SECTION H: INSTRUCTIONS TO OFFERORS

This Request for Proposal solicits participation by Offerors to provide covered health care services to members enrolled in the Acute Care and CRS Programs. The services are to be provided in a managed care environment with reimbursement to Offerors awarded contracts on a capitated rate basis. Offerors are advised that services shall commence on October 1, 2013.

All Acute Care Offerors, if awarded a contract, are required to be organizations that contract with the Centers for Medicare and Medicaid Services to provide and manage Medicare benefits for dual eligible members in all (Geographic Service Area) GSAs in which they are awarded a contract. See Section I: Exhibit D, Medicare Requirements for additional details regarding this requirement.

The Solicitation Process shall be in accordance with the "RFP and Contract Process" rules set forth in Title 9 Chapter 22 Article 6 and effective November 11, 2012. These rules are posted on the AHCCCS internet website at:

http://www.azahcccs.gov/reporting/Downloads/UnpublishedRules/NOFR22_6.pdf

The RFP and Contract Process rules were also published on October 5, 2012 in the Arizona Administrative Register at:

http://www.azsos.gov/public_services/Register/contents.htm

Please read this RFP in its entirety as many provisions have changed from previous RFPs.

Please note that *days* as referenced in Instructions to Offerors means *calendar days*, unless otherwise specified. If a due date falls on a Saturday, Sunday or legal holiday, then the due date is considered the next *business day*. A business day means a Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.

Computation of time begins the day after the event that triggers the period and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.

RFP Sections, Attachments, & Exhibits

The RFP document consists of Sections A through I. Separate section numbers have been created, specific to the CRS Program, when necessary.

Offerors bidding on the **Acute Care Program (Acute)**, should reference RFP **Sections A, B, C, D1, E1, F-A1, F-A2, G, H, and I** for documents pertaining to the Acute Care Program information and requirements.

Offerors bidding on the **CRS Program (CRS)** should reference RFP **Sections A, B, C, D2, E2, F-A1, F-A2, G, H, and I** for documents pertaining to the CRS Program information and requirements.

Once the RFP is awarded the Acute and CRS RFP documents will be separated to develop two unique contracts.

RFP sections will be posted to the Bidders' Library as follows:

Sections A, B, & C

Section A: Solicitation Page
Section B: Capitation Rates
Section C: Definitions

Section D: Program Requirements
Section D1: Acute Care Program Requirements
Section D2: CRS Program Requirements

Section E: Contract Terms and Conditions
Section E1: Acute Care Program Contract Terms and Conditions
Section E2: CRS Program Contract Terms and Conditions

Section F: Attachments
Attachment A1 – Enrollee Grievance System
Attachment A2 – Provider Claims Disputes
Attachment B1 – Acute Care Program Contractors' Chart of Deliverables
Attachment B2 – CRS Program Contractor's Chart of Deliverables

Section G: Representations and Certifications of Offeror

Section H: Instructions to Offerors

Section I: Exhibits
Exhibit A – Offeror's Checklist
Exhibit B – Minimum Subcontract Provisions
Exhibit C – Attestation Form
Exhibit D – Medicare Requirements

All references to Section D throughout Section H, Instructions to Offerors, correspond to Section D1 for the Acute Care Program and D2 for the CRS Program, as applicable.

1. PROSPECTIVE OFFERORS' INQUIRIES

Any questions related to this solicitation must be directed to the Solicitation Contact Person listed in Section A, Solicitation Page. Questions shall be e-mailed to the Solicitation Contact Person on the Acute Care and CRS Program RFP YH14-0001 Questions and Responses Template document available in the Bidders' Library. Any correspondence pertaining to this RFP must refer to the appropriate page, section and paragraph number. AHCCCS will respond, in writing, to all questions submitted through this process via a posting in the Bidders' Library or a formal amendment to the RFP in accordance with the schedule of milestone dates found in Paragraph 12, RFP Milestone Dates, of this section. Offerors shall not contact or ask questions of AHCCCS staff related to the RFP unless authorized by the Contracting Solicitation Contact Person.

2. PROSPECTIVE OFFERORS' CONFERENCE AND TECHNICAL INTERFACE MEETING

An Offerors' Conference will be held on November 9, 2012, beginning at 9:00 a.m. Arizona time, at AHCCCS, 701 E. Jefferson, in the Gold Room on the 3rd Floor. The purpose of this conference will be to: 1) orient new Offerors to AHCCCS, 2) clarify the contents of this solicitation, and 3) clarify AHCCCS PMMIS System and interface requirements. Questions posed during the Prospective Offerors' Conference must be submitted as specified in Paragraph 1, Prospective Offerors' Inquiries, of this section. Verbal responses provided during the Conference are not binding.

3. PROPOSAL OPENING

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

4. LATE PROPOSALS

Late proposals will not be considered.

5. WITHDRAWAL OF PROPOSAL

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

6. AMENDMENTS TO RFP

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

7. EVALUATION FACTORS AND SELECTION PROCESS

The items which are designated for scoring in this RFP shall be evaluated and scored using only the information submitted to AHCCCS by the Offeror, including verbal responses provided as part of the Oral Presentation. It is the responsibility of the Offeror to clearly and comprehensively respond to each requested item and to ensure that there are no omissions or ambiguities. Failure of the Offeror to provide a clear, thorough, and detailed response may affect the award of points for a scored item.

Through an attestation process, the Offeror is required to specifically acknowledge the importance of several contractual provisions and their critical value to the AHCCCS program. This information will not be scored, however it will be verified through the readiness review process. If during the readiness review, AHCCCS determines that the successful Offeror (Contractor) fails to satisfy any of the requirements of the attestation and/or is unprepared to receive membership, AHCCCS may limit or prohibit the assignment of members for any GSAs in which the Contractor was awarded a contract. Under these circumstances, AHCCCS will authorize assignment when it is satisfied that the requirements have been met.

The final decision regarding both the number of Contractors in a particular GSA and which Offerors are awarded contracts will be made by AHCCCS. The decision will be guided, but not bound, by the scores awarded by the evaluators. However, AHCCCS will ultimately make its decision based on a determination of which proposals are deemed to be most advantageous to the State.

Although AHCCCS does not anticipate this situation will occur, if there is no responsive and responsible bid for a particular rural GSA, AHCCCS may assign that rural GSA to the successful bidder in another GSA. Should this occur, the capitation rate awarded would equal the top of the actuarially sound capitation rate range published by AHCCCS (which is the midpoint), with an 8% administrative component.

