Ohio | Department of Medicaid

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Clinical Utilization Management and Prior Authorization Program
ODMR-2223-0006
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The Ohio Department of Medicaid

Clinical Utilization Management and Prior Authorization Program

ODMR-2223-0006

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SECTION I. GENERAL PURPOSE

1.1 General Overview

The Ohio Department of Medicaid (ODM) releases this Request for Proposals (RFP) to solicit bids for the purpose of obtaining one vendor to implement and manage a statewide clinical utilization management and prior authorization program for hospital and other services provided to Ohio Medicaid consumers, and measure quality of care for services ODM provides to Medicaid consumers. ODM is seeking Proposals from Offerors to provide ODM with specified Institutional Quality and Hospital Utilization Management Program services. This RFP is being issued in accordance with the requirements of the Code of Federal Regulations (CFR) 42 CFR § 456.3, Statewide Surveillance and Utilization Control Program.

The purpose of this program is to support the ODM Bureau of Program Integrity's (BPI) quality efforts by obtaining an external vendor to implement and manage a statewide quality and hospital utilization control program for services provided to Ohio Medicaid consumers. The selected Offeror will be responsible for utilization reviews, including focused reviews, prior authorizations, special reviews, retrospective reviews, pre-certification reviews, and medical record reviews of denied Managed Care prior authorizations as requested. The selected Offeror will provide reports and analysis of review findings to ODM. Additionally, the selected Offeror will conduct quality of care studies as requested, conduct provider education, and provide technical assistance to policy and operational units within ODM.

ODM is seeking vendors who have received designation by the Centers for Medicare and Medicaid Services (CMS) as a quality improvement organization (QIO) or QIO-like entity. Proposals from Offerors who do not demonstrate the organization is a Medicare QIO or QIO-like entity will not be considered.

For the purpose of this RFP, the terms "offeror" or "vendor" may be used interchangeably in reference to consulting or professional services firms that are interested in responding to this opportunity. The terms "bid" and "Proposal" may be used interchangeably to indicate materials submitted to ODM by an Offeror in order to be considered for award of a contract for services described in this RFP. The terms "contractor", "selected vendor", or "selected offeror" may be used interchangeably in reference to a vendor selected by ODM through this RFP for contract award.

1.2 Background

The Ohio Medicaid Program serves in excess of three million low-income Ohioans with comprehensive health care services funded through a combination of state and federal revenues. These persons are served by more than 100,000 active providers, which include both institutional and non-institutional community-based providers. In State Fiscal Year (SFY) 2021, Ohio's Medicaid program had expenditures of over 31.5 billion dollars, making it one of the largest single providers of health care benefits to Ohioans. As part of its mission, the Medicaid program must ensure the integrity of payments made to participating providers.

The primary purpose of the utilization review (UR) contract is to attain measurable improvement in the appropriate utilization (or, measurable true reduction in inappropriate utilization) of Medicaid services, specifically inpatient medical, inpatient psychiatric, and outpatient hospital services for the Fee for Service (FFS) population, while recovering reimbursement from providers of inappropriate Medicaid services. One

product of utilization review will be the recovery of Medicaid reimbursement made for services which were not medically necessary, were not performed in the most appropriate setting, or were otherwise not provided or billed in accordance with the Ohio Administrative Code (OAC) Rules found in Chapter 5160.

"Measurable improvement" will be performed by the selected vendor and shall include a reduction in inappropriate admissions or services targeted for post payment review. "Reduction" in inpatient and outpatient hospital services shall be measured from baselines established in reports submitted by the current utilization review vendor. The selected Offeror will be expected to review utilization targets based on provider trends and review findings.

In an effort to measure quality across the continuum of care, the selected Offeror will be required to provide analyses of the care for the FFS population, including the Covered Families and Children (CFC) and Aged, Blind and Disabled (ABD) population, as well as, suggestions for quality improvement across the delivery systems. Additionally, the program is intended to support ODM's efforts to slow the rate of growth of Medicaid expenditures while improving health outcomes.

In alignment with ODM's core purpose, "Focus on the Individual", the selected vendor will contribute directly to ODM's goal of increasing the quality of healthcare by assessing the quality of inpatient and outpatient services, as well as safeguarding against unnecessary or inappropriate use of Medicaid services against excessive payments.

1.3 Objectives

ODM, as Ohio's single state Medicaid agency, must implement a statewide surveillance and utilization program that:

A. Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments.

B. Assesses the quality of those services.

C. Provides for the control of the utilization of all services provided under a state plan.

D. Provides for the control of the utilization of inpatient services for both medical and psychiatric services

1.4 Program Resource Library

ODM recognizes that interested applicants may not be familiar with some of the documents referenced in this RFP, and has therefore created a Resource Library which may be accessed on the ODM website at:

https://medicaid.ohio.gov/stakeholders-and-partners/legal-and-contracts/requests-for-proposals

1.5 Glossary

Aged, Blind and Disabled (ABD) – Adults 65 and older may be eligible for Medicaid. Individuals of any age with disabilities, including individuals who are legally blind, may also qualify for Medicaid.

Behavioral Health (BH) - Mental health and substance use disorder treatment services.

Covered Families and Children (CFC) – Families, children up to age 19, and pregnant women with limited incomes are covered through Medicaid under Healthy Start or Healthy Families.

All Patient Refined Diagnosis Related Group (APR-DRG) – A patient classification system that reflects clinically cohesive groupings of services that consume similar amounts of hospital resources.

Fee-for-Service (FFS) Medicaid – The FFS system is a traditional indemnity health care delivery system. The providers bill Medicaid for covered services delivered to eligible consumers.

Home health services - skilled nursing and other therapeutic services, i.e., home health nursing, home health home aide, and home health skilled therapy services covered by Medicaid, when ordered by a qualifying physician and furnished by a Medicare Certified Home Agency (MCHHA). Source: Chapter 5160-12 of the Administrative Code, https://codes.ohio.gov/ohio-administrative-code/chapter-5160-12.

Managed Care Organizations (MCO) – Managed care organization is a health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM to provide Medicaid services in accordance with Chapter 5160-26 of the Administrative Code.

Medicare Home Health Agency (MCHHA) - MCHHAs are the only provider type certified by the Centers for Medicare and Medicaid Services (CMS) through the Ohio Department of Health permitted to furnish home health services and collect Medicare or Medicaid payments for home health services rendered. MCHHAs must be certified in accordance with Chapter 3701-60 of the Administrative Code and meet the conditions of participation in accordance with 42 C.F.R. Part 484. Source: OAC 5160-12-03. https://codes.ohio.gov/ohio-administrative-code/chapter-5160-12.

Prior Authorization (PA) – A requirement that a provider justify the need for delivering a particular service in order to receive reimbursement. Imposed by a health plan or third-party administrator.

Psychiatric Pre-Certification (Pre-Cert) - A requirement whereby ODM (or its contracted medical review entity) assures that covered psychiatric services are medically necessary and are provided in the most appropriate and cost-effective setting.

Enhanced ambulatory patient grouping system (EAPG) - A patient classification system that reflects clinically similar groupings of outpatient procedures, encounters, or ancillary services based upon utilization of hospital resources.

1.6 Statutory Authority

This RFP is being issued in accordance with the requirements of the Code of Federal Regulations (CFR) 42 CFR § 456.3, Statewide Surveillance and Utilization Control Program.

SECTION II. PROCUREMENT PROCESS INFORMATION

2.1 Anticipated Procurement Timetable

DATE	EVENT/ACTIVITY
September 29, 2022	ODM releases RFP on ODM and Ohio|Buys websites; Question & Answer (Q&A) period opens. - RFP becomes active; Offerors may submit inquiries for RFP clarification.
October 12, 2022	Q&A period for Offeror questions closes at 8 a.m. on this date. **- No further inquiries for RFP clarification will be accepted.**
2:00 PM October 26, 2022	**Deadline for Offerors to submit Proposals to ODM (2:00 PM COLUMBUS, OH LOCAL TIME)** - This begins the ODM process of Proposal review. **LATE BIDS WILL NOT BE CONSIDERED. NO EXCEPTIONS WILL BE MADE.**
December 1, 2022	ODM issues contract award notification letter *(estimated).* **- Offerors that submitted Proposals in response to this RFP will be sent letters stating whether their Proposal was selected for award of the contract.**
January 9, 2023	Controlling Board review of contract (*estimated*). **- Contract with the selected Offeror may require review and approval.**
February 1, 2023	Implementation (*estimated - following notification of all contractual and funding approvals*). **- ODM contracts are not valid and effective until the Ohio Office of Budget & Management approves the purchase order.**
Three biennial periods ending June 30, 2031	Possible contract(s) renewal period.

ODM reserves the right to revise this schedule if needed and/or to comply with the State of Ohio procurement procedures and regulations.

Ohio|Buys provides the primary platform for Supplier partners to engage in procurement activities with the State of Ohio. For additional information on submitting Proposals see the "Viewing and Responding to Solicitations" Learner Guide or the "Viewing and Responding to Solicitations" Supplier Training Video linked below.

Learner Guide
https://procure.ohio.gov/bidders-and-suppliers/resources/Bidder+and+Supplier+Training/02_OB+training

Viewing and Responding to Solicitations
https://www.youtube.com/watch?v=K6iE32BUMJ0&feature=youtu.be

In accordance with Ohio Revised Code (ORC) § 126.07, ODM contracts are not valid and enforceable until the Office of Budget and Management (OBM) certifies the availability of appropriate funding, as indicated

by the approval of the Purchase Order (PO). The selected Offeror may neither perform work nor submit an invoice for payment for work performed for this project for any time period prior to the PO approval date. ODM will notify the selected Offeror when the requirements of ORC § 126.07 have been met and send them a copy of the PO.

Subject to Controlling Board approval, the contract period is expected to run from contract award through June 30, 2025, with the possibility for three (3) renewal contracts through June 30, 2031, contingent upon satisfactory performance, continued availability of funding, and all required approvals. Renewal may be subject to approval by the Controlling Board.

2.2 Internet Question and Answer Period

Potential Offerors or other interested parties may submit clarifying questions regarding this RFP during the Q&A Period as outlined in Section II, Anticipated Procurement Timetable. To make an inquiry, offerors must login to Ohio|Buys, navigate to the solicitation, open the Inquiry tab, and submit their inquiry.

The purpose of the Q&A period is to provide potential Offerors the opportunity to seek clarity regarding the requirements and specifications of the RFP. Questions about this RFP must reference the relevant part of the RFP, the heading for the provision under question, and the page number where the provision can be found. ODM may, at its option, disregard any questions that do not appropriately reference an RFP provision or location within the RFP, that do not include identification of the originator of the question, or that do not seek clarification regarding the requirements or specifications of the RFP, in the opinion of ODM. Questions submitted after 8:00 a.m. on the date the Q&A period closes will not be answered.

ODM's responses to all questions asked via the Internet will be posted in the Ohio|Buys website through the Inquiry tab for public reference by any interested party. ODM will not provide answers directly to the potential Offerors (or any interested party) who submitted questions. ODM is under no obligation to acknowledge questions submitted through the Q&A process if those questions are not in accordance with these instructions.

ODM's answers may be accessed on the Ohio|Buys Public Solicitations page by opening the Solicitation Overview and navigating to the inquiries section of that page. ODM strongly encourages potential Offerors to ask questions early in the Q&A period so that answers can be posted with sufficient time for follow-up questions. ODM strives to answer all questions within two business days, however in the event of a high volume of potential Offeror questions, the response time may exceed the two business day time frame. The potential Offeror will not receive a personalized response nor an automated response when ODM has answered the question.

