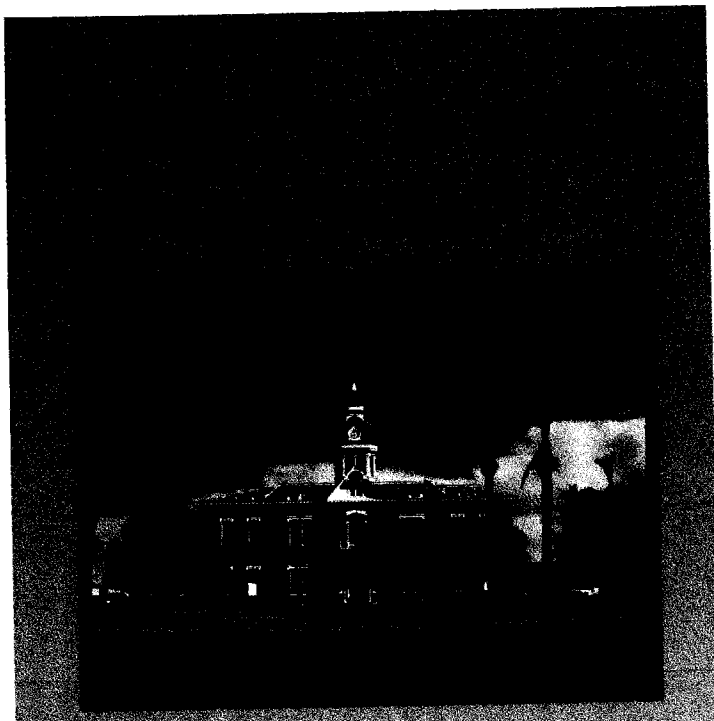

To:
Arizona Health Care Cost Containment System
701 E. Jefferson Street
Phoenix, AZ

For:
Pinal County Government

Prepared By:
Pinal/Gila Long Term Care
971 N. Jason Lopez Circle, Bldg. D
Florence, AZ 85132

PINAL • COUNTY
Wide open opportunity

A. GENERAL MATTERS

Subject Requirement:	***Reqmt. Page #***	***Offeror's Page #***
Offeror's signature page	(Front Page)	2
Amendment One	N/A	3
Amendment Two	N/A	32
Offeror's Checklist (this attachment)	N/A	41
Completion of all items in Section G of the RFP	Section G	43

AHCCCS	Notice of Request for Proposal		AHCCCS Arizona Health Care Cost Containment System
	SOLICITATION NO.: **YH12-0001**	PAGE 2	701 East Jefferson, MD 5700
		OF 160	Phoenix, Arizona 85034

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and best-and-final offers (if any). Signature also acknowledges receipt of all pages indicated in the Table of Contents.

Arizona Transaction (Sales) Privilege Tax License No.: _____

Federal Employer Identification No.: 86-6000556

For clarification of this offer, contact:

Name: Donna Beedle

Phone: (520) 866-6798 or (520) 483-0866

E-Mail Address: donna.beedle@pinalcountyaz.gov Fax: (520) 866-6708

P.O. Box 2140, 971 N. Jason Lopez Circle
Company Name

Florence, AZ 85132
Address
City State Zip

Signature of Person Authorized to Sign Offer 3/16/11

Pete Rios
Printed Name

Chairman, Pinal County Board of Supervisors
Title

CERTIFICATION

By signature in the Offer section above, the bidder certifies:

The submission of the offer did not involve collusion or other anti-competitive practices.

The bidder shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 99-4 or A.R.S. §§ 41-1461 through 1465.

The bidder has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted offer. Failure to provide a valid signature affirming the stipulations required by this clause shall result in rejection of the offer. Signing the offer with a false statement shall void the offer, any resulting contract and may be subject to legal remedies provided by law.

The bidder certifies that the above referenced organization ___ is/X_ is not a small business with less than 100 employees or has gross revenues of $4 million or less.

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

Your offer, including all exhibits, amendments and best-and-final offer (if any), contained herein, is accepted.

The Contractor is now bound to provide all services listed by the attached contract and based upon the solicitation, including all terms, conditions, specifications, amendments, etc., and the Contractor's Offer as accepted by AHCCCS.

This contract shall henceforth be referred to as Contract No. YH12-0001-_____.

Awarded this _____ **day of** _____ **2011**

_____
Michael Veit, as AHCCCS Contracting Officer and not personally

AHCCCS	**SOLICITATION AMENDMENT** Solicitation Number: RFP YH12-0001 Amendment Number 1 (One) Solicitation Due Date: April 1, 2011 3:00 PM (MST)	Arizona Health Care Cost Containment System (AHCCCS) 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Contract Management Specialist: Jamey Schultz, CMS E-mail: Jamey.Schultz@azahcccs.gov

A signed copy of this amendment shall be included with the proposal, which must be received by AHCCCSA no later than the Solicitation due date and time. This solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.	This Solicitation Amendment is hereby executed this the 24th day of February, 2011, in Phoenix, Arizona.
Signature [signature] Date 3/16/11	[signature]
Typed Name and Title	Michael Veit
Chairman, Pinal County Board of	Contracts and Purchasing Administrator
Name of Company Pinal County Supervisors	

ORIGINAL

ALTCS RFP YH12-0001 QUESTIONS AND RESPONSES

DATE: February 24, 2011

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
1	Capitation Template – Document F			Please confirm that the case management fee and risk/contingency are separate from the administrative portion of the capitation bid and not included in the 8 percent maximum.	The case management component and the risk/contingency component are not included in the 8 percent administrative maximum.
2				Is inclusion of the questions being addressed required as part of the narrative responses?	The number of pages that may be submitted for submission requirement 7 is four pages of narrative description of the claims adjudication process, five pages of flowcharts and up to four pages for the remittance advice.
3	Data Supplement	Utilization Data	ftp site	Can we assume that the Nursing home cost, and the assisted living cost is presented in the utilization data net of the share of cost? Can AHCCCS provide clearer direction to bidders on the distribution of the share of cost by placement within a county?	Yes, the Offeror can assume that the Nursing home cost and assisted living cost is presented net of share of cost. It is not necessary to know the distribution of share of cost by placement for rate development or the bid submission. AHCCCS estimates that more than 95% of share of cost is for members residing in nursing facilities.
4	Data Supplement Section C TREND AND RATE SETTING ASSUMPTIONS			Please confirm the paid through date for the encounters that are represented within the databook.	The Databook is based on encounter dates of service (DOS). The Databook includes information through the first December encounter cycle. Any encounters that were approved and adjudicated by the first December encounter cycle with DOS between 10/01/07 – 06/30/10 would be included in the databook.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
5	Policies and Manuals 419 ALTCS Network Standards	General Requirements		The requirement states "The standard (either an "X" or a number of facilities/providers required in the tables below) will indicate the number of providers by a specific city, zone, facility location or countywide coverage." Will this requirement be adjusted if the specific location does not currently have the required number of facilities in it?	This requirement will not be adjusted. Offerors should address any gaps or network deviations in the Network Development and Management Plan.
6	Reference Materials – Case Management Training	Bidders Library	N/A	In review of the references materials we noted some discrepancies in the document name and the uploaded file. Could you please review the materials under Case Management Training and confirm that the items posted reflect what we should use during the current procurement?	The links have been changed and this issue has been resolved.
7	ALTCS Bidders Library/ Policies and Manuals	Provider Affiliation Transmission User Manual		The Bidders' Library links to a Provider Affiliation Transmission User Manual dated October 1, 2009, which appears to be the manual used by Acute Care health plans as there are no distinguishing criteria (e.g., Definitions, AHCCCS question/contact person) for ALTCS. To what extent, if any, does AHCCCS expect an ALTCS-only plan to comply with the Provider Affiliation Transmission User Manual dated October 1, 2009 for the CYE2012?	The Provider Affiliation Transmission User Manual is intended for use by Acute Care contractors only, not ALTCS contractors. This link will be removed from the Bidders' Library.
8	Data Supplement Section C TREND AND RATE SETTING ASSUMPTIONS	Overview	1	General Trend and Rate Setting Assumptions states that "For any GSA where the historical encounters varied significantly from financials AHCCCS may use a true-up factor to account for possible missing encounters. Please provide additional support to identify the impact of this true-up factor either separately or within the databook information. For example, what time periods and GSA's were impacted	After further review of the data AHCCCS will not be using a true-up factor for the base data.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				by this factor? Were only specific services impacted? What is the magnitude of the impact to the base data?	
9	I. Instructions to Offerors	Q1	1	Is an actuarial certification required if Offeror submits a rate within the published rate range?	Yes. An actuarial certification is required for all Offerors.
10	Section A- Data Supplement Instructions and Overview	**None**	1	When will AHCCCS notify proposers when individuals have been approved to access data and reports on the EFT/SFTP?	On average it is taking two days for notification once all paperwork is submitted. All Offerors that have completed and submitted the appropriate paperwork have been approved and notified as of February 25, 2011.
11	Program Requirements	3/Member Identification Cards	18	Beginning October 1, 2011 the Contractor is responsible for paying the costs of producing AHCCCS member identification cards. The Contractor will receive an invoice the month following the issue date of the identification card. What is the anticipated form and format of this invoice? An example will be helpful. How will the Contractor's capitation rate be adjusted to account for this additional expense? What is the anticipated form of payment that will be acceptable to ALTCS?	A process is currently in place for the AHCCCS Acute Care Contractors where the contracted vendor receives a file from AHCCCS and invoices each Contractor for identification cards produced and sent out to enrolled members. Contractors will pay the vendor directly, using a form of payment acceptable to the vendor. This is the same process that would be utilized during CYE12. The cost of cards is estimated to be immaterial thus capitation rates will not be adjusted.
12	Program Requirements	3/Member Identification Cards	18	During CYE 2012 AHCCCS will meet with Contractors to develop a process for Contractors to also produce and issue member identification cards. Contractors will have complete responsibility for the production, distribution and cost of member identification cards by no later than October 1, 2012. Please define the testing process regarding the transfer of the data necessary to produce ID cards? Please describe the minimum requirements regarding the material used for ID cards? Will ALTCS have minimum specifications for the placement of critical telephone numbers and web site addresses? Will the process mentioned above give the Contractor adequate time for design and testing? How will the Contractor's	A workgroup will be formed comprised of Contractors receiving awards for CYE12 and AHCCCS staff to implement this requirement. Policies and procedures as well as specifications for testing and data transfers will be developed by the group. The cost of cards is estimated to be immaterial thus capitation rates will not be adjusted.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				capitation rate be adjusted to account for this additional expense (including design and testing)?	
13	Program Requirements	4/Open/Annual Enrollment - Open Enrollment Subsection	18	Should AHCCCS add choice of Contractors to a Geographic Service Area (GSA) other than Maricopa County, all existing members in that GSA will be given the opportunity to choose the Contractor with whom they will be enrolled [42 CFR 438.56(c)(2)(ii)]. Please clarify the intent of this requirement since the maximum number of contracts ALTCS intends to award is limited to "1" in all other GSAs?	The language allows AHCCCS flexibility; however, at this time AHCCCS does not intend to add choice of Contractors to any GSA other than Maricopa County.
14	Program Requirements	3/Enrollment and Disenrollment	18	What is the process Contractors will need to use to report members' acute care health plan choice to AHCCCS?	We believe you are referring to when a member becomes ineligible for ALTCS but remains eligible for the acute care program. This is a very rare occurrence, however, in the event it does occur, the Contractor shall obtain the member's health plan choice and submit that choice to the Communication Center in the Division of Member Services (DMS).
15	Program Requirements	3/Enrollment and Disenrollment	18	Can AHCCCS confirm that the Contractor is only responsible for Member Identification Cards for the ALTCS members in each contracted GSA?	Contractors will only be responsible for Member Identification cards for their own assigned members in each GSA.
16	Program Requirements	3/Enrollment and Disenrollment	18	Will AHCCCS send selected vendors 5010 formatted files for testing and operations? If not, can AHCCCS provide the date it intends to begin transmitting 5010 file formats?	Yes. All testing with selected vendors (outbound and inbound) will be conducted in applicable HIPAA 5010 file formats. All 5010 formats will be in place for October 1, 2011.
17	Program Requirements	3/Enrollment and Disenrollment	18	Where on the 834 or other file will AHCCCS communicate the member's selected PCP to Contractors?	PCP data is assigned and maintained by the Contractor. At this time AHCCCS does not receive or maintain this information.
18	Program Requirements	4/Open/Annual Enrollment - Annual Enrollment Choice Subsection	19	For counties with more than one Contractor, AHCCCS may require a monthly submission of network information (PCPs, nursing facilities, Assisted Living Facilities etc.) to support initial enrollment, annual enrollment choice and open enrollment. Details will be provided at a later date.	If AHCCCS decides to require this information, details and formatting requirements will be provided with adequate time for design and testing. If AHCCCS deems the expense to be material, capitation may be adjusted.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				Will the process mentioned above give the Contractor adequate time for design and testing? How will the Contractor's capitation rate be adjusted to account for this additional expense (including design and testing)?	
19	Program Requirements	5/Enrollment Hierarchy - Auto-Assignment Algorithm	19	The algorithm is a mathematical formula used to distribute members to the various Contractors in a manner that is predictable and consistent with AHCCCS goals. So the Offeror may determine the impact of this subsection on its enrollment projections and process for establishing competitive capitation rates please define "AHCCCS goals" as used in this context. Will a timeframe be established and shared with Offerors?	Based on historical data, an estimated 5% of new members in Maricopa County are auto-assigned. In order to ensure that new Contractors reach an enrollment level that allows for efficiencies and improved viability, AHCCCS may auto-assign a higher percentage of new members to the new Contractor for a period of time. Decisions will be made based on the outcome of the awards and member assignment and will be shared with all Contractors prior to October 1, 2011.
20	Program Requirements	5/Enrollment Hierarchy - Auto-Assignment Algorithm	19	AHCCCS may change the algorithm at any time during the term of this contract. AHCCCS is not obligated to adjust the algorithm for any financial impact this may have on a Contractor. Will ALTCS give the Contractor at least 90 days notice prior to any adjustment? It will be helpful if ALTCS provides all impacted Contractors with a timeframe and projected impact the algorithm change will have on the Contractors to allow for personnel and network adjustments. Will ALTCS analyze personnel and network adequacy of the Contractors to make sure there will be adequate supports and network to serve the members? Please also provide an example or rationale as to under what circumstances and when AHCCCS may make changes to this algorithm.	Given that on average approximately 5% of new enrollment is auto-assigned in Maricopa county, AHCCCS does not anticipate that algorithm changes will result in significant personnel or network adjustments. Contractors will be given adequate notice of planned algorithm changes. Any pertinent data will be shared at that time. No example will be given.
21	Program Requirements	5/Enrollment Hierarchy	19	What is the mathematical formula AHCCCS will use to auto-assign members?	AHCCCS will assign a percentage to each Contractor for auto-assignment based on estimated final Contractor enrollment in Maricopa county. AHCCCS may initially favor Contractors new to a GSA in determining the algorithm. The auto-assignment

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
					percentages will be shared prior to October 1, 2011. The mathematical formula programmed into the system allows assignment to the Contractor that is farthest away from their assigned target percentage.
22	Program Requirements	5/Enrollment Hierarchy	19	Based on AHCCCS' experience, what is the expected percentage of members who will choose vs. those who will be auto-assigned for each GSA?	Information regarding historical auto-assignment and choice is provided in the Data Supplement section of the Bidders' Library.
23	D- Program Requirements	8 - Contract Termination, first paragraph	21	The RFP states: "...AHCCCS reserves the right to extend the term of the contract on a month-to-month basis to assist in any transition of members." Please add language to the effect that rates will remain actuarially sound, assignment algorithm will remain the same, and the program will remain stable.	AHCCCS will not add this language.
24	D- Program Requirements	8 - Contract Termination, subsection a	22	The RFP states that Contractor shall be responsible for "Payment of all outstanding obligations for medical care rendered to members, until AHCCCS is satisfied that the Contractor has paid all such obligations." Please revise as follows: "Payment of all outstanding obligations for covered medical care rendered to members, until Contractor reasonably demonstrates that Contractor has paid all such obligations, or until AHCCCS is otherwise satisfied that the Contractor has paid all such obligations."	Change will be considered for possible future amendment.
25	D- Program Requirements	8 - Contract Termination, subsections c, d, e and f	22	Please insert the phrase "which release shall not be unreasonably withheld or delayed" at the end of subsections c, d, e and f.	Change will be considered for possible future amendment.
26	Program Requirements	10/Covered Services	22	Please provide a list of DME codes for reimbursement on provider fee schedules when providers bill with the following modifiers: LL, NR, RA and RB. Please provide the provider reimbursement amounts when the previously mentioned modifiers are indicated.	Current AHCCCS Fee Schedules are available on the AHCCCS Website.
27	Program Requirements	17/ Member Handbook and	41	When there are program changes, notification shall be provided to the affected members at least 30 days	AHCCCS will provide direction in the event notification to members of a program change is

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
		Member Communications		before implementation. Under what circumstances does a "program change" require 30 day prior notification? We understand the importance of keeping our member's informed regarding program changes that have an impact on the member. In our experience there are multiple program changes each year that may not impact the member, the member's access to care or member's covered services. It would be helpful if ALTCS could provide direction.	necessary.
28	Program Requirements	17/ Member Handbook and Member Communications	41	The Contractor shall produce and provide the following printed information to each member or family within 12 business days of receipt of notification of the enrollment date [42 CFR 438.10(f)(3)] Can the Contractor reasonably expect that we will also be allowed 12 business days after receipt of enrollment notification to produce the member's ID card as specified in Section D 3, Member Identification Cards?	A process is currently in place for the AHCCCS Acute Care Contractors where the contracted vendor receives a file from AHCCCS and invoices each Contractor for identification cards produced and sent out to enrolled members. A workgroup will be formed comprised of Contractors receiving awards for CYE12 and AHCCCS staff to implement this requirement. Policies and procedures (which will address timing) as well as specifications for testing and data transfers will be developed by the group.
29	Program Requirements	17/ Member Handbook and Member Communications, Subsection I.	41	The handbook must be submitted to AHCCCS, Division of Health Care Management for approval within four weeks of receiving the annual renewal amendment and upon any changes prior to distribution. In the event that AHCCCS, Division of Health Care Management hasn't provided comment on a Contractor's submitted handbook, can the Contractor then assume that it is approved?	No. Member handbooks must be approved by AHCCCS prior to distribution.
30	Program Requirements	20. Quality Management	43	Participation in community initiatives including applicable activities of the Medicare Quality Improvement Organization (QIO). Please describe any anticipated, expected or planned community initiatives that ALTCS and the QIO may	AHCCCS does not have any information related to any specific community initiatives at this time that the ALTCS Contractor would be required to participate in. AHCCCS can not estimate anticipated personnel needs or costs, without a project being specified.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				implement during the contract period that will require mandatory Contractor participation. Please describe the expected personnel needs or other cost of these anticipated, expected or planned community initiatives. Please describe how much advanced notice the Contractor will receive prior to a mandatory participation. Is the QIO aware of these anticipated, expected or planned community initiatives?	Contractors would be made aware of an activity/initiative when AHCCCS is made aware. This requirement was added to a previous ALTCS contract at the request of the QIO and other community agencies.
31	Prog. Reqs	D.20	43	States "The Contractor must ensure that the Quality Management/Quality Improvement Unit within the organization is separate and distinct from any other units or departments such as Medical Management or Case Management.? Does this require separate and distinct staff?	Section D, Paragraph 25 (Staff Requirements and Support Services) states that an individual staff member is limited to occupying a maximum of two of the Key Staff positions. The Contractor must be able to demonstrate, however, how it will maintain a separate and distinct Quality Management/Quality Improvement Unit and the steps that it will take to ensure that the Unit is able to successfully carry out the functions of a Quality Management Program, as outlined in Section D, Paragraph 20(A).
32	Program Requirements	20. Quality Management, Subsection B.I	44	The current AHCCCS established performance measures may be subject to change when these core measures are finalized and implemented. The Contractor must have a process in place for internal monitoring of performance measures rates, using the standard methodology established or adopted by AHCCCS, for each required performance measure. Will the Contractor receive advanced notification of at least 90 days prior to implementation of these changes? Will the Contractor have at least 90 days to implement any changes? Will ALTCS adjust capitation rates if these changes result in additional program or administrative costs?	If the core measures are mandated by the Centers for Medicare and Medicaid Services (CMS), AHCCCS will add the specific requirements to the Contractors contract. As AHCCCS is made aware of performance measure requirements, it will communicate the changes to Contractors in a timely manner and costs will be analyzed to determine if a capitation rate adjustment is necessary. It is anticipated that there would be at least 90 days notice prior to any mandated changes to performance measures.
33	Section D, Program	25. STAFF REQUIREMENTS	48	When should a proposer notify AHCCCS of a possible request for an exception to the contract requirement -	While AHCCCS does not encourage exceptions to Key Staff Position requirements, as part of the

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
	Requirements, a subsection of A. General	and SUPPORT SERVICES		"An individual staff member is limited to occupying a maximum of two of the Key Staff positions listed below unless prior approval is obtained by AHCCCS, Division of Health Care Management"? As part of the proposal? Upon contract award?	proposal, the Offeror should indicate if an individual will be occupying more than two of the Key Staff positions and that the Offeror will be requesting an exception if awarded a contract.
34	D. Program Requirements	25/Staff Requirements and Support Services	51	The CYE2012 requirement for Case Management Supervisor requires "3 years of management/ supervisory experience in the healthcare field". How does an organization factor in an individual's promotion from within their organization? Example: Case Manager with experience who has shown leadership skills and would be promoted from within.	In a future amendment for October 1, 2011, AHCCCS will modify Paragraph 25, Staff Requirements and Support Services, subsection Additional Required Staff, bullet y - Case Management Supervisor(s) to read: "To oversee case management staff who shall have the qualifications of a case manager as defined in Section D, Paragraph 16 and a minimum of three years of management/supervisory experience in the health care field or a minimum of three years of case management experience."
35	Program Requirements	28/Network Development	54	The Contractor shall design their provider networks to maximize the availability of community based primary care and specialty care access and that reduces utilization of emergency services, one day hospital admissions, hospital based outpatient surgeries when lower cost surgery centers are available, and hospitalization for preventable medical problems. Please define "community based primary care and specialty care" as used in this section. Please be specific as to "AHCCCS Provider Types".	This term refers to primary and specialty care providers who, whenever possible, practice in the community in which the member resides. A list of AHCCCS provider types for primary care and specialty care is available in the Bidders' Library.
36	Program Requirements	28/Network Development	54	The Contractor is expected to design a network that provides a geographically convenient flow of patients among network providers. Please provide a definition of "geographically convenient flow" as used in this section. Especially in consideration of the requirement in this section: The Contractor shall develop and maintain a provider	Contractors are expected to develop a network that affords providers with a reasonable opportunity for sufficient members who may utilize their services. The Contractor is expected to establish and maintain a network that is responsive to the needs of each individual as well as the membership in general. As such, providers must be geographically positioned to

