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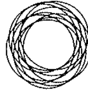

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June 10, 2011

Hand Delivered

Mr. Thomas J. Betlach, Director
Mr. Michael Veit, Chief Procurement Officer
Contracts and Purchasing Administrator
Arizona Health Care Cost Containment System
Contracts and Purchasing Section
701 East Jefferson, MD 5700
Phoenix, Arizona 85034

Appeal of Decision of Procurement Officer: MCP Protest of Award for ALTCS - Pima and Santa Cruz Counties (GSA 50), Solicitation Number YH12-0001

Dear Director and Mr. Veit:

This firm represents Southwest Catholic Network Corporation, dba Mercy Care Plan ("Mercy Care" or "MCP"). Mercy Care protested the decision of the Arizona Health Care Cost Containment System ("AHCCCS") declining to award Mercy Care the Arizona Long Term Care System ("ALTCS") contract for Pima and Santa Cruz counties. By decision dated June 3, 2011, the Contract and Purchasing Administrator awarded Mercy Care an additional point, but denied all other bases of protest asserted by Mercy Care. A copy of the Administrator's June 3, 2011, decision is attached hereto as Exhibit 1. As a result of the Administrator's decision, a difference of .37 points exists between Mercy Care and the successful bidder. As explained in detail below, scoring errors remain which, if corrected, would result in the award of the contract to Mercy Care for Pima and Santa Cruz Counties. Accordingly, Mercy Care appeals the June 3, 2011, decision of the Contracts and Purchasing Administrator and requests a hearing pursuant to Arizona Administrative Code ("AAC") R9-22-604(I)(2)(d). Mercy Care is also open to a meeting with AHCCCS on these issues to promote discussion and mutual understanding in an attempt to avoid further legal proceedings.

As required by AAC R9-22-604(I)(2), Mercy Care provides the following information:

Interested Party/Protesting Party:	**Southwest Catholic Health Network Corporation dba Mercy Care Plan 4350 East Cotton Center Blvd., Bldg. D Phoenix, Arizona 85040 (602) 453-8365**
Bid Solicitation Number:	**YH12-0001**
Relief Requested:	**Award of the ALTCS Contract for Pima and Santa Cruz Counties**

All additional information required by the Administrative Code, including a detailed statement of the legal and factual basis for the appeal, are provided in the remaining portions of this letter. Copies of all relevant documents are included as exhibits or have been provided with the protest and are cross-referenced in this letter.

I. AHCCCS FAILED TO PROVIDE REQUESTED DOCUMENTS IN SUPPORT OF ITS CALCULATIONS

In its protest, Mercy Care pointed out an error in the transcription of Mercy Care's score on the "Encounters Submission Requirement" subcategory. Mercy Care was awarded 6 points in this subcategory. However, only 5 points were transferred to the AHCCCS scoring sheet for the "Encounters" calculation table. Accordingly, Mercy Care was shorted a point under this category. The Administrator provided the following response to this protest point:

***Response*:** AHCCCS has verified that MCP's final score for the Encounter Submission requirement was six points. This value was correctly recorded on the total Organization score sheet used to calculate MCP's final score.

***Decision*:** No additional point is awarded.

***Appeal*:** AHCCCS has provided no support for its position. Mercy Care requested copies of all scoring materials to permit it to evaluate its bases for protest. AHCCCS failed to provide any Master Scoring Tool showing how the points for each bidder were totaled and weighted. On May 17, 2011, Mercy Care followed up with the Administrator specifically requesting this information:

> I wanted to touch base with you regarding Mercy Care's bid protest relating to the ALTCS program. As I understand it, the Mercy Care team requested all scoring materials. Scoring sheets were provided, but no master scoring tool. As you are aware, points from the scoring sheets are weighted to reach a total score. Without the master scoring tool, Mercy Care is unable to confirm the mathematical calculations or to determine the impact of various scoring errors on its total score. This information is critical to the protest.
>
> We are requesting AHCCCS to provide the master scoring tool immediately so that Mercy Care can timely complete its protest.

[Exhibit 2] The Administrator has not responded to this request, and AHCCCS has never provided the final calculations.[1] Yet, it maintains that the Master Scoring Tool, which it has

[1] This violates A.R.S. § 32-121, *et seq*. Continued failure to respond may force Mercy Care to file an action against AHCCCS pursuant to A.R.S. § 39-121.02.

never provided, proves that there was no error in the total scores. Mercy Care questions whether all six points were, in fact, awarded because the calculation table provided by AHCCCS clearly reflects only five points transferred for the subcategory "Encounters." Mercy Care respectfully maintains that the failure to provide the requested Master Scoring Tool, as well as the decision regarding the apparent calculation error, is improper. Mercy Care should have been provided with the requested information and, based on the documentation in its possession, it is entitled to the award of an additional point.

II. SCORING ERRORS

GRIEVANCE & APPEALS

Question 15 - Provide a flowchart and comprehensive written description of the Offeror's grievance system. At a minimum, the description should include the member grievance and appeal process, and the provider and subcontractor claim dispute process. Include in the description how data resulting from the grievance system is used to improve the operational performance of the Offeror. The submission requirement will be maximum of four pages of narrative with a maximum of three pages of flowcharts.

Submission/ Question Number	AHCCCS Evaluation/Scoring Criteria
15-1	Did the Offeror's description include flowcharts and written descriptions for grievances, including (must meet a through c below to receive point): a. When, where and how to file b. Resolution requirements, including timeliness in accordance with AHCCCS rules. c. Response requirements (Scored 0 out of 1 point)
15-2	Did the Offeror's proposal include flowcharts and written descriptions for appeals, including (must meet a through c below to receive point): a. When, where and how to file b. Resolution requirements, including timeliness in accordance with AHCCCS rules c. Notice requirements (Scored 0 out of 1 point)

According to the AHCCCS Scoring Team notes, Mercy Care did not receive full points on 15-1 and 15-2 because it failed to state "where" grievances and appeals can be filed. As explained in Mercy Care's protest, however, Mercy Care's proposal states that such information is explained by the Case Manager and can be found in the member handbook and on Mercy Care's website.

The last paragraph above the "Member Grievances" section of the Proposal clearly includes the requisite information. That paragraph states:

> Our members and their families/caregivers are educated regarding their grievance, appeals, and State Fair Hearing rights by their Case Manager (CM) during the initial in-person assessment. The CM gives and reviews with the member a new member packet. This packet includes a: a) member handbook, b) provider directory including a zip code specific urgent care listing, c) information on HIPAA, d) member rights and responsibilities acknowledgement, e) Critical Service Gap Report Form, f) self-directed attendant care pamphlet, and g) advance directives form. The CM thoroughly reviews items from the member handbook such as: instructions on how to file a grievance or appeal or request a State Fair Hearing; the entire spectrum of Long Term Care (LTC) services; behavioral health crisis line; translation and transportation services. At the same time, the member and member's family/caregiver are advised that if the member or member's family/caregiver is unable to file a grievance or appeal themselves, their CM, as the member's advocate will assist the member or member's family/caregiver in completing the process. (Proposal, page 130) (Emphasis supplied). Mercy Care's proposal also states that, "this information is also available on our website and at no cost to the member or the member's family/caregiver by contacting either the CM or our Member Services Department (via our toll-free line)." (Proposal, page 130) (emphasis supplied). Both the handbook and the website provide the necessary information, including an address and phone number, directing members how to file grievances.

The Administrator declined to award any points, however, and gave the following response:

Response: MCP's statement that information on how to file member grievances or appeals is contained in the handbook and website, and is covered by case managers, is not sufficient to be awarded the point. The evaluation team required the Offeror to specify where members file grievances and appeals: by address, phone number, or a website containing an address and phone number. While MCP's proposal covered how and when members could get assistance in filing a grievance or appeal, it did not specify where members file grievances and appeals.

Decision: No additional point is awarded for either 15-1 or 15-2.

Appeal: Mercy Care respectfully disagrees with this response and decision. Mercy Care does provide information by which members will be notified of where grievances and appeals can be filed. The criteria here is whether Mercy Care provides critical information for filing grievances to its members, such as when, where, and how to file. Mercy Care's proposal makes clear that the Mercy Care handbook, which is provided to every member, includes the necessary

phone numbers, address, and website information. Thus, Mercy Care has satisfied the fundamental requirement set forth by item 15-1 and the Administrator's decision is unfounded. Indeed, AHCCCS is presumably not interested in obtaining the specific phone number, address, or website – it has that information about Mercy Care. Rather, it is presumably interested in knowing that Mercy Care provides that information to its members and, it is clear that Mercy Care does. By denying Mercy Care points, the Administrator is putting form over substance.

Further, the Administrator's position that a specific address, phone number or website must be included in the proposal is belied by the fact that full points were awarded on the proposal of Bridgeway Health Solutions which stated that grievance and appeal procedures are communicated to members via a member handbook. (Bridgeway Proposal, page 150). No specific address, phone number or website was provided. Yet, Bridgeway received full points. The two responses provide the same information but were scored differently. This is plainly improper and Mercy Care, like Bridgeway, should be awarded full credit for 15-1 and 15-2, amounting to 2 points.

CASE MANAGEMENT

Question 22 - Describe the process the Offeror will employ in assessing and meeting the needs of complex care members via service planning and coordination of multiple providers and involved entities specifically for (1) members needing behavior management and (2) members with complex medical care needs.

Submission/ Question Number	AHCCCS Evaluation/Scoring Criteria
22-5	The Offeror's narrative mentions Nursing Facility, Home and Community Based, Assisted Living Facilities/Centers as viable placement settings for these members (need to have all three mentioned to receive the point). (Emphasis supplied) (Scored 0 out of 1 point)

Submission Number and Evaluation Item 22-5

Mercy Care's proposal addresses all three placement settings identified in evaluation criterion 22-5 as options for members with complex medical conditions or who have behavioral health issues. Specifically:

- "Mercy Care's Case Management program has been working with ALTCS complex care members since 2000. Mercy Care has been continuously enhancing the Case Management program to meet the needs of its complex care members. As a result, in 2004 MCP established two specialty teams – high risk behavioral health (BH team) and Medically

Complex Care team (MCCT) – to serve members with the most severe behavioral and complex care issues." (Proposal, page 150) (emphasis supplied).

- "Members assigned to one of the complex care teams are identified in a variety of ways …" and "[o]ur general CMs are assigned a case load based on the member's placement in either a home setting, Assisted Living Facilities, or Nursing Homes." (Proposal, page 150 and FN 2) (emphasis supplied).