Offeror Proposals in response to this RFP are to take into account any information communicated by ODM in the Q&A process for the RFP. It is the responsibility of all potential Offerors to check this site on a regular basis for responses to questions, as well as for any addenda, alerts, or other pertinent information regarding this RFP because these items become incorporated within the RFP. Once submitted questions have been answered, responses are clearly identified through the Inquiry tab located within the RFP in the Ohio|Buys website . ODM does not consider questions asked during the inquiry period through the inquiry process as exceptions to the terms and conditions of this RFP.

Requests for copies of any previous RFPs, Request for Letterhead Bids (RLBs), etc. or for past Offeror Proposals, score sheets or contracts for this or similar past projects are not clarification questions regarding the present RFP, but are Public Records Requests (PRRs), and should be submitted to: mcdlegal@medicaid.ohio.gov.

If Potential Offerors experience technical difficulties accessing the Ohio|Buys website where the RFP, and its related documents are published, they may contact Ohio Shared Services at 877-644-6771 for assistance..

2.3 Communication Prohibitions

From the date this RFP is issued until a contract is awarded, there may be no communications concerning the RFP between any Offeror and any employee, contractor, or subcontractor of ODM, who is in any way involved in the development of the RFP or the selection of the Offeror.

The only exceptions to this prohibition are as follows:

A. Communications conducted pursuant to Section 2.2, Internet Question & Answer (Q&A) Period;

B. As necessary in any pre-existing or on-going business relationship between ODM and any Offeror that could submit a Proposal in response to this RFP; and

C. As part of any Offeror interview process, Proposal clarification, or negotiation process initiated by ODM, which ODM deems necessary in order to make a final selection.

ODM is not responsible for the accuracy of any information regarding this RFP that is obtained or gathered through a source other than the Q&A process described in this RFP. Any attempts at prohibited communications by Offerors may result in the disqualification of those Offerors' Proposals.

If interested Offerors need to communicate regarding this RFP, they must contact ODM using one of the mechanisms above. Offerors are cautioned that communication attempts which do not comply with these instructions will not be answered, and that ODM will not consider any Proposals submitted to any address other than the one provided in this RFP. Any communication considered prohibited, or Proposals not submitted to the proper address, may disqualify Offerors from participation in this RFP.

2.4 Amendments and Addenda to the RFP

If ODM revises this RFP before the Proposals are due, an amendment will be issued in OhioBuys. If an Offeror has submitted a Proposal prior to an amendment being issued and wishes to be considered, the Offeror must resubmit their Proposal in response to the latest round of the RFP. Proposals submitted in response to amended RFPs prior to the most recent amendment may not be opened or evaluated. ODM may issue amendments any time before Proposals are due, and it is each prospective Offeror's responsibility to check for amendments and other current information regarding this RFP.

Offerors may view amendments by navigating to the OhioBuys Public Solicitations page and searching for the amendment.

After the Proposal due date, ODM will distribute addenda or other announcements only to those Offerors whose Proposals are under active consideration. When ODM issues an addendum to the RFP after the due date for Proposals, ODM will permit Offerors to withdraw their Proposals within five (5) business days after the addendum 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 interest. Alternatively, ODM may allow Offerors that have Proposals under active consideration to modify their Proposals in response to the addendum.

SECTION III. OFFEROR QUALIFICATIONS AND EXPERIENCE

3.1 Mandatory Requirements

Offerors MUST meet and provide proof of, at minimum, ALL of the following qualifications. Offerors who do not meet ALL the below requirements will be disqualified from further consideration for contract award.

A. The selected vendor must have received designation by the Centers for Medicare and Medicaid Services (CMS) as a Quality Improvement Organization (QIO) or QIO-like entity. Proposals from vendors who do not demonstrate that the organization is a Medicare QIO or QIO-like entity will not be considered.

B. Complete and return all requirements and forms in Attachment A upon submission of Proposal.

C. Submission with Proposal of a selected Ohio certified Minority Business Enterprise (MBE) subcontractor assigned, at a minimum, job duties that will equate to a minimum of 15 percent of the total dollar amount of the contract per state fiscal year (SFY). This requirement is further described in MBE (EDGE) Subcontracting Requirements.

   a. If the submitting organization is a State of Ohio Minority Business Enterprise (MBE), Encouraging Diversity, Growth and Equity (EDGE) Offeror, or Veteran Business Enterprise (VBE), provide copy of current certification from DAS.

3.2 Organizational Experience and Capabilities

Proposals should demonstrate significant organizational expertise of the prime Offeror. Proposals must include, at a minimum, the following demonstrated experience as detailed below; and as part of the evaluation process, this information will be scored by ODM:

A. Demonstrated experience relevant to completing the work identified in the Scope of Work and Specification of Deliverables Sections of this RFP. Include information on the background of the firm, including any subcontractors who would perform work under any contract resulting from this RFP.

B. Samples (excerpts and/or Executive Summaries acceptable) of at least two, but no more than four, similar sized projects completed or begun in the past five (5) years that demonstrate expertise and experience in providing expert assistance in the strategies and objectives listed in section 1.3.

C. Demonstrated knowledge of and experience in Medicaid, include Ohio-specific knowledge and experience.

D. Demonstrated familiarity with and experience in the practical application of the laws and regulations impacting Medicaid operations. Include Ohio-specific knowledge and experience.

E. Names and contact information for at least three entities for which the Offeror has performed similar large-scale projects in the past five (5) years.

The Offeror information provided for all the above topics should include summary descriptions of all successfully completed projects, any notable accomplishments and outcomes, and contact information for an Offeror's customers that received the services provided—if not already included as a reference. Offeror experience and knowledge should be demonstrated by providing key samples, excerpts, or copies representative of the quality of relevant work.

3.3 Staff Experience and Capabilities

Offeror must have staff proposed for the program with demonstrated quality improvement experience and knowledge of Medicaid programs and delivery systems. This means that the proposed staff must have experience with the following:

A. Medicaid consumers, policies, data systems.

B. Utilization review programs.

C. Quality assessment and improvement methods.

D. Evidence-based clinical guidelines.

E. Research designs, methods, and statistical analysis.

F. Claim submission and correct coding requirements, both professional and institutional (inpatient and outpatient).

G. HIPAA billing requirements and guidelines.

H. National Uniform Billing Committee (NUBC) manual.

I. Electronic Data Interchange (EDI) guidelines and companion guides.

J. All Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement.

K. Enhanced Ambulatory Patient Groups (EAPG) reimbursement.

L. Ohio Revised Code and Ohio Administrative Code Rules - 5160 Medicaid.

M. Centers for Medicare and Medicaid Services (CMS) rules and regulations or other pertinent federal guidelines.

Key Personnel Title:

Offeror must have the specified number of executive and professional personnel, management analysts, system analysts, programmers, consultants, etc., who will be involved in providing the Deliverables, and indicate where these personnel will be physically located during the time that they are involved in the work.

Offeror must identify, by position and by name, those staff they consider key to the program's success. Additionally, the Offeror should provide resumes, education, experience and a list of related published works for key personnel that will be assigned to this program. Key personnel should include, at a minimum, at least one of the following personnel, unless otherwise specified below:

A. Medical Director, located and licensed in Ohio;

B. Project Leader;

C. Project Managers (2);

D. Director of Quality Studies;

E. Database Administrator; and

F. Biostatistician.

Medical Director

The Medical Director will act as both Medical Director and Principal Clinical Coordinator for the program. The Medical Director will provide clinical direction for the Utilization Management program. Responsibilities of the Medical Director include:

A. Oversight of all physician reviewer activities (recruiting, training, and supervising).

B. Oversight of medical record reviews and appeals.

C. Provide medical and technical expertise and guidance on criteria interpretation and other professional issues.

D. Respond to calls or correspondence from physicians and providers.

E. Manage quality assurance procedures to ensure consistent and appropriate application of criteria.

The Medical Director is expected to provide medical oversight and clinical leadership in the development and execution of health care quality improvement efforts involving physicians, hospitals, and managed care organizations. The Medical Director must be a licensed and Ohio board certified Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO). A minimum of five (5) years prior medical director or administrative experience is required.

Project Leader

The Project Leader will oversee the start-up and ongoing operations of the proposed program. The Project Leader will be expected to:

A. Establish action plans, budgets, timetables, and performance measurements.

B. Obtain and allocate resources.

C. Review progress of the contract to accomplish established objectives.

The Project Leader must have the ability to operate independently; a proven track record in planning, conducting and overseeing programs of major significance; experience with Utilization Review and Quality Assurance; and prior fiscal management responsibilities. A Bachelor's Degree in business, health administration, management, or public health is required. Minimum qualifications include five (5) years of experience in a lead position in a quality and utilization management program, including the two (2) most recent years being in health care management.

Project Manager

At least two (2) Project Managers are required, one Project Manager will be assigned to the Quality and Hospital Utilization Management Program and one Project Manager will be assigned to the Behavioral Health special review prior authorization of services program. The Project Managers' responsibilities include the following:

A. Management of the implementation and operation of the utilization management plan, which encompasses prospective pre-admission reviews and retrospective review of services provided in a hospital setting.

B. Management of the program's Quality of Care Studies, which involves collaboration with ODM in the development of study design and methodology, coordination of study analysis, and dissemination of study findings.

C. Management of the implementation and operation of the special review of prior authorization services, which encompasses prospective review of Assertive Community Treatment (ACT) and other mental health and substance use services and level of care.

These positions are expected to be assigned to persons who have a background in medicine and clinical care and are licensed, Registered Nurses in Ohio. At a minimum, Project Managers must have five (5) years of experience in the management of activities in a quality and utilization management program, of which at least two (2) years of experience were in Medicaid programs.

Director of Quality Studies

A Director of Quality Studies is needed to serve as principal investigator of quality studies. The Director of Quality Studies will be responsible for:

A. Research and sampling design of studies, including clinical measurement.

B. Assuring that studies take into account existing clinical practice guidelines, as well as other previous clinical studies using the same research techniques or performed in the same clinical areas.

C. Assuring that studies are designed to meet the objectives and answer the research questions agreed upon with ODM.

D. Overseeing implementation of the study, analysis and report production.

E. Presenting results of the study to ODM and other forums upon reasonable request.

The Director of Quality Studies must have an M.D., D.O., or clinical Ph.D., with at least five (5) years of experience in clinical research, including at least three (3) studies (please describe) serving as the principal investigator. Identify authored articles in professional journals, if applicable.

Database Administrator

A Database (IT) Administrator for the program. Responsibilities of this position will include the following:

A. Create, maintain and update ODM and other databases that will be used to perform contract activities.

B. Assure that the Offeror receives data in a timely fashion.

C. Maintain reasonable access to data for analytical purposes.

The Database Administrator must have at least a Bachelor's Degree in computer science with at least five (5) years' experience including programming, systems analysis and database management. The Database Administrator must possess the technological skills necessary to adequately perform duties utilizing healthcare claims from ODM's current Medicaid Information Technology System (MITS) or any new Medicaid Information Technology System (MITS), or both.

Biostatistician

As needed, assign and specify a Biostatistician for the Quality and Hospital Utilization Management Program. Responsibilities include the following:

A. Assure that the sampling design meets agreed upon confidence intervals and that sampling weights are constructed consistently with the complexity of the sampling design.

B. Determine which statistical tests are used in analysis of the data and assuring that they are used appropriately.

C. Participate in the development of abstracting and survey tools, train abstractors and surveyors and oversee tests of inter-rater reliability.

