SECTION I. INSTRUCTIONS TO OFFERORS

1. PROSPECTIVE OFFERORS' INQUIRIES

Any questions related to this solicitation must be directed to the Solicitation Contact Person listed in Section A. Offerors shall not contact or ask questions of other AHCCCS staff unless authorized by the Contracting Solicitation Contact Person. Questions shall be e-mailed to the Solicitation Contact Person on the ALTCS RFP YH12-0001 Questions and Responses document available in the Bidder's Library. Any correspondence pertaining to this RFP must refer to the appropriate page, section and paragraph number. AHCCCS will respond, in writing, to all questions submitted through this process via a posting in the Bidder's Library or a formal amendment to the RFP in accordance with the schedule of milestone dates found in Paragraph 11 of this section.

2. PROSPECTIVE OFFERORS' CONFERENCES AND TECHNICAL INTERFACE MEETING

An Offerors' Conference will be held on February 9, 2011, from 8:30 a.m. until 4:30 p.m., at AHCCCS' 701 E. Jefferson building in the Gold Room on the 3rd Floor. The purpose of this conference will be to: 1) orient new Offerors to AHCCCS, 2) clarify the contents of this solicitation, and clarify AHCCCS PMMIS System and interface requirements. Any doubt as to the contents and requirements of this solicitation or any apparent omission or discrepancy should be presented at this conference. Questions posed during the Prospective Offeror's Conference must be submitted as specified in Paragraph 1 of this section. Verbal responses provided during the Conference are not binding.

3. PROPOSAL OPENING

Proposals may be opened publicly immediately following the proposal due date and time. The name of each Offeror will be read publicly and recorded but no other information contained in the proposals will be disclosed. Proposals will not be available for public inspection until after contract award.

4. LATE PROPOSALS

Late proposals will not be considered.

5. WITHDRAWAL OF PROPOSAL

At any time prior to the proposal due date and time, the Offeror (or designated representative) may withdraw its proposal. Withdrawals must be provided in writing and submitted to the Solicitation Contact person listed in Section A.

6. AMENDMENTS TO RFP

Amendments may be issued subsequent to the issue date of this solicitation. Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person listed in Section A.

7. ON-SITE REVIEW

Prior to contract award, all Offerors may be subject to on-site review(s) to determine that an infrastructure is in place that will support the provision of services to the ALTCS population within the GSAs bid.

8. BEST AND FINAL OFFERS

AHCCCS reserves the right to accept any or all initial offers without further negotiation and does not anticipate conducting a best and final offer (BFO). Offerors are advised to submit their most competitive offers at the outset. However, if it is considered in the best interest of the State, AHCCCS may issue a written request to submit a BFO. This request will notify the Offeror of the date, time and place for the resubmission of the capitation rate bid. If there is a BFO process, an Offeror will not be allowed to increase a previously submitted rate. If an Offeror does not submit a notice of withdrawal and does not respond timely to a requested BFO, its immediate previous offer will be considered its best and final offer. A BFO submitted with any components outside the specified ranges or maximum limit will not be accepted.

9. AWARD OF CONTRACT

Notwithstanding any other provision of this solicitation, AHCCCS expressly reserves the right to:

a. Waive any immaterial mistake or informality;
b. Reject any or all proposals, or portions thereof; and/or
c. Reissue a Request for Proposal

"Incumbent Contractor" means an entity that is a party to State Contract Number YH07-0001 as of the date the Proposals are due under this RFP.

"Successful Incumbent Contractor" means an Incumbent Contractor that is awarded a contract under this RFP.

"Unsuccessful Incumbent Contractor" means an Incumbent Contractor that is not awarded a contract under this RFP.

"New Contractor" means an entity that is awarded a contract under this RFP that is not an Incumbent Contractor or an incumbent Contractor that is new to a GSA.

The Offeror must bid on at least one entire GSA in order to be considered for a contract award. Although AHCCCS encourages Offerors to bid on multiple GSAs, AHCCCS may limit the number of GSAs awarded to any one Offeror, if deemed in the best interest of the State.

AHCCCS will not make an award in a GSA to an organization that also has a management service agreement with another Contractor in the same GSA. AHCCCS will not make an award to two or more Contractors that utilize the same management service company in that GSA. In either of those events, AHCCCS will make any award to the higher scoring Offeror.

If an Offeror had an ALTCS contract in a GSA that was terminated by AHCCCS, and that same GSA is in the Offeror's proposal, AHCCCS may reject the proposal with respect to that GSA. If, as of the date proposals are due, an Offeror is materially out of compliance with a managed care contract with any governmental entity, including Arizona, AHCCCS may reject a proposal from the Offeror unless AHCCCS has obtained assurances satisfactory to AHCCCS that the noncompliance will be resolved prior to October 1, 2011 and that the noncompliance will not recur.