- "MCP identifies members to be assigned to the Medically Complex Care Team (MCCT) due to their complex chronic care needs … [and] members are identified for management by the MCCT if they are: 1) residing in the community/assisted living facilities … or 2) residing in a nursing facility…. Due to these special complex care needs, these members are assigned to MCP RN CMs for optimal case management and service coordination." (Proposal, page 151) (emphasis supplied).

Despite the fact that Mercy Care addressed all three placement settings, the Administrator denied this protest point on the following basis:

Response: Although the Offeror's proposal notes that MCP assigns case managers to members based on the various types of placement settings, the proposal fails to discuss the process for ensuring that all three placement settings are considered as viable options for members needing behavior management and members with complex medical care needs.

Decision: No additional point is awarded.

Appeal: The Administrator is improperly adding a new scoring criterion. The specified criterion is whether the three placement settings are "mentioned." While the Administrator concedes that Mercy Care's proposal mentions all of the placement settings as required by the scoring criterion, he denies this protest point because Mercy Care purportedly "fails to discuss the process for ensuring that all three placement settings are considered as viable options for members...." But the scoring criterion does not require a discussion of the process, only that the three placement settings be mentioned. The denial of this protest point constitutes the improper insertion of additional criteria and should not be permitted. Because Mercy Care fully met the AHCCCS scoring criterion, it should be awarded an additional point under this section.

Question 24 – Program – Case Management Scenarios.

Submission/ Question Number	AHCCCS Evaluation/Scoring Criteria
24-A(4)	Other proposed steps/actions likely to improve members/caregivers' health, quality of life, and overall system experience. (Scored 0 out of 5 points)

Submission/ Question Number	AHCCCS Evaluation/Scoring Criteria
24-B(3)	Other proposed steps/actions likely to improve members/caregivers' health, quality of life, and overall system experience. (Scored 0 of 5 points)
24-C(3)	Other proposed steps/actions likely to improve members/caregivers' health, quality of life, and overall system experience. (Scored 0 of 5 points)
24-D(4)	Other proposed steps/actions likely to improve members/caregivers' health, quality of life, and overall system experience. (Scored 0 of 5 points)

Submission Numbers and Evaluation Items 24-A(4), 24B(3), 24(C)(3), and 24-D(4)

The scoring methodology for case management scenarios included points for "other proposed steps/actions likely to improve members/caregivers' health, quality of life and overall system experience." To be eligible for points, these steps/actions could not belong in one of the defined categories for which points also would be awarded. On each of the evaluation items noted above, Mercy Care was awarded 0 out of 5 points, and the AHCCCS Scoring Team Notes stated that Mercy Care's responses fell within the parameters of the pervious categories. As explained in the protest, however, Mercy Care's proposal, in each instance, went beyond the parameters of the other categories in the question. Specifically:

With respect to 24-A(4), Mercy Care's proposal states:

- "Patient Centered Medical Home" as part of PCP choice action (Proposal, page 156 – "Oscar is also made aware of our Patient Centered Medical Home (PCMH) program that serves members through "in-home" visits at the member's placement (NF, ALF or the member's home) that is part of his PCP choice options.");

- Family night/social interaction and "Respite Care" (Proposal, pages 157- 58 – "Additionally, the CM recommends, with Oscar's agreement, that the Activities Director schedule a family night where Oscar's family/friends can visit, have dinner, and socialize.");

- Inquiry about satisfaction with services (Proposal, page 156 – "The CM also asks Oscar about his satisfaction with the services provided in the NF, identifies issues to be investigated and, if necessary, files a grievance on Oscar's behalf.")

With respect to 24-B(3), Mercy Care's proposal states:

- "The CM discusses with Magda and Raquel the challenges associated with caring for and having the early stages of dementia." (Proposal, page 160)
- "The CM offers community resources such as the Alzheimer's Association which provides resources and education for members and families living with dementia." (Proposal, page 160)
- "Raquel and the family will be encouraged to attend regularly scheduled support groups offered for caregivers and to perhaps take Magda, since individuals in the early stage of the disease are also invited to the meetings." (Proposal, page 160)

With respect to 24-C(3), Mercy Care's proposal states:

- "Depending on Wanda's care plan, the PCP may want to consider if hospice is an appropriate option for Wanda. If hospice is appropriate, the PCP will discuss the option with Wanda and her son to determine what their wishes are…." (Proposal, page 162)
- "The CM explains that MCP LTC members enrolled with Mercy Care Advantage are able to use the contracted Patient Centered Medical Home (PCMH) program that serves members through "in-home" visits at the member's placement (NF, ALF or the member's home). The CM will assist in coordinating care with Wanda's current PCP and MAP if Wanda would like to continue with her current plan. If Wanda and her son choose to enroll in the PCMH program described above, and choose to enroll in MCP's MAP, the CM will assist in coordinating the change so Wanda will be eligible at the beginning of the following month." (Proposal, page 162.)

With respect to 24-D(4), Mercy Care's proposal states:

- "Joyce will be provided with family/caregiver support group information, such as the Brain Injury Association of Arizona, Alliance for the Mentally Ill and TBI Caregivers Support Group." (Proposal, page 164) (emphasis supplied).
- "The BH CM will ask Roger if he has any recall of the support services he received in the other state. The BH CM will review the medical records from the other state to see if they can determine the support services he received. The BH CM will discuss with Roger his interests and preferences for meaningful activities such as the TBI Adult Day program." (Proposal, page 165) (emphasis supplied).

Discounting these additional actions that are designed to meet the criteria of improving health, quality of life and system experience, the Administrator again imposes new requirements in each category:

> The steps/actions also would have to be atypical modalities that went above and beyond basic and ordinary actions of case managers, such as arranging community referrals and covered services.

(Denial letter, pages 6, 8 and 9).

The Administrator gave the following response on each of these items:

Response: This evaluation item required responses which documented activity beyond the standard of care and routine expectations. The activities described by MCP are not exceptional and are considered routine processes.

Decision: No additional points are awarded.

Appeal: Once again, the Administrator's denial is based on additional requirements not contained in the scoring criteria. The scoring criteria require the identification of actions "likely to improve members/caregivers' health, quality of life, and overall system experience" that are outside the parameters previously discussed in the question. Mercy Care's proposal meets these requirements in each instance. In denying these protest points, however, the Administrator inserts the additional criteria that the actions must be "atypical modalities that went above and beyond basic and ordinary actions of case managers...." The insertion of new scoring criterion to provide a basis for protest denial is inappropriate.

Moreover, Mercy Care respectfully disagrees that the extra actions identified are "basic and ordinary" and "routine." Indeed, Mercy Care is not required by contract, the RFP, or the AHCCCS Medical Policy Manual ("AMPM") – three guidelines that set forth the standard of care – to provide the additional services that are described in its proposal. Therefore, the actions listed in the proposal are, by definition, not routine or part of the standard of care. Neither the Scoring Team nor the Administrator reference any materials beyond their own undocumented subjective judgment, which is inadequate support for this conclusion. Their failure to cite any evidence supporting their subjective assertion that these activities are routine demonstrates that the activities are not, in fact, routine. The objective guidelines set forth in the contract, RFP and AMPM establish that the activities listed in Mercy Care's proposal are above and beyond. Full points should be awarded for these items, for an additional 20 points.

24-B(2)	Consideration of other in-home services • Interpretation/translation services • Assistance with change of PCP • DME needs assessment • Options for member being able to go to church • Other (Scored 4 of 5 points)

Submission Number and Evaluation Item 24-B(2)

Mercy Care's proposal addresses the member's ability to participate in religious services: "The CM will ask Raquel to explore the option of having someone from the church come to the home for pastoral services." (Proposal, page 160) The Administrator, however, denied a point concluding church to the patient does not count as church:

***Response*:** In order to receive a point, the Offeror was required to allow or facilitate the member's participation in services in a church setting. (Emphasis supplied) MCP's proposal offers an option for the member to receive pastoral services in her home but does not address physically attending church.

***Decision*:** No additional point is awarded.

***Appeal*:** The Administrator's denial is based on a requirement not set forth in the scoring criteria. The Administrator states that, "Offeror was required to allow or facilitate the members's participation in services in a church setting." (Emphasis supplied) However, the criteria only states that Mercy Care offer "options for member being able to go to church." Thus, the Administrator's additional criteria that the church experience be in a church setting is improper. Further, item 24-B(2) relates to "Consideration of other in-home services," which by its own description contemplates in-home services. Mercy Care clearly offers an option for the member to experience church in her home. The failure to award a point under "consideration of other in-home services" because Mercy Care recommended that they be provided in the home, as opposed to at church, is improper. While either setting may be appropriate, both should merit a point. Mercy Care should be awarded an additional point.

MEDICAL MANAGEMENT

Question 28 - Describe the process used by the Offeror for the adoption and dissemination of clinical criteria used for decision making that would ensure consistent application of the criteria for clinical decision making.

Submission/ Question Number	AHCCCS Evaluation/Scoring Criteria
28-4	The Offeror describes the use of more extensive criteria for cases when its experience shows higher costs associated with furnishing of excessive services, or attended by a physician whose pattern of care frequently is found questionable. (Scored 0 out of 2 points)

Submission Number and Evaluation Item 28-4

In its protest, Mercy Care pointed out that the scoring criteria, requiring "more extensive criteria" and "costs" associated with "excessive services" are inconsistent with the question which is based on "clinical criteria." "Clinical criteria" are publicly available, nationally accepted, and not based on cost or level of utilization. Despite the fact that the scoring criteria are not reasonably related to the question, the Administrator refused to award any points on Mercy Care's protest:

***Response*:** In order to receive points, the Offeror was required to identify additional criteria in conjunction with clinical criteria for cases when its experience shows a higher cost or utilization of services, or a physician whose pattern of care frequently is found to be questionable. MCP's submission response did not identify any additional criteria. No Offerors were awarded a point for 28-4, therefore MCP suffered no loss in points for this evaluation item.

***Decision*:** No additional points are awarded.

***Appeal*:** The response to Mercy Care's appeal on this issue basically concedes that the scoring criteria was invalid because the scoring criteria were based on costs of providing services, not clinical criteria. The response acknowledges that Mercy Care did in fact provide additional clinical criteria. However, rather than openly acknowledging the fact that the scoring criteria did not fit the question, Administrator merely stated that, "No Offerors were awarded a point for 28-4, therefore, MCP suffered no loss in points for this evaluation item." The fact that other Offerors were not awarded points does not matter unless they protested their scoring. MCP did protest, the basis for the protest and appeal is valid, and therefore, MCP should be awarded full points.