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				Network Development and Management Plan which ensures that the provision of covered services will occur as stated above [42 CFR 438.207(b)]. Would ALTCS consider there to be a difference in "geographically convenient flow" in urban or rural GSAs? Would ALTCS consider there to be a difference in "geographically convenient flow" for specific "zones" within Maricopa and Pima GSAs based on availability of providers and concentration of members? If yes, please define. How would the Offeror demonstrate a "geographically convenient flow" in its Network Development Plan?	ensure that members are able to fully access needed services in a timely manner. This requirement applies to rural and urban areas or zones. It is up to the Offeror to determine how to demonstrate that its network will meet this requirement.
37	Program Requirements	28/Network Development	54	Please define "community norms"	Community norms refer to services and settings generally available to the general public.
38	Program Requirements	28/Network Development	57	What are the numbers of members who are dual eligible versus non-dual eligible?	Information regarding dual and non-dual placement and member months by county is available in the Data Supplement portion of the Bidders' Library.
	Program Requirements	28/Network Development	57	Does the January 1, 2013 deadline imposed for Maricopa and Pima Counties also apply to all other counties where AHCCCS requires Contractors to be a MA Plan and/or MA SNP or attempt to develop a formal relationship with a MA Plan and/or MA SNP? If the expectation is that a Contractor in a rural county establish a MA/SNP plan or relationship with such earlier than January 1, 2013, is this expected to be in place by October 1, 2011; January 1, 2012; or at the time of bid submission?	The January 1, 2013 deadline does apply to other non-Maricopa/Pima counties. The RFP / Contract will be amended to include this deadline.
39	Program Requirements	28/Network Development	57	Can AHCCCS elaborate on the goals and objectives, and expected collaboration with Contractors to develop E-prescribing during the contract period?	AHCCCS expects to develop goals and objectives in the future. Contractors will be informed at that time.
40	Program Requirements	28/Network Development	57	In relation to dual eligibles, what are the acceptable qualifications for attempting to develop a formal relationship with a MA Plan and/or MA SNP? What constitutes a formal relationship, e.g., LOI, contract? Can multiple Contractors have a formal relationship	A formal relationship includes a contractual arrangement between the Contractor and the MA/MA SNP to work together and share information for the purpose of coordinating care for the member. Multiple Contractors can have a formal relationship

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				with the same MA/MA SNP vendor?	with the same MA/MA SNP vendor.
41	Program Requirements	31/Provider Registration	59	The National Provider Identifier (NPI) is required on all claim submissions and subsequent encounters (from providers that are eligible for a NPI). Please provide detailed instructions for submitting claims and encounters for providers that are ineligible for obtaining an NPI.	AHCCCS policies and processes define and recognize types of providers who are Atypical (not eligible) for National Provider Identifier purposes. Detailed instructions for the submission of claims and encounters are included in the AHCCCS Fee For Service Provider Manual and the AHCCCS 837 Companion Documents available in the Bidders' Library.
42	Program Requirements	32/Network Summary	59	In addition to the above, for counties with more than one Contractor AHCCCS may require a monthly submission of network information (PCPs, nursing facilities, Assisted Living Facilities etc.) to support initial enrollment, annual enrollment choice and open enrollment. If needed, details will be provided at a later date. Please provide additional information about this requirement. Under what circumstances will AHCCCS need this network information? Will there be specific file formatting requirements? Depending on the specifications the Contractor will need adequate time to program and test to meet these specifications.	The Division of Member Services may require additional information to assist members when they are choosing Contractors. If AHCCCS decides to require this information, details and formatting requirements will be provided with adequate time for design and testing.
43	Program Requirements	31/Provider Registration	59	Will AHCCCS provide a database or other resource to look up provider AHCCCS ID numbers? If so, when can Contractors expect to receive this information?	Contractors receive a weekly provider extract file with identification numbers which details additions, terminations and changes to AHCCCS registered providers.
44	D- Program Requirements	33 - Subcontracts	60	The RFP states: "A merger, reorganization, or change in ownership of an Administrative Services subcontractor of the Contractor shall require a contract amendment and prior approval of AHCCCS." To confirm, is this intended to require AHCCCS approval of assigning a subcontract to a new owner or effecting the amendment, rather than approval of the subcontract merger, reorganization or change in	If a Contractor has an approved subcontract with a third party for Administrative Services, and the entity providing the Administrative Services merges, reorganizes, or changes ownership, then the Contractor is obligated to provide notice to AHCCCS of the change, and AHCCCS reserves the right to withdraw its approval of the subcontract for Administrative Services upon any such change. If the

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				ownership itself? (Similar to the requirement on page 75, Section 49, which states: "If there is a change in ownership of the entity with which the Contractor has contracted for management services, AHCCCS must review and provide prior approval of the assignment of the subcontract to the new owner.")	approval is withdrawn, the Contractor must resume direct performance of the administrative services. The Contractor may request continued approval of the subcontractor for Administrative Service in advance of any merger, reorganization, or change of ownership by the Administrative Services subcontractor.
45	Program Requirements	44/Claims Payment/Health Information System	70	In the General Claims Processing Requirements subsection there is a paragraph that reads: "Standardized claims for services must be submitted pre R9-22-719, therefore: • Roster billing is not permitted for nursing facilities for dates of service on or after October 1, 2011; • Contracts shall work with all other providers to eliminate roster billing and submit standardized claims with dates of service on or after October 1, 2012." To make sure the Offeror is clear please define "roster billing". A representative example would be very helpful for the Offeror and a useful communication tool with providers. To be clear, is it the intent of this provision that the nursing home (for October 1, 2011) and other providers (after October 1, 2012) must prepare and submit a valid and accurate claim in the appropriate format? Would AHCCCS consider it to be acceptable if the Offeror/Contractor prepared the claim for the nursing home/provider and then adjudicated the claim to identify under/over billing or fraud? What is the penalty for failure to perform relative to these requirements? Will the Contractor be subject to sanctions in accordance with Section D, Paragraph 80, Sanctions?	Any claim that does not meet the standardized claim requirements of R9-22-719 is considered roster billing. Effective October 1, 2011 all nursing facilities must prepare and submit a claim in the standardized format – UB04 or 837 Institutional. Effective October 1, 2012 all other providers must prepare and submit a claim in the appropriate standardized format. It would not be appropriate for the Contractor to prepare the claim for the nursing facility/provider and then adjudicate the claim as this does not meet R9-22-719. Failure to comply with Contract requirements may result in sanctions in accordance with Section D, Paragraph 80, Sanctions.

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46	D. Program Requirements	44. Claims Payment/ Health Information System	70	As this is a significant change in contract language as addressed by AHCCCS at the Bidders' Conference, please provide AHCCCS's definition of "Roster Billing" and examples of what methodologies may and may not be used by the health plans for CY2012.	Any claim that does not meet the standardized claim requirements of R9-22-719 is considered roster billing.
47	D. Program Requirements	44. Claims Payment/ Health Information System	70	Is "Roster Billing" also disallowed for adult immunization billing?	Currently roster billing for adult immunization is not allowed. Additionally, Contractors must work with all other providers (other than nursing facilities) to eliminate roster billing and submit standardized claims with date dates of service on or after October 1, 2012. Nursing facilities shall be in compliance by October 1, 2011.
48	D. Program Requirements	44. Claims Payment/ Health Information System	70	Please provide a sample or cross-reference for the "standardized claim" form (if other than the UB-04), or otherwise describe the process, AHCCCS expects all nursing facilities to use when submitting claims to ALTCS Contractors on or after October 1, 2011.	AHCCCS expects nursing facilities to use a UB-04 standardized claim form or an 837 Institutional electronic format.
49	Program Requirements	45/Minimum Capitalization Requirements	73	In this section (Minimum Capitalization Requirements) the New Offerors subsection includes the following sentence: "The capitalization requirement is subject to a $5,000,000 ceiling regardless of the number of GSAs awarded." However, in the Continuing Offerors subsection includes the following sentence: "Continuing Offerors that are bidding a new GSA must provide the additional capitalization for the new GSA they are bidding." Please reconcile the differences between these statements – is the capitalization requirement of a continuing offeror capped at a ceiling of $5,000,000 or does the continuing offeror have a competitive disadvantage of providing the additional capitalization of any new GSA they way want to bid? Is the intent to reduce competitive proposals for new GSAs?	The sentence following the one you quoted in the Continuing Offeror's section states "Continuing Offerors will not be required to provide additional capitalization if they currently meet the equity per member standard with their existing membership and their excess equity is sufficient to cover the proposed additional members, or they have at least $5,000,000 in equity." Thus, there is a level playing field for both new and continuing Offerors and no intent to reduce competitive proposals for new GSAs.
50	Program Requirements	52/Financial Viability Standards	75	If, in the course of fulfilling the administrative requirements set forth by the contract, a Contractor	AHCCCS will consider new Contractor start-up costs and lower membership when monitoring compliance

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				incurs administrative costs that result in a ratio of greater than 8%, will AHCCCS consider alternatives to enforcement of the administrative ratio until such time that the Contractor's membership grows to a level supporting the stated ratio?	with the administrative cost ratio.
51	Program Requirements	52/Financial Viability Standards	75	How is the medical expense ratio calculated, e.g., on a cash or accrual basis? In accordance with NAIC requirements?	Contractors are required to prepare and present financial statements on the accrual basis of accounting in accordance with GAAP. The calculation for medical expense ratio is provided in this section of the RFP, Section D, Paragraph 52, Financial Viability Standards.
52	D- Program Requirements	53 – Separate Incorporation	76	The RFP states: "Within 60 days of contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract." The Contractor understands that using a separate "doing business as" entity name, for use solely for the performance of the requirements of this or another AHCCCS contract, will meet this requirement. Under what circumstances would this scenario not be acceptable?	It is incorrect to assume that use of a d/b/a meets the requirement. The RFP requires the establishment of a corporate entity whose only authorized business is to provide services and coverage under the contract with AHCCCS. It is acceptable to have a single corporate entity that is authorized to provide services under multiple contracts with AHCCCS (e.g., one corporate entity that holds separate contracts with AHCCCS for both the acute and long term care programs).
53	Program Requirements	56 Compensation	77	The RFP lists 7 data sources (a – g) utilized by its actuaries as their basis for rate setting. What assumptions did AHCCCS make in regards to the completeness of the encounter data utilized in the databook, by county?	See Section C - ALTCS General Trend and Rate Setting Assumption for completion factors by GSA.
54	Program Requirements	56/Compensation	77	How will Medicare risk adjustment payments impact capitation payments?	Medicare risk adjustment payments have no impact on AHCCCS' capitation payments to the Contractor.
55	Program Requirements	56/Compensation	77	Which data elements in which files will be used to indicate Prior Period Coverage (PPC) capitation, prospective capitation, reinsurance and payments from liable first and third parties?	Please clarify the question. What files are being referenced?
56	SECTION D. PROGRAM REQUIREMENT	56. COMPENSATION	78	Section states that "AHCCCS adjusts its rates to best match payment to risk" and in renewal years AHCCCS may look at reinsurance, Medicare	The mix of dual and non-duals are reflected in the data used for capitation rate setting, and rarely is there a significant shift that affects the rates. AHCCCS

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	S			enrollment, HCBS member mix and member share of cost values to determine if adjustment are necessary. The RFP also identifies how AHCCCS analyzes or reconciles differences in reinsurance experience, HCBS member mix experience and member share of cost experience. Please provide additional information related to how AHCCCS reviews, analyzes or reconciles deviations in the rate development driven by Medicare enrollment.	monitors dual enrollment for consistency from year to year to determine if changes to capitation rates are necessary. AHCCCS will pay particular attention to Contractors in Maricopa county that may differ from the county average mix of dual and non/dual members to determine if a capitation rate adjustment is necessary.
57	Program Requirements	58. Reinsurance	79	A change in the reinsurance program is the requirement that an inpatient stay occur before a 'regular reinsurance case' can be created. AHCCCS has provided an overall estimate of the impact of this change, but what is AHCCCS's actuarial estimate (percentage) of the reduction in reinsurance which will result from this change by county?	AHCCCS will provide this information by GSA with the reinsurance offset information in the Bidders' Library prior to 3/1/11.
58	Program Requirements	58/Reinsurance	79	Can AHCCCS describe how the reinsurance recoveries are reconciled and flow through the capitation calculation?	Reinsurance is a per member per month offset, by GSA, to the Acute component of the capitation rates. Reinsurance recoveries are not reconciled.
59	Program Requirements	58/Reinsurance-Regular Reinsurance subsection	80	Regular reinsurance coverage applies to prospective enrollment periods and is only available for members who have had an inpatient stay during the contract year. Once an inpatient stay has occurred, all reinsurance covered services for the entire contract year may be applied to meet the deductible. Please define an "inpatient stay"? Is there a limit on the length of stay (must the member have a minimum length of stay)? Will ALTCS accept notice of prior authorization? What protection does the Contractor have if the inpatient claim is not received until 11 months after the end of the contract year?	There is no minimum or maximum limit to the length of stay. Once the inpatient encounter is adjudicated and approved through both the encounter and reinsurance edits, the system will automatically assign to the reinsurance case all reinsurable encounters for that member. Encounters are reviewed individually for timeliness and reinsurance edits. The reinsurance time limit is 15 months from end date of service. AHCCCS will not accept notice of prior authorization.
60	D- Program Requirements	59 – Capitation Adjustments	83	The RFP states: "In these instances the adjustment and assumptions will be discussed with the Contractor prior to modifying capitation rates." Please insert the	Regarding: (i) Contractor is always given the contract amendment for signature. Contractor

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				following sentence at the end of this section: Notwithstanding any other provision of this Agreement: (i) any modification materially, adversely affecting Contractor's compensation, reimbursement, or scope of services provided hereunder shall not be effective without Contractor's prior written consent; and (ii) if the Contractor and AHCCCS cannot reach agreement on the terms of such written modification within sixty (60) days after Contractor delivers a notice of termination to the AHCCCS, the Contractor may terminate this Agreement without penalty upon the expiration of such sixty (60) day period.	has the option not to sign. (ii) Contract language already stipulates the terms for notification to AHCCCS of intent not to renew or continue as an AHCCCS Contractor. See Section E, Paragraph 25, Term of Contract and Option to Renew for further information.
61	Program Requirements	60/Member Share of Cost	84	How is the Share of Cost calculated, and how does it apply to the capitation calculation?	The AHCCCS Division of Member Services (DMS) calculates a member's SOC based on many factors such as a member's income and spousal deductions. Members are notified by letter of their SOC. For more specifics see the ALTCS Eligibility Policy Manual on the AHCCCS Website. For capitation rate development, Share of Cost is calculated using most recent historical actual share of cost information for ALTCS members by GSA. Share of Cost is an offset to the capitation rate. See the Capitation Bid Template in the Bidders' Library for further information regarding how SOC applies to the capitation calculation.
62	Program Requirements	60/Member Share of Cost	84	How is the Share of Cost information shared with Contractors? Is it located within the 834 enrollment files?	SOC information is transmitted on the 834 roster files to the Contractor. In addition, Contractors may log on to the AHCCCS Online website and/or PMMIS to obtain individual member's SOC information.
63	Program Requirements	73/Data Exchange Requirements	93	Where can Contractors find Companion Guides or instructions for proprietary file formats and reports?	All data exchange related documentation including HIPAA Companion Guides, and technical guidelines for proprietary file formats are available in the Bidders' Library.

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64	Program Requirements	78/Operational and Financial Readiness Reviews	96	Please describe the Operational and Financial Readiness Review process, including specific milestones for system testing, on-site visits, AHCCCS departments that will be involved and their roles, and subcontracted entities with whom Contractors will interact. Please provide an explicit list of all file formats and reports that will be required to test during Readiness Review.	Readiness Reviews typically begin in mid-summer and assess a new Contractor's ability to implement the contract October 1st. In general, areas assessed are: the hiring of staff, physical plant operations, claims processing, case management, quality management, medical management, encounter reporting, grievance system; development of policies and procedures etc. Explicit information regarding milestones, participants, file formats and reports is not available at this time.
65	Program Requirements	78/Operational and Financial Readiness Reviews	96	Will AHCCCS provide additional information or guidance for new MCOs to begin implementation procedures prior to contract award?	Information will not be provided prior to contract award. Prior to contract implementation AHCCCS will schedule a series of meetings with new Contractors to provide guidance and assistance. Meetings will be scheduled as soon as feasibly possible (late May or early June).
66	D- Program Requirements	80 – Sanctions; Care Notice Process	98	The RFP provides that AHCCCS may provide a notice and opportunity to cure. Please change the word "may" to "shall."	Contract language will not be changed.
67	Program Requirements	85/Enrollment and Capitation Transaction Updates	101	Will AHCCCS provide a list of Rate Codes, a description of their values and their impact on the capitation received by the Contractor?	EPD capitation rates are paid by contract type, not rate code. Contract types J and 2 are tied to full EPD capitation rates. Contract types L and 4 are tied to Acute Care Only capitation rates. Contract types M and O are tied to PPC rates. A list of rate codes is located in the Bidders' Library in the Rates section, bullet point Enrollment Rate Codes and Eligibility Categories. Rate code descriptions are located at: http://www.azahcccs.gov/commercial/ContractorResources/manuals/TIG/HealthPlan/codes/RF401rate.aspx. Contract type descriptions are located at: http://www.azahcccs.gov/commercial/ContractorResources/manuals/TIG/HealthPlan/codes/ContractTypes.aspx.

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68	E – Contract Terms and Conditions	4 – Contract Interpretation and Amendment; Written Contract Amendments	103	The RFP states: "The contract shall be modified only through a written contract amendment within the scope of the contract signed by the procurement officer on behalf of the State." Please add to the end of this sentence the phrase "and signed by a duly authorized representative of Contractor."	Change will be considered for possible future amendment
69	E – Contract Terms and Conditions	4 – Indemnification	104	The RFP states: "The Contractor agrees to indemnify, defend, and hold harmless the State from and against any and all claims, losses, liability, costs, and expenses, including attorney's fees and costs, arising out of litigation against AHCCCS including, but not limited to, class action lawsuits challenging actions by the Contractor." Would it be accurate to revise this sentence to clarify it only refers to actions arising out of litigation against AHCCCS "as a result of Contractor's performance or nonperformance of this Agreement"?	Change will be considered for possible future amendment.
70	E – Contract Terms and Conditions	19 – Temporary Management / Operation of a Contractor and Termination	107	The RFP states: "AHCCCS reserves the right to terminate this contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the contract…." Please insert the word "material" before "term or condition."	Change will be considered for possible future amendment.
71	E – Contract Terms and Conditions	19 – Temporary Management / Operation of a Contractor and Termination	107	The RFP states: "The Contractor shall be liable for any excess costs incurred by AHCCCS in re-procuring the materials or services." Please insert the word "commercially reasonable" before "excess."	Change will be considered for possible future amendment.
72	E – Contract Terms and Conditions	25 – Term of Contract and Option to Renew	108	The RFP states: "If the Contractor chooses not to renew this contract, the Contractor may be liable for certain costs associated with the transition of its members to a different Contractor." What does the phrase "certain costs" refer to?	Certain costs include any costs incurred related to transitioning members due to the Contractor's choice to not renew during a five year contract cycle.
73	E – Contract Terms and Conditions	29 -- Contract	110	The RFP states: "In the event of a conflict in language between the two documents referenced, the provisions and requirements set forth and/or	If there is a conflict between the AHCCCS RFP and the Offeror's proposal, what is in the AHCCCS RFP will govern. This language will be clarified in a

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				referenced in the RFP shall govern." Which two documents are referenced here? If this refers to all documents identified in this paragraph, what is the order of precedence?	future amendment to Section E.
74	E – Contract Terms and Conditions	29 -- Contract	110	The RFP states: "AHCCCS reserves the right to clarify any contractual relationship in writing, and such written clarification shall govern in case of conflict with the applicable requirements stated in the RFP or the Contractor's proposal." Would such written clarification require a contract amendment to be effective?	Not all clarifications will require an amendment to the contract.
75	E – Contract Terms and Conditions	38 – Cooperation with Other Contractors	111	The RFP states: "AHCCCS may award other contracts for additional work related to this contract and Contractor shall fully cooperate with such other contractors and AHCCCS employees or designated agents, and carefully fit its own work to such other contractors' work. The Contractor shall not commit or permit any act which will interfere with the performance of work by any other contractor or by AHCCCS employees." What does the phrase "and carefully fit its own work to such other contractors' work" mean? Also, is it accurate to change the phrase "shall not commit" to "shall not knowingly commit"?	AHCCCS will consider clarification and change in a future amendment.
76	G. Representations I. Instructions to Offerors	Section G. I. General Matters	137-141 151	The editable form for General Matters that is posted on the web is in 10.5 font and so our response is automatically formatted as 10.5 font. Will AHCCCS accept this section in a 10.5 font?	Yes
77	G. Representations I. Instructions to Offerors	Section G. I. General Matters	137-141 151	The editable form for General Matters that is posted on the web is already paginated and has a footer. Will AHCCCS post a revised template? If not, please provide direction regarding how to comply with pagination requirements.	Offerors can save the word document as their own file and then change the footer to exclude the AHCCCS pagination.