The Biostatistician must have a Master's Degree in statistics, biostatistics, or mathematics, or a Ph.D. in a related subject. In addition, the Biostatistician must have at least three (3) years of experience, including at least two studies (please describe) serving as a biostatistician.

Other Necessary Positions

In addition, the Offeror must submit general job descriptions/requirements of other staff positions to be assigned to this program, including:

A. Medical record extractors;

B. Review nurses;

C. Physician reviewers;

D. Data processors;

E. Data analysts;

F. Registered Health Information Administrator (certified medical coder); and

G. Information Systems Manager.

3.4 Replacement of Key Personnel

A. After execution of the Contract, ODM must approve the replacement of any key personnel. ODM reserves the right to disapprove a key staff member's replacement if it determines the minimum education and experience requirements are not met. The Offeror must use all commercially reasonable efforts to ensure the continued availability of those key personnel. Also, the Offeror may not remove those personnel from the project without the prior written consent of ODM, except if doing so is necessary for legal or disciplinary reasons. However, the Offeror must make a reasonable effort to give ODM 30 calendar days' prior, written notice of the removal.

Offeror's notice to ODM to remove or replace key personnel must include two qualified replacement candidates' resumes with detailed documentation of the proposed candidate's experience with projects of similar size and scope to the subject of this RFP.

B. If the Offeror removes key personnel from this project for any reason other than those specified above, ODM may assess liquidated damages in the amount of $1,500.00 for every day between the date on which the individual was removed and the date that the Contract is terminated, or the individual's qualified replacement, selected in accordance with the process identified in this Section, starts performing on the project. ODM also may provide the Offeror with written notice of its default under this section, which the Offeror must cure within 30 days. Should the Offeror fail to cure its default within the 30-day cure period, the Contract may be terminated immediately for cause, and ODM will be entitled to damages in accordance with the Suspension and Termination Section of the executed Contract due to the termination. Should ODM assess liquidated damages, or otherwise be entitled to damages under this provision, ODM may offset these damages from any fees due under the Contract.

C. ODM has an interest in ensuring that its operations are carried out in an efficient, professional, legal, and secure manner. Therefore, ODM will have the right to require the Offeror to remove any individual involved in the Project, if ODM 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 the Contract has become unavailable, and the Offeror must follow the procedures identified above for replacing unavailable Key Project Persons. This provision also applies to people that the Offeror's subcontractors engage, if they are listed by name as a Key Project Person in the RFP Documents.

3.5 Subcontractor Identification and Participation Information

Offerors must clearly identify the subcontractor(s) and their tasks in their Proposals. The Proposal must include a letter from the proposed subcontractor(s), signed by a person authorized to legally bind the subcontractor, indicating the following:

A. Subcontractor's legal status, federal tax ID number, and principal business address;

B. Name, phone number, and email address of a person who is authorized to legally bind the subcontractor to contractual obligations;

C. A complete description of the work the subcontractor will do;

D. A commitment to do the work, if the Offeror is selected;

E. A statement that the subcontractor has read and understands the RFP, the nature of the work, and the requirements of the RFP; and

F. The MBE certification number, if applicable, a copy of their current MBE Certification letter must be included.

3.6 Sensitive Personal Information

It is the sole responsibility of the Offeror submitting a Proposal to remove all personal confidential information (such as home addresses and social security numbers) of Offeror staff and/or of any subcontractor and subcontractor staff from resumes or any other part of the Proposal package.

Following submission to ODM, all Proposals submitted may become part of the public record. **ODM reserves the right to disqualify any Offeror whose Proposal is found to contain such prohibited personal information.**

3.7 Proprietary Information

Proprietary Information is information that meets the definition of "trade secret" as defined in ORC section 1333.61(D). During the term of the Contract, the selected Contractor must not withhold from ODM Proprietary Information to the extent any such Proprietary Information is reasonably necessary to do work for under the Contract.

To the extent Contractor wishes to avail itself of any of the protections provided herein, the selected Contractor must prominently mark the top or bottom of each individual record containing information the selected Contractor deems proprietary as "proprietary," regardless of media type (e.g., CD-ROM, Excel file), prior to its release to ODM, unless otherwise specified by ODM. If the Contractor fails to mark a record as proprietary, the selected Contractor waives any claim that the record is proprietary, and ODM may not hold the record confidential. Upon request from ODM, the selected Contractor must notify ODM in writing and within the timeframe specified by ODM of the specific Proprietary Information contained in the record, the nature of the Proprietary Information, the legal basis that supports that the information is proprietary, and the specific harm or injury that would result from disclosure.

Notwithstanding the forgoing, ODM is permitted to share or disclose (without a subpoena, grand jury subpoena, or court order) Proprietary Information to CMS, the U.S. Department of Health and Human Services, the Office of the Inspector General, the Ohio Auditor of State, the Ohio Attorney General, the Medicaid Fraud Control Unit (MFCU), and/or ODM-contracted entities who perform duties connected to the administration of the ODM's program and who agree to be bound by the standards of confidentiality in this Contract.

If the selected Contractor chooses to challenge any order, subpoena, or grand jury subpoena requiring disclosure of Proprietary Information submitted to ODM, or any legal action brought to compel disclosure under ORC section 149.43, the selected Contractor must provide for the legal defense of all such Proprietary Information. The selected Contractor is responsible for and must pay for all legal fees, expert and consulting fees, expenses, and costs related to this challenge against disclosure, regardless of whether those legal fees, expert and consulting fees, expenses, and costs are incurred by the selected Contractor or by ODM. If the selected Contractor fails to promptly notify ODM in writing that the selected Contractor intends to legally defend against disclosure of Proprietary Information, that failure will be deemed to be a waiver of the proprietary nature of the information, and a waiver of any right of the selected Contractor to proceed against ODM for violation of this Contract or of any laws protecting Proprietary Information. Such failure will also be deemed a waiver of trade secret protection in that the selected Contractor failed to make efforts that are reasonable under the circumstances to maintain the information's secrecy.

SECTION IV. SCOPE OF WORK & SPECIFICATIONS OF DELIVERABLES

4.1 Scope of Work

The selected Offeror will be responsible for the Deliverables as described in Section 4.2, including all preparatory and intervening steps, whether or not ODM has explicitly specified or delineated them within the RFP. In developing their Proposals, all Offerors must fully and appropriately plan and cost out their proposed projects, including all necessary preparatory and intervening steps.

The selected Offeror will be required to implement and manage a statewide quality and utilization control program. Specifically, the selected Offeror will be responsible for utilization reviews, including focused reviews, prior authorizations, special reviews, retrospective reviews, pre-certification reviews, and medical record reviews of Managed Care prior authorizations and/or claims denied based on medical necessity criteria as requested, conduct provider education, and provide technical assistance to ODM. The selected Offeror will demonstrate an expertise regarding Medicaid populations, developing a comprehensive plan for utilization control, and claims data management and reporting. Additionally, Offeror Proposals submitted in response to this RFP must reflect the Offeror's understanding of, and commitment to, performing the Scope of Work fully.

4.2 Specifications of Deliverables

ODM requires the selected Offeror to be responsible for, at minimum, the following services:

A. **Special Reviews:** The selected Offeror will conduct all reviews in accordance with the OAC 5160-2-03 Conditions and Limitations and OAC 5160-1-31, which describes the Special Review/Prior Authorization Program. All reviews must include the use of Ohio-based physicians to ensure practice patterns within Ohio are taken into consideration. To implement and manage the Special Review Program, the selected Offeror will be required to:

1. Develop the methodology and criteria that will be used when a provider requests prior authorization.

2. Select the medical criteria used to determine appropriateness and medical necessity of the request.

3. Train Medicaid providers, ODM staff, and the selected Offeror/subcontractor staff on the prior authorization program.

4. Maintain a reporting mechanism that meets notification requirements described in OAC 5160-1-31 and 5160-2-03.

5. Develop and implement procedures for all prior authorization review denials, including specific documentation of all the reasons for denials.

6. Develop a plan for and participate in hearings when prior authorizations are appealed.

B. Retrospective Reviews:

All reviews must be conducted in accordance with OAC 5160-2-13, which describes utilization control policies for hospital services. Reviews should also meet applicable federal guidelines and should support ODM's program integrity initiatives to ensure appropriate utilization of hospital services. All reviews must include the use of Ohio-based physicians to ensure practice patterns within Ohio are taken into consideration, where determined appropriate. Ohio Medicaid utilizes Milliman Care Guidelines for retrospective review determinations.

The 19retrospective reviews must consist of at least 1,700 inpatient and outpatient claims being reviewed on a monthly basis. The claims will be reviewed for proper coding, level of care, medical necessity and quality of care. The time period for the selection of claims will be determined by, and coordinated with, ODM. Selected Offeror will be required to develop a plan for utilization management that includes post-payment reviews for services and/or admissions provided in the hospital (inpatient and outpatient) setting.

The claims are selected based upon the following examples of current target areas:

1. **Billing Errors**: This target consists of inpatient admissions which have either the admission source or the patient disposition (discharge status) coded incorrectly.

2. **Readmissions**: This target looks at claims that include readmissions within one day, and within 30 days of the initial admission.

3. **Target Diagnostic Related Groups (DRG)**: This target consists of looking at DRGs that represent a potential for upcoding or other billing errors, or higher than expected utilization.

4. **Medical Necessity and Short Lengths of Stay**: This target consists of claims with significantly short lengths of stay based on the DRG and/or primary diagnosis for any diagnosis or procedure; claims for procedures which have significantly higher denial rates due to medical necessity concerns and have short lengths of stay; and selected claims with short lengths of stay.

5. **Compliance**: This target consists of comparing the diagnostic and procedural information reported on the claim against the medical record documentation for consistency.

6. **Outpatient/Ambulatory**: This target consists of incorrect coding/number of units, billing issues and inappropriate hospital setting.

7. **Bill audit**: This target reviews DRG-exempt facility claims once a year for accuracy of billing itemized charges.

8. **Transfers:** This target reviews the documented reasons for and the appropriateness of the transfer.

9. **Outliers:** This target reviews claims with outliers to determine if days or services were covered and medically necessary.

In addition to the target areas listed above, the selection methodology for retrospective reviews is continuously monitored by ODM and updated based on provider utilization trends and national trends in public and private insurance markets.

To implement and manage the Retrospective Review Program, the selected Offeror will be required to:

1. Develop the methodology and criteria used to select procedures and/or admissions. (Note: selection criteria must address provider incentives likely under a prospective payments system, such as, medical necessity of admission, discharge/transfer decisions, and accuracy of coding.)

2. Include in the program a mechanism that verifies that the services were performed in the most appropriate location.

3. Include in the program a mechanism to verify that information given during the pre-certification process was accurate if pre-certification is applicable.

4. Select the medical criteria used to determine appropriateness of the procedure and/or admission.

5. Provide (number) license(s) granting ODM staff access to Milliman Care Guidelines.

6. Incorporate participation in the provider appeal process as described in OAC 5160-2-12.

7. Train Medicaid providers, ODM staff, and the selected Offeror/subcontractor staff on the retrospective review program.

8. Maintain a reporting mechanism that meets the notification requirements of ORC § 164.57

9. Develop a process for referring quality of care findings to ODM.

10. Monitor and provide suggested updates to the program to ensure that appropriate procedures and/or admissions are reviewed.

11. Ensure that reviews support quality of care studies and the pre-certification program plan described in this Section.