QUALITY MANAGEMENT

Question 31 – Program – Quality Management Scenarios.

Submission/ Question Number	AHCCCS Evaluation/Scoring Criteria
31-A(2)	Ongoing monitoring during I.J. Coordinate with ADHS to determine whether or not there is anything the • Contractor can do to assist the facility in obtaining licensure • Contractor staff onsite assessment of member needs and remain onsite until immediate jeopardy is abated • Ongoing monitoring of the ALH until compliance is reached, including a process to assist the owner in keeping licensure / compliance up to date

Submission/ Question Number	AHCCCS Evaluation/Scoring Criteria
	• Other (Earned 4 of 5 points) (emphasis supplied).
31-A(5)	Other proposed steps/actions likely to improve members/caregivers' health, quality of life and overall system experience. (Earned 0 of 5 points)
31-B(5)	Other proposed steps/actions likely to improve members/caregivers' health, quality of life and overall system experience. (Scored 1 of 5 points)

Submission Number and Evaluation Item 31-A(2)

Mercy Care was improperly denied a point for failure to coordinate with ADHS to obtain licensure. The proposal clearly addresses this point. "MCP's provider relations personnel will continue to work with the facility to assist them in obtaining the required operating license." (Proposal, page 190) The Administrator nonetheless denied the protest point:

***Response*:** The MCP proposal refers to working with the facility, not coordinating with ADHS. Coordination with ADHS is critical, as it is the licensing agency and is positioned to provide the most comprehensive and expedient response to address the deficiencies. MCP's proposal received 4 out of 5 points.

***Decision*:** No additional point is awarded.

Appeal: The criteria here is whether MCP addressed coordinating with ADHS to assist the facility in obtaining licensure. As the Administrator's decision acknowledges, the only entity that can issue the license is ADHS. Even though Mercy Care's proposal discusses working to obtain the required licensure, the Scoring Team and the Administrator were apparently playing a version of "Magic Words." Unless the "Magic Words" "assist the facility to coordinate with DHS in obtaining the required operating license" were included, the points were not awarded. (Emphasis supplied) That is not an appropriate scoring criteria. It elevates form over substance. Mercy Care specifically said that it will assist the facility in obtaining the required operating license and the entity that issues the required operating license is ADHS.

In addition, it is clear that Mercy Care would be coordinating with ADHS because the question itself references coordination with ADHS. Thus, the evaluation criteria should not be about using specific "Magic Words," but about demonstrating the ability to provide the services required by the RFP. Here, the required services include helping the facility obtain required licenses, which necessarily involves coordinating with ADHS. Full points should be awarded.

Submission Number and Evaluation Item 31-A(5)

As with the case management scenarios discussed above, the scoring methodology for quality management scenarios contained an evaluation item for "other" steps/actions likely to improve members/caregivers' health, quality of life, and overall system experience." Mercy Care proposed such additional actions: "Help the member pack their belongings, including any prescribed or over the counter medications." (Proposal, page 189) To be eligible for points, these steps/actions could not belong in one of the defined categories for which points also would be awarded.

Here again, however, the Administrator imposes his own criteria not contained in the AHCCCS scoring criteria: "The steps/actions also would have to be atypical modalities that went above and beyond basic and ordinary actions of case managers, such as arranging community referrals and covered services."

He denied this protest point for the following reason:

Response: This evaluation item required responses which documented activity beyond the standard of care and routine expectations. The activities described by MCP are not exceptional and are considered routine processes.

Decision: No additional points are awarded.

Appeal: Here the question is whether Mercy Care's response sets forth, "other proposed steps/actions likely to improve members/caregivers health, quality of life and overall system experience." In fact, what the Scoring Team and the Administrator were looking for were items within Mercy Care's proposal that go "beyond the standard of care and routine expectations." One of the items Mercy Care set forth was, "help the member pack their belongings, including any prescribed or over the counter medications." While the Scoring Team and the Administrator describe these activities as "not exceptional and considered routine processes," that is simply not the case. Nothing within the ALTCS contracts or any of the guidance or rules requires these actions by the provider. Specifically, the objective guidelines set forth in the contract, RFP and AMPM establish that the activities listed in Mercy Care's proposal are above and beyond. Further, the Long Term Care Facility Closure Guidelines provided by AHCCCS make clear that actions such as helping a member pack their belongings is not required or expected. (*See* Exhibit 3 [LTC Guidelines, 2002 and 2007]) The Guidelines only provide that a case manager should ensure that belongings are forwarded to a new setting, but helping a member pack is above and beyond.

By implementing this criteria, the Scoring Team is trying to impose or imply responsibilities that are not spelled out and, apparently, are completely subjective. That is an error and is improper. By describing specific actions that are not called for in any of the contracts

or guidance, and are not called for in any of the general publications on care, Mercy Care has clearly described a criteria that "goes above and beyond." MCP should be awarded full points.

Submission Number and Evaluation Item 31-B(5)

Mercy Care protested this item because it called for other actions likely to improve "member/caregivers' health, quality of life and overall system experience," and Mercy Care provide such actions in its proposal:

- With respect to Post Transition Monitoring, the proposal states that, "[f]ollowing MCP's P&P for all members transferred there will be post transition clinical monitoring performed by a QM RN from the On-Site team. A QM RN performs an on-site clinical audit at the new placement within 24 hours for all members…." (Proposal, page 193) (emphasis supplied).

As noted, the scoring methodology for quality management scenarios contained an evaluation item for "other" steps/actions. To be eligible for points, these steps/actions could not belong in one of the defined categories for which points also would be awarded.

As in other questions, the Administrator denied this protest point injecting the additional requirement that: "The steps/actions also would have to be atypical modalities that went above and beyond basic and ordinary actions of case managers, such as arranging community referrals and covered services." The Administrator's stated basis for denial was as follows:

Response: This evaluation item required responses which documented activity beyond the standard of care and routine expectations. The activities described by MCP are not exceptional and are considered routine processes.

Decision: No additional points are awarded.

Appeal: The decision to not award additional points for this item are the same with 31-A(5). Mercy Care set forth steps that it would take that go above and beyond what is required in any of the contracts, guidances or other standard of care materials that control the situation and would improve health, quality of life and system experience. Again, without reference to any bases for a standard of care, the Scoring Team along with the Administrator have imposed entirely subjective evaluations on whether something goes beyond the routine processes. Neither the scoring criteria nor the decision by the Administrator point to or cite any materials that show that the activities described by Mercy Care are routine processes. Indeed, it is clear that performing an on-site clinical audit within 24 hours for all members is above and beyond the requirements set forth in the contract, RFP and AMPM. Mercy Care should be awarded full points on this criteria.

NETWORK DEVELOPMENT AND MANAGEMENT

Question 36 - The Offeror must submit a Network Development and Management Plan. The submission may exceed the three page maximum.

Submission/ Question Number	AHCCCS Evaluation/Scoring Criteria
36-E	Did the Offeror's description include a plan for interventions to fill network gaps and evaluation of those interventions? This description must include both out of network referrals and expedited/temporary credentialing. (Scored 0 out of 2 points)

Submission Number and Evaluation Item 36-E

In its protest, Mercy Care asserted that AHCCCS erred in finding that its proposal did not address the evaluation of interventions based upon the following language: "Using the results from the information and data sources listed above, MCP modifies our network development action plans as necessary, to reflect successful closure of gaps, the addition of newly targeted areas for network improvement, and/or the changes to the type of intervention strategies being employed. Each evaluation methodology is continually reviewed to determine the effectiveness of any interventions." (Proposal, page 240) (emphasis supplied).

The Administrator denied this protest point on the following basis:

Response: In order to receive points, the Offeror was required to describe a plan for evaluating interventions for filling network gaps. MCP's citation referred to the continual review of methodologies. While related, the two activities are not identical, and it was not clear to the evaluators that the latter type of evaluation occurs.

Decision: No additional points are awarded.

Appeal: Again, the Scoring Team and the Administrator appear to be imposing "Magic Words" criteria. The question was, "did the Offeror's description include a plan for intervention to fill network gaps and evaluation of those interventions?" Mercy Care was not awarded any points because, "MCP's citation referred to the continual review of methodologies," but according to the Scoring Team and the Administrator, it did not describe a plan for "evaluating interventions for filling network gaps." However, Mercy Care clearly stated that, "MCP modifies our network development action plans as necessary, to reflect successful closure of gaps, the addition of newly targeted areas for network improvement, and/or the changes to the type of intervention strategies being employed." That conduct clearly constitutes "evaluating interventions for filling network gaps" entitling Mercy Care to full points. If there is a

substantive difference here, it is one known only to the Scoring Team and Administrator. Such subjective differences cannot be the basis for failing to award points. Mercy Care clearly answered the question asked, and should be awarded full points.

Question 40 - Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the claims dispute process.

Submission/ Question Number	AHCCCS Evaluation/Scoring Criteria
40-J	Are the interventions that resulted from information collected by the Offeror shared with the impacted providers? (Scored 0 out of 1 point)

Submission Number and Evaluation Item 40-J

Mercy Care's proposal does address how the results of interventions would be communicated to providers: "If a PICRI is received outside of the Provider Services Department, our written P&Ps and training protocols requires the receiving employee to refer an electronic copy of the PICRI to the Provider Services Department if further action is required. <u>The assigned PSR will follow-up with the provider to make sure we understand the purpose of the PICRI</u> (if applicable) and if the provider agrees with the resolution. This contact may happen, at the next scheduled provider visit or the PSR may contact the provider via telephone call or visit prior to that date (depending on the purpose of the PICRI)." (Proposal, page 310) (emphasis supplied).

The Administrator nonetheless denied this protest point:

Response: Evaluation item 40-J cannot be viewed in isolation of the other evaluation criteria for Submission Requirement 40. Evaluation item 40-J pertained specifically to interventions implemented based on findings resulting from the tracking and trending of provider inquiries, provider complaints and provider requests for information. While MCP outlined a process for communicating with individual providers based on individual provider inquiries, complaints, and requests for information (PICRI), it did not outline any process for sharing information about interventions implemented as a result of the tracking and trending of such inquiries, complaints, or requests for interventions.

Decision: No additional point is awarded.

