Ohio | Department of Job and Family Services

REQUEST FOR APPLICATIONS

Ohio Medicaid Managed Care Program

ISSUED BY:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Policy and Health Plan Services
RFA Number: JFSR1213-07-8019

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SECTION I - INTRODUCTION: GENERAL PURPOSE AND APPLICANT INFORMATION

I. A. Background

The Ohio Department of Job and Family Services (ODJFS) is the single state agency responsible for the administration of the Ohio Medical Assistance Program authorized under Title XIX of the Social Security Act (also referred to as Medicaid) and Title XXI of the Social Security Act (also referred to as the State Children's Health Insurance Program (SCHIP) implemented in Ohio as a Medicaid expansion program. Medicaid and SCHIP are federal and state funded assistance programs that provide health care coverage to certain low-income and medically vulnerable individuals of all ages. Ohio operates a combined Medicaid and SCHIP program. The Bureau of Policy and Health Plan Services (BPHPS) is the bureau within ODJFS' Office of Ohio Health Plans (OHP) that is responsible for the development, administration, and oversight of the Ohio Medicaid managed care program.

Medicaid is Ohio's largest health payer and covers approximately 2.2 million Ohioans (1 in 5) including 2 in 5 births. Medicaid spending accounted for approximately 30 percent of total state government spending and 4 percent of the Ohio economy in SFY 2010. While a significant component of Ohio's economy and health care delivery network, Medicaid's current rate of expenditure growth is unsustainable. A new and innovative way of meeting and delivering the health care needs of Ohio's most vulnerable population is needed and overdue.

On January 13, 2011, Governor John Kasich created the Office of Health Transformation (OHT) to address Medicaid spending issues, plan for the long-term efficient administration of the Ohio Medicaid program, and to improve overall health system performance (Executive Order 2011-02K). Medicaid

transformation has the potential to significantly impact both the personal health of many Ohioans and the financial health of the state.

The vision of OHT is to accomplish these goals using Governor Kasich's core principles of health transformation as a framework. These principles include:

- **Market-based** - Reset the rules of health care competition to incentivize keeping people healthy.
- **Personal responsibility** – Reward Ohioans who take responsibility to stay healthy and expect people who make unhealthy choices to be responsible for the cost of their decisions.
- **Evidence based** – Rely on evidence based data to complement a lifetime of experience, so doctors can deliver the best quality care at the lowest possible cost.
- **Transparent** – Make information about price and quality transparent, and get the right information to the right place at the right time to improve care and cut costs.
- **Value** – Pay only for what works to improve and maintain health – stop paying for what does not work including medical errors.
- **Primary care** – Transform primary care from a system that reacts after someone gets sick to a system that keeps people as healthy as possible.
- **Chronic disease** – Prevent chronic disease whenever possible and, when it occurs, coordinate care to improve quality of life and help reduce chronic care costs.
- **Long-term care** - Enable seniors and people with disabilities to live with dignity in the setting they prefer, especially their own home, instead of a higher-cost setting like a nursing home.
- **Innovation** – Innovate constantly to improve health and economic vitality – demonstrate to the nation why Ohio is a great place to live and work.

OHT has created a road map to improve the performance of Medicaid and to control costs. Several strategies have emerged that are based upon OHT's core principles to accomplish this goal, namely, improving health care coordination

and health outcomes for Medicaid beneficiaries. Improving care coordination will achieve better health outcomes and cost savings through the creation of a single point of care coordination, the promotion of health homes and accountable care organizations (ACOs). OHT's vision is further supported by OHP's Medicaid Quality Strategy. OHP's Medicaid Quality Strategy has five main priorities:

1. Make health care safer;
2. Improve health care coordination;
3. Promote evidence-based prevention and treatment practices;
4. Support person and family centered health care; and
5. Ensure effective and efficient administration.

Because the largest percentage of Ohio's Medicaid beneficiaries are enrolled in the managed care system (over 77%), one of the most efficient and effective ways to transform the Medicaid program to improve health outcomes and care coordination is to implement these strategies in the managed care system. This Managed Care Request for Applications (RFA) is designed to identify managed care plans that can provide managed care services utilizing a person-centered care management approach to optimize the health outcomes of individuals being served.

I. B. Purpose and Scope of Request for Applications (RFA)

The Ohio Department of Job and Family Services (ODJFS) is seeking Applicants to enter into a provider agreement for the delivery of medically necessary Medicaid covered health care services, and care coordination, to Ohio's managed care populations under a full risk arrangement. Successful Applicants will be expected to materially improve health outcomes for Ohio's Medicaid managed care populations by providing adequate access to all Medicaid covered medically necessary services and delivering efficient and effective coordinated care. The services required as part of the contract include, but are not limited to: providing covered health care services, establishing and contracting with a credentialed provider network, utilization management, care management,

provider services, financial management, claims management, sufficient information systems, promoting coordination and continuity of preventive health services and other services necessary to improving health outcomes. In order to assure the delivery of the above, rigorous contractual expectations, including comprehensive performance standards and monitoring processes will be utilized.

To date, Ohio's mandatory Medicaid managed care populations have been limited to the populations set forth in Ohio Revised Code 5111.16. With the passage of HB 153 by Ohio's 129th General Assembly in July 2011, through Ohio Revised Code 5111.16, ODJFS has the authority, contingent on approval from the federal government in some cases to include additional Medicaid eligibility groups in the managed care program in addition to the covered families and children (CFC) and a portion of the adult aged, blind, disabled (ABD) population that are currently covered under managed care. The additional Medicaid populations may include individuals who are in nursing homes, individuals who receive services through a Medicaid waiver, and individuals who are dually eligible for Medicaid and Medicare.

As of the implementation date of this RFA, ODJFS will include in the RFA, the segment of ABD children that are non-institutional, non-dual, non-spend down and non-waiver. Currently, there is a monthly average of 37,000 ABD children served through Ohio Medicaid's fee-for-service program at a cost of approximately $302 million per year. These children often have complicated and long-term medical conditions, but receive little assistance in accessing and coordinating care.

- The per member per month costs for this population increased by an average of 8% per year from FY07 to FY10.
- The major cost drivers for this population were Inpatient Hospital, Outpatient Hospital, Prescription Drugs, and Home Health Services.

These four categories of service accounted for 68% of the per member per month increase from FY07 to FY10.

- The number of emergency room visits per member per month for this population increased by 4% in both FY09 and FY10.
- The number of inpatient hospital admissions per member per month for this population increased by 2% per year from FY07 to FY10.

Without some form of care coordination, these children will continue to experience difficulties in managing complicated medical conditions, and have less than desirable health outcomes at a significant cost to the Medicaid program.