Claims To Be Excluded from Fee-for-Service Retrospective Review:

1. Crossover claims where Medicare is the primary payer.

2. Claims where the consumer had a retroactive eligibility change from fee-for-service to managed care.

3. Claims for inpatient services rendered to incarcerated individuals participating in the Inpatient Hospital Services Benefit program.

4. Claims for inpatient services rendered under the Presumptive Eligibility program.

5. Claims for Inpatient and Outpatient services subjected to mass adjustment by ODM.

Retrospective reviews will primarily be focused on inpatient care, and the sampling methodology will need to be updated to take into account changes in trends in the insurance market and in utilization trends.

C. Special Reviews:

The selected Offeror shall be responsible for performing special reviews. The selected Offeror shall assist with reimbursement for noncovered items and services which may be available contingent upon an approved prior authorization. Prior authorization must be obtained from ODM, or its designee, by the provider before services are rendered or the items are delivered.

D. Focused Reviews:

The selected Offeror will conduct focused reviews on an as-needed basis for specific provider's claims as determined by ODM. Focused reviews allow ODM the opportunity to take a closer look at issues that may arise out of the retrospective review program, quality of health care studies, or issues that come to the attention of ODM through any number of sources (e.g. consumer complaint, legislative inquiry, ODM Surveillance and Utilization Review Section (SURS), or other program integrity initiatives). Focused reviews may identify service and procedure targets for pre-certification review.

As an example of a focused review, the selected Offeror would analyze the claims data of selected providers that rebill a large number of claims with codes that have been upgraded, to determine if a problem exists with that provider. A "bill audit" may be performed to compare a provider's medical records to the services and charges submitted on their claims.

The methodology used for focused reviews must fulfill the agency's Medicaid utilization management objectives and permit focused reviews of either a physician or an institution. The selected Offeror will be required to participate in designing focused review projects through data analysis, targeting, sampling and reporting. The size and scope of the focused reviews will vary depending on the nature of the issue necessitating the review.

E. Community Behavioral Health Service Reviews:

The selected Offeror shall be responsible for performing Community Behavioral Health Service Reviews. Reimbursement for some behavioral health services covered under the Medicaid program is available only upon obtaining prior authorization; prior authorization must be obtained from ODM, or its designee, by the provider before services are rendered.

All reviews must be conducted in accordance with OAC Chapter 5160-27 and OAC rule 5160-8-05 as applicable. All reviews must include the use of Ohio-based physicians and medical staff to ensure practice patterns within Ohio are taken within consideration, where appropriate. The selected Offeror must perform the following tasks:

1. Develop the methodology and criteria used to determine the appropriateness of the behavioral health service. Criteria must align with the aforementioned OAC rules.

2. Conduct retrospective reviews of an agreed upon number of claims, if requested by ODM.

3. Conduct provider education as needed.

4. Provide activity and other types of reports as requested by ODM.

5. Participate, with ODM, in an agreed upon appeal process and participate in appeal hearings, as required.

The selected Offeror may be required, on a case-by-case basis, to review a prior authorization request for a behavioral health service not currently covered by Ohio Medicaid. The number of these types of reviews is expected to be low.

The selected Offeror will be required to support and respond to provider PA requests:

1. For Assertive Community Treatment (ACT), substance use disorder residential, and substance use disorder partial hospitalization services, the selected Offeror will respond by either approving or denying a PA within 48 hours of receiving a provider's request.

2. For all other PA requests, the selected Offeror will respond by either approving or denying a PA within 72 hours of the provider's request.

F. <u>Psychiatric Hospital Admission Reviews:</u>

The selected Offeror will be required to develop a plan for utilization management that emphasizes prospective reviews for prior authorization of services across all mental health and substance abuse settings.

The plan should include a mechanism to review services that can be performed for non-medically necessary purposes to determine that the procedure is medically necessary. The plan should also include a mechanism to determine the most appropriate location of care. The goal of the pre-certification program is to use prospective solutions to avoid inappropriate patterns of utilization and levels of care.

All reviews must be conducted in accordance with the OAC 5160:2-40, which describes the pre-certification review process for hospital services. The reviews must also meet applicable federal guidelines, and should reflect ODM's program integrity initiatives by ensuring appropriate utilization of hospital services. All reviews must include the use of Ohio-based physicians to ensure practice patterns within Ohio are taken into consideration, where determined appropriate ODM expects the selected Offeror to conduct continuous data analysis to monitor and update the pre-certification program.

To implement and manage the Pre-certification Review Program, the selected Offeror will be required to:

1. Develop the methodology and criteria that will be used to select psychiatric admissions.

2. Select the medical criteria used to determine appropriateness of the admission.

3. Train Medicaid providers, ODM staff, and the selected Offeror/subcontractor staff on the pre-certification review program.

4. Maintain a reporting mechanism that meets notification requirements described in OAC 5160-2-40.

5. Monitor and provide suggested updates to the program to ensure that appropriate admissions are reviewed.

6. Develop and implement procedures for all pre-certification review denials in accordance with OAC 5160-2-40, including documentation of all reasons for denials or subsequent reversals of determinations.

7. Develop a plan for and participate in hearings when pre-certification denials are appealed.

G. <u>Mobile Response and Stabilization Service (MRSS) Prior Authorizations:</u>

The selected Offeror must monitor practices to ensure consistent application of the ODM Service authorization criteria. The selected Offeror should ensure that an inter-rater reliability process is in place and should report the inter-rater reliability data to ODM upon request.

When issuing a denial of service, the selected Offeror must clearly state all the clinical rationale for the denial per approved clinical guidelines and standards of care and note whether a denial was reviewed by a nurse, physician, or other agreed upon practitioner type.

The selected Offeror must prior authorize some HCPCS code S9482 for the provision of stabilization services as a component of the mobile response and stabilization service in the fee-for-service system. The selected Offeror must do the following:

1. Develop the methodology and criteria used to determine the appropriateness of stabilization services rendered more than six weeks after the completion of mobile response. Criteria must align with OAC rules 5122-29-14, 5160-27-13, and 5160-1-01.

2. Conduct retrospective reviews of an agreed upon number of claims, if requested by ODM.

3. Conduct provider education as needed.

4. Provide activity reports, and other types of reports as requested by ODM.

Once the requirement of prior authorization is met, the appropriateness of stabilization services will be determined based on medical necessity.

Upon receipt of a prior authorization request, the prior authorization request must be reviewed and a decision rendered within 48 hours, including weekends. However, the decision may be pended if more information is needed and will restart when the additional information is received. This process applies to all prior authorization requests.

Selected Offeror shall comply with the following terms, or requirements, for this service;

1. Type of clinicians expected to perform the reviews will be determined by ODM during discussions with the selected Offeror.

2. All the selected Offeror's medical review policies should be available to ODM for review.

3. The selected Offeror must participate, with ODM, in an agreed upon appeal process and participate in appeal hearings as required.

4. The selected Offeror must meet with ODM staff regularly and upon request to discuss coverage policies and clinical needs.

5. The ODM clinical and policy teams will create a training that provides an overview of the current MRSS rule and any needed intricacies about interpretation. In addition, the clinical and policy teams will remain accessible to the selected Offeror for ongoing conversation and questions.

H. <u>Prior Authorization for Non-Institutional Services:</u>

The selected Offeror must have internal monitoring practices to ensure consistent application of the ODM Service authorization criteria. The selected Offeror should ensure that an inter-rater reliability process is in place and should report the inter-rater reliability data to ODM upon request.

When issuing a denial of service, the selected Offeror must clearly state all the clinical rationale for the denial per approved clinical guidelines and standards of care and note whether a denial was reviewed by a nurse and/or a physician. The selected Offeror will be responsible for development and presentation of appeal summaries in state hearings as part of member's due process rights.

The selected Offeror is expected to prior authorize some CPT/HCPCS Level II codes for types of services including but not limited to transportation, outpatient dental procedures, durable medical equipment, skilled therapies, hearing/vision, acupuncture, laboratory and chiropractor services and temporary procedure codes will require medical necessity reviews by the selected Offeror. Some CPT/HCPCS codes always require prior authorization while other procedures codes have limit-based edits in place. When there are limit-based edits in place, a PA review for medical necessity may be needed to either approve

or deny the additional supplies or service. For limit-based edits that pay and post, a PA review would not be required

Regardless of a request's technical merits, <u>all</u> prior authorizations must be reviewed for medical necessity.

The selected Offeror must provide notice to the provider and individual as expeditiously as the individual's health condition requires, but no later than ten (10) calendar days following receipt of the request for service. If a provider indicates or the selected Offeror (or ODM) determines that following the standard authorization timeframe could seriously jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function, the selected Offeror must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the individual's health condition requires but no later than forty-eight (48) hours after receipt of the request for service. All pediatric PA requests are to be reviewed for medical necessity according to federal EPSDT requirements and are time sensitive.

Types of clinicians expected to perform the review:

1. Prior authorization approvals may be processed by Registered Nurses (RN)

2. Prior authorization denials for medical necessity must be reviewed/approved by a physician under the direction of the Medical Director.

All selected Offeror medical review policies should be available to ODM for review.

The selected Offeror will meet with Clinical staff regularly and upon request to discuss coverage policies and clinical needs.

Additional reports as requested based on VUE360/FI system functionality and data access.

I. <u>Provider Prior Authorization Appeal Requests:</u>

The selected Offeror will perform provider appeals of Managed Care Entity denials in accordance with OAC 5160-1-31. The selected Offeror will make a standard reconsideration determination within ten calendar days of receipt of a valid request. If an expedited review is requested because the service or item qualifies as urgent care services, the reconsideration determination will be made no later than forty-eight hours after receipt of a valid reconsideration.

1. Selected Offeror shall perform external medical reviews at the request of a provider for disputes resultingfrom an MCE's denial, limitation, reduction, suspension, or termination of a service due to a lackof medical necessity.

    a. Selected Offeror must assign a reference number to each request for external medical review, which is available for the provider, MCE, and ODM for tracking and reporting purposes.

b. The request for external medical review from provider may be submitted in writing to the Selected Offeror.

c. If the MCE and provider disagree that the reduction, limitation, denial, suspension, or termination of a service is subject to external medical review, ODM or its designee willdetermine if the EMR will be conducted.

d. Selected Offeror shall review requests for EMRs to determine if they are valid requests byverifying:

   i. The denial, limitation, reduction, suspension, or termination was based on medical necessity.

   ii. Provider has exhausted the MCE internal appeals process or provider claim dispute resolution process; or provider has attempted to complete MCE internal appeals process or provider claim dispute resolution process but has not received a timely response from the MCE.

e. Selected Offeror will track requests for external medical reviews that are determined to be invalid requests. If selected Offeror determines a request for an external medical review is not valid due to a denial reason other than medical necessity, selected Offeror will notify ODM usingan ODM approved established process.

f. The determination regarding whether or not a request is valid will be made byappropriately qualified staff.

2. Selected Offeror shall conduct the review and render a determination as to whether or not the MCE'sdenial, limitation, reduction, suspension, or termination of a service due to a lack of medicalnecessity was appropriate and in accordance with Ohio's rules and laws.

   a. Selected Offeror will request all appropriate documentation from the MCE to make itsdetermination.

   b. For external medical record requests that are associated with expedited service authorization decisions, the determination must be issued as expeditiously as the member's health condition requires, but no later than 3 business days from the selected Offeror'sreceipt of the valid external medical review.

   c. For external medical review requests that are associated with standard service authorization decisions or claim denials, the determination must be issued within 30 calendar days from the selected Offeror's receipt of the valid request for an external medical review.

   d. Selected Offeror will share the outcome of its determination with MCE and provider.