Appeal: Mercy Care was not awarded an additional point because the Scoring Team and the Administrator concluded that Mercy Care "did not <u>clearly</u> indicate how the results of interventions are communicated to/shared with impacted providers." (Emphasis supplied) The Administrator utilized scoring criteria that neither matches the questions nor matches the underlying Scoring Team notes/comments. The question itself is fairly straightforward, "[a]re the

interventions that resulted from information collected by Offeror shared with the impacted providers?" (Emphasis supplied) The response by the Administrator acknowledges that Mercy Care outlined the process for communicating with individual providers based on provider inquiries, complaints and requests for information, but maintains that Mercy Care "did not outline any process for sharing information about interventions implemented as a result of the tracking and trending of such inquiries, complaints, or requests for interventions."

First, the question itself does not ask for a process for sharing information about interventions resulting from "tracking and trending of inquiries, complaints, or requests for interventions." That is an entirely different question. The question asked whether the interventions that resulted from information collected by the Offeror is shared with the impacted providers. Second, Mercy Care's answer describes very specifically how that is done by stating that the assigned PSR will follow up with the provider to make sure we understand the purpose of the provider inquiries, complaints and requests for information. Under the existing question and the existing criteria, Mercy Care's response meets the requirements. MCP should be awarded full points.

Question 43 - The Offeror must describe how their organization will handle the potential loss (i.e. contract termination, closure) in a GSA of a (a) nursing facility and (b) an assisted living facility.

Submission/ Question Number	AHCCCS Evaluation/Scoring Criteria
43-B	Did the response describe how the Offeror will work with the facility to avoid closure or contract termination? (Scored 0 out of 1 point)

Submission Number and Evaluation Item 43-B

Mercy Care's proposal described how it would work with the facility to avoid closure or contract termination. "MCP routinely monitors the network for viability and continuity, with focus on SNFs and ALFs with known or suspected viability problems or known to be at risk for closure. This monitoring serves as an early warning system and allows us to identify possible loss of a SNF/ALF, prevent abrupt closure, prevent member disruption, and provide for seamless delivery of services to members. The following are examples of key indicators used in our monitoring process:

- State licensure issues
- Medicare/Medicaid sanction reports
- Credentialing or re-credentialing concerns

- Failure to secure or renew required insurance
- Multiple facility requests within short time lines for advance payments to cover expenses
- Concerns raised by Case Managers (CMs), quality management (QM) staff and provider service representatives (PSRs) that suggest that facility closure may occur
- Member or provider complaints about the availability of care or services

In addition to monitoring SNFs and ALFs, we maintain communication with officials from state agencies (e.g., Arizona Department of Health Services (ADHS)) to identify potential closures." AND "MCP's primary concerns during SNF/ALF losses are the safety of members and continuity of care. We take the actions listed below upon learning of potential contract termination, closure for any reason, or serious quality of care concerns:

- Facilitate a meeting with the SNF/ALF and AHCCCS to be held prior to the effective date of contract termination or any change related to contract status that could have an impact on members and/or their representatives."

(Proposal, page 317) (emphasis supplied).

The Administrator nonetheless denied this protest point:

Response: In order to receive a point, the Offeror was required to describe how it will work with the facility to avoid closure or contract termination. MCP's proposal addressed communication with state agencies to identify facilities facing potential closure, and the steps it would take to ensure member safety prior to termination. However, the proposal did not describe how it would work with the affected facility in advance to avoid closure or contract termination.

Decision: No additional point is awarded.

Appeal: The question asked for a description of how the Offeror will work with the facility to avoid closure or contract termination. The response provided that Mercy Care monitors the viability and continuity with SNFs and ALFs that have known or suspected viability problems or known to be at risk for closure. At that point, Mercy Care has identified those SNFs and ALFs who might be in danger of closure or contract termination. If they are closed or their contract is terminated, they will no longer be either viable or able to continue. With that "early warning" system in place, Mercy Care can work with the SNF/ALF to prevent abrupt closure which would be the result of a contract termination or closure and provide a seamless delivery of services. Once again, the scoring criteria seemed to look for the use of the Magic Words, "avoid closure or contract termination," even though that's exactly what the question asked for, i.e., how does one avoid closure or contract termination? One does that by monitoring viability and working to prevent abrupt closure or disruption. It is hard to imagine a clearer answer to the specific question asked.

Full points should be awarded.

Question 44 - Describe the process for addressing provider performance issues, up to and including contract termination.

Submission/ Question Number	AHCCCS Evaluation/Scoring Criteria
44-C	Did the Offeror describe a process for communicating the reason for contract termination to the provider? (Scored 0 out 1 point)

Submission Number and Evaluation Item 44-C

Mercy Care's proposal described the process for communicating the reason or contract termination to the provider: "Should the problem continue, MCP sends a letter to the provider that explains the issue and requests a Corrective Action Plan (CAP). The provider must submit the CAP within 15 business days and the CAP must be approved by MCP. The PSR sends a follow up letter to the provider reminding them of the CAP due date and content. Upon receipt and approval of the CAP by MCP, the PSR monitors the provider's performance until the CAP is successfully completed. If the provider does not improve performance, the MCP Medical Director or Chief Medical Officer contacts the provider by letter, telephone call or site visit to discuss non-compliance and offer assistance. MCP may recommend further corrective action, panel or referral restrictions or possible termination from the network if unacceptable performance continues." (Proposal, page 321)

The Administrator nonetheless denied this protest point:

Response: In order to receive a point, the Offeror was required to describe a process for communicating the reason for contract termination to the provider. While MCP's proposal addressed its efforts to communicate the reason for corrective action throughout the Corrective Action Plan (CAP) process, the proposal did not specify a process for communicating the reason for contract termination at the point of termination. The proposal simply stated that, "Upon AHCCCS approval, MCP implements the termination by notifying MCP departments, the provider and affected members; arranging for transition of care; and updating our claims/provider data management systems to reflect the termination."

Decision: No additional point is awarded.

Appeal: The question asked the Offeror to "describe a process for communicating the reasons for contract termination to the provider." Mercy Care described in detail sending a letter to the provider "that explains the issue [i.e., the reason for contract termination] and requests a corrective plan of action." The corrective plan of action sets forth the basis for the termination

and how the basis will be corrected. By explaining the issue for the termination, requesting a corrective plan of action, and requiring Mercy Care's approval of the corrective plan, Mercy Care is communicating the reason for contract termination to the provider. The reason for the contract termination is the issue of the corrective plan of action. Again, Mercy Care can only assume that the reason no points were awarded is that rather than use the word "issue" Mercy Care was supposed to use "the reason for contract termination." Again, neither the Scoring Team nor the Administrator should play a game of "Magic Words."

Full points should be awarded.

Question 45 – Provider Network Roster Requirement

Submission/ Question Number	AHCCCS Evaluation/Scoring Criteria
45	Offerors shall develop and maintain a provider network, supported by written agreements, which is sufficient to provide all covered services to ALTCS members [42 CFR 438.206]. *Additional language detailed ALTCS RFP Evaluation Tool.*

Submission Number and Evaluation Item 45

In its protest, Mercy Care asserted that AHCCCS erred in not awarding points for a number of providers for which no "provider type" was shown in its original electronic Network Summary Template submission. MCP asserts that the reason that the template does not show "provider type" is because at the time of the submission, the providers in question had applied for but not yet received their AHCCCS provider number or their "provider type" designation, which AHCCCS furnishes when it assigns the provider number. The RFP specifically permitted respondents such as MCP to submit providers with pending AHCCCS number applications as long as that was indicated to AHCCCS. MCP made this indication by entering "XX" in the "provider type" column (Column E) of the spreadsheet and noting in the "limitations/restrictions" column (Column N), that the providers were "in process of registering with AHCCCS.

***Response*:** Offerors were instructed to submit rosters, as specified in ACOM 420 Network Summary Policy, which could include providers without AHCCCS provider identification numbers. However, AHCCCS made no assurance that these providers would be included for the purposes of scoring. There is no guarantee that a provider without an AHCCCS provider identification number will become a registered AHCCCS provider, and the evaluation team did not count any providers without an AHCCCS provider identification number.

***Decision*:** No additional points are awarded.

Appeal: This is the clearest example of the Scoring Team and the Administrator imposing new criteria for scoring purposes not found in the RFP. This is both arbitrary and capricious. The issue here is whether Mercy Care could include within its provider network providers who had not yet been given "AHCCCS provider numbers" and therefore have a provider type. The submission question never required that all providers set forth as being part of the network have AHCCCS numbers at the time of the submission. In fact, as is pointed out in Mercy Care's protest at page 20, the ACOM 420, which is specifically referenced in the RFP, contemplates including providers who do not yet have provider numbers. That ACOM 420 states: "Provider type: If the provider is an AHCCCS registered provider insert the provider type ... if the provider has not yet registered with AHCCCS at this time, place 'XX' in the column. Note: In the event of a contract award, the contractor must insure the provider has registered with AHCCCS prior to providing services to members." In other words, AHCCCS's own words and documents specifically approve including providers who do not yet have AHCCCS numbers at the time of the RFP response. It is only necessary that they have AHCCCS numbers prior to providing services. By inserting a requirement that Mercy Care only include AHCCCS providers who have numbers, an entirely new and different criteria was imposed. Significantly, the Administrator's decision wholly fails to address the provisions in ACOM 420 described above.

It is both arbitrary and capricious for the Scoring Team and Administrator to provide offerors with specific instructions and guidelines to rely on in submitting proposals, but later retract such guidelines and impose new ones. Here, Mercy Care relied on the information and guidelines provided by AHCCCS for responding to item 45 and responded the way it did based on the guidelines. It is improper for the Administrator to now change the guidelines.

That is a clear legal error and the additional points should be awarded.

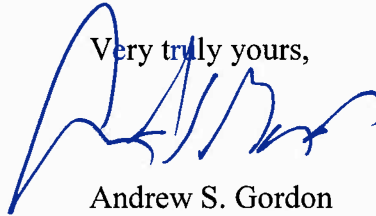
CONCLUSION AND RELIEF REQUESTED

The prior analysis clearly demonstrates that numerous scoring errors, as well as a calculation error, reduced Mercy Care's final score for its Proposal. The errors, taken together, significantly decrease Mercy Care's final score. Accordingly, Mercy Care protests these errors and calls for their correction. Had Mercy Care properly been awarded points, it would have placed Mercy Care with the highest score for Pima and Santa Cruz Counties and resulted in Mercy Care being awarded the ALTCS contract for Pima and Santa Cruz Counties.