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78	G Representations I. Instructions to Offerors	Section G, I. General Matters	137-141, 151	Does AHCCCS plan to release an editable form for General Matters? The form currently on the website cannot be edited and loses its formatting when converted from Adobe.	Yes. This is now available in the Bidders' Library.
79	G. Representations	#7 and #8	139-141	As to information required in Section G and, under Contract No. YH07-0001, reportable within 120 days after year end, does AHCCCS want incumbent contractors to complete this information for the bid submission, within 120 days of year end, and/or both?	Both. Offerors should complete Section G as part of the bid process; Contractors should complete within 120 days of year end.
80	Section G-General Matters	8. Related Party Transactions (b)	140-141	The RFP asks offerors to "List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each transaction and the date thereof. Include a justification as to (1) the reasonableness of the transaction, (2) its potential adverse impact on the fiscal soundness of the disclosing entity, and (3) that the transaction is without conflict of interest:" Should the offeror place the list before or after subsections (i) and ii)?	The Offeror can place the list before subsections (i) and (ii).
81	G Representations I. Instructions to Offerors	Section G, I. General Matters	137-141, 151	Does AHCCCS plan to release an editable form for General Matters? The form currently on the website cannot be edited and loses its formatting when converted from Adobe.	Yes. This is now available in the Bidders' Library.
82	H	Introduction	142	Please provide the specific weighting by factor (A – D).	AHCCCS is not providing weighting.
83	Section H. Evaluation Factors and Selection Process	A. Capitation	143	AHCCCS has provided three years (one partial) of data as part of the databook. How much weight did AHCCCS give to each year (if any) in the development of it's published rate ranges? Will AHCCCS give direction on how mush weight was given to unaudited financial data, relative to accepted encounters?	For all GSAs except GSA 42, the base period is 100% CYE10 encounters from the databook with completion factors. The base for GSA 42 was set using 50% CYE09 and 50% CYE10. See Section C - ALTCS General Trend and Rate Setting Assumptions for additional information on trends. Unaudited financial data was used as a check on trends, base and final ranges
84	Section H. Evaluation Factors and	A. Capitation	143	Will AHCCCS aggregate or group specific counties base data to develop the capitation rate ranges? For example, will high cost counties be identified and	AHCCCS is not setting rates by county, but by GSA. No GSAs will be grouped for the base. Trends will be smoothed and depending on the credibility (by

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	Selection Process			aggregated to form the basis of the rate range development. If so, please provide the groupings methodology.	membership) will be a blend of the GSA trends and the statewide trends.
85	Instructions to Offerors	2. Prospective Offerors' Conferences and Technical Interface Meeting	145	The text in this paragraph indicates that the Offeror's Conference will be held on February 9, 2011, from 8:30a.m. until 4:30p.m. Are you able to provide any clarification as to what hours the general portion of the conference will take place versus the PMMIS System portion of the conference? This information is being requested so that we may make necessary arrangements to have the appropriate staff in attendance at the correct times.	Please see the Bidders' Library for further information on the Offerors' Conference.
86	I	9	146	"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." Under what conditions would an award be made to a terminated bidder?	It is unknown at this time what circumstances may exist that would cause AHCCCS to award a contract to a previously terminated Contractor.
87	Instructions to Offerors	9/Award of Contract	147	Does AHCCCS intend to equalize membership among all Contractors in GSA 52?	Enrollment after contract award is addressed in Section I, Instructions to Offerors, Paragraph 9, Award of Contract.
88	Instructions to Offerors	9/Award of Contract	147	If AHCCCS chooses to expand the number of Contractors in a GSA, what mechanism will AHCCCS use to determine the maximum number of health plans awarded contracts for each region, particularly in GSA 52?	The mechanism will be based upon the circumstances that would lead AHCCCS to make such a decision. Those circumstances are unknown at this time.
89	Instructions to Offerors	9/Award of Contract	148	Based on information released at the Bidder's Conference, it is our understanding that selective assignments will be performed by AHCCCS for Unsuccessful Incumbents in GSAs in which multiple contracts are awarded. For members who did not exercise choice, AHCCCS will selectively assign the Unsuccessful Incumbent's membership to the Contractor with the lowest capitation rate. Before selective assignment occurs, AHCCCS will contact	The description in the question posed is not accurate. Please see Section I, Instructions to Offerors for information regarding the assignment of members in the event that there is an Unsuccessful Incumbent. The methodology described is only intended for use with this RFP process. New members that do not exercise choice in Maricopa County after contract award will be assigned as described in Section D, Paragraph 5, Enrollment Hierarchy.

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				Contractors with higher capitation rates and allow them to lower their capitation rate to a value equal to the lowest capitation rate. If multiple Contractors have equally low capitation rates, then selective assignments will be made to the Contractor with the lowest membership. Will the hierarchy described above survive the initial reassignment and become the methodology used on an ongoing basis?	
90	14. Contents of Offeror's Proposal	Parag. 2 (no title)	150	The RFP requires that responses be in 11 point font or larger. Is it acceptable to use 9 or 10 point font in tables, charts, and diagrams – for example, 11 point font in organizational charts and various types of flowcharts and diagrams is fairly uncommon. In addition, tables that include numbers or that are structured to compare or group certain types of information in text are often more readable in 9 or 10 point font.	For tables, charts and diagrams the font may be no less than 9 point font. All other responses must be 11 point font or larger.
91	Offeror's Check List & I	14	150	What defines permitted attachments?	See each submission requirement for applicable attachments.
92	I. Instructions to Offerors	14. Contents of Offeror's Proposal	150	Does a hard copy of the Network Summary Template need to be included in the scanned PDF version of the proposal?	No. The hard copy does not need to be included in the PDF version of the proposal.
93	Instructions to Offerors	14/Capitation & Capitation Bid Submission Subsection	151	In Section B. Capitation, the following sentence is included: "AHCCCS will only evaluate the Offeror's full long term capitation rates." However, in Capitation Bid Submission there is the following: 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.**"	Each component of the capitation bid submission will be scored separately for the full long term capitation rate only. The sentence was meant to clarify that bidders would only be submitting a bid for full long-term capitation rates and AHCCCS would only be scoring the full long term care rate. The Acute Care Only and Prior Period Coverage rates will be set by AHCCCS.

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				Please clarify these two statements – will AHCCCS only evaluate the Offeror's full long term capitation rates or will each component of the capitation bid submission be scored separately?	
94	Section I. Instruction to Offerors	14. CONTENTS OF OFFEROR'S PROPOSAL SECTION B.	151	Capitation states that "AHCCCS will publish actuarially sound rate ranges by GSA for the medical component of the capitation rates prior to March 1, 2011." Please clarify if only the lower bound and midpoint PMPM's for each GSA will be provided, or if additional detail will be shared as it relates to the development of these rate ranges. For example, will the specific assumptions for trend or adjustments for programmatic changes be provided which are utilized in the development of the GSA specific rate ranges?	Information regarding rate setting assumptions and trend are currently available in the Data Supplement section of the Bidders'Library.
95	Section I Instructions to Offerors	Paragraph 14, Contents of Offeror's Proposal, B, Capitation	152	Regarding subsequent capitation rate amendments, for the administrative component specifically, will AHCCCS apply the bid Administration percentage to the adjusted rates or will AHCCCS leave the pmpm amount calculated in the original bid?	For awarded rates and any subsequent capitation rate amendments, AHCCCS will use the bid Administration percentage to calculate the dollar amount of the administration component of the capitation rate.
96	Instructions to Offerors	14/Capitation & Capitation Bid Submission Subsection	152	"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." Please clarify this statement and provide instructions to locate the referenced case management model.	The Case Management Model is one tool the Offeror might use to assist in the development of the case management component of the capitation rate. The Case Management Model is available in the Data Supplement section of the Bidders' Library.
97	Instructions to Offerors	14/Capitation & Capitation Bid Submission Subsection	152	"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	1. Yes, the Contractor may choose not to sign the amendment and provide notice of termination. 2. Any rate changes must be actuarially sound and subject to CMS approval. 3. Sufficient explanation will be provided regarding the basis for any rate changes.

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				published or the awarded capitation rates." There are several questions regarding this statement: 1. Will the Contractor have the right to reject this contract amendment and terminate the contract? 2. Will AHCCCS provide the Contractor with detailed information to determine if the rates offered meet the requirements of the Social Security Act § 1903(m)(2)(A); 42 CFR §438.6(c)(1)(i)(2009); Pub. L. No 111-3, 123 Stat.8, 103; and the American Academy of Actuaries practice note on guidance for certifying Medicaid managed care rates? 3. Will AHCCCS fully disclose its actuarial assumptions, including justification for why these assumptions were not included in the RFP capitation rate ranges published?	
98	I	B.1	152	Will AHCCCS provide Offeror the opportunity to submit test documents to the SFTP to assure accessibility?	Yes, the Offeror may submit test files. Upon submission, notify Celia Rodriguez via e-mail at Celia.Rodriguez@azahcccs.gov for confirmation of receipt.
99	Section I. Instruction to Offerors	14. CONTENTS OF OFFEROR'S PROPOSAL SECTION B.	152	AHCCCS is requesting an actuarial certification to accompany the proposals. Is there a standard template or specific language that AHCCCS is requesting offerors to include in the actuarial certification? Is there a specific level of detail required as a part of the certification?	AHCCCS is not requiring a specific level of detail and no template will be provided for the actuarial certification.
100	Section I	C. Organization, Question 5	153	In regards to the functional organizational chart of the key program areas and responsibilities requested for question 5, is there a page limit restriction associated with this requirement?	Yes, the standard three page limit applies.
101	C. Organization	6, Sanctions	153	This question requires (1) a description of and specific reason for a sanction, and timeline for resolving any deficiencies, (2) for the bidder and any legally related entities, (3) imposed by a Medicaid program, Medicare, or state insurance regulator, (4) over three	The three page limit requirement stands.

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				years, (5) within the three-page limit in 11 point font size. To permit a comparable level of specificity in responses from both regional, single-plan bidders and multi-state, multi-plan bidders, please consider removing or raising the page limit on this question. We believe that even well run and largely compliant multi-plan entities may need additional space to provide the level of detail and scope of information required. Although a three-page limit can be followed, a likely result is that AHCCCS may receive more summarized or aggregated responses from multi-state, multi-plan bidders, compared to smaller bidders.	
102	I	C.7	153	The instructions state: "Include an actual sample of the remittance advice (front and back)." Are the related page(s) included in the page limitation of the narrative or flow charts?	No. Remittance advice sample (front and back) or a written narrative of the remittance advice may be up to an additional four pages.
103	I. Instructions to Offerors	14.C. Organization	153	Please clarify. Question 7 directs the Offeror to include an actual sample of the remittance advice used. Will AHCCCS count the 2-page (front and back) sample as part of the page limitation for this submission requirement and, if so, within in which (narrative or flowcharts) should the Offeror account for the sample?	The number of pages that may be submitted for submission requirement 7 is four pages of narrative description of the claims adjudication process, five pages of flowcharts and up to four pages for the remittance advice.
104	I. Instructions to Offerors	Sanctions C6	153	Should encounter sanctions that were suspended by AHCCCS be included?	Yes. All sanctions received by an Offeror should be listed. The status of the sanction "suspended" should also be listed.
105	I. Instructions to Offerors	Q5	153	Can you define" Information Systems" as it is a required component of the organizational chart?	The component of the Offeror's organization which supports the Information Systems, whether the systems themselves are internal to the organization (full spectrum of systems staffing), or externally contracted (internal oversight and support).
106	I. Instructions to Offerors	Q5	153	Can the organizational chart have separate pages/charts for each functional area? Should it include job functions or staff names?	The submission response is limited to three pages and should include job functions.

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107	Organization	Information Systems/Question 14	154	Question 14 reads as follows: Describe the Offeror's plans and ability to support current and future IT Federal mandates. Please specify which future IT Federal mandates are being referenced in the above question.	Future IT Federal mandates may include, but are not limited to, areas such as, compliance with HIPAA version migrations, implementation of additional HIPAA format requirements, Legislative related requirements; etc...
108	I. Instructions to Offerors	14.D. Program, Case Management Submissions	155	Question 21 The question asks about "HCBS Member needs and service authorizations". Does HCBS refer specifically to members in their own home or to all members in HCB settings including ALFs?	HCBS in this context refers to members in both their own home and community residential settings.
109	Section I	D. Program/Quality Management Submissions, 31 (A)	158	In regard to Scenario A, please specify which type of facility the immediate jeopardy is taking place in.	Licensing requirements specify the number of residents that can reside in each type of facility. In Scenario A, it states that there are six Medicaid members in the facility. This indicates the facility is likely an Assisted Living Facility.
110	I. Instructions to Offerors	14.D. Program, Quality Management Submissions	158	Please clarify. Question 31 provides two quality of care scenarios which inherently include some unknowns that would be discovered during the investigation and handling of the issues. For purposes of describing the process and timeframes it will utilize within the page limit specifications of the bid submission requirement, what parameters (one or more alternative sets of facts/data) does AHCCCS expect the Offeror to use in completing the scenario? That is, does AHCCCS expect, as an outcome of describing each of their processes, to have each Offeror design a single set, albeit different, of complete facts/data for the case and, for the particular case scenario the Offeror describes, how the Offeror will handle the situation?	Please refer back to the first paragraph in Submission #31 for information regarding what should be included in the submission response.
111	I. Instructions to Offerors	Q 34	158	Can you define "service sites of members that reside in their own home"? Does this refer to in-home services only?	The service site for members that reside in their own home would include their home and any community based service sites that a member residing in their

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
					own home may access for services.
112	I	D.35	159	The actual Oral Presentations are to last approximately two hours. Is that one hour per scenario? New information is provided for the selected scenario (D.24, A – D) and an entirely new scenario is provided. "Offerors will be allotted time to privately discuss each scenario and to prepare a timed oral presentation." 1. Is the new information for scenario A – D given to offeror separately from the totally new scenario? 2. If yes, home much "…time to privately discuss and prepare…" is available prior to presentation? 3. If yes to #1, is the new scenario then provided immediately following the first presentation? How much time is allocated to preparing that presentation? 4. If both sets of new information are handed to Offeror at the same time: How much private discussion and preparation time is allotted? Does AHCCCS expect both scenarios to be presented consecutively after one private discussion and preparation period? 5. What equipment is permissible? What equipment does AHCCCS provide for the preparation - flip charts, white boards, overheads, etc.? 6. Will there be an opportunity to provide Offeror date/time requirements to assure availability of participating presenters? 7. Is it permissible to have a different team of 5 presenters for each of the 4 Member Scenarios?	Amount of time will be specified during the Oral Presentation. 1. Yes. New information will be provided for the selected Case Management scenario. A new Quality Management scenario will be provided. 2. Amount of time will be specified during the Oral Presentation. Both scenarios will be completed within the two hour time allotment. 3. See response to #2. 4. See response to #2. 5. A white board will be provided. Offerors should bring whatever tools that they may need to conduct an oral presentation. 6. Please see submission #35 for details of dates the oral presentations will be scheduled and when Offerers will be notified of their specific date and time. 7. Offerors are limited to a five team members total as specified in submission #35.
113	I	E.36	159	Does the Network Management plan (unlimited	No.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				pages) have to follow the format prescribed in the AHCCCS Policy for development of a "Network Management and Development Plan"?	
114	I	E.45	160	Is it true that ALL network LOI and Contract information ***must only*** be provided electronically by 3 PM on April 1, 2011 (Due date and time)? Can AHCCCS guarantee availability to the EFT/SFTP for all bidders on that day? Will EFT/SFTP be available prior to April 1 for uploading?	The information must only be submitted electronically. The EFT/SFTP server is available prior to April 1 for testing and /or early submission. AHCCCS cannot guarantee that unforeseen circumstances (power outage, fire) may not adversely affect server availability. The Offeror may submit test files. Upon submission, notify Celia Rodriguez via e-mail at Celia.Rodriguez@azahcccs.gov for confirmation of receipt. AHCCCS will notify Offerors in the event of EFT/SFTP unavailability.
115	I	E.45	160	How does AHCCCS evaluate and score the adequacy and accessibility of the Network Summary Report?	AHCCCS does not reveal its scoring methodologies.
116	I. Instructions to Offerors	14.E.Provider Network Submissions	160	Question 45 directs the Offeror to use the Network Summary template described in ACOM 420 *Network Summary Policy*. The Bidders' Library provides a Network Summary Template under the subsection "Forms". Should the Offeror use the template provided in the current policy, the Draft Policy for CYE2012 or the Network Summary Template provided in the Bidders' Library?	Offerors should use the Network Summary Template provided in the Bidders' Library (updated on 2/16/2011).

AHCCCS	**SOLICITATION AMENDMENT** Solicitation Number: RFP YH12-0001 Amendment Number 2 (Two) Solicitation Due Date: April 1, 2011 3:00 PM (MST)	Arizona Health Care Cost Containment System (AHCCCS) 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Contract Management Specialist: Jamey Schultz, CMS E-mail: Jamey.Schultz@azahcccs.gov

A signed copy of this amendment shall be included with the proposal, which must be received by AHCCCSA no later than the Solicitation due date and time. This solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 11th day of March, 2011, in Phoenix, Arizona.
Signature	Date 3/16/11	
Typed Name and Title		Michael Veit
Chairman, Pinal County Board of Supervisors		Contracts and Purchasing Administrator
Name of Company Pinal County		

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
1	General Question			In restating the question from AHCCCS that we are responding to in our proposal, can this be in 9pt font as opposed to 11pt font? We understand that our response must be in 11pt font.	Yes
2	Program Requirements	12/Behavioral Health		Does the psychiatric inpatient bed days benefit extend to payment for bed days once a member is transitioned to the state psychiatric hospital?	Yes, however, payment is determined by the unique factual circumstances specific to the AzSH placement.
3	Data Supplement Section C TREND AND RATE SETTING ASSUMPTIONS			General Trend and Rate Setting Assumptions of the ALTCS RFP contains historical enrollment for the Acute Care Only members for the time periods that are in the databook. It is noted in the databook supplement that the Other population includes these Acute Care Only members. Does the Acute Care expenditures associated with the Other population include expenditures that are associated with these Acute Care Only members? If so, please provide either the actual dollar amounts, or the percentage of the total acute care expenditures for the Other population that are attributable to Acute Care Only members.	Yes. The expenditures of the Other population include expenditures for Acute Care Only. Historically, the acute component in the full EPD capitation rate is used to set the acute component in the Acute Care Only population. This is done due to the small population size of the Acute Care Only members. AHCCCS plans to follow this methodology for CYE12. Thus assume the dollar amount associated with Acute Care Only members is equal to the PMPM of acute component expenses divided by all prospective member months multiplied by Acute Care Only members.
4	Data Supplement Section C Utilization and Costs			Are the databook expenditures net or gross of reinsurance amounts?	Databook expenditures are actual expenditures and have not been adjusted for reinsurance amounts.
5	Data Supplement Section C TREND AND RATE SETTING ASSUMPTIONS			Section C - General Trend and Rate Setting Assumptions contains a matrix that represents historical and prospective Fee Schedule Changes. With regard to the Provider Fee Increase (PFI) for Behavioral Health, does the 9.1% PFI effective 10/1/2007 and the 3.8% PFI effective 10/1/2008 apply to all Behavioral Health expenditures or just to Behavioral Health Inpatient expenditures?	The 10/01/07, 10/01/08 and 10/01/10 provider fee schedule changes relate to all behavioral health expenditures. The 2/1/09 provider fee schedule changes relates to all behavioral health service rates set by ADHS so they exclude the tier per diem at an acute hospital, which remained flat. The 4/1/11 provider fee schedule changes exclude behavioral health inpatient service rates set by ADHS.
6	Data Supplement Section C TREND AND RATE SETTING			Section C - General Trend and Rate Setting Assumptions contains a matrix that represents historical and prospective Fee Schedule Changes. With regard to the Free-Standing Dialysis PFI,	COS 37, Outpatient Facility Visits. Data is not available regarding the portion of expenditures of that COS impacted by the fee schedule change.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
	ASSUMPTIONS			what COS does this PFI impact? And what portion of expenditures of that COS is impacted by this PFI?	
7	Forms- Network Summary Form			The second column of the Network Summary form (PC ID#) requires a Contractor Identification Number. How do new bidders obtain this number?	New Offerors are not required to fill out the second column.
8	Section I. Instruction to Offerors	14. CONTENTS OF OFFEROR'S PROPOSAL SECTION B.		AHCCCS will publish actuarially sound rate ranges by GSA for the medical component of the capitation rates prior to March 1, 2011. Where are these rates published?	These rates are available in the Data Supplement portion of the Bidders' Library in the Data Supplement, under Section F, Bid Submission Tools.
9	Section C - General Trend and Rate Setting Assumptions, "Table I: Fee Schedule Changes"			This section lists the historical and prospective fee schedule changes for HCBS (home only) providers as 5% and 2.5% rate decreases on 10/1/2009 and 10/1/2010, respectively, and a 2.5% reduction on 4/1/2011. In the databook, there are 14 categories of service that are listed as HCBS home services. Do these fee schedule changes for HCBS (home only) apply to all 14 categories of services associated with HCBS home services? If not, could you please indicate which categories of service that these rate decreases apply to?	The changes for HCBS apply to all 14 categories of service.
10	Capitation			Please provide the actuarial memorandum for the development of the rate ranges for this RFP.	No actuarial memorandum will be provided for the rate ranges. AHCCCS will provide an actuarial certification to CMS at the time the final rates are submitted for approval, no later than September 1, 2011.
11	Capitation			If actuarial memorandum is not available, which factors were adjusted to determine the endpoints of the rate ranges? Examples might be improvements in medical management of acute services, improvements in the HCBS mix, etc. Can you provide those adjustments?	All of the assumptions for developing each mid-point of the range are provided in the Data Supplement, including a discussion of the HCBS mix. The ranges were then developed by computing appropriate deviations from the means.
12	Data Supplement			Pima County claims totals as found in the data supplement files are significantly lower than costs found in the unaudited financials. Were the ranges based on the supplemental files alone, or were adjustments made to account for the differences	The base data used for Pima GSA was the CYE10 encounters which, when adjusted by a completion factor, fall within a reasonable range when compared to the financials. Trends for Pima GSA were based on statewide trends without Pima GSA

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				between the supplemental files and the financials?	data due to the encounter issues for Pima in CYE08 and CYE09.
13	Data Supplement			GSA 44 and GSA 50 consistently show much smaller historical reinsurance offsets than the other GSAs. This differential is not consistent with acute costs in those GSAs relative to other GSAs. Are these reinsurance costs representative of the catastrophic acute costs experienced in these GSAs, or were there extenuating circumstances that led to unusually low reinsurance offsets?	GSA 50 has had historical encounter issues. AHCCCS attributes the low reinsurance payments in CYE08 to the fact that the Contractor did not adjudicate encounters on time and thus missed reinsurance timely filing deadlines. GSA 44 has lower TBI/BEH cases as well as lower regular RI cases. No extenuating circumstances that AHCCCS knows about led to the low reinsurance payments in that GSA.
14	RFP Amendment Number 1	Q&A #2	1	Please clarify- The response to this question also appears as the response to Q#103 regarding the Instructions to Offerors section 14.C.7. Is this the same answer to the question posed by the Offeror: "Is inclusion of the questions being addressed required as part of the narrative responses?" If the Offeror repeats the RFP Bid Requirement, will AHCCCS consider only the space utilized by the response to the requirement?	Inclusion of the question being addressed is not required. The total response (including any restatement) must be within the page limit specified.
15	RFP Amendment Number 1	Q&A #80	20	When the Offeror is required to provide a list as a part of its response to a disclosure requirement in Schedule G (e.g., items 7d and 8), may the Offeror include this as an exhibit/attachment to Schedule G within the General Matters section of the bid response, providing all disclosure information is included in the exhibit and the two parts are fully cross-referenced?	Yes
16	RFP Amendment Number 1	Question 90	22	When using Visio (standard flow charting software), the template shapes generally do not provide adequate spacing for 9 point font in certain shapes. Would a smaller font be acceptable if it can be clearly read within the lines of the template shape or will AHCCCS consider allowing more pages for flow charts given the font size limitation?	A minimum of 8 point font is acceptable for flowcharts only.
17	Program Requirements	19/Pre-Admission Screening and Resident	42	What is the difference between the Preadmission Screening and Resident Review (PASRR) mentioned on page 42 and the Pre-admission Screening (PAS) tool referenced in Sections 2	In order to qualify for ALTCS all applicants must meet both financial and medical eligibility. The PAS is conducted to determine if the person meets medical eligibility for ALTCS. The PASRR is