A response to this Request for Proposal is an offer to contract with AHCCCS based upon the terms, conditions, scope of work and specifications of the RFP. All of the terms and conditions of the contract are contained in this solicitation, solicitation amendments and subsequent contract amendments, if any, signed by the AHCCCS Contracting Officer. Proposals do not become contracts unless and until they are accepted by the Contracting Officer. The proposal provided by the Offeror will become part of the contract with AHCCCS. A contract is formed when the AHCCCS Contracting Officer signs the award page and provides written notice of the award(s) to the successful Offeror(s), and the Offeror accepts any special provisions to the contract and the final rates

awarded. All Offerors will be promptly notified of award. If a successful Offeror wishes to decline an awarded contract, they must do so in writing within 16 days of the date of the award letter.

AHCCCS reserves the right to modify the number of contracts to be awarded in any GSA; however, AHCCCS anticipates awarding contracts as follows:

GSA #	County or Counties	Number of Awards
40	Pinal, Gila	1
42	Yuma, LaPaz	1
44	Apache, Coconino, Mohave, Navajo	1
46	Cochise, Graham, Greenlee	1
48	Yavapai	1
50	Pima, Santa Cruz	1
52	Maricopa	3

At any time during the term of this Contract (including extensions thereof), AHCCCS may make additional awards to qualified Offerors based on the evaluations of the proposals received in response to this RFP.

An Unsuccessful Incumbent Contractor in Maricopa County other than an Incumbent Contractor with a capped contract under State Contract Number YH07-0001 may request, in writing, to have its enrollment capped and to continue providing services under the terms and condition of this RFP. The deadline for such a request is 2 days from the date of the award letter. Only one capped contract in Maricopa County may be granted. Capped contracts will not be allowed in any other counties/GSAs. If more than one Unsuccessful Incumbent Contractor requests a capped contract, AHCCCS shall consider the request of the Offeror with the highest overall score or, in the case of negligible difference between the scores of the Unsuccessful Incumbent Contractors, consider the request that is in the best interest of the State applying the factors in Section H. AHCCCS may, in its sole discretion, grant or deny a capped contract request. If a capped contract is granted in Maricopa County, AHCCCS will notify the requesting Offeror(s) and all Contractors that were awarded a contract in Maricopa County within 9 days of the award letter.

If a capped contract is granted, the Contractor would continue to serve its existing members but would not receive any new members. The capped Contractor will receive a capitation rate factoring in the following:

- the bottom of the actuarial rate range for the medical component (as adjusted by Section D, Paragraph 56, Compensation and Paragraph 59 Capitation Adjustment); and
- the lesser of the lowest awarded administration rate or the Offeror's administration bid; and
- the lesser of the lowest awarded case management rate or the Offeror's case management bid.

At no time during the course of a capped contract will any Contractor in that GSA be entitled to any reconciliations other than reconciliations already provided for in this RFP.

The enrollment cap will not be lifted during the term of this or any subsequent contract period unless one of the following conditions exists:

a. Another contractor is terminated and increased member capacity is needed, or
b. Legislative action creates a sudden and substantial increase in the overall AHCCCS population, or
c. Extraordinary and unforeseen circumstances make such an action necessary and in the best interest of the State.

Enrollment After Contract Award:

In the event that there is an Unsuccessful Incumbent Contractor for a particular GSA, AHCCCS will enroll the Unsuccessful Incumbent Contractor's members to the New and Successful Incumbent Contractors effective October 1, 2011, subject to subsequent member choice when applicable, applying the following methods.

A Contractor awarded a capped contract under this RFP will not be assigned any members from an Unsuccessful Incumbent Contractor.

For GSAs in which only one Contract is awarded:

AHCCCS will assign all members from the Unsuccessful Incumbent Contractor for the GSA to the Contractor to which an award is made under this RFP for that GSA.

For GSAs in which Multiple Contracts are awarded:

If a GSA in which multiple Contracts are made has an Unsuccessful Incumbent Contractor with respect to that GSA, AHCCCS will "selectively assign" the Unsuccessful Incumbent Contractor's members to New and/or Successful Incumbent Contractors applying the method described below. After selective assignments have been made, members so assigned will be offered an opportunity to change enrollment, effective October 1, 2011, to any other Contractor in the same GSA. Any members who do not exercise choice will remain with the Contractor to which they were selectively assigned. AHCCCS will notify Contractors of the transition process and timelines as soon as possible after contract awards.

The purpose of selective assignment is to maximize the assignment of members to Contractors with the lowest capitation rates to the extent compatible with the primary goal of minimizing the need for members to change in-home service providers, alternative residential providers or nursing facility providers. AHCCCS may consider other factors consistent with the best interest of the member when determining which Contractor best aligns with the member's needs.

