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VIA EMAIL & HAND DELIVERY
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Dear Ms. LaPorte:

On behalf of Health Net Access, Inc. dba Arizona Complete Health-Complete Care Plan ("AzCH"), this letter responds in opposition to the bid protest (the "Protest") filed by Blue Cross and Blue Shield of Arizona Health Choice ("Health Choice") on December 21, 2023, regarding Arizona Health Care Cost Containment System ("AHCCCS") RFP No. YH24-0001, Long Term Care for Individuals Who are Elderly and/or Have a Physical Disability (ALTCS E/PD) (the "RFP"). AzCH, as a contract awardee under the RFP, is an interested party in this matter and has standing to respond to the Protest.[1] AzCH is contemporaneously providing a copy of this response to Health Choice's counsel and counsel for all other known potentially interested parties.

[1] Although the pertinent Arizona regulations are silent on whether the contract awardee may respond to a protest, in the absence of state law, Arizona courts seek guidance from federal law when applying Arizona procurement statutes and regulations. *See Ariz.'s Towing Pros., Inc. v. State*, 196 Ariz. 73, 76–78 (App. 1999) (relying on federal law in considering state bid protest); *see also New Pueblo Constructors, Inc. v. State*, 144 Ariz. 95, 101 (1985) ("In the absence of controlling state authority, state courts naturally look for guidance in public contract law to the federal court of claims and the federal boards of contract appeals."). Under federal law, the contract awardee is permitted to participate in the protest and defend its contract award. *See, e.g.*, 4 C.F.R. § 21.0(b); 14 C.F.R. §§ 17.3(n), 17.15(f); *Benefits Consulting Assocs., LLC v. United States*, 93 Fed. Cl. 254, 267-68 (2010) (contract awardee had standing to intervene in bid protest where awardee had interest in contract award and awardee's interest could not be adequately represented by either protestor or government).

AHCCCS conducted a comprehensive and thoughtful procurement of the long-term care plans that will serve Arizona's most vulnerable populations. AHCCCS spent more than a year developing the RFP with the assistance of an outside consultant. AHCCCS engaged more than 20 evaluators who participated in 30 evaluation meetings and carefully reviewed and evaluated the proposals against detailed RFP requirements, with AHCCCS's outside consultant facilitating the process to ensure consistency and fairness. Following the evaluation of proposals, AHCCCS selected AzCH and Arizona Physicians IPA, Inc. dba UnitedHealthcare Community Plan ("APIPA") for statewide contract awards after determining that their proposals were the most advantageous to the State. AzCH received the highest overall score and ranked first of the five offerors that responded to the RFP.

Health Choice received the second lowest overall score, ranking fourth out of the five offerors. Notwithstanding this, Health Choice now asks the Procurement Officer to ignore that determination and instead cancel the RFP and reissue the solicitation, or alternatively rescore the proposals. As described below, none of the issues Health Choice raises has any merit, and the Protest should be denied.

First, Health Choice fails to demonstrate how, but for the alleged "errors" it identifies, it would have received a contract award. Health Choice was ranked fourth among the five offerors. Health Choice does not and cannot explain how it would have received a ranking sufficient to make it susceptible to contract award under the RFP. Health Choice's Protest should be denied in its totality on this basis alone.

Second, AHCCCS's scoring methodology fully complied with applicable law, and Health Choice fails to show any irregularity in the process or improper conduct by any party. Contrary to Health Choice's assertions in its Protest, AHCCCS appropriately disclosed the factors to be used in the evaluation in the RFP, and AHCCCS did not wait until reviewing the proposals to determine the scoring methodology to be used in the evaluation. Instead, the procurement file confirms that the scoring methodology was locked down before proposals were opened ***or*** reviewed. Regardless of the factual inaccuracy of its arguments, Health Choice identifies no authority which required AHCCCS to finalize the scoring methodology by the time the RFP was issued. And to the extent Health Choice contests the sufficiency of what the RFP disclosed concerning the evaluation process, Health Choice waived those arguments by failing to timely raise them.

Third, Health Choice's challenges to the ranking scoring methodology AHCCCS employed must be rejected because Health Choice failed to timely raise such challenges, and even if timely, those challenges are meritless. Health Choice cites no authority supporting its argument that AHCCCS's ranking methodology is improper. The use of a ranking scoring methodology by AHCCCS was within its discretion, and Health Choice identifies no errors in that process. Health Choice is also wrong to argue that this methodology did not allow for "negligible differences in scores," as it plainly did.

Fourth, Health Choice waived any argument regarding the weighting of evaluation factors by failing to timely protest the RFP specifications concerning the evaluation, and in any event, Health Choice's arguments should be rejected on the merits. Nothing required AHCCCS to disclose the specific weights to be assigned to individual evaluation factors.

Fifth, AHCCCS should reject Health Choice's challenges to the consensus scoring on a handful of evaluation criteria. Health Choice is essentially asking the Procurement Officer to re-evaluate the proposals. The decisionmaker in a bid protest, however, should not step into the shoes of the evaluators and second-guess evaluation exercised within their discretion. In any event, for each challenged criterion, the evaluators' consensus scores were reasonable and consistent with the RFP.

For all these reasons, and as detailed below, the Procurement Officer should deny the Protest.

Health Choice's request to stay contract performance should also be denied. Health Choice fails to demonstrate any reasonable likelihood of success or explain how a stay of contract performance would be in the State's best interest—which it would not.

AHCCCS's award decision fully complies with applicable law and the requirements and terms of the RFP. Health Choice cannot establish that AHCCCS acted outside of its legal authority to solicit services under the RFP. Nor can Health Choice establish that, but for the alleged improprieties about which it complains, there is a substantial probability that Health Choice would have been awarded a contract under the RFP. Under such circumstances, the Protest must be denied.

Factual Background

I. AzCH

AzCH, an Arizona corporation, is one of Arizona's longest serving and most experienced managed care plans. AzCH, together with its affiliated entities, have over 18 years' experience serving members in all three of Arizona's Geographic Service Areas ("GSAs"). AzCH, either itself or through an affiliated entity, presently serves as an AHCCCS Complete Care ("ACC") plan, a Regional Behavioral Health Authority ("RBHA"), and Dual Eligible Special Needs ("D-SNP") plan. AzCH also provides Marketplace products in Arizona, and its affiliate previously served as a contractor for the ALTCS program from 2006 to 2017.

AzCH and its affiliates comprise the largest ACC/RBHA plan in Arizona. Together with its affiliates, AzCH provides integrated physical and behavioral health services to nearly 450,000 members—many who have highly complex needs. AzCH's experience and the trusted partnerships it has developed throughout Arizona will allow it to deliver innovative, accessible, and high-quality care to ALTCS members who are elderly and/or have a physical disability.

AzCH benefits from the resources and backing of its ultimate parent company, Centene Corporation ("Centene"). Centene is the largest Medicaid managed care organization in the United States, serving more than 15 million Medicaid members in 30 states. Centene is also the largest Long Term Services & Support ("LTSS") managed care organization in the country, serving over 415,000 members eligible for LTSS across 16 states. Centene's core philosophy is that quality healthcare is best delivered locally—with local brands and local teams—to provide fully integrated, high-quality, and cost-effective services. In Arizona, AzCH has coupled its local roots and expertise with national best practices and innovation to deliver collaborative, member-centered care to help transform healthcare and improve the health of the communities it serves and especially the State's most vulnerable populations.

AzCH believes that healthier individuals build healthy families and thriving communities. AzCH's approach to community giving involves reinvesting profits into outcome-based programs designed to yield tangible improvements in health outcomes, supporting and participating in events to strengthen the overall fabric of community health, and providing financial support to projects and organizations with a focus on health and well-being. In 2022, AzCH invested over $2.7 million in grants and sponsorships to Arizona communities. The recipients of these funds were in all three GSAs, consistent with AzCH's commitment to improve the health and lives of members across Arizona and in all of the communities AzCH serves, whether rural, urban, or tribal.

II. The RFP

Following more than a year of development, AHCCCS issued the RFP on August 1, 2023, to solicit a contractor to implement and operate the ALTCS program for individuals who are elderly and/or have a physical disability ("E/PD"). [Ex. A, RFP, § D(1), p. 42]. Relevant excerpts of the RFP are attached hereto as **Exhibit A**. The RFP provides that the contractor(s) selected for award will be responsible for providing integrated care addressing physical and behavioral health needs and LTSS for the following elderly or physically-disabled individuals: (1) adults and children with and without General Mental Health/Substance Use needs; (2) adults with a Serious Mental Illness designation; (3) children with a Serious Emotional Disturbance designation; and (4) children with Special Health Care Needs. [*Id.*]. Awarded contractors under the RFP will be required to provide covered medical services in a managed care environment reimbursed on a capitated rate basis. [Ex. A, RFP, § H, p. 2].

The state is divided into three GSAs—North, South, and Central. [Ex. A, RFP, § H, p. 8]. The RFP required each offeror to bid on all three GSAs and to indicate the order of preference for GSAs to be awarded. [*Id.* p. 7]. The RFP reflects that AHCCCS anticipated awarding contracts to a maximum of two contractors in the North GSA, a maximum of two contractors in the South GSA, and a maximum of three contractors in the Central GSA. [*Id.* p. 8]. But the use of the term "maximum" gave AHCCCS the discretion to award fewer contracts in each GSA.

The RFP specified that contract awards would be made to the responsible offeror(s) whose proposal was determined to be the most advantageous to the State based upon the RFP's evaluation

criteria. [Ex. A, RFP, § H, p. 5]. Proposals were to be evaluated based upon the offeror's ability to satisfy the RFP's requirements in a cost-effective manner. The RFP identified two categories of evaluation criteria that would be scored during proposal evaluations: (1) Programmatic Submission Requirements; and (2) Financial Submission Requirements, with Programmatic Submission Requirements being the more important of the two. [*Id.*].

The RFP states that the Programmatic and Finance Requirements would be evaluated and weighted. [Ex. A, RFP, § H, p. 6]. Regarding the Programmatic Requirements, the RFP set forth 11 different categories of Narrative Submission Requirements identified as B1 through B11. [Ex. A, RFP, § I, Ex. H]. All of the Narrative Submission Requirements other than B1 and B2 were to be scored. [*Id.*]. The RFP also included as a Programmatic Requirement "oral presentations," which were listed as B12. [Ex. A, RFP, § H, p. 18]. With respect to the Finance Requirements, the RFP provides that the Capitation Agreement/Administrative Code Bid would be scored for each offeror and that score applied to all GSAs bid by the offeror. [*Id.* p. 6]. In contrast, the Case Management Cost Bid would be scored by GSA for each offeror. [*Id.*].

AHCCCS's final award decision was to be guided—but not bound—by the scores awarded by the evaluators. [Ex. A, RFP, § H, p. 5]. AHCCCS's final award decision would be based upon a determination of which responsive and responsible proposal(s) were deemed most advantageous to the State. [*Id.*].

To the extent there was only a negligible difference in scores between two or more competing proposals for a particular GSA, the RFP provided AHCCCS with the discretion to consider additional factors in making an award decision, including:

- Potential disruption to members, and/or
- An offeror who has performed in a satisfactory manner (in the interest of continuity of care), and/or
- An offeror who participates satisfactorily in other lines of AHCCCS business, and/or
- An offeror's past performance with AHCCCS, and/or
- An offeror's past Medicare performance, and/or
- The nature, frequency, and significance of any compliance actions, and/or
- Any convictions or civil judgments entered against the offeror's organization, and/or
- Administrative burden to AHCCCS.

[Ex. A, RFP, § H, p. 6]. In the RFP, AHCCCS also expressly reserved the right to, among other things, waive any immaterial mistake or informality in a submitted proposal. [*Id.* p. 7].

III. Amendments to the RFP

AHCCCS provided prospective offerors with two opportunities to submit questions concerning the RFP, with deadlines of August 8, 2023 and August 22, 2023, for each round. [Ex.

A, RFP, § H, p. 12]. After each round of questions, AHCCCS published written amendments to the RFP, responding to the questions received. [Ex. A, RFP, Amendments 1, 2].

AHCCCS amended the RFP a third time on September 8, 2023, making numerous minor revisions to the RFP's Section H, Instructions to Offerors. [Ex. A, RFP, Amendment 3].

IV. Proposals Received under the RFP

The deadline for submission of proposals was October 2, 2023. [Ex. A, RFP, § H, p. 4]. AHCCCS received a total of five proposals. In addition to AzCH, APIPA, and Health Choice, AHCCCS received proposals from Mercy Care (administered by Aetna Medicaid Administrators) ("Mercy Care") and Banner-University Care Advantage dba Banner-University Family Care ("Banner").

V. Evaluation of Proposals

AHCCCS tasked 22 individuals with subject matter expertise to review and evaluate the proposals as part of teams, with each team assigned a particular aspect of the scored evaluation criteria to review and score. [Ex. B, Executive Summary, p. 2]. The team members individually reviewed their assigned portion of each proposal against the relevant RFP requirements; later, with the assistance of a facilitator, each team convened to participate in one or more consensus evaluation meetings. [Ex. B, Overview of RFP Evaluation Process, p. 1]. True and correct copies of excerpts from AHCCCS's Final Evaluation Report, including the Executive Summary and Overview of RFP Evaluation Process, are attached hereto as **Exhibit B**. Through these meetings, each team arrived at a consensus ranking for each offeror with respect to a particular scored criterion. These ranks were used to calculate a score for the offeror for each scored criterion with the sum of the scores for all criteria comprising the offeror's total score. [Ex. B, Overview of RFP Evaluation Process, p. 4].

VI. Evaluation of BAFOs and Oral Presentations

As part of the Programmatic Requirements, the RFP stated that offerors would be required to participate in oral presentations. [Ex. A, RFP, § H, p. 18]. The RFP expressly states that the oral presentations would be used in the evaluation process. [*Id.*]. The RFP outlined detailed instructions regarding the oral presentations, including identifying the required participants for each offeror and the parameters of the presentation which could not include the distribution of previously prepared presentations or materials. [*Id.*].

The RFP also reserved to AHCCCS the right to request Best and Final Offers ("BAFOs"). [Ex. A, RFP, § H, p. 20]. After its initial review and evaluation of the five submitted proposals, AHCCCS exercised its discretion to request a BAFO for the Cost Bid portion of the RFP from each of the five proposers. The BAFOs were required to be submitted to AHCCCS by October 23, 2023. Each offeror submitted a BAFO.

After receipt of the BAFOs, AHCCCS scheduled in-person oral presentations with each of the five offerors, which took place between October 24 and November 2, 2023. The oral presentations were scored and factored into the total score of each offeror.

VII. Final Evaluation Scores and Award Decisions

AHCCCS's evaluation team ultimately recommended that AHCCCS award statewide contracts to AzCH and APIPA. The overall final scores and rankings were as follows:

Offeror	Total Score Out of Maximum 1,000 Points	Ranking
AzCH	715	1
APIPA	668	2
Mercy Care	557.5	3
Health Choice	537	4
Banner	522.5	5

[Ex. B, Executive Summary, p. 4]. As the above table reflects, there was a clear break in the total scores between the second-ranked offeror, APIPA, and the third-ranked offeror, Mercy Care. Health Choice trailed even farther behind, receiving 178 points fewer than first-ranked AzCH and 131 points fewer than second-ranked APIPA.

On December 1, 2023, AHCCCS notified AzCH and APIPA of the decision to award them each a statewide contract under the RFP. True and correct copies of the AzCH and APIPA award letters are attached hereto as **Exhibits C** and **D**, respectively. AHCCCS also formally accepted the offers of AzCH and APIPA the same day; true and correct copies of the offers and acceptances are attached hereto as **Exhibits E** and **F**, respectively.

VIII. Award Protests under the RFP

On December 21, 2023, Health Choice protested AHCCCS's award decisions under the RFP. Mercy Care and Banner also protested the award decisions.[2]

[2] AzCH is separately responding to the Mercy Care and Banner protests.