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
		Review (PASRR)		(Introduction / ALTCS Eligibility: Medical Eligibility section on page 17) and 3 (Enrollment Disenrollment / Disenrollment to Acute Care Program section on page 18)?	conducted prior to a member's admission to a nursing facility and is used to determine whether a member has any diagnosis or other presenting evidence that suggests the potential of mental illness or mental retardation and whether a member requires the level of care provided in a nursing facility and/or needs specialized services.
18	Program Requirements	31/Provider Registration	59	Will AHCCCS provide new offerors a database or other resource to look up provider AHCCCS ID numbers prior to bid submission? If so, when can new offerors expect to receive this information?	No database will be provided to new Offerors prior to bid submission.
19	Program Requirements	32/Network Summary	59	Do non-emergency Transportation Providers (i.e. ITM) require AHCCCS Numbers?	Yes, all providers require AHCCCS Provider Identification numbers.
20	GENERAL QUESTION: D. Program Requirements	44. Claims Payment/ Health Information System	70	In Amendment 1 issued by AHCCCS on 2/25/11, AHCCCS' response to Question 46 indicated that "Any claim that does not meet the standardized claim requirements of R9-22-719 is considered roster billing." Please verify the reference to R9-22-719 is correct, as we believe the correct reference may be R9-22-705.	This reference should be corrected to reflect R9-22-710 as stated in RFP Section D, Paragraph 44, Claims Payment/Health Information System.
21	D- Program Requirements	53 – Separate Incorporation	76	The RFP states: "Within 60 days of contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract." AHCCCS previously clarified that it is acceptable to have a single corporate entity that is authorized to provide services under multiple contracts with AHCCCS (e.g., one corporate entity that holds separate contracts with AHCCCS for both the acute and long term care programs). Contractor also administers benefits for AHCCCS dual eligible Medicaid/Medicare members, and maintains a Medicare Advantage contract with	It is acceptable for the Contractor to use the same corporate entity for Medicaid and Medicare contracts.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				CMS. Contractor understands that it will continue to be acceptable to use the corporate entity that is authorized to provide services under the multiple AHCCCS contracts for the Medicare Advantage program. Please advise if this is not correct.	
22	D- Program Requirements	59 – Capitation Adjustments	83	The RFP states: "In these instances the adjustment and assumptions will be discussed with the Contractor prior to modifying capitation rates." AHCCCS previously responded that Contractor is always given a contract amendment for signature, and has the option not to sign. Will the contract be revised to incorporate language establishing that: 1. Modification of the capitation rates will not be effective without a contract amendment? and 2. Contractor is not obligated to sign any contract amendment?	No capitation rate change can be made without a contract amendment. Per response to Question #60 in Amendment #1: (i) Contractor is always given the contract amendment for signature. Contractor has the option not to sign. (ii) Contract language already stipulates the terms for notification to AHCCCS of intent not to renew or continue as an AHCCCS Contractor. See Section E, Paragraph 25, Term of Contract and Option to Renew for further information..
23	E – Contract Terms and Conditions	29 -- Contract	110	The RFP states: "AHCCCS reserves the right to clarify any contractual relationship in writing, and such written clarification shall govern in case of conflict with the applicable requirements stated in the RFP or the Contractor's proposal." AHCCCS previously responded that not all clarifications will require an amendment to the contract. Will the contract be revised to incorporate language establishing that any such clarification that materially, adversely affects Contractor's compensation, reimbursement, or scope of services will not be effective without being adopted pursuant to a contract amendment?	Change will be considered for possible future amendment.
24	Provider Network	Section H	142	The second paragraph describes that **"network development portion of Provider Network"** will be scored by GSA. The remaining submission	The "network development portion" refers to the Network Summary, Submission #45. The "network management portion" refers to all other

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				areas: the **network management portion of Provider network...."** are anticipated to be scored statewide, not specific to any GSA". Please clarify your definition of "network development" versus "network management" and where would the **network summary** fall between these two categories?	network submission requirements, #36 through 44.
25	Instructions to Offerors B. Capitation	Capitation Bid Submission	151	Each capitation bid will encompass three components; a medical component, a case management component, and an administrative component. Each component will be scored separately. Please provide additional details on how these components will be scored. Will each component have a maximum point level? Will the weighting for the three components be different than 33.3% each?	No further information will be provided regarding the scoring of the capitation bid.
26	Instructions to Offerors B. Capitation	Capitation Bid Submission	151	Will the rate bid for case management remain static, regardless of changes in the underlying case mix over the term of the contract, or will it be adjusted in the annual rate setting meeting to reflect the change in mix for a contractor?	The case management component is reviewed each year for necessary adjustments due to mix change or other factors.
27	RFP Section I; Instructions to Offerors	B. Capitation	152	Please clarify the name of the folder located on the FTP/SFTP server to be used for offeror's bid submissions. Specifically, should bid materials be submitted directly to "/EFPRFP12" or will a subfolder be created for offeror bid submissions (such as an "IN" folder)?	Each Offeror has an available folder listed by the Offeror's name that can be used for the bid submission. The folders can be located when logged on to the AHCCCS sftp. https://sftp.statemedicaid.us/ EPDRFP12 >Data SupplementFiles > (offeror folder name) use tab UPLOAD
28	Section I. Instruction to Offerors	14. CONTENTS OF OFFEROR'S PROPOSAL SECTION B.	152	Is the actuarial certification of the rates for the overall rate (the sum of the three components), a separate certification for each component of the rate that is being bid or only the medical component of the rate?	The actuarial certification is for the total rate bid.
29	Section I	C. Organization, Question 5	153	Regarding the requirement to provide functional organizational charts of the key program areas and responsibilities are Offerors allotted the three page limit per functional area?	The standard page limit of 3 applies to the total submission.
30	I (Instructions to Offerors)	Information Services	154	Regarding the sentence underneath Question 14 (which states: *Reference: Section D, Paragraphs*	The sentence is in reference to Questions 11 through 14.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				44, Claims Payment/Health Information System; 73, Data Exchange Requirements. Question: is this sentence in reference to Question 14 - or is it in reference to Questions 11 through 14?	
31	I. Instructions to Offerors; #14, Contents of Offeror's Proposal	35	159	The reference for the submission requirement cites Paragraph 26 for Quality Management and Attachment H(1) for Enrollee Grievance System Standards and Policy. Are these correct?	The correct references for Submission Requirement #35 is: *Section D, Paragraphs 20, Quality Management, 22, Grievance System; Section F, Attachments, B(1), Enrollee Grievance System; ACOM, 406 Enrollee Grievance Policy; AMPM Chapter 900; 42 CFR 438.240; 42 CFR 438.408; 42 CFR 438.414*
32	I. Instructions to Offerors; #14, Contents of Offeror's Proposal	45	160	What GSAs have Zone requirements?	Two GSAs have Zone requirements – GSA 50, Pima County and GSA 52 – Maricopa. See ACOM Policy 419 Network Standards.
33	Section I	E.45	160	The RFP states: LOIs and contracts should NOT be included with the Offeror's proposal. Please confirm that this statement also indicates that LOIs and Contracts need not be provided electronically via the EFT site.	LOIs and contracts should not be provided via the EFT, however, they must be available for review if requested by AHCCCS.
34	Instructions to Offerors	14. E. Provider Network Submissions	160	Specifically to the provider network, are DD Group Homes a requirement of the ALTCS network? Previously they have been included in the DES program at AHCCCS, but the current requirements for each GSA include "DD Group Home" in the "HCBS Community" provider section. Is this correct for each GSA's requirements?	DD Group Homes are a covered service (see Section D, paragraph 10) and must be available when appropriate.
35	Provider Network		160	On the network summary - will you make a distinction between contracted providers and providers solicited through a Letter of Intent(LOI)? Furthermore, will you consider adopting a similar methodology utilized by Medicare Advantage whereby a random sample of providers is selected to determine if they truly are contracted or if providers actually agreed to contract (via LOI)? If not, what alternative methodology might you consider employing to ensure that providers listed in a network disk, in fact agreed to enter into a contract with a health plan or are currently	There will be no distinction between contracts and Letters of Intent. AHCCCS will not reveal its scoring or verification methodologies.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				contracted?	
36	Provider Network	Question 45	160	How will the network summary be scored beyond meeting the minimum network standards?	AHCCCS will not reveal its scoring or verification methodologies.
37	ALTCS Bidders Library/ACOM	Chapter 300 – Financial	310-1	In the Bidder's Library link to the ACOM, the delivery supplemental policy indicates that it applies to all Acute contractors. Under the ALTCS program, is this policy also applicable? If so, what is the method of transmitting delivery information to AHCCCS for the delivery supplemental payments?	There is no delivery supplemental payment for the ALTCS program. This payment only applies to Acute contracts as the policy describes.

A. GENERAL MATTERS

Subject Requirement:	***Reqmt Page #***	***Offeror's Page #***
Offeror's signature page	(Front Page)	2
Amendment One	N/A	3
Amendment Two	N/A	32
Offeror's Checklist (this attachment)	N/A	41
Completion of all items in Section G of the RFP	Section G	43

B. CAPITATION

Subject Requirement:	***Reqmt Page #***	***Offeror's Page #***
Capitation Rate Bid (via EFT/SFTP and hard copy)	1	58

C. ORGANIZATION

Subject Requirement:	***Reqmt Page #***	***Offeror's Page #***
Moral and Religious Objection	2	62
Organization and Staffing	3	63
	4	92
	5	95
Sanctions	6	97
Claims	7	98
	8	108
	9	111
Encounters	10	114
Information Systems	11	122
	12	137
	13	140
	14	141
Grievance System	15	144
Corporate Compliance	16	151
Finance and Liability Management	17	156
	18	157
	19	160

D. PROGRAM

Subject Requirement:	***Reqmt Page #***	***Offeror's Page #***
Case Management	**20**	162
	21	165
	22	168
	23	171
	24A	174
	24B	177
	24C	180
	24D	183
Medical Management	**25**	186
	26	192
	27	195
	8	198
	29	201
Quality Management	**0**	204
	1A	207
	31B	210
	32	213
	33	216
	34	219
Oral Presentation	**35**	The Offeror shall submit the names and resumes of the participating individuals via the EFT/SFTP server by 3:00 p.m. on April 8

E. PROVIDER NETWORK

Subject Requirement:	***Reqmt Page #***	***Offeror's Page #***
Provider Network	36	224
	37	290
	38	291
	39	294
	40	297
	41	300
	42	303
	43	306
	44	309
Network Summary	45	Via EFT/SFTP
	Attestation Sheet	313

SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR

The Offeror must complete all information requested below.

1. CERTIFICATION OF ACCURACY OF INFORMATION PROVIDED

By signing this offer the Offeror certifies, under penalty of law, that the information provided herein is true, correct and complete to the best of Offeror's knowledge and belief. Offeror also acknowledges that should investigation at any time disclose any misrepresentation or falsification, any subsequent contract may be terminated by AHCCCS without penalty to or further obligation by AHCCCS.

2. CERTIFICATION OF NON-COERCION

By signing this offer the Offeror certifies, under penalty of law, that it has not made to any provider any requests or inducements not to contract with another potential Contractor in relation to this solicitation.

3. CERTIFICATION OF COMPLIANCE - ANTI-KICKBACK / LABORATORY TESTING

By signing this offer, the Offeror certifies that it has not engaged and will not engage in any violation of the Medicare Anti-Kickback or the "Stark I" and "Stark II" laws governing related-entity and compensation there- from. If the Offeror provides laboratory testing, it certifies that it has complied with and has sent to AHCCCS simultaneous copies of the information required to be sent to the Centers for Medicare and Medicaid Services. (See 42 USC §1320a-7b, PL 101-239, PL 101-432, and 42 CFR §411.361.)

4. AUTHORIZED SIGNATORY

Authorized Signatory for Pinal/Gila Long Term Care
[OFFEROR'S Name]

Pete Rios — Chairman, Pinal County Board of Supervisors
[INDIVIDUAL'S Name] — Title]

is the person authorized to sign this contract on behalf of Offeror.

5. OFFEROR'S MAILING ADDRESS

AHCCCS should address all notices relative to this offer to the attention of:

Donna Beedle, — Director, CEO, Pinal Gila Long Term Care
Name — Title

971 N. Jason Lopez Circle, Bldg D, P.O. Box 2140 — (520) 866-6798
Address — Telephone Number

Florence — Arizona — 85132
City — State — ZIP

6. OFFEROR GENERAL INFORMATION

a. If other than a government agency, when was your organization formed? N/A, Offeror is a political subdivision of the State of Arizona.

b. License/Certification: Attach a list of all licenses and certification (e.g. federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper listing the license requirements and the renewal dates.

As an enterprise fund of Pinal County Government, Pinal/Gila Long Term Care does not have, nor is required to have, any licensure by the Arizona Department of Insurance, or any certifications such as NCQA or JCAHO.

Have any licenses been denied, revoked or suspended within the past 10 years? Yes ____ No _X_ If yes, please explain.

c. Civil Rights Compliance Data: Has any federal or state agency ever made a finding of noncompliance with any civil rights requirements with respect to your program? Yes ____ No _X_ If yes, please explain.

d. Accessibility Assurance: Does your organization provide assurance that no qualified person with a disability will be denied benefits of or excluded from participation in a program or activity because the Offeror's facilities (including subcontractors) are inaccessible to or unusable by persons with disabilities? (Note: Check local zoning ordinances for accessibility requirements). Yes_X_ No ___ If yes, describe how such assurance is provided or how your organization is taking affirmative steps to provide assurance. _The

P/GLTC administrative offices in Florence were inspected by the Pinal County Department of Building Safety and it was determined that this facility meets local zoning ordinances for handicapped requirement; Pinal County Code Ordinance Number 33194-BCD. P/GLTC has two satellite offices in Gila County that are located in Globe and Payson. P/GLTC leases the building from Gila County and a private party respectively. Both locations follow the standard Arizona Code regarding the Disability Act and are accessible and usable by persons with disabilities.

To ensure that subcontractors comply with handicap accessibility building codes, all P/GLTC contracts include such assurances of handicapped accessibility. During annual contract monitoring, P/GLTC verifies the physical location is in compliance. Any noncompliance would require the subcontractor to submit a plan of correction or if the noncompliance was egregious enough, P/GLTC could issue a Notice to Cure Breech.

e. Prior Convictions: List all felony convictions within the past 15 years of any key personnel (i.e., Administrator, Medical Director, financial officers, major stockholders or those with controlling interest, etc.). Failure to make full and complete disclosure shall result in the rejection of your proposal.

There have been no felony convictions of any key personnel.

f. Federal Government Suspension/Exclusion: Has Offeror been suspended or excluded from any federal government programs for any reason? Yes____ No _X__ If yes, please explain.

g. Provide the name(s) of the in-house or independent actuary, or actuarial firm used to assist in developing capitation rates and / or reviewing published capitation rate information.

Lance Malkind, ASA, MAAA
Name

4301 N. 21st Street, #21, Phoenix, AZ 85016
Address City State Zip

h. Did any other firm or organization provide the Offeror with any assistance in making this offer (to include developing capitation rates or providing any other technical assistance and/or reviewing published capitation rates)? Yes X No ____ If yes, what is the name of this firm or organization?

Nancy E. Hook, MHSA, Hook & Associates, LLC
Name

237 West Portland Street Phoenix Arizona 85003
Address City State Zip

i. Has the Offeror contracted or arranged for Management Information Systems, software or hardware, for the term of the contract? Yes X No ____ If yes, is the Management Information System being obtained from a vendor? Yes X No ____ If yes, please provide the vendor's name, the vendor's background with AHCCCS, the vendor's background with other HMOs or managed care entities, and the vendor's background with other Medicaid programs.

PLEXIS HEALTHCARE SYSTEMS

Founded in 1996, Plexis Healthcare Systems now supports nearly 100 clients administering benefits for over 60 million individuals on three different software platforms. Of those, Plexis Claims Manager (PCM) is the original platform and the one most widely utilized. Plexis started as a managed care focused organization. Their first customer was a managed services organization based in Phoenix, Arizona. Since then, Plexis has continued to branch out into other areas of managed care as well as fee for service environments. Currently Plexis supports managed care clients of the following types;

- Preferred Provider Organizations;
- Physician Hospital Organization;
- Health Maintenance Organization including staff model HMOs engaged in PACE (long term care in the home, Program for All Inclusive Care for the Elderly) and the largest long term care health plan in the country. These clients must interact with both CMS and Medicaid;
- Medicare Advantage Health Plans;
- Medicaid Health Plans including county based organizations beginning with Yavapai County in 2000 and Pinal/Gila Long Term Care in 2005. Plexis has a history of supporting Medicaid clients in Oregon, Arizona, Michigan, California, New York, Maryland and the District of Columbia;
- Managed Services Organizations including managed care carve outs (behavioral health, vision, radiology, oncology, etc.)
- Independent Provider Associations
- Medical Groups
- Medicare Advantage and Medicaid Health Plans (primary payor and secondary payor) also known as Medi/Medi plans
- Safety net programs for those who are to young for Medicare and who can not, for various reasons, qualify for Medicaid financially

Over half of Plexis' client base is engaged in managed care. Plexis provides a broad and deep set of advanced tools for managed care organizations, particularly for entities engaged in Medicaid and Medicare Advantage in capitated environments where encounter processing in conjunction with the state or the federal government is the cornerstone of the organization's success.

CH Mack

CH Mack has been successfully delivering Care Management software solutions to the healthcare and human services industry for over twelve (12) years. CH Mack has been successfully deploying integrated Medical Management (Case Mgt / Disease Mgt / Utilization Mgt) solutions for large managed care organizations for over seven (7) years. Currently CH Mack integrated medical management solutions are deployed at 65 organizations and in use by over 8,500 licensed users including Medicaid, AHCCCS/ALTCS, Medicare Advantage Plans, Managed Care Organizations (MCOs) and Health Maintenance Organizations (HMOs).

CH Mack Care Management solutions encapsulate several years of working with leading edge healthcare and human services organizations, nationwide, in the implementation of technology to support fully integrated medical management best practices. The features and functions provided by CH Mack Care Management solutions to facilitate proactive care management through a fully integrated database of member and provider information—coordinating all interactions using collaborative workflow management. It supports the real-time communication of information between all members of the care team, inside and outside the four walls of traditional healthcare settings.

CH Mack's solutions are being utilized today by a broad spectrum of healthcare and human services organizations to seamlessly integrate care management processes across the entire Continuum of Care, truly providing a 360° view of member care throughout her/his lifetime.

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7. FINANCIAL DISCLOSURE STATEMENT

The Offeror must provide the following information as required by 42 CFR 455.103. This Financial Disclosure Statement shall be prepared as of December 31, 2010. However, continuing Offerors who have filed the required Financial Disclosure Statement to AHCCCS within the last 12 months need not complete this section if no significant changes have occurred since the last filing.

a. Ownership: List the name and address of each person with an ownership or controlling interest, as defined by 42 CFR 455.101, in the entity submitting this offer:

Name	Address	Percent of Ownership or Control
Pinal County Board of Supervisors		
Pete Rios	P.O. Box 827, Florence, AZ 85132	33.33% Control
Bryan Martyn	P.O Box 827, Florence, AZ 85132	33.33% Control
David Snider	P.O. Box 827, Florence AZ 85132	33.33% Control

b. Subcontractor Ownership: List the name and address of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more:

Name	Address	Percent of Ownership or Control
Horizon Home Care government.	P.O. Box 827, Florence, AZ 85132	100% Control by Pinal County

Names of above persons who are related to one another as spouse, parent, child or sibling:
None

c. Ownership in Other Entities: List the name of any other entity in which a person with an ownership or control interest in the Offeror entity also has an ownership or control interest:

None

d. Long-Term Business Transactions: List any significant business transactions, as defined in 42 CFR 455.101, between the Offeror and any wholly-owned supplier or between the Offeror and any subcontractor during the five-year period ending on the Contractor's most recent fiscal year end:

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction

Ownership of Subcontractor	Type of Business	Name of Related Party	Dollar Amount Paid for Reporting Period
None	HCBS Services	HORIZON HOME CARE	$16,931,120.36
100%	HCBS Services	AT HOME SOLUTIONS	$13,485,597.61
None	Nursing Homes	APACHE JUNCTION HEALTH CARE CENTER	$13,327,909.91
None	HCBS Services	SOREO IN HOME SUPPORT SERVICES	$10,091,073.27
None	HCBS Services	LUTHERAN SOCIAL SERVICES OF THE SW	$8,071,604.19
None	HCBS Services	ACCENTCARE INC.	$7,959,235.15
None	Nursing Homes	COPPER MOUNTAIN INN	$6,634,004.91