Accordingly, Mercy Care hereby requests that it be awarded the ALTCS contract for Pima and Santa Cruz Counties.

If you have any questions or require additional information, please do not hesitate to call me.

Very truly yours,



Andrew S. Gordon

ASG:slm
Enclosures
cc: Mark Fisher
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Exhibit 1

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Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

June 3, 2011

Andrew S. Gordon
Coppersmith Schermer & Brockelman
2800 North Central Avenue, Suite 1200
Phoenix, Arizona 85004

Re: Decision of Procurement Officer: MCP Protest of Award for ALTCS – Pima and Santa Cruz Counties (GSA 50), Solicitation Number YH12-0001

Dear Mr. Gordon:

Pursuant to Arizona Administrative Code ("A.A.C.") section R9-22-604(G), this letter serves as the Decision of the Procurement Officer in response to the protest of Request for Proposal ("RFP") number YH12-0001 filed by Mercy Care Plan ("MCP") which was received by the Arizona Health Care Cost Containment System (AHCCCS) on May 20, 2011.

After careful consideration, as set forth below, AHCCCS has determined that MCP is entitled to one point claimed in the protest. However, the additional point, when weighted, does not change MCP's ranking among the Offerors in Pima and Santa Cruz Counties (GSA 50). Therefore, the protest is denied.

This letter provides a point by point response to each of the arguments made in the MCP May 20, 2011 protest. MCP's arguments are summarized in the interest of space. However, the full protest language can be found in the original letter. The relevant AHCCCS submission requirements and the corresponding evaluation criteria are included for each section.

RESPONSE TO ASSERTION OF CALCULATION ERROR

MCP asserts that AHCCCS committed an arithmetic error in totaling the points that were awarded for the Encounters Submission requirement within Organization. MCP asserts that it was awarded six points, but when the total points for Encounters was transferred to the table used for calculating the overall Organization score, a value of five points was incorrectly recorded.

Response: AHCCCS has verified that MCP's final score for the Encounter Submission requirement was six points. This value was correctly recorded on the total Organization score sheet used to calculate MCP's final score.

Decision: No additional point is awarded.

ORGANIZATION AND STAFFING

Question 3 - Submit current resumes of key personnel as required in Section D, Paragraph *25,* Staff Requirements and Support Services documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included long term care experience. If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description is limited to 2 pages.

Submission/ Question Number	AHCCCS Evaluation/ Scoring Criteria
3-4	Financial Officer/CFO: The Financial Officer has 3 years relevant managed care experience. "Relevant" is defined to mean previous management experience in the AHCCCS or in another state's Medicaid managed care program. Management is defined as supervisory level or above. (Scored 0 out of 1 point)
3-5	Financial Officer/CFO: The Financial Officer has 3 years experience with the elderly and physically disabled, through publicly funded programs. (Scored 0 out of 1 point)
3-28	Provider Services Manager: The Provider Services Manager has 3 years managed care experience in Medicaid managed care. (Scored 0 out of 1 point)

Submission Number and Evaluation Item 3-4
MCP asserts that its Chief Financial Officer (CFO) satisfied the evaluation criterion for three years of relevant experience based on his tenure at Health Net of Arizona from 2003 to 2010 and at Chandler Regional Hospital from 1996 to 2000.

Response: Evaluation item 3-4 defines relevant experience as experience in AHCCCS or in another state's Medicaid Managed Care Program. In evaluating the responses, the evaluation team only considered experience with Medicaid Managed Care organizations and not provider organizations, such as Chandler Regional Hospital. Furthermore, the description of the CFO's prior position at Health Net did not specify Medicaid managed care activities. AHCCCS awarded points only for information that was explicitly provided in the resume.

Decision: No additional point is awarded.

Submission Number and Evaluation Item 3-5

MCP asserts that its Chief Financial Officer (CFO) satisfied the evaluation criterion for three years of experience with the elderly and physically disabled (EPD) through publicly-funded programs.

Response: Evaluation item 3-5 defines experience as experience with the elderly and physically disabled through a publicly funded program. The resume did not explicitly state that Health Net and Chandler Regional Hospital serve the elderly and physically disabled through publicly funded programs. Even if the Offeror believes this information to be common knowledge which satisfies a criterion for scoring, the evaluation team could not award points unless experience with the elderly and physically disabled through a publicly funded program was explicitly stated in the resume.

Decision: No additional point is awarded.

Submission Number and Evaluation Item 3-28

MCP asserts that its Provider Services Manager satisfied the evaluation criterion for three years of relevant experience through her tenure at MCP as an employee and independent consultant, and her prior positions at Sonora Quest Laboratories and Insight Health Corporation.

Response: Evaluation item 3-28 defines experience as managed care experience in Medicaid Managed Care. The resume did not explicitly state that either Sonora Quest Laboratories or Insight Health Corp. is a Medicaid Managed Care entity. AHCCCS awarded points only for information that was explicitly provided in the resume.

If the number of months in a particular position was not specified, scorers were instructed to calculate as follows:

- All Offerors providing a two year span, such as 2008-2009, were given credit for 2 months of experience (one month was credited for each year). All Offerors providing a range which encompassed a full year, such as 2008-2010, were given credit for 12 months for each full year encompassed in the range plus one month for each of the separate years cited. Therefore, in the case of 2008-2010, the Offeror would receive 12 months for 2009 and 1 month each for years 2008 and 2010 for a total of 14 months. All Offerors providing a span that included the term "to present" were given credit for 3 months for the months of January through March of 2011.

Applying these rules, the Provider Services Manager was credited with 18 months of experience, which failed to meet the 36 month requirement.

Decision: No additional point is awarded.

CLAIMS AND ENCOUNTERS

Question 7 - Provide a detailed flowchart and narrative description of the claims adjudication process, addressing both paper and electronic claims submissions. Include in the description the following: monitoring process for accurate and timely claim adjudication; how deficiencies are identified and resolved; timeliness standards and cost avoidance/TPL activities; and how claim inquiries are handled. Include an actual sample of the remittance advice (front and back) or a written narrative of the remittance advice. The submission requirement will be a maximum of four pages of narrative and an additional five pages of flowcharts.

Submission/ Question Number	AHCCCS Evaluation/ Scoring Criteria
7-1	The submission includes the following remittance advice requirements a. A description of all denials and adjustments b. The reasons for such denials and adjustments c. The amount billed d. The amount paid e. Application of COB and SOC, and f. Provider rights for claim disputes (Scored 0 out of 1 point)

Submission Number and Evaluation Item 7-1
MCP asserts that AHCCCS erred in not awarding a point for items 7-1.a and 7-1.b. The items address two required elements for remittance advice samples: a description of all denials and adjustments (7-1.a) and the reason for such denials and adjustments (7-1.b). MCP also challenges item 7-1.e, asserting it met the standard through inclusion on the sample remittance advice of the following: *"Code/Description: 23 - Payment adjusted because charges have been paid by another payer"* and through inclusion of a field for *"Patient Co-Pay"*, which MCP defines as equivalent to share of cost. MCP notes that another offeror, EverCare," also included a field for Co-Pay. (The field was empty in both offerors' remittance advice samples, due to lack of any owed co-pay amount.)

Response: For 7.1a/b, AHCCCS evaluators required specific mention of a description of denials and adjustments and the reasons for such denials and adjustments. MCP's sample remittance advice is specific to adjustments only, and therefore, the proposal did not meet the evaluation criteria specific to denials.

Regarding 7.1e, an Offeror was required to mention application of both COB and SOC. MCP's proposal mentioned COB, but failed to mention SOC. MCP's assertion that Co-

Pay and Share of Cost are the same is not correct. These are distinct items with different definitions.

Regarding the comparison to Evercare, Evercare's proposal narrative did specifically address SOC. Therefore, Evercare was awarded a point.

Decision: No additional point is awarded.

Question 9 Provide a description of the clinical edits and data related edits included in the claims adjudication process.

Submission/ Question Number	AHCCCS Evaluation/ Scoring Criteria
9-1	Mentions Key Clinical Edits (must include a through c to receive point) a. Correct Coding Initiative (CCI) for Professional and Outpatient services b. Multiple Surgical Reductions c. Global day Bundling (Scored 0 out of 1 point)
9-2	Mentions Key Data Assessment Edits (must include a through g to receive point) a. Benefit Packages b. Timeliness c. Data Accuracy d. Adherence to AHCCCS Policy e. Provider Qualifications f. Member Eligibility and Enrollment g. Over Utilization standards (Scored 0 out of 1 point)

Submission Number and Evaluation Item 9-1

MCP asserts that AHCCCS erred in not awarding it a point for mentioning the three required key clinical edits, including Correct Coding Initiative (CCI) for professional and outpatient services. MCP cites the following language from its proposal:

> *"Professional claims (HCFA 1500s) that reach an adjudicated status of 'Pay' are automatically reviewed against nationally recognized standards such as the Correct Coding Initiative (CCI), medical policy requirements [e.g., American Medical Association (AMA)], and maximum unit requirements supplied by AHCCCS, with recommendations applied during an automatic re-adjudication process. Other methodologies utilized throughout the autoadjudication process*

include, but are not limited to, Multiple Surgical Reductions and Global Day E & M Bundling."

MCP further asserts that its reference to HCFA 1500s satisfies the AHCCCS evaluation requirement that CCI must be used for professional services.

Response: In order to receive a point, the Offeror was required to mention CCI editing for both Outpatient (OP UB04) and Professional (HCFA 1500) services regardless of setting. MCP's response addressed only CCI editing for Professional (HCFA 1500) services.

Decision: No additional point is awarded.

Submission Number and Evaluation Item 9-2
MCP asserts that AHCCCS erred in not awarding it a point for mentioning the seven required key data assessment edits, including timeliness. MCP cites the following language from its proposal:

> *"[c]laim edit rules are set to validate the claim against the network provider, member, dates of service, services rendered, and units authorized."* MCP asserts that, *"claim edit rules include 'dates of service' and 'dates of service' is, definitionally, a timeliness standard."*

Response: In order to receive a point, the Offeror was required to specifically mention the application of edits for claims submission timeliness standards. MCP's proposal mentioned date of service editing without any mention of timeliness. Date of service-related editing without additional description does not constitute an evaluation against, or an application of, AHCCCS timeliness standards. AHCCCS will not infer that such an evaluation will occur and could not award points for information that is not explicitly stated by the Offeror.