If AHCCCS deems that there is a negligible difference in scores between two or more competing proposals for a particular GSA, in the best interest of the State AHCCCS may consider additional factors in awarding the contract including, but not limited to:

1. An Offeror's past Medicare performance; and/or
2. An Offeror who is an incumbent health plan and has performed in an adequate manner (in the interest of continuity of care); and/or
3. An Offeror who participates satisfactorily in other lines of AHCCCS business; and/or
4. An Offeror's past performance with AHCCCS; and/or
5. The nature, frequency and significance of any compliance actions; and/or
6. Any convictions or civil judgments entered against the Offeror's organization; and/or

7. Potential disruption to members; and/or
8. Administrative burden to the Agency; and/or
9. Amount of choice and competition.

The Offeror should note that, if successful, it must meet all AHCCCS requirements, irrespective of what is requested and evaluated through this solicitation. The proposal provided by the Offeror will become part of the contract with AHCCCS.

All of the components listed in Paragraph 15, Contents of Offeror's Proposal, of this section, will be evaluated against relevant statutes, rules, policies, the requirements specified in this RFP, and other referenced sources.

Contracts will be awarded to Offerors whose proposals are deemed to be most advantageous to the State in accordance with Paragraph 09, Award of Contract, of this section.

Acute Scoring

AHCCCS has established a scoring methodology to evaluate an Offeror's ability to provide cost-effective, high-quality contract services in a managed care setting in accordance with the AHCCCS mission and goals. The following four components will be evaluated and weighted in the order listed:

Capitation and Program (Program includes Oral presentations)
Access to Care/Network and Organization

The Capitation section will be scored by GSA. The remaining submission areas will be scored on a statewide basis, not specific to any GSA. The scores received for each of the four required components will be weighted separately and then combined to derive a final score for the Offeror, by GSA.

CRS Scoring

In order to be considered for the CRS contract, Offerors are required to bid for and be awarded an Acute Care contract for at least one GSA. AHCCCS will combine the raw scores from an Offeror's Acute Care submission, excluding capitation, with the raw scores from the additional required submissions for the CRS proposal including CRS capitation, and apply CRS-specific weighting, to determine the final scoring and awards for the CRS Program contract.

The following four components will be evaluated and weighted in the order listed:

Program (including Oral presentations) and Access to Care/Network
Organization
Capitation

8. ON-SITE REVIEW

Prior to contract award, all Offerors may be subject to on-site review(s) to determine that an infrastructure is in place that will support the provision of services within the GSAs bid. AHCCCS reserves the right to not assign membership to Contractors that are determined to not meet minimum readiness requirements.

9. AWARD OF CONTRACT

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

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

A response to this Request for Proposal is an offer to contract with AHCCCS based upon the terms, conditions, scope of work and specifications of the RFP. All of the terms and conditions of the contract are contained in this solicitation, solicitation amendments and subsequent contract amendments, if any, signed by the AHCCCS Contracting Officer. Proposals do not become contracts unless and until they are accepted by the Contracting

Officer. The proposal provided by the Offeror will become part of the contract with AHCCCS. A contract is formed when the AHCCCS Contracting Officer signs the award page and provides written notice of the award(s) to the successful Offeror(s), and the Offeror accepts any special provisions to the contract and the final rates awarded. All Offerors will be promptly notified of award. If a successful Offeror wishes to decline an awarded contract, they must do so in writing within 16 calendar days of the date of the award letter.

Acute Care Program

"***Incumbent Contractor***" means an entity that is a party to State Contract Number YH09-0000 as of the date the Proposals are due under this RFP.

"***Successful Incumbent Contractor***" means an Incumbent Contractor that is awarded a contract under this RFP in the GSA in which they serve under YH09-0000.

"***Unsuccessful Incumbent Contractor***" means an Incumbent Contractor that is not awarded a contract under this RFP in the GSA in which they serve under YH09-0000.

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

Although AHCCCS encourages Offerors to bid on multiple GSAs, AHCCCS may limit the number of GSAs awarded to any one Offeror, if deemed in the best interest of the State.

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

If an Offeror had a contract in a GSA that was terminated by AHCCCS, and that same GSA is in the Offeror's proposal, AHCCCS may reject the proposal with respect to that GSA. If, as of the date proposals are due, an Offeror is materially out of compliance with a managed care contract with any governmental entity, including Arizona, AHCCCS may reject a proposal from the Offeror unless AHCCCS has obtained satisfactory assurances that the non-compliance will be resolved prior to October 1, 2013 and that the non-compliance will not recur.

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

GSA #:	*County or Counties*	*Number of Awards:*
2	Yuma, La Paz	Maximum of 2
4	Apache, Coconino, Mohave, and Navajo	Maximum of 2
6	Yavapai	Maximum of 2
8	Gila, Pinal	Maximum of 2
10	Pima, Santa Cruz*	Maximum of 5
12	Maricopa	Maximum of 7
14	Graham, Greenlee, Cochise	Maximum of 2

*Note: *AHCCCS anticipates awarding up to five contracts in the Pima County portion of the Pima/Santa Cruz GSA. Contracts in Santa Cruz County will be awarded to two of the five Pima contract awardees.*

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

Capped Contract Awards
An Unsuccessful Incumbent Acute Care Contractor in Maricopa or Pima County may request, in writing, to have its enrollment capped and to continue providing services under the terms and condition of this RFP. The deadline for such a request is two days from the date of the award letter. Only one capped contract in Maricopa and Pima Counties may be granted. Capped contracts will not be allowed in any other counties/GSAs. If more than one Unsuccessful Incumbent Contractor requests a capped contract, AHCCCS shall consider the request of the Offeror with the highest overall score or, in the case of differences deemed to be negligible by AHCCCS between the scores of the Unsuccessful Incumbent Contractors, consider the request that is in the best interest of the State after applying the evaluation factors. AHCCCS may, at its sole discretion, grant or deny a capped contract request. If a capped contract is granted in Maricopa or Pima Counties, AHCCCS will notify the requesting Offeror(s) and all Offerors that were awarded a contract in Maricopa or Pima Counties within nine days of the award letter.

If a capped contract is granted, the Contractor would continue to serve its existing members but would not receive any new members. AHCCCS intends to hold an open enrollment for all members assigned to the capped Contractor during the first year of the contract to allow members a choice of all available Contractors.

The capped Contractor will be awarded capitation rates factoring in the following:

a. The bottom of the actuarial rate range for the medical component (as adjusted by Section D, Paragraph 53, Compensation and Section D, Paragraph 55, Capitation Adjustments); and
b. The lesser of the lowest awarded administration rate or the Offeror's administration bid.

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

The enrollment cap will not be lifted at any time during the total contracting period specified in Section E, Contract Terms and Conditions unless one of the following conditions exists, in which case AHCCCS may lift the cap:

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

CRS Program
AHCCCS will award one statewide CRS contract. No capped contract will be permitted for CRS.