For a period of three (3) years from the implementation date of January 1, 2013, ODJFS reserves the right, in its sole discretion and upon federal approval if required, to enroll any additional Medicaid populations with the successful implementing Applicants of this RFA. As a condition of award and contracting with ODJFS, Applicants must agree to allow the addition of these additional categories of Medicaid populations into their health plan and to provide care according to revised terms in the Provider Agreement. Conversely, ODJFS may also issue future RFAs, or take other actions to implement alternative care programs with any Medicaid population or to allow the entry of additional care management options, including, but not limited to ACOs and patient-centered medical homes.

I. C. Ohio's Medicaid Program - Background

Individuals eligible for Ohio Medicaid generally fall into one of two categories: Covered Families and Children (also called CFC or Healthy Start/Healthy Families) and Aged, Blind or Disabled (ABD). In Ohio, the CFC population includes the Children's Health Insurance Program, Low Income Families, children, pregnant women, individuals age 19-20, current and former foster care children and transitional medical assistance populations pursuant to Chapter

5101:1-40 of the Ohio Administrative Code (OAC). While the CFC population is comprised of low-income families, pregnant women and children, the ABD population is comprised mostly of individuals with disabilities or those who are 65 years or older (for complete descriptions of these populations please see the Definitions section of this document). As of May 2011, there were 2,160,090 million total Medicaid beneficiaries comprised of 1,638,968 million CFC beneficiaries (76%), and 515,893 ABD beneficiaries (24%). Although the ABD population represents about 25% of all Medicaid members, it comprises over 70% of total Medicaid spending. Conversely, the CFC population represents approximately 75% percent of Medicaid population, but less than 30% percent of total Medicaid spending. One of Ohio Medicaid's main priorities is to improve health outcomes through enhanced systems of care management and coordination for all Medicaid beneficiaries.

Medicaid Delivery Systems

The Ohio Medicaid program currently delivers a comprehensive health care benefit package through two distinct delivery systems:

Fee-For-Service

The fee-for-service (FFS) system is a traditional indemnity health care delivery system in which payment is made to a health care provider after a service is rendered and billed. Providers must be licensed or certified to enter into provider agreements to serve Medicaid beneficiaries. In the FFS delivery system, Medicaid beneficiaries are generally free to seek care from any Medicaid provider.

Full-Risk Managed Care

The Ohio Medicaid managed care program operates under the authority of Ohio law in accordance with a State Plan Amendment approved by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. Ohio's managed care program operates statewide and currently includes the CFC population and certain members

of the ABD population. ODJFS enters into provider agreements with managed care plans (MCPs) that are licensed by the Ohio Department of Insurance and also meet ODJFS requirements. MCPs are paid on a per-member per month capitated basis, roughly mid-month of the month of coverage. (See Applicant Library for latest capitation payment schedule.)

Scope of Services Delivered by Ohio's Medicaid Managed Care Program

The MCPs assume the risk for all medical benefits and administrative costs (e.g., member services line, the 24/7 toll-free medical advice line for members, care management, etc.). MCPs must provide all services set forth in the latest executed Medicaid managed care provider agreement, including all medically necessary services as defined in Chapter 5101:3-26-03 of the Ohio Administrative Code (OAC). Services may be added or removed from the managed care delivery system as ODJFS makes revisions to OAC rules or the Medicaid provider agreement. In addition, should the dually eligible for Medicaid and Medicare or waiver populations be added to the system, an MCP may be required to provide services that are non-medical in nature (e.g., wheelchair ramps, connection to community support services, etc.).

I. D. Population and Service Regions

Covered Populations

Successful Applicants of this RFA will provide services to most of Ohio's Covered Families and Children (CFC) and a large portion of the Aged, Blind and Disabled (ABD) population.

Covered Families and Children (CFC): The CFC population includes individuals who have been determined eligible for the Medicaid program by meeting certain requirements for citizenship and residency, and the categorical and income requirements pursuant to Chapter 5101:1-40 of the Ohio Administrative Code (OAC) in one of following coverage categories: low-income families (LIF), children, pregnant women, children

in the custody of the public children services agency or private child placement agency, children in receipt of adoption or foster care assistance under Title IV Section E or state or federal adoption assistance, individuals age 19 through 20, former foster care individuals younger than 21 who have aged out of foster care, and transitional medical assistance. In Ohio, CHIP and non-ABD Medicaid are combined into the CFC program. CHIP beneficiaries are children with family income above 90% FPL and up to 200% FPL with no creditable insurance coverage. Creditable insurance coverage is defined in OAC rule 5101:1-37-01. The CFC population, with limited exceptions pursuant to ORC section 5111.16, will continue to be mandatorily enrolled in Ohio's Medicaid managed care program. Mandatory enrollment exceptions include: children receiving services through the program for medically handicapped children (Bureau of Children with Medical Handicaps or BCMH) established under ORC section 3701.023, children receiving Supplemental Security Income and children who receive services and/or payments under Title IV Section E of the Social Security Act (Foster Care and Adoption Assistance). These populations have the option of enrolling in Medicaid's fee-for-service system.

Aged, Blind, and Disabled (ABD): Ohio Revised Code section 5111.16 (as revised July 1, 2011) permits ODJFS to place certain ABD eligible individuals into Ohio's Medicaid managed care program. For a definition of ABD please see the Definitions section of the RFA. Applicants must be willing and able to provide care management and access to medical services to Ohio's ABD population. In Ohio, ABD individuals that are mandatorily required to participate in managed care under this RFA include: (1) ABD adults that are non-dually eligible for Medicare, non-institutional, and non-waiver; and (2) ABD children that are non-dually eligible for Medicare, non-institutional, and non-waiver. ABD children meeting the criteria in (2) above, and receiving services through the

program for medically handicapped children established under ORC section 3701.023, children receiving Supplemental Security Income and children who receive services and/or payments under Title IV Section E of the Social Security Act (Foster Care and Adoption Assistance) have the option of enrolling in Medicaid's fee-for-service system.

Regions

Based upon the desire to encourage market stability, increase consumer choices, preserve current utilization patterns, and simplify program administration for providers, ODJFS divided the state into three regions: Central/Southeast, Northeast, and West. Each region contains multiple counties as depicted in the regional map available in the Applicant Library. Applicants can apply for one or more region(s). Successful Applicants must serve all Medicaid members eligible for managed care within their region.