3. Selected Offeror shall allow for external medical review requests to be submitted by providers electronically. This portal must include at least the following:

    a. Ability for MCE providers to request EMR.

    b. Ability to send and receive narrative and any attachments as accompanyingdocumentation to support request for EMR.

    c. Any other information identified by ODM.

4. Selected Offeror shall provide ODM role-based access to routine and ad hoc reports with information both for individual and aggregate EMR data as specified by ODM. ODM may perform audits ormake other requests for information and documentation. Selected Offeror shall provide all informationrequested by ODM in a timely manner.

5. Selected Offeror shall permit ODM-contracted MCEs with role-based access to information about EMRsrequested from the MCE.

    a. This access will ensure the MCE can:

        i. Receive notification of a requested EMR.

        ii. Receive notification of the outcome of an external medical review and any associated documentation.

        iii. Permit the MCE to upload any attachments or other documentation to support their decision to reduce, deny, or suspend a service due to lack of medical necessity.

6. Selected Offeror shall assign as a clinical peer a health care professional who meets the following minimum qualifications:

    a. Is an expert in the treatment of the covered person's medical condition that is thesubject of the review;

    b. Has knowledge of all relevant Ohio laws and rules specific to the service(s) subject to theexternal medical review;

    c. Is knowledgeable about the recommended health care service or treatment throughrecent or current actual clinical experience treating patients with the same or similarmedical condition of the covered person; and

    d. Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit or regulatory body that raise a substantial question

as tothe clinical peer's physical, mental or professional competence or moral character.

7. Selected Offeror shall assure the clinical peer health care professional performing the review:

   a. Is not under contract to provide the disputed service with the MCE at any time whileconsidering the dispute

   b. Is not rendering care and services to the member.

   c. Does not have or acquire any personal or professional interest in connection with the review, direct or indirect, that could present a conflict or perceived conflict of interest,or that otherwise could compromise the impartiality of the review.

Reviews shall be performed by a physician Medical Director who holds a current and non-restricted Ohio license and is certified by the American Board of Medical Specialties. All review determinations will be authorized by an Ohio licensed physician.

Potential Offeror, or their proposed subcontractor, shall be nationally accredited in independent review.

PLEASE NOTE: It is at ODM's discretion to determine if services described in this Section I will be needed during the term of the contract. Additionally, during the term of the contract, ODM may determine that the Services in this Section I may be removed from this Contract and be procured separately.

J. <u>Prior Authorization for Home Health Services:</u>

The selected Offeror will act as a designee on behalf of ODM, to receive and prior authorize (or deny) requests for additional home health nursing and home health aide services, when the request is for additional units of service beyond fourteen hours per week, and if ordered by an individual's treating clinician.

Upon receipt from a Medicare Home Health Agencies (MCHHA) provider, the selected Offeror will review and consider all documentation submitted to support the request and ensure compliance with OAC Chapter 5160-12-01 prior to approving or denying the request.

Prior authorization approvals must be processed by Registered Nurses (RN). The selected Offeror must have an internal form and monitoring practices to ensure consistent application of the ODM Service authorization criteria. The selected Offeror should ensure that an inter-rater reliability process is in place and should report the inter-rater reliability data to ODM upon request. The selected Offeror will meet with Clinical staff regularly and upon request to discuss coverage policies and clinical needs. All selected Offeror medical review policies must be available to ODM for review.

The selected Offeror must provide notice to the MCHHA provider and individual as expeditiously as the individual's health condition requires, but no later than five (5) calendar days following receipt of the request for service, unless the MCHHA provider, or ODM determines that following the standard authorization timeframe could seriously jeopardize the individual's life or health or ability to attain,

maintain, or regain maximum function. In such cases, the selected Offeror must adjust to provide an authorization decision and provide notice of the authorization decision as expeditiously as the individual's health condition requires but no later than forty-eight (48) hours after receipt of the request for additional service.

K. Prior Authorization for Private Duty Nursing:

The selected Offeror will act as a designee on behalf of ODM, to receive, review and adjudicate prior authorization requests for private duty nursing upon request from a Medicare certified home health agency (MCHHA) that meets the requirements in accordance with rule 5160-12-03 of the Administrative Code, an otherwise accredited agency that meets the requirements in accordance with rule 5160-12-03.1 of the Administrative Code, and a non-agency nurse that meets the requirements in accordance with rule 5160-12-03.1 of the Administrative Code, or a case manager from one of the following care coordination entities: Ohio Home Care Waiver Agency, PASSPORT Administrative Agencies, County Boards of Developmental Disabilities. The requestor must submit the following form https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM02374fillx.pdf and supporting documentation including a plan of care (e.g., https://www.cdc.gov/wtc/pdfs/policies/CMS-485-P.pdf).

Prior authorization denials for medical necessity must be reviewed/approved by a physician under the direction of the Medical Director. When issuing a denial of service, the selected Offeror must clearly state all rationale for the denial per approved clinical and procedural guidelines, and standards of care, and note whether a denial was reviewed by a nurse and/or a physician. The selected Offeror will be responsible for development and presentation of appeal summaries in state hearings as part of member's due process rights.

Upon receipt, the selected Offeror, specifically a Registered Nurse, will review and consider all documentation submitted to support the request and ensure compliance with OAC Chapter 5160-12-02 prior to approving or denying the request. A Registered Nurse must also complete an ODM-standardized assessment and acuity tool https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM02376.pdf. The assessment must be completed and documented no later than 10 business days following the initial request. Expedited requests must be completed the same day or within 24 hours. The selected Offeror must have the capacity to complete the assessments in-person as directed by ODM.

After the assessment is completed, the selected Offeror will determine the outcome of the referral request including notification of outcome and issuance of due process rights https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM02373fillx.pdf. The selected Offeror will notify the referral source (if authority exists to do so), individual, provider, and case manager, if applicable, of the determination (denial, modification, or approval) including authorized amount, scope and duration of services). The selected Offeror shall represent ODM at any hearing filed resulting from the prior authorization requested.

L. Offeror Prior Authorization Appeal Requests:

The selected Offeror will perform provider appeals when designated by ODM. The selected Offeror will make a standard reconsideration determination within ten calendar days of receipt of a valid request. If an expedited review is requested because the service or item qualifies as urgent care services, the

reconsideration determination will be made no later than forty-eight hours after receipt of a valid reconsideration.

The request for reconsideration may be reviewed by a nurse, and if the newly submitted documentation does not substantiate the request, a review would be conducted by a clinical peer.

M. Reporting and Analysis:

In order to monitor and evaluate utilization of medical services in the Medicaid population, various reports will be required from the selected Offeror. These include, but are not limited to, activity reports related to the pre-certification, prior authorization, and special review program and the retrospective and quality review program. The accuracy of all reports must be verified by the selected Offeror prior to submission to ODM. The selected Offeror is responsible for developing and implementing all reports in accordance with ODM's specifications.

All reports must be submitted within thirty days of the end of the reporting period unless an alternate time frame has been established by ODM in writing. Reports must be submitted electronically, but also be available in hard copy form. Reports should be accurate and complete.

The following mandatory reports are required for the Pre-certification and Special Review Program:

1. A monthly report summarizing work completed. The source of the report will be mutually agreed upon by both parties. At a minimum, the report must include the total number of cases completed, the number of cases recommended, the number of cases referred to physician advisors, and the outcome of pre-certification/special review.

2. A monthly report detailing work completed including specific information related to individual cases.

3. A monthly report documenting reconsiderations of initial adverse decisions and the reconsideration outcomes.

The selected Offeror is encouraged to identify and develop additional reports needed to monitor utilization of medical services by the Ohio Medicaid population.

The following mandatory reports are required for the Retrospective Review Program:

1. A monthly retrospective review schedule and a frequency report.

2. A quarterly report summarizing work completed including the total number of cases denied by review category and the net dollar savings associated with these categories.

3. A monthly report detailing work completed, including specific information related to individual cases.

4. A monthly report finalizing all review activity for a specific review month after the appeal deadline has been reached.

5. A monthly report that details sample selection methodology.

Reports of quality concerns, using processes established by Medicare for quality screens and levels include:

1. Initial and final quality concerns issued on a monthly basis.

2. Quarterly report demonstrating trends.

The selected Offeror is encouraged to identify and develop additional reports needed to monitor utilization of medical services by the Ohio Medicaid population. Other reports may be requested by ODM as needed.

The following reports are required for Non-Institutional Services Prior Authorization: Monthly reports of number of finalized reviews by category sorted by approvals and denials and also sorted by adult and pediatric (under age 21).

N. Health Care Studies:

In each fiscal year of the contract, the selected Offeror is responsible for production of up to four (4) studies which support efforts towards increasing quality of care, improving beneficiary access, and reducing costs. Specific study topics will be assigned to the selected Offeror by ODM. The number of studies in a given year is negotiable depending on the scope of each study and may be modified through a joint agreement between the selected Offeror and ODM depending on research needs and scope.

The selected Offeror may be required to conduct studies, share tools, or coordinate analysis with other ODM contractors. Clinical outcome-based studies are used to evaluate the quality of care delivered to Medicaid managed care organization (MCO) enrollees and to compare outcomes by MCO may be developed and performed.

The selected Offeror may work with current and historical FFS claims, as well as, managed care encounter data. The selected Offeror is expected, where necessary, to retrieve medical records for analysis, or survey individual patients about their outcomes. ODM will compare the results of quality reviews and coordinate improvement activities across delivery systems (managed care and fee-for-service). The studies will be supportive of ODM's overall health care quality improvement strategy.

For each of the health care studies, the selected Offeror is expected to make recommendations to ODM which include:

1. Prospective solutions to identified patterns of inappropriate utilization of Medicaid services.

2. Methods to identify/screen appropriate and inappropriate utilization of health care services through the use of provider profiling measures of claims data.

3. Suggestions for effectively incorporating study findings into ODM's quality improvement strategy, thereby furthering ODM's efforts as prudent purchasers of health care services.

4. Recommendations for defining and measuring improvement in utilization, clinical decision making, and clinical outcomes as a result of implementing these solutions. These solutions must proactively involve the education and cooperation of the provider community.

The selected Offeror is responsible for developing a plan for health care studies and necessary follow-up.

Data Collection and Sampling

The source of data for the health care studies will be medical records, administrative data, surveys, or a combination of the three. Eligibility data, FFS claims data, and managed care encounter data will be provided by ODM to the selected Offeror. Offeror will be responsible for transferring necessary data to its own systems for data analysis.

Offeror will sample the administrative data for the health care studies to determine which medical records to request, will request the records from institutional and physician providers, and then will extract the data needed to complete the study from the records. Depending on the number of records requested from a provider, the Offeror will either review the records at the provider's site or will review copies of the records sent by mail (secure mail, fax, or other secure electronic transfer).

The data collection and sampling performance standards are:

1. Obtaining from providers no less than 80% of the medical records that were selected as part of the sample.

2. Achieving an inter-rater reliability score, as measured by Cohen's Kappa or another measure appropriate to the data, of no less than 0.7 (95% confidence interval).

3. Submitting a final report for each study area to ODM on dates that are established by ODM in conjunction with the selected Offeror.

4. Submitting a complete report for each study area to ODM which addresses each of the topics identified by ODM for inclusion in the report and each other topic that is important to understanding the background, methods, results, and limitations of the study.

The selected Offeror is required to use qualified surveyors, provide training to the surveyors in data abstraction, and measure inter-rater reliability. The selected Offeror is responsible for selecting a sufficient sample of medical records and provider sites to assure valid studies. The expected statewide and sampling subgroup confidence interval for the studies is 95 percent.