10. ACUTE CARE PROGRAM ENROLLMENT AFTER CONTRACT AWARD

Member Assignment
Beginning October 1, 2013, AHCCCS will favor new and small Contractors in each GSA as applicable. Small Contractors will be determined based on enrollment as of May 1, 2013. A small Contractor is defined by GSA and has a membership level as delineated in the following table:

County/GSA	GSA-specific Enrollment Threshold
Maricopa – GSA 12	<65,000
Pima County Only	<35,000
Rural GSAs (including Santa Cruz County)	less than or equal to 45% of enrollment in the entire GSA

Conversion Group Assignment

Members who are enrolled as of June 30, 2013 with an Unsuccessful Incumbent Contractor which was not granted a capped contract (Conversion Group) will be assigned to new and small Contractors within their GSA, effective October 1, 2013. These members will be allowed to remain with the Contractor to which they were assigned or choose a different Contractor by August 31, 2013 from any of the incumbent or new Contractors in the GSA that are effective October 1, 2013.

If the number of members in the Conversion Group in a GSA is enough to bring all new and small Contractors within the GSA above the thresholds listed in the table above, the members will be assigned at random until all of the new and small Contractors reach the thresholds. The remaining members of the Conversion Group will then be auto-assigned to all Contractors in the GSA according to the CYE 14 algorithm methodology as described in ACOM Draft Policy, Auto-Assignment Algorithm.

If the number of Conversion Group members in a GSA is not enough to bring all new and small Contractors within the GSA above the thresholds listed in the table above, a random assignment will be utilized to bring all new and small Contractors as close to equal as possible, without reducing any Contractor size.

In a rural GSA, if both Contractors are new to AHCCCS, the Conversion Group members will be assigned approximately equally between the two Contractors.

In the Maricopa GSA, if there are no Unsuccessful Incumbent Contractors and/or if in the Maricopa and Pima GSAs, there is one Unsuccessful Incumbent Contractor and a capped contract is awarded, there will be no Conversion Group members to assign to the new Contractor(s).

During the Conversion Group assignment process, members may intentionally be assigned to Contractors they are currently enrolled with for Medicare services in order to maximize alignment and care coordination opportunities.

For members being auto-assigned in July 2013, the algorithm will be based on the CYE 13 contract. For members auto-assigned during August and September 2013, the algorithm will be based on the CYE 13 contract with Unsuccessful Incumbent Contractors in each GSA excluded, except in family continuity, newborn enrollment, and 90-day re-enrollment situations. For GSAs in which all Contractors are unsuccessful, the CYE 13 algorithm will remain in effect through September 30, 2013. Details on member choice of Contractors for the months proceeding October 1, 2013 and impacts on Unsuccessful Incumbent Contractors will be released at a later date.

If during the readiness review, AHCCCS determines the Contractor fails to satisfy any of the requirements of the attestation and/or is unprepared to receive membership:

- The Contractor may not be included in the assignment of Conversion Group members for any GSAs in which the Contractor was awarded a contract; and
- For members being auto-assigned, AHCCCS may not permit members to be auto-assigned until such time that AHCCCS is satisfied that the requirements have been met.

Enhanced Auto-Assignment Post-Conversion

At the conclusion of the Conversion Group auto-assignment, New Contractors and Successful Incumbent Contractors still below the thresholds on September 1, 2013 will receive members under an enhanced auto-assign algorithm beginning October 1, 2013. The enhanced algorithm will be based on the factors used in the CYE 14 algorithm and will continue to favor those Contractors below the threshold through December 2013. **In this situation, as described in ACOM Draft Policy, Auto-Assignment Algorithm, Contractors not qualifying for the enhanced auto-assignment algorithm will not receive any members via auto-assignment for the time period.**

AHCCCS may evaluate the enrollment by Contractor throughout the remaining months of CYE 14 to determine whether to continue and/or reinstate the enhanced algorithm for some additional period. AHCCCS does not anticipate continuing the enhanced auto-assign algorithm past September 2014.

All efforts will be made to auto-assign members based on the methodology in ACOM Draft Policy, Auto-Assignment Algorithm and the thresholds above, however amounts may not be exact due to issues such as family continuity, newborns, 90-day re-enrollment etc.

See ACOM Draft Policy, Auto-Assignment Algorithm for more information.

11. FEDERAL DEADLINE FOR SIGNING CONTRACT

The Centers for Medicare and Medicaid Services (CMS) has imposed strict deadlines for finalization of contracts in order to qualify for Federal financial participation. This contract, and all subsequent amendments, must be completed and signed by both parties, and must be available for submission to CMS prior to the beginning date for the contract term (October 1, 2013). All public entity Offerors must ensure that the approval of this contract is placed on appropriate agendas sufficiently in advance of the deadline to ensure compliance with this requirement. In the event CMS denies or withholds Federal financial participation due to the Offeror's failure to comply with this requirement, payments to the Contractor will be reduced by the amount of the Federal financial participation denied or withheld. Additionally, all member choice and assignment may be frozen if the Contractor fails to submit the signed amendment by the effective date of an amendment. This freeze will last until CMS approves the tardy submission.

12. RFP MILESTONE DATES

The following is the schedule of events regarding the solicitation process:

Activity	Date
RFP Issued	November 1, 2012
Prospective Offerors' Conference and Technical Interface Meeting	November 9, 2012
First Set of Technical Assistance and RFP Questions Due	November 14, 2012
RFP Amendment Including Responses to RFP Questions Issued On or Before	November 27, 2012
Second Set of Technical Assistance and RFP Questions Due	December 10, 2012
Second RFP Amendment Including Responses to RFP Questions Issued On or Before	December 19, 2012
Proposals Due by 3:00 p.m.	**January 28, 2013**
Contracts Awarded On or Before	March 22, 2013
Readiness Reviews Begin On or After	April 1, 2013
New Contracts Effective	October 1, 2013

Note: *Dates are subject to change.*

13. BIDDERS' LIBRARY

The Bidders' Library contains critical reference material including but not limited to AHCCCS policies, Offeror's Checklist, utilization and cost data, member data, and performance requirements to assist the Offeror in preparing a thorough and realistic response to this solicitation. References are made throughout this solicitation to material in the Bidders' Library and Offerors are responsible for reviewing the contents of the Bidders' Library material as if they were printed in full herein. AHCCCS may continue to update the Bidders' Library after this solicitation is released; the Offeror is responsible for monitoring updates to the Bidders' Library. The Bidders' Library is located on the AHCCCS website at http://azahcccs.gov/commercial/purchasing/bidderslibrary/YH14-0001.aspx.