None	Nursing Homes	MARAVILLA CARE CTR DBA PINNACLE HEALTH	$6,454,591.99
None	Nursing Homes	PAYSON CARE CENTER	$5,726,409.12
None	Nursing Homes	HERITAGE HEALTH CARE	$5,416,377.86
None	Transportation	DEPENDABLE MEDICAL TRANSPORT SERVICES LLC	$4,328,663.46
None	Nursing Homes	ARCHSTONE CARE CENTER	$4,326,601.40
None	HCBS Services	PRILEO HOME CARE	$4,260,733.12
None	Hospital	CASA GRANDE REGIONAL MEDICAL CENTER	$3,395,929.95
None	Nursing Homes	SANTA ROSA CARE CENTER	$3,394,306.21
None	Nursing Homes	SPRINGDALE WEST	$3,219,284.94
None	Nursing Homes	CHULA VISTA CARE CENTER	$3,104,192.38
None	Nursing Homes	RIM COUNTRY HEALTH & RETIREMENT	$3,025,662.02
None	Nursing Homes	EAST MESA HEALTH CARE CENTER	$2,722,752.38
None	Nursing Homes	RIM COUNTRY HEALTH & RETIREMENT COMMUNITY	$2,715,318.03
None	Hospital	PHOENIX CHILDREN'S HOSPITAL HOPE	$2,619,009.60
None	Nursing Homes	MI CASA NURSING CENTER	$2,007,944.61
None	Nursing Homes	LA CANADA CARE CENTER	$1,737,526.63
None	Hospital	BANNER BAYWOOD MEDICAL CENTER	$1,587,886.16
None	Transportation	MEDICAL TRANSPORTATION BROKERAGE	$1,585,385.74
None	Assisted Living Facilities	AZ MENTOR	$1,380,219.40
None	Dialysis Center	RENAL CARE GROUP	$1,362,874.41
None	Nursing Homes	DESERT HAVEN CARE CENTER	$1,146,488.60
None	Nursing Homes	POSADA DEL SOL	$1,068,921.45
None	Nursing Homes	HERITAGE HEALTH CARE CENTER	$1,066,379.79
None	Assisted Living Facilities	DESERT PAVILLION CARE CENTER	$1,060,031.87
None	Hospital	BANNER GOOD SAM MEDICAL	$968,395.94
None	Nursing Homes	DEVON GABLES HEALTH CARE CENTER	$936,577.68
None	HCBS Services	COMFORT KEEPERS	$925,383.99
None	Nursing Homes	DESERT LIFE HEALTH CARE CENTER	$923,019.35
None	Nursing Homes	RIDGECREST HEALTHCARE	$827,887.86
None	HCBS Services	SYNERGY HOME CARE	$821,936.67
None	Hospital	MOUNTAIN VISTA MEDICAL CENTER	$815,224.05
None	HCBS Services	AFFINITY HOME HEALTH INC	$813,398.33
None	Nursing Homes	CATALINA CARE CENTER	$784,276.46
None	Nursing Homes	HEARTHSTONE OF MESA	$775,019.14
None	Assisted Living Facilities	GARNET AT CASA GRANDE	$757,443.94
None	HCBS Services	CONCENTRIC HOMECARE SOLUTIONS	$730,406.67
None	Hospital	CHANDLER REGIONAL HOSPITAL	$689,829.31
None	Nursing Homes	SPRINGDALE VILLAGE	$689,704.18
None	Nursing Homes	EVERGREEN FOOTHILLS	$677,054.57
None	Hospital	PAYSON REGIONAL MEDICAL CENTER	$656,151.90

None	Nursing Homes	CITADEL CARE CENTER	$650,229.11
None	Assisted Living Facilities	BAXTER ELDERLY CARE INC.	$629,252.04
None	Nursing Homes	LIFE CARE CENTER OF TUCSON	$628,194.73
None	Assisted Living Facilities	THE GARNET	$554,918.64
None	Assisted Living Facilities	LITA CARING HOME	$543,836.43
None	Assisted Living Facilities	ASSISTED LIVING CONCEPTS	$507,901.56
None	Hospital	BANNER DESERT MEDICAL CENTER	$490,421.32
None	Hospital	ST. JOSEPH'S HOSPITAL - PHOENIX	$478,001.90
None	Nursing Homes	SCOTTSDALE VILLAGE SQUARE	$438,110.18
None	Assisted Living Facilities	LEGACY SENIOR MANAGEMENT	$431,240.72
None	Ambulance	SOUTHWEST AMBULANCE OF CASA GRANDE	$428,775.02
None	Nursing Homes	MOUNTIAN VIEW CARE CENTER	$423,110.41
None	Nursing Homes	MARA VILLA CARE CENTER	$410,403.24
None	Assisted Living Facilities	ALONA TURALBA dba CASA APLAYA	$405,270.01
None	Durable Medical Equip	RTA HOMECARE	$404,125.42
None	Nursing Homes	BELLA VITA HEALTH & REHAB CENTER	$400,486.38
None	Assisted Living Facilities	SUPREME ADULT CARE HOME	$397,982.87
None	Assisted Living Facilities	GOLDEN AGE SUPERVISORY HOME	$386,546.83
None	Durable Medical Equip	SYMBIUS MEDICAL LLC	$372,713.85
None	HCBS Services	PINAL-GILA COUNCIL FOR SENIOR CITIZENS	$368,633.70
None	Assisted Living Facilities	ASSISTED LIVING BY SHOLT	$368,377.94
None	Nursing Homes	SPRINGDALE VILLAGE HEALTHCARE	$365,053.25
None	Nursing Homes	AZ STATE VETERANS HOME	$363,928.55
None	Hospital	COBRE VALLEY REGIONAL MEDICAL CENTER	$360,904.10
None	Durable Medical Equip	HANGER PROSTHETICS & ORTHOTICS	$360,176.91
None	Ambulance	SOUTHWEST AMBULANCE	$349,650.24
None	Nursing Homes	THE CARING HOUSE	$341,246.45
None	Primary Care Physician	SUNLIFE FAMILY HEALTH CARE	$335,574.24
None	Durable Medical Equip	PRN MEDICAL SERVICES, INC.	$328,996.00
None	Assisted Living Facilities	QUALITY CARE ASSISTED LIVING	$327,279.55
None	Durable Medical Equip	LIFECARE SOLUTIONS INC	$315,896.31
None	Nutrition	OPTION 1 NUTRITION SOLUTIONS	$311,091.98
None	Hospital	BANNER BAYWOOD HEART HOSPITAL	$307,510.38
None	Specialist	HARRISON J. BACHRACH MD	$306,011.59
None	Hospital	MERCY GILBERT MEDICAL CENTER	$294,338.69
None	Assisted Living Facilities	MELODY CARE HOME	$287,668.71
None	Assisted Living Facilities	ST. RAPHAEL FAMILY HOME	$287,041.90
None	Hospital	CHILDREN'S HOSPITAL AND REGIONAL MC	$282,828.75
None	Infusion	SIRONA INFUSION LLC	$282,817.13
None	Nursing Homes	PLAZA HEALTH CARE	$281,232.11
None	Assisted Living Facilities	LEGACY PALMS ASSISTED LIVING	$276,887.57

None	Hospital	SCOTTSDALE HEALTHCARE	$262,906.42
None	Hospital	ST. LUKE'S MEDICAL CENTER	$260,216.39
None	Assisted Living Facilities	ORDINARY LIFESTYLES	$257,983.00
None	Hospital	NW MEDICAL CENTER ORO VALLEY	$254,398.93
None	Hospital	LOS NINOS HOSPITAL	$247,520.17
None	HCBS Services	NURSING SOLUTIONS	$245,645.77
None	Dialysis Center	RENAL CARE GROUP - AHWATUKEE	$242,412.40
None	HCBS Services	ARBOR ROSE ADULT DAY CARE	$227,857.49
None	Environmental	STAUFFER PLUMBING	$213,705.00
None	Hospital	PHOENIX CHILDREN'S HOSPITAL	$208,586.81
None	Radiology	AZ TECH RADIOLOGY & OPEN MRI	$208,272.29
None	Hospital	BANNER GATEWAY MEDICAL CENTER	$206,468.26
None	HCBS Services	PINAL/GILA COUNCIL FOR SENIOR CITIZENS	$198,841.82
None	Assisted Living Facilities	HELP LLC RESIDENTIAL AGENCY	$196,408.23
None	Specialist	IRONWOOD CANCER RESEARCH CENTERS, PC	$187,084.55
None	Fiscal Employee Agent	PUBLIC PARTNERSHIPS	$186,928.00
None	Assisted Living Facilities	ACTIVE ASSISTED LIVING, LLC	$186,544.59
None	Durable Medical Equip	STATESERV HOME CARE LLC	$185,792.70
None	Assisted Living Facilities	SUNRISE VISTA CARE CENTER	$182,977.58
None	Specialist	ADVANCED CARDIAC SPECIALISTS	$182,132.66
None	Hospital	BANNER BOSWELL MEDICAL CENTER	$181,324.92
None	Assisted Living Facilities	MELODY CARE HOME LLC	$174,490.01
None	Assisted Living Facilities	LOST DUTCHMAN CARE HOME	$173,966.10
None	Specialist	SOUTHWESTERN EYE CENTER	$171,482.05
None	Assisted Living Facilities	FREEDOM MANNOR	$169,773.10
None	Specialist	AZ HEART INSTITUTE	$165,917.90
None	Hospital	MARICOPA HEALTH SYSTEMS	$165,690.49
None	Nursing Homes	DESERT SKY HEALTH CARE	$160,856.63
None	Hospital	MESA GENERAL HOSPITAL	$158,239.46
None	HCBS Services	ARBOR ROSE SENIOR CARE LLC	$156,870.41
None	Ambulance	NATIVE AMERICAN AIR AMBULANCE	$154,734.31
None	Specialist	DONALD W. HILL MD	$154,683.89
None	Hospital	KINDRED HOSPITAL TUCSON	$153,336.73
None	Assisted Living Facilities	I G H ADULT CARE	$149,942.82
None	Hospital	UNIVERSITY MEDICAL CENTER	$149,311.96
None	Dialysis Center	AZ KIDNEY DISEASE & HYPERTENSION	$148,682.38
None	Assisted Living Facilities	THE MANSION OF DUDLEYVILLE	$148,077.97
None	Assisted Living Facilities	LEGACY SENIOR MANAGEMENT LLC	$146,871.43
None	Specialist	CANCER TREATMENT CENTER AZ LLC	$142,824.95
None	Hospice	RTA HOSPICE, COMMUNITY HOSPICES OF AMERICA	$136,793.50
None	Assisted Living Facilities	ZEN FAMILY CARE AT WAYNE RANCH	$132,293.81
None	Specialist	MDMED	$131,728.76

None	Hospital	TUCSON MEDICAL CENTER	$130,909.67
None	Behavioral Health	NEW BEGINNINGS & HOPE LLC	$130,564.98
None	Specialist	HOSPITALISTS OF AZ	$127,240.10
None	Behavioral Health	HORIZON HUMAN SERVICES	$126,489.94
None	Dialysis Center	DESERT KIDNEY ASSOCIATES	$123,551.69
None	HCBS Services	HOME HEALTH INSIGHTS INC	$121,742.63
None	Ambulance	PROFESSIONAL MEDICAL TRANSPORT	$121,118.31
None	Ambulance	ELOY FIRE DISTRICT	$121,066.18
None	Nursing Homes	MARYLAND GARDENS CARE CENTER	$120,866.10
None	Assisted Living Facilities	LITA CARING HOME II	$119,413.36
None	Hospital	CORNERSTONE HOSITAL OF SE AZ	$119,387.39
None	Assisted Living Facilities	ALOTT OF CARE	$114,052.02
None	Behavioral Health	VISTA CARE LLC dba 3 SPRINGS SIERRA VISTA	$113,966.82
None	Specialist	MEDICAL DIAG IMAGING-CG	$113,553.28
None	Specialist	ADULT MEDICINE ASSOCIATES	$112,722.52
None	Behavioral Health	MOUNTAIN HEALTH & WELLNESS	$112,433.83
None	Primary Care Physician	MD ROOM SERVICE/DOCTOR CARE PLLC	$111,438.44
None	Radiology	EVAC LLC (radiology)	$109,054.60
None	Lab Services	SONORA QUEST LABORATORIES	$107,950.92
None	Hospice	HOSPICE FAMILY CARE	$106,444.04
None	Nursing Homes	TRILLIUM SPECIALTY HOSPITAL	$105,422.46
None	Assisted Living Facilities	TUNGLAND CORP	$101,565.10
None	Hospital	GILBERT HOSPITAL	$100,834.48
None	Assisted Living Facilities	DEVEREUX ARIZONA	$100,214.50
None	Hospital	AZ HEART HOSPITAL	$99,226.32
None	Hospital	NORTHWEST HOSPITAL LLC	$97,937.65
None	Hospice	HOSPICE OF THE VALLEY	$97,335.24
None	Hospital	SELECT SPECIALTY HOSPITALS	$95,490.73
None	Radiology	ASSOCIATED RADIOLOGY LTD.	$95,258.96
None	Specialist	MEDPRO	$90,615.50
None	Environmental	AZ BRIDGE TO INDEPENDENT LIVING	$90,360.00
None	Ambulance	AIR EVAC SERVICES	$85,927.53
None	Durable Medical Equip	SOUTHWEST MEDICAL & REHAB	$83,417.30
None	Ambulance	TRI CITY FIRE DISTRICT	$82,742.86
None	Dialysis Center	WESTERN SKIES DIALYSIS	$82,334.04
None	Hospital	ARIZONA REGIONAL MEDICAL CENTER	$80,534.46
None	Primary Care Physician	AMERICAN PHYSICIANS	$80,017.34
None	Dialysis Center	SOUTHWEST KIDNEY INSTITUTE	$79,596.26
None	Behavioral Health	KAREN LOMBARDI CISW	$75,941.60
None	Environmental	JUERGENS CONSTRUCTION	$75,226.31
None	Specialist	UNIVERSITY PHYSICIANS	$74,487.93
None	Radiology	AZ RADIATION THERAPY SERVICES	$74,461.01
None	Durable Medical Equip	PREFERRED HOME CARE INFUSION	$73,349.02

None	Lab Services	LABCORP OF AMERICA HOLDINGS	$73,145.73
None	Hospital	PROMISE SPECIALTY HOSPITAL OF PHOENIX	$71,406.69
None	Assisted Living Facilities	SIMPLE SOLUTIONS ASSISTED LIVING	$71,394.22
None	Specialist	AZ INSTITUTE OF NEUROLOGY	$71,367.16
None	Specialist	REHAB ARIZONA	$69,844.67
None	Ambulance	LIFESTAR EMS dba CANYON STATE AMBULANCE	$69,003.24
None	Assisted Living Facilities	HOME SWEET HOME ON FLORIAN LLC	$68,761.59
None	Infusion	KORMAN HEALTHCARE	$66,578.36
None	Hospital	BANNER MESA MEDICAL CENTER	$64,288.14
None	Behavioral Health	HELPING ASSOCIATES INC	$63,993.46
None	Assisted Living Facilities	DAISY HOME LLC	$63,695.75
None	Primary Care Physician	GERALD MUTHU LLC	$62,460.89
None	Hospital	KINDRED HOSPITAL PHOENIX	$61,535.80
None	Specialist	AZ ADVANCED UROLOGY PLLC	$61,034.36
None	Durable Medical Equip	HILL-ROM COMPANY, INC	$59,887.33
None	Assisted Living Facilities	DESERT PALMS	$58,452.00
None	Durable Medical Equip	KCI USA INCORPORATED	$58,187.24
None	Assisted Living Facilities	DESERT ROSE ASSISTED LIVING	$58,054.64
None	Specialist	BAYWOOD MEDICAL ASSOCIATES	$57,705.43
None	Specialist	AZ ONCOLOGY ASSOCIATES	$56,969.54
None	Hospital	MAYO CLINIC ARIZONA	$56,266.55
None	Therapy	ON THE MEND ON THE MOVE	$55,913.29
None	Hospital	KINDRED HOSPITAL SCOTTSDALE	$55,830.58
None	Nursing Homes	DESERT COVE NURSING CENTER	$55,410.76
None	Behavioral Health	AURORA BEHAVIORAL HEALTH	$53,525.12
None	Specialist	AZ CORRIDOR EMERG PHYSICIANS	$53,472.31
None	Nursing Homes	CHANDLER HEALTH CARE CTR	$53,421.32
None	HCBS Services	RELIABLE NURSES LLC	$53,405.76
None	HCBS Services	COMFORT-N-HOME	$53,314.11
None	Nursing Homes	NORTH MTN MEDICAL & REHAB CENTER	$52,771.16
None	Infusion	APRIA HEALTHCARE INC	$50,862.21
None	Ambulance	AMERICAN AMBULANCE	$50,837.45
None	Dialysis Center	PHOENIX DIALYSIS CENTER	$50,643.91
None	Assisted Living Facilities	DESERT OASIS ASSISTED LIVING HOME	$49,843.05
None	Specialist	VALLEY ANESTHESIA CONSULTANTS	$49,443.41
None	Assisted Living Facilities	RENATA'S HOME FOR THE ELDERLY LLC	$49,347.54
None	Radiology	CHANDLER RADIOLOGY ASSOCIATES	$48,951.23
None	Ancillary Services	PENTEC HEALTH INC	$47,684.49
None	HCBS Services	PAYSON REGIONAL HOME HEALTH AGENCY	$47,448.71
None	Specialist	AIA HOSPITALIST LLC	$46,680.20
None	HCBS Services	HERITAGE HOME HEALTH CARE	$45,874.11

None	Therapy	SPINE ORTHOPEDICS & SPORTS PT	$45,868.12
None	Specialist	GREATER AZ GASTRO ASSOCIATION	$45,361.47
None	Assisted Living Facilities	A PROMISE TO CARE	$44,716.33
None	Specialist	EMERGENCY PHYSICIANS SOUTHWEST PC	$44,631.14
None	Assisted Living Facilities	THE VINEYARD	$44,140.86
None	Primary Care Physician	BANNER PHYSICIAN HOSPITAL ORGANIZATION	$43,000.00
None	Specialist	GENTIVA REHAB WITHOUT WALLS	$42,843.41
None	Durable Medical Equip	DYNAVOX SYSTEMS, INC.	$42,327.95
None	Dentist	NEIL REISER DDS	$42,240.51
None	Specialist	CEDARS HEART CLINIC	$42,024.33
None	HCBS Services	FOUNDATION FOR SENIOR LIVING	$41,780.35
None	Environmental	AMERI-FAB	$41,461.25
None	Specialist	PETER MYSKIW DPM	$41,418.77
None	Primary Care Physician	PINNACLE HEALTH CENTER	$40,524.52
None	Specialist	ACCLAIMED INTERNAL MEDICINE	$40,498.22
None	Assisted Living Facilities	ALICE'S HOME/NENITA DE LOS SANTOS	$39,795.60
None	Specialist	BILTMORE CARDIOLOGY PLLC	$39,066.64
None	Primary Care Physician	JABER ABAWI MD INC	$39,038.60
None	Ambulance	RURAL METRO-MARICOPA	$38,342.74
None	Primary Care Physician	AZ STATE PHYSICIANS ASSOCIATION	$37,590.00
None	Behavioral Health	THE OAKS TREATMENT CENTER	$37,410.00
None	Assisted Living Facilities	ENCANTO PALMS	$37,319.09
None	Specialist	TRI CITY CARDIOLOGY CONSULTANTS, PC	$37,046.48
None	Assisted Living Facilities	FAMILY CARE HOMES INC	$37,010.95
None	Assisted Living Facilities	NORTH PARK MANOR	$35,940.12
None	Specialist	DIXIE MEDICAL CENTER PHYSICIANS	$35,922.61
None	Nursing Homes	PARK REGENCY HEALTHCARE	$35,736.13
None	Nursing Homes	HACIENDA SKILLED NURSING	$35,686.55
None	Therapy	NANETTE BURNETT PT	$35,670.94
None	Specialist	MICHAEL D. ELLIOT MD	$35,003.50
None	Dentist	COUNTRY CLUB DENTAL INC	$34,626.51
None	Nursing Homes	CAPRI AT THE POINTE REHAB	$32,889.36
None	Dentist	CORONADO DENTAL SERVICES INC	$32,613.95
None	Primary Care Physician	APOGEE MEDICAL GROUP	$32,427.84
None	Specialist	WESTERN VASCULAR INSTITUTE PLLC	$31,983.74
None	Specialist	JEAN LETARTE, MD	$31,537.55
None	Specialist	ASSOCIATED INTERNISTS OF AHWATUKEE	$31,457.08
None	Assisted Living Facilities	LEISURE LIVING FOR THE ELDERLY INC	$31,455.08
None	Hospital	JOHN C. LINCOLN DEER VALLEY	$30,844.31
None	Assisted Living Facilities	SEARLES CARE HOME	$30,784.48
None	Specialist	PIONEER HOSPITALISTS	$30,185.88
None	HCBS Services	PAYSON REGIONAL HOME HEALTH	$30,023.83

None	Primary Care Physician	COTTONWOOD MEDICAL CENTER	$29,874.26
None	Assisted Living Facilities	SUN VALLEY CARE HOME	$29,835.85
None	Specialist	NEUROLOGY AND SLEEP MEDICINE	$29,657.87
None	Primary Care Physician	NORTHWEST ALLIED PHYSICIANS LLC	$29,353.97
None	Primary Care Physician	BRENT LAYTON	$29,353.50
None	Primary Care Physician	TUCSON LONG TERM CARE	$29,317.87
None	Specialist	MT. MORIAH MEDICAL CENTER PC	$28,722.71
None	Specialist	SCOTTSDALE MEDICAL SPECIALISTS	$28,491.83
None	Specialist	ADVANCED ORTHOPAEDICS	$28,431.38
None	Durable Medical Equip	FIKES BRACE & LIMB	$28,059.21
None	Behavioral Health	DEER OAKS SOUTHWEST	$27,422.75
None	HCBS Services	RELIABLE HOME HEALTH LLC	$27,411.25
None	Nursing Homes	MARYLAND GARDENS	$26,993.52
None	Specialist	CASA GRANDE REGIONAL ANESTHESIA	$26,070.06
None	Nursing Homes	SUNCREST HEALTH CARE CENTER	$26,030.93
None	Primary Care Physician	GOOD HEALTH MEDICAL PC	$25,995.47
None	Primary Care Physician	MAIN STREET FAMILY PRACTICE	$25,209.28

e. Criminal Offenses: List the name of any person who has ownership or control interest in the Offeror, or is an agent or managing employee of the Offeror and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs:

Name Address Title

None

f. Creditors: List name and address of each creditor whose loans or mortgages exceed 5% of total Offeror equity and are secured by assets of the Offeror's company.
Description Amount

Name Address of Debt of Security

None

g. Outstanding Legal Actions:

1. Are there any lawsuits, judgments, tax deficiencies or claims pending against your organization?
Yes ___ No _X_ If yes, provide details including the dollar amount.

2. Has your organization ever gone through bankruptcy? Yes ___ No _X_ If yes, provide the year.

8. RELATED PARTY TRANSACTIONS

a. Board of Directors: List the names and addresses of the Board of Directors of the Offeror.

Name/Title	Address	City	State	Zip
Pete Rios	P.O. Box 827,	Florence,	Arizona	85132
Bryan Martyn	P.O Box 827,	Florence,	Arizona	85132
David Snider	P.O. Box 827,	Florence	Arizona	85132

b. Related Party Transactions: Describe transactions between the Offeror and any related party in which a transaction or series of transactions during any one fiscal year exceeds 2% of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each transaction and the date thereof. Include a justification as to (1) the reasonableness of the transaction, (2) its potential adverse impact on the fiscal soundness of the disclosing entity, and (3) that the transaction is without conflict of interest:

i) Describe all transactions between Offeror and any related party which includes the lending of money, extensions of credit or any investment in a related party. This type of transaction requires review and approval in advance by the Office of the Director:

Description of Transaction	Name of Related Party and Relationship	Dollar Amount for Reporting Period

Justification:

ii) List the name and address of any individual who owns or controls more than 10% of stock or that has a controlling interest (i.e. formulates, determines or vetoes business policy decisions):

Name	Address	Controller	Has Controlling Owner Or Interest? Yes / No

As a government agency, instead of owners we have three members of the Pinal County Board of Supervisor who are the elected officials with authority to determine policy and make overall strategic business decisions for P/GLTC and the rest of Pinal County. The Board members are:

Pete Rios	P.O. Box 827, Florence, Arizona 85132	Controller	Yes
Bryan Martyn	P O. Box 827, Florence, Arizona 85132	Controller	Yes
David Snider	P.O. Box 827, Florence, Arizona 85132	Controller	Yes

9. OFFEROR'S OFFSHORE PERFORMANCE OF WORK PROHIBITED

Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in the specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers. **Offerors shall declare all anticipated offshore services in the proposal.**

NONE

END OF SECTION

B. CAPITATION

Subject Requirement:	***Reqmt. Page #***	***Offeror's Page #***
Capitation Rate Bid (via EFT/SFTP and hard copy)	1	58

Requirement 1: Capitation Rate Bid Submission

Capitation rate bid submission to AHCCCS via the EFT/SFTP server by 3pm on April 2, 2011.