Section II - Program Requirements

Current program requirements for the Ohio Medicaid managed care program are found within the ODJFS Managed Care Plan (MCP) provider agreement, Chapter 5101:3-26 of the Ohio Administrative Code, Ohio Revised Code and the code of federal regulations (CFR). The following sections will assist Applicants in locating program requirements and provides a brief description of a few program highlights.

II. A. Applicant Library

Successful Applicants must meet and follow all Ohio Medicaid managed care program requirements. The information contained in this RFA is not an exclusive list of all program requirements. Program requirements are found within the Medicaid managed care provider agreement, Chapter 5101:3-26 of the Ohio Administrative Code and various provisions of federal and state law. All current program requirements, and any known changes to those requirements, can be found in the Applicant Library. The Applicant library may be accessed on-line at

http://jfs.ohio.gov/OHP/bmhc/ManagedCareRFA_LibrarySFY2013.stm. In addition, the applicant library contains several documents that further explain the operation of the program. In the applicant library, Applicants will find extensive information about program requirements and the future direction of Ohio's Medicaid program. The library includes, but is not limited to, the following topics:

- reference to specific federal and state law that directly affects Ohio's Medicaid managed care program;
- demographic and utilization information about the populations that will be served by managed care;
- information about payment rates and rate development;
- an explanation of the managed care enrollment process;
- Ohio's quality strategy;
- the current Ohio Medicaid managed care provider agreement including provider panel, pay-for-performance and transition of care requirements.

Note: All program requirements and covered services are subject to change at any time, including prior to a successful Applicant signing a provider agreement and throughout the operation of the program.

II. B. Highlighted Program Requirements

The following is a brief description of a few program requirements along with a preliminary list of functions that will be finalized after the release of the RFA. Refer to the materials in the Applicant Library for detail.

1. MCP Accountability and Pay-for-Performance (P4P) System

The top priority of Ohio Medicaid, improving health outcomes, is monitored and encouraged through a variety of methods, including the MCP accountability and P4P system. In addition to the strategies identified below, Ohio Medicaid continues to pursue promising strategies that increase the value of health care by

using payment reform as a means to reward the delivery of high quality person-centered health care. As a result, Ohio Medicaid recently joined the Catalyst for Payment Reform (CPR) and its partners to coordinate efforts to improve the value in health care purchasing. The guiding principles of this collaborative can be found at http://www.catalyzepaymentreform.org/Principles.html.

a. MCP Accountability

ODJFS has a statewide comprehensive strategy for assessing and improving the quality of health care services offered by MCPs. ODJFS sets expectations for performance as measured by both processes and outcomes. MCPs are held accountable to minimum levels of performance in key program areas. The current performance measures are located in the MCP Provider Agreement in the Applicant Library. MCP administrative functions and the quality of care received by MCP members will be evaluated using a broad set of administrative and performance measures. MCPs with performance levels below the minimum performance standards are subject to a progressive series of penalties, such as implementing corrective actions or monetary sanctions (see the MCP Provider Agreement in the Applicant Library).

b. Pay for Performance (P4P) Program

In addition to corrective measures, the Ohio Medicaid Managed Care Program uses financial incentives for MCPs to improve performance in program priority areas, as established in the ODJFS Quality Strategy. Beginning SFY 2013, MCP performance will be assessed on six clinical performance measures to determine the MCP's annual incentive payment. A set of standards will be set for each measure. The MCP's performance result, in comparison to these standards, will determine the amount of the incentive payment earned per measure. More money is awarded as MCP performance rises. (See the MCP Provider Agreement in the Applicant Library for more information on the P4P Incentive System.)

2. Care Coordination

Fostering a delivery system that is less fragmented, promotes clear communication, and ensures that patients and providers have access to accurate, timely information to optimize care is a key priority for ODJFS. This can be accomplished by implementing strategies to improve care coordination, defined as the planned organization of activities between patients and providers to ensure the appropriate delivery of health care services. In Ohio, Medicaid managed care plans perform care coordination activities for all of their beneficiaries. There are, however, beneficiaries with chronic illnesses who would benefit from intensive care coordination that can effectively be provided through care management programs or Medicaid health home services as summarized in the paragraphs below.

a. Care Management Programs

Managed care plans must provide care management services to monitor and coordinate the care for beneficiaries with special health care needs. ODJFS promotes a care management program approach that recognizes beneficiaries have varying needs and require differing levels of interventions. To that end, the MCPs must design a care management program using risk stratification levels (low, medium and high) to determine the intensity and frequency of follow up care that is required for each beneficiary participating in the care management program.

ODJFS is placing an emphasis on targeting those beneficiaries who are high risk/high cost, have uncoordinated care and for whom the MCP can have the greatest positive impact on health outcomes and cost. Given that these beneficiaries will demand an intense level of management and interaction, the MCP's high risk care management program must include the following components:

- Utilization of industry standard predictive modeling, health risk assessments, and physician referrals to identify beneficiaries' eligibility for care management;

- Completion of a comprehensive health assessment that evaluates the member's physical, behavioral, social and psychological needs;
- Development of an individualized, person-centered care treatment plan based on the health assessment that establishes prioritized goals and actions, facilitates seamless transitions between care settings, creates a communication plan with providers and beneficiaries, and monitors whether the beneficiary is receiving the recommended care;
- Identification of a single point of care management for the beneficiary;
- Formation of a multidisciplinary care management team;
- A minimum staffing ratio of 1 full time equivalent for every 25 beneficiaries in care management; and
- A minimum of one face-to-face encounter with the beneficiary every three months.

The MCP must also have a care management system that integrates information about the beneficiary in a meaningful way in order to facilitate effective care management. The system should have the ability to track the results of the health assessment and the care treatment plan, and have the ability to share care management information with the beneficiary, the primary care provider and specialists. The MCP must be able to submit a list of the beneficiaries who are being care managed to ODJFS for performance monitoring and reporting purposes in the electronic format specified in the RFA Library.

b. Medicaid Health Homes

The Medicaid Health Home initiative included in the SFY 2012-2013 budget expands the traditional medical home model by enhancing coordination of medical and behavioral health care consistent with the needs of individuals with severe and/or multiple chronic illnesses. Health Homes are an intense form of care management that includes a comprehensive set of services and meaningful

use of health information technology. For each chronically ill person in the Medicaid program, a Health Home will be required to:

- Provide quality-driven, cost-effective, culturally appropriate, person-centered services;
- Coordinate or provide access to high-quality and evidence-based preventive/health promotion services, mental health and substance use/dependence services, comprehensive care management across settings, individual and family supports, and long-term care services;
- Build linkages to other community and social supports to aid the patient in complying with their care treatment plan;
- Form a team of healthcare professionals and develop a person-centered care plan that integrates clinical and non-clinical health care needs and/or services;
- Establish a continuous quality improvement program; and
- Use electronic health records, link services with health information technology, and communicate across teams and with individual and family caregivers.