Decision: No additional point is awarded.

Question 10 - Submit a description of the Offeror's encounter submissions process, including, but not limited to, how accuracy, timeliness and completeness are ensured, how data is extracted from the system and the remediation process when AHCCCS standards are not met. The description should include the tracking, trending, reporting, process improvement, and monitoring submissions of encounters and encounter revisions. Include any feedback mechanisms to the encounter process that improves encounter accuracy, timeliness and completeness. The submission requirement will be a maximum of four pages and four pages of flowcharts.

Submission/ Question Number	AHCCCS Evaluation/ Scoring Criteria
10-9	There is a method for process improvement based upon encounters submission outcomes that includes Provider Training Report to Management Team. (Scored 0 out of 1 point)

Submission Number and Evaluation Item 10-9
MCP asserts that AHCCCS erred in not awarding a point because of its failure to include the words "Provider Training Report" in its response. MCP points to its statement that:

> *"Remediation Strategies" constitutes "MCP's Health Plan Operations (HPO) team, under the direction of VP of HPO and supported by two encounter specialists who research each pending or denial edit from AHCCCS."*

MCP asserts that the phrase *"under the direction of VP of HPO"* makes clear that the Management Team receives a Provider Training Report.

Response: In order to receive the point, the Offeror was required to mention the provision of a Provider Training report to a Management Team. AHCCCS will not infer that such a report exists based upon MCP's statement that the team works under Management direction. AHCCCS will not award points for information that is not explicitly stated by the Offeror. No Offerors were awarded a point for 10-9.

Decision: No additional point is awarded.

GRIEVANCE & APPEALS

Question 15 - Provide a flowchart and comprehensive written description of the Offeror's grievance system. At a minimum, the description should include the member grievance and appeal process, and the provider and subcontractor claim dispute process. Include in the description how data resulting from the grievance system is used to improve the operational performance of the Offeror. The submission requirement will be maximum of four pages of narrative with a maximum of three pages of flowcharts.

Submission/ Question Number	AHCCCS Evaluation/ Scoring Criteria
15-1	Did the Offeror's description include flowcharts and written descriptions for grievances, including (must meet a through c below to receive point): a. When, where and how to file

	b. Resolution requirements, including timeliness in accordance with AHCCCS rules c. Response requirements (Scored 0 out of 1 point)
15-2	Did the Offeror's proposal include flowcharts and written descriptions for appeals, including (must meet a through c below to receive point): a. When, where and how to file b. Resolution requirements, including timeliness in accordance with AHCCCS rules c. Notice requirements (Scored 0 out of 1 point)

Submission Number and Evaluation Items 15-1 and 15-2
MCP asserts that AHCCCS erred in not awarding points for its presentation of a complete description for grievances (15-1) and appeals (15-2), including when, where, and how to file a grievance or appeal. MCP cites the following language from its proposal:

> *"Our members and their families/caregivers are educated regarding their grievance, appeals, and State Fair Hearing rights by their Case Manager (CM) during the initial in-person assessment…The CM thoroughly reviews items from the member handbook such as: instructions on how to file a grievance or appeal Or request a State Fair Hearing…At the same time, the member and member's family/caregiver are advised that if the member or member's family/caregiver is unable to file a grievance or appeal themselves, their CM, as the member's advocate will assist the member or member's family/caregiver in completing the process.[1]"*

MCP also notes that this information is available on its website. Finally, MCP asserts that another offeror submitted "essentially the same" response and was awarded the point.

Response: MCP's statement that information on how to file member grievances or appeals is contained in the handbook and website, and is covered by case managers, is not sufficient to be awarded the point. The evaluation team required the Offeror to specify where members file grievances and appeals: by address, phone number, or a website containing an address and phone number. While MCP's proposal covered how and when members could get assistance in filing a grievance or appeal, it did not specify where members file grievances and appeals.

[1] Except as noted, ellipses in this and other items indicate where AHCCCS has omitted language from MCP's protest letter not considered germane to the evaluation result. Please see original protest letter for full MCP text.

Decision: No additional point is awarded for either 15-1 or 15-2.

CASE MANAGEMENT

Question 22 - Describe the process the Offeror will employ in assessing and meeting the needs of complex care members via service planning and coordination of multiple providers and involved entities specifically for (1) members needing behavior management and (2) members with complex medical care needs.

Submission/ Question Number	AHCCCS Evaluation/ Scoring Criteria
22-5	The Offeror's narrative mentions Nursing Facility, Home and Community Based, Assisted Living Facilities/Centers as viable placement settings for these members (need to have all three mentioned to receive the point). (Scored 0 out of 1 point)

Submission Number and Evaluation Item 22-5
MCP asserts that AHCCCS erred in not awarding a point for its mentioning of Nursing Facilities, Home and Community-Based and Assisted Living Facilities/Centers as viable placement settings for meeting the needs of complex care members, specifically members needing behavior management and members with complex medical care needs. MCP cites language in the proposal regarding establishment of two specialty teams (high risk behavioral health and medically complex care) to serve members with the most severe behavioral and complex care issues. MCP further cites from the following language:

> *"[o]ur general CMs are assigned a case load based on the member's placement in either a home setting, Assisted Living Facilities, or Nursing Homes...MCP identifies members to be assigned to the Medically Complex Care Team (MCCT) due to their complex chronic care needs... [and] members are identified for management by the MCCT if they are: 1) residing in the community/assisted living facilities ...or 2) residing in a nursing facility... Due to these special complex care needs, these members are assigned to MCP RN CMs for optimal case management and service coordination.*[2]"

Response: Although the Offeror's proposal notes that MCP assigns case managers to members based on the various types of placement settings, the proposal fails to discuss the process for ensuring that all three placement settings are considered as viable options for members needing behavior management and members with complex medical care needs.

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[2] Ellipses included in original protest language.

Decision: No additional point is awarded.

Question 24 - Program - Case Management Scenarios.

Submission/ Question Number	AHCCCS Evaluation/ Scoring Criteria
24-A(4)	Other proposed steps/actions likely to improve members/caregivers' health, quality of life, and overall system experience. (Scored 0 out of 5 points)
24-B(1)	Considerations related to assessment of critical services • Review of difference between previous and current case manager's assessment of member service hours (less hours despite apparent -increased need, inter-rater reliability, supervisory review) • Notice of Action • Review of Service Gaps • Respite request • Other (Scored 4 of 5 points)
24-B(2)	Consideration of other in-home services • Interpretation/translation services • Assistance with change of PCP • DME needs assessment • Options for member being able to go to church • Other (Scored 4 of 5 points)
24-B(3)	Other proposed steps/actions likely to improve members/caregivers' health, quality of life, and overall system experience. (Scored 0 of 5 points)
24-C(3)	Other proposed steps/actions likely to improve members/caregivers' health, quality of life, and overall system experience. (Scored 0 of 5 points)
24-D(4)	Other proposed steps/actions likely to improve members/caregivers' health, quality of life, and overall system experience. (Scored 0 of 5 points)

Submission Number and Evaluation Item 24-A(4)
The scoring methodology for case management scenarios included points for "other proposed steps/actions likely to improve members/caregivers' health, quality of life and overall system experience." To be eligible for points, these steps/actions could not belong in one of the defined categories for which points also would be awarded.

These steps/actions also would have to be atypical modalities that went above and beyond basic and ordinary actions of case managers, such as arranging community referrals and covered services.

MCP asserts that it proposed three steps/actions that should be considered part of the "other proposed steps/actions" category. These are: availability of a patient centered medical home; scheduling by the nursing facility of a family night for the member; and inquiry by the case manager of the member's satisfaction with nursing facility services.

Response: This evaluation item required responses which documented activity beyond the standard of care and routine expectations. The activities described by MCP are not exceptional and are considered routine processes.

Decision: No additional points are awarded.

Submission Number and Evaluation Item 24-B(1)
MCP asserts that evaluators erred in not awarding a point for its discussion of respite care. MCP cites the following language from its proposal:

> *"[t]he CM will also inform Magda and Raquel that MCP has a number of Romanian speaking adult foster care homes that could be used for extended respite care. The CM offers respite care service on Sundays so that Raquel and her family can go to church."*

Response: MCP's proposal does address respite as noted. Therefore, five of five points should have been awarded in this category.

Decision: One additional point is awarded.

Submission Number and Evaluation Item 24-B(2)
MCP asserts it should receive full points for "consideration of other in-home services." MCP notes that evaluators wrote "0" next to "options for member being able to go to church" and asserts that this was addressed in its proposal through the following language:

> *"The CM will ask Raquel to explore the option of having someone from the church come to the home for pastoral services."*

In addition, MCP argues that the availability of multi-cultural and multi-lingual (including Romanian) adult day health care centers should earn credit in the "other" category of this evaluation item.

Response: In order to receive a point, the Offeror was required to allow or facilitate the member's participation in services in a church setting. MCP's proposal offers an option for the member to receive pastoral services in her home but does not address physically attending church. MCP's provision of multi-cultural and multi-lingual adult day health care services was recognized through the "other" category of item B.2.

In regard to footnote number 3, the provision of in-home services may include services in the community, as described in AHCCCS policy and as evidenced in MCP's response, e.g., MCP's mention of adult day health care services.

Decision: No additional point is awarded.

Submission Number and Evaluation Item 24-B(3)
As previously noted, the scoring methodology for case management scenarios included points for "other proposed steps/actions likely to improve members/caregivers' health, quality of life and overall system experience." To be eligible for points, these steps/actions could not belong in one of the defined categories for which points also would be awarded.

The steps/actions also would have to be atypical modalities that went above and beyond basic and ordinary actions of case managers, such as arranging community referrals and covered services.

MCP asserts that it proposed three steps/actions that should be considered part of the "other proposed steps/actions" category. These are: discussion by the case manager with the member and daughter of the challenges associated with caring for and having early stages of dementia; offering community resources such as the Alzheimer's Association; and encouraging attendance at support groups.

Response: This evaluation item required responses which documented activity beyond the standard of care and routine expectations. The activities described by MCP are not exceptional and are considered routine processes.

Decision: No additional points are awarded.

Submission Number and Evaluation Item 24-C(3)
As previously noted, the scoring methodology for case management scenarios included points for "other proposed steps/actions likely to improve members/caregivers' health,

quality of life and overall system experience." To be eligible for points, these steps/actions could not belong in one of the defined categories for which points also would be awarded.