If there is a need for selective assignment in a GSA, after all contracts have been awarded and accepted, AHCCCS will offer New Contractors and any Successful Incumbent Contractors (other than the Successful Incumbent Contractor with the largest enrollment in the GSA) an opportunity to amend its Contract to accept the lowest awarded capitation rate in the GSA. Acceptance of this offer may increase a Contractor's probability of being included in selective assignment as described below.

Selective assignment will be based on the following order of priority:

Identify the Contractor whose network best aligns with the member's service provider(s).

- If only one Contractor's network aligns with the member's service providers, the member will be assigned to that Contractor.
- If more than one Contractors' network aligns with the member's service providers, the member will be assigned to the Contractor with lowest awarded capitation rate.
- If more than one Contractors' network aligns with the member's service providers and more than one Contractor has the lowest awarded capitation rate, the member will be assigned to the Contractor with the lowest membership in the GSA until all contractors have membership as close to equal as possible.

As stated above, following selective assignment, all members so assigned will be provided the opportunity to change to another Contractor in the same GSA. No Contractor will be guaranteed a minimum membership at any time, including when members are selectively assigned.

10. FEDERAL DEADLINE FOR SIGNING CONTRACT

The Center for Medicare and Medicaid Services (CMS) has imposed strict deadlines for finalization of contracts in order to qualify for federal financial participation. This contract, and all subsequent amendments, must be completed and signed by both parties, and must be available for submission to CMS prior to the beginning date for the contract term (October 1, 2011). All public entity Offerors must ensure that the approval of this contract is placed on appropriate agendas sufficiently in advance of the deadline to ensure compliance with this requirement. In the event CMS denies or withholds federal financial participation due to the Offeror's failure to comply with this requirement, payments to the Contractor will be reduced by the amount of the federal financial participation denied or withheld.

11. RFP MILESTONE DATES

The following schedule for the ALTCS RFP solicitation is subject to change:

Activity	Date
RFP Issued	January 31, 2011
New Offerors, Prospective Offerors Conference and Technical Assistance Session	February 9, 2011
Technical Assistance and RFP Questions Due	February 14, 2011
RFP Amendment and Formal Response to Questions	February 25, 2011
Second Set of Technical Assistance and RFP Questions Due	March 4, 2011
Second RFP Amendment Issued and Formal Response to Second Set of Questions	March 11, 2011
Proposals Due by 3:00 P.M.	**April 1, 2011**
Contracts Awarded On or About	May 9, 2011
Member Transition Activities Begin	May 16, 2011
Readiness Reviews Begin	July 1, 2011
New Contracts Effective	October 1, 2011

12. AHCCCS' BIDDER'S LIBRARY

The Bidder's Library contains critical reference material including but not limited to AHCCCS policies, Letter of Intent template, Offeror's checklist, utilization and cost data, member data and performance requirements to assist the Offeror in preparing a thorough and realistic response to this solicitation. References are made throughout this solicitation to material in the Bidder's Library and Offerors are responsible for reviewing the contents of the Bidder's Library material as if they were printed in full herein. The Bidder's Library is located on the AHCCCS website at http://www.azahcccs.gov/commercial/Purchasing/bidderslibrary/YH12-0001.aspx

13. OFFEROR'S INABILITY TO MEET REQUIREMENTS

If a potential Offeror cannot meet the minimum capitalization requirements, the performance bond requirements, or the minimum network standards described herein, AHCCCS requests that the potential Offeror not submit a bid.

14. CONTENTS OF OFFEROR'S PROPOSAL

All proposals (original and six copies) shall be organized with strict adherence to the Offeror's Checklist (see Bidder's Library), as described in this section and submitted using the forms and specifications provided in this RFP. A scanned PDF version of the Offeror's proposal must be submitted to AHCCCS within seven (7) days after the submission of the Offeror's proposal via the EFT/SFTP server. Instructions for access to the EFT/SFTP server are included in Section A of the Data Supplement in the Bidder's Library. In the event that hard copy submissions differ from electronic submissions, the hard copy submissions will prevail.

All pages of the Offeror's proposal must be numbered sequentially with documents placed in sturdy 3-inch, 3-ring binders. All responses shall be in 11 point font or larger with borders no less than ½". Unless otherwise specified, responses to each submission requirement should be limited to three (3) 8½" x 11" one sided, single spaced, type written pages. Erasures, interlineations or other modifications in the proposal must be initialed in original ink by the authorized person signing the offer. AHCCCS will only consider the information provided within the allotted page limit and permitted attachments, if any, in response to a specific submission requirement when evaluating the Offeror's bid. At no time will AHCCCS consider information outside the allotted page limit and permitted attachments, or any other information provided elsewhere in the bid when reviewing a specific response to an individual submission requirement. A policy, brochure, or reference to a policy or manual does not constitute an adequate response. AHCCCS will not reimburse the Offeror for the cost of proposal preparation.