Standard of Review

Under Arizona law, to successfully protest an award decision, the protestor must prove by a preponderance of the evidence that: (i) the procurement process was tainted by violations of applicable statutes or rules, substantial irregularities in the proceedings, or improper conduct by any of the participants to the process; (ii) such improprieties were materially prejudicial to the protestor; and (iii) but for such improprieties, there is a substantial probability that the protestor would have been a recipient of the contract award.[3]

Furthermore, when deciding whether an agency failed to evaluate proposals in accordance with the governing statutes and regulations,[4] the agency is entitled to broad discretion.[5] The agency is entrusted with substantial discretion in determining which bid is the most advantageous because "the agency is responsible for defining its needs and the best method for accommodating them."[6] "A protester's mere disagreement with a procuring agency's judgment is insufficient to establish that the agency acted unreasonably."[7]

Although the standard of review of this Protest is as described above, it is relevant to consider that if a court ultimately reviews AHCCCS's contract award decisions, the question before the court will not be "whether the court would reach the same conclusions as the agency regarding the comparison of proposals, but, rather, whether the conclusions reached by the agency lacked a reasonable basis and, therefore, were arbitrary or capricious, in which case, courts have a role to review and instruct."[8] Moreover, "[i]t is well-established that contracting officers have a

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[3] *See Cigna Healthcare of Ariz., Inc. & Conn. Gen. Life Ins. Co. v. Ariz. State Procurement Off.*, 04-0008-ADM, at 39 (May 6, 2005).

[4] The Director of AHCCCS "has full operational authority to adopt rules for the RFP process and the award of contracts under A.R.S. § 36-906." *See* A.A.C. R9-22-601(A). AHCCCS proposal or contract protests are governed by R9-22-604. Although AHCCCS is exempt from the Arizona Procurement Code, A.A.C. R9-22-601(C), that Code still provides guidance. Moreover, Arizona's caselaw discussing the standards of review for bid protests is applicable here. In the absence of state law, and as noted above, Arizona courts seek guidance from federal law when applying Arizona procurement statutes and regulations. *See Ariz.'s Towing Pros., Inc.*, 196 Ariz. at 78; *see also New Pueblo Constructors, Inc.*, 144 Ariz. at 101.

[5] *See Magellan Health Servs. of Ariz., Inc. v. Ariz. Dep't of Health Servs.*, 13F-006-ADM, at 70 n.165 (Dec. 6, 2013); *see also Software Eng'g Servs., Corp. v. United States*, 85 Fed. Cl. 547, 5556 (2009) (noting that an agency has great discretion in composing its evaluation team that should not be questioned unless the protestor alleges bad faith, conflict of interest, or actual bias).

[6] *Magellan Health Servs. of Ariz., Inc.*, 13F-006-ADM, at 69 n.165 (citing *TriWest Healthcare All. Corp.*, B-401652.12, 2012 CPD ¶ 191 (Comp. Gen. July 2, 2012)).

[7] *See Gonzales-Stoller Remediation Servs., LLC*, B-406183.2, et al., 2012 CPD ¶ 134, at *4 (Comp. Gen. Mar. 2, 2012) (citing *James Constr.*, B-402429, 2010 CPD ¶ 98 (Comp. Gen. Apr. 21, 2010)).

[8] *One Largo Metro, LLC v. United States*, 109 Fed. Cl. 39, 74 (2013).

great deal of discretion in making contract award decisions, particularly when, as here, the contract is to be awarded to the bidder or bidders that will provide the agency with the best value."[9]

Responses to Health Choice's Protest Arguments

I. Health Choice Is Not Entitled to Any Relief Because It Cannot Make the Necessary Showing of Prejudice.

As noted above, Health Choice bears the burden of proving that the procurement process was tainted by violations of applicable law, substantial irregularities, or improper conduct, ***and*** that such improprieties materially prejudiced Health Choice such that, but for those improprieties, Health Choice would have received a contract. Health Choice entirely fails to explain how it was prejudiced by the protest issues it raises. In particular, Health Choice cannot show that it would have been awarded a contract "but for" these alleged "irregularities" that were no different from previous AHCCCS procurements Health Choice participated in and benefited from.[10] Indeed, its Protest is replete with vague statements that, but for AHCCCS's "errors," Health Choice would "have received a higher score." [Protest, p. 2; *see also id.* pp. 14, 16, 17]. Although all of Health Choice's arguments are meritless, even if AHCCCS agreed with ***any*** of those arguments, the Protest should be denied because Health Choice does not explain ***how*** these issues if corrected would result in it receiving a contract under the RFP.

Additionally, Health Choice is not an interested party that may raise several of the arguments included in the Protest. In particular, Health Choice argues that: (1) Mercy Care's proposal—which was not awarded a contract—was rated more favorably for Criteria B5, B6, and B7; (2) AHCCCS failed to give Health Choice "credit" for multiple sections of its proposal; (3) Health Choice was improperly scored on its past performance; and (4) there were possible errors in Health Choice's rankings in the non-benefit cost bid scores. But any alleged advantage by AzCH or another offeror would not have somehow vaulted Health Choice in front of the three offerors that finished ahead of Health Choice. While an offeror whose economic interest is affected by the loss of an award can be an interested party, under the Procurement Code—which is persuasive authority here—"[w]hether an offeror or prospective offeror has an economic interest depends upon the circumstances in each case."[11] Here, Health Choice fails to show that there is a substantial chance that it would have been awarded a contract if any of the top three-ranked offerors' scoring was changed, or even if a proposal was rejected. Therefore, Health Choice was not prejudiced, and its interest was not "affected substantially and directly by . . . loss of an award."[12]

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[9] *Banknote Corp. of Am. v. United States*, 365 F.3d 1345, 1355 (Fed. Cir. 2004).
[10] *See Cigna Healthcare of Ariz., Inc*., 04-0008-ADM, at 39; *see also Labatt Food Serv., Inc. v. United States*, 577 F.3d 1375, 1378 (Fed. Cir. 2009) (requiring protestor to show that show that "but for the error, it would have had a substantial chance of securing the contract").
[11] A.A.C. R2-7-101(30).
[12] *Id.*

Moreover, per the RFP, AHCCCS anticipated awarding contracts to a maximum of two contractors in the North GSA, a maximum of two contractors in the South GSA, and a maximum of three contractors in the Central GSA. [Ex. A, § H, p. 8]. The RFP provides that AHCCCS could make at most two statewide contract awards. [*Id.*]. To be susceptible to contract award, then, Health Choice must show how it would have been ranked first, second, or, at the very least, third based on the protest grounds it raises. But Health Choice does not explain its path to a contract even if any of its Protest grounds had merit. For example, to the extent AHCCCS's ranking methodology was inappropriate, that methodology nevertheless applied equally to all offerors and Health Choice does not demonstrate that, but for that methodology, it would have received a contract. And indeed, as discussed below, the result that follows from correcting several of the purported "errors" Health Choice identifies does not result in Health Choice displacing either of the selected offerors, AzCH or APIPA, in the rankings. Putting aside the merits of any of Health Choice's arguments, the Protest must be denied solely on the basis that Health Choice cannot establish the required prejudice.

II. AHCCCS Properly Evaluated and Scored the Proposals.

As explained above, assuming Health Choice is an interested party with standing to file the Protest—which it is not—Health Choice bears the burden of proving that the procurement process was tainted by violations of applicable law, substantial irregularities, or improper conduct. Health Choice cannot satisfy that burden. AHCCCS acted within its significant discretion in designing the RFP and in selecting the plans most advantageous to the State. All of Health Choice's challenges to the evaluation and scoring of proposals should be rejected.

1. AHCCCS Developed Its Scoring Methodology *Before* Opening or Reviewing Proposals.

Health Choice contends that AHCCCS did not adopt a scoring methodology until after the proposals were opened and reviewed. Indeed, Health Choice specifically contends that AHCCCS did not finalize the scoring methodology until November 15, 2023. [Protest, p. 6]. This makes no sense because, as Health Choice acknowledges, this is the last day that the evaluation team met. [*See id.*]. It is also inaccurate as shown by numerous documents in AHCCCS's procurement file.

Health Choice's argument is premised on the following single sentence in the RFP Executive Summary: "The Scope Team met October 2, 2023, through November 15, 2023, to determine the scoring methodology and came to an agreement to apply the scoring methodology detailed in the Evaluation Process Overview document available in the procurement file." [Ex. B, Executive Summary, p. 2]. But this appears to be simply confusion over wording, as other contemporaneous documents in the procurement file clearly confirm that the scoring methodology was in place ***before*** offers were received on October 2, 2023.

Specifically, the scoring methodology and scoring tools were formally approved by the Scope Team at a September 21, 2023 meeting [**Exhibit G**, Sept. 21, 2023 Scope Team Meeting

Agenda], and the "Evaluation Process Overview document" referenced in the Executive Summary unequivocally confirms that "[a]ll Scoring documents ***were locked down prior to October 2, 2023***" [Ex. B, Overview of RFP Evaluation Process, p. 1 (emphasis added)].[13] It is also clear that the evaluators were trained regarding the 1-through-5 ranking rubric at the scoring training on October 3, 2023—again confirming that this methodology was already in place before evaluators began reviewing the proposals. [**Exhibit I**, ALTCS E/PD Scoring Training Presentation Oct. 3, 2023, pp. 32, 34, 36]. In context, the November 15, 2023 date referenced in the Executive Summary refers to the date scoring ended, ***not*** the date the scoring methodology was finalized. [*Id.* p. 6].

As discussed further below, AHCCCS has used a consensus ranking evaluation process in its procurements for more than a decade.[14] This is likely what AHCCCS meant in the RFP when AHCCCS stated that it "has established a scoring methodology to evaluate an Offeror's ability to provide cost-effective, high-quality contract services in managed care setting in accordance with the AHCCCS mission and goals" [Ex. A, RFP, § H, p. 5]—language that is identical to past requests for proposals by AHCCCS, including the last procurement for ALTCS E/PD services.[15]

Thus, Health Choice's Protest is simply factually incorrect; AHCCCS developed the scoring criteria and methodology before opening or reviewing the proposals. Further, AHCCCS did not "violate" the RFP even if the scoring methodology to be used in this RFP was developed

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[13] AHCCCS's records also confirm that the oral presentation script to be used with the offerors was finalized before opening any of the proposals. [**Exhibit H**, AHCCCS003634].

[14] AHCCCS, RFP No. YH18-0001 ALTCS E/PD ("2018 ALTCS E/PD RFP"), Awards and Scores by GSA (reflecting AHCCCS's ranking of plans), https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH18/Procurement/AwardsandScoresbyGSA.pdf; AHCCCS, 2018 ALTCS E/PD RFP, Overview of RFP Evaluation Process (reflecting use of consensus evaluation and scoring), https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH18/Procurement/EvaluationProcessOverview.pdf; *see also* AHCCCS, RFP No. YH19-0001 Complete Care ("2019 Complete Care RFP"), Awards and Scores by GSA, https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH19/AnticipatedProcurementTimeline/ACCAwardsScoresGSA.pdf; AHCCCS, RFP No. YH14-0001 ACUTE/CRS ("2014 Acute/CRS RFP"), Summary of ACUTE/CRS RFP Awards (reflecting rankings by offerors), https://www.azahcccs.gov/PlansProviders/Downloads/Solicitations/BiddersLibrary/Procurement/AwardsandScoresbyGSA.pdf; AHCCCS, 2014 Acute/CRS RFP, Overview of RFP Evaluation Process (reflecting use of consensus scoring for both narrative submissions and oral presentations), https://www.azahcccs.gov/PlansProviders/Downloads/Solicitations/BiddersLibrary/Procurement/RFPOverviewofEvaluationProcess.pdf.

[15] AHCCCS, 2018 ALTCS E/PD RFP, § H, Instructions to Offerors, p. 230, https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH18/ReqForProp/ReqForProp_Solicitation.pdf; AHCCCS, 2014 Acute/CRS RFP, § H, Instructions to Offerors, p. 290, https://www.azahcccs.gov/PlansProviders/Downloads/Solicitations/BiddersLibrary/YH14-0001/SectH_InstructionsOfferors.pdf.

or finalized after the RFP was issued. Health Choice does not cite any statute, RFP provision, or other authority requiring AHCCCS to have finalized its scoring methodology by the time it issued the RFP. Further, nothing required AHCCCS to amend the RFP as the scoring methodology did not require any change in the language of the RFP.

Unlike the federal procurement decisions Health Choice cites, this is not a situation in which AHCCCS announced "one evaluation plan" in the RFP and then subsequently "follow[ed] another."[16] It is true that "once offerors are informed of the criteria against which their proposals will be evaluated, the agency must adhere to those criteria in making its award decision or inform all offerors of any significant changes made in the evaluation scheme."[17] But Health Choice confuses the criteria against which proposals will be evaluated—i.e., the evaluation factors—with the scoring methodology. The factors by which proposals were evaluated never changed after issuance of the RFP, and Health Choice identifies nothing requiring AHCCCS to notify offerors of the scoring methodology.

The governing procurement regulations simply provide that AHCCCS must ensure the RFP includes "[t]he factors used to evaluate a proposal."[18] Here, AHCCCS outlined the evaluation factors in Section H of the RFP, factors which were consistent with the ultimate scoring of the proposals. [RFP, § H, pp. 5-6]. No law required AHCCCS to include scoring or weighting information in the RFP. And to the extent Health Choice challenges AHCCCS's failure to describe its scoring methodology in the RFP, it waived that argument.[19]

It is axiomatic that "a party who has the opportunity to object to the terms of a government solicitation containing a patent error and fails to do so prior to the close of the bidding process waives its ability to raise the same objection subsequently in a bid protest action."[20] When there is a "deficiency or problem in a solicitation[,] the proper procedure for the offeror to follow is not to wait to see if it is the successful offeror before deciding whether to challenge the procurement, but rather to raise the objection in a timely fashion."[21] Otherwise, offerors could take advantage of the procuring agency and other offerors by choosing to remain silent about a perceived deficiency in

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[16] *See PharmChem Labs., Inc.*, B-244385, 1991 WL 216281, at *3 (Comp. Gen. Oct. 8, 1991); *Lab'y Corp. of Am. Holdings v. United States*, 115 Fed. Cl. 643, 650 (2014).
[17] *PharmChem Labs.*, B-244385, at *3.
[18] A.A.C. R9-22-602(A)(4); *see also* A.A.C. R9-28-602.
[19] A.A.C. R9-22-604(D)(1)-(2) ("A protester filing a protest alleging improprieties in an RFP or an amendment to an RFP shall file the protest at least 14 days before the due date of receipt of proposals. . . . Any protest alleging improprieties in an amendment issued 14 or fewer days before the due date of the proposal shall be filed before the due date for receipt of proposals.").
[20] *Blue & Gold Fleet, L.P. v. United States*, 492 F.3d 1308, 1313 (Fed. Cir. 2007); *see also CRAssociates, Inc. v. United States*, 102 Fed. Cl. 698, 711 (2011).
[21] *Blue & Gold Fleet, L.P.*, 492 F.3d at 1314.

the solicitation, "roll the dice and see if they receive award and then, if unsuccessful, claim the solicitation was infirm."[22]

Health Choice knew when the RFP was published on August 1, 2023, that the RFP did not describe in detail the scoring criteria. Any protest of the RFP specifications was due at least 14 days prior to the submission of proposals, yet Health Choice failed to timely protest this specification. Furthermore, Health Choice knew when AHCCCS published Amendment 1 to the RFP that AHCCCS would not be providing scoring or weighting details under the RFP. [Ex. A, RFP, Amendment 1, Q&A 23, 24, 25, and 35]. Yet again, Health Choice did nothing. In these circumstances, Health Choice has waived any protest regarding AHCCCS's "failure" to further describe the scoring methodology in the RFP.

Health Choice next complains about "overlap between the Scope and Evaluation Team," and states that this created a problem because "at the same time that the evaluators were reviewing the proposals and determining strengths and weaknesses, some (but not all) of those evaluators were also meeting to decide upon a scoring methodology." [Protest, pp. 6-7]. This argument again appears founded on the mistaken premise that the scoring methodology was not finalized until the end of the scoring process, which is not the case. Numerous documents in the public procurement file, including the evaluators' training documents, confirm that the scoring methodology and tools were "locked down" prior to October 2, 2023; thus, Health Choice is wrong to argue that the evaluators did not know what methodology was being used. [Ex. B, Overview of RFP Evaluation Process, p. 1; *see also* Ex. G; Ex. I].