14. MINIMUM CAPITALIZATION

If the Offeror cannot meet the minimum capitalization requirements or the performance bond requirements, described herein for the Acute Care Program and/or the CRS Program, AHCCCS requests that the Offeror not submit a proposal.

Minimum Capitalization Requirements – Acute Care Program:
The Offeror must meet a minimum capitalization requirement for each GSA bid in the Acute Care Program. The capitalization requirement must be met within 30 days after contract award**.**

Minimum capitalization requirements by GSA are as follows:

Geographic Service Area (GSA)	**Capitalization Requirement**
Mohave/Coconino/Apache/Navajo	$4,400,000
La Paz/Yuma	$3,000,000
Maricopa	$5,000,000
Pima/Santa Cruz	$4,500,000
Cochise/Graham/ Greenlee	$2,150,000
Pinal/Gila	$2,400,000
Yavapai	$1,600,000

New Offerors (any Offeror that is not currently an Acute Care Contractor with AHCCCS): To be considered for a contract award in a given GSA or group of GSAs, a new Offeror must meet the minimum capitalization requirements listed above. The capitalization requirement is subject to a $10,000,000 ceiling regardless of the number of GSAs awarded. This requirement is in addition to the Performance Bond requirements defined in Section D, Paragraphs 46, Performance Bond or Bond Substitute, and 47, Amount of Performance Bond, and must be met with cash with no encumbrances, such as a loan subject to repayment. The capitalization requirement may be applied toward meeting the equity per member requirement (see Section D, Paragraph 50, Financial Viability Standards) and is intended for use in operations of the Contractor.

Incumbent Contractors: Incumbent Contractors that are bidding a county or GSA in which they currently have a contract must meet the current equity per member standard for their current membership (see CYE 13 contract Section D, Paragraph 50, Financial Viability Standards). Successful Incumbent Contractors that do not meet the current equity standard must fund, through capital contribution, the necessary amount to meet the equity per member requirement within 30 days after contract award. Incumbent Contractors that are bidding a new GSA must provide the minimum capitalization requirement listed above for each new GSA they are bidding. The capitalization requirement for new GSAs is subject to a $10,000,000 ceiling regardless of the number of new GSAs awarded. Incumbent Contractors will not be required to provide additional capitalization for new GSAs if

their excess equity within 30 days of contract award is at least $10,000,000 above all current equity per member requirements.

Minimum Capitalization Requirement – CRS Program: The Offeror must meet a minimum capitalization requirement for the CRS Program bid. The capitalization requirement must be met within 30 days after contract award. The minimum capitalization requirement is $5,500,000.

New Offerors (any Offeror that is not currently the CRS Contractor with AHCCCS): To be considered for a contract award, a new Contractor must meet the minimum capitalization requirement listed above. This requirement is in addition to the Performance Bond requirement defined in Section D, Paragraphs 46, Performance Bond or Bond Substitute, and 47, Amount of Performance Bond, and must be met with cash with no encumbrances, such as a loan subject to repayment. The capitalization requirement may be applied toward meeting the equity per member requirement (see Section D, Paragraph 50, Financial Viability Standards) and is intended for use in operations of the Contractor.

Incumbent Contractor: The Incumbent Contractor must meet the current equity per member standard for its current membership (see CYE 13 contract, Attachment J, Paragraph 50, Financial Viability Standards). If the Successful Incumbent Contractor does not have excess equity in an amount sufficient to meet the minimum capitalization requirement, it must fund, through capital contribution, the necessary amount to meet the minimum capital requirement of $5,500,000 within 30 days after contract award.

15. CONTENTS OF OFFEROR'S PROPOSAL

All proposals (original and six copies) shall be organized with strict adherence to Exhibit A, Offeror's Checklist, as described below in this section and submitted using the forms and specifications provided in this RFP. A PDF version of the Offeror's proposal must also be submitted to AHCCCS by 3:00 p.m. Arizona time on January 28, 2013 via the EFT/SFTP server. Instructions for access to the EFT/SFTP server are included in the General Section of the Bidders' Library. The Offeror will upload the proposal to a secured location on the EFT/SFTP server as follows:

- Folder: AcuteCare-CRS-RFP14
  - Sub-Folder: CapitationandProposalSubmission
    - Sub-Folder: <Offeror's Name>

In the event that hard copy submissions differ from electronic submissions, the hard copy submissions will prevail.

NOTE: AHCCCS will post all proposals including capitation rate bids to the website once the contract awards have been made. No pages will be withheld with the exception of Section G: Representations and Certifications of Offeror. The Offeror shall not designate any information to be proprietary in nature with the exception of Section G: Representations and Certifications of Offeror.

All pages of the Offeror's proposal must be numbered sequentially with documents placed in sturdy 3-inch, 3-ring binders. All responses shall be in Times New Roman 11 point font or larger with borders no less than ½". Unless otherwise specified, responses to each submission requirement must be limited to five (5) 8½" x 11" one sided, single spaced, type written pages. Erasures, interlineations, or other modifications in the proposal must be initialed in original ink by the authorized person signing the offer. AHCCCS will only consider the information provided within the allotted page limit and permitted attachments, if any, in response to a specific submission requirement when evaluating the Offeror's bid. At no time will AHCCCS consider information outside the allotted page limit and permitted attachments, or any other information provided elsewhere in the bid when reviewing a specific response to an individual submission requirement.

Except in the case of a negligible difference, in scores between two or more competing proposals for a particular GSA, as referenced in Paragraph 7, Evaluation Factors and Selection Process, only information expressly provided by the Offeror will be considered. No inferences or assumptions will be made by the evaluation team when scoring in order to evaluate information submitted by the Offeror which is not clear, explicit, or thoroughly presented. Use of contingent language such as 'exploring' or 'taking under consideration' will not be given any weight during the scoring evaluation process. A policy, brochure, or reference to a policy or manual does not constitute an adequate response and will not be given any weight during the scoring evaluation process.

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

All proposals will become the property of AHCCCS. AHCCCS will not reimburse the Offeror for the cost of proposal preparation.

During the readiness review process AHCCCS will verify that the Offeror has made sufficient progress related to commitments in the Offeror's RFP proposal.

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

A. General Matters
   A1. Offeror's Bid Choice Form
B. Attestation
C. Capitation
D. Executive Summary and Disclosure
E. Narrative Submissions
   Acute Care
   - Access to Care/Network
   - Program
   - Organization

   CRS
   - Access to Care/Network
   - Program
   - Organization

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

Proposals that are not submitted in conformance with the requirements described herein may not be considered. References to certain sections of the RFP document in Section H are intended only to provide general assistance to Offerors and are not necessarily intended to represent all requirements. Other possible resources may be found in the Bidders' Library. It is the obligation of the Offeror to identify all relevant information.