It is the responsibility of the Offeror to examine the entire RFP, seek clarification of any requirement that may not be clear, and check all responses for accuracy before submitting its proposal. The proposal becomes a part of the contract; thus, what is stated in the proposal may be evaluated either during the proposal evaluation process or during other reviews. Proposals may not be withdrawn after the published due date and time.

All proposals will become the property of AHCCCS. The Offeror may designate certain information to be proprietary in nature by typing the word "proprietary" on top of every page for which nondisclosure is requested. Final determinations of nondisclosure, however, rest with the AHCCCS Director. Regardless of such determinations, all portions of the Offeror's proposal, even pages that are proprietary, will be provided to CMS or its designees.

All proposals shall be organized according to the following major categories:

A. General Matters
B. Capitation
C. Organization
D. Program
E. Provider Network

Each section shall be separated by a divider and contain all information requested in this solicitation. Numbering of pages should continue in sequence through each separate section. For example, "Provider Network" would begin with the page number following the last page number in "Program". Each section shall begin with a table of contents.

Proposals that are not submitted in conformance with the guidelines described herein will not be considered. References to various sections of the RFP document in Section I are intended to be of assistance and are not intended to represent all requirements. Other possible resources may be found in the Bidder's Library.

All responses incorporating examples of past performance and/or outcome data must comply with the following requirements:

- An Incumbent Contractor must submit based on their ALTCS line of business

- New Offerors currently operating as Managed Care Organizations (MCO), must submit all historical information from the same MCO in a single line of business

The following specifies the submission requirements.

A. GENERAL MATTERS

See the Offeror's Checklist contained in the Bidder's Library for information to be submitted under this section.

B. CAPITATION

Capitation is a fixed (per member) monthly payment to the Contractor for the provision of covered services to members. It is an actuarially sound amount to cover expected utilization and costs in a risk-sharing managed care environment.

AHCCCS will only evaluate the Offeror's full long term care capitation rates. The PPC and Acute Care Only rates will be published by AHCCCS prior to October 1, 2011.

To facilitate the preparation of its capitation proposals, AHCCCS will provide Offerors with a Data Supplement located in the Bidder's Library. This data source should not be used as the sole source of information in making decisions concerning the capitation proposal. Information referenced below is located in this Data Supplement. Each Offeror is solely responsible for research, preparation and documentation of its capitation proposal.

Capitation Bid Submission

1. All GSAs in which an Offeror bids will require a capitation rate bid submission. Each bid will encompass three components; a medical component, a case management component and an administrative component. **Each component will be scored separately.**

Bid component limits:

- AHCCCS will publish actuarially sound rate ranges by GSA for the medical component of the capitation rates prior to March 1, 2011. These ranges will be equivalent to the bottom half of the actuarially sound rate ranges, from the minimum to the midpoint.
- AHCCCS will not provide a range or a maximum for the case management component.
- AHCCCS will limit the administrative component to a maximum of 8%. The administrative component is calculated as: Administration / (Net NF + Net HCBS + Acute Care Prior to Reinsurance offsets + Case Management).
- Capitation bids submitted with any component outside of the published range or the administrative maximum will not be accepted.

AHCCCS reserves the right to request supporting documentation for any component of the capitation rate bids submitted.

If any moral or religious objections are submitted as specified in Section I, Paragraph 14, C. 2, the Offeror must not exclude direct and related costs from the capitation bid(s). If awarded a contract, capitation will be reduced for these costs via a subsequent contract amendment.

AHCCCS will provide, by GSA, the HCBS/NF mix percentages, Share of Cost (SOC) amounts and reinsurance offsets that must be used in the bid submission. The HCBS/NF mix percentages and SOC amounts are currently available in the Data Supplement. The reinsurance offsets will all be at the $20,000/$30,000 deductible levels and will be published prior to March 1, 2011.

AHCCCS is also providing Offerors with a case management model. This model is designed to assist Offerors in establishing the case management component of the capitation rates. The use of this model is optional and is not a required submission with the RFP. For further case management information, the Offerors may also review financial statements and case management component amounts included in the current and historical capitation rates. The case management component amounts included in capitation rates can be found in the ALTCS actuarial certifications which are located on the AHCCCS website at: http://www.azahcccs.gov/commercial/ContractorResources/capitation/capitationrates.aspx#

A template for the capitation rate bid submission is included in the Data Supplement. The template must be completed for each GSA in which the Offeror submits a bid. The template(s) must be submitted to AHCCCS via the EFT/SFTP server by 3 p.m. on the Proposal Due Date in Section A. Instructions for access to the EFT/SFTP are included in Section A of the Data Supplement.

In addition to the electronic submission of the template(s), hard copies of the completed template(s) for each GSA in which the Offeror submits a bid must be included in the RFP submission. A hard copy of an actuarial certification of all rates submitted, signed by a qualified actuary, must also accompany the RFP submission. The Offeror may submit a separate certification for each GSA or a single certification that covers all GSAs bid.