Health Choice next argues that because the Scope Team, not the evaluators, made the recommendation to award statewide contracts to AzCH and APIPA, that somehow means "[t]he persons who actually reviewed and evaluated the proposals were not necessarily involved in the discussions regarding who should receive the contract award." [Protest, p. 7]. This argument is nonsensical, particularly following Health Choice's complaint about an ***overlap*** between the evaluators and Scope Team. Regardless, however, AHCCCS's award decision reflects the input of the evaluators as the two offerors with the highest scores after the evaluators' consensus scoring were chosen for contract awards. The suggestion that the awards do not actually reflect the evaluators' assessment of the proposals is specious. And to the extent that Health Choice challenges the fact that the RFP did not actually bind AHCCCS to follow the evaluators' scoring decisions, again Health Choice failed to timely raise such a challenge as that fact was known when the RFP was first published. [*See* Ex. A, RFP, § H, p. 5].

The non-binding *Guidesoft* decision[23] that Health Choice cites is distinguishable and does not support granting the Protest. First, that decision involved a procurement subject to the Arizona Procurement Code, which this procurement is not. Additionally, in the procurement described in *Guidesoft*, the scoring criteria—"the process of assigning numerical values to the proposal

[22] *Id.* at 1314 (quoting *Argencord Mach. & Equip., Inc. v. United States*, 68 Fed. Cl. 167, 175 n.14 (2005)).
[23] *Guidesoft, Inc. v. Arizona Dep't of Admin.*, 22F-003-ADM (May 22, 2023).

responses received, in an effort to compare Offerors' strengths and weaknesses"—was not developed until ***after the initial review of the proposals***.[24] Although the ALJ found nothing in the Arizona Procurement Code explicitly forbidding the formulation of scoring criteria after opening and reviewing bids, she recognized that "[w]ithout preset Scoring Criteria, the members of the Evaluation Committee could easily sway the scoring in favor of one offeror or against another offeror" and thus "such a process is antithetical to the purposes of the code."[25] Unlike *Guidesoft*, the 1-through-5 ranking rubric to be used by evaluators here ***was in place before the opening or review of proposals and has been part of AHCCCS's procurements for the last decade***. [*See* Ex. B, Overview of RFP Evaluation Process, p. 1; Ex. G; Ex. I, pp. 32, 34, 36; *supra* notes 14-15]. Thus, the fairness concerns at issue in *Guidesoft* are not present here, there is no prejudice to the offerors, and *Guidesoft* does not support granting Health Choice the relief it seeks.[26]

In short, Health Choice fails to meet its burden to show a violation of any applicable statute or rule, any substantial irregularity in the process, or any improper conduct with respect to when AHCCCS finalized and made the scoring criteria known to offerors.

2. AHCCCS's Ranking Scoring Methodology Was Appropriate.

Health Choice also asserts error in the procurement process on the basis that the ranking scoring methodology used by AHCCCS was improper, including that it allegedly "improperly and arbitrarily discounted a large percentage of points that was not tied to substantive differences in the proposals" and "ensures that there will not be a negligible difference in the scores between two ranked answers." [Protest, pp. 8-9]. As discussed below, Health Choice's argument is misplaced on a number of grounds and should be rejected.

As is common in Arizona government procurements, AHCCCS's scoring process used a weighted allocation of points based on a consensus ranking of the respondents on the various criteria. [Ex. A, RFP, § H, pp. 5-6; *see also* Ex. B, Overview of RFP Evaluation Process]. This consensus ranking evaluation process appears to have been first developed and utilized by AHCCCS for the 2014 Acute/CRS RFP, issued November 1, 2012,[27] and is similar to the scoring process used by AHCCCS in other procurements over the past decade, including the most recent

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[24] *Id.* ¶¶ 11, 20, 23.
[25] *Id.* ¶¶ 26, 29.
[26] Health Choice cites a California state court decision, *Eel River Disposal & Res. Recovery, Inc. v. Cnty. of Humboldt*, 221 Cal. App. 4th 209, 238 (2013), for the proposition that the mere potential of bias in the procurement requires a rebid. That decision is not binding or even persuasive, and regardless, Health Choice fails to show the existence of any deviation, let alone a "significant deviation[]," in the procurement that would justify the extraordinary relief of canceling the RFP and reissuing the solicitation. *See id.*
[27] *See* AHCCCS, 2014 Acute/CRS RFP, https://www.azahcccs.gov/PlansProviders/HealthPlans/YH14-0001.html.

prior procurement for the ALTCS E/PD program,[28] as well as the most recent procurement for the Arizona Complete Care program[29] in which Health Choice participated and was awarded a contract.[30]

AHCCCS described the development and use of this scoring methodology as follows:

> From an evaluation perspective as well as in other aspects, RFP YH14-0001 represents a unique procurement in the history of the AHCCCS Program. Unlike prior AHCCCS procurements, the evaluation process underwent substantial redesign where a Consensus Evaluation approach was used for both the narrative submissions and the oral presentations. For these areas, AHCCCS did not use an allocation of individual points by Team Members (also referred to as Evaluators) for each submission requirement based on an ideal score. Instead, the Agency relied on a consensus evaluation process where Team Members ranked the submission requirements from each Offeror on a statewide basis. Thus, each Offeror's submissions were evaluated through a comparison with those by the other Offerors. The submissions were then ranked, through the consensus process, according to the strengths of the particular Offeror's responses as compared against, and contrasted with, the other Offerors. To achieve the consensus ranking, all Evaluators engaged in a collaborative process which culminated in the consensus ranking approved by each evaluator.
>
> AHCCCS Evaluators developed consensus rankings based on their overall judgment as to the ***relative*** quality of Offerors' responses. Major observations identified by the Evaluators in reaching the consensus rankings were specifically noted for each Offeror's submission using the Submission Evaluation Considerations. The major observations provide insight regarding Offerors' responses but do not determine the final rankings. Importantly, the observations were not necessarily equal in importance in the opinion of Evaluators. Additionally, the observations do not necessarily reflect ***all*** of the factors considered by Evaluators in deriving their final, consensus rankings. Successful challenges to

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[28] *See* AHCCCS, 2018 ALTCS E/PD RFP, issued November 1, 2016, https://www.azahcccs.gov/PlansProviders/HealthPlans/YH18-0001.html.

[29] *See* AHCCCS, 2019 Complete Care RFP, https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH19/ACC_RFP_11022017.pdf.

[30] *See* AHCCCS Awards Contracts to Managed Care Organizations to Provide AHCCCS Complete Care Integrated Services Effective Oct. 1, 2018, https://www.azahcccs.gov/shared/News/PressRelease/AHCCCSAwardsContractstoManagedCareOrganizations.html.

> particular observations, therefore, would not necessarily constitute a basis for changing the rankings.[31]

This description from 2013 comports with the scoring methodology described in the RFP and implemented by AHCCCS to score the offerors' responses here as reiterated in its Overview of RFP Evaluation Process. [*See* Ex. B, Overview of RFP Evaluation Process].

Not only has consensus scoring and ranking of proposals long been used by AHCCCS, including in other procurements where this scoring methodology was not challenged by Health Choice because it won a contract,[32] Health Choice's Protest grounds based on AHCCCS's scoring methodology in this procurement fail for multiple reasons. First, these arguments have been waived.[33] AHCCCS's intended use of this scoring methodology was discussed and disclosed in the RFP, including specifically that portions of offerors' responses would be "evaluated and weighted" to arrive at a "score" using an "established [] scoring methodology to evaluate an Offerors' ability to provide cost-effective, high quality contract services in a manage care setting in accordance with the AHCCCS mission and goals." [Ex. A, RFP, § H, pp. 5-6].[34] Additionally, and as noted above, in answers to questions incorporated in RFP Amendment 1, which was posted more than 14 days prior to the response deadline, AHCCCS stated—including in response to multiple questions submitted by Health Choice—that "AHCCCS will not be providing scoring or weighting details." [Ex. A, RFP, Amendment 1, Q&A 23, 24, 25, and 35]. Thus, Health Choice was on notice of the scoring methodology to be used by AHCCCS, including the fact that AHCCCS would not provide specific scoring or weighting details, more than 14 days prior to the

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[31] *See* AHCCCS, Decision of Procurement Officer: Bridgeway Protest re AHCCCS Solicitation Number YH14-0001, Apr. 24, 2013, pp. 2-3 (emphasis in original), https://www.azahcccs.gov/PlansProviders/Downloads/Solicitations/BiddersLibrary/Capped/AHCCCSResponseToBridgewayProtestRFPYH14-0001.pdf.

[32] *See* AHCCCS, 2019 Complete Care RFP, Awards and Scores by GSA, *supra* note 14.

[33] *See* A.A.C. R9-22-604(D); *see also Blue & Gold Fleet, L.P.*, 492 F.3d at 1314.

[34] AHCCCS has used similar language to describe this scoring methodology in various requests for proposals since first using it in a 2014 procurement. For example, in the 2014 Acute/CRS RFP, AHCCCS stated that it "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 AHCCCS mission and goals" and that, in accordance with this methodology, portions of Offerors' responses would be "evaluated and weighted" to arrive at a "score" for each Offeror. *See* 2014 Acute/CRS RFP, § H, Instructions to Offerors, pp. 289-90, https://www.azahcccs.gov/PlansProviders/Downloads/Solicitations/BiddersLibrary/Procurement/YH14-0001RFP_attachments_included.pdf. Similar language was also used in the most recent ALTCS E/PD procurement prior to this one. *See* 2018 ALTCS E/PD RFP, § H, Instructions to Offerors, pp. 229-30, https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH18/ReqForProp/ReqForProp_Solicitation.pdf.

RFP response deadline. Any protest associated with AHCCCS's use of this scoring methodology was therefore due at least 14 days prior to the due date for proposals. Health Choice's protest of the scoring methodology filed after the awards were announced is therefore untimely and should be rejected on that basis alone.

Even if timely, which they are not, Health Choice's arguments regarding AHCCCS's scoring methodology lack merit. For example, despite the fact that AHCCCS has used the subject scoring methodology for more than a decade, Health Choice cites no authority that would support a finding that AHCCCS's scoring methodology is improper. The Arizona Procurement Manual cited by Health Choice does not apply to this procurement.[35] Even if the Arizona Procurement Manual did apply, the RFP is not in conflict with the Arizona Procurement Manual. For example, as discussed above and consistent with the Arizona Procurement Manual, the RFP clearly set forth the evaluation factors to be used to evaluate the proposals as required by A.A.C. R9-22-602. AHCCCS utilized those criteria in evaluating the offerors' proposals and selecting the offerors for award. Additionally, although the Arizona Procurement Manual provides examples of scoring methodologies that may be used under the Arizona Procurement Code, those examples are not exclusive methods for evaluating proposals, a point which Health Choice concedes. [Protest, p. 9]. Ultimately, the Arizona Procurement Manual does not address the scoring methodology AHCCCS used in this procurement, much less conclude that such scoring process is improper or disallowed.

AHCCCS also had legitimate and non-arbitrary reasons for using the scoring methodology it chose. By awarding points based on where a bidder ranked against other bidders within a particular evaluation subfactor, AHCCCS rewards a bidder for finishing at or near the top of several subfactors. Without such conversion, by contrast, a bidder could finish at or near the bottom of multiple subfactors and yet end up on top by simply doing very well on a single factor. There may be arguments for conducting an evaluation either way, but, ultimately, the decision regarding which scoring methodology to use is solely within AHCCCS's discretion. Health Choice cannot show otherwise.

Health Choice points to language in Paragraph 8 of Section H of the RFP identifying "additional factors" that AHCCCS "may" consider when "in the best interest of the State" in awarding a contract "[i]f AHCCCS determines that there is a negligible difference in scores between two or more competing proposals for a particular [GSA]." [Protest, pp. 8-9; Ex. A, RFP, § H, p. 5]. Although the RFP accounted for the ***possibility*** that there may be negligible differences

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[35] The Arizona State Procurement Manual is adopted under and in accordance with the Arizona Procurement Code, A.R.S. § 41-2501, *et seq*., and A.A.C. R2-7-101, *et seq*. *See* Arizona Procurement Manual, § 1.1-1.2, https://spo.az.gov/sites/default/files/Arizona%20State%20Procurement%20Manual%20DC%20009%20r0.pdf. AHCCCS is exempted from the Arizona Procurement Code for provider contracts pursuant to title 36, chapter 29, articles 2 and 3, including procurement of provider contracts for the ALTCS E/PD Program. *See* A.R.S. § 41-2501(I).

in scores and provided additional factors that AHCCCS ***may*** consider in awarding the contracts in the case of such negligible differences, the RFP did not guarantee that negligible differences in scores would occur as a result of the scoring process utilized by AHCCCS, nor did it require AHCCCS to consider any of the additional factors listed even if there were negligible differences in scores. Thus, even if Health Choice were correct that the scoring methodology used by AHCCCS precludes there ever being a negligible difference in the scores, AHCCCS's scoring methodology is not in conflict with the RFP.

The RFP does not define the phrase "negligible differences in scores." Nonetheless, Health Choice's contention that the scoring process used by AHCCCS eliminates the possibility of any negligible difference in the scores for any of the criteria, though irrelevant even if true, is simply incorrect. For example, evaluators had the option of ranking one or more offerors equally on a given criteria if appropriate, thereby awarding identical points to multiple offerors. [Ex. B, Overview of RFP Evaluation Process, p. 5]. This actually occurred with respect to the Non-Cost Benefit Bids for two of the offerors, both of which received an identical ranking (4) and number of points (30) on that criteria.[36] Accordingly, it is entirely possible that two, or even all, offerors could have been awarded identical points overall had the responses warranted such, a result that would unquestionably represent a "negligible difference in scores" between the offerors.

Not only were negligible differences in scores mathematically possible, the scores of some of the offerors differed by less than fifteen points out of one thousand, or 1.5%, an amount that is arguably negligible even by Health Choice's own standards. For example, Health Choice argues in its scoring example in its Protest that scores ranging from 100% to 96% all represented an "A+ score," suggesting a negligible difference in the scores. The difference between 100% and 96% is more than 250% greater than the difference between the scores of the fourth- and fifth-ranked vendors here. Thus, though there were differences between the scores of the first-ranked vendor and second-ranked vendor, and an even more significant difference between the second-ranked vendor and third-ranked vendor, the differences among the third- through fifth-ranked vendors were arguably negligible. As noted above, there was a clear break in the scores awarded to the offerors ranked second and third. Because AHCCCS elected to award contracts to the two offerors whose scores were substantially higher than all of the other offerors, there was no need for AHCCCS to resort to the methodology in the RFP for differentiating among scores with negligible differences.

Finally, Health Choice's suggestion that the scoring process ultimately failed to reflect how well the proposals met the RFP criteria is similarly incorrect and oversimplifies the process used to arrive at the scores, much less the final decision. The procurement file is replete with documentation establishing the thoughtful and thorough evaluation process AHCCCS used in

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[36] *See* AHCCCS, Overall Scoring Tool, *available at* https://www.azahcccs.gov/PlansProviders/HealthPlans/ALTCS_EPD_PROCUREMENT_FILE.html.

reaching its decision, including the detailed process by which the scores were determined. The end result of the scoring process was scores on the various criteria, and overall, that identified the ***relative*** differences among the offerors, with offerors with superior responses ranking higher and receiving more points, offerors with inferior responses ranking lower and receiving fewer points, and offerors with equivalent responses ranking the same and receiving identical points. Health Choice's assertion that the scoring methodology failed to reflect how well the proposals met the RFP is simply without basis or merit and should be rejected.

3. Health Choice Waived Any Argument Regarding AHCCCS's Disclosures about the Weighting of Evaluation Factors, and in Any Event, AHCCCS Was Not Required to Disclose the Weighting to Be Used in the Procurement.

Health Choice knew when the RFP was published on August 1, 2023, that the RFP did not disclose how the identified evaluation factors would be weighted. By not challenging this specification or lack thereof at least 14 days before the date proposals were due, Health Choice waived any argument about what the RFP should or should not have disclosed concerning the weighting of evaluation factors.[37] Moreover, when offerors (including Health Choice) expressly asked for more information about scoring or weighting of criteria under the RFP, AHCCCS replied unequivocally that it would not provide any scoring or weighting details. [Ex. A, RFP, Amendment 1, Q&A 23, 24, 25, and 35]. Yet again, despite being on notice that AHCCCS had "failed" to provide weighting information, Health Choice "s[a]t on [its] rights to challenge what [it] believe[d] is an unfair solicitation" and did not timely protest these specifications before AHCCCS's receipt of proposals.[38] Consequently, these arguments are waived.