16. SUBMISSION REQUIREMENTS

A. General Matters

See Section I: Exhibit A, Offeror's Checklist for information to be submitted under this section.

B. Attestation

In addition to complying with all contractual requirements, the Offeror must specifically acknowledge the importance of the following provisions and their critical value to the AHCCCS program. The statements in the attestation are not intended to alter or amend the contractual obligations set forth elsewhere in the RFP. In the event of any inconsistency or ambiguity regarding the meaning of an attestation, the provisions of the RFP are controlling.

The Offeror can find the following information on the Attestation Form in Section I, Exhibit C, Attestation Form. The Offeror should complete the Attestation Form and submit as required per Section I: Exhibit A, Offeror's Checklist.

ATTESTATION	
Corporate Compliance	
AHCCCS is committed to protecting the public from fraud, waste and abuse. As part of this commitment, AHCCCS Contractors must comply with all applicable Federal and State program integrity requirements. The Offeror attests that it will:	
1. ☐	Have a corporate compliance program and plan consistent with 42 CFR 438.608, and practices which comply with program integrity requirements specified in 42 CFR 455, and the AHCCCS requirements described in the ACOM Policy 103 and the contract, by the contract start date *RFP Section D, Paragraph 62, Corporate Compliance*
Staffing	
The Offeror will demonstrate by the start date of the contract that all staff shall be fully qualified to perform the requirements of the contract. The Offeror attests that it will:	
2. ☐	Maintain a local presence within the State of Arizona as outlined in Section D, Paragraph 16, Staffing Requirements and Support Services, of the contract *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
3. ☐	Limit Key Staff to occupying a maximum of two of the Key Staff positions *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
4. ☐	Have local staff available 24 hours a day, seven days a week to work with AHCCCS and/or other State agencies on urgent issue resolutions *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
5. ☐	Not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities *RFP, Section D, Paragraphs 16, Staff Requirements and Support Services and 62 Corporate Compliance*
6. ☐	Screen all employees and subcontractors to determine whether any of them have been excluded from participation in Federal health care programs *RFP, Section D, Paragraphs 16, Staff Requirements and Support Services and 62 Corporate Compliance*
7. ☐	Require all staff members to have appropriate training, education, experience and orientation to fulfill the requirements of the position *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
8. ☐	Have sufficient staffing levels to operate in compliance with the terms of the contract *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*

9. ☐	Have an Administrator/Chief Executive Officer (CEO) who shall have the authority and ability to direct Arizona priorities. *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
Information Systems	
The Offeror will demonstrate by the start date of the contract that its information system has clearly defined change control processes. The Offeror attests that it will:	
10. ☐	Maintain a change control process which includes the Offeror's ability to participate in setting and modifying the priorities for all information systems including those of the Parent Company, subcontractors and vendors *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
11. ☐	Maintain system upgrade and conversion processes which include appropriate planning and implementation standards *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
12. ☐	Have structures in place to ensure and support current and future IT Federal mandates *RFP, Section D, Paragraph 64, Systems and Data Exchange Requirements*
Claims/Encounters Processing	
The Offeror will demonstrate by September 1, 2013 that its systems and related processes can support the following key components of the AHCCCS Medicaid claims processing lifecycle. The Offeror attests that the entity and its IT system will:	
13. ☐	Accept and process both paper and electronic submissions *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*
14. ☐	Allow for the proper load of provider contract terms, support processing of claims within timeliness standards, incorporate coordination of benefit activities, and generate claims payments and HIPAA compliant remittance advices *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*
15. ☐	Have the ability to generate encounter submissions and have the appropriate remediation processes in place when standards are not met *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*
Quality Management	
The Offeror attests that, by the start date of the contract, it will have:	
16. ☐	A process to include the health risks assessment tool in the new member welcome packet. The Offeror has/will have a process for coordination of care across the continuum based on early identification of health risk factors or special care needs, including those members identified who would benefit from disease management and care coordination. [42 C.F.R. 438.208] *AMPM Chapter 900*

17. ☐	A process that requires the reporting of all incidents of abuse, neglect, exploitation, unexpected deaths, healthcare acquired and provider preventable conditions to the AHCCCS Clinical Quality Management Unit *AMPM Chapters 900 and 1000*
18. ☐	Processes in place to receive data and forms from a provider's certified electronic medical records including Early, Periodic, Screening, Diagnostic and Treatment forms, performance measure and audit information, and information to facilitate assistance with care coordination activities *AMPM Chapter 400*
19. ☐	A process that meets AHCCCS requirements for identifying, reviewing, evaluating and resolving quality of care or service issues raised by any source *RFP, Section D, Paragraph 23, Quality Management and Performance Improvement (QM/PI)*
20. ☐	A process to provide recurring scheduled transportation for members with on-going medical needs, including, but not limited to dialysis, chemotherapy, and radiation *RFP, Section D, Paragraph 11, Special Health Care Needs*
MCH/EPSDT	
The Offeror attests that it will have:	
21. ☐	A process and a plan that includes outreach and care coordination processes for children with special health care needs and other hard to reach populations, and coordination with community and government programs *AMPM Chapter 400*
Medical Management	
The Offeror attests that it will have:	
22. ☐	A process in place for proactive discharge planning when members have been admitted to an inpatient facility *RFP, Section D, Paragraph 24, Medical Management (MM)*
23. ☐	A process that ensures that practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in that field and disseminated to providers *RFP, Section D, Paragraph 24, Medical Management (MM)*
24. ☐	A process in place to provide emergency services without prior authorization regardless of contract status of the provider *AMPM Chapter 310F*
25. ☐	A process to analyze utilization data and use the results to implement medical management changes to improve outcomes and experience *RFP, Section D, Paragraph 24, Medical Management (MM)*
26. ☐	Disease and chronic care management programs that are designed to coordinate evidence based care focused on improving outcomes for members with one or more chronic illnesses which may include behavioral health conditions *RFP, Section D, Paragraph 24, Medical Management (MM)*
Behavioral Health	
The Offeror attests that it will have:	
27. ☐	A process for identifying members with behavioral health care needs and assisting members in accessing services in the Regional Behavioral Health Authority system *RFP, Section D, Paragraph 12, Behavioral Health Services; AMPM Chapters 400 and 1000*