O. Provider Education:

The selected Offeror will be required to develop educational materials and conduct provider education seminars at various times during the contract period. The selected Offeror will be:

1. Providing any necessary clinical criteria in support of changes made to the current program, in addition to communicating the changes to the provider community through educational seminars and mailing educational materials to providers.

2. Educating the provider community regarding prospective changes to the utilization review program resulting from the identification of inappropriate utilization of Medicaid services through the post payment and focused review processes. This educational opportunity may be through a seminar or through the development and dissemination of an Ohio Medicaid institutional utilization review program provider electronic newsletter.

3. Developing and regularly producing provider e-newsletters throughout the contract period with input and final content approval from the ODM team. The selected Offeror will be expected to provide ongoing updates regarding the operations of the Institutional Utilization Review program and communicate to the provider community through these periodic provider newsletters. Development will include: 1) a detailed concept for the newsletter (including frequency, length, focus, etc.); and 2) a plan to address provider education that incorporates utilization management activities and quality of care studies, and documented impact from provider education.

P. Technical Assistance:

ODM is structured to operate as a matrix organization to provide flexibility needed to respond to and act in an external environment that remains highly volatile, both at the level of federal policy and within the health care marketplace. ODM conducts much if its program development and reform activities through teams made up of staff from both policy and operational bureaus. The pace of change in health care, social services and in state/federal and state/local relationships makes organizational flexibility and "out of the box" thinking a critical success factor. This flexibility and creativity is enhanced through teamwork.

The selected Offeror may provide up to 600 hours of technical assistance to policy and operational units within ODM. This work will primarily involve clinical expertise and guidance, as needed, in support of policy development and operational functions. Examples of technical assistance work may include, review of new or existing procedure codes for a recommendation on the appropriate setting (inpatient or outpatient), guidance on medical coding questions, or assistance in developing clinical screens to be used by ODM to make coverage determinations for services that require hospitalization (e.g. procedures related to the treatment of obesity).

Q. Data Management:

1. Data Processing

ODM will provide data to the selected Offeror to carry out the functions of the contract. The cost of this Deliverable will be incorporated into the proposed fee of the project. Data to be provided may include:

a. FFS claims data;

b. MCO encounter data;

c. Medicaid eligibility data;

d. Long term care Minimum Data Set (MDS) data;

e. Medicaid provider files;

f. MCO primary care provider (PCP) database; and

g. Medicaid procedure, drug, and diagnosis reference files.

The selected Offeror will be responsible for maintaining reasonable access to data at all times and for receiving this data in a timely fashion. The following standards apply:

A. Reasonable access means the ability to retrieve all data in a batch processing mode so that analytical processing can be completed within 24 hours. Note that this is a minimum standard which should be applied to complicated analytical processes involving multiple large data sets over multiple years. Less complicated processes using smaller data sets should be able to be completed in less time.

B. Receiving data in a timely fashion means being able to provide reasonable access to monthly updates within 48 hours of receipt of the data.

To ensure successful data management, the selected Offeror must develop a plan and timetable for initial data base design and set-up of historical and initial reference files, and provide a description of how the data bases will be set up and accessed for use by the selected Offeror in carrying out the contract.

R. Other Prior Authorizations

The selected Offeror may be required to perform prior authorizations in order to continue the provision of various services after an allowed amount of services has been rendered. This may include additional behavioral health prior authorizations, as well as others that may be required through changes to policies ODM is not currently aware of, but may come up through the life cycle of a contract resulting from this RFP.

SECTION V. BUSINESS CONTINUITY PLAN

A. Offeror recognizes that certain services covered in this RFP are vital to ODM and must be continued without interruption. Offeror shall be prepared to continue providing such services identified by ODM, during periods of disaster, crisis, or other unexpected break in services based upon a Business Continuity Plan (Plan). Offeror is required to implement and maintain a sustainable Plan throughout the term of the Contract resulting from this RFP and provide a summary of the Plan to ODM upon request. The Plan will, at a minimum address the following:

1. How the Offeror will enable continued performance under this Contract in the event of a disaster or other unexpected break in services;

2. How the Offeror will ensure the continuity for identified vital services and supporting facilities;

3. Disaster recovery plans for critical technology and systems infrastructure; and

4. Proper risk controls (collectively, the "Contingency Plans") to enable continued performance under the Contract in the event of a disaster or other unexpected break in services.

B. For purposes of this Section, the term “Disaster” means an unanticipated incident or event, including, without limitation, force majeure events, technological accidents or human-caused events that (i) may cause a material service or critical application to be unavailable without any reasonable prediction for resumption, or (ii) causes data loss, property damage, or other business interruption without any reasonable prediction for recovery within a commercially reasonable time period.

C. The awarded Offeror will update and test the operability of any applicable Plan at least annually and will implement such Plan upon the occurrence of a Disaster.

SECTION VI. PROPOSAL FORMAT AND STRUCTURE

6.1 Complete Proposal Content Requirements

The Offeror’s Proposal package will consist of the following items in subsequent order:

A. Technical Proposal, including any Offeror appendices;

1. Attachment A: completed and signed by Offeror;

2. Attachment F: completed and signed by Offeror.

B. Cost Proposal, Attachment C completed and signed by Offeror;

6.2 Organizational Structure of the Technical Proposal

The Offeror must provide one (1) signed original paper copy and one (1) electronic copy (USB drive) of the Proposal, which must include:

Completed Technical Proposals may be organized by separating sections to correspond with Attachment B, but at minimum, must include the following:

A. Mandatory Offeror Requirements;

B. Staff Experience and Capabilities;

C. Organizational Experience and Capabilities;

D. Subcontractor Identification and Participation Information;

E. Scope of Work;

F. Deliverables and Proposed Work Plan;

G. Business Continuity Plan; and

H. MBE Documentation.

Offerors are prohibited from including project cost information (any dollar amounts which might be deemed indicative of the relative cost of the project), proprietary, personal, or confidential information in the Technical Proposals. Any Offeror including such information may be disqualified from consideration.

Offeror attachments to Proposal must include at minimum:

6.2.1 Required Offeror Information (Attachment A) Requirements

Offerors are to review Attachment A and complete and sign each of the provided signature blocks to note the Offeror's acknowledgment and intent of compliance. All original signatures must be in blue ink.

6.2.2 Terms and Conditions (Attachment F) Requirements

Offerors are to review Attachment F – Terms and Conditions, and sign each of the provided signature blocks to note the Offeror's acknowledgment and intent of compliance. All original signatures must be in blue ink.

Offerors are to identify any exceptions to the Terms and Conditions utilizing the format provided in Attachment F. Exceptions appearing elsewhere in the Offeror's Proposal may not be considered by ODM. If exceptions are not noted in Attachment F, but raised during Contract negotiations, ODM reserves the right to cancel the negotiation if, at its sole discretion, it deems that to be in the best interest of ODM.

6.3 Cost Proposal (Attachment C) Requirements

The Cost Proposal must contain one original and one electronic copy (USB) **provided in a sealed, separate envelope labeled: "DO NOT OPEN. COST PROPOSAL ENCLOSED FOR THE Clinical Utilization Management and Prior Authorization Program, RFP#: ODMR-2223-0006 SUBMITTED BY [OFFEROR'S NAME]."**

Offerors are to complete the Cost Proposal Form, provided as Attachment C to this RFP according to instructions, sign it, and submit it fully completed as the separate sealed Cost Proposal. The Cost Proposal Form requires interested Offerors to price those services defined in the Specifications of Deliverables, and to offer ODM its rates per deliverable and per annum total for each state fiscal year, as indicated in Attachment C. The price offered in the Offeror's Cost Proposal will be the price in effect throughout the contract period.

Offerors are to use the format in Attachment C, Cost Proposal Form, to submit their proposed fee for the entire project. At the Offeror's discretion, additional documentation may also be included with the completed Attachment C as explanatory information, but when making the Offeror selections and when executing the contract, ODM will consider only the dollar amount displayed on the Cost Proposal Form.

In calculating their total proposed fee, Offerors must consider costs resulting from each Deliverable listed, as well as all program, preparatory, primary and incidental costs necessary to complete all program activities (whether explicitly identified by ODM in this RFP or not).

ODM is not liable for any costs an Offeror incurs in responding to this RFP or form participating in the evaluation process, regardless of whether ODM awards the Contract through this process, cancels or reissues this RFP for any reason, or contracts for the work through some other process or through another RFP.

6.4 Proposal Submission

The Offeror's original Technical and Cost Proposals must contain all the information and documents specified in this Section. The Offeror's total complete Proposal submission (the original Technical and Cost Proposals, all required copies, and USB drives) must be received by ODM OCP no later than **2:00 p.m**. **Columbus, OH Local Time** on **October 26, 2022.** Faxed or e-mailed submissions will not be accepted. Proposals must be addressed, for hand delivery or delivery by a private delivery company, as described below:

Office of Contracts and Procurement, RFP/RLB Unit
Ohio Department of Medicaid
ODMR-2223-0006
50 West Town Street
Columbus, Ohio 43215

Offerors are **STRONGLY** encouraged to use a private delivery company (e.g., FedEX, UPS, etc.) to deliver their Proposals, or to hand deliver them, to the above address, as these types of companies are capable of delivering directly to ODM's security desk in the building, where it will be received and date and time

stamped. While using the United States Postal Service (USPS) is an option, it can add several days to the delivery process and could result in an Offeror's Proposal being late and disqualified from consideration. All Proposals must be received by OCP by the posted submission deadline, date and time. **No exceptions will be made.**

The address for USPS deliveries is:

Ohio Department of Medicaid
Office of Contracts and Procurement
ODMR-2223-0006
PO Box 182709
Columbus, Ohio 43218-2709

The entire Technical Proposal must be converted into one single, searchable .pdf document. If the Proposal's size necessitates more than a single .pdf document to contain the entire Technical Proposal, Offerors must still send the electronic copy of the Proposal, but use the fewest separate .pdf documents possible. The electronic copy of the Cost Proposal must include all Cost Proposal components, including any required or voluntary attachments. The USB containing the Cost Proposal must be submitted in the sealed envelope containing the original hardcopy Cost Proposal, and the number of photocopies, if required, indicated in section 6.2.

USB drives must be labeled with the Offeror's name, the RFP number, and the Proposal submission date. The USB drives may be used in the formal ODM Proposal review process, and will be used by ODM for archiving purposes and for fulfillment of Public Records Requests. Failure to include or to properly label the USB drives may, at ODM discretion, result in the rejection of the Offeror from any consideration.

It is the Offeror's responsibility to ensure that all copies and all formats of the Proposal are identical. Any pages or documents omitted from any or all copies can negatively affect the Offeror's score and possibly result in disqualification. In the event of any discrepancies or variations between copies, ODM is under no obligation to resolve the inconsistencies and may make its scoring and Offeror selection decisions accordingly, including the decision to disqualify the Offeror.

ODM reserves the right not to review submitted appendices which include information or materials not required in the RFP. **Failure by any Offeror to complete, sign, and return the Attachments A, C, and F documents with its Proposal may result in rejection of the Proposal as being non-responsive and disqualified from further consideration.**

ODM will not accept multiple Proposals from a single Offeror to the requirements of this RFP. Further, any Offeror that submits multiple Proposals may have all of its Proposals rejected.