Even if these arguments were timely, they should be rejected on the merits. Health Choice points to the Arizona Procurement Code in support of its argument that AHCCCS should have disclosed the weighting of evaluation factors in the RFP, but as established above, the Code does not apply to this procurement. And indeed, the regulations applicable to this AHCCCS procurement could have incorporated provisions of the Code that require disclosure of the weighting or relative value of evaluation criteria, but they do not. Health Choice has to resort to arguing the concepts of "best practices" or "fundamental policies of public procurements" because it cannot point to any statutory or regulatory procedure violated or improper procedure that AHCCCS employed. Instead, Health Choice simply suggests that there is a "strong preference" in the world of public procurement for disclosure of the relative weight of evaluation factors. [Protest, p. 11].[39] But the existence of a "strong preference" does not meet Health Choice's burden to show,

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[37] A.A.C. R9-22-604(D).

[38] *See Blue & Gold Fleet, L.P.*, 492 F.3d at 1314.

[39] And notwithstanding what Health Choice cites, federal law also states that while "[a]ll factors and significant subfactors that will affect contract award and their relative importance shall be stated clearly in the solicitation, ... ***[t]he rating method need not be disclosed in the solicitation***." 48 C.F.R. § 15.304(d) (emphasis added). Here, the RFP disclosed the evaluation factors to be used

by a preponderance of the evidence, that AHCCCS violated pertinent law, that there was a substantial irregularity in the process, or that there was any improper conduct.[40]

4. AHCCCS's Evaluation of the Proposals Was Reasonable and Conducted in Accordance with the RFP.

Health Choice next challenges a handful of scoring decisions by the evaluators. But it is a central tenet of procurement law that the scoring of proposals is well within the discretion of the evaluators and should not be second-guessed through a bid protest.[41] "Because the review of an agency's scoring determinations is only appropriate to determine whether those determinations were reasonable and consistent with the terms of the RFP and applicable law, '[a] protestor's mere disagreement with a procuring agency's judgment is insufficient to establish that the agency acted unreasonably.'"[42] Moreover, "[m]inor errors in the procurement process, evaluation, or contract award will not suffice to rescind a contract."[43]

All of the offerors were evaluated using the same evaluation criteria and the same procedures. Health Choice cannot show otherwise. Contrary to its claims, Health Choice cannot

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in the procurement and "their relative importance"—indeed, the RFP stated that the Programmatic Requirements would be weighted more heavily than the Financial Requirements. [Ex. A, RFP, § H, p. 6]. The fact that the RFP did not disclose the weights of the specific evaluation factors is not necessarily a problem even under federal law. *See, e.g.*, *Beta Analytics Int'l, Inc. v. United States*, 67 Fed. Cl. 384, 399-400 (2005) (rejecting arguments that the solicitation failed to disclose the numerical weight of each factor and subfactor and reasoning that the protestor "cited no authority supporting the proposition that the exact numerical value or even relative ***weight*** of the technical factors must be disclosed" (emphasis in original)). The court in the case Health Choice cites, *Isratex, Inc. v. United States*, 25 Cl. Ct. 223 (1992), relied upon a specific statute that applied to procurements by the armed forces—which since has been repealed—that expressly required a solicitation to "set forth the relative importance of subfactors" in the evaluation. *See id.* at 228.

[40] *Cigna Healthcare of Ariz., Inc.*, 04-0008-ADM, at 39.

[41] *See, e.g.*, *E.W. Bliss Co. v. United States*, 77 F.3d 445, 449 (Fed. Cir. 1996) (technical ranking decisions are "minutiae of the procurement process" that involve discretionary decisions not to be second-guessed); *Ginn Grp., Inc. v. United States*, 159 Fed. Cl. 593, 603 (2022) (noting that second-guessing the agency's evaluation of only a part of an offeror's approach to a subpart of a subpart of a proposal should be avoided); *Dismas Charities, Inc. v. United States*, 61 Fed. Cl. 191, 203 (2004) ("The decision as to whether an offeror should have scored a 3, 4, or 5 on any question is properly left to the discretion of the agency.").

[42] *Magellan Health Servs. of Ariz., Inc.*, 13F-006-ADM at 67 (quoting *Gonzales-Stoller Remediation Servs., LLC*, B-406183.2, at *4).

[43] *Id.*

show that AHCCCS acted unfairly or irrationally in evaluating the offers submitted in response to the RFP.

Here, the record shows that AHCCCS's evaluation process was extensive, thorough, and fair. Even if Health Choice could demonstrate prejudice from any of the scoring issues raised in its Protest—which it cannot—Health Choice fails to show any impropriety in the evaluators' scoring of the proposals.

a. Health Choice's Desire for Greater Specificity in the Explanations for Its Scores Is Not a Valid Protest Ground.

In its Protest, Health Choice complains that the written explanations and rationale for the evaluation scores it received under Narrative Submission Criteria B4, B5, B6, and B7 were not detailed enough. Unsurprisingly, Health Choice believes AHCCCS's evaluation narratives do not adequately explain why Health Choice's evaluation scores were not higher. But the rationale and ranking documents prepared by AHCCCS fully complied with all published requirements and evaluation procedures under the RFP. The RFP certainly did not require, or even disclose as a possibility, the provision of written evaluation narratives of the scope and sheer volume that Health Choice requests in its Protest.

In fact, the legal authorities Health Choice cites in support of this argument actually support that AHCCCS's evaluation narratives comport with all applicable procurement laws. Specifically, Health Choice cites *General Security Services Corp.*, a federal procurement decision in which the Comptroller General ***rejected*** a protest argument regarding lack of detail and specificity in the agency evaluation reports and ultimately found that the agency satisfied any obligations by making note of portions of the protester's proposal that supported a lower score.[44] Similarly here, AHCCCS noted multiple deficiencies and distinguishing factors about the Health Choice proposal that led to AHCCCS's scoring determinations:

- Under Narrative Submission Criterion B4, the relevant evaluation report notes that Health Choice "did not clearly describe its approach for continual skill building for case managers";

- Under Narrative Submission Criterion B5, the evaluation report makes note of a number of deficiencies in Health Choice's proposal, including Health Choice's failure to describe clearly "how it incorporates health equity when matching members with case managers," "its timeframe for implementing systems or processes not currently in place," "its support plan for case managers," "how it encourages active participation from providers," or "how supervisory staff would perform ongoing oversight";

[44] *Gen. Sec. Servs. Corp.*, B-280388, 99-1 CPD ¶ 49 (Comp. Gen. Sept. 25, 1998).

- Under Narrative Submission Criterion B6, AHCCCS noted that the Health Choice proposal failed to describe clearly how the referenced HIE or CLRS tools would be used in addressing health disparities and failed to provide clear examples of using data to inform development and measurement of evidence-based initiatives; and

- Under Narrative Submission Criterion B7, AHCCCS highlighted that Health Choice did not clearly describe the unique aspects of each service area, how approaches address the needs of members in rural areas, or its data sources and tools for monitoring access to care and network adequacy.

[Ex. B, Ranking and Rationale for B4, B5, B6, and B7]. AHCCCS's procurement file offers reasonable bases for the evaluation scores Health Choice received. This is significantly different than the circumstances in the bid protest decision Health Choice cites, in which the agency's award memorandum contained "no hint as to the basis for the scoring of the proposals and provide[d] no assessment of the strengths and weaknesses in the various proposals."[45]

Even when it acknowledges that AHCCCS did make substantive evaluation comments regarding its proposal, Health Choice complains that the rationale and ranking documents "***merely observe*** the level of detail in the proposals," as if the evaluation of how clearly and thoroughly Health Choice described its ability to meet AHCCCS's needs is not a valid basis for scoring proposals. [Protest, p. 12 (emphasis added)]. The RFP, however, plainly advised all offerors of the importance of clearly and thoroughly articulating their respective offerings and capabilities, stating that "[f]ailure of the Offeror to provide a ***clear, thorough, and detailed*** response may affect scoring." [Ex. A, RFP, § H, p. 5 (emphasis added)]. Accordingly, AHCCCS's lower scoring of the Health Choice proposal due to a lack of clarity in multiple parts is not a valid protest ground.

Lastly, Health Choice appears to claim that differences between the preliminary scores its proposal received from individual evaluators and the final consensus scores somehow render AHCCCS's evaluation determinations to be arbitrary and capricious. It is a well-established principle of government procurement law, however, that there is nothing inherently objectionable in an agency's decision to develop a consensus rating instead of relying upon individual evaluator scores.[46] Moreover, the fact that evaluators may have individually rated Mercy Care's proposal for Criteria B5, B7, and B9 more favorably than they did on a consensus basis for those categories does not, by itself, warrant questioning the final evaluation results.[47] As pointed out in countless bid protest decisions, agency evaluators may properly discuss the relative strengths and weaknesses of proposals in order to reach a consensus rating, and such consensus rating will often

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[45] *See Opti-Lite Optical*, B-281693, 99-1 CPD ¶ 61, at *4 (Comp. Gen. Mar. 22, 1999).
[46] *See Res. Applications, Inc*., B-274943 et al., 97-1 CPD ¶ 137 (Comp. Gen. Mar. 5, 1997); *Appalachian Council, Inc*., B-256179, 94-1 CPD ¶ 319 (Comp. Gen. May 20, 1994).
[47] *See Syscon Servs., Inc*., B- 235647, 89-2 CPD ¶ 258 (Comp. Gen. Sept. 21, 1989); *Dragon Servs., Inc*., B-255354, 94-1 CPD ¶ 151 (Comp. Gen. Feb. 25, 1994).

differ from the ratings given by individual evaluators because such discussions generally operate to correct mistakes or misperceptions that may have occurred in the initial evaluation.[48] Thus, a consensus score need not be the score the evaluators initially awarded—the score may properly be determined after discussions among the evaluators.[49] In short, the overriding concern in the evaluation process is that the final score assigned accurately reflect the actual merits of the proposals, not that it be directly traceable back to the scores initially given by the individual evaluators.[50] Further, the observations in the ranking and rationale documents do not necessarily reflect ***all*** of the factors considered by evaluators in deriving their final, consensus rankings. Those documents are not a verbatim transcript or recording of what transpired to ultimately reach the consensus ranking. As AHCCCS reasoned in a prior decision denying a bid protest, even a successful challenge to a particular observation "would not necessarily constitute a basis for changing the rankings."[51]

Here, the record establishes that the AHCCCS consensus reports for Criteria B4, B5, B6, and B7 reasonably reconcile the differences of opinion among the evaluators and accurately reflect the relative qualities of the proposals—including Health Choice's proposal. [Ex. B, Ranking and Rationale for B4, B5, B6, and B7]. Health Choice's receipt of better preliminary scores from individual evaluators than the final consensus scores it received under the RFP's evaluation criteria is not evidence of any legal error by AHCCCS—especially given that AHCCCS's consensus scoring reports properly documented and identified the factual bases for Health Choice's consensus rankings.

Accordingly, Health Choice's Protest grounds based upon claims that AHCCCS's evaluation reports do not contain enough detail, or contradict the RFP's evaluation requirements, should be denied.

b. <u>AHCCCS Did Not Employ Undisclosed Evaluation Criteria.</u>

Health Choice vaguely asserts that "in several instances," the evaluators marked Health Choice's proposal down for "failing to provide information that was not part of the question asked." [Protest, p. 15]. It provides only two specific examples. [*Id.*] Health Choice's argument that it was evaluated based on undisclosed evaluation criteria has no basis in the record.

Health Choice fails to demonstrate that the evaluators applied undisclosed criteria in the evaluation. While agencies should identify the major evaluation factors to be used in a procurement, agencies "are not required to identify all areas of each factor which might be taken

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[48] *See Schweizer Aircraft Corp*., B-248640.2; B-248640.3, 92-2 CPD ¶ 200 (Comp. Gen. Sept. 14, 1992); *Cadmus Grp., Inc*., B-241372.3 et al., 91-2 CPD ¶ 271 (Comp. Gen. Sept. 25, 1991).
[49] *See GZA Remediation, Inc*., B-272386, 96-2 CPD ¶ 155 n.3 (Comp. Gen. Oct. 3, 1996).
[50] *Id*.; *Dragon Servs., Inc.*, B-255354, at *8.
[51] Decision of Procurement Officer: Bridgeway Protest re AHCCCS Solicitation Number YH14-0001, *supra* note 31.

into account, provided that the unidentified areas are reasonably related to or encompassed by the stated criteria."[52] The RFP appropriately disclosed the evaluation criteria to be applied in the procurement, and that criteria reasonably gave room to the evaluators to assess how well each offeror addressed that criteria.

Here, the evaluators' observations about Health Choice's proposal under Narrative Submission Criteria B5 and B6 in the ranking and rationale documents were encapsulated within the published criteria under those respective factors. For example, Health Choice complains about the evaluators' observation under Criterion B5 that its proposal failed to provide a timeline for implementation of new systems and processes. [Protest, p. 15]. However, a close review of this criterion indicates that its considerations include how offerors would implement person-centered service planning, and Health Choice's proposal stated that it would implement new processes and systems for case oversight to achieve this person-centered service planning. It was therefore reasonable under this criterion to consider Health Choice's timeline for instituting such new processes. As for Health Choice's contention that the agency should not have credited AzCH for health equity accreditation under Criterion B6 because that criterion was focused on data to improve member health incomes and inform program initiatives, health equity accreditation, however, necessarily involves evaluation of plans' data collection practices and thus it was inherently reasonable to consider such accreditation as part of that criterion.

In sum, the items about which Health Choice complains are not undisclosed evaluation criteria and were reasonably related to or encompassed within the evaluation factors disclosed in the RFP. The Procurement Officer should reject Health Choice's argument that AHCCCS did not evaluate proposals in accordance with the RFP.

c. AHCCCS Acted within Its Discretion in Scoring Health Choice's Proposal.

Health Choice's arguments regarding AHCCCS's alleged failure to give Health Choice "credit" for multiple sections of its proposal ultimately boil down to Health Choice simply disagreeing with the evaluators' criticisms of its proposal. But "a protester's mere disagreement with a procuring agency's judgment is insufficient to establish that the agency acted unreasonably."[53] The Procurement Officer should reject Health Choice's invitation to second-guess the evaluators' proper exercise of their discretion.[54]

To challenge its scoring under Narrative Submission Criteria B4 through B8, Health Choice does nothing more than take the subjective criticisms of the evaluators regarding a lack of sufficient detail and description in the Mercy Care proposal and respond that, in Mercy Care's estimation, there was sufficient detail in its proposal. The sections of the consensus scoring report for Criteria B5 through B8 cited by Health Choice, however, do not state that Health Choice's

[52] *Avogadro Energy Sys*., B–244106, 91–2 CPD ¶ 229 (Comp. Gen. Sept. 9, 1991).
[53] *Gonzales-Stoller Remediation Svcs., LLC*, B-406183.2, at *4.
[54] *See Software Eng'g Servs.*, 85 Fed. Cl. at 556.

proposal was devoid of any discussion of the areas highlighted in Health Choice's Protest. [Ex. B, Ranking and Rationale, B5, B6, B7, and B8]. Instead, the ranking and rationale documents cited by Health Choice state that Health Choice's proposal did not address these topics with enough clarity in the subjective estimation of AHCCCS's evaluators. [*See id*.].

This kind of subjective determination of sufficiency or clarity is within the proper discretion of the evaluators, and Health Choice's differing and self-serving opinion as to how much clarity is contained within its proposal is not a valid protest ground. Applicable procurement law is clear that "[a]n offeror has the burden of submitting an adequately written proposal, and an offeror's mere disagreement with the agency's judgment concerning the adequacy of the proposal is not sufficient to establish that the agency acted unreasonably."[55] Consequently, Health Choice's subjective determination that its proposal included sufficient detail and clarity to have received higher scores under the RFP is not a meritorious protest ground, and should be denied.

d. There Were No Errors in AHCCCS's Scoring of "Past Performance."

Narrative Criterion B11

Health Choice asserts that AHCCCS improperly relied upon undisclosed evaluation criteria to score Narrative Submission Criterion B11, STAR rating. [Protest, pp. 17-18]. Health Choice's arguments are without merit, including because they are untimely and otherwise fail to clearly state grounds upon which the protest could be granted.

Health Choice takes issue with its ranking, and ultimately its score, on Criterion B11, asserting that it should have been ranked higher because it had a higher STAR rating than some other offerors which ranked higher than Health Choice. Health Choice presumes its lower score may have been the result of Health Choice submitting a rating from an Arizona HIDE SNP plan rather than from an Arizona FIDE SNP plan and alleges that such a differentiation based upon plan type was not disclosed within the RFP. [Protest, p. 17]. Assuming that Health Choice is correct that its lower ranking and score was the result of differentiation based on plan type, the potential for such differentiation was apparent from the RFP, and Health Choice's protest is untimely.