The steps/actions also would have to be atypical modalities that went above and beyond basic and ordinary actions of case managers, such as arranging community referrals and covered services.

MCP asserts that it proposed two steps/actions that should be considered part of the "other proposed steps/actions" category. These are: discussion of hospice option by the member's PCP with the member and availability of patient-centered medical home should the member enroll in MCP's Medicare Advantage plan.

Response: This evaluation item required responses which documented activity beyond the standard of care and routine expectations. The activities described by MCP are not exceptional and are considered routine processes.

Decision: No additional points are awarded.

Submission Number and Evaluation Item 24-D(4)

As previously noted, the scoring methodology for case management scenarios included points for "other proposed steps/actions likely to improve members/caregivers' health, quality of life and overall system experience." To be eligible for points, these steps/actions could not belong in one of the defined categories for which points also would be awarded.

The steps/actions also would have to be atypical modalities that went above and beyond basic and ordinary actions of case managers, such as arranging community referrals and covered services.

MCP asserts that it proposed two steps/actions that should be considered part of the "other proposed steps/actions" category. These are: providing family/caregiver support group information and discussing with the member his interests and preferences for meaningful activities, such as the TBI Adult Day program.

Response: This evaluation item required responses which documented activity beyond the standard of care and routine expectations. The activities described by MCP are not exceptional and are considered routine processes.

Decision: No additional points are awarded.

MEDICAL MANAGEMENT

Question 28 - Describe the process used by the Offeror for the adoption and dissemination of clinical criteria used for decision making that would ensure consistent application of the criteria for clinical decision making.

Submission/ Question Number	AHCCCS Evaluation/ Scoring Criteria
28-4	The Offeror describes the use of more extensive criteria for cases when its experience shows higher costs associated with furnishing of excessive services, or attended by a physician whose pattern of care frequently is found questionable. (Scored 0 out of 2 points)

Submission Number and Evaluation Item 28-4
MCP asserts that clinical criteria refers to nationally-accepted clinical criteria that are publicly available, but that evaluation item 28-4:

> *"does not correlate with the 'clinical criteria' that is the basis of the question because...clinical criteria are not cost-based criteria. The process for adoption of clinical criteria is not dependent upon the extent to which services are utilized by a member or ordered by a provider. Further, there are no nationally accepted clinical criteria or 'more extensive' criteria to be utilized. The clinical criteria simply are what they are."*

Response: In order to receive points, the Offeror was required to identify additional criteria in conjunction with clinical criteria for cases when its experience shows a higher cost or utilization of services, or a physician whose pattern of care frequently is found to be questionable. MCP's submission response did not identify any additional criteria. No Offerors were awarded a point for 28-4, therefore MCP suffered no loss in points for this evaluation item.

Decision: No additional points are awarded.

QUALITY MANAGEMENT

Question 31 - Program - Quality Management Scenarios.

Submission/ Question Number	AHCCCS Evaluation/ Scoring Criteria
31-A(2)	Ongoing monitoring during I.J.

	• Coordinate with ADHS to determine whether or not there is anything the Contractor can do to assist the facility in obtaining licensure • Contractor staff onsite assessment of member needs and remain onsite until immediate jeopardy is abated • Ongoing monitoring of the ALH until compliance is reached, including a process to assist the owner in keeping licensure / compliance up to date • Other (Earned 4 of 5 points)
31-A(5)	Other proposed steps/actions likely to improve members/caregivers' health, quality of life and overall system experience.(Earned 0 of 5 points)
31-B(5)	Other proposed steps/actions likely to improve members/caregivers' health, quality of life and overall system experience. (Scored 1 of 5 points)

Submission Number and Evaluation Item 31-A(2)
MCP asserts that evaluators erred in finding that it did not address coordination with ADHS to obtain licensure for the facility in the scenario. MCP cites the following language from its proposal:

> *"MCP's provider relations personnel will continue to work with the facility to assist them in obtaining the required operating license."*

Response: The MCP proposal refers to working with the facility, not coordinating with ADHS. Coordination with ADHS is critical, as it is the licensing agency and is positioned to provide the most comprehensive and expedient response to address the deficiencies. MCP's proposal received 4 out of 5 points.

Decision: No additional point is awarded.

Submission Number and Evaluation Item 31-A(5)
As with the case management scenarios, the scoring methodology for quality management scenarios contained an evaluation item for "other" steps/actions. To be eligible for points, these steps/actions could not belong in one of the defined categories for which points also would be awarded.

The steps/actions also would have to be atypical modalities that went above and beyond basic and ordinary actions of case managers, such as arranging community referrals and covered services.

Mercy Care asserts it was improperly awarded "0" points for this criterion because its proposal included the following language:

> *"Help the member pack their belongings, including any prescribed or over the counter medications."*

Response: This evaluation item required responses which documented activity beyond the standard of care and routine expectations. The activities described by MCP are not exceptional and are considered routine processes.

Decision: No additional points are awarded.

Submission Number and Evaluation Item 31-B(5)
As noted, the scoring methodology for quality management scenarios contained an evaluation item for "other" steps/actions. To be eligible for points, these steps/actions could not belong in one of the defined categories for which points also would be awarded.

The steps/actions also would have to be atypical modalities that went above and beyond basic and ordinary actions of case managers, such as arranging community referrals and covered services.

Mercy Care asserts it was improperly awarded "0" points on this criterion because its proposal included the following proposed steps/actions: an onsite clinical audit at the new placement within 24 hours for all members; addressing identified gaps in care with the member's PCP, the member or member's family/caregiver and facility's administrator or DON (if applicable); and evaluation by the QM/UM Committee of its performance, with results to be shared with other program contractors.

Response: This evaluation item required responses which documented activity beyond the standard of care and routine expectations. The activities described by MCP are not exceptional and are considered routine processes.

Decision: No additional points are awarded.

NETWORK DEVELOPMENT AND MANAGEMENT

Question 36 - The Offeror must submit a Network Development and Management Plan. The submission may exceed the three page maximum.

Submission/ Question Number	AHCCCS Evaluation/ Scoring Criteria
36-E	Did the Offeror's description include a plan for interventions to fill network gaps and evaluation of those interventions? This description must include both out of network referrals and expedited/temporary credentialing. (Scored 0 out of 2 points)

Submission Number and Evaluation Item 36-E
MCP asserts that AHCCCS erred in finding that its proposal did not address the evaluation of interventions. MCP cites the following proposal language:

> *"Using the results from the information and data sources listed above, MCP modifies our network development action plans as necessary, to reflect successful closure of gaps, the addition of newly targeted areas for network improvement, and/or the changes to the type of intervention strategies being employed. Each evaluation methodology is continually reviewed to determine the effectiveness of any interventions."*

Response: In order to receive points, the Offeror was required to describe a plan for evaluating interventions for filling network gaps. MCP's citation referred to the continual review of methodologies. While related, the two activities are not identical, and it was not clear to the evaluators that the latter type of evaluation occurs.

Decision: No additional points are awarded.

Question 40 - Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the claims dispute process.

Submission /Question Number	AHCCCS Evaluation/ Scoring Criteria
40-J	Are the interventions that resulted from information collected by the Offeror shared with the impacted providers? (Scored 0 out of 1 point)

Submission Number and Evaluation Item 40-J
MCP asserts that AHCCCS erred in finding that it did not clearly indicate how the results of interventions are communicated to/shared with impacted providers. MCP cites the following proposal language:

"If a PICRI is received outside of the Provider Services Department, our written P&Ps and training protocols requires the receiving employee to refer an electronic copy of the PICRI to the Provider Services Department if further action is required. The assigned PSR will follow-up with the provider to make sure we understand the purpose of the PICRI (if applicable) and if the provider agrees with the resolution. This contact may happen, at the next scheduled provider visit or the PSR may contact the provider via telephone call or visit prior to that date (depending on the purpose of the PICRI)."

Response: Evaluation item 40-J cannot be viewed in isolation of the other evaluation criteria for Submission Requirement 40. Evaluation item 40-J pertained specifically to interventions implemented based on findings resulting from the tracking and trending of provider inquiries, provider complaints and provider requests for information. While MCP outlined a process for communicating with individual providers based on individual provider inquiries, complaints, and requests for information (PICRI), it did not outline any process for sharing information about interventions implemented as a result of the tracking and trending of such inquiries, complaints, or requests for interventions.

Decision: No additional point is awarded.

Question 43 - The Offeror must describe how their organization will handle the potential loss (i.e. contract termination, closure) in a GSA of a (a) nursing facility and (b) an assisted living facility.

Submission /Question Number	AHCCCS Evaluation/ Scoring Criteria
43-B	Did the response describe how the Offeror will work with the facility to avoid closure or contract termination? (Scored 0 out of 1 point)

Submission Number and Evaluation Item 43-B
MCP asserts that AHCCCS erred in not awarding a point for describing how it would work with a facility to avoid closure or contract termination. MCP cites the following language from its proposal:

"MCP routinely monitors the network for viability and continuity, with focus on SNFs and ALFs with known or suspected viability problems or known to be at risk for closure. This monitoring serves as an early, warning system and allows us to identify possible loss of a SNF/ALF, prevent abrupt closure, prevent member disruption, and provide for seamless delivery of services to members."

MCP also lists key indicators used in the monitoring process, cites language regarding communication with state agencies to identify potential closures, and cites the action taken upon learning of potential contract termination, closure or serious quality of care concerns:

> *"Facilitate a meeting with the SNF/ALF and AHCCCS to be held prior to the effective date of contract termination or any change related to contract status that could have an impact on members and/or their representatives."*

Response: In order to receive a point, the Offeror was required to describe how it will work with the facility to avoid closure or contract termination. MCP's proposal addressed communication with state agencies to identify facilities facing potential closure, and the steps it would take to ensure member safety prior to termination. However, the proposal did not describe how it would work with the affected facility in advance to avoid closure or contract termination.

Decision: No additional point is awarded.

Question *44* - Describe the process for addressing provider performance issues, up to and including contract termination.

