been approved or denied.

The work is completed in an office environment; however, it would be advantageous to enable mobile usage (for example, from a laptop or tablet PC with a wireless connection) when such technology is feasible.

Current platform is JavaScript running on an NT web server with an Oracle database on an AIX server. This is not likely to change in the foreseeable future. Upon release of Version 2.0, the system will be accessed using the Netscape 7.0x or the Internet Explorer 6.0 browser. The browser will change to later versions of either Netscape or Internet Explorer as whenever such change is necessary and feasible.

Users also work with the Medicaid Management Information System (MMIS), the Client Registry Information System, Enhanced (CRIS-E), and the Decision Support System (DSS).

3.4 User Profiles

3.4.1 BHCS Client Coordinator

Representative	Kim Reedy, Shirley Boykins, Terri Dickerson, Ida Pritchett, Sandee Ferguson
Description	Determines eligibility of consumers submitted by HSFAs
Type	Knowledgeable in the business aspects of the system.
Responsibilities	Receive HSFA records, make a timely determination, forward demographic data to Intake Coordinator, and (currently) return to HSFAs for action.
Success Criteria	Ability to receive submission and respond electronically. Reduced turnaround time.
Involvement	Implementation Review Team (Terri and Shirley), user testers (all)
Deliverables	None.
Comments / Issues	Restructuring forms, rules, and roles – the business process is a moving target.

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3.4.2 BHCS Intake Coordinator

Representative	Erick Draper, Terri Dickerson, Melanie Jones
Description	Inputs data into CRIS-E and MMIS, sets final approval and effective date of service, will forward to HSFA when MCATS workflow permits.
Type	Knowledgeable in the business aspects of the system.
Responsibilities	See Description.
Success Criteria	Ability to enter data into CRIS-E and MMIS free of errors.
Involvement	User tester.
Deliverables	None.
Comments / Issues	Ability to use the MCATS to transfer data to MMIS and CRIS-E.

3.4.3 BHCS Analysis and Program Management

Representative	Lesli Anderson, Erin Higgins, Kelley Scott
Description	Analyze data sent by HSFAs and BHCS.
Type	Knowledgeable in the business aspects of the system.
Responsibilities	Develop profiles of consumers and providers.
Success Criteria	Reports reflect current and accurate data. Data can be manipulated for statistical purposes.
Involvement	User lead
Deliverables	None.
Comments / Issues	Ability to use data for quality assurance reviews.

3.4.4 HSFAs

Representative	Daryl Shrider, Kevin O'Connor, Joan Gravel, work managers of regional contractors, Home Services Facilitators, and data entry personnel
Description	Works with consumers to determine eligibility and assign providers.
Type	Knowledgeable in business aspects of system, some system experts.
Responsibilities	Input and revision.
Success Criteria	Data Collection Checklist and related materials are accurate and easily sent to BHCS.
Involvement	Implementation Review Team
Deliverables	None.
Comments / Issues	Agencies can be replaced at end of 3-year contract period.

3.4.5 MIS

Representative	Ranjit Sandhu, Barbra Valentine, Harold Thomas, Jay Waugh
Description	Developers of MCATS
Type	Experts and gurus.
Responsibilities	Analysis, implementation, and testing of system.
Success Criteria	System functional and relatively bug-free
Involvement	Nearly total.
Deliverables	Vision, Requirements, Object and Data models, working system.
Comments / Issues	None.

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3.5 Key Stakeholder or User Needs

Need	Priority	Current Solution	Proposed Solutions
Eliminate paper, reduce lag time in mail and faxes	1	Basic database	Integrate various systems into one.
Reduce time required to secure authorizations	2	Basic database	Various cosmetic enhancements

Also see Summary of Capabilities (Section 4.2) and Assumptions & Dependencies (Section 4.3).

3.6 Alternatives and Competition

3.6.1 *Home-grown system*

It is an available solution, but is inadequate to meet needs. Paradox database used is unstable in multi-user environments. Access database is more stable, but less robust than Oracle.

3.6.2 *Existing MCATS*

Available, but inadequate to meet growing needs. Does not integrate modules.

3.6.3 *Hire contractor to develop system*

Knowledge is a plus, but is costly.

3.6.4 *Purchase off-the shelf system, or from another state*

Off-the-shelf software has recently become available, but has not been extensively researched.

3.6.5 *MIS*

Best knowledge of existing system, can apply to new system. Problem is contractor/staff turnover.