The RFP provided a format for submission of responses to Criterion B11, including that offerors should identify the "TYPE OF PLAN (FIDE/DSNP; SNP; MEDICARE ADVANTAGE)," in that order, indicating that this information could be considered as part of AHCCCS's evaluation. [Ex. A, RFP, § H, p. 18]. The Narrative Submission Requirements further indicated that different plan types may receive different weights. For example, for STAR ratings from another state, the RFP expressed a preference for FIDE SNP/DSNP Plan STAR ratings over any other type of SNP. [Ex. A, RFP, § I, Ex. H, p. 5]. The request for plan type, along with the specific reference to a preference order for out-of-state plans, apparently gave enough of an indication that differing plan types may receive different weights that Health Choice itself

[55] *SC&A, Inc*., B-270160.2 et al., 96-1 CPD ¶ 197, at *5 (Comp. Gen. Apr. 10, 1996).

submitted a question to AHCCCS asking "[w]ill there be a difference in weight for Arizona DSNP Star Ratings versus non-Arizona DSNP Star Ratings or AZ MA Plans," and "[i]f so, would AHCCCS be willing to provide the different weights." [Ex. A, RFP, Amendment 1, p. 7]. In response, AHCCCS stated it "will not be providing scoring or weighting details." [Ex. A, RFP, Amendment 1, p. 7]. Accordingly, not only did Health Choice recognize this issue prior to the proposal submission deadline, but it availed itself of the question and answer process to ask whether AHCCCS would provide more information on the weighting of plan types, including as between differing Arizona plans—e.g., Arizona DSNP versus Arizona Medicare Advantage. If Health Choice was dissatisfied with AHCCCS's response, or otherwise believed the RFP was unclear as to whether plan type may be considered, Health Choice was required to raise that issue through a protest prior to the response deadline.[56] The failure to do so renders its protest untimely, and it should be rejected on that basis alone.

Even if the protest were timely, Health Choice ultimately fails to clearly state grounds that would sustain a protest. Health Choice asserts that had Criterion B11 been scored the way Health Choice suggests it should have been scored, Health Choice would have received 20 points for B11 instead of the 8 points it actually received, for a difference of 12 points. [Protest, p. 17]. Even if Health Choice's argument had merit—which it does not—its math is incorrect.

Accepting Health Choice's scoring methodology, which would have rank determined solely by comparing STAR ratings, "Health Choice should have tied for first place." [Protest, p. 17]. A tie for first place on B11 would not result in Health Choice being awarded the full 20 points available for B11. Instead, Health Choice would have split the available points for first (20 points) and second (16 points) evenly with APIPA, the other entity with a 4 STAR rating, resulting in 18 points for each of them. [Ex. B, Overview of RFP Evaluation Process, pp. 3-5]. Applying this same methodology across the five offerors would result in APIPA and Health Choice in a tie for first with 18 points each, AzCH alone in third with 12 points (based on its 3.5 STAR rating), and Banner and Mercy Care tied for fourth (based on their 3 STAR ratings), with 6 points each. Replacing the originally awarded points with these revised point totals for B11 does not change the overall rank order, with Health Choice remaining in fourth place, and actually widens the gap between APIPA in second and Mercy Care in third, which would further support AHCCCS's award decision. Thus, even if Health Choice's argument were accepted and its methodology applied, there would be no material prejudice to Health Choice, nor any substantial probability that it would have been awarded the contract but for this purported error. For this reason alone, Health Choice's Protest on this point must be denied.

Narrative Criterion B10

Health Choice criticizes AHCCCS's scoring of Narrative Submission Criterion B10, Compliance Review, asserting that AHCCCS did not disclose how it would be evaluated, and alleging that Health Choice's self-proclaimed "most logical and straightforward scoring process"

[56] *See* A.A.C. R9-22-604(D).

should have been used. [Protest, pp. 18-19]. Health Choice's arguments are again without merit, including because they are untimely and otherwise fail to clearly state grounds upon which the Protest could be granted.

Health Choice's criticism that the RFP lacked detail as to how the compliance review would be evaluated, even if correct, was apparent at the time the RFP was issued. Indeed, Health Choice submitted multiple questions relating to Criterion B10 during the question and answer process prior to the due date for proposals. [Ex. A, RFP, Amendment 1, Q&A 22-23]. In response, AHCCCS stated it "will not be providing scoring or weighting details." [*Id.*]. If Health Choice had further concerns about the scoring of B10, including any alleged lack of detail regarding the scoring or weighting of B10, it was required to raise those issues prior to the proposal response deadline.[57] Its failure to do so constitutes a waiver of those arguments, and its protest on these grounds should be rejected.

Moreover, Health Choice has not cited any authority for its allegation that AHCCCS's methodology for evaluating Criterion B10, as interpreted by Health Choice, is improper, or that Health Choice's preferred scoring process is the correct process or was otherwise required to be used by AHCCCS in its evaluation of the proposals. Certainly, Health Choice has not identified how it was materially prejudiced by these alleged deficiencies, much less that but for those alleged deficiencies, there is a substantial probability that Health Choice would have been awarded the contract.

Finally, Health Choice asserts that AzCH "appears to have been scored based on their last ALTCS OR result in 2021 rather than their more recent ACC or RBHA OR, as was the case with all other current non-ALTCS contractors," and that this purported disparate treatment was improper. [Protest, p. 19]. Health Choice does not cite or otherwise reference any support for this contention, and it is otherwise unclear what Health Choice relies upon for this statement. Nonetheless, it appears inaccurate for a number of reasons. First, AzCH is not an existing ALTCS provider in Arizona and would therefore not have an "ALTCS OR result in 2021" upon which AHCCCS could have based its review or scoring of AzCH. Second, all three scoring tools for Criterion B10 identify "Arizona Complete Health-Complete Care Plan RBHA OR 2020" as the "Most Recent AHCCCS OR Results" for AzCH that were used in the evaluation, including a live link to the AzCH RBHA OR 2020 review document. [**Exhibit J**, AHCCCS001499 EPD RFP_YH41-0001_Scoring Tools B10.xlsx; AHCCCS001500 EPD RFP_YH41-0001_Scoring Tools B10.xlsx; AHCCCS001501 EPD RFP_YH41-0001_Scoring Tools B10.xlsx]. AHCCCS Operational Reviews are available on the AHCCCS website, and the most recent AHCCCS Operational Review for AzCH is the Arizona Complete Health-Complete Care Plan RBHA OR 2020, which was completed in May 2021.[58] Thus, there appears to be no merit whatsoever to Health Choice's claims in this regard.

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[57] *See* A.A.C. R9-22-604(D).

[58] *See* AHCCCS Operational Reviews,

e. There Were No Errors in the Non-Benefit Cost Bid Scores.

Health Choice alleges ***possible*** errors in the non-benefit cost bid scores, asserting that "[i]t appears that Health Choice's ranking may have been reduced" for reasons that Health Choice believes invalid, and that "it appears that Health Choice was inappropriately and arbitrarily singled out and penalized when other bidders who submitted similarly structured rates were not." [Protest, p. 19]. Ultimately, Health Choice concedes that it does not know whether its ranking on the non-benefit cost bid scores was appropriate or not. [Protest, p. 19].

Assuming there was an error, and assuming Health Choice were awarded the relief "it appears" may have been appropriate according to Health Choice, the result would be an additional 20 points for Health Choice and 20 fewer points for Mercy Care. That would mean that Health Choice and Mercy Care would essentially flip in the rankings, with Health Choice coming in a distant third at 557.00 (compared to its original 537.00) and Mercy Care fourth at 537.5 (compared to its original 557.5). This purported error has no impact whatsoever on the scores or ranking of the two highest ranked offerors, AzCH and APIPA, which were awarded the contracts. Accordingly, even if this purported error existed, it did not materially prejudice Health Choice, nor is there a substantial probability that Health Choice would have been awarded a contract but for the purported error, and the protest fails on these grounds.

Responses to Health Choice's Requested Relief

Because Health Choice cannot make the necessary showing of prejudice and its Protest is meritless, the Procurement Officer should deny its requests for relief, including any stay of the procurement while the Protest is pending.

I. Any Attempt to Reissue the RFP Would Substantially Prejudice AzCH.

Health Choice contends that the errors in the procurement process require that AHCCCS cancel the RFP and issue a new solicitation. But if the awards arising out of the RFP were retracted and a new solicitation issued, it would result in substantial prejudice to the current awardees, including AzCH. All offers and awards are currently public information, and any rebid scenario would allow offerors to undercut these public offers. This outcome is particularly prejudicial to both awardees considering Health Choice has no viable grounds for this Protest, has failed to demonstrate any prejudice for the alleged procurement irregularities, and does not even try to demonstrate how reissuing the solicitation is in the best interest of the State—which is unsurprising as it is contrary to the State's best interest. At most, Health Choice argues the "'best interest of the state' ***should*** mean that the process results in the selection of contractors who demonstrate substantive performance benefits to Arizona Medicaid members and the citizens of the state of

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https://www.azahcccs.gov/Resources/OversightOfHealthPlans/OpReviews.html.

Arizona." [Protest, p. 20 (emphasis in original)]. This has already been satisfied. Thus, a rebid is not appropriate relief, particularly where none of Health Choice's protest grounds are viable.

II. No Stay of the Contract Should Be Awarded.

It is in the State's best interest to reject this Protest and allow AzCH to begin working towards contract performance. Accordingly, AzCH requests that the Procurement Officer reject Health Choice's request to stay the contract award.

Pursuant to A.A.C. R9-22-604(E), a stay of the contract award may only be granted before the contract is awarded. Here, Health Choice failed to file a protest before the contract was awarded to AzCH and APIPA on December 1, 2023. Health Choice does not dispute this. For this reason alone, Health Choice's request for a stay should be denied.

In addition, staying this award does not further the best interests of the State, nor does Health Choice demonstrate as such. It is in the State's best interest not to impede efforts by the contract awardees to begin implementing contract performance which will provide efficiencies and innovations to ALTCS members beyond those under the current contracts. Additionally, there are significant readiness activities that must occur before the contracts' "go live" date of October 1, 2024. This is particularly true with respect to AzCH, which is not an incumbent ALTCS contractor. For these reasons, no stay should be granted, and AzCH and APIPA should be allowed to continue with contract performance.

Conclusion

This Protest reflects Health Choice's efforts to supplant the judgment of AHCCCS's evaluators with its own to further its own interests. Health Choice fails to show how the evaluation of its proposal, or any other proposal, reflects any violations of relevant procurement statutes and regulations, or any improper conduct on the part of AHCCCS. Rather, it is apparent that AHCCCS evaluated the proposals in accordance with the terms of the RFP and exercised its considerable discretion to find that Health Choice's proposal fell short in certain crucial areas.

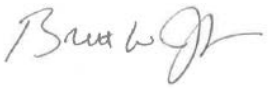
Health Choice has not shown, and cannot show, that AHCCCS violated any law in this procurement, and as indicated herein, AzCH was properly selected as an awardee under the RFP. Based on the RFP's published evaluation criteria and AHCCCS's reasonable judgment, AzCH's proposal was more advantageous to the State of Arizona. That sound discretionary judgment should not be disturbed because Health Choice did not approve of the end result.[59] The Procurement Officer should deny the Protest.

[59] To the extent additional information is provided related to this matter or Health Choice's attempts to supplement its protest, AzCH retains the right to also supplement its opposition.

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

Very truly yours,

Snell & Wilmer



Brett W. Johnson PC

BWJ:th

Copy to (via email only):

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EXHIBIT A

Notice of Request for Proposal

SOLICITATION # YH24-0001

LONG TERM CARE FOR INDIVIDUALS WHO ARE ELDERLY AND/OR HAVE A PHYSICAL DISABLITY (ALTCS EPD)

AHCCCS Procurement Officer:
Meggan LaPorte
Chief Procurement Officer
E-Mail: RFPYH24-0001@azahcccs.gov

Issue Date: August 1, 2023

RFP DESCRIPTION:	**LONG TERM CARE FOR INDIVIDUALS WHO ARE ELDERLY AND/OR HAVE A PHYSICAL DISABILITY (ALTCS EPD)**
PRE-PROPOSAL CONFERENCE:	A Pre-Proposal Conference has **NOT** been scheduled.
QUESTIONS DUE: *Questions shall be submitted to the procurement officer on the Q&A form provided with this RFP. Answers will be posted publicly on the AHCCCS website in the form of a Solicitation Amendment for the benefit of all Potential Offerors.*	**AUGUST 8, 2023** AND **AUGUST 22, 2023** by 5:00 PM Arizona Time
ALL OFFERORS MUST SUBMIT THEIR INTENT TO BID FORM BY: *Refer to RFP Instructions to Offerors for details*	**AUGUST 31, 2023** by 3:00 PM Arizona Time
PROPOSAL DUE DATE: *Proposals shall be submitted in accordance with this RFP's Instructions to Offerors prior to the time and date indicated here, or as may be amended through a Solicitation Amendment.*	**OCTOBER 2, 2023** by 3:00 PM Arizona Time

Late proposals shall not be considered.
OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION.

Persons with a disability may request reasonable accommodation, such as a sign language interpreter, by contacting the person named above. Requests should be made as early as possible to allow time to arrange the accommodation.

OFFER AND ACCEPTANCE

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and final proposal revisions (if any). Signature also certifies Small Business Status.

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

Federal Employer Identification No.: _____

E-Mail Address: _____

_____
Company Name

_____
Address

_____
City State Zip

For clarification of this offer, contact:

Name: _____

Title: _____

Phone: _____

_____
Signature of Person Authorized to Sign Offer

_____
Printed Name

_____
Title

CERTIFICATION

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

1. The submission of the offer did not involve collusion or other anti-competitive practices.
2. The Offeror shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 2009-09 or A.R.S. §§ 41-1461 through 1465.
3. The Offeror 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.
4. The Offeror _____is / _____ is **not** a small business with less than 100 employees or has gross revenues of $4 million or less.
5. The Offeror is in compliance with A.R.S. § 18-132 when offering electronics or information technology products, services, or maintenance; and
6. The Offeror certifies that it is not debarred from, or otherwise prohibited from participating in any contract awarded by federal, state, or local government.

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

Your offer, including all exhibits, amendments, and final proposal revisions (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.

The Contractor is cautioned not to commence any billable work or to provide any material or service under this contract until Contractor receives purchase order, contact release document or written notice to proceed.

This contract shall henceforth be referred to as

Contract No. _____
Contract Service Start Date: _____
Award Date: _____

_____
MEGGAN LAPORTE, AHCCCS CHIEF PROCUREMENT OFFICER

SECTION D: PROGRAM REQUIREMENTS

1. PURPOSE, APPLICABILITY, AND INTRODUCTION

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Title XIX Medicaid program operating under Arizona Section 1115 Demonstration Waiver (1115 Waiver) and Title XXI program operating under Title XXI Arizona State Plan authority. In 1982, Arizona introduced its innovative Medicaid program by establishing AHCCCS, a demonstration program based on principles of managed care. In doing so, AHCCCS became the first statewide Medicaid managed care system in the nation.

The purpose of this Contract between AHCCCS and the Contractor is to implement and operate the Arizona Long Term Care System (ALTCS) Program for individuals who are Elderly and/or have a Physical Disability (E/PD) pursuant to A.R.S. § 36-2931 et seq.

The ALTCS E/PD (Contractor) shall be responsible for the provision of integrated care addressing physical and behavioral health needs and Long Term Services and Supports (LTSS) for the following Title XIX individuals who are E/PD including the populations below and excluding AHCCCS Complete Care (ACC), Department of Economic Security (DES)/Division of Developmental Disabilities (DDD), Department of Child Safety (DCS)/Comprehensive Health Plan (CHP), and AHCCCS Complete Care-Regional Behavioral Health Agreement (ACC-RBHA) enrolled members.

1. ALTCS qualified individuals including:
    a. Adults and children with and without General Mental Health/Substance Use (GMH/SU) needs,
    b. Adults with a Serious Mental Illness (SMI) designation,
    c. Children with a Serious Emotional Disturbance (SED) designation, and
    d. Children with Special Health Care Needs (SHCN).