Lance Malkind, ASA, MAAA, Inc.
4301 N. 21st St., #21
Phoenix, AZ 85016

Phone: (602)284-1248
E-mail: LMalkind@aol.com

Actuarial Statement of Opinion

I, Lance Malkind, am a self-employed consulting actuary and have been a member of the American Academy of Actuaries since 1980.

In my professional opinion, the capitation rates proposed by Pinal Gila Long Term Care for the Arizona Health Care Cost Containment System's Long Term Care contract #YH12-0001 are actuarially sound and appropriate for the services to be provided under that contract.

Lance Malkind

Lance Malkind
Associate of the Society of Actuaries
Member of the American Academy of Actuaries

March 26, 2011

ORIGINAL

AHCCCS Capitation Calculation For Rates for CYE12
EPD RFP Bid Submission:
Pinal/Gila Long Term Care - GSA 40

Service Category	Pinal/Gila GSA 40		
	Gross	MIX	Net
Nursing Facility	$ 4,729.05	24.86%	$ 1,175.64
Share of Cost			$ (212.17)
Net Nursing Facility			**$ 963.47**
HCBS Home and Community	$ 1,791.86	75.14%	$ 1,346.40
Net HCBS			**$ 1,346.40**
Acute Care Prior to Reinsurance			$ 687.40
Reinsurance Offset			$ (196.76)
Net Acute Care			**$ 490.64**
Medical Component			**$ 2,800.51**
Case Management			$ 125.00
Administration		6.50%	$ 202.95
Sub-Total of Scored Components			**$ 3,128.46**
Risk/Contingency at 1%			$ 33.25
Net Capitation			**$ 3,161.71**
Premium Tax (98% of Final Cap)			$ 64.52
Net Cap w/ Premium Tax			**$ 3,226.23**

C. ORGANIZATION

Subject Requirement:	***Reqmt. Page #***	***Offeror's Page #***
Moral and Religious Objection	2	62
Organization and Staffing	3	63
	4	92
	5	95
Sanctions	6	97
Claims	7	98
	8	108
	9	111
Encounters	10	114
Information Systems	11	122
	12	137
	13	140
	14	141
Grievance System	15	144
Corporate Compliance	16	151
Finance and Liability Management	17	156
	18	157
	19	160

Requirement 2: Submit a statement of any moral and religious objections to providing any services covered under Section D, Program Requirements of the ALTCS RFP.

Pinal/Gila Long Term Care (P/GLTC) cites no moral or religious objection to providing ALTCS covered services.

Requirement 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.

Key personnel and resumes are included as required.

Donna M. Beedle, BS, MPA
Chief Executive Officer

SUMMARY
EXPERIENCE:

27 years Health and Human Services Programs
1 year Long Term Care

EDUCATION

2009 Master of Public Administration, Arizona State University
1998 Bachelor of Science, Business Administration, Arizona State University

EMPLOYMENT HISTORY

PINAL COUNTY
October 2009-Present

Pinal/Gila Long Term Care Director

- Provide acute, long term and behavioral health care services to 1,500 elderly, physically disabled and/or ventilator dependent members.
- Manage financials of health plan with annual revenues totaling over $60 million.
- Direct a staff of 86 in the advocacy and clinical management of members with chronic disease and end of life issues including case management, provider relations and quality management.
- Oversees provision of case management to 450 SMILE (non-ALTCS) members.
- Administer 300 provider contracts with responsibility for contract negotiations, network development and credentialing.
- Ensure plan members receive health care services that are culturally responsive including recruitment and retention of a diverse work force and provider network.

MARICOPA COUNTY
March 1992-October 2009

Program Director

- Develop and implement strategic plans.
- Provide leadership to 40 staff across 6 teams.
- Participate in policy development and legislation at state, county, and local levels.
- Assure consistency, compliance, and congruence between state and county mission.
- Insure achievement of goals, objectives, and Managing for Results (MFR) metrics.
- Direct development of strategic partnerships with community organizations.
- Lead management gap/needs analysis, process consolidation, and continuous improvement.
- Oversee administrative service and fiscal management functions.
- Apply innovative solutions to enhance services and augment available resources.
- Lead evaluation of process and outcome program evaluation.

Contract Manager

- Administered annual contracting process with community organizations.
- Facilitated contract negotiations.
- Collaborated with contractors to establish performance measures.
- Developed, implemented, and monitored fiscal agent and contract budgets.
- Performed programmatic and fiscal audits.
- Provided technical assistance and/or corrective action plans.
- Prepared monthly, quarterly, and annual reports.

Program Coordinator

- Administered U.S. Health and Human Service grant programs.
- Directed compilation of utilization statistics for use in program assessment and planning.
- Served as liaison to planning council and quality assurance committee.
- Prepared formula and supplemental grant applications.
- Coordinated Request for Proposals, Request for Quotes and Review of Qualifications Processes annually.

Marlene Bluestein, MD
Chief Medical Officer

SUMMARY
EXPERIENCE:
12 years Long Term Care

Licensure and Certifications
Arizona, #13289

July 1, 2977	Diplomate, National Board of Medical Examiners
1979	Diplomate, American Board of Internal Medicine
1988	Subspecialty Certificate in Geriatrics, American Board of Internal Medicine
1995	Geriatrician of the Year, Arizona Geriatric Society

EDUCATION

1964 - 1968	Masters of Business Administration, Brandeis University
1972 - 1977	MD, S.U.N.Y. at Buffalo School of Medicine, M.D.
1976 - 1977	Medical Internship, University of Wisconsin Hospitals
1977 - 1979	Medical residency, University of Wisconsin Hospitals
1979 - 1981	Geriatric Fellowship, University of Wisconsin Hospitals
1981	Certificate in Health Services Administration, University of Wisconsin School of Public Health
1980 - 1981	Visiting Fellow in Geriatric Medicine, University College Hospital, London England

EMPLOYMENT HISTORY

Pinal County Government
Pinal Gila Long Term Care (PGLTC), Florence AZ
1999 to Present

Chief Medical Officer
- PGLTC is a Medicaid managed care heath plan serving all of the eligible elderly and physically disabled patients in Pinal and Gila counties of Arizona.

Saguaro Physicians, Tucson, AZ
2008 to Present

Private Practitioner
Geriatric/Internal Medicine Practice

Tucson House Calls, Tucson, AZ
2002-2009

Founder and Practitioner
- Tucson House Calls is a house call practice comprised of geriatricians and nurse practitioners.

American Physicians, Phoenix, AZ
2001-2002

Regional Director
- House call and skilled nursing facility delivery system.

Carondelet Hospice Service, Tucson, AZ
1998-2000

Associate Medical Director

Health Partners of Arizona, Tucson, AZ
1993-1999

Statewide Medical Director
- Medicare Health Plan

Health Partners of Southern Arizona, Tucson, AZ
1992-1997

Senior Population Leader

University Medical Center, Tucson, AZ
1981-1991

Geriatrician

Veterans Administration Medical Center, Tucson, AZ
1981-1991

Chief, Geriatric Medical Service

Susan M. Murphy, MPA, CPA
Chief Financial Officer/Contract Compliance Officer

SUMMARY
EXPERIENCE:

27 years Health and Human Service Programs
9 years Long Term Care
9 years as Chief Financial Officer
2 years as Contract Compliance Officer

EDUCATION

2007 Master of Public Administration, Troy University
1977 Bachelor of Arts, University of Arizona
1994 Arizona Certified Public Accountant

EMPLOYMENT HISTORY

Pinal/Gila Long Term Care, Florence, AZ
2002 - Present

Chief Financial Officer

- Direct preparation of monthly, quarterly and annual financial reporting required by AHCCCS.
- Oversee financial management of health plan with annual revenues in excess of $60M.
- Direct preparation of budget based on historical analysis and future trended projections.
- Direct capitation rate development; prepare prospective financial statements and other financial information in response to AHCCCS Requests for Proposals (RFP).
- Serves as Contract Compliance Officer, primary point-of-contact for AHCCCS for all operational issues including execution of contract requirements and deliverables.
- Oversee Corporate Compliance process and reporting requirements related to fraud and abuse.
- Direct biannual preparation and completion of financial audit conducted by independent auditor.
- Oversee all aspects of P/GLTC technology and advancements including Information Technology (IT), system administration for claims and benefits, case management, medical management, and quality management systems.
- Administer AHCCCS electronic data interchange transactions including enrollment and eligibility, encounter data, capitation and reinsurance.
- Assume duties in Director's absence.

Interim Director
October 2008 - October 2009

- Assumed role and responsibilities of Director during position vacancy.
- Directed staff of 85 case managers, provider relations, finance, and quality management
- Insured continuity of integrated services to 1450 elderly/physically disabled members
- Insured financial monitoring and viability.
- Assured AHCCCS contract compliance.
- Oversight of provider contracts and procurement processes.

Interim Network Management and Development Director
November 2009 - July 2010

- Assumed role of Network Management and Development Director during position vacancy.
- Development and monitoring of provider network.
- Provided supervision of Provider Relations Supervisor and Representatives, Contract Specialists, Credentialing Coordinator and Community Relations and Outreach Coordinator.
- Oversight of procurement/contracting processes.
- Coordinated of Grievance and Appeals process.

- Responsible for process improvement initiatives

CIGNA HealthCare of Arizona, Tucson, AZ
1994 - 2002
Claims Liaison Manager

- Liaison between national field claim offices, local provider network, health plan contracting and provider services department.
- Manage claim research/adjustment projects, appeals and contract reconciliations on multiple claim platforms. Perform prepayment claim audits for national claim system conversion.
- Supervise overpayment and recovery function related to capitation leakage and contract interpretation.

Finance Manager

- Manage patient financial services, cash control and financial analysis for staff model clinics.
- Develop annual budget, perform monthly financial forecasts and cost center analysis.
- Provide financial analysis for contracting department related to fee schedules, capitation and practitioner/facility agreements.
- Supervise claims liaison and overpayment/recovery function.
- Oversight of contract performance standards including encounter monitoring and chart audits.
- Supervise Y2K preparation for local health plan.

Government Programs Coordinator

- Oversight of HCFA compliance requirements for Medicare+Choice program.
- Manage staff model subcontracts with three local AHCCCS health plans.
- Ensure collection and timely filing for encounter data validation requirements.
- Coordinate local efforts for Medicare audits.

Center Administrator

- Manage two staff model clinics providing primary care, laboratory, radiology and pharmacy services.
- Supervise nursing, medical records and front desk personnel.
- Oversight of all center activities including encounter collection and cash receipts.

AHCCCS Coordinator

- Coordinate all aspects of local response to RFP for AHCCCS contract.
- Implement AHCCCS required policies and procedures.
- Educate clinical and administrative staff to ensure compliance with AHCCCS Program Requirements.
- Perform claims liaison function with provider network and third party administrator.

Desert Hills Center for Youth/Families, Tucson, AZ
1985 - 1993
Controller

- Manage Accounting and Business Office functions of a multi-level of care adolescent psychiatric facility; including general ledger, payroll, accounts payable, accounts receivable and billing.
- Prepare annual budget, monthly financial statements, rate filings and cost reports.
- Provide financial analysis for administration and board of directors.
- Oversight of annual independent audit.
- Oversight of system administration with local vendor.

Accounting Manager

- Supervise general accounting, payroll and accounts payable, maintain subsidiary ledgers.
- Prepare quarterly payroll reports and ensure compliance with all state and federal requirements.
- Assist in preparation of annual budget and prepare budget variance analyses.
- Coordinate required activities for independent audit.

Darla Bodar, R. Ph. Permit No. S010106
Pharmacy Coordinator/Director

SUMMARY

EXPERIENCE

18 years - B.S. Pharmacy degree with a total of 18 years experience in the pharmaceutical industry including consulting, managed care, Long Term Care, hospital pharmacy and retail.
8 years - Clinical Director for United Drugs Pharmacy Benefit Management (PBM)

EDUCATION

1989-1992 B.S. Pharmacy, University of Oklahoma
1986-1989 Northeastern State Univ., Tahlequah, OK

EMPLOYMENT HISTORY

United Drugs, Phoenix, AZ
2004-present

Clinical Director,

- Provide pharmacy consulting services to 4 Medicaid PBM clients covering 9500 lives and over$7.6 million annual revenue.
- Provide consulting services to PBM clients including the evaluation, assessment and reporting of interventions based on data.
- Participate in Pharmaceutical and Therapeutic Committees, report on formulary adherence, suggest formulary changes and cost containment strategies.
- Oversees the clinical department if United Drugs PB, including:
  - Developing and managing formularies.
  - Developing and instituting client cost savings programs.
  - Managing the prior authorization department.
  - Managing system edits for DUR, quantity limits.
  - Step Therapies, and other system requirements that relate to processing claims.

Pharmercia Long term Care Pharmacy
2003 to 2004

Pharmacist

Chief Pharmacist, Goot United Drug, Glendale, AZ

- Chief pharmacist in a long term care retail compounding pharmacy located in a medical building which provides close contact with patients and physicians.
- Responsible for servicing individuals, group homes, and other long term care, facilities where major emphasis is on customer care.
- Supervisor of 3 employees and Midwestern Univ. College of Pharmacy student preceptor.
- Staff pharmacists for Pharmercia Long Term Care- duties included filling prescriptions, I.V. preparation and general oversight for daily pharmacy functions in a busy long term care setting.

WalMart Pharmacy, Phoenix, AZ
2001 to 2003

Pharmacist

- Retail pharmacist excelling in customer service and patient counseling.
- Responsible for filling medications, narcotic inventory, supervising 4 technicians.
- Daily contact with physicians regarding third party formularies.

- Trained multiple store locations on new pharmacy input software.

USPHS, Phoenix Indian Medical Center, Phoenix, AZ
1997 to 2001

Lieutenant Commander

- Clinical pharmacist in 180-bed facility responsible for extensive patient counseling
- Filling prescriptions
- IV's, chart reviews
- Checking blood pressure and blood sugar
- Working in conjunction with physicians regarding patient's drug therapy
- Gained knowledge of government hospital formulary with face-to-face interactions with physicians regarding formulary-based med changes
- Heavy emphasis on patient counseling

K-Mart Pharmacy, Nashville, TN
1995 to 1997

Pharmacist

- Retail pharmacist responsible for daily retail pharmacy operations excelling in customer care.

Safeway Pharmacy, Honolulu, HI
1994 to 1995

Pharmacist

- Retail pharmacist in a multi-cultural setting responsible for daily retail operations and again excelling in customer service.
- Received numerous awards for customer care.

Ocso, Pharmacy, Phoenix, AZ
1992 to 1994

Pharmacist

- Retail pharmacist responsible for daily retail pharmacy operations.

Alexa Carrara, D.D.S.
Dental Coordinator

SUMMARY
EXPERIENCE:

5 years Long Term Care Contractor

Licensure

Arizona Dental License #D5847
New York Dental License #054948
DEA License #BC8319003

EDUCATION:

1999 – 2003 University of Missouri, Kansas City School of Dentistry, Doctor of Dental Surgery
1994 – 1998 BS Biochemistry, University of Arizona

EMPLOYMENT HISTORY

Southern Arizona Veterans Administration Health Care System, Tucson, AZ
January 2010 - Present

Staff Dentist

- Responsible for providing the complete range of dental care to patients including all elements of a general practice staff dentist.
- Patient population includes medically compromised, outpatients, and nursing home patients.
- Examine, diagnose, develop treatment plans, and provide a full range of dental care.
- Chair side skills include: operative dentistry, Implant placement and restoration, rotary Endodontic treatment, removable prosthetics, Oral Surgery, Periodontics, and patient education.
- Provide timely, accurate and complete record documentation utilizing the computerized medical record system.
- Provide appropriate consults and referrals to medical and dental specialists.
- Provide clinical training for residents, and other staff as indicated.
- Participate in the Dental Service quality Management and Peer Review programs.
- Determine future budgetary, personnel, and space and equipment requirements for the Service.
- Provide administrative oversight for surgical case treatment in the operating room.
- Posses computer skills; good work ethics, administrative skills and be a team player.

Pascua Yaqui Tribal Dental Center, Tucson, AZ
June 2005 - January 2010

Contract Dentist

- Tribal Dental Clinic provides dental services to members of Pascua Yaqui Indians.
- Provide direct care in state of the art dental facility funded by casino revenue. Ideal treatment plans provided.
- Provide general dental procedures including: diagnosis of dental disease, treatment plans, cosmetic dentistry, crowns, veneers, bridges, endodontic therapy, placement and restoration of dental implants, dentures, removable partial dentures, composite fillings, pedodontics, conscious sedation, oral surgery, periodontal treatments. Recognize and refer complex cases to specialists in supporting community.
- Work with medically compromised pa0tients and coordinate dental treatment with medical doctors and behavior health specialists to achieve better whole body health in team environment.
- Organize and participate in community outreach projects designed to education community on

dental oral health topics.

- Work with Pima Community College Dental Hygiene Externs in the clinic. Supervise direct patient care, diagnosis, grading of technique and professionalism.
- Supervise Dental Assisting Externs. Work chair side. Provide direction and feedback.
- Develop and institute staff training for infection control and team building for monthly meetings.

James B. Rohen, D.D.S. , Tucson, AZ
January 2005 - January 2010

Private Practice Associate/ Partner

- Associate dentist in private practice.
- Fee for service. High end restorative procedures.
- Proficient in: diagnosis, treatment planning complex restorations, oral surgery, dentures, removable partial dentures, dental implant restoration, crowns, bridges, composite and amalgam fillings, endodontic therapy, veneers, pedodontic treatment, treatment of geriatric patients, conscious sedation, periodontal treatment.
- Coordinate complex treatments with various dental specialists.
- Responsible for obeying HIPPA privacy acts. Maintain correct and appropriate records of patient treatments, diagnosis, and conversations. OSHA officer for office.
- Organize and coordinate staff training.
- CPR training for office.
- Emergency Action Planning for office.
- Marketing plans for success of office.
- Take direction from Senior Dentist.
- Supervise dental staff of assistants, hygienist, front office staff.

Lutheran Medical Center, Tucson, AZ
June 2005 - January 2010

Clinical Faculty

- Supervise, mentor and educate dental resident during year long dental residency.
- Provide hands on training in: diagnosis, treatment planning, record keeping, working with dental auxiliary staff, communication with patients, communication with dental lab technicians, basic restorative procedures, use of different restorative materials, oral surgery, periodontal treatment, fixed orthodontics, removable prostodontics, implant placement and restoration, endodontic therapy, pedodontics.
- Evaluate progress through course of residency.
- Provide detailed evaluations in tri-annual period.
- Provide community outreach opportunities for residents.

Arizona School of Dental Oral Health, Gilbert, AZ
June 2005 - January 2010

Adjunct Clinical Faculty

- Supervise dental students at extern site.
- Provide instruction in the following fields: professionalism and conduct, patient communication, communication and working with dental auxiliary, communication with dental labs, diagnosis of dental disease, review of patient medical history and recognizing potential complications to dental treatment, treatment plan sequence of needed treatment, periodontal treatment, composite fillings, crowns, bridges, dentures, treatment of facial trauma, oral surgery.

Andrea Kennedy
Claims Administrator/Corporate Compliance Officer

SUMMARY

EXPERIENCE

25 years Health and Human Services Programs
9 years Long Term Care

EDUCATION

2003 Certified Public Manager, Arizona State University
2006 Certified Procedural Coding, Central Arizona College

EMPLOYMENT HISTORY

Pinal County Government
Pinal/Gila Long Term Care, Florence, AZ
2002 to present

Claims Manager

- Ensure claim payments are made timely and accurately while processing over 10,000 claims a month.
- Prepare monthly Dashboard and manage results to ensure contract compliance.
- Supervise staff of six Claims Specialists.
- Liaise with Provider Services to ensure claims are paid per contract.
- Audit claim payments to ensure claims are paid accurately.
- Supervise the TPL function to ensure we are the payer of last resort.
- Train staff and provider community on new initiatives such as NPI, electronic claims, etc.
- Prepare and track all reinsurance claims for accuracy and maximum expense offset.
- Track and deposit members' Share of Cost payments and handle correspondence as needed.
- Liaise with Independent Auditors during our financial audits.

Pinal County Medical Assistant Program, Florence, AZ
1986 -2002

Claims Coordinator

- Oversaw overall financial management activities of the Claims Unit.
- Processed the County's Indigent Populations medical claims in a timely manner. Saved the county money by monitoring and maintaining our budget.
- Coordinated and oversaw the Account Clerk I and the Eligibility Workers.
- Took advantage of all quick payment discounts, and avoided penalties.
- Recommended and implemented accounting policies and procedures.
- Maintained internal financial information, reconciled funds, and prepared fiscal reports.
- Updated the system with cost ratios, price changes and discount percentages to ensure payment calculations were correct.
- Assisted in preparation of the department budgets, produced reports for payment and monitored budget outflow.
- Processed overpayments and credits, filed liens, and prepared deposits with the Treasurer's Office.

Eligibility Supervisor

- Oversaw and supervised 23 Aide workers.
- Processed Fraud and Abuse referrals.
- Evaluated and reviewed staff performance, kept statistics on error rates, payroll, hiring, disciplinary actions, and industrial claims etc.

Eligibility Worker

- Interviewed and processed applications to determine AHCCCS eligibility.
- Handled approximately 1,200 cases annually, performed random Quality Assurance checks to catch errors that were tied to sanctions by the State Quality Control Office.