AHCCCS will adjust the awarded capitation rates via contract amendment prior to October 1, 2011 for Contractor specific capitation factors (e.g., Nursing Facility/HCBS mix adjustments) and reserves the right to adjust awarded capitation rates for program changes, legislative requirements, Contractor experience, and/or actuarial assumptions that were not previously included in the RFP capitation rate ranges published or the awarded capitation rates.

Reference: Section D, Paragraph 56, Compensation

C. ORGANIZATION

Moral and Religious Objections

Moral and Religious Objection Submission

2. Submit a statement of any moral and religious objections to providing any services covered under Section D, Program Requirements of the ALTCS RFP. If moral and religious objections are identified describe, in as much detail as possible, all direct and related services that are objectionable. Provide a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc.

Reference: Section D, Paragraph 10, Covered Services

Organization and Staffing

Organization and Staffing Submissions

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.

4. For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each. If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s).

5. Submit a functional organizational chart of the key program areas, responsibilities and areas that report to that position for the following functional areas: Case Management, Quality Management, Medical Management, Prior Authorization, Grievance System (Member Grievances and Appeals and Provider Claim Disputes) Provider Services, Finance, Claims, Encounters and Information Systems.

   The chart must identify the functions that will be subcontracted in a Delegated Agreement, Management Service Agreement and or Service Level Agreement.

Reference: Section D, Paragraphs 25, Staff Requirements and Support Services; 33 Subcontracts

Sanctions

Sanctions Submission

6. Describe any sanctions levied against the Offeror, its parent corporation or any legally related corporate entity since January 1, 2008 that have been imposed by AHCCCS, Medicaid programs in other states, Medicare or any state insurance regulatory body. Include the description of the sanction, the specific reason for the sanction and the timeline to resolve or correct the deficiency. Indicate any sanctions that are currently in dispute. Sanctions are defined as any monetary and non-monetary punitive actions taken by regulatory bodies.

Reference: Section D, Paragraph 80, Sanctions

Claims

Claims Submissions

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.

8. Describe what the Offeror will be doing to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.

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

Reference: Section D, Paragraphs 29 Network Management; 44 Claims Payment/Health Information System; 63 Coordination of Benefits/Third Party Liability

Encounters

Encounters Submission

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.

Reference: Section D, Paragraphs 73 Data Exchange Requirements; 74 Encounter Data Reporting; Encounter Manual; AHCCCS Data Validation Technical Document

Information Services

Information Services Submissions

11. Describe the structure (internal and external) of the Offeror's information system and the hardware and software that supports or will support the ALTCS line of business, including a diagram of the information system and data processing flow with all existing or planned interfaces. If not a current ALTCS Contractor, the Offeror must include a detailed plan for ensuring that all IS requirements will be met prior to the contract start date. The submission requirement will be a maximum of ten pages, plus flowcharts.

12. Describe the Offeror's information system change order and software modification processes, the date of the last major version update, and indicate if there is a planned system conversion within the contract period (five years). If yes, indicate which subsystems were/will be affected and describe the planning and system implementation process.

13. Indicate how many years the Offeror's IT organization or software vendor has supported the current or proposed information system software version currently operated by the Offeror. If Offeror's software is vendor supported, include vendor name(s), address, contact person and version(s) being used.

14. Describe the Offeror's plans and ability to support current and future IT Federal mandates.

Reference: Section D, Paragraphs 44, Claims Payment/Health Information System; 73, Data Exchange Requirements

Grievance System

Grievance System Submission

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 a maximum of four pages of narrative with a maximum of three pages of flowcharts.

References: Section D, ¶22 Grievance System., Section F Attachments, Attachment B(1), Enrollee Grievance System Standards and Processes and, Attachment B(2), Provider Claim Dispute System Standards and Policy, 42 CFR 438; A.R.S. 36-2903.01(B) and A.A.C. Title 9, Chapter 34, Articles 2 and 4.

Corporate Compliance

Corporate Compliance Submissions

16. Describe the Offeror's Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff involved in compliance along with staff levels of authority. The submission requirement will be a maximum of three pages of narrative plus one organizational chart.

Reference: Section D, Paragraph 70, Corporate Compliance

Finance and Liability Management

Finance and Liability Management Submissions

17. Submit the organization's three most recent audited financial statements and the related parent company financial statements if applicable. The Offeror may exceed the three-page limit. Existing ALTCS Contractors which have met this submission requirement through current contract requirements do not need to resubmit the three most recent financial statements.

    Note: The organization refers to the separate corporation established for the purposes of this contract. If no separate corporation currently exists, the Offeror should submit audited financial statements for the line of business most like the services provided under this contract.