The Health Home initiative will build on the medical home initiatives already underway throughout Ohio. It will add to these efforts by taking advantage of the federal Affordable Care Act provision that allows states to claim a 90 percent federal match for eight quarters (two years) for a defined set of care coordination services for individuals who are severely chronically ill or have multiple chronic conditions.

Ohio's Medicaid Health Homes initiative will initially focus on Medicaid beneficiaries who meet the State's definition of serious and persistent mental illness (which includes adults with serious mental illness [SMI] and children with serious emotional disturbance [SED]), initially using a regional approach. Ohio's Community Behavioral Health Centers (CBHCs) will be eligible to apply to become Medicaid health homes for Medicaid beneficiaries with SPMI. The goals of Ohio's CBHC health homes for those with SPMI are aligned to those of CMS:

improve the integration of physical and behavioral health care; lower rates of hospital ED use; reduce hospital admissions and re-admissions; reduce healthcare costs; decrease reliance on long-term care facilities; improve the experience of care, quality of life and consumer satisfaction and improve health outcomes.

For further details on health homes, please refer to the RFA library and the CMS Health Homes Guidance Letter. All qualifying Medicaid patients under the care of a Health Home will receive these additional services, including those who are dually eligible for Medicaid and Medicare. The state will work with CMS to design payment methods that work for Ohio, and phase the program in by condition and/or geography.

MCPs will participate in the Health Homes initiative by performing the following functions:

- Participate in the formation of health home community collaboratives;
- Identify and enroll Medicaid eligible individuals for health home services using results from historical claims review, predictive modeling and health risk assessments;
- Provide financial management including payment for health home services and on-practice-site nurse care managers;
- Provide Care Management support such as patient utilization summaries, inpatient discharge coordination, Emergency Department use, 24/7 nurse lines, transportation coordination, education programs and materials, and coordinated care treatment plans;
- Provide outcomes evaluation on an individual level including data collection and member surveys;
- Provide Health Homes-related Health Information Technology (HIT) integration assistance.

c. Patient Centered Medical Homes (PCMH)

The Patient Centered Medical Home model of care is one that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient's family. Care is managed using modern tools such as registries, information technology, health information exchange and other means to assure that patients get the appropriate care when and where they need and want it in a culturally appropriate manner.

Ohio's first major step in moving toward this model is the recent establishment of the Ohio Patient-Centered Primary Care Collaborative (OPCPCC). The OPCPCC is a coalition of primary care providers, insurers, employers, consumer advocates, government officials and public health professionals who are joining forces to create a more effective and efficient model of healthcare delivery in Ohio.

Successful Applicants that support the Patient Centered Medical Home model of care will be expected to participate in the OPCPCC in order to help ensure that the PCMH model in Ohio achieves:

- Enhanced communication between providers, purchasers, and consumers;
- Identification and dissemination of best practices;
- Increased number of engaged patients, providers, employers & insurers (specific targets & dates to be set);
- Better care, better health, better satisfaction, better value; and
- National leadership in terms of collaborative process and sustainable model.

d. Pediatric Accountable Care Organizations (ACOs)

HB 153 of Ohio's 129th General Assembly invests $87 million in start-up funding and encourages children's hospitals and networks of physicians to team up to create pediatric ACOs, which will provide additional attention and care to the unique needs of 37,000 disabled children on Medicaid. Pediatric ACOs will hold participating physicians responsible for the quality of care delivered to patients and provide a financial incentive back to the providers for delivering high-quality, efficient care.

HB 153 specifically requires the department to develop a recognition system in the form of administrative code rules to recognize pediatric accountable care organizations as entities that would be able to meet the complex medical and behavioral needs of children with disabilities through new approaches to care coordination. Successful Applicants will be expected to participate in and support ODJFS's ACO initiative.

This is a preliminary list of functions that will be finalized after the release of this RFA. Once the functions are finalized, the functions will be specified by ODJFS in the MCP Provider Agreement.

3. **EPSDT – Early and Periodic Screening, Diagnosis and Treatment (HealthChek in Ohio)**

   EPSDT refers to Medicaid's comprehensive and preventive child health services for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes physical exams, immunizations, lead testing, vision testing, hearing testing, dental exams, developmental screenings, mental health screenings, follow-up treatment, support services and more. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to individuals eligible for EPSDT even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. The MCP must provide access to medically necessary EPSDT

services to all members under the age of twenty-one (21) years and submit reports as required by ODJFS. The MCP must comply with federal and state rules and provider agreement requirements, including those requirements applicable to EPSDT.

An MCP's obligations under EPSDT will consist of two mutually supportive, operational components: (1) assuring the availability and accessibility of required medical services; and (2) helping Medicaid beneficiaries and their parents or guardians effectively use these resources. MCPs must manage a comprehensive child health program of screening, prevention diagnosis and treatment, seek out and inform eligibles and their families of the benefits of prevention and available health services and assistance, assess the child's health needs through initial and periodic examinations and evaluations, and assure that the health problems found are diagnosed and treated early, before they become more complex and costly.

4. Staffing Requirements

Staffing Requirements – In State Positions

Past program experience indicates that there is significant value to having key staff located in Ohio. Having key operational personnel familiar with Ohio communities is essential to working towards Medicaid's goal of improving health outcomes and establishing a single point of care coordination. Therefore, the MCP is responsible for maintaining a significant local (within the state of Ohio) presence. Positions that must be located within Ohio include the following:

- Administrator/CEO/COO
- Medical Director/CMO
- Contract Compliance Officer
- Provider Services Representatives

- Care Management Director
- Utilization Management Director
- EPSDT/Maternal Child Health Manager
- Quality Improvement Director

An individual staff member is limited to occupying only one of the key staff positions listed above unless prior written approval is obtained from ODJFS. A summary of the basic responsibilities of each of these positions is included in the Applicant Library.

In addition to the staff positions identified above, successful Applicants will be required to maintain a member services call center in Ohio.

II. C. Integrated Data Systems

To effectively provide patient-centered coordinated care, the MCP must have a robust data system which integrates claims data with information related to patient demographics, care management activities, provider services, and appeals/grievances. The MCP must utilize a decision support system which is capable of producing patient-specific profiles and aggregate population-based reports. This system must support a workflow solution which enables the management of members' health care needs, including preventive services as well as interventions for those with high cost and/or chronic conditions. In addition, the MCP's data systems must be able to interface with providers, health care systems, and member support services to effectively coordinate care and transition members between care settings.