Lynne Braatz
Dispute and Appeal Manager

SUMMARY
EXPERIENCE:
5 years Long Term Care

EDUCATION:
December 2004 Bachelor of Arts in Liberal Studies, Northern Arizona University

EMPLOYMENT HISTORY

Pinal County Government
Pinal/Gila Long Term Care, Florence, AZ
May 06 – present

Administrative Assistant
- Supports the Chief Medical Officer and the Director of Quality/Utilization management
- Represents PGLTC as AHCCCS's primary contact in regards to Grievances, Transplants, Member Appeals, and Dental Director related activities. Manages/maintains records for QM/UM Department at PGLTC in accordance with state law.
- Coordinates payments and arrangements for accommodations for any off site training sessions for departmental staff.
- Maintains/processes all Notice of Action (NOA) letters and databases for any denied services. Provides backup functions to prior authorization clerk as needed. Performs special project work and any other duties as assigned.
- Provides clerical support to QM/UM Department similar to office manager duties to include payroll duties, office supply maintenance, and internal policy development/revision in accordance with state and federal regulations.

Clerical/Prior Authorization Clerk
- Processed referral requests and hospital admissions to ensure financial reimbursement to providers.
- Maintained records substantiating referrals/admissions. Assisted providers by locating contracted physicians.
- Submitted payroll for processing.

Auto Safety House, Phoenix
March 2002 – May 2006

Clerical/Warranty Administrative Assistant
- Processed claims electronically and monitored financial reimbursement.

Home Depot, Mesa, AZ
October2001 – March 2002

Cashier
- Opened, closed, and balanced cash register daily to include opening/closing duties such cleaning and stocking work area.
- Provided customer service (product/location info).

Cummins Southwest, Phoenix, AZ
February 1998 – October 2001

Clerical/Service Writer

- Performed customer service related duties, prepared invoices, processed warranty claims, and monitored financial reports.

Rhonda Montgomery
Community Relations & Outreach Coordinator/Business Continuity Planning and Recovery Coordinator

SUMMARY
EXPERIENCE
2 years Long Term Care

EDUCATION:
July 2011 Masters of Business Administration, University of Phoenix
May 2000 Bachelor of Arts in Print Journalism, Arizona State University

EMPLOYMENT HISTORY

Pinal County Government
Pinal/Gila Long Term Care, Florence, AZ
July 2009 to Present

Community Relations & Outreach Coordinator
- Chair Diversity Committee and facilitate cultural competency initiative throughout organization
- Chair and facilitate two Councils that bring groups together to implement program change
- Responsible for creation and design of provider and member newsletters
- Creation and design of all informational brochures, flyers, and handouts
- Maintain community relationships and attend networking groups throughout two counties
- Special event coordination
- Public speaker and representation at community events and health fairs
- Development and implementation of adult foster care initiative
- Liaison with community leaders and organizations

Casa Grande Regional Medical Center, Casa Grande, AZ
July 2006 to February 2009

Marketing Coordinator
- Grant proposal writer
- Liaison with various department heads and physicians for marketing efforts
- Responsible for creation and programming for website content
- Creation and design of all advertising materials including; billboards, newspaper, maps, local directories, and in-theatre animations
- Maintained vendor relationships and community networking
- Responsible for all event and in-studio photography including studio set up
- Special event coordination-Jeff Dunham Fundraising Event, physician speakers
- Community relations including representation at health fairs
- Responsible for strategic marketing plans
- Liaison with media for story placement and coverage
- Creation and layout of monthly employee newsletter
- Coordination of employee recognition program

State of Arizona/Dept. of Health, Phoenix, AZ
April 2005 to February 2006

Regional Liaison for Bureau of EMS

- Grant proposal writer
- Coordinated and supervised video production
- Created and implemented marketing materials
- Public speaking and presentations to various groups
- Collaborated with outside vendors to create media
- Creation and design of department newsletter
- Represented department and collaborated with outside providers
- Conference and event planning

The Arizona Republic, Phoenix, AZ
July 2001 to August 2004

Marketing Coordinator (part-time)

- Assisted in creating promo plan for local television at a daily newspaper
- Assisted with creation and implementation of various marketing materials
- Conference and event planning

Monty Typer, Inc., Chandler, AZ
September 1995 to July 2001

Owner

- Small business owner of a transcription service
- Wrote restaurant reviews, edited web sites
- Consultant for multi-media organization
- Transcribed celebrity interviews for various publications
- Responsible for day to day operations as well as sales and marketing

Los Angeles Magazine, Los Angeles, CA
July 1992 to August 1995

Editorial Coordinator

- Wrote, designed and produced cover and fashion shoots
- Wrote restaurant and nightlife reviews
- Compiled special listing sections for a monthly city magazine
- Supervised and managed a staff of 6 interns for a publishing company
- Scheduled work hours, resolved conflicts and trained staff
- Coordinated the collection and preparation of operating reports

Kelly S. Morgan, RN, MN, CPHQ

Director, Quality and Medical Management/Coordinator
SUMMARY
EXPERIENCE:

32 years Professional Nursing
20 years Healthcare Management
16 years Quality Management / Performance Improvement
6 years Managed Care
1 year Long Term Care

EDUCATION

1995 Master of Nursing (Administration), University of Phoenix
1992 Bachelor of Arts, Management, University of Phoenix
1979 Associate Degree, Nursing, Pima Community College, Tucson, AZ

CERTIFICATION

2001 – Present Certified Professional in Healthcare Quality (CPHQ)
1997 - 2002 Certified Infection Control Practitioner (CIC)
1985 – 1997 Certified Emergency Nurse (CEN)

EMPLOYMENT HISTORY

Pinal/Gila Long Term Care, Florence, AZ
2010 – Present
Director, Quality and Medical Management

- Develop, implement, and execute Quality and Medical Management programs
- Ensure Quality and Medical Management regulatory compliance at all
- Provide direction and management for assigned staff, supporting their professional growth and development within the confines of budgetary constraints
- Develop/implement infrastructure required for consistent quality and medical performance.
- Review and determine the appropriateness of care and services provided by individual and organizational providers
- Support health care partners in the improvement of care and services through use of the corrective action plan, provider watch, and pay for performance initiatives.
- Ensure members receive timely access to appropriate, high quality care and services through utilization management, including pre-service, concurrent, and retrospective management and performance monitoring.

University Physicians Health Plan, Tucson, AZ
2005 – 2010
Director, Clinical Programs and Systems Quality and Medical Management Systems

- Responsible for Organizational Departments during transformational period in which the plan grew from 13,000 with two single county lines of business and to 135,000 members in eight counties
- Developed and implemented Medical Management and System organization and department level infrastructure to enable transition into a third party liability (TPL) role for a under-performing Medicaid plan and the addition of a Medicare Special Needs Plan (SNP) in two markets and expansion of acute AHCCCS plan from one into eight counties.
- Expanded functional programs, including Disease Management, Technology Assessment, Grievance Systems and Decision Support.

- Responsible for multi-million dollar budget development and execution, resulting in a substantial improvement in MLR while incentivizing members to improve EPSDT and Maternal health care services and performance measures.
- Lead Medical and Quality Program regulatory compliance, improving from 90% improvement in Medical Management compliance and 16% improvement in both Quality Management and Authorization and Grievance Systems.
- Quality Management and Medical System liaison for corporate information system (IS) initiatives, including a Medical Management system conversion.
- Note – also held the titles of Director, Quality and Medical Management Systems and Director of Quality and Medical Management during tenure. Responsibilities included above.

Carondelet Health Network, Tucson, AZ
1998 – 2005
Manager/Director, Quality and Medical Staff

- Managed quality programs to ensure network level adherence to standardized reporting and regulatory compliance for three hospital network within Ascension Health.
- Managed medical staff services, including peer review, for over 3000 Professional Staff
- Performed as Network Lead and national liaison for successful Patient Safety IHI initiatives, including fall reduction, medication reconciliation, VTE prevention, 100K Lives Campaign, and congestive heart failure care.
- Developed sentinel/significant event response program, including structure and process for investigation, communication, resolution, and continued monitoring.
- Managed Medical Staff Services and Quality Management staff, facilitating their professional growth and development

Quality Associate

- Liaison for all non-physician quality management activities for three hospital system, including home health agency and hospice care.
- Developed and provided quality management training programs for network.
- Developed unit based QM and Performance Improvement indicator system to allow unit based monitoring that aligned with organizational goals

Vencor Hospital-Tucson, Tucson, AZ
1995 – 1998
Quality Review Manager

- Managed quality, case management, utilization review, infection control, and employee health programs and processes for inpatient acute long term care facility.
- Managed regulatory compliance for organization, including but not limited to JCAHO and Fire Safety
- Developed, implemented, evaluate effectiveness of and provide oversight for Quality and Medical Management and Infection Control Plans in collaboration with physician and corporate leaders.

University Medical Center, Tucson, AZ
1986 – 1995
Manager, Emergency Department and Urgent Care

- Managed all functional and operational aspects of Level 1 Trauma Emergency Department and Urgent Care Services with over 50,000 annual visits and 100 FTE.
- Prepared and executed multi-million dollar annual budget, consistently achieving financial targets while improving service delivery.

Assistant Nurse Manager and Staff Nurse, Emergency Department and Urgent Care

- Managed 12 hour ED shifts and staff, including patient care and flow, scheduling, and performance
- Provided triage and direct patient care in Level 1 Trauma ED with physician residency program
- Acted as Pre-hospital liaison services for emergency medical (ambulance) services

Connie Mueller, RN, CPHQ
Performance/Quality Improvement Coordinator

SUMMARY

EXPERIENCE

2 years Long Term Care

EDUCATION

2000 Healthcare Quality Certification Board, (HCB) Certificate
1977 Registered Nurse, Good Samaritan School of Nursing, Portland, OR

EMPLOYMENT HISTORY

Pinal County Government
Pinal/Gila Long Term Care
2009 to Present

Quality Management Nurse

- Performs clinical data collection and data entry
- Assists with provider communications regarding clinical priorities and performance improvement projects
- Assists data analyst with data validation and clinical performance reporting
- Presents performance results at quarterly Quality Management Meetings
- Attends and participates @ AHCCCS-sponsored Quality Meetings
- Prepares and presents clinical topic educational presentations for case management staff, members, and providers

Women's Healthcare Associates, Portland OR
2006 - 2008

Quality Improvement Coordinator

- Researched guidelines and additional information related to quality management, including reviewing patient medical records, collecting data and investigating areas of identified interest and importance.
- Provided input and helped to set goals for QI committee meetings, QI initiatives, and the development of quality indicators.
- Designed data collection tools, evaluation criteria, and reporting formats for projects as defined by the QI committee.
- Participated in developing a database for projects to ensure ongoing reporting and monitoring of quality measure performance.
- Coordinated the reporting of quality measure analysis results to the QI committee and other clinical staff.
- Assisted in the development of risk management patient care protocols/procedures and staff training related to emergency cart standardization, patient complaints, autoclave processes and conscious sedation procedures.
- Developed and maintained monitoring criteria for all patient care protocols and guidelines.
- Contributed in grant writing activities as requested by leadership staff.

Oregon Medical Professional Review Organization, Portland OR
1995 to 2005

Quality Improvement Specialist

- Assisted hospital staff in technical aspects of data collection, validation, and reporting, on the telephone and in person.
- Coordinated quarterly Hospital Advisory Committee meetings, including developing agendas, recruiting members, facilitating meetings, and serving as liaison between the advisory committee and OMPRO leadership.
- Coordinated numerous OMPRO educational events, including supervising team members, co-developing curricula, recruiting presenters, marketing programs, and evaluating events. Clinical and nonclinical topics covered include heart failure, acute myocardial infarction, surgical infection prevention, data collection and validation, human factors analysis, and principles of conducting rapid cycle systems changes using the Plan-Do-Study-Act (PDSA) cycle.
- Co-developed annual Oregon Hospital Quality Awards program, including determining selection criteria, recruiting advisory panel which included physicians, nurses, and the healthcare advisor to Governor Kulongoski.

Mueller International
1993 to 1995

Office Manager

- Reorganized and maintained computerized inventory system.
- Installed and operated computerized accounting system.
- Performed customer relations management including providing product quotes and authorizing warehouse releases.

James Kilgore, MD
1991 to 1992

Office Nurse

- Performed general office duties in a plastic surgery practice, including instructing patients, assisting in minor office surgery, removing sutures and drains, obtaining vital signs, changing dressings, administering medications.

St. Vincent Hospital and Medical Center
1990 to 1991

Resource Nurse

- Performed all aspects of patient care including wound care, IV fluid and medication administration, monitoring vital signs, pulmonary care and patient education. My unit handled a variety of post surgical cases specifically in the areas of urology, gynecology, orthopedics, and plastic surgery.

The American SIDS Institure
1998

Research Nurse

- Provided specialty nurse coordination support to Portland office of American SIDS Institute for testing of, and follow-up with, siblings of infants who had succumbed to SIDS. Responsibilities included training parents in the use of monitors and event recorders, teaching infant CPR, assisting with sleep studies, and providing ongoing monitoring and consultation.

Jakenna L. Lebsock
Maternal Health/EPSDT Coordinator

SUMMARY

EXPERIENCE

5 years Long Term Care

EDUCATION

May 2006 Master of Public Administration, University of Arizona
May 2004 Dual bachelors of Science, Marketing and Management, Johnson & Wales University

EMPLOYMENT HISTORY

Pinal County Government
Pinal/Gila Long Term Care, Florence AZ
October 2006 – Present

Maternal Health/EPSDT Coordinator

- Manage the Maternal Child/EPSDT Program; work with case managers to ensure member compliance with program requirements, chair the Children's Task Force and arrange and/or deliver professional development sessions for appropriate staff, write and execute the annual plan and prepare all materials for the annual audit.
- Develop and implement member and provider interventions for quality management, medical management, and MCH/EPSDT programs; coordinate education sessions for staff members, track and analyze data, conduct regular program reviews to ensure compliance and achievement of internal and regulatory goals.
- Coordinated the development of the Self-Directed Attendant Care (SDAC) program for AHCCCS; served as the primary contact and facilitator for all work groups, designed the SDAC member manual, networked with members and professionals across the state to ensure stakeholder buy-in for the program.

Pima County Community and Economic Development Department
May 2005 – October 2006

- Produced comprehensive articles and reports that served as tools to obtain/sustain funding for multiple programs including Affordable Housing, Community Development Block Grant (CDBG), and Outside Agencies; sample audiences include HUD and the Pima County Board of Supervisors

- Created new marketing tools for various programs including flyers, brochures, newsletters and manuals; marketing pieces were distributed to stakeholders, service providers and clients throughout Pima County and Southern Arizona

Denver Mayor's Office of Workforce Development (MOWD) Internship
March 2004 – May 2004

- Built MOWD/airport businesses relations at Denver International Airport (DIA), including employee training opportunities, newsletters, monthly meetings, and groundwork for a MOWD office at DIA

- Planned a special job fair for Transportation Security Administration (TSA), with over 400 qualified applicants attending

- Compiled a 30-page training manual, focusing on filing systems, computer usage, general operating procedures and a complete contact list of businesses at DIA

Mary Goodman
Behavioral Health Coordinator

SUMARY
EXPERIENCE
20 years Long Term Care
EDUCATION
9/1981 – 5/1985 Social Work and criminal Justice, Sioux Falls College, now known as University of Sioux Falls Sioux Falls, South Dakota

EMPLOYMENT HISTORY
Pinal County Government
Pinal/Gila Long Term Care, Florence, AZ
3/2003-present

Case Manager Supervisor/Behavioral Health Coordinator

- Position created to cover half of a Case Manager (CM) Supervisor position and to cover the Behavioral Health (BH) Coordinator position. Please see below for description of the BH Coordinator position. The CM
- Supervisor completes supervision of professional Case Management activities, including: monitoring case management services; develop processes that promote effective/ efficient case management services; hire, train, supervise and evaluate the performance of Case Managers; review and revise policies and procedures to assure compliance with AHCCCSA mandates; conduct staffings with Case Managers and other departments to determine appropriate services and solve complex member issues; research and resolve provider complaints, concerns, and claim disputes.
- Supervised 4-6 Case Managers.

Pinal/Gila Long Term Care, Florence, AZ
4/2002-3/2003

Behavioral Health Coordinator/Case Manager III

- Position created to cover half of a caseload (24 members) and to provider coordination of the BH requirements directed by AHCCCCSA mandates.
- Include: designing and conducting all behavioral health education for CM; conduct BH orientation for new CM; conduct audits focused on BH documentation; conduct initial and quarterly BH consultations with CM; assist CM with screening members for appropriateness of BH services; monitor CM compliance with AHCCCS guidelines for members receiving BH services; participate in meetings internally and those mandated by AHCCCS;
- Assist with review of BH providers; identify areas of need and assist with finding resources to meet those needs.

Pinal/Gila Long Term Care, Florence, AZ]

Case Manager III

- Position is responsible for: managing a caseload of elderly and or physically disabled members who live in a home based setting or a nursing home setting;
- Assess member's needs for care, develop care plans, and
- Ensures that the care would be cost effective; arrange for services to meet stated needs and monitor progress toward members' goals; resolve members complaints and concerns,
- Maintains data in system on all members assigned to caseload; and
- Monitors for members' readiness for moving to a lesser restrictive environment.

Christine P. Liberato, M.P.H.
Director, Network Management and Development Department/Provider Services Manager

SUMMARY
EXPERIENCE

5 years Chairperson, Managed Care Section, Arizona Public Health Association
9 years Adjunct Professor, Midwestern University
2 years President, Arizona School Health Association
1 year Chairperson, Health Education Section , Arizona Public Health Association
1 year as Director, Network Management and Development

EDUCATION

1977-1979 M.P.H. University of Hawaii School of Public Health
1973-1977 B.A. Biology University of Hawaii Hilo Campus

EMPLOYMENT HISTORY

Pinal County Government
Pinal/Gila Long Term Care, Florence, AZ
July 2010 to Present

Director, Network Management & Development

- Responsible for creating and maintaining a comprehensive network of physicians, hospitals, ancillary providers, skilled nursing facilities and home and community-based services that meet the needs of elderly and disabled members enrolled in the Arizona Health Care Cost Containment System (AHCCCS) through contractual agreements that meet minimum access and availability standards established by funder.

Vice President, Regional General Manager
Coventry Health Care, Inc.
SW Advantra PPO
November 2008- March 2010

- Responsible for product strategy, operations and profitability of Coventry's Southwest Medicare PPO in the states of Texas, AZ and NM. Oversee and benefit design, marketing, sales, risk adjustment and day-to-day operations. Coordinated Medicare product expansion application.

Vice President, Operations and Compliance
United Health Care, AmeriChoice Division
APIPA Personal Care Plus Plan
October 2006-November 2008

- Initially in a national role, owned oversight responsibility for start-up Special Needs Plans in NY, NJ and AZ which included benefit design, member material production, sales, marketing, enrollment, compliance and operational oversight.

- Role transitioned into a local AZ Special Needs Plan focus responsible for day-to-day plan operations, compliance and risk adjustment resulting in a reported **$22 million profit** in 2007 with only a membership of 13,000 members. Achieved 100% release from a CMS Corrective Action Plan within 6 months of initiation.

Vice President, Administration & Compliance
Sun Health MediSun
2001- 2006

- Directly responsible for the overall operations, sales, member retention, customer services, risk adjustment, compliance and profitability of Sun Health MediSun (now Banner MediSun) MAPD products including CCP, PFFS, Chronically-Ill SNP and Medicare Supplement Policies covering a total of 18,000 members with a combined annual revenue of over $164 million and $1.5 million net profit in 2005. Dually responsible for interpreting federal regulations related to Medicare Advantage Part C and Part D and ensuring adherence to all CMS standards and requirements.

Operations Director
Maricopa Integrated Health Systems
August 1995- June 2001

- Responsible for benefits design, member services, grievance and appeals, maternal and child health, marketing and compliance. Operating on a combined annual budget of $100 million, provided oversight of multiple products including an ALTCS Plan (*Maricopa County Long Term Care Plan-MCLTCP*), an AHCCCS Acute plan (*Maricopa Health Plan*), a Medicare + Choice plan (*Maricopa Senior Select Plan*), and an Employee Health Plan (*HealthSelect Plan*).

During this period, MCLTCP was the sole contractor for ALTCS in Maricopa County. Designed and implemented a comprehensive Compliance and Auditing Program for Medicare and Medicaid products to ensure compliance with regulatory bodies.

Case Management Administrator
Maricopa Managed Care Systems
January 1994-August 1995

- Administered and over-sighted the Case Management component of the ALTCS (Maricopa County Long Term Care Plan) program which provides medical care and long term care services to an enrolled population of frail elderly and individuals with disabilities. Directed over 100 case managers in the coordinated delivery of nursing home and home and community-based services to over 8,000 ALTCS members.
- Led a system-wide initiative to deflect long term care members from high cost nursing home care into less costly community based settings in order to achieve the optimal ratio of institutionalized to HCBS members.

Maternal and Child Health Manager
Maricopa County Health Plan
January 1989-February 1994

- Designed, implemented and evaluated intervention and outreach programs targeted at high risk chronically ill adults, high risk pregnant women and high risk children with asthma who were enrolled in Maricopa County Health Plan, an AHCCCS Acute Plan with over 40,000 members.

Jennifer Kelly
Case Management Administrator

SUMMARY
EXPERIENCE:
6 years Long Term Care

EDUCATION
1998 Bachelor of Arts – Social Work and Criminal Justice, University of Wisconsin
2003 Master of Social Work (Advanced Standing PAC), Arizona State University

EMPLOYMENT HISTORY

Pinal County Government
Pinal/Gila Long Term Care, Florence, AZ
2005 – Present

Director, Case Management
- Supervise ALTCS and Community Programs Case Management staff.
- Train and educate Case Management staff.
- Monitor requirements of ALTCS and AAA to stay within the guidelines.
- Conduct outreach to the community

Community Program Supervisor
- Supervise SMILE, MOSAIC and Care Giver Program.
- Train and educate Case Management staff.
- Monitor requirements of grant to stay within the guidelines.
- Conduct Outreach to the community.
- Monitored the appropriateness of clients for Long Term Care.

Correctional Services Corporation, Florence, AZ
2003 - 2005

Programs Supervisor
- Supervised all program employees
- Handled Urinalysis testing for female employees.
- New Employee orientation, training, and education.
- Identified problems with current operations then creating and implementing a better system that is easier and more efficient for the organization as a whole.
- Acting Deputy Warden.
- Assisted in all organizational crises.
- Assisted in Incident Management System issues.

Correctional Programs Officer
- Monitored inmates
- Documented progress in Substance Abuse programming.
- Developed tool for program auditing purposes.
- Case Work including writing reports for reclassification as well as for release purposes.
- New employee training, annual training for employees.
- Acting Programs Supervisor.

Visiting Angels, Scottsdale, AZ
2003 - 2004

Care Services Coordinator

- Coordinated and Supervised Caregivers.
- Data base entry, travel, budgeting, problem solving, assessments, crisis intervention and networking.
- Identified problems and eligibility for assistance and need for services including AHCCCS.
- Reviewed medical, legal or financial issues.
- Monitored in-home care or other services.