18. Submit the organization's plan for meeting the Performance Bond or Bond Substitute requirement including the type of bond to be posted, source of funding and timeline for meeting the requirement.

19. Submit the organization's plan for meeting the minimum capitalization requirement.

Reference: Section D, Paragraphs 45 Minimum Performance Bond or Bond Substitute; 46 Performance Bond or Bond Substitute; 52, Financial Viability Standards

D. PROGRAM

Case Management Submissions

20. Describe how the Offeror has or will implement inter-departmental coordination between case management and other areas of the organization to improve member health and service outcomes. Provide an example of how the Offeror improved member health or service outcomes because of inter-departmental coordination.

21. Describe the Offeror's plan for monitoring and improving, as needed, the level of consistency among case managers with regard to the assessment of HCBS member needs and service authorizations.

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.

23. Describe the Offeror's process for assessment and care planning of members for home-based services by case managers.

24. The Offeror must submit responses to the following four case management scenarios. The Offeror should clearly identify each case scenario and describe how the case would be managed and coordinated, and address the following (including timeframes as appropriate): 1) interaction of the case manager with the member and others as applicable; 2) assessment of the member's status and needs; 3) Care Plan/Services developed to meet the needs of the member, including immediate and long term outcomes that are member-specific and measurable. The submission requirement will be a maximum of three pages per scenario.

    A. Oscar is a 42 year old male. He is married with 2 children under 10 years old at home. Oscar is a newly enrolled ALTCS member. He is quadriplegic as a result of a fall from his roof. Member was working full-time in the construction field prior to his injury. He was not on AHCCCS prior to current enrollment. Oscar now has limited use of his limbs, only having very spastic control of one arm. He is mostly dependent for all ADLs and IADLs. He has begun to feed himself with a splint and adaptive utensils although this is very messy. He requires bowel care. Oscar was admitted to his current NF placement 2 weeks ago after a 3-month hospital/rehab stay. Oscar

expresses dissatisfaction with the care at the nursing home. He states the caregivers are not as responsive as at "the last place". They handle him "roughly" and all the other residents are "too old" so there is nothing for him to do. Staff state that member presents as "angry" and "depressed"; he is never satisfied with whatever they do for him. He occasionally becomes very agitated when caregivers come to give his care and has ordered staff to leave. He often sleeps all morning and into the early afternoon and does not want to be disturbed for care. Oscar complains he is not getting enough Physical Therapy (PT) and that his custom wheelchair is hard to maneuver. Staff report that the member has become confused and disoriented recently. He sometimes forgets that he just had PT and also how some of the buttons on his wheelchair work. They say he gets mad if staff remind him when he forgets. Oscar has gone home once since admission so that his wife, April, could experience caring for him at home and the challenges involved. There were some accessibility barriers at home, primarily at the entrance and in the master bathroom. April would like Oscar to come home but she thinks it would be very hard to do everything for him on top of working (she has a part time job but worries that they now need a full time income) and caring for 2 kids. She also has concerns about Oscar's ability to control his anger. There is a possibility that Oscar's brother may be available to help them with care when/if Oscar is discharged. Oscar's wife asked for assistance getting a wheelchair accessible van so she could transport Oscar as needed. April would like to have more therapeutic home visits while Oscar remains in the NF to prepare them all for his homecoming. Oscar talks a lot about working again to help support his family.

B. Magda is an 83 year old female. She has been enrolled in ALTCS for 2 years. She has Diabetes (is on dialysis) and was recently diagnosed with early stage Dementia. Her daughter, Raquel, moved Magda into her home from Romania a few years before she became ALTCS eligible. She is not eligible for Medicare. Also in the home are the son-in-law and 4 grandchildren (ages 10–16). Member speaks very little English. Daughter's English is better. Daughter works outside the home M-F, leaving in the late morning and returning in the evening. Member is confused and she is not always steady on her feet without guidance. She has fallen a few times while walking with her walker and fell in the shower last week. Daughter is afraid to leave Magda alone for more than a very short time when she naps in the afternoon. The member has been getting Attendant Care. The daughter leaves for work when the caregiver arrives but there have been a couple of occasions recently when the caregiver did not show up on time and daughter had to stay home from work until someone else could take over for her. The caregiver gets member out of bed and dressed and prepares her breakfast every morning, she gets member off to dialysis on M-W-F, she prepares lunch on T-Th and stays with member until oldest grandchild gets home in late afternoon. Member needs prompts to finish meals and to get enough water during the day, and to take her meds. Caregiver cleans house and does the laundry too. The member's daughter requested an increase in Attendant Care hours when the new case manager came to complete a reassessment. Daughter feels member's confusion has increased and caregiver needs to do more for her. Case manager assessed member to need less hours of service per week than prior assessment. Daughter has asked about receiving "respite" on Sundays when the family goes to church because member gets too agitated during the service to accompany them any longer. Member says she misses getting out and going to church and says her daughter is just embarrassed that she can't speak English well. Member's daughter has asked for a new PCP. She says she has difficulty making appointments with the current PCP.