SECTION VII. CRITERIA FOR PROPOSAL EVALUATION & SELECTION

7.1 Scoring of Proposals

Offerors submitting a response will be evaluated based on the capacity and experience demonstrated in their Technical and Cost Proposal. All qualifying Proposals will be reviewed and scored by a Proposal

Review Team (PRT), comprised of staff from ODM. Offerors should not assume that the review team members are familiar with any current or past work activities with ODM. PRT members will be required to sign disclosure forms to establish that they have no personal or financial interest in the outcome of the Proposal review and contractor selection process.

Selection of the Offeror will be based upon the criteria described in this RFP. ODM reserves the right to reject any and all Proposals, in whole or in part, received in response to this request. ODM may waive minor defects, but ODM will only do so if ODM believes that it is in ODM's interest and only if the defects do not cause any material unfairness to other Offerors. In scoring the Proposals, ODM may score in five phases:

1. Phase I. Review—Initial Qualifying Criteria;
2. Phase II. Review—Technical Proposal;
3. Phase III. Review—Cost Proposal;
4. Phase IV. Review- Selection Criteria; and
5. Phase V. Review – (optional) Interview

ODM may decide which phases are necessary, and ODM may rearrange the order in which it proceeds with the phases. ODM may add or remove sub-phases at any time, if ODM believes doing so will improve the evaluation process. ODM may seek clarifications from the Offerors during any of these phases.

A. Phase I. Review—Initial Qualifying Criteria:

Proposals must pass Phase I. Review – Initial Qualifying Criteria as required in the Technical Proposal Score Sheet provided as Attachment B to be considered for further scoring and possible award. Phase I criterion consists of, at a minimum, Proposal Acceptance Criteria, including the Mandatory Requirements, stipulated in this RFP. Please refer to Attachment B for a complete listing of initial disqualifiers.

B. Phase II. Review—Criteria for Scoring the Completed Technical Proposal:

The PRT will then score those qualifying Technical Proposals not eliminated in Phase I. Review, by assessing how well the Offeror meets the requirements as specified in the RFP. Using the score sheet for Phase II scoring (see Attachment B), the PRT will read, review, discuss, and reach consensus on the final Technical score for each qualifying completed Technical Proposal.

Any Proposal that does not meet the minimum required Technical Proposal score as defined in Attachment B will be disqualified from any further consideration and not be considered for award of the contract. The accompanying Cost Proposal will neither be evaluated nor considered a public record and will be returned to the Offeror, or destroyed.

Please refer to Attachment B for maximum and minimum allowable scoring thresholds and definitions of scoring values.

IMPORTANT: Before submitting a Proposal to this RFP, Offerors are strongly encouraged to use Attachment B to review their Proposals for completeness, compliance, and quality.

C. Phase III. Review—Criteria for Considering the Cost Proposal:

Cost Proposals will only be opened by the PRT if an offeror has met the minimum mandatory requirements, as indicated in Phase I, and the minimum Technical score, as indicated in Phase II. Offerors are to propose their compensation using the Cost Proposal Form provided as Attachment C to this RFP. All Proposals for compensation must be presented in the format and categories as prescribed on that form. No other categories of costs will be considered by ODM. No additional fees or costs of any sort will be paid under this contract.

Travel Reimbursement

Travel costs should be included in the overhead, per diem, or the hourly rates which are built into the cost of the Deliverables. Travel is not to be listed separately unless otherwise specified in this document.

Cost Negotiations

ODM may, at its sole discretion, negotiate with one or more Technically qualified Offerors. Following negotiations, upon request by ODM, an Offeror may: 1) submit one last and best offer; 2) request that ODM view its original Cost Proposal as its last and best offer; or 3) formally withdraw from further consideration. The Offeror shall formally indicate its choice according to directions provided by ODM at that time. Upon receipt of the last and best offer(s), ODM will then use that Offeror's revised Cost Proposal to compute the Offeror's revised cost points as detailed in Attachment E, Cost Point Calculation.

D. Phase IV. Selection Criteria

The total point value of the Technical Proposal Score will be 75% of the Maximum Available Points for the Technical and Cost Proposal. The Cost Proposal will comprise 25% of the Maximum Available Score available for the Technical and Cost Proposal. Ten (10) points may be added to the Offeror's total score for submitting no exceptions to the ODM Terms and Conditions. The point totals in the table are whole numbers having been rounded by generally accepted rounding methodology.

Criteria	Maximum Available Points
Proposal Technical Requirements	650
Proposal Cost	217
Maximum Available Points - Technical and Cost Proposals	867
Points for No Exceptions to ODM's Terms and Condition	+10
Maximum Available Points	**877**

The Offeror with the overall highest point total will be recommended for selection. If two or more of the Proposals have the same final score after calculation of the overall Proposal scores, the Proposal with the higher Technical score will prevail.

E. Phase V. (Optional) Interviews:

At the sole discretion of ODM, ODM may request one or more Offeror(s) that have submitted a Proposal to participate in an in-depth interview/discussion and/or demonstration of its Proposal. Offerors shall bear

all costs of any scheduled interview/discussion and/or demonstration. The purpose of this phase is to: (1) clarify an Offeror's Proposal and ensure a mutual understanding of the Proposal's content; (2) showcase an Offeror's approach to requirements in this RFP; (3) demonstrate the Offeror's professionalism, qualifications, skills and working knowledge; and (4) verify an Offeror's submission. If one or more interview/discussion and/or demonstration is conducted, the result of this phase may lead to the elimination of an Offeror's Proposal if, in ODM's sole determination, an Offeror fails to fulfil one or more of the purposes of this phase. Additionally, if an interview or demonstration occurs, ODM may develop scoring criteria to be used for all participating Offerors. These scores may be added to those Offerors' Proposal scores, or may replace certain criteria scores, at the discretion of ODM.

7.2 Veteran-Friendly Business Enterprise Program

A "Veteran-friendly business enterprise" (VBE) means a sole proprietorship, association, partnership, corporation, limited liability company, or joint venture that meets veteran employment standards as defined in rule 123:5-1-01(JJ) of the Ohio Administrative Code (OAC). OAC rule 123:5-1-16(B)(3) provides procedures for applying preference for VBE submissions. ODM will follow these procedures for any certified VBE Proposal submissions. VBE certification documentation must be included in the Offeror's Proposal.

The Veteran-Friendly Business Enterprise Program (VBE) applies to all state agencies' purchases made by bid or Proposal under Chapter 125 of the Ohio Revised Code (ORC). Essentially, the Program allows for:

A. Prices on bids submitted by veteran-friendly businesses to exceed those prices on bids submitted by businesses not certified as veteran-friendly by up to five percent and still be eligible for winning the award; and

B. Scores on Proposals submitted by veteran-friendly businesses can be up to five percent lower than the Proposal scores submitted by businesses not certified as veteran-friendly and still be eligible for winning the award.

7.3 Clarifications and Exceptions and Assumptions Review

ODM reserves the right to request clarifications from Offerors regarding any information in their Technical and/or Cost Proposals or related forms as it deems necessary at any point in the Proposal review process. Any such requests initiated by ODM, and Offerors' verbal or written response, shall not be considered a violation of the communication prohibitions contained in Section 2.3 of this RFP.

ODM may review submitted exceptions and assumptions and may enter into negotiations with one or more Offeror. ODM reserves the right to negotiate with Offerors for adjustments to their Proposals at any point in the Proposal review process should ODM determine, for any reason, to adjust the scope of the project for which this RFP is released. Such communications are not violations of any communications prohibition, and are expressly permitted when initiated by ODM, but are at the sole discretion of ODM. An Offeror must not submit a Proposal assuming that there will be an opportunity to negotiate any aspect of the Proposal, and any Proposal that is contingent on ODM negotiating with the Offeror may be rejected.

ODM may reject any Proposal if the Offeror takes exception to the terms and conditions of this RFP, includes unacceptable assumptions or conditions in its Proposal, fails to comply with the procedure for

participating in the RFP process, or fails to meet any requirement of this RFP. ODM reserves the right to reject, in whole or in part, any and all Proposals where ODM has determined that award of a Contract would not be in the best interest of the Offeree or the State; and ODM may decide not to award a contract to any or all of the Offerors responding to this RFP.

7.4 No Obligation to Award

ODM is under no obligation to issue a contract as a result of this, or any, solicitation. ODM reserves the right to not select any Offeror as a result of this solicitation.

7.5 Final Offeror Recommendation

The PRT will provide its recommendation to the Director of ODM (or the Director's designee) for review, approval, and award of the contract.

7.6 Contract Award

ODM plans to award the Contract based on the schedule in the RFP, so long as ODM decides the work is in ODM's best interest.

Included with this RFP, as Attachment D, is a sample of the Contract for the RFP. The Contract will bind ODM only when duly executed by ODM and the selected Offeror's authorized representatives. After Contract execution, ODM may issue a purchase order.

If ODM awards a Contract pursuant to this RFP, and the selected Offeror is unable or unwilling to perform the work, ODM may cancel the Contract, effective immediately on notice to the selected Offeror. ODM then may return to the evaluation process under this RFP and resume the process without giving further consideration to the originally selected Proposal. Additionally, ODM may seek such other remedies as may be available to ODM in law or in equity for the selected Offeror's failure to perform under the Contract.

SECTION VIII. PROTEST PROCEDURE

8.1 Protests

An Offeror objecting to any matter relating to this RFP may file a protest using the following guidelines:

A. Protests may be filed by a prospective or actual bidder 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 ODM;

5. A statement as to the form of relief requested from ODM; and

6. 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. A timely protest shall be considered by ODM if it is received by OCP as delineated below:

1. A protest based on alleged improprieties in the issuance of the RFP or any other event preceding the closing date for receipt of Proposals, shall be filed no later than the closing date and time for receipt of Proposals, as specified in Section 2.1, Anticipated Procurement Timetable, of this RFP.

2. For a protest based upon the award selection, a notice of an intent to file a protest shall be filed within 7 calendar days after issuance of the award and denial letters, and the protest shall be filed no later than 2:00 p.m. on the thirtieth (30^{th}) calendar day after issuance of the award and denial letters. The timestamp on the e-mail receipt shall be used to determine the timeliness of the protest.

C. A protest received by OCP after the time periods set forth in Item B of this Section may be considered by ODM if ODM determines that the protest raises issues significant to ODM's procurement system. ODM shall notify any Offeror who filed an untimely protest as to whether the protest will be considered.

D. All protests must be filed at the following location:

Deputy Legal Counsel, Office of Contracts and Procurement
ODM_Procurement@medicaid.ohio.gov

E. When a timely protest is filed, the selection or contract process may be suspended until a decision on the protest is issued or the matter is otherwise resolved, unless the Director of ODM determines that a delay will severely disadvantage ODM. The Offeror(s) who would have been awarded the contract shall be notified of the receipt of the protest, and may be offered the opportunity to respond.

F. ODM shall issue written decisions on all timely protests and shall notify any Offeror who filed an untimely protest as to whether or not the protest will be considered

SECTION IX. CONDITIONS AND OTHER REQUIREMENTS

This Section notifies Offerors seeking award of the contract of certain conditions and requirements which may affect their eligibility or willingness to participate in this procurement process, their eligibility to be awarded a contract, and of requirements that would be in effect should they be awarded a contract.

9.1 Start Work Date

The selected Offeror must be able to begin work no later than seven (7) working days after the issuance of a purchase order, or as directed by ODM. The selected Offeror will be notified by ODM when work may begin. Any work begun by the selected Offeror prior to notification by ODM will NOT be compensated.

9.2 Trade Secrets Prohibition; Public Information Disclaimer

Offerors are **prohibited** from including any trade secret information, as defined in ORC § 1333.61, in their Proposals. Any Proposals submitted in response to an ODM procurement effort which make claims of trade secret information may be disqualified from consideration immediately upon the discovery of such unallowable claim. ODM shall consider all submissions to be free of trade secrets and shall treat them accordingly. These submissions shall become the property of ODM.