SECTION III – PROCUREMENT TIMELINE, APPLICANT INQUIRIES AND LETTER OF INTENT

III. A. Procurement Timetable

January 11, 2012	**ODJFS Releases RFA / Question & Answer Period Opens**
January 25, 2012	**Deadline for Submitting Questions to ODJFS (10 a.m. EST)**
February 17, 2012	**ODJFS Issues Final Applicant Questions & Answers**
February 27, 2012	**Potential Applicants Notify ODJFS of Intent to Submit Application by Region (3 p.m. EST)**
March 19, 2012	**Deadline for Application Submissions to ODJFS (3 p.m. EST)**
April 9, 2012	**ODJFS Issues Selection Notification Letters (estimated)** **Deadline to File Protest to Selections (8 days after issuance of selection notification letters)**
April – July 2012	**Estimated Readiness Review Phase for Selected Applicants**
August 31, 2012	**Provider Agreement Signed (estimated)**
January 1, 2013	**Initial Program Implementation (estimated)**

III. B. Applicant Inquiries – Question & Answer Process

Potential Applicants may ask clarifying questions regarding this RFA via the Internet during the Question & Answer Period as outlined in III A. "Procurement Timetable." To ask a question, potential Applicants must use the following Internet process:

* **Access the ODJFS Web Page at http://jfs.ohio.gov//**
* **Select "About JFS" on the front page**
* **Select "Doing Business with ODJFS"**
* **Select "Requests for Proposals (RFP), Letterhead Solicitations, and Other Invitations"**
* **RFA Number JFSR1213-07-8019**
* **Select "Ask a Question about this RFA" function**
* **Follow the instructions to send an e-mail question.**

Inquiries about this RFA must include: (1) the relevant part of this RFA, (2) the heading for the provision under question, and (3) the page number of the RFA where the provision can be found. The potential Applicant must also include: (1) the name of the representative for the potential Applicant, (2) the potential Applicant company name and (3) a business phone number for the representative.

ODJFS will not respond to any questions submitted after **10:00 a.m. EST** on **January 25, 2012.** ODJFS is under no obligation to acknowledge questions submitted through the Question & Answer process if those questions are not clarifying questions pertaining to this RFA or not in accordance with these instructions. ODJFS may, at its discretion, disregard any questions which do not appropriately reference an RFA provision or location, or which do not identify the name of the potential Applicant and its representative.

IMPORTANT: Requests for copies of previous RFAs, past applications, score sheets or provider agreements for this or similar past projects are Public Records Requests (PRRs), and are not clarification questions. PRRs should not be submitted through the Question and Answer process described above and the time frames for the ODJFS Question and Answer process for the RFA do not apply to PRRs.

Requirements under a past RFA or current provider agreement may or may not be required by ODJFS under this or any future RFA or provider agreement. If Applicants ask questions about existing or past RFAs or provider agreements using the Question & Answer process, ODJFS will use its discretion in deciding whether to provide answers. Applicants are to base their RFA responses and the details of their proposed operations, on the requirements and performance expectations established in this RFA and NOT on details of any previously released RFA.

ODJFS' responses to all questions received through the Question and Answer process will be posted on the Internet website dedicated to this RFA for reference by all potential Applicants. Potential Applicants will not receive personalized or individual e-mail responses. Clarifying questions asked by potential Applicants and ODJFS responses to them comprise the "ODJFS Question and Answer Document" for this RFA. If possible, ODJFS will post an interim Question and Answer Document, without identifying the names of the Applicants asking questions, as well as a final version (in which all Applicants that posed questions will be identified). Applicants are to ask questions as early as possible in the Question & Answer period so that interim answers can be posted with sufficient time for the possibility of Applicants' follow-up questions.

Applications for this RFA must take into account any information communicated by ODJFS in the final Question and Answer Document of this RFA. **It is the**

responsibility of all potential Applicants to check this site on a regular basis for responses to questions, as well as for any amendments or other pertinent information regarding this RFA.

Once the ODJFS Question and Answer Document is available, it will be accessible and will be clearly identified on the website dedicated to this RFA.

*Should Applicants experience technical difficulties accessing the ODJFS website where the RFA and its related documents are published, they may contact the ODJFS Office of Contracts and Acquisitions, RFA/RLB Unit, at (614) 728-5693 for guidance.

III. C. Letter of Intent

Potential Applicants with an interest in submitting an application must notify ODJFS by submitting a non-binding letter of intent. The letter of intent must be received no later than **February 27, 2012**, at 3:00 p.m. EST. The letter must be delivered to:

Office of Contracts & Acquisitions
ATTN: RFA/RLB Unit
Ohio Department of Job & Family Services
30 E. Broad Street, 31st Fl.
Columbus, Ohio 43215-3414

The letter of intent must include:

1. A statement of interest in submitting an application in response to this RFA;

2. The region or regions for which the Applicant intends to submit an application(s); and

3. A statement indicating that the Applicant understands that the state of Ohio and ODJFS have no liability or responsibility for any costs incurred by Applicants in preparing a response to this RFA, including undergoing the readiness review process, and that all such costs are the responsibility of the Applicant**.**

A list of all Applicants submitting a letter of intent and information regarding the regions of interest for each Applicant will be made available on the internet. This list can be found in the Applicant Library shortly after the submission date.

If ODJFS does not receive a letter of intent from Applicants by February 27, 2012 at 3:00 p.m. EST, then any subsequent application for this RFA will not be considered.

SECTION IV - APPLICATION, SCORING, SELECTION and READINESS REVIEW

IV. A. Definitions / Applicable Regulations

Throughout this RFA, the terms listed below are defined as follows:

Aged Blind or Disabled (ABD) Medicaid Beneficiary: A person who has been determined eligible for the Medicaid program by meeting certain residency, citizenship, income and asset requirements and by meeting one of the following criteria: aged 65 or older, blind as defined in 42 USC 1382c, or has a disability as determined by the Social Security Administration (see Chapter 5101:1-39 of the Ohio Administrative Code).

Some ABD beneficiaries access Medicaid services through the Medicaid fee for service delivery system and others through the Medicaid managed care delivery system. For a complete ABD population profile, Applicants should refer to the Applicant Library. For the scope of present and future enrollment in the managed care delivery system, Applicants should refer to Section I.D of this RFA.

Applicant: A health plan which submits an application in response to this RFA. In its application the Applicant must use the name of the health plan as it appears on the license issued, or the licensure application currently under review, by the Ohio Department of Insurance (ODI).