C. Wanda is a 66 year old female who has been on ALTCS for the past 6 months. She is enrolled in a Medicare Advantage Plan. Her physician is in the MAP's network but not the Contractor's. She is diagnosed with Diabetes, Peripheral Neuropathy, Hypertension and Congestive Heart Failure. Wanda has required verbal prompting for bathing, dressing, grooming and eating. She also required stand by assistance when bathing. She needed assistance in putting on her shoes and socks. Wanda was living with her son and daughter-in-law while receiving Attendant Care, however, 6 weeks ago, her son moved her into an Assisted Living Facility (ALF) near them

without the involvement of the case manager. She had had several falls at home and the son felt she was in need of more care and supervision than the family thought they could handle. She had been able to ambulate with the use of a walker but she was starting to forget to use it occasionally. Wanda fell for the first time at the ALF 4 weeks ago with no injury according to the son. She was hospitalized as a result of a 2nd fall 2 weeks ago that resulted in a broken nose. While in the hospital member was diagnosed with pelvic cancer and has begun treatment. Member was discharged from the hospital back to the same ALF at son's request. Member is now non-ambulatory, more confused, sometimes combative, needing near total care for ADLs, including needing to be fed. The ALF provider is willing to keep Wanda.

D. Roger is a 39 year old male. His diagnoses include Schizoaffective Disorder and Traumatic Brain Injury. He also has seizures and occasional upper respiratory infections. His sister, Joyce, just moved him here from another state after their mother/Roger's guardian died. Joyce is now member's guardian and he is staying with her. She is struggling to manage Roger on her own despite having had some training in behavior management. Roger's behaviors include being resistive to care (refuses to bathe, change clothes and take meds), some verbal and physical aggression (uses profanity, throws objects and has taken a swing at Joyce twice since being in her care), fabrication (makes up stories about his past life and what others have done to or told him), and one recent attempt to leave home without supervision. Joyce reports that in the other state, Roger received some support services in the home (she's unclear on the nature of those services) and she thinks he went to a day program of some kind. At this time, member is only followed by a PCP. Roger needs supervision due to his impaired judgment, need for redirection and prompts and because of risks of injury related to his potential aggression. Member continues to have seizures at least twice a week; his risk of falling during seizures is high. Member's behaviors have escalated in the past month. Roger spends most of the day in his room. He says he is bored with nothing to do but watch television. Joyce reinforces Roger's positive behavior with cigarettes. Joyce wants help with Roger's behavioral health needs but she does not know what kind of services are available for him in Arizona.

References: Section D, Paragraph 16, AMPM, Chapter 1600

Medical Management Submissions

25. Describe how utilization data is gathered, analyzed, and reported by the Offeror. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. The submission requirement will be a maximum of three pages of narrative. Additionally, the Offeror must include three sample utilization reports that demonstrate how data is gathered, analyzed, monitored and evaluated when a variance has been identified. Each sample should be no more than one page.

26. Provide an example of how the Offeror's analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.

27. Describe existing or planned Chronic Care/Disease Management programs that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Disease Management programs' data are analyzed and the results utilized by the Offeror to improve member outcomes.

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.

References: Section D, Paragraph 21, Medical Management (MM); AMPM, Chapter 1000, 42 CFR 438.240 (b)(3)

Quality Management Submissions

29. Describe how the Offeror identifies quality improvement opportunities. Describe the process utilized to select a performance improvement project, and the process utilized to implement or enhance multi-departmental interventions to improve care or services. Include information on how interventions will be evaluated for effectiveness.

30. Describe how the Peer Review Committee is structured and utilized by the Offeror and how its reviews/decisions are made and incorporated into the Offeror's quality management process.

31. The Offeror must submit responses to the following two quality-of-care scenarios. The Offeror should clearly identify each case scenario and describe the process that will be utilized beginning with when it becomes aware or is made aware of the situation. Timeframes should be included as appropriate. The submission requirement will be a maximum of three pages per scenario.

    A. The Offeror is notified of an immediate jeopardy at a facility in a rural county that has been operating without a license for several months. Efforts by the Offeror and the Arizona Department of Health Services to assist the owner in submitting the license renewal and supporting documentation have been unsuccessful. Six Medicaid members reside in this facility, two of which are enrolled with another Medicaid Contractor. The only other placement in the service area, an assisted living home, was recently shut down due to abuse and neglect of residents. There is one nursing facility in the geographic service area.

    B. The Offeror is notified of an immediate jeopardy at 4:15 P.M., on a Friday, before a holiday weekend, that a nursing facility in the Phoenix area will not have air conditioning/cooling available for approximately four days. Arizona Department of Health Services licensing staff, local city staff, and the Ombudsman are on site. Reporters are on the way. It is July and currently 116 degrees outside. There are 48 Medicaid members in the facility spread out across several AHCCCS Contractors.