Proposals received are deemed to be public records pursuant to ORC § 149.43. For purposes of this Section, the term "Proposal" shall mean both the Technical Proposal (or application or other response documentation) and the Cost Proposal submitted by Offerors/applicants and any attachments, addenda, appendices, or sample products. However, any Cost Proposals that are unopened at the conclusion of the procurement are not considered public record.

9.3 Contractual Requirements

A. Any contract resulting from the issuance of this RFP is subject to the terms and conditions as provided in the model contract, which is included as Attachment D of this RFP. The Offeror must review and sign Attachment F Terms and Conditions, agreeing to the Terms and Conditions of the model contract as part of their Proposal submission.

B. The Offeror, and any subcontractor(s), will not use or disclose any information made available to them for any purpose other than to fulfill the contractual duties specified in the RFP. The Offeror, and any subcontractor(s), agrees to be bound by the same standards of confidentiality that apply to the employees of ODM and the State of Ohio. Any violation of confidentiality will result in an immediate termination of the contract, and may result in legal action.

C. If this RFP results in a Contract award, the Contract will consist of this RFP, including all attachments, written amendments to this RFP, the Q&A, the Offeror's Proposal, and written, authorized amendments to the Offeror's Proposal. It also will include any materials incorporated by reference in the above documents and any purchase orders and amendments issued under the Contract. The form of the Contract is included as an attachment to this RFP, but it incorporates all the documents identified above. This set of materials supersedes any and all prior agreements, negotiations, correspondence, undertakings, promises, covenants, arrangements, communications, representations, and warranties, whether oral or written, of any party to this agreement. If there are conflicting provisions between the documents that make up the Contract, the order of precedence for the documents is as follows:

1. The Contract (Attachment D) in its final form

2. The RFP including supplements and attachments, along with the amended and clarified version of Offeror's Response as accepted by ODM
3. The attached Attachment C: Cost Proposal
4. The applicable Purchase Order

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.

9.4 Public Release of Evaluations and/or Reports

Any release of data, evaluations and/or reports or data sharing shall be role-based and project specific, and in accordance with state and federal regulations. Any requests for access to data will be directed by ODM and decisions about providing data to any parties will be at the sole discretion of ODM.

9.5 Ethical & Conflict of Interest Requirements

A. No contractor or individual, company or organization seeking a contract with ODM shall promise or give to any ODM employee anything of value that is of such character as to manifest a substantial and improper influence upon the employee with respect to his or her duties;

B. No contractor or individual, company or organization seeking a contract shall solicit any ODM employee to violate any of the conduct requirements for employees;

C. Any contractor acting on behalf of ODM shall refrain from activities which could result in violations of ethics and/or conflicts of interest. Any contractor or potential contractor who violates the requirements and prohibitions defined here or of ORC § 102.04 is subject to termination of the contract or refusal by ODM to enter into a contract; and

D. ODM employees and contractors who violate ORC §§ 102.03, 102.04 2921.42 or 2921.43 may be prosecuted for criminal violations.

9.6 Americans with Disabilities Act (ADA)

The selected Offeror, its officers, employees, members, and subcontractors will be required to meet the standards of current and ongoing compliance with all statutes and regulations pertaining to The Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

9.7 Confidentiality and Health Insurance Portability & Accessibility Act (HIPAA) Requirements

The selected Offeror must maintain the confidentiality of information and records in accordance with state and federal laws, rules, and regulations. As a condition of receiving the contract from ODM, the selected Offeror, and any subcontractor(s), will be required to comply with Title 42 of the United States Code (USC) § 1320-d, and the implementing regulations found at 45 CFR § 160 and § 164 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 selected Offeror from

or on behalf of ODM that meets the definition of PHI as defined by HIPAA and the regulations promulgated by the United States Department of Health & Human Services, specifically 45 CFR 164.501 and any amendments thereto.

9.8 Unresolved Findings for Recovery (ORC § 9.24), Labor Practices, and Debarments

A. **Unresolved Findings for Recovery**. ORC § 9.24 prohibits ODM from awarding a contract to any entity against whom the Auditor of State has issued a finding for recovery, if the finding for recovery is "unresolved" at the time of award. By submitting a Proposal, the Offeror warrants that it is not now, and will not become, subject to an "unresolved" finding for recovery under ORC § 9.24 prior to the award of any contract arising out of this RFP, without notifying ODM of such finding. ODM will review the Auditor of State's website prior to completion of evaluations of Proposals submitted pursuant to this RFP. ODM will not evaluate a Proposal from any Offeror whose name, or the name of any of the subcontractors proposed by the Offeror, appears on the website of the Auditor of the State of Ohio as having an "unresolved" finding for recovery.

B. **Unfair Labor Practices.** By submitting a Proposal, the Offeror warrants that neither the Offeror nor its principals are on the most recent list established by the Ohio Secretary of State, pursuant to ORC § 121.23, which would identify the Offeror as having more than one unfair labor practice contempt of court finding.

C. **Federal Debarment Requirements.** By submitting a Proposal, the Offeror warrants that neither the Offeror nor any of its principals or subcontractors, are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from that participation in transactions by any federal agency. By submitting a Proposal, the Offeror warrants within three years preceding their submission that neither the Offeror nor any of its principals:

1. Have been convicted of, or had a civil judgment rendered against them for commission of fraud or other criminal offense in connection with obtaining, attempting to obtain, or performing a federal, state, or local public transaction or contract under a public transaction; for violation of federal or state antitrust statutes; for commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements; or for receiving stolen property; or

2. Are presently indicted or otherwise criminally or civilly charged by a government entity (Federal, State, or local) for the commission of any of the offenses listed in Item 1 above and have not had any federal, state, or local, public transactions terminated for cause or default.

9.9 Mandatory Contract Performance Disclosure

Each response must disclose whether the Offeror or any proposed subcontractor has received a formal claim for breach of contract. For purposes of this disclosure, "formal claims" means any claims for breach that have been filed as a lawsuit in any court, submitted for arbitration (whether voluntary or involuntary, binding or not), or assigned to mediation. If any such claims are disclosed, Offeror shall fully explain the details of those claims, including the allegations regarding all alleged breaches, any written or legal action resulting from those allegations, and the results of any litigation, arbitration or mediation regarding those

claims, including terms of any settlement. While disclosure of any formal claims in response to this section will not automatically disqualify an Offeror from consideration, at the sole discretion of ODM, such claims and a review of the background details may result in a rejection of the Offeror's Proposal. ODM will make this decision based on its determination of the seriousness of the claims, the potential impact of the behavior that led to the claims could have on the Offeror's performance of the work, and the best interests of ODM.

9.10 Mandatory Disclosures of Governmental Investigations

Each response must indicate whether the Offeror and any of the proposed subcontractor(s) have been the subject of any adverse regulatory or administrative governmental action (federal, state, or local) with respect to Offeror's performance. If any such instances are disclosed, Offeror must fully explain, in detail, the nature of the governmental action, the allegations that led to the governmental action, and the results of the governmental action including any legal action that was taken against Offeror by the governmental agency. While disclosure of any governmental action in response to this Section will not automatically disqualify an Offeror from consideration, such governmental action and a review of the background details may result in a rejection of the Offeror's Proposal at the sole discretion of ODM.

9.11 Minority Business Enterprise Subcontracting Requirements

This RFP contains a sheltered solicitation subcontracting requirement which requires the Offeror to seek and set aside at least 15 percent of the work to be exclusively performed by Ohio certified Minority Business Enterprise (MBE) businesses. Proposal must include the selected subcontractor's name, MBE certification number, and the stated percentage of the cost of work to be performed. Proposal must also include a letter from the selected MBE subcontractor, on company letterhead and signed by an individual authorized to commit the business to performing the work outlined in the Proposal.

For more information regarding Ohio MBE certification requirements, including a list of Ohio certified MBE businesses, please visit the DAS Equal Opportunity Division website at:

http://das.ohio.gov/Divisions/EqualOpportunity/MBEEDGECertification/tabid/134/default.aspx.

A. **Sheltered Solicitation**. In seeking solicitations from Ohio certified MBE subcontractors, the Offeror must:

1. Utilize a competitive selection process to which only Ohio certified MBEs may respond;

2. Have established criteria by which prospective Ohio MBEs will be evaluated including business ability and specific experience related to the work requirements of this RFP; and

3. Require the Ohio certified MBE subcontractor maintain a valid certification throughout the term of the contract, including any renewals.

Tracking. The selected Offeror shall indicate on all invoices submitted for payment, the dollar amount attributed to the work provided by the selected Ohio certified MBE subcontractors. Compliance with Offeror's proposed cost set-aside percentage is a term of the awarded contract and failure to attain the

proposed percentage by the expiration of the contract may result in the Offeror being found in breach of contract.

Remedies. The selected Offeror may apply in writing to ODM for a waiver or modification of its proposed MBE set-aside cost percentage. However, a modification or waiver request may not be submitted before at least thirty percent (30%) of the work is completed or after eighty percent (80%) of the work is completed. Offeror shall submit evidence acceptable to ODM demonstrating that Offeror made a good faith effort to seek and maintain relationships with Ohio certified MBE subcontractors, in order to justify the granting of a waiver or modification. Within a reasonable amount of time, ODM will determine whether Offeror's good faith efforts and submitted documentation justify the granting of a waiver or modification. If a waiver or modification is denied, Offeror will have an opportunity to attain the percentage before the completion of the work. Compliance with any modified cost set-aside percentage will be a term of the contract and failure to attain the percentage by the expiration of the contract may result in the Offeror being found in breach of contract.

9.12 Corrective Action Plan

A Corrective Action Plan (CAP) is a technique to help ensure delivery of selected Offeror's services agreed upon in this RFP. A CAP is designed to mitigate the effects of selected Offeror's non-performance. A CAP is not a contract renegotiation or amendment. The CAP does not alter or amend the obligations set forth in this RFP. If selected Offeror is out of compliance with the terms of this RFP, the selected Offeror may submit to ODM a CAP. The CAP must include a full description of the deficiency, any actions or resources needed to address the deficiency, and the timeline and person(s) responsible for enacting the plan. Additionally, the ODM may, at its option, request a CAP to be completed by the selected Offeror.

SECTION X. ATTACHMENTS

A. Required Offeror Information and Certifications
B. Technical Proposal Score Sheet
C. Cost Proposal Form
D. ODM Model Contract
E. Cost Point Calculation
F. Acknowledgements, Exceptions, and Assumptions

Thank you for your interest in this project.

Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

Date: October 14, 2022

To: RFP Participants

From: Office of Contracts and Procurement

Re: ODMR-2223-0006 REQUEST FOR PROPOSALS
Clinical Utilization Management and Prior Authorization Addendum 1

This Addendum makes changes to the ODMR-2223-0006 RFP ("RFP"). Carefully read the Addendum, which is hereby incorporated into the RFP. To the extent that any term, sentence, or provision of the RFP contradicts or varies from this Addendum, this Addendum controls.

Addendum Adjusting Attachment C

The Review Breakdown Table on page 2 of 3 is hereby updated in the following:

(1) The Estimated Annual Volume of Reviews for the Prior Authorization for Home Health Services is updated to **NUMBER**.
(2) The Estimated Annual Volume of Reviews for the Prior Authorization for Private Duty Nursing is updated to **750**.

For your convenience, an updated Attachment C, Cost Proposal Form is included herein.