Submission /Question Number	AHCCCS Evaluation/ Scoring Criteria
44-C	Did the Offeror describe a process for communicating the reason for contract termination to the provider? (Scored 0 out 1 point)

Submission Number and Evaluation Item 44-C

MCP asserts that its should be awarded a point for describing its process for communicating the reason for contract termination to a provider who is being terminated due to performance issues. MCP cites the following language from its proposal:

> *"Should the problem continue, MCP sends a letter to the provider that explains the issue and requests a Corrective Action Plan (CAP). The provider must submit the CAP within 15 business days and the CAP must be approved by MCP. The PSR sends a follow up letter to the provider reminding them of the CAP due date and content. Upon receipt and approval of the CAP by MCP, the PSR monitors the provider's performance until the CAP is successfully completed. If the provider does not improve performance, the MCP Medical Director or Chief Medical Officer contacts the provider by letter, telephone call or site visit to discuss non-compliance and offer assistance. MCP may recommend further*

corrective action, panel or referral restrictions or possible termination from the network if unacceptable performance continues."

Response: In order to receive a point, the Offeror was required to describe a process for communicating the reason for contract termination to the provider. While MCP's proposal addressed its efforts to communicate the reason for corrective action throughout the Corrective Action Plan (CAP) process, the proposal did not specify a process for communicating the reason for contract termination at the point of termination. The proposal simply stated that, "Upon AHCCCS approval, MCP implements the termination by notifying MCP departments, the provider and affected members; arranging for transition of care; and updating our claims/provider data management systems to reflect the termination."

Decision: No additional point is awarded.

Question 45 - Provider Network Roster Requirement

Submission /Question Number	AHCCCS Evaluation/ Scoring Criteria
45	Offerors shall develop and maintain a provider network, supported by written agreements, which is sufficient to provide all covered services to ALTCS members [42 CFR 438.206]. *Additional language detailed in ALTCS RFP Evaluation Tool.*

Submission Number and Evaluation Item 45
MCP asserts that AHCCCS erred in not awarding points for a number of providers for which no "provider type" was shown in its original electronic Network Summary Template submission. MCP asserts that the reason that the template does not show "provider type" is because at the time of the submission, the providers in question had applied for but not yet received their AHCCCS provider number or their "provider type" designation, which AHCCCS furnishes when it assigns the provider number. MCP notes that it was permitted by the RFP to submit providers with pending AHCCCS number applications as long as that was indicated to AHCCCS. MCP made this indication by entering "XX" in the "provider type" column (Column E) of the spreadsheet and noting in the "limitations/restrictions" column (Column N), that the providers were "in process of registering with AHCCCS.

Response: Offerors were instructed to submit rosters, as specified in ACOM 420 *Network Summary Policy*, which could include providers without AHCCCS provider identification numbers. However, AHCCCS made no assurance that these providers would be included for the purposes of scoring. There is no guarantee that a provider

without an AHCCCS provider identification number will become a registered AHCCCS provider, and the evaluation team did not count any providers without an AHCCCS provider identification number.

Decision: No additional points are awarded.

CONCLUSION

With the exception of the one point allocated for evaluation item 24-B(1), the evaluation team correctly scored MCP's proposal. The cumulative effect of the additional point, when weighted, is not material to the award of the contract. Evercare retains the highest score with 82.34 points. MCP's revised score is 81.97.

MCP's protest is denied, and the decision not to award a contract to MCP in Pima and Santa Cruz Counties is upheld. In accordance with A.A.C. R9-22-604 (I), you may file an appeal of the Procurement Officer's Decision within five (5) days from the date the Decision is received.

Sincerely,

Michael Veit
Chief Procurement Officer
AHCCCS Administration

Exhibit 2

Sheri McAlister

From: Kim Fatica
Sent: Tuesday, May 17, 2011 3:41 PM
To: Andy Gordon; Roopali Desai
Subject: FW: Mercy Care Bid Protest

From: Kim Fatica
Sent: Tuesday, May 17, 2011 3:41 PM
To: 'michael.veit@azahcccs.gov'
Subject: Mercy Care Bid Protest

Mr. Veit:

I wanted to touch base with you regarding Mercy Care's bid protest relating to the ALTCS program. As I understand it, the Mercy Care team requested all scoring materials. Scoring sheets were provided, but no master scoring tool. As you are aware, points from the scoring sheets are weighted to reach a total score. Without the master scoring tool, Mercy Care is unable to confirm the mathematical calculations or to determine the impact of various scoring errors on its total score. This information is critical to the protest.

We are requesting AHCCCS to provide the master scoring tool immediately so that Mercy Care can timely complete its protest.

Thank you for your assistance.

Kim

Kimberly Fatica
Coppersmith, Schermer & Brockelman
2800 N. Central Ave., Ste. 1200
Phoenix, Arizona 85004
602.381.5474 (O)
602.772.3774 (F)

Exhibit 3

AHCCCS
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
Committed to Excellence in Health Care

Jane Dee Hull
Governor

Phyllis Biedess
Director

April 3, 2002

LONG TERM CARE FACILITY CLOSURE GUIDELINES

Purpose: To provide the program contractor with a recommended set of guidelines for use in the event of a long term care facility closure. These guidelines are meant to supplement any existing policies currently in effect and do not represent the sum of all Program Contractor responsibilities. Any procedures or guidelines must be flexible, taking into account the nature of the closure and local emergency response teams (fire and police) presence.

Notification of Closure

A long term care facility may notify a program contractor, ADHS, or AHCCCS about a closure. If the program contractor is notified, they should immediately call the Office of Managed Care or the Office of Medical Management. Likewise, if AHCCCS is notified first, they will contact the program contractors who have members in the facility. OMC or OMM staff will inform appropriate personnel at AHCCCS and coordinate AHCCCS' level of involvement. AHCCCS staff will meet to discuss how AHCCCS staff will be specifically involved.

Transfer of Members

Outside of a disaster situation (in which law enforcement takes responsibility for moving members) the program contractor is responsible for coordinating member moves to other facilities. That responsibility includes, but is not limited to, discussing the situation with members and families, on-site supervision of moves (including nights and weekends if necessary) and ensuring that charts, medications, and belongings are forwarded to the member's new setting. A master list of all members and their new location must be maintained and made available to AHCCCS.

Post Re-location Follow up

Program Contractors are responsible for following up with the new facilities and answering any questions or concerns these providers have. Also, program contractor staff must follow up with members and families after the move in order to ensure there are no outstanding issues. Program Contractors should assess the need to make on-site visits to the new settings at the time of the transfers and/or after the transfers are complete.

Staffing and Staff Coordination

Program Contractors should assign the appropriate amount of staff to achieve all the targeted timeframes and to safely move members. This may vary depending on how fast the move must be accomplished and the number of members residing in the facility.

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Internet: www.ahcccs.state.az.us

Appropriate program contractor departments should coordinate closure activities. Case management, quality management, provider services, and the medical director should communicate closely.

Charts
Program Contractors must ensure that adequate copies of important chart material are forwarded to the new facility. This includes, but is not limited to, the following:

- Face Sheet
- Current Physicians Orders
- Med Sheet
- Treatment Sheet
- Care Plan
- Negative TB Test or CXR.

Medications
Most often it is desirable for medications to accompany the resident when being moved.

High Risk Members
Special attention may need to be paid to high-risk members, including members with unstable medical conditions and significant behavioral health problems. Among others to be considered high risk are members with significant skin breakdown and on ventilators. The Program Contractor may need to spend extra time counseling these members and their families, as unanticipated moves can further exacerbate their conditions.

Evaluation
After the move the program contractor should gather input from all involved staff to evaluate the move and to identify areas of success and areas for improvement.

Multiple Program Contractors
Program Contractors utilizing the same closing facility are encouraged to coordinate their activities so as to minimize the impact on both the closing facility and the facilities receiving residents.

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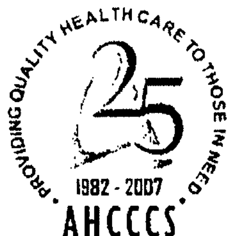
Janet Napolitano, Governor
Anthony D. Rodgers, Director



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LONG TERM CARE FACILITY CLOSURE GUIDELINES

Purpose: To provide the program contractor with a recommended set of guidelines for use in the event of a long term care facility closure. These guidelines are meant to supplement any existing policies currently in effect and do not represent the sum of all Program Contractor responsibilities. Any procedures or guidelines must be flexible, taking into account the nature of the closure and local emergency response teams (fire and police) presence.

Notification of Closure

A long term care facility may notify a program contractor, ADHS, or AHCCCS about a closure. If the program contractor is notified, they should immediately call the Division of Health Care Management (DHCM), ALTCS Unit or Clinical Quality Management Unit. Likewise, if AHCCCS is notified first, they will contact the program contractors who have members in the facility. DHCM staff will inform appropriate personnel at AHCCCS and coordinate AHCCCS' level of involvement. AHCCCS staff will meet to discuss how AHCCCS staff will be specifically involved.

Transfer of Members

Outside of a disaster situation (in which law enforcement takes responsibility for moving members) the program contractor is responsible for coordinating member moves to other facilities. That responsibility includes, but is not limited to, discussing the situation with members and families, on-site supervision of moves (including nights and weekends if necessary) and ensuring that charts, medications, and belongings are forwarded to the member's new setting. A master list of all members and their new location must be maintained and made available to AHCCCS.

Post Re-location Follow up

Program Contractors are responsible for following up with the new facilities and answering any questions or concerns these providers have. Also, program contractor staff must follow up with members and families after the move in order to ensure there are no outstanding issues. Program Contractors should assess the need to make on-site visits to the new settings at the time of the transfers and/or after the transfers are complete.

Staffing and Staff Coordination

Program Contractors should assign the appropriate amount of staff to achieve all the targeted timeframes and to safely move members. This may vary depending on how fast the move must be accomplished and the number of members residing in the facility.

Appropriate program contractor departments should coordinate closure activities. Case management, quality management, provider services, and the medical director should communicate closely.

Charts

Program Contractors must ensure that adequate copies of important chart material are forwarded to the new facility. This includes, but is not limited to, the following:

- Face Sheet
- Current Physicians Orders
- Med Sheet
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Medications

Most often it is desirable for medications to accompany the resident when being moved.

High Risk Members

Special attention may need to be paid to high-risk members, including members with unstable medical conditions and significant behavioral health problems. Among others to be considered high risk are members with significant skin breakdown and on ventilators. The Program Contractor may need to spend extra time counseling these members and their families, as unanticipated moves can further exacerbate their conditions.

Evaluation

After the move the program contractor should gather input from all involved staff to evaluate the move and to identify areas of success and areas for improvement.

Multiple Program Contractors

Program Contractors utilizing the same closing facility are encouraged to coordinate their activities so as to minimize the impact on both the closing facility and the facilities receiving residents.

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April 3, 2002, Revision 04/30/07