Applicant Library: The website located on Ohio's Medicaid managed care website that contains hyperlinks to referenced material useful to the Applicant in completion of this RFA. The website address is: http://jfs.ohio.gov/OHP/bmhc/ManagedCareRFA_LibrarySFY2013.stm. These materials include the current and proposed managed care Provider Agreement, demographic information and selected sections of the Ohio Administrative Code.

Care management: Care management is a collaborative process that assesses plans, implements, coordinates, monitors and evaluates the options and services required to meet a member's health care needs across the continuum of care. It is characterized by advocacy, communication, and resource management to promote quality, cost-effective, positive outcomes. For a complete listing of Care Management Program Requirements, the Applicant should refer to the MCP Provider Agreement, Appendix K.

Children's Health Insurance Program (CHIP): Enacted in 1997, CHIP is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The federal government matches state spending for CHIP but federal CHIP funds are capped.

Formerly known as **SCHIP**, or State Children's Health Insurance Program, the name was changed when the program was reauthorized in 2009.

Commercial: A line of business that a plan has that provides managed care services to public employees, private employers or plans that do not fit into any other line of business.

Corporate Family: Limited to the Applicant, the parent company for whom the Applicant is a subsidiary and any subsidiary of either the parent company or Applicant. All such entities must be shown on the Table of Organization that each Applicant is required to submit as part of Appendix A of the application.

Covered Families and Children (CFC) Beneficiary: Is a person who has been determined eligible for the Medicaid program by meeting certain requirements for citizenship and residency, and the categorical and income requirements pursuant to Chapter 5101:1-40 of the Ohio Administrative Code in one of following coverage categories: low-income families (LIF), children, pregnant women, children in the custody of the public children services agency or private child placement agency, children in receipt of adoption or foster care assistance under Title IV-E or state or federal adoption assistance, individuals age 19 through 20, former foster care individuals younger than 21 who have aged out of foster care, and transitional medical assistance. In Ohio, CHIP and non-ABD Medicaid are combined into the CFC program. CHIP beneficiaries are children with family income above 90% FPL and up to 200% FPL with no creditable insurance coverage. Creditable insurance coverage is defined in OAC rule 5101:1-37-01.

Delegated Entity: Is an entity that is not part of the Applicant or the Applicant's corporate family, but has a contract with either the Applicant or the Applicant's corporate family to perform business functions on behalf of the Applicant or the Applicant's corporate family.

Enrollee: A Medicaid eligible individual enrolled in Medicaid Managed Care.

Line of Business (LOB): For purposes of responding to this RFA, LOB is Medicaid, Medicare Part C only, and Commercial as defined herein.

Managed Care Plan (MCP): Otherwise known as plan, means a Health Insuring Corporation (HIC) licensed by ODI that enters into a provider agreement with ODJFS in the managed care program pursuant to rule 5101:3-26-04 of the Ohio Administrative Code.

Medicare: The Federal health insurance program created by Title XVIII of the Social Security Act for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Member: A Medicaid eligible individual enrolled in an MCP. Same meaning as enrollee.

Nursing facility (NF): Any long-term care facility (excluding intermediate care facilities for the mentally retarded/developmentally disabled), or part of a facility, currently certified by the Ohio department of health as being in compliance with the nursing facility standards and Medicaid conditions of participation.

Parent Company: A corporation or other business enterprise that owns controlling interests in one or more subsidiary companies.

Primary Care Provider (PCP): An individual physician (M.D. or D.O.), physician group practice, or an advanced practice nurse as defined in section 4723.43 of the Revised Code, or advanced practice nurse group practice within an acceptable specialty, contracting with an MCP to provide services as specified in paragraph (B) of rule 5101:3-26-03.1 of the Ohio Administrative Code. Acceptable specialty types include family/general practice, internal medicine, and obstetrics/gynecology (OB/GYN).

Provider Agreement: A formal agreement between ODJFS and an MCP for the provision of services to Medicaid beneficiaries who are enrolled in an MCP. (Note: ODJFS anticipates several amendments to the MCP

Provider Agreement effective January 1, 2013.) MCPs must execute the current version of the provider agreement as it exists at the time of execution.

Special Needs Plan (SNP): A special needs plan (SNP) is a special type of Medicare advantage plan that provides more concentrated health care for specific groups of people. It is designed to attract and enroll Medicare beneficiaries who are identified as special needs individuals on examination. According to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, special needs individuals are classified in three ways: (1) institutionalized beneficiaries (2) dually eligible beneficiaries and (3) beneficiaries with chronic conditions.

Subsidiary: A company whose voting stock is more than 50% controlled by another company, usually referred to as the parent company.

IV. B. Application Process

In order to be considered, an Applicant must meet the mandatory application requirements set forth below and submit a complete application by the deadline.

1. Mandatory Application Requirements.

The Applicants must meet all of the following mandatory requirements in order for ODJFS to consider the application:

a. Submission of the Letter of Intent detailed in Section III.C "Letter of Intent" by the specified deadline;
b. Meet the minimum EDI experience requirements set forth in Appendix A;
c. Submission of a complete application (Appendices A – E) no later than the specified deadline as indicated in Section III.A of this RFA, including a properly executed copy of the Applicant Information & Attestation/Acknowledgement (Appendix A); and
d. If the Applicant does not currently provide Ohio Medicaid managed health care services then the Applicant or its corporate family must currently serve at least 100,000 lives. ODJFS will review

information submitted in Appendix B to verify that this mandatory requirement is met.

2. Application

Only Applicants that meet the Mandatory Application Requirements will have their application scored by ODJFS. Applicants can receive a maximum of 100,000 points for each region. The following listing provides the maximum points available for each component (Appendices B - E) in the application:

Appendices of the Application	**Maximum Points**
A. Applicant Information & Attestation/Acknowledgement	Mandatory Requirement
B. Applicant's Contract/Compliance Experience	30,000
C. Clinical Performance	30,000
D. Care Coordination	30,000
E. Provider Panel	10,000
TOTAL	**= 100,000**

IV. C. Submission

Only one application will be accepted per Applicant. If more than one application is received from an Applicant, ODJFS at its sole discretion will choose which application to score. Applications must include all information specified in Appendices A – E. However, if the Applicant is applying for only one region, they must complete the portion of Appendix E related to the region in which the Applicant is applying.[1] If an Applicant is applying for only one region then only

[1]Appendix E contains various worksheets that are specific to the three regions specified in the RFA. Applicants applying for only one region need only complete that portion of Appendix E relevant to the selected region. See Appendix E for more information.

that portion of Appendix E that is relevant to the selected region will be reviewed and scored.