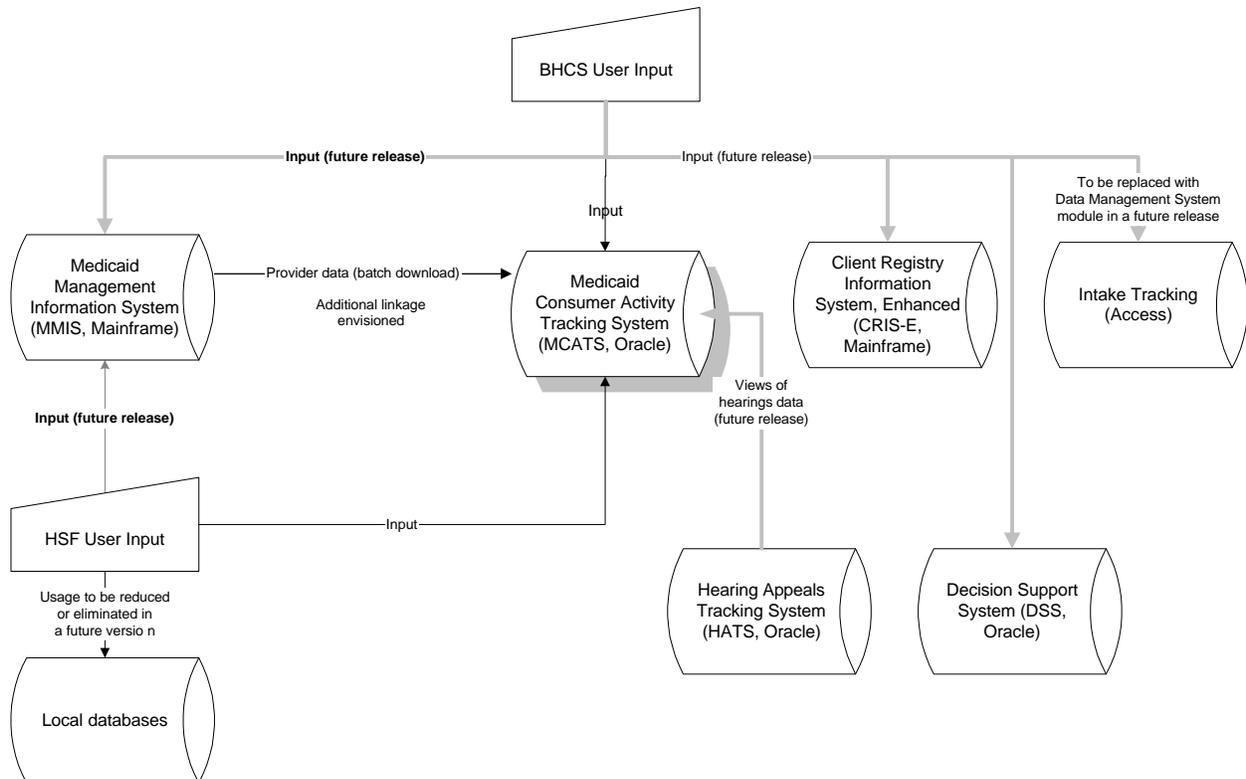
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4. Product Overview

4.1 Product Perspective

12/19/2003

MCATS Product Perspective



4.2 Summary of Planned Capabilities

The Office of Management Information Systems is planning to transition MCATS from the Internal Administration Systems Section to the Medicaid Systems Section. The terms for this transition will be stated in a Transition Document currently under development. Current planning indicates that the transition will take place following completion of MCATS version 2.2, and prior to work on version 3.0; however, this is subject to change.

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Version	Description	Supporting Features
For completion by the Internal Administrative Systems Section		
2.1	Disenrollment	Add Disenrollment functionality to remove consumers from the active program. Also see Section 4.3.1.
2.2	BHCS Workflow	Assign DCC to a group manager, and manage DCCs within BHCS.
For completion by the Medical Systems Section		
3.0 (Required by MIS)	Data Model Revisions	Review of the system's logical model to fix problems with handling demographic data, removal of little-used tables, allowing multiple types for one person (e.g., consumer, voluntary caregiver, provider), and to simplify changes in the data model to be made necessary by later releases.
3.1	Mainframe Links	Create MCATS interface to MMIS and CRIS-E to eliminate multiple data entry.
3.2	Program Monitoring	Enable system to accommodate multiple programs, view complete consumer history in one place, maintain history (consumer/provider). Replace Intake Tracking System, Manage slots and provide year-end reporting.
3.3	Care Management	Add All-Services Plan, linked to MMIS, store progress notes and communication records, care planning, and identify input by case manager.
3.4	Functionality	Simplify movement between screens, easy interagency transfers, automatic population of fields/record cloing, ability for all HSFAs to read all consumer records, and improved Print Screen capability.
3.5	Hearings	Link to HATS, generate due process notifications, and create a hearings database module.
4.0	Basic Reporting	Automatic time tracking, cost-effectiveness reporting.
4.1	Enhanced Reporting	Create data mart to be loaded into DSS, track hospitalizations, episodes, and outcomes, and create GIS mapping data.
Later	Archive	Move disenrollments to archive to optimize system performance.
	Copy/Edit and Deletion	Provide for copy/edit and deletion rules.
	Help	Context-sensitive Help and improved Error Messages.
	Incident Reporting	Track complaints related to Consumer treatment.
	Pre-Screening	Module used by the HSFAs as data collected prior to completion of the DCC. Usually, it is used prior to a denial due to lack of slots available (see 4.3.6).
	Remote Access	Enable the system to be used on a tablet or laptop with wireless modem.
	Superuser	Add Superuser capabilities for HSFAs and BHCS.