In the event that a provision of Federal or State law, regulation, or policy is repealed or modified during the term of this Contract, effective on the date the repeal or modification by its own terms takes effect:

1. The provisions of this Contract shall be deemed to have been amended to incorporate the repeal or modification.

2. The Contractor shall comply with the requirements of the Contract as amended, unless AHCCCS and the Contractor otherwise stipulate in writing.

ALTCS services are provided in the 15 Arizona counties, either directly or indirectly, by Contractors under contract with AHCCCS. The Contractor coordinates, manages, and provides physical health care, long term care, behavioral health care, and case management services to ALTCS members.

AHCCCS Mission and Vision: The AHCCCS mission and vision is to reach across Arizona to provide comprehensive quality health care to those in need while shaping tomorrow's managed health care from today's experience, quality, and innovation. AHCCCS supports a program that promotes the values of:

1. Choice.

2. Dignity.

3. Independence.

4. Individuality.

5. Privacy.

6. Self-determination.

Initiatives: AHCCCS' focus on continuous system improvement results in the development of initiatives aimed at building a more cohesive and effective health care system in Arizona by reducing fragmentation, structuring provider reimbursements to incentivize quality outcomes, leveraging Health Information Technology (HIT), and working with private sector partners to further innovation to the greatest extent. The Contractor shall collaborate with AHCCCS and be innovative in the implementation of these AHCCCS initiatives and focus on topics such as:

1. Health equity.

2. Telehealth services.

3. Accessing behavioral health services in schools.

4. Whole Person Care.

5. Care coordination and integration.

6. Public/private partnerships.

7. Electronic Visit Verification (EVV).

8. Emergency Triage, Treat, and Transport (ET3).

9. Payment modernization.

10. Health Information Technology (HIT).

11. Health Information Exchange (HIE)

12. Arizona Healthcare Directives Registry (AzHDR).

13. Justice System transitions.

14. Targeted Investment (TI) program.

15. Housing and Health Opportunities (H2O).

16. Home and Community Based Settings Rules.

Whole Person Care Initiative: The goal of AHCCCS' Whole Person Care Initiative (WPCI) is to address the Health-Related Social Needs (HRSN) of our members, which have a direct impact on their health outcomes. The Contractor shall implement strategies and practices to expand upon AHCCCS' efforts to address a member's whole person health care. When addressing HRSN, areas of focus can include but are not limited to increasing access to safe and affordable housing, nutritious food, utility assistance,

education, employment, transportation, connection to others in the community, as well as physical, environmental, and interpersonal safety.

The Contractor shall join the AHCCCS-Approved Closed-Loop Referral System (CLRS) and actively encourage provider network utilization of the CLRS to refer members to Community Based Organizations (CBOs) that provide services addressing HRSN. The Contractor's Care Management staff shall utilize the CLRS to screen and refer each member of their caseload annually at a minimum. Additionally, the Contractor shall partner with the Health Information Exchange/Health Information Organization (HIE/HIO) to outreach to CBOs to participate in the CLRS.

The Contractor shall actively encourage provider usage of HRSN screening and referral tools available through or compatible with the CLRS to screen and refer members for HRSN. At a minimum, the provider's tool must screen for the following HRSN regardless of the screening tools selected:

1. Homelessness/Housing Instability.
2. Food Insecurity
3. Transportation Assistance.
4. Employment Instability.
5. Utility Assistance.
6. Interpersonal Safety.
7. Justice/Legal Involvement.
8. Social Isolation/Social Support.

In conjunction with utilization of the CLRS, the Contractor shall also maintain a publicly available Community Resource Guide with information on local resources that address and provide support for HRSN. The Community Resource Guide shall be updated at least quarterly and made available on the Contractor's website as specified in ACOM Policy 404. The resources provided in the Community Resource Guide shall be focused on the needs and geographic area of the Contractor's member population.

The Contractor shall monitor, promote, and educate providers on the use and importance of SDOH International Classification of Diseases, Tenth Revision (ICD-10) codes, commonly known as "Z" codes. These codes shall be included on claims to support data collection on the HRSN experienced by AHCCCS members. To the extent feasible, the Contractor and its providers shall use the CLRS to promote health equity by leveraging data within the CLRS to identify and address health disparities across member demographic criteria.

Integrated Health Plan: The Contractor shall operate as a single entity responsible for ensuring the delivery of medically necessary covered services for members and shall provide all major administrative functions of a Managed Care Organization (MCO) including but not limited to:

1. Network Management/Provider Relations.

2. Member Services.

3. Quality Management (QM).

4. Performance Improvement (PI).

5. Medical Management (MM).

6. Integrated Systems of Care (ISOC).

7. Finance.

8. Claims/Encounters.

9. Information Services.

10. Grievance and Appeal System.

The Contractor shall not delegate or subcontract key functions of health plan operations that are critical to the integration of physical and behavioral health care for members as set forth in Contract, unless one entity under subcontract provides all of the delegated functions for both the Medicaid, which includes physical and behavioral health, and Medicare Lines Of Business (LOBs). Refer to Section D, Paragraph 33, Subcontracts and ACOM Policy 438.

The Contractor shall have organizational, management, staffing and administrative systems capable of meeting all Contract requirements with clearly defined lines of responsibility, authority, communication, and coordination within, between and among Contractor's departments, units, or functional areas of operation.

> ***Integrated Health Care Service Delivery***: The Contractor shall increase and promote the availability of integrated, holistic care for members with chronic behavioral and physical health conditions that will help members achieve better overall health and an improved quality of life.
>
> The Contractor shall develop and promote care integration activities such as establishing integrated settings which serve members' primary care and behavioral health needs and encouraging member utilization of these settings. The Contractor shall consider the behavioral health needs, in addition to the primary health care needs, of members during network development and provider contracting to ensure member access to care, care coordination and management, and to reduce duplication of services.

System Values and Guiding Principles: The following values, guiding system principles and goals are the foundation for the development of this Contract. The Contractor shall administer and ensure delivery of services consistent with these values, principles, and goals:

1. ***Accessibility of Network***: Network sufficiency supports choice in individualized member care and availability of services. Provider networks are developed to meet the unique needs of members with a focus on accessibility of services for aging members and members with disabilities, cultural preferences, and individual health care needs. Services are available to the same degree as services for individuals not eligible for AHCCCS.

2. ***Collaboration with Stakeholders***: Ongoing collaboration with members' families, service providers, community advocates, and AHCCCS Contractors plays an important role for the continuous improvement of the ALTCS Program.

3. ***Consistency of Services***: Development of network accessibility and availability of services to ensure delivery, quality, and continuity of services in accordance with the Person-Centered Service Plan (PCSP) as agreed to by the member and the Contractor.

4. ***Member-Centered Case Management***: Members are the primary focus of the ALTCS Program. The member and family/representative, as appropriate, are active participants in the planning for and the evaluation of the provision of LTSS. Services are mutually selected through person-centered planning to assist the member in attaining their individually identified goals. Education and up-to-date information about the ALTCS program, choices of options, and mix of services shall be readily available to members.

5. ***Member-Directed Options***: To the maximum extent possible, members are to be afforded the opportunity to exercise responsibilities in managing their personal health and development by making informed decisions about how best to have needs met including who will provide the service and when and how the services will be provided.

6. ***Most Integrated Setting***: Members are to live in the most integrated and least restrictive setting and have full access to the benefits of community living. To that end, members are to be afforded the choice of living in their own home or choosing an Alternative Home and Community Based Service (HCBS) Setting rather than residing in an institution.

7. ***Person-Centered Service Planning***: The PCSP process maximizes member-direction and supports the member to make informed decisions, so that they can lead/participate in the PCSP process to the fullest extent possible. The AHCCCS PCSP safeguards against unjustified restrictions of member rights and ensures that members are provided with the necessary information and supports to gain full access to the benefits of community living to the greatest extent possible. The Plan ensures responsiveness to the member's needs and choices regarding service delivery and individual goals and preferences. The member and family/representative shall have immediate access to the member's PCSP. Refer to AMPM Exhibit 1620-10.

The Arizona Association of Health Plans: To assist in reducing the burden placed on providers and to enhance Contractor collaboration, the Contractor is required to be a member of the Arizona Association of Health Plans (AzAHP). AzAHP is an organization dedicated to working with elected officials, AHCCCS, MCOs, health care providers, and consumers to keep quality health care available and affordable for all Arizonans.

2. ELIGIBILITY

The Contractor is not responsible for determining eligibility.

Financial Eligibility: Anyone may apply for ALTCS at any of the ALTCS eligibility offices located throughout the State. The applicant shall be an Arizona resident as well as a U.S. citizen or qualified legal immigrant as defined in A.R.S. § 36-2903.03. To qualify financially for the ALTCS Program, applicants shall have countable income and resources below certain thresholds. AHCCCS Medical Assistance Eligibility Policy Manual provides a detailed discussion of all eligibility criteria. The Manual is available on the AHCCCS website.

INSTRUCTIONS TO OFFERORS TABLE OF CONTENTS

INTRODUCTION

This Request for Proposal (RFP) solicits participation by Managed Care Organization Offerors to provide covered health care services to members who are elderly and/or have a physical disability (E/PD) and who are enrolled in the ALTCS E/PD Program. Covered services are to be provided in a managed care environment with reimbursement to Offerors awarded contracts on a capitated rate basis.

All Successful Offerors 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 Areas (GSAs) in which they are awarded a Contract. Refer to Contract Section D, Paragraph 66, Medicare Requirements and Paragraph 22 of this Section for additional details regarding this requirement.

The Solicitation Process shall be in accordance with the *RFP and Contract Process* rules set forth in A.A.C. Title 9, Chapter 28 Article 6.

POLICIES

The Contract incorporates requirements specified in the RFP. To the extent possible, draft AHCCCS policies have been developed to reflect new or amended provisions and are posted to the Bidders' Library. Refer to Paragraph 17, Bidders' Library in this Section.

DEFINITIONS

Best and Final Offer: A revision to an Offer submitted after negotiations are completed that contains the Offeror's most favorable terms for price, service, and products to be delivered. Sometimes referred to as a Final Proposal Revision.

Day: A calendar day, 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 business day.

Exhibit: Any item labeled as an Exhibit in the Solicitation or placed in the Exhibits section of the Solicitation.

Incumbent Contractor: An entity that is a party to State ALTCS E/PD Contract Number # YH18-0001 as of the date the Proposals are due under this RFP.

Offer: A response to a Solicitation. (Also referred to as a bid, response, or proposal)

Offeror: An entity who responds to a Solicitation.

Procurement Officer: The person, or their designee, duly authorized by the State and AHCCCS to enter into and administer Contracts and make written determinations with respect to the Contract.

Proposal: Refer to "Offer".

Solicitation: An Invitation for Bids ("IFB"), a Request for Proposals ("RFP"), or a Request for Quotations ("RFQ").

Solicitation Amendment: A written document that is authorized by the Procurement officer and issued for the purpose of making changes to the Solicitation.

Successful Incumbent Contractor: An Incumbent Contractor that is awarded a Contract for a specific GSA under this RFP where the Incumbent Contractor holds a Contract through September 30, 2023, in one or more of the same counties comprising the specific GSA(s) established for October 1, 2024.

Successful Offeror: A responsible and responsive Offeror awarded a Contract under this RFP.

Unsuccessful Offeror: An Incumbent Contractor that is not awarded a Contract for a specific GSA under this RFP where the Incumbent Contractor holds a Contract through September 30, 2023, in one or more of the same counties comprising the specific GSA(s) established for October 1, 2024.

RFP LAYOUT

The RFP document consists of requirements found in Sections A through I

Section A: Solicitation and Offer Page
Section B: Capitation Rates
Section C: Definitions
Section D: Program Requirements
Section E: Contract Terms and Conditions
Section F: Attachments
Attachment F1: Member Grievance and Appeal System Standards
Attachment F2: Provider claim Dispute Standards
Attachment F3: Contractor Chart of Deliverables
Section G: Representations and Certifications of Offeror Instructions and Attestation
Section H: Instructions to Offerors
Section I: Exhibits
Exhibit A: Offeror's Checklist
Exhibit B: Offeror's Bid Choice Form
Exhibit C: AHCCCS Questions and Answers Form
Exhibit D: Offeror's Intent to Bid
Exhibit E: Boycott of Israel Disclosure
Exhibit F: State Only Pregnancy Terminations
Exhibit G: Transition Requirements
Exhibit H: Narrative Submission Requirements
Exhibit I: Disclosure of Information

INSTRUCTIONS

1. PROSPECTIVE OFFERORS' INQUIRIES

Any inquiries related to this Solicitation shall be directed to the AHCCCS Procurement Officer listed in RFP Section A, Solicitation and Offer Page and as delineated in Paragraph 7, Amendments to RFP in this Section. Offerors shall not contact or ask questions of AHCCCS staff related to the RFP unless authorized by the AHCCCS Chief Procurement Officer. Questions pertaining to the RFP shall be submitted in accordance with the schedule included in Paragraph 16, Anticipated Procurement Timeline in this Section or as otherwise specified in the RFP Bidders' Library. Questions shall be e-mailed to the AHCCCS Procurement Officer listed in RFP Section A, Solicitation and Offer Page utilizing RFP Section I, Exhibit C; Offerors shall not modify the format of this Template. AHCCCS will respond in writing to questions submitted through this process via a formal amendment to the RFP at its discretion. Refer to Paragraph 7, Amendments to RFP in this Section.

2. NO RIGHT TO RELY ON VERBAL RESPONSES

Any inquiry that results in changes to the Solicitation shall be answered solely through a written Solicitation Amendment. An Offeror may not rely on verbal responses to its inquiries.

3. PERSONS WITH DISABILITIES

Persons with a disability may request reasonable accommodation, such as a sign language interpreter, by contacting the AHCCCS Procurement Officer listed in RFP Section A, Solicitation and Offer Page. Requests shall be made as early as possible to allow time to arrange the accommodation.

4. PROPOSAL OPENING

After the deadline for submitting Proposals, AHCCCS may open Proposals publicly and announce and record the names of the Offerors, or alternatively open proposals and post the names of the Offerors on the AHCCCS public website. Proposals will not be available for public inspection until after Contract Award.

5. LATE PROPOSALS

Late Proposals received after 3:00 p.m. Arizona Time on October 2, 2023, will not be considered.

6. WITHDRAWAL OF PROPOSAL

At any time prior to the Proposal due date and time, the Offeror may withdraw any previously submitted Proposal. Withdrawals shall be provided in writing and submitted to the AHCCCS Procurement Officer listed in RFP Section A, Solicitation and Offer Page. Proposals cannot be withdrawn after the published due date and time.

7. AMENDMENTS TO RFP

AHCCCS may issue amendments to the RFP subsequent to the issue date of this Solicitation on its own initiative. AHCCCS will respond in writing to questions submitted through the process described in Paragraph 1, Prospective Offerors' Inquiries in this Section via a formal amendment to the RFP in accordance with the procurement timeline. AHCCCS is under no obligation to answer all questions submitted. The Offeror shall acknowledge all amendments to the RFP by signing the signature page of each amendment and by submitting to AHCCCS all signed signature pages with the Offeror's Proposal.

8. EVALUATION FACTORS AND SELECTION PROCESS

In accordance with A.R.S. § 36-2903 et seq., awards shall be made to the responsible Offeror(s) whose Proposal is determined in writing to be the most advantageous to the state based upon the evaluation criteria.

Proposals will be evaluated based upon the ability of the offeror to satisfy the requirements of the RFP in a cost-effective manner. The scored portions of the evaluation are listed in their relative order of importance.

1. Programmatic Submission Requirements
2. Financial Submission Requirements

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 with the exception of past performance. 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. 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 scoring.

It is critical that the Offeror recognizes the importance of all contractual provisions and their value to the AHCCCS Program. The RFP Submission Requirements address limited subject matter areas; however, the importance of topics not addressed in the Submission Requirements are not to be minimized. Regardless of whether or not a particular topic is presented in the Submission Requirements, a Successful Offeror is required to comply with all contractual provisions as acknowledged by the Offeror's submittal of a signed Proposal.

The final decision regarding the particular Offerors awarded Contracts will be made by AHCCCS. The decision will be guided, but not bound, by the scores awarded by the evaluators. AHCCCS will make its decision based on a determination of which Proposals are deemed to be most advantageous to the State and in accordance with Paragraph 11, Award of Contract, in this Section.