Access to Care ***(Only Offerors submitting a proposal for the CRS Program must attest to #29)***	
The Offeror attests that it will have:	
28. ☐	A comprehensive network that complies with all Acute Care network sufficiency standards as outlined in RFP YH14-0001 and ACOM Draft Policy, Acute Network Standards, no later than August 1, 2013 *RFP, Section D, Paragraph 27, Network Development*
29. ☐ ***CRS Only***	A comprehensive network that complies with all CRS network sufficiency standards as outlined in RFP YH14-0001 (see Section D, Paragraphs 10, Scope of Services and 27, Network Development), no later than August 1, 2013 *RFP, Section D, Paragraph 27, Network Development*
30. ☐	A process for researching, resolving, tracking and trending provider inquiries/complaints and requests for information that includes contacting providers within three days and resolving issues within 30 days *RFP, Section D, Paragraphs 27, Network Development and 29, Network Management*
31. ☐	A process for monitoring and addressing provider performance issues up to and including contract termination *RFP, Section D, Paragraphs 27, Network Development and 29, Network Management*
Finance	
The Offeror attests that it will:	
32. ☐	Have a separate entity established for purposes of this contract within 120 days of the contract award if the Offeror is a non-governmental *New Contractor*. *RFP, Section D, Paragraph 51, Separate Incorporation*
33. ☐	Meet the minimum capitalization requirements within 30 days of the contract award if the Offeror is a *New Contractor;* or, fund through a capital contribution the necessary amount to meet the equity per member requirement within 30 days of the contract award if the Offeror is a *Successful Incumbent Contractor.* *RFP, Section D, Paragraph 45, Minimum Capitalization; Section H, Instructions to Offerors-Paragraph 14, Minimum Capitalization*
34. ☐	Secure a performance bond as defined in amount and type in Section D, Paragraphs 46, Performance Bond or Bond Substitute and 47, Amount of Performance Bond, and ACOM policies 305 and 306 no later than 30 days after notification by AHCCCS of the amount required. *RFP, Section D, Paragraphs 46, Performance Bond or Bond Substitute; 47, Amount of Performance Bond*

C. Capitation

Capitation is a fixed (per-member) monthly payment to a Contractor for the provision of covered services to members. It is an actuarially sound amount computed to cover expected utilization and costs:

- By individual risk groups, by GSA, in a risk-sharing, managed care environment for Acute Care Contractors; and
- Across all coverage types, statewide, in a risk-sharing, managed care environment for the CRS Contractor.

Acute Care Program Capitation Rates
Prior Period Coverage (PPC), SOBRA Family Planning Extension Program and State Only Transplant rates will be set by the AHCCCS actuaries and not bid by the Offeror. All other risk groups and the Delivery Supplement (hereafter referred to as risk groups) will be subject to competitive bidding, including:

- TANF all risk groups
- SSI with and without Medicare
- AHCCCS Care
- Delivery Supplement

Offerors are encouraged to submit their most competitive bids as AHCCCS anticipates that there will be no best and final offers. Offerors should note that AHCCCS will not increase a Contractor's capitation rates throughout the term of this contract if a Contractor later determines that the rates bid (with or without subsequent adjustment and update by AHCCCS) are insufficient.

Acute Care Program Capitation Bid Submission (Submission Requirement No. 1)
All GSAs for which an Offeror bids will require a capitation rate bid submission for each risk group. Each bid will encompass two components; a gross medical component and an administrative component. Each component will be scored separately. The lowest bid within each GSA and risk group will receive the maximum allowable points. Conversely, the highest bid will receive the least number of points.

Bid component requirements:

1. Offerors will submit a gross medical component PMPM bid for each risk group by GSA. Neither reinsurance offsets nor capitation withheld for payment reform initiatives should be considered in the medical component bid. Prior to October 1, 2013 AHCCCS will develop projections for reinsurance offsets and will adjust awarded capitation rates accordingly.
    - Capitation bids submitted with a medical component outside of the published ranges (described below) will earn a medical component score of zero points.
2. Offerors will submit an administrative component PMPM bid for each risk group by GSA. The administrative component is limited to a maximum of 8%. The administrative component percentage shall be calculated as: Administration / Gross Medical Component.
    - Capitation bids submitted with an administrative component exceeding 8% will earn an administrative component score of zero points.

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

It is recommended that Offerors bid rates reflecting the average monthly cost of a member utilizing the Data Book provided in the Bidders' Library (and used by AHCCCS' actuaries). Rates will be adjusted after award as indicated below.

If any moral or religious objections are submitted as specified in Paragraph 16, Submission Requirements, of this section the Offeror must not exclude direct and related costs from the capitation bid(s). If awarded a contract, capitation will be reduced for these costs via a subsequent contract amendment.

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

On or about December 14, 2012, AHCCCS will publish an actuarially-sound capitation rate range for the medical component for each risk group that will be bid by GSA. These ranges will be equivalent to the bottom half of the actuarially sound rate ranges, from the minimum to the midpoint. AHCCCS' actuaries set rate ranges based on average expenditures. The rate ranges will exclude reinsurance offsets and will not reflect any withheld amounts for payment reform initiatives.

A template for the capitation rate bid submission is included in the Data Supplement. The template must be completed for each GSA in which the Offeror submits a bid. The template(s) must be submitted in Microsoft Excel to AHCCCS via the EFT/SFTP server by 3 p.m. Arizona time on the Proposal Due Date in Section A, Solicitation Page. Instructions for access to the EFT/SFTP are included in the General Section of the Bidders' Library. In addition to the electronic submission of the template(s), hard copies of the completed template(s) for each GSA in which the Offeror submits a bid must be included in the RFP submission. In the case of differences between the hard copies and the electronic template submissions, the hard copies will prevail and will be the official bids that are scored. The Offeror must have an actuary who is a member of the American Academy of Actuaries certify that the bid submission is actuarially sound by including a signed hard copy of an actuarial certification of all rates submitted with the RFP submission. The Offeror may submit a separate certification for each GSA or a single certification that covers all GSAs bid.

Acute Care Program Capitation Adjustments After Award

AHCCCS will adjust the awarded medical components of the capitation rates for reasons including, but not limited to, the following:

- Program changes
- Legislative requirements
- Changes in trend assumptions
- Updated encounter experience
- Actuarial assumptions that were not previously included in the published capitation rate ranges or the awarded capitation rates
- Payment reform withhold

Prior to October 1, 2013, AHCCCS will provide fully loaded capitation rates including the following components by risk group by GSA:

- The awarded medical component, adjusted as noted above
- The awarded administrative component
- The reinsurance offset determined by AHCCCS' actuaries
- Risk contingency and premium tax

The CYE 14 fully loaded capitation rates will be amended retroactively to October 1, 2013 to account for risk adjustment based on the Contractor's membership. For more detail on risk adjustment and the proposed methodologies effective on and after October 1, 2013, see Section I of the Data Supplement in the Bidders' Library.