4.3 Assumptions and Dependencies

4.3.1 Disenrollment

- This module may enable code reuse.

4.3.2 BHCS Workflow

- See Use Cases: Assign Group, and Manage DCC for details.

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4.3.3 *Archive*

- Stakeholders need to consider and set rules for archiving records, to optimize system performance. Such rules would include whether archiving should be done automatically after a set length of time (perhaps three years), in addition to archives done following a disenrollment.

4.3.4 *Copy/Edit and Deletion*

- Current BHCS philosophy requires HSFs to input much data, to ensure that all questions are fully answered and to ensure accuracy. Since adding this capability necessarily moves the system away from this philosophy, BHCS must determine the appropriate level of input to require.
- BHCS needs to determine business rules for how erroneous data are to be corrected.

4.3.5 *Pre-Screening*

- Prescreen integration depends on a successful data conversion between HSFA prescreening databases and the MCATS.

4.3.6 *Remote Access*

- Remote access requires availability of tablets or modems with wireless access. The use of tablets may require the use of an alternative operating system (Windows XP Tablet PC Edition), but this requirement is not expected to affect system development.

5. **Product Features**

See Section 4.2.

6. **Constraints**

Database and possible batch download constraints may be imposed by HATS and the mainframe systems as part of MCATS linkage to those systems. Timeframe is subject to the availability of qualified staff.

7. **Quality Ranges**

The application should be available for use during normal working hours and should respond at an acceptable speed, in the opinion of BHCS. Since the system will transmit confidential client data on the Internet, sophisticated encryption capabilities and password protection schemes (*e.g.*, the smart ID key) are essential.

8. **Precedence and Priority**

See Section 4.2, Summary of Capabilities. BHCS requires version 2.1 (Disenrollment & Program Change) to be in production by February 27, 2004. The effect of the database remodel (3.0) on later versions of the system will be substantial, but its impact on timelines is unknown at this time.

As a general guideline, BHCS would like to see versions 2.2 through 3.4 completed (in the order shown in section 4.2) during 2004, with the remaining releases to be completed in 2005; however BHCS recognizes that completion dates for later releases cannot be estimated until requirements gathering is completed.

9. **Other Product Requirements**

9.1 **Applicable Standards**

Internet Best Practices, documented in the InnerWeb.

9.2 **System Requirements**

Netscape 7.0x or Internet Explorer 6.0 browser with JavaScript enabled, as updated (see User Environment, section 3.3) Windows 98, NT, or XP; Oracle database; Pentium III processor or better; a 17" monitor, cable modem access; and a minimum of 256 Mb memory, with 512 Mb memory recommended.

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9.3 Performance Requirements

The system requires a broadband connection.

9.4 Environmental Requirements

Until a secure wireless interface is feasible, the MCATS will be run in a normal office setting. Error handling and recovery must be written to enable a graceful exit from the situation causing a database or memory error without abruptly closing the system or rebooting the machine. Following deployment of a revised data model, all lookup tables must be maintainable by BHCS.

10. Documentation Requirements

10.1 Online Help

An HTML-based context-sensitive online help system is to be developed in a future version.

10.2 Installation Guides

The nature of the system makes an installation guide unnecessary.

Minimum System Specifications to Support MCATS As of 4/30/04

Browser: Netscape 7.02 or Microsoft IE 6.0 with Javascript enabled
Operating System: Microsoft Windows 98, NT, 2000, ME, XP
Hardware: Pentium III processor or greater
256 MB RAM minimum, 512 Mb RAM recommended.
17" color monitor minimum - resolution 800 by 600 minimum
Internet connection: High speed DSL or cable modem access

SUPPLEMENTAL INFORMATION TRAILER

This page is the last page of supplemental information for this competitive document. If you received this trailer page, all supplemental information has been received.

Note: portions of the supplemental information provided may or may not contain page numbers. The total number of pages indicated on the cover page does not include the pages contained in this supplement.