32. Describe and provide an example of the Offeror's experience and commitment to improving quality of care and performance in specific measures of health care services. Describe how this commitment is spread throughout the Offeror's program.

33. Describe how feedback (complaints, survey results etc.) from members and providers is or will be used to drive changes and/or improvements to the Offeror's operations. Provide a member and a provider example of how feedback was used by the Offeror to drive change.

34. Describe the process that will be utilized by the Offeror to monitor services and service sites of members that reside in their own home. Describe what steps will be utilized if non-compliance is identified.

35. Oral Presentation

Responsive Offerors shall participate in a scheduled oral presentation, to last approximately two hours. All presentations will be scheduled to occur during the weeks of April 11 and 18. Presentations will be audio-taped by AHCCCS solely for the Agency's use in the evaluation process. AHCCCS shall notify each Offeror of their scheduled presentation no later than 5:00 pm on April 1.

The Offeror shall bring no more than five individuals to the meeting. Among these five individuals, the Offeror shall include persons with expertise in:

- clinical integration of acute, behavioral health, and long-term care services;
- case management;
- quality management; and
- network development

The Offeror shall submit the names and resumes of the participating individuals via the EFT/SFTP server by 3 p.m. MST on April 8. The Offeror shall indicate if a participant is a contractor/consultant not employed by the Offeror, and what role each individual will play during the implementation phase and the first year of the contract.

During the meeting, the Offeror will present solutions, and respond to oral questions, to two scenarios posed by AHCCCS. Offerors will be allotted time to privately discuss each scenario and to prepare a timed oral presentation. AHCCCS will:

- select a single scenario from submission requirement 24, A through D. All Offerors will be provided with new information about the selected scenario at the oral presentation.

- present to all Offerors a new quality management case for the second scenario. This scenario will be provided at the oral presentation.

References: Section D, Paragraphs 20, Quality Management (QM); 26, Grievance System AMPM, Attachments H(1), Enrollee Grievance System Standards and Policy; ACOM, 406 Enrollee Grievance Policy; Chapter 900; 42 CFR 438.240; 42CFR 438.408; 42 CFR 438.414

E. PROVIDER NETWORK

Provider Network Submissions

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

37. Any Offeror who is new to a GSA must submit a description of how it will launch a network capable of supporting its membership by October 1, 2011. Incumbent Contractors that are not new to a GSA are exempt from this requirement.

38. Describe how the Offeror will communicate with its provider network in explaining the standards for the program, changes in laws and regulations, and changes in subcontract requirements.

39. Describe how data and information obtained from throughout the organization are used to manage the network and identify how provider issues are communicated within the organization. Provide an example of how this process has been used in your organization.

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

41. Describe the process for ensuring that provider services staff receive adequate training.

42. Describe the process for evaluating provider services staffing levels based on the needs of the provider community.

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.

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

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]. The ACOM *ALTCS Network Standards Policy* specifies the network standards that have been established for most services (institutional, HCBS, acute, alternative residential, non-emergency transportation, etc.) by county and GSA. The Offeror's network will be evaluated by service and by site in each GSA bid by the Offeror.

    The Offeror must provide a listing of its provider network using the Network Summary template as described in ACOM 420 *Network Summary Policy*. Offerors shall have contracts with providers or signed Letters of Intent (LOIs) in order to complete the Network Summary template. The Sample LOI is the only format permitted. A signed LOI will receive the same weight and consideration as a signed contract. LOIs and contracts must be available for review by AHCCCS, when requested, as evidence of an understanding between the Offeror and provider. LOIs and contracts should NOT be included with the Offeror's proposal. AHCCCS may verify any or all referenced LOIs or contracts. New Offerors should not complete Column 2, AHCCCS Contractor Identification Number, of the Network Template. Incumbent Contractors should use their assigned Contractor number as defined in the *Network Summary Policy*.

    All Offerors must sign the Network Attestation Statement. Any network gap must be noted on the Attestation Statement.

    The LOI and Network Summary templates, and the Network Attestation Statement, are available in the Bidder's Library. The template(s) and the Network Attestation Statement must be submitted to AHCCCS via the EFT/SFTP server by 3 p.m. on the Proposal Due Date in Section A. There is no hard copy requirement for this submission. Instructions for access to the EFT/SFTP are included in Section A of the Data Supplement. The Offeror should upload to its designated folder using the names "Network Summary" and "Network Attestation Statement" for the two documents.

References: *Section D, Paragraphs 25, Staff Requirements and Support Services; 28, Network Development, and 29, Network Management; ACOM Policies 415, Provider Network Development and Management Plan; 416, Provider Information; 419 ALTCS Network Standards; 420 Network Summary*