CRS Program Capitation Rates

The medical components of the CRS capitation rates will be set by the AHCCCS actuaries and not bid by the Offeror. AHCCCS will set three unique medical component rates for the following service types:

- Acute services
- Behavioral health services
- CRS services

The medical component rates will be combined to compute a total medical component for each coverage type, as follows:

- CRS Fully Integrated: acute services + behavioral health services + CRS services = total medical
- CRS Partially-Integrated – Acute: acute services + CRS services = total medical
- CRS Partially-Integrated – BH: behavioral health services + CRS services = total medical
- CRS Only: CRS services = total medical

CRS Program Capitation Bid Submission* *(Submission Requirement No. 2)
The Offeror will submit a capitation rate bid submission for the administrative component. The lowest bid will receive the maximum allowable points. Conversely, the highest bid will receive the least number of points.

Bid component requirements:

1. Offerors will submit a single administrative component bid that will be added to the total medical component by coverage type. The administrative component will not vary by coverage type.
2. The administrative component bid will be stated as a per member per month (PMPM) figure.
    - Capitation bids submitted with an administrative component PMPM value exceeding $60 PMPM will earn an administrative component score of zero points.

Offerors are encouraged to submit their most competitive administrative component bid as there will be no best and final offers. Offerors should note that AHCCCS will not increase a Contractor's administrative rate throughout the term of this contract if a Contractor later determines that the rate bid (with or without subsequent adjustment and update by AHCCCS) is insufficient.

CRS Program Capitation Resources
To facilitate the preparation of its administrative component bid and review of total medical component rates, AHCCCS will provide Offerors with a Data Supplement located in the Bidders' Library. This data source should not be used as the sole source of information in making decisions concerning the administrative bid. Information referenced below is located in this Data Supplement. Each Offeror is solely responsible for research, preparation and documentation of its administrative capitation proposal.

A template for the administrative bid submission is included in the Data Supplement. The template must be submitted in Microsoft Excel to AHCCCS via the EFT/SFTP server by 3 p.m. Arizona time on the Proposal Due Date in Section A, Solicitation Page. Instructions for access to the EFT/SFTP are included in the General Section of the Bidders' Library. In addition to the electronic submission of the template, a hard copy of the completed template must be included in the RFP submission. In the case of differences between the hard copy and the electronic template submission, the hard copy will prevail and will be the official bid that is scored.

On or about December 14, 2012, AHCCCS intends to publish actuarially-sound total medical component rates by coverage type.

The Offeror must have an actuary who is a member of the American Academy of Actuaries provide an attestation that the total medical component rates set by AHCCCS, and the administrative component bid submitted with the RFP submission, are reasonable in relation to medical services and administrative costs expected to be incurred for the period of October 1, 2013 through September 30, 2014. The Offeror's proposal must include this attestation and must include the Offeror's agreement to accept the published total medical component rates. A signed hard copy of this attestation must be included with the RFP submission.

CRS Program Capitation Adjustments After Award
AHCCCS will adjust the total medical component rates for reasons including, but not limited to, the following:

- Program changes
- Legislative requirements
- Changes in trend assumptions
- Updated encounter experience
- Actuarial assumptions that were not previously included in the published capitation rate ranges or the awarded capitation rates

Prior to October 1, 2013, AHCCCS will provide fully loaded capitation rates including the following components by coverage type:

- The total medical component, adjusted as noted above
- The awarded administrative component
- The reinsurance offset determined by AHCCCS' actuaries
- Risk contingency and premium tax

D. Executive Summary and Disclosure

1. ***Executive Summary***: The Offeror must provide an Executive Summary that includes an overview of the organization and its relevant experience, a high-level description of its proposed approach to meeting contract requirements and a discussion of how it will bring added value to the program. In the final portion of the Executive Summary, the Offeror must describe how it will meet the requirements specified in Section I, Exhibit D, Medicare Requirements, Section 2. The Executive Summary will not be scored, but may be used in whole or part by AHCCCS in public communications, following contract awards. (4 page limit)

2. ***Moral or Religious Objections***: The Contractor must notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. The Contractor may propose a solution not already contemplated by this Contract to allow members to access the services. The Contractor must identify solutions pertinent to the Acute Care Program and the CRS Program if submitting proposals for both. AHCCCS does not intend to offer the services on a fee-for-service basis to the Contractor's enrollees. The proposal must be submitted to AHCCCS in writing as part of this submission. This submission will not be scored.

E. Narrative Submissions

ACUTE CARE – NARRATIVE SUBMISSIONS	
Access to Care/Network	
1.	AHCCCS anticipates that its membership will grow as a result of implementation of the Affordable Care Act (ACA). It is estimated that an additional 180,000 to 430,000 new members will be eligible and enrolled with AHCCCS in the first year of implementation. These growth figures are dependent on decisions made by Governor Brewer and Arizona lawmakers regarding the many options under the ACA. In addition to the increased AHCCCS enrollment, the implementation of the Health Insurance Exchange will increase demand for provider accessibility. What steps will the Offeror take to ensure access to care to support the influx of members?

	In addition to network management, how will the Offeror ensure its operational and administrative structure is sufficient to efficiently implement all program operations to accommodate the membership growth?
2.	Describe how the Offeror evaluates and measures its network in order to ensure timely access to care to underserved populations, identify deficiencies in the network, manage the network, make improvements to the network and sustain an adequate network.
Program	
3.	AHCCCS supports efforts to reward desired care outcomes attained through care coordination and the provision of the best and most appropriate evidence-based care that results in lower costs. How will the Offeror use data and evidence based decision support tools, both within its organization and in working with providers and stakeholders, to maximize care coordination for members, improve outcomes, and create cost efficiencies? How will these tools and data be used to implement outcome- and value-oriented payment models? Describe the Offeror's experience and specific results.
4.	Mr. Andrews is a member in your plan. He is extremely overweight, and spends long periods in bed due to ill health and complete exhaustion. He has no family. He can not walk 100 feet without resting. His medical diagnosis is COPD and he has a chronic cardiac condition following two heart attacks and stent insertions. When he becomes short of breath, he becomes very anxious and calls 911 to take him to the ER. He has been to the ER 12 times in the last six months. His PCP has referred him to the health plan for disease management. Please describe how the Offeror would address the needs of Mr. Andrews. Describe what systemic processes the Offeror will use to improve health care outcomes for members with one or more chronic illnesses.