ODJFS will not consider any additional materials submitted by the Applicant in the evaluation and selection process if these materials were not required to be submitted pursuant to the instructions provided in the RFA. The attestation clause in the form set forth in Appendix A must be signed by an individual authorized by the Applicant to attest to the accuracy of all information submitted with the application.

ODJFS requires application submissions in both paper and electronic format. The application must be prepared and submitted in accordance with instructions found in this Section. The application submission must be comprised of:

8 paper copies (**one signed original** and **7** copies) and **8** CD-ROM copies.

The Applicant's total application submission and all required copies must be received by ODJFS no later than 3:00 p.m. EST on**, March 19, 2012.** Faxes or e-mailed submissions will not be accepted. **Applications must be addressed to:**

Office of Contracts & Acquisitions
Ohio Department of Job and Family Services
30 East Broad Street, 31st Floor
Columbus, Ohio 43215-3414
ATTN: RFA/RLB Unit

The Applicant's original application must contain all the information and documents specified in this RFA. All copies (both paper and CD-ROM) of the original application must include copies of ALL information, documents, spreadsheets and pages in the original application.

CD-ROMs must be labeled with the Applicant's name, the RFA number, and the application submission date or application due-date, at minimum. The requested CDs will be used by ODJFS for archiving purposes and for fulfillment of Public Records Requests and failure to include them or to properly label them may, at ODJFS' discretion, result in the rejection of the Applicant from consideration.

All application submissions must be received, complete, and at the above address, via mail or hand delivery by the above date and time. Materials received separately from an Applicant's submission will not be added to the proposal nor considered in the review and scoring process. Materials received after the date and time as stated above will not be included in any previous submissions, nor will they be considered. **ODJFS is not responsible for applications incorrectly addressed or for applications delivered to any ODJFS location other than the address specified above**. No confirmation of mailed proposals can be provided.

For hand delivery on the due date, Applicants need to allow sufficient time for downtown parking considerations, as well as for security checks at both the lobby of the Rhodes State Office Tower (address as stated above) and again on the 31st Floor. All applications must be received by the due date by the Office of Contracts & Acquisitions, on the 31st Floor of the Rhodes Tower.

Subject to the requirements of state and federal law, information provided in the applications will be held in confidence and not be revealed or discussed prior to the award of a provider agreement. All submissions become the property of ODJFS and may be returned only at the discretion of ODJFS. After the selection process is completed, **the entire content of the submitted applications will be available through ODJFS as public information.**

Any trade secret, proprietary, or confidential information (as defined in ORC 1333.61) found anywhere in an application to this RFA shall result in immediate disqualification of that application. ODJFS shall consider all applications voluntarily submitted in response to an ODJFS RFA to be free of trade secrets and such applications shall, in their entirety, be made a part of the public record. **Applicants must maintain all supporting data and documentation used in completing the application until December 31, 2012.**

Submission of an application indicates acceptance by the Applicant of the conditions contained in this RFA, unless clearly and specifically noted in the application submitted and confirmed in the provider agreement between ODJFS and the Applicant selected.

IV. D. Application Scoring

For each region, ODJFS will contract with four (4) Applicants that best demonstrate the ability to meet requirements as specified in this RFA and successfully pass readiness review. Applicants submitting a response will be evaluated based on the capacity and experience presented in their applications. All proposals will be reviewed and scored by an Application Review Team (ART), comprised of staff from the ODJFS Office of Ohio Health Plans, other ODJFS offices, or from other state agencies whose staff have appropriate expertise for evaluation of responses to this RFA. Applicants should not assume that the review team members are familiar with any current or past work activities with ODJFS. Applications containing assumptions, lack of sufficient detail, poor organization, lack of proofreading, and unnecessary use of self-promotional claims will be evaluated accordingly. ART members will be required to sign disclosure forms to establish that they have no personal or financial interest in the outcome of the application review and Applicant selection process. Scoring of any applications will be done through the consensus of the ART. The ART will read, review, discuss and reach consensus on the final technical score for each qualifying application.

Selection of the Applicant will be based upon the criteria specified in this RFA. Any applications not meeting the requirements established herein will not be scored or may be held pending receipt of required clarifications. The ART reserves the right to reject any and all applications, in whole or in part, received in response to this request. ODJFS may, at its sole discretion, waive minor errors, omissions, or other defects in Applicant's applications when those defects do not unreasonably obscure the meaning of the content.

Applicant responses to the RFA will be evaluated using the score sheets in the RFA, each provided at the end of the Appendix to which it refers. These separate score sheets taken in total constitute the Application Score Sheet, containing all criteria, and their relative importance within the entire RFA scoring process, on which applications will be evaluated and the successful applicant selected. There are no other criteria or standards beyond those established in these individual score sheets and the related scoring methodology. Applicants are not to fill in and return those score sheets with their applications. However, ODJFS strongly encourages Applicants to use them to evaluate the quality and responsiveness of their application packets prior to submission.

If an Applicant does <u>not</u> pass the Mandatory Application Requirements in Section IV.B.1, <u>or</u> score a minimum of 60,000 points for a region, then the Applicant will be excluded from selection for that region.

IV. E. Applicant Selection

Four plans will be selected for each of the three regions. Any Applicant that receives a tentative award in all three regions will be considered a "statewide" plan. ODJFS seeks to ensure some variation between regional applications and

is interested in creating opportunities for innovation in health care, which involve establishing strong, working community relationships. To ensure variation and to avoid four statewide plans, ODJFS will allow no more than three statewide plans. ODJFS will utilize a selection process that will tentatively award a provider agreement to each of the three highest scoring applications within a region, while guaranteeing that for each region; at least one managed care plan is unique to each region. The selection process is in two stages.

First stage:

The Applicants with the three (3) highest ranking scores in each region will be selected to enter into the readiness review process. This will be based on scores alone and may involve the use of tie breakers.

Second Stage:

The second stage will be applied sequentially in each region, starting with the West region, then the Northeast region and ending with the Central/Southeast region. For the West region, the highest scoring Applicant in the region will be selected as long as the Applicant has not been selected for a region in the first stage. However, an Applicant selected for the fourth place in the West region is not eligible for a fourth place selection in the Northeast or Central/Southeast regions.

For the Northeast region, the highest scoring Applicant in the Northeast region that was not selected in the first stage and not selected for the fourth place for the West region will be selected. An Applicant awarded fourth place in the Northeast region is not eligible for a fourth place in the Central/Southeast or the West regions.

For the Central/Southeast region, the highest scoring Applicant in the Central/Southeast region that was not selected in the first stage and not selected

for the fourth place selection in either the West region or the Northeast region will be selected.