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

- Potential disruption to members, and/or
- An Offeror who has performed in a satisfactory manner (in the interest of continuity of care), and/or
- An Offeror who participates satisfactorily in other lines of AHCCCS business, and/or
- An Offeror's past performance with AHCCCS, and/or
- An Offeror's past Medicare performance, and/or
- The nature, frequency, and significance of any compliance actions, and/or
- Any convictions or civil judgments entered against the Offeror's organization, and/or
- Administrative burden to the Agency.

If awarded a Contract, the Offeror shall meet all AHCCCS requirements, irrespective of what is requested and evaluated through this Solicitation. The Proposal submitted by the Offeror will become part of the Contract with AHCCCS and the Offeror shall comply with all commitments and statements included in its RFP submission.

AHCCCS anticipates utilizing the Offerors' past performance when evaluating the Offeror's Proposal.

Programmatic and Finance Requirements will be evaluated and weighted. The Capitation Agreement/Administrative Cost Bid will be scored for each Offeror and the score for that Offeror will be applied to all GSAs bid by that Offeror. The Case Management Cost Bid will be scored by GSA for each Offeror. With the exception of Narrative Submission Requirements noted as a non-scored item and Narratives that are noted as GSA-specific, Narrative Submission Requirements will be scored for each Offeror and the score for that Offeror will be applied to all GSAs bid.

9. CLARIFICATION OF OFFERS

AHCCCS may request clarification of an offer any time after the Proposal due date and time. Clarifications may be requested orally or in writing. If clarifications are requested orally, the Offeror shall confirm the request in writing. A request for clarification shall not be considered a determination that the Offeror is susceptible for award.

10. READINESS REVIEW

AHCCCS will conduct readiness reviews to evaluate the Successful Offerors' ability to implement the terms of the Contract. Readiness reviews, which will begin after Contract award, assess Successful Offerors' ability to provide covered services to members at the start of the program and medical service implementation date. Refer to Paragraph 16, Anticipated Procurement Timeline in this Section.

In the event AHCCCS determines that a Successful Offeror fails to meet readiness requirements, AHCCCS reserves the right to:

a. Impose Administrative Action(s), and/or
b. Negotiate with Contractors under the ALTCS E/PD Contract #YH18-0001 to extend service provision until a time specified by AHCCCS.

AHCCCS may incorporate an Information Technology Demonstration (IT Demo) in May or June 2024, as part of the readiness review, where Successful Offerors will be required to participate in the IT demonstration utilizing mock data running through PMMIS. The IT demonstration will encompass up to a 30-day cycle in order to incorporate a full month of PMMIS activity.

Successful Offerors may be subject to onsite review(s) as part of readiness reviews to determine the adequacy of Successful Offerors' infrastructure to support the provision of services to the population for the awarded GSA(s).

The Successful Offeror shall ensure it has a comprehensive network that complies with all network sufficiency standards as specified in Contract and ACOM Policy 436, no later than June 1, 2024 [42 CFR 438.207(b)-(c)]. Provider contracts supporting network sufficiency shall be finalized, executed, and loaded with contracted fee schedules prior to the start of this Contract. Regular reporting will be required throughout the readiness process.

Successful Offerors will be required to provide transition updates telephonically and/or through ad-hoc deliverables as well as attend meetings after the October 1, 2024, transition date. These meetings will be scheduled approximately every six weeks. However, the meetings may be held more frequently. Agenda items discussed at these meetings will include, but not be limited to, updates on the transition, key transition indicators, grievance, appeal, and complaint information, and updates on commitments specified in the Offeror's RFP submission.

11. AWARD OF CONTRACT

AHCCCS shall award a Contract or Contracts to the responsible and responsive Offeror(s) whose Proposal is determined most advantageous to the State.

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 the Solicitation.

A Proposal submitted in response to this RFP is an offer to contract with AHCCCS based upon the terms, conditions, scope of work (Program Requirements), and specifications of the RFP. The Proposal submitted by the Offeror will become part of the Contract with AHCCCS. A Contract is formed when the AHCCCS Procurement 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 the Contract award.

AHCCCS will award Contracts in each GSA to Successful Offerors in the best interest of the State.

No capped enrollment contracts will be awarded.

Each Offeror shall elect to bid on all three GSAs and indicate the order of preference for GSAs to be awarded. Refer to Section I, Exhibit B: Offeror's Bid Choice Form.

The three GSAs are specified below:

GEOGRAPHIC SERVICES AREAS
North GSA Mohave/Coconino/Apache/Navajo/Yavapai
South GSA Cochise/Graham/Greenlee/ La Paz/Pima/Santa Cruz/Yuma (Including zip codes 85542, 85192, and 85550)
Central GSA Maricopa/Gila/Pinal (Excluding zip codes 85542, 85192, and 85550)

AHCCCS anticipates awarding a maximum of two Contractors in the North GSA, a maximum of two Contractors in the South GSA, and a maximum of three Contractors in the Central GSA.

A Successful Offeror may be awarded a Contract as follows, except as otherwise determined by AHCCCS and in the best interest of the state:

a. Both the Central GSA and the North GSA,
b. Both the Central GSA and the South GSA,
c. The Central GSA, the South GSA, and the North GSA, or
d. The Central GSA only.

AHCCCS will not award the South GSA only or the North GSA only. AHCCCS will not make an award specific to Pima County; but will award the South GSA which will include all seven counties identified above.

AHCCCS intends to make a total of three awards for this RFP, awarding GSAs based upon the winning bids in each GSA and may also consider Order of Preference indicated on Section I, Exhibit B: Offeror's Bid Choice Form. Awards may result in zero, one, or two statewide Contractors.

Offerors owned by the same parent organization shall not submit separate Proposals in response to the Solicitation; only one Proposal is permitted on behalf of all Offerors owned by the same parent organization. The one Proposal shall indicate a single legal entity name and bid for all GSAs.

In the event a protest or unforeseen circumstance delays the October 1, 2024, implementation in one or more GSAs, the current ALTCS E/PD Contractors shall be required to continue provision of services according to the terms of their existing Contract, until such time as determined by AHCCCS and in the best interest of the State.

12. REJECTION OF A PROPOSAL - RESPONSIBILITY, RESPONSIVENESS, SUSCEPTIBILITY, AND BEST INTEREST

In accordance with applicable procurement regulations and best practices, at any time after the Proposal due date and time or during the evaluation of the Proposal, AHCCCS may reject an Offer based upon a determination that Offeror is not responsible, or that the proposal is not responsive or not susceptible for award. AHCCCS may reject the Offer if doing so is in the best interest of the State.

For purposes of this Paragraph 12, Rejection of a Proposal – Responsibility, Responsiveness, Susceptibility, and Best Interest, Offeror is defined as an entity, including parent companies or subsidiaries of the entity, who responds to a Solicitation.

When rejecting a proposal, AHCCCS may consider any of the following:

a. Whether the Offeror has had a contract within the last five years that was terminated for cause due to breach or similar failure to comply with the terms of the contract,
b. Whether the Offeror has had a Contract that was terminated by AHCCCS for any reason,
c. Whether the Offeror's record of performance includes factual evidence of failure to satisfy the terms of the Offeror's agreements with any party to a contract. Factual evidence may consist of documented vendor performance reports, customer complaints, and/or negative references,
d. Whether the Offeror is legally qualified to contract with the State and the Offeror's financial, business, personnel, or other resources, including subcontractors. Legally qualified includes if the vendor or if key personnel have been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity, including but not limited to being disapproved as a subcontractor of any public procurement unit or other governmental body,
e. Whether the Offeror promptly supplied all requested information concerning its responsibility,
f. Whether the Offer was sufficient to permit evaluation by the State, in accordance with the evaluation criteria identified in this Solicitation or other necessary offer components. Necessary offer components include: attachments, documents or forms to be submitted with the offer, an indication of the intent to be bound, reasonable or acceptable approach to perform the Scope of Work (Program Requirements), acknowledged Solicitation Amendments, references to include experience verification, adequacy of financial/business/personal or other resources to include a performance bond and stability including subcontractors, and any other data specifically requested in the Solicitation,
g. Whether the Offer was in conformance with the requirements contained in the Scope of Work, Terms and Conditions, and Instructions for the Solicitation including its Amendments and all documents incorporated by reference,
h. Whether the Offer limits the rights of the State,
i. Whether the Offer includes, or is subject to, unreasonable conditions, to include conditions upon the State necessary for successful Contract performance. The State shall be the sole determiner as to the reasonableness of a condition,
j. Whether the Offer materially changes the contents set forth in the Solicitation, which includes the Scope of Work (Program Requirements), Terms and Conditions, or Instructions,
k. Whether the Offeror provides misleading or inaccurate information,
l. Whether the Offer fails to meet the minimum mandatory requirements of the RFP,
m. Whether the Offer satisfies the requirements of the RFP in a cost effective manner, as determined by AHCCCS,

n. Whether the Offeror's pricing is unrealistic, and/or unreasonably or unsubstantiatedly high, and/or excessive when compared to other bids submitted, or
o. Any other criteria deemed appropriate by AHCCCS to determine if the Offer is in the best interest of the State, and
p. AHCCCS may reject a Proposal from the Offeror before the date of Contracts Award if the Offeror is materially out of compliance with a Managed Care Contract with any governmental entity.

13. PROTESTS

Protests shall comply with the requirements set forth in A.A.C R9-28-601 et seq. and in particular A.A.C. R9-28-604. All protests shall be filed to the AHCCCS Procurement Officer in writing by email.

14. ENROLLMENT AND MEMBER TRANSITION AFTER CONTRACT AWARD

During the transition period, prior to October 1, 2024, AHCCCS intends to notify members of changes to assigned Contractors.

Successful Incumbent Contractors may not retain all members enrolled in their E/PD Contractor as of September 30, 2024.

If during the readiness review, AHCCCS determines the Successful Offeror is unprepared to receive membership, no members will be enrolled with the Contractor effective October 1, 2024.

If there is one or more Unsuccessful Incumbent Contractors in a GSA, AHCCCS will "selectively assign" the Unsuccessful Incumbent Contractor(s)' members to New and/or Successful Incumbent Contractor(s) applying the selective assignment method specified below. Additionally, because a choice of Contractor has not previously been an option for members in the North GSA and South GSA (excluding Pima County), in the event there is a Successful Incumbent Contractor for the North and South GSAs, AHCCCS will selectively assign a portion of the Successful Incumbent Contractor's members to the newly awarded Contractor, effective October 1, 2024.

Members assigned by AHCCCS to a Contractor will be offered a choice of Contractors with the member's health plan assignment notification.

AHCCCS intends to selectively assign members in June 2024, with a choice of Contractor offered to members in July 2024. Contractor changes will be effective October 1, 2024. Any members who do not exercise choice will remain with the Contractor to which they were selectively assigned. AHCCCS will notify Contractors of the transition process and timelines as soon as possible after Contract awards.

Selective assignment will be based upon consideration of all of the following factors:
a. The provider network which best aligns with the member's service provider(s):
    i. In-home service providers,
    ii. Alternative HCBS providers,
    iii. Nursing facility providers,
b. Successful Offeror(s) with the least number of members within the GSA, and
c. D-SNP Enrollment (for dual eligible members only).

During the selective assignment process, AHCCCS may identify that there is no Successful Offeror which is contracted with providers of in-home, alternative HCBS, or Nursing Facility services for specific members. In this case, AHCCCS will work with the Successful Offeror(s) in an effort to preserve member services and placement.

AHCCCS may consider other factors beyond those specified above consistent with the best interest of the member when determining which Contractor best aligns with the member's needs.

AHCCCS does not guarantee a minimum membership or equal distribution of member placement type at any time, including when members are selectively assigned.

Refer to Paragraph 22, Participation as a Medicare Advantage Dual Special Needs Plan (D-SNP) in this Section for information on member assignments related to Medicare Alignment.

Member Transition: A Successful Offeror shall provide a smooth transition for members that minimizes disruption and inconvenience. Successful Offerors are responsible for the continuation of member use of service providers and the provision of services as described in RFP Section I, Exhibit G, Transition Requirements. Additionally, a Successful Offeror shall provide education and information to members regarding the transition and what to expect as directed by AHCCCS.

AHCCCS will provide new Contractors with historical encounter data for members enrolled with the Contractor. Additional information regarding this data provision will be provided to Contractors post-Contract award. Contractors shall utilize this data for medical management purposes.

Successful Offerors shall designate a key staff person with appropriate training and experience to function as the Transition Coordinator as specified in Contract Section D, Paragraph 10, Transition Activities. The Transition Coordinator shall be available 24 hours a day, seven days a week to work on the post-award transition including urgent issue resolutions.

15. 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 (FFP). This Contract, and all subsequent amendments, shall be timely, completed, and signed by both AHCCCS and the Successful Offeror. The Successful Offeror shall ensure this Contract and all subsequent amendments are submitted to AHCCCS sufficiently in advance for submission to CMS prior to the effective date of the initial Contract and/or Contract amendments. AHCCCS will specify the date that signed Contracts and amendments are due. All public entity Offerors shall 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 (FFP) due to the Successful Offeror's failure to execute this Contract or a subsequent contract amendment within the timeframe prescribed by AHCCCS, in addition to any other remedies and/or sanctions, AHCCCS may deny or withhold payments to the Contractor until such time as CMS authorizes expenditure of FFP.

16. ANTICIPATED PROCUREMENT TIMELINE

The following is the anticipated schedule of events regarding the Solicitation process.

ANTICIPATED PROCUREMENT TIMELINE RFP YH24-0001	
DATE	**ACTIVITY**
August 1, 2023	**Issue RFP**
August 8, 2023	Prospective Offerors' First Set of Technical Assistance and RFP Questions Due by 5:00 p.m. Arizona Time
August 22, 2023	Prospective Offerors' Second Set of Technical Assistance and RFP Questions Due by 5:00 p.m. Arizona Time
August 31, 2023	Deadline to request access to the AHCCCS Secure File Share (ASFS) by 3:00 p.m. Arizona Time
October 2, 2023	**Proposals Due by 3:00 p.m. Arizona Time**
December 13, 2023	**Contract Award/Transition of Services Begin**
October 1, 2024	**Implementation/Effective Date**
Note: Dates and activities are subject to change.	

17. BIDDERS' LIBRARY

The Bidders' Library contains critical reference material, including but not limited to, AHCCCS policies, Offeror' Bid Choice Form, utilization and cost data, member data, and performance requirements to assist the Offeror to prepare a Proposal to this Solicitation. References are made throughout this Solicitation to materials in the Bidders' Library, and Offerors are responsible for reviewing the contents of the Bidders' Library materials as if the materials were printed in full herein. AHCCCS may continue to update the Bidders' Library after this Solicitation is issued; the Offeror is responsible for monitoring updates to the YH24-0001 – ALTCS EPD Bidders' Library.

18. MINIMUM CAPITALIZATION

The Successful Offeror is required to meet a minimum capitalization requirement for each GSA awarded. The Successful Offeror shall submit, within 30 days after notification of Contract award documentation, information substantiating that the minimum capitalization requirement per GSA has been met. Effective October 1, 2024, the ALTCS E/PD minimum capitalization may be applied to the Successful Offeror's equity per member standard, which continues throughout the term of the Contract. Refer to Contract Section D, Paragraph 48, Financial Reporting and Viability Standards.

Minimum Capitalization Requirements: Minimum capitalization requirements by GSA are as follows:

GSA	ALTCS E/PD MINIMUM CAPITALIZATION REQUIREMENT
North Mohave/Coconino/Apache/Navajo/ Yavapai	$2,300,000
South Cochise/Graham/Greenlee/ La Paz/Pima/Santa Cruz/Yuma	$6,200,000
Central Maricopa/Gila/Pinal	$11,600,000

New Offerors: 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.

Successful Incumbent Contractors: To be considered for an E/PD Contract award in a given GSA or group of GSAs, a Successful Incumbent Contractor shall meet the E/PD Minimum Capitalization Requirements listed above. If a Successful Incumbent Contractor's unrestricted equity as defined and restricted for the equity per member ratio in ACOM Policy 305, per GSA, meets the minimum capitalization listed above for the GSA within 30 days of Contract award, the Contractor will be considered to have met minimum capitalization. If a Successful Incumbent Contractor's unrestricted equity as defined and restricted for the equity per member ratio in ACOM Policy 305, per GSA, does not meet the minimum capitalization listed above for the GSA within 30 days of Contract award, the Successful Incumbent Contractor must fund, through capital contribution, the necessary amount to meet the minimum capitalization. Successful Incumbent Contractors that are awarded a GSA in which they do not hold a current Contract must provide the minimum capitalization requirement listed above for each new GSA, within 30 days of contract award. Any excess equity in an awarded GSA may be used to meet the minimum capitalization in another GSA.