National Association of Social Workers, Tempe, AZ
2002 - 2003

Executive Director Intern

- Planned budgets for the next fiscal year at the State Capital.
- Developed, reviewed, implemented and managed a strategic plan for Social Work Day.
- Supervised volunteers for the event.
- Developed a booklet for executing future events.
- Reviewed training providers applications to ensure credibility and protection of professionals who attend seminars held for Continuing Education Credits imperative to keep licensure.
- Developed and implemented policies for training providers and followed up with phone calls.
- Conducted classes pertaining to new Arizona Board of Behavioral Health Licensure requirement.
- Met with Legislatures and attended legislative sessions regarding passage of Licensure for the BBHE.
- Aided in fundraising for at-risk children.
- Attended Board meetings.

Correctional Services Corporation, Florence, AZ
2001 - 2002

Substance Abuse Counselor
Case Management

- Conducted classes in substance abuse, life skills, anger management, grief, rational emotive behavior therapy, adult children of alcoholics
- Assisted in Incident Management System issues.

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Requirement 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.

KEY POSITIONS / EMPLOYEES NOT FULL TIME

Below is a listing of key positions/employees which are not full time. The justification for non-full time status is included.

Position	Name	Starting Date	Proportion of hours per week dedicated to the ALTCS Program
Medical Director	Marlene Bluestein, MD	1/1999	50%

Dr. Bluestein is an Arizona-licensed physician who oversees all major clinical components of the health plan. As Medical Director, she devotes as much time as necessary to make the required program decisions and timely medical decisions. She is available via telephone, including after hours. It is not necessary that Dr. Bluestein work full time as the Pinal/Gila Long Term Care (P/GLTC) Medical Director due, in part, to the relatively low member enrollment. With 1,500 members, she meets or exceeds AHCCCS requirements in approximately 20 hours per week. These requirements include medical/quality management, prior authorization, concurrent review, credentialing, grievance, appeal and fair hearing processes. She also provides oversight and is involved in provider profiling and recruitment, medical management activities, assessment, development and implementation of quality management/medical management plans. Dr. Bluestein also serves as Chairperson of Quality Management, Medical Management, Peer Review and Credentialing Committees.

In addition to Dr. Bluestein's P/GLTC Medical Director role, she is also a private practice geriatrician, caring for home and community based patients. Dr. Bluestein's personal interaction with patients provides a unique and very valuable perspective in serving P/GLTC members. Dr. Bluestein's ongoing interaction with professional colleagues in the community is key in improving provider relations.

On the rare occasion Dr. Bluestein is unavailable due to vacation or Continuing Medical Education (CME), Rhema Sayers, MD, serves as back-up to ensure continuous medical direction. Dr. Sayers is an Arizona licensed physician who serves as Cochise Health Systems Medical Director.

Pharmacy Benefit Director	Darla Bodnar, RPH	1/2004	10%

Darla Bodnar is a licensed clinical pharmacist who serves under (United Drug) contract as the P/GLTC Pharmacy Benefit Manager. Under Dr. Bluestein's leadership, Ms. Bodnar assists P/GLTC in formulary development, prior authorization and step therapy protocols. United Drugs also provides claim processing, after hours management and prior authorization. P/GLTC consistently achieves among the lowest pharmacy costs in the state, driven in part by our high generic utilization, a well-managed formulary, and high provider acceptance.

Due to the relatively low volume of prescriptions, the cyclical nature of formulary revision and the high quality and timeliness of service provided by United Drugs, the amount of time required for our Pharmacy Benefit Director is less than full time.

Quality Management Director	Kelly Morgan, RN	7/2010	50%
Medical Management Director	Kelly Morgan,, RN	7/2010	50%
Kelly Morgan, RN, manages P/GLTC Quality Management and Medical Management. She successfully achieves this under the direction of Dr. Bluestein, Chief Medical Officer, and with the support of a staff of four RNs, three support staff, and 1.5 FTE Quality Improvement Coordinators. Relatively low enrollment (1,500 members) and the nature of the functions promote the ongoing achievement of AHCCCS clinical requirements and development of new and innovative disease and pre-disease management programs.			
Dental Director/Coordinator	Alexa Carrara,, DDS	11/2007	5%
Dr. Carrara is an Arizona licensed dentist and is under contract to provide P/GLTC consultation services. Given low enrollment and recent dental benefits cuts, Dr. Carrara easily fulfills the requirements of this position.			
Claims Administrator	Andrea Kennedy	3/2002	85%
Corporate Compliance Officer	Andrea Kennedy	3/2002	15%
Andrea Kennedy spends 85% of time as Claims Administrator, Accounting and Information Systems Section and 15% as Compliance Officer. The amount of time spent on compliance is adequate to successfully implement and oversee P/GLTC's compliance program. Ms. Kennedy makes herself available to all employees, presents fraud and abuse information at all-staff meetings and possesses designated and recognized authority to access records and make independent referrals to AHCCCS, Office of the Inspector General (OIG)			
Maternal Health/EPSDT Coordinator	Jakenna Lebsock, MPA	10/2006	5%
Jakenna Lebsock functions as P/GLTC's Maternal/Child Health Coordinator and achieves the required duties due to the very small number of EPSDT members and the lack of maternity cases addressed by P/GLTC. Ms. Lebsock functions primarily as a Disease Management Coordinator. In addition to condition specific initiatives, the Disease Management Program includes health promotion activities such as smoking cessation, weight management, and medication safety, which are congruent with concerns of maternal and adolescent members.			
Performance/Quality Improvement Coordinator	Connie Mueller, RN,	1/2009	60%
Connie Mueller, P/GLTC's Performance Improvement (PI) nurse is a qualified RN with CPHQ certification. She is responsible for facilitating Performance Measures and Performance Improvement Project initiatives. In addition, she serves as chairperson of the Quality Task Force and as the Plan-Do-Study-Act (PDSA) resource for the entire health plan. Due to membership, the work of Data Analysts and established processes that resulted in statistically significant improvement in performance, Connie currently completes her duties as a part time employee. The Director of Quality and Medical Management and Disease Management Coordinator serve as a back up if Ms. Mueller is unavailable.			

Chief Financial Officer	Susan Murphy, CPA	9/2002	85%
Contract Compliance Officer	Susan Murphy, CPA	9/2002	15%
Susan Murphy oversees budgeting, accounting systems, financial reporting and information technology/systems. She also serves as Contract Compliance Officer with oversight of all operational issues. Susan achieves these functions with the support of 17 accounting and information systems staff and through collaborative working relationships with Management Team members. Susan oversees the collaborative effort to coordinate and track contract deliverable submission and communication with AHCCCS including coordination of audits and OFRs.			
Business Continuity Planning & Recovery Coordinator	Rhonda Montgomery	7/2009	20%
Community Relations & Outreach Coordinator	Rhonda Montgomery	7/2009	80%
Rhonda Montgomery is the designated staff person responsible for P/GLTC Business Continuity and Recovery Planning. Rhonda reviews the Business and Continuity Plan annually and assures submission to AHCCCS and P/GLTC staff training on the approved plan. Rhonda also serves as the liaison to the Pinal County Office of Emergency Management. In this role, Rhonda assures focus on and attention to emergency management policy for Special Needs Population. Rhonda also serves as P/GLTC's Community Relations and Outreach Coordinator. Ms. Montgomery convenes Member Council meetings, attends outreach events and sustains relationships with community partners.			

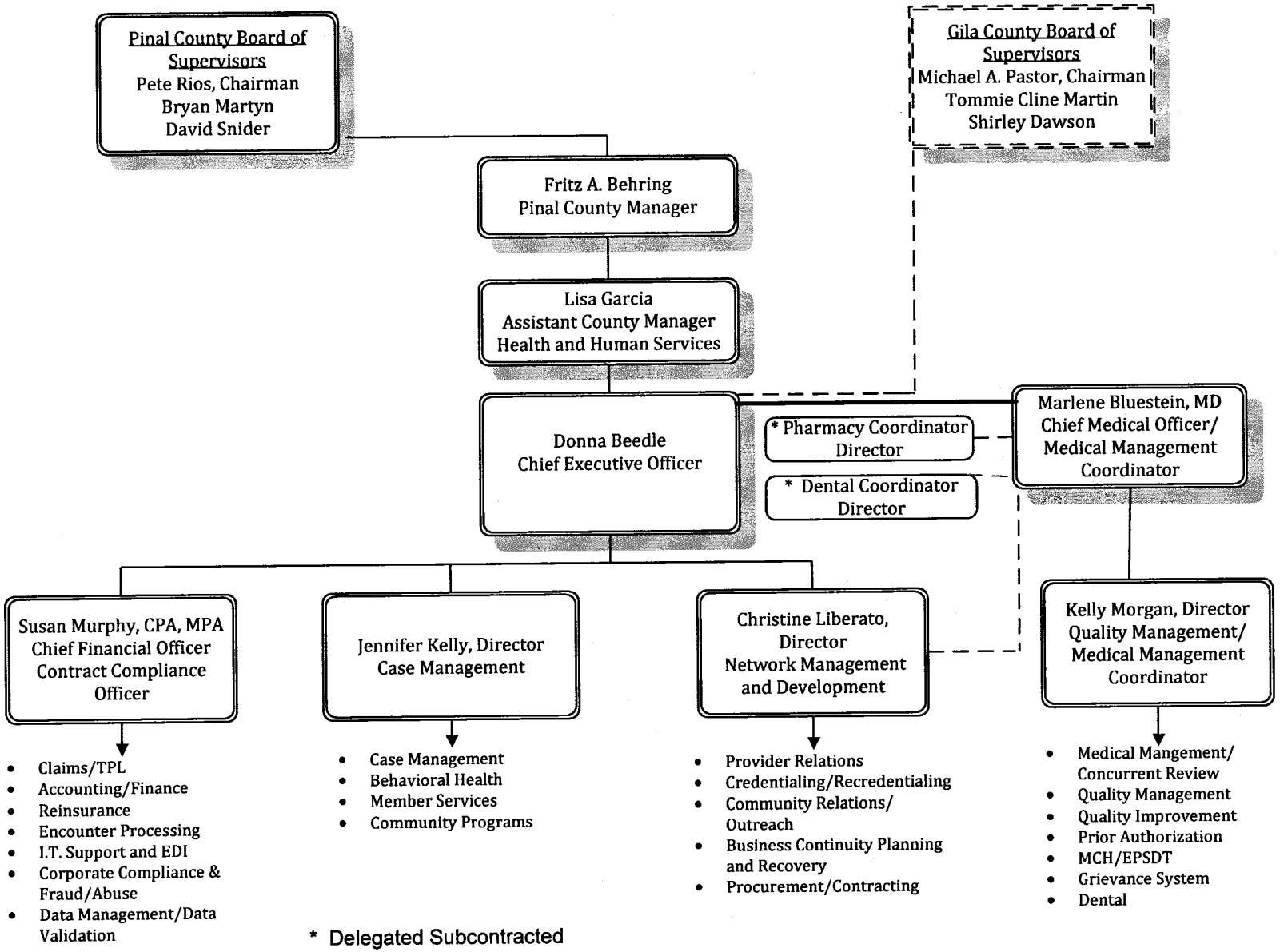
Requirement 5: Submit a functional organizational chart of the key program areas, responsibilities and areas that report to that position.

Functional organizational chart is included as required.

Pinal/Gila Long Term Care

Functional Organizational Chart

Exhibit 4-1



* Delegated Subcontracted

Requirement 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.

The table below represents sanctions incurred by Pinal/Gila Long Term Care (P/GLTC) since January 1, 2008. The discussion is in order of financial significance.

Description	Reason	Quarter Incurred	Amount
Encounter	Pended encounters > 120 days	CYE08	$21,615
Notice of Action	Timeliness/Language -11/07, 05/08	CYE08	$20,000
Encounter	Pended encounters > 120 days	CYE09	$11,700
Encounter	Data Validation - CYE05	CYE09	$20,763
Encounter	Pended encounters > 120 days	CYE10	$54,580
Encounter	Pended encounters > 120 days	CYE11	$12,455

(P/GLTC) had sanctions imposed due to encounter issues, specifically, pended encounters that were not resolved within the required 120 days. The pended encounters were not resolved within the required timeframe due to deficiencies in the encounter monitoring process. Subsequently the process has been reviewed and revised by the P/GLTC CFO and internal encounter unit. Additional staff have been assigned to the task of pend resolution and root cause determination. As a result, the number of encounters pended for greater than 120 days has decreased 95% from 798 in December 2010 to 37 in February 2011. These efforts will continue in order to minimize the number of pended encounters over 120 days.

In 2005 P/GLTC implemented a system conversion for claims processing and benefit administration. The conversion occurred at the time of the initial migration to HIPAA compliant 837 transactions. Due to system export issues and syntactical errors, a high volume of encounters were submitted incorrectly. Subsequently, there were omission error limits that exceeded AHCCCS allowable rates causing a sanction of $20,763. Since that time P/GLTC technical staff, in conjunction with the system vendor, have resolved the root cause issues and no further sanctions have been incurred related to Data Validation Studies.

A similar situation occurred with the implementation of the AHCCCS required Notice of Actions (NOA). AHCCCS had mandated the NOA warning process when a denial letter (NOA) was sent to a member past timeliness standards in 2007. Another NOA with incorrect/unclear language was sent to a member in 2008. In November of 2007 P/GLTC asked for and received technical and operational assistance regarding letter templates, appropriate language, legal resources, and implemented the new NOA guide. By the end of contract year 2008, P/GLTC staff was re-trained, additional audit processes were implemented and no other sanctions have been incurred.

There are no sanctions currently in dispute, nor are there any sanctions for any other business of P/GTLC. All sanctions against P/GTLC regarding the NOAs and data validation have been resolved; all monetary penalties have been paid or waived.

Requirement 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, cost avoidance TPL activities and how claims inquiries are handled.

P/GLTC has utilized its claim system - Plexis Claims Manager (PCM) developed by Plexis Healthcare Systems since 2005. The system is robust in capabilities, capacity and flexibility. Claims are processed locally by P/GLTC Claims Specialists. Each Specialist is assigned claims based on service or provider type. This allows for individual expertise and promotes ongoing provider relations. Assignments are rotated for cross-training and depth. P/GLTC strives to process claims efficiently and accurately. On a rotating (quarterly) basis, a Claims Specialist is assigned the role of Provider Liaison. Responsibilities include provider calls, claim research and provider education. Issues are elevated to the assigned Provider Relations Representative as needed. P/GLTC exceeds AHCCCS timeliness standards of 90% of claims processed within 30 days of receipt and 99% within 60 days of receipt with rates of 99.91% and 100% respectively for the most recent contract year. P/GLTC has exceeded this requirement with a five-year average of 18 days; 17.71 days in the most recent contract year.

Claims Adjudication Process

PCM's flexibility enables P/GLTC to identify and adjust specific ALTCS benefit structures, Share of Cost (SOC) accumulators, age limits (i.e. EPSDT services), and contract types such as ALTCS, Acute Only, QMB and PPC. PCM also contains prior authorization rules by code/code set, place of service, and provider type. Most set up options and assignments have effective and termination dates, allowing the adjudication process to compare a date of service of a claim and eligibility span of the member. This process aligns the appropriate benefit structure to the service. This flexibility was demonstrated when the P/GLTC System Administrator performed changes required to implement the adult and QMB benefit re-design was effective October 1, 2010 without system vendor intervention.

Payment methods supported by the System include flat rates, case rates, percent billed, per diems, capitation, or a combination of multiple methodologies (e.g., AHCCCS outpatient fee schedule methodology). Fee schedules have effective and termination dates, against which the adjudication process compares a date of service of a claim to identify the one to use.

All providers are maintained in the system based on contract status (current or terminated, contracted or non-contracted), and reimbursement rates or methodology. The adjudication process determines contract status of a provider, the related fee schedule and applicable authorization requirements. The System Administrator transfers contracted providers who have yet to complete the re-credentialing process into a System "Network" to deny claims until the process has been completed. Claims submitted appropriately by non-contracted providers are processed at 100% of the AHCCCS fee schedule. Providers have six months from date of service for initial claims submission and one year from date of service to submit a clean claim. Any initial claim submitted past that timeframe automatically enters a DENY status upon adjudication.

Claims are received electronically or via paper. (See Exhibits 7-1 and 7-2) All claims are date stamped upon receipt. Paper claims are hand stamped with the date and a sequential number. Paper claims are sorted by form type (CMS 1500, ADA form, or UB04) and provider/specialty and distributed to the appropriate Claims Specialist. P/GLTC does not accept roster billing. All required fields and additional information provided are entered into the system from paper claims. Electronic claims are downloaded via a SFTP connection with P/GTLC's contracted clearinghouse. Included in the HIPPA compliant 837 file is a receive date, the day claims were received by

the clearinghouse. Claims are imported into the claims payment system via an EDI Gateway and mapped into the system ready for adjudication. The receive date is mapped into the field "Received". Following the import process, a report is distributed to claims staff to alert them to the new claims. This report includes the System claim number and claim type, enabling distribution to the appropriate staff.

PCM performs a claim review to determine if all required fields are populated (i.e. Member ID, Provider ID, procedure code, and diagnosis, etc.). PCM verifies member eligibility to ensure the member is eligible for the date(s) of service and confirms coverage for each procedure line (service). The existence of other insurance, provider contract information, and fee schedule are part of this confirmation. PCM searches for a valid authorization when required. The claim is then priced-based on the applicable payment method (capitated or fee-for-service), contract, and fee schedule. The system computes the amounts for contractual adjustments, write-off, deductibles, co-payment/co-insurance, Share of Cost, Room and Board, interest or quick pay discount, and net pay.

Prepayment claim review is performed before the adjudication process is complete. The prepayment review ensures claim processing accuracy and avoids unnecessary denials. The Claims Department makes every effort to pay claims upon initial submission. During the adjudication process, if the System assigns a PEND/DENY status, rather than deny those lines, the claim is forwarded to the appropriate section for prepayment review (See Exhibit 7-3) For example, if the number of units or maximum dollars in the authorization is not sufficient to pay the claim, or there is an indication of other coverage that requires verification, the claim is routed to the appropriate section, Case Management, Medical Management, or the P/GLTC TPL Specialist for authorization edits, insurance verification, etc. Prepayment review findings are maintained in a database. On a monthly basis the Claims Manager and CFO monitor results for trends and determine root causes. They also identify internal training needs for authorization/claims staff or necessary provider education. Summary prepayment information is discussed at the quarterly Medical/Utilization Management (M/UM) Committee.

Claims Specialists review other claims in PEND or DENY status and determine if there are other issues involved such as billing errors. When needed, the Claims Specialists contact the provider billing office, offering training on proper claim submission. Once the above procedures are completed, each claim procedure line updates with the appropriate final Explanation of Benefit (EOB) code. As the adjudication process finalizes, each claim and claim procedure line are assigned an appropriate status relevant to each step in the adjudication process.

Upon completion of the adjudication process, the Claims Specialists run a preliminary Explanation of Payment (EOP)/Remittance Advice report which is reviewed for accuracy of paid amount, provider tax identification number, and pay-to address. Any errors that could impact encounter results, such as appropriate procedure code or modifier for a particular provider or type of service are corrected. The Payables Batch is then closed for that paid date and a final EOP is generated. This report is reviewed and approved by the Claims Manager. Accounting staff initiate the general ledger interface and claims expense is translated to the general ledger system accounts. The final EOPs/remittance advices are sorted by provider and submitted to the County finance department for check generation and mailing. Accounting staff generate an ACH file to initiate electronic funds transfers (EFT). The remittances for providers requesting EFT are sent electronically on the day of transfer. Information on the remittance includes: Claim Number, Member Name, Provider Name, Procedure/Revenue code, amount billed, amount paid, EOB codes and descriptions and reasons for denials,

deductions, partial payments/adjustments, application of COB, Share of Cost (SOC) for ALTCS institutional claims, and provider rights for claim disputes. P/GLTC also uses the footer of the remittance for provider information such as; web location for member eligibility and claims status, the claims assistance line and the availability of electronic funds transfers. (See Ehibit 7-4)

Post payment audits are performed on samples of processed (paid and denied) claims pulled from each paid date and reviewed for accuracy and timeliness. Areas audited to ensure compliance are timeliness, authorization requirements, COB), accuracy of provider or vendor information (Tax Identification Number (TIN), pay-to address), fee schedule accuracy, trauma code identification, and decision/denial reason. These audits are reviewed at quarterly Utilization Management Committee meetings. Encounter related issues that could result in encounter pends not previously identified are captured in post payment audits. Claims with errors related to third party payors or with TPL are reviewed to ensure P/GLTC is processing claims as the payor of last resort. (See Cost Avoidance efforts below).

The Claims Manager performs contract load auditing for 100% of new and renegotiated contracts. The areas audited include; provider demographics, effective/termination dates, tax identification number, rates and fee schedule assigned in the System. Ongoing audits of claim paid amounts against contract rates are part of the standard post payment audit process.

Claim denials are reviewed. The top five denial reasons and providers are analyzed by the Claims Manager and CFO to identify trends. Staff members receive additional training, providers are educated, and the system is corrected, depending on the analysis. Denial data is included as a component of the AHCCCS required Claims Dashboard and reviewed at the quarterly UM Committee meeting.
Deficiencies discovered by these audits are shared with individual Claims Specialists or in weekly staff meetings. Remedial training on identified problem areas is given as necessary. A claim aging report is generated weekly and reviewed by the Claims Manager. This report tracks pended claims and the number of days elapsed since the receive date. Deficiencies causing the claims to pend are reviewed. Internal system/setup issues are forwarded to the internal System Administrator (or vendor if warranted). Corrective action plans are developed and monitored to ensure completion, process improvement and/or adjustments to established goals. The Claims Manager reviews a Claims Examiner Performance report routinely with individual Claims Specialists. Claims staff is continually advised of their individual performance levels in order to identify and discuss processing shortfalls. The Claim Specialists are required to meet assigned performance measures specific to accuracy (95%) and timeliness (95%). These numbers are tracked and reviewed at least quarterly. Since the reporting requirement for this standard was initiated in 2007 average rate has been 96% to 99.80%. The P/GLTC Claims Department ended its most recent contract year with a rate of 99.73%.

Cost Avoidance/TPL Activities
P/GLTC makes every effort to ensure all third party payors are identified. Coordination of benefit activities occurs throughout the organization, particularly in the Claims Department. (See Exhibit 7-5) The Claims Department includes a TPL Specialist whose primary function is to determine if third party payor information is complete and accurate. They verify such information on a routine basis and update the claims system and the case /medical management system. Both systems house member information, including commercial insurance and Medicare coverage. The coverage information includes effective/termination dates, policy numbers and benefits available (i.e. pharmacy coverage, Medicare information-Parts A,B,D), It is, part of the daily roster (834) download. A separate TPL file is also downloaded daily. This file is forwarded to the TPL Specialist and contains