In order to be selected to enter readiness review, an applicant must meet all minimum requirements. If a selected Applicant is found to not meet the minimum requirements, then the selection shall revert to the next highest scoring Applicant for that region that does not result in more than three statewide plans.

It is anticipated that there will be no more than four (4) selections made in each region. ODJFS reserves the right to utilize the results of this RFA for up to two years from the date of initial selection to enter into a provider agreement with another selected MCP to assure consumers have at least three MCP options in a region. ODJFS may enter into a provider agreement with the next highest scoring MCP that meets minimum qualifications and passes the readiness review process in a timely fashion.

Handling Tie Scores between Applicants

If a successful Applicant in a region cannot be determined as a result of tie scores, then ODJFS will use the scores on individual components of the application to break the tie. ODJFS will compare the scores on individual application appendices in the following order:

1. C. Health Outcomes
2. D. Care Coordination
3. E. Provider Relations (combine all Appendix E's for the statewide award process)
4. B. Applicant's Contract/Compliance Experience

The first Applicant to score higher on an appendix will be chosen. If a tie remains after comparing the scores on the individual appendices as listed above, then the tie will be broken by a random selection method.

ODJFS is under no obligation to issue a provider agreement as a result of this solicitation if, in the opinion of ODJFS and the proposal review team, none of the

applications are responsive to the objectives and needs of ODJFS. ODJFS reserves the right to not select any vendor should ODJFS decide not to proceed. Changes in this RFA of a material nature will be provided via the agency website. All vendors are responsible for obtaining any such changes without further notice by ODJFS.

All applications and any other documents submitted to ODJFS in response to the RFA shall become the property of ODJFS. The RFA and, after formal announcement by ODJFS of the results of this RFA project (e.g., notices provided to responding Applicants regarding Applicant selection, notice of project cancellation, etc.), any applications submitted in response to the RFA are deemed to be public records pursuant to O.R.C. 149.43. For purposes of this section, "application" shall mean all materials submitted including the application, any attachments, addenda, or appendices submitted by the Applicant.

IV. F. Protest

Any potential, or actual, Applicant objecting to the award of a provider agreement resulting from the issuance of this RFA may file a protest of the award of the provider agreement, or any other matter relating to the process of soliciting the applications. Such a protest must comply with the following guidelines:

A. A protest may be filed by a prospective or actual bidder objecting to the award of a provider agreement resulting from this RFA. The protest shall be in writing and shall contain the following information:

1. The name, address, and telephone number of the protestor;
2. The name and number of the RFA 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 ODJFS;

5. A statement as to the form of relief requested from ODJFS; 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 ODJFS, if it is received by ODJFS' Office of Legal & Acquisition Services, within the following periods:

1. A protest based on alleged improprieties in the issuance of the RFA or any other event preceding the closing date for receipt of applications which are apparent or should be apparent prior to the closing date for receipt of applications shall be filed no later than 3:00 p.m. the closing date for receipt of applications, as specified in Section III.A, Procurement Timetable, of this RFA.

2. If the protest relates to the announced intent to award a provider agreement, the protest shall be filed no later than 3:00 p.m. of the seventh *(7th)* calendar day after the issuance of formal letters sent to all responding Applicants regarding the State's intent to make the award. The date on these ODJFS letters to responding Applicants is the date used to determine if a protest regarding the intent to award is submitted by the end of the protest period.

C. An untimely protest may be considered by ODJFS if ODJFS determines that the protest raises issues significant to the department's procurement system. An untimely protest is one

received by ODJFS' Office of Legal & Acquisition Services after the time periods set forth in Item B. of this section.

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

Chief Legal Counsel
ODJFS Office of Legal & Acquisition Services
30 East Broad Street, 31st Floor
Columbus, Ohio 43215-0423

E. When a timely protest is filed, a provider agreement shall not proceed until a decision on the protest is issued or the matter is otherwise resolved, unless the Director of ODJFS determines that a delay will severely disadvantage the Department. The Applicant(s) who would have been awarded the provider agreement shall be notified of the receipt of the protest.

F. ODJFS' Office of Legal & Acquisition Services shall issue written decisions on all timely protests and shall notify any Applicant who filed an untimely protest as to whether or not the protest will be considered.

IV. G. Readiness Review Process

Upon receiving a tentative award, an Applicant must successfully complete readiness review in order for ODJFS to enter into a provider agreement with the Applicant. The Applicant must demonstrate to ODJFS' satisfaction that it can and will meet all program requirements including accurate and timely completion of all information system functions, operational readiness to transition potential members (e.g., adequate provider panel, call centers, new member materials, pharmacy program, and program

integrity), and the ability to provide adequate access to all Medicaid-covered medically necessary services. Should the Applicant not be able to demonstrate this to ODJFS' satisfaction within 60 days of receiving notice of being selected to receive the tentative award, then ODJFS may offer the provider agreement to the next highest scoring Applicant per the selection criteria. ODJFS in its sole discretion may allow time in addition to 60 days for completion of readiness review.

Readiness review will begin with a face-to-face meeting in Columbus, Ohio, between the Applicant and ODJFS to determine a timeline and to identify all necessary submissions to document readiness. Successful Applicants should expect the face-to-face meeting to occur within the week following release of the tentative awards. In addition, prior to implementation and the MCP's initial receipt of membership, ODJFS, or its designee, may conduct a site visit to confirm all necessary components are in place.

ODJFS expects to begin enrollment on a regional basis beginning January 1, 2013. **ODJFS retains the right to phase-in regions and enroll Medicaid eligible individuals based upon ODJFS, MCP, or community readiness.**

Note: An Applicant selected by ODJFS to receive a provider agreement must consider all ODJFS program requirements to be non-negotiable. Failure to agree to meet these requirements will render the ODJFS selection of the Applicant null and void. All MCPs will have opportunities to provide input on the ODJFS program requirements after execution of their provider agreements.

APPENDICES

Each individual appendix is comprised of instructions for completing the appendix, the form(s) that must be completed and submitted as part of the application, and the scoring methodology. Applicants are NOT to fill out and submit any scoring documents. The scoring methodology and any scoring sheets were included in the Request for Applications (RFA) for the purpose of providing the Applicant with an understanding of the relative importance of the information that is required to be submitted and how applications will be evaluated and Applicants selected. Applicants are strongly encouraged to use all scoring information, including scoring sheets, to evaluate their own application packages for completeness, quality, and compliance with instructions and requirements prior to submitting them to ODJFS. Fillable forms are located in the RFA Applicant Library at the link below.
http://jfs.ohio.gov/OHP/bmhc/ManagedCareRFA_LibrarySFY2013.stm