5.	George Robertson, a 29 year old AHCCCS member, was involved in a motor vehicle accident on March 1, 2012. After immediate stabilization at the scene, George was rushed to the Arizona General Hospital and treated in the emergency room as a trauma patient. George sustained multiple injuries including a fractured femur, internal bleeding, and trauma to the sternum. After surgery to resolve the internal bleeding, and internal fixation of the fractured femur, George was transferred to the hospital floor. George has been an AHCCCS member for five years. George has a history of substance abuse which may have been a contributing factor in the accident. George is in active substance abuse treatment with a Regional Behavioral Health Authority provider but is not consistent in participating in treatment. After 21 days in the hospital, George is discharged home. George lives alone in a run-down apartment complex in Phoenix. George must navigate two flights of stairs to reach his apartment. Four weeks after discharge, George was found by a maintenance worker at the bottom of the stairs. Paramedics were called and George was rushed to the emergency room. George was diagnosed with a head injury, later determined to be a traumatic brain injury, and broken ribs that were sustained from the fall down a flight of stairs. George was found to be in possession of illegal substances by the paramedics, resulting in police involvement at the hospital. After an additional four day inpatient stay, George is transitioned by the hospital Social Worker to a skilled nursing facility that specializes in TBI patients. The skilled nursing facility is not a contracted provider. Describe what processes would be used to coordinate care for George as he moves through the continuum of care related to these documented health issues. What does the Offeror see as the greatest setback risks/challenges for George and how will the Offeror proactively address these concerns?
6.	Describe the Offeror's experience in Medicare Advantage and/or Medicare Special Needs Plans. Describe processes that will be utilized to enhance and maximize care coordination and improve member experience for members being served for both Medicare and Medicaid services by the Offeror and for members who will only be served for Medicaid by the Offeror. What strategies will be used to increase and maintain aligned Medicaid and Medicare enrollment
Organization	
7.	The health care system in the United States is currently on an unsustainable path. The projected growth of Medicare and Medicaid based on demographics and historical trends result in public programs that consume an excessive portion of the U.S. Gross Domestic Product. There have been numerous studies that document that while having some of the highest costs in the world, the U.S. health care system based on some measures does not have the best outcomes. Recently the Institute of Medicine (IOM) released a report titled *Best Care at Lower Cost* that estimated $750 billion nationally is "wasted". This includes $210 billion in unnecessary services, $130 billion in inefficient care - $190 billion in excess administration - $105 billion in inflated prices - $55 billion in prevention failures and $75 billion in fraud. The same IOM study also identified various strategies that should be pursued to improve care and lower costs. As one of the single largest payers in the state of Arizona, AHCCCS has an important role

	to play in helping to move the health care system to a more sustainable model that improves outcomes. As a participant in the AHCCCS program, provide specific initiatives and efforts your organization will pursue to deal with "waste" that exists within the existing system and improve outcomes. Provide specific information describing the initiatives that would be pursued to improve quality and enhance cost containment including but not limited to the stakeholders involved, the timelines for implementation and the desired outcomes.
8.	The Offeror is required to develop a compliance program designed to guard against fraud and abuse. Beyond the requirements outlined in the RFP and AHCCCS policies, describe additional activities your compliance program will take to limit, identify, and address fraud and abuse. Describe the Offeror's experience using these methods and include examples of successful application.
9.	Describe in detail the ongoing processes and strategies the Offeror will implement to minimize the need for providers to utilize the claims dispute process to obtain proper reimbursement. In addition, describe the interventions and strategies the Offeror will employ to resolve claims disputes without resorting to the hearing process.
10.	**Information Technology (IT) Systems Demonstration** Demonstrate, by participating in mock Information Systems scenarios over a 10-day period, that the Offeror will understand how to, and have the capability to, accurately and timely: • Process data exchanged with AHCCCS • Administer actions based on the data processed Supplemental materials to assist in preparation for this demonstration are available in the Bidders' Library under the heading "Information Technology (IT) Systems Demonstration," and include: • Guidelines • 10-day Calendar • User Guides and Manuals These mock scenarios will begin on Tuesday, January 29, 2013. For this Submission Requirement, the Offeror shall provide written acknowledgement as follows: • <Offeror> acknowledges that its participation in the IT Systems Demonstration beginning on January 29, 2013, constitutes fulfillment of Submission Requirement No.10 • <Offeror> acknowledges that it will comply with the stated guidelines and calendar for this process. • <Offeror> acknowledges that the IT Systems Demonstration will be scored as part of the Offeror's Proposal

[End of Acute Care Program Submissions]

CRS – NARRATIVE SUBMISSIONS	
Access to Care/Network	
11.	Describe the steps that the Offeror will take to ensure that individuals with a qualifying CRS condition under R9-22-1301 et seq. are able to access the care needed, including specialty care, to serve their qualifying medical condition(s) as well as their other medical and behavioral health needs. Also describe how the Offeror will leverage and balance the use of providers in the multi-specialty interdisciplinary clinics (MSICs) versus those in the broader community.
Program	
12.	A 13-year old foster child diagnosed with Spina Bifida, Intermittent Explosive Disorder, history of poly-substance abuse, and PTSD resulting from sexual abuse, is enrolled in CRS. Describe the comprehensive treatment plan developed for all diagnoses to address the complex care needs of the child.
13.	Describe the Offeror's approach to integrating and coordinating behavioral health services for CRS members.
14.	Describe the mechanisms that the Offeror will use to ensure that all providers, including those within the MSIC setting and those outside of the MSIC setting, have access to the data needed to appropriately coordinate care for the member.
Organization	
15.	Describe the role that stakeholder input will play in all facets of the CRS Program. Provide a written narrative outlining your organization's expectations, goals and responsibilities for the Ombudsman/Client Advocate as well as the client advocacy program.

[End of CRS Program Submissions]

E. Oral Presentations

All Offerors shall participate in a scheduled oral presentation to last up to two hours. All presentations will be scheduled to occur during the weeks of February 18 and March 6, 2013. Presentations will be audio-taped by AHCCCS solely for the Agency's use in the evaluation process. AHCCCS shall notify each Offeror of their scheduled presentation no later than 5:00 pm Arizona time on January 31, 2013.

The purpose of the oral presentation is for the Offeror to demonstrate its expertise by presenting solutions to health care situations and operational challenges and responding to oral questions posed by AHCCCS. A previously prepared presentation about the Offeror will not be allowed. Offerors will be allotted time to privately discuss each question and to prepare a timed oral presentation.

The Offeror shall bring no more than six individuals to the meeting. All participants must be employees of the Offeror; no consultants may participate. Among these six individuals, the Offeror shall include persons with expertise in:

- Quality Management;

- Medical Management; and
- Comprehensive knowledge of the Offeror's Operations

The Offeror shall submit the names and resumes of the participating individuals via the EFT/SFTP server by 3 p.m. Arizona time on February 13, 2013.

AHCCCS will provide a white board or flip charts and markers for Offeror use in preparing for the Oral Presentation.

The Offeror will not be permitted to bring laptops, tablets or any prepared handouts into the room. Outside communication will be prohibited including but not limited to use of cell phones, telephones or text messaging. Offerors will be able to utilize any hard copy material brought with them including copies of policies and procedures as they prepare for the presentation.