This requirement is in addition to the Performance Bond requirements specified in Contract Section D, Paragraphs 44, Performance Bond or Bond Substitute, and Contract Section D, Paragraph 45, Amount of Performance Bond or Bond Substitute, and shall be met with cash with no encumbrances, such as a loan subject to repayment or other restrictions on equity specified in ACOM Policy 305.

19. CONTENTS OF OFFEROR'S PROPOSAL

If AHCCCS determines a Proposal to be non-responsive, AHCCCS may reject the proposal.

The Offeror's Proposal shall be organized with strict adherence to RFP Section I, Exhibit A, Offeror's Checklist and submitted using the forms and specifications provided in this RFP.

The Offeror shall submit its Offer via the ASFS. Instructions for access to the ASFS are included in RFP Section I, Exhibit D, The Offeror shall upload the Proposal to the secured location on the ASFS.

The deadline to request access to the ASFS specified in RFP Exhibit D, Offeror's Intent to Bid.

The Offeror shall submit the following electronically via the ASFS in its corresponding health plan folder by the date listed on RFP Section A, Solicitation and Offer Page:

a. Capitation Agreement/Administrative Cost Bid Submission: (1) Agreement Accepting Capitation Rates [pdf] (2) Non-Benefit (Administrative and Case Management) Costs Bid Workbook [Excel] (3) Actuarial Certification [pdf], and
b. One searchable PDF version of the Offeror's Executive Summary (RFP Part B1),
c. One searchable PDF version of the Offeror's Contract citations (RFP Part B2),
d. One searchable PDF version of the Offeror's Narrative Submission Requirements and corresponding responses (RFP Part B4-B10),
e. Oral Presentation participant names, titles, and resumes (RFP Part B12), and
f. One searchable PDF version of the Offeror's **entire** Proposal.

Upon upload of the Offeror's Proposal to the ASFS, the Offeror shall email notification to the AHCCCS Procurement Officer listed on RFP Section A, Solicitation and Offer Page. AHCCCS will provide email notification to the Offeror upon receipt of a document when received within normal business hours (8 a.m. to 5 p.m. Arizona Time). When received outside of normal business hours, email notification will be provided to the Offeror the next business day. Notification of receipt will be provided only to the contact person provided on the Offeror's Proposal, Section A, Solicitation and Offer Page, regardless of the individual who sent, or individuals cc'd on, the email. The notification shall serve *only* as confirmation that a document from the Offeror was received to the ASFS.

The email notification from AHCCCS does not confirm whether or not the document conforms to the material elements of the submission requirement(s) or whether or not the Offeror's Proposal qualifies as responsive.

Rejection of CONFIDENTIAL/PROPRIETARY Requests: AHCCCS will post all Proposals including Capitation Agreement/Administrative and Case Management Costs bids to the AHCCCS website once the Contract awards have been made. **The Offeror shall not designate any information to be confidential or proprietary in nature.** All pages will be disclosed regardless of their designation. The Offeror shall not submit any documents with headers or footers indicating any confidentiality or proprietary designation.

All Proposals shall be in Calibri 11-point font or larger with borders no less than ½". Unless otherwise specified, responses to each submission requirement shall be limited to the page limit specified for each submission requirement and be provided on 8½" x 11" one sided, single spaced, type written pages. Erasures, interlineations, or other manual modifications in the Proposal are prohibited. All pages of the Offeror's Proposal shall be numbered sequentially. Numbering of pages shall continue in sequence through each separate section. The Offeror shall clearly label each section of the Proposal and the Proposal shall contain all information requested in this Solicitation. When converting the Proposal to a PDF document, the PDF page numbering and the document page numbering shall align. The Proposal shall be submitted as a searchable PDF unless otherwise specified.

When submitting its Proposal, the Offeror shall ensure its company name and AHCCCS Solicitation Number is clearly indicated.

The Offeror has the discretion to include or exclude the narrative submission requirement text as a part of the Offeror's response; however, the required page limit applies regardless of whether or not the text is included. 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 Proposal. At no time will AHCCCS consider information outside the allotted page limit and permitted attachments, or any other information provided elsewhere in the Proposal 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 8, Evaluation Factors and Selection Process in this Section, 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 Offeror's 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.

All Proposals will become the property of AHCCCS. AHCCCS will not provide any reimbursement for the cost of developing or presenting Proposals in response to this RFP. Failure to include the requested information may have a negative impact on the evaluation of the Offeror's Proposal.

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

20. SUBMISSION REQUIREMENTS

The Offeror shall ensure its Proposal complies with, at a minimum, relevant statutes, rules, policies, the requirements specified in this RFP, and other referenced sources.

Refer to RFP Section I, Exhibit D: Offeror's Intent to Bid for additional requirements regarding electronic submission of the Offeror's Proposal via access to the AHCCCS Secure File Share (ASFS). **Failure to submit an Intent to Bid by the due date will disqualify any potential offeror from submitting a proposal for the Solicitation. The deadline to request access to the AHCCCS Secure File Share (ASFS) is as specified in RFP Section I, Exhibit D.**

If AHCCCS determines a Proposal to be non-responsive, AHCCCS may elect not to score the Proposal.

The Offeror's Proposal shall contain the following and be organized as follows:

PART A

A1 Offeror's Checklist (RFP Section I, Exhibit A)
A2 Completed and Signed Offeror's Intent to Bid (Section I, Exhibit D)
A3 Completed and Signed Solicitation Offer and Offer Page (RFP Section A)
A4 Completed and Signed Offeror's Bid Choice Form (Section I, Exhibit B)
A5 Completed and Signed Solicitation Amendment(s) (refer to Bidders' Library)

PART B

B1 Executive Summary (Refer to information below)
B2 Cite Contracts (Refer to information below)
B3 Health Equity Requirement (Refer to information below)
B4-B11 Narrative Submission Requirements (RFP Section I, Exhibit H)
B12 Oral Presentation Information (Refer to information below)

PART C

C1 Agreement Accepting Capitation Rates (Refer to information below)
C2 Administrative Cost Component Bid (Refer to information below)
C3 Case Management Cost Component Bid (Refer to information below)
C4 Actuarial Certification (Refer to information below)

PART D

D1 Intent to Provide Insurance (Refer to information below)
D2 Representations and Certifications of Offeror and Disclosure of Information Instructions and Attestation (RFP Section G)
D3 Boycott of Israel Disclosure (RFP Section I, Exhibit E)
D4 Moral or Religious Objections (Refer to information below)
D5 State Only Pregnancy Terminations Agreement (RFP Section I, Exhibit F)
D6 Disclosure of Information (RFP Section I, Exhibit I)

❖ PART B

Narrative Submission Requirements (B1-B11): The Offeror is required to respond to the Narrative Submission Requirements found in RFP Section I, Exhibit H utilizing the instructions specified in Paragraph 19, Contents of Offeror's Proposal in this Section, and the additional instructions below.

B2 – Cite Contracts: Refer to Section I, Exhibit H for submission requirements and submit utilizing the following format (1-page limit):

	MCO NAME AND NUMBER OF CONTRACT	NAME OF PROGRAM	STATE
1.			
Description:			

	MCO NAME AND NUMBER OF CONTRACT	NAME OF PROGRAM	STATE
2.			
Description:			

	MCO NAME AND NUMBER OF CONTRACT	NAME OF PROGRAM	STATE
3.			
Description:			

B10 – Compliance Reviews (Submission is required for Non-Incumbent Offerors only): Refer to Section I, Exhibit H for submission requirements and submit utilizing the following format:

	CORRESPONDING NAME AND CONTRACT NUMBER FROM B2
1.	
Description:	

B11 – D-SNP STAR Rating: Refer to Section I, Exhibit H for submission requirements and submit utilizing the following format:

	MEDICARE PLAN NAME	MEDICARE CONTRACT NUMBER	CORRESPONDING CONTRACT FROM B2	TYPE OF PLAN (FIDE/DSNP; SNP; MEDICARE ADVANTAGE)	STAR RATING
1.					

B12 - ***Oral Presentation Information***: Offerors shall participate in a scheduled oral presentation pertaining to key areas of the ALTCS E/PD Program. Oral presentations will be in-person; however, AHCCCS reserves the right to change from in-person oral presentations to use of a virtual format. Should AHCCCS change to use of a virtual format for oral presentations, all Offeror's participants may be required to be in attendance in one room and on video for the duration of the oral presentation session and all requirements below shall apply.

All oral presentations will be scheduled to occur during the weeks of October 23 and October 30, 2023. Presentations may be audio-taped by AHCCCS for the Agency's use in the evaluation process. Audio-taped oral presentations will be published on the AHCCCS website once the Contract awards have been made. AHCCCS will notify each Offeror of its scheduled 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 individuals with expertise in:

- Medical Management,
- Case Management, and
- Quality Management

The Offeror will not be permitted to distribute previously prepared presentations or materials to AHCCCS. The Offeror may bring a laptop for accessing and referencing materials including but not limited to policies and procedures. The Offeror will not be permitted to utilize a laptop for presenting Oral Presentations. Additionally, the Offeror shall supply its own internet connection. Cell phones are not allowed in the room; therefore, the Offeror shall not rely on utilization of a cell phone for internet connection. Outside communication (e.g., cell phones, instant messaging, email, text messaging) is prohibited for the duration of the oral presentations. The Offeror is also permitted to utilize any hard copy reference material brought with them. AHCCCS will provide a whiteboard or flip charts and markers for Offeror use in preparing for the Oral Presentation.

AHCCCS may have staff in the room at all times for the oral presentation process including during presentation preparation, whether in-person or virtual, to ensure compliance with these requirements.

The Offeror shall submit with its Proposal a list of names and titles along with resumes of the participating individuals in accordance with Paragraph 19, Contents of Offeror's Proposal in this Section.

❖ **PART C**

AHCCCS' actuaries will develop components of the capitation rates including the medical services component, share of cost offset, reinsurance offset, underwriting gain, and premium tax. These components will not be bid by the Offeror. The capitation rates developed by the AHCCCS actuaries will be actuarially sound according to the applicable provisions of 42 CFR Part 438 and applicable Actuarial Standards of Practice and will follow Generally Accepted Actuarial Principles and Methodologies.

Data Supplement: AHCCCS has provided Offerors with an RFP Data Supplement file on the Bidders' Library and ASFS within each Offeror's folder for informational purposes. The Offeror shall not consider the Data Supplement the sole source of information in making decisions. Refer to the Bidders' Library section Data Supplement for Offerors.

The complete capitation rates will be published by AHCCCS prior to October 1, 2024. Refer to the Bidders' Library section Data Supplement for Offerors, Section F, Rate Development Information.

C1 - ***Agreement to Accept Capitation Rates***: The Offeror shall submit an agreement that the Offeror will accept the actuarially sound capitation rates computed prior to October 1, 2024. The agreement shall be signed by the Offeror's Chief Executive Officer. This is a required submission.

AHCCCS intends to set the underwriting gain equal to one percent of the capitation rate for each risk group excluding premium tax.

Administrative and case management cost components will be bid by the Offerors. AHCCCS may use these bids in developing capitation rates; however, AHCCCS reserves the right to adjust the capitation rates, including the administrative and case management cost components, to maintain compliance with the Medicaid and CHIP Managed Care Final Rule and additional guidance from CMS published annually in the Medicaid Managed Care Rate Development Guides.

If any moral or religious objections were submitted as part of the RFP, the Offeror shall not exclude from the administrative and case management bid submission(s) any related administrative and case management costs.

C2 - ***Administrative Cost Component Bid***: The Offeror shall bid on the administrative cost component of the capitation rates. The Offeror shall include an administrative bid for each membership tier. AHCCCS will include a Non-Benefit Costs Bid Submission workbook as well as instructions in Section F – Rate Development Information, found in the Bidder's Library, Data Supplement for Offerors. The Offeror shall submit a single Workbook in Excel to AHCCCS via the ASFS server in accordance with Paragraph 19, Contents of Offeror's Proposal in this Section.

C3 - ***Case Management Cost Component Bid***: The Offeror shall bid on the case management cost component of the capitation rates. The Offeror shall include a case management bid for each GSA where the Offeror is submitting a bid. AHCCCS will include a Non-Benefit Costs Bid Submission Workbook as well as instructions in Section F – Rate Development Information, found in the Bidder's Library, Data Supplement for Offerors. The Offeror shall submit a single Workbook in Excel to AHCCCS via the ASFS server in accordance with Paragraph 19, Contents of Offeror's Proposal in this Section.

C4 - ***Actuarial Certification***: The Offeror shall ensure that an actuary who is a member of the American Academy of Actuaries certifies that the Administrative and Case Management Cost Bid Submissions meets the requirements of 42 CFR 438.5(e) by submitting a signed actuarial certification of all rates submitted with the submission. Further detail regarding the requirements of the bids can be found in the Bidders' Library, Data Supplement, Section F - Rate Development Information in the Non-Benefit Costs Bid Requirements document.

AHCCCS reserves the right to request supporting documentation for any component of the Administrative and Case Management Costs Bid submission.

AHCCCS reserves the right to request Best and Final Offers. In the event AHCCCS exercises this right, all Offerors that submitted a Proposal that is susceptible to award may be asked to provide a Best and Final Offer. The State reserves the right to award a Contract on the basis of initial Proposals received; therefore, the Offeror is encouraged to submit its most competitive bid.

❖ PART D

D1 - ***Intent to Provide Certificate of Insurance***: The Offeror shall provide a brief statement that, if notified of contract award, the Offeror will submit to AHCCCS for review and acceptance, the applicable certificate/s of insurance as required within this RFP document, within ten (10) business days of such notification.

D2 - ***Representations and Certifications of Offeror and Disclosure of Information Instructions and Attestation***: The Offeror shall complete and submit RFP Section G. The Offeror shall complete Section I, Exhibit I, Disclosure of Information and submit to the AHCCCS Provider Enrollment Portal (APEP) per the MCO Instructions document referenced in RFP Section G.

D3 - ***Boycott of Israel Disclosure***: The Offeror shall complete and submit RFP Section I, Exhibit E.

D4 - ***Moral or Religious Objections***: The Contractor shall 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 submit a Proposal addressing members' access to the services. AHCCCS does not intend to offer the services on a Fee-For-Service basis to the Contractor's members. The Proposal shall be submitted to AHCCCS in writing as part of this submission. This submission will not be scored.

D5 - State Only Pregnancy Terminations Agreement: The Offeror shall complete and submit RFP Section I, Exhibit F.

21. PUBLIC RECORD

All Offers submitted and opened are public records and must be retained by the State for a period of time in accordance with the law. Offers shall be open and available to public inspection after Contract award in the procurement file which will be posted publicly on the AHCCCS website.

22. PARTICIPATION AS A MEDICARE ADVANTAGE DUAL SPECIAL NEEDS PLAN (D-SNP)

Successful Offerors are required to be organizations that contract with CMS to provide and manage Medicare benefits for dual eligible members in all Geographic Service Areas (GSAs) in which they are awarded a Contract. Refer to Contract Section D, Paragraph 66, Medicare Requirements for additional details regarding this requirement.

Successful Offerors will be required to offer Medicare benefits to Medicaid members who are also enrolled in Medicare (full benefit dual eligible members) through a State-contracted D-SNP for all counties in an E/PD Contractor's awarded GSAs. Successful Offerors will be required to implement companion Medicare Advantage Fully Integrated D-SNPs (FIDE SNPs) effective January 1, 2025. All Offerors are required to submit a non-binding Notice of Intent to Apply (NOIA) as a FIDE D-SNP to CMS on a date to be determined by CMS, but no later than the end of November 2023. Additional information and exact submission dates for Medicare Advantage Contract Year (CY) 2025 can be found on www.cms.gov.

Medicare Alignment: Effective January 1, 2025, full benefit dual eligible members may only be enrolled with a D-SNP that is aligned with their Medicaid health plan. Aligned enrollment means a Medicaid plan that is (1) the same organization as the D-SNP, (2) the D-SNP's parent organization, or (3) another entity owned and controlled by the D-SNP's parent organization as applicable to those full benefit dual eligibles who select enrollment in a Medicare Advantage FIDE SNP (refer to *FIDE SNP Exclusively Aligned Enrollment* below).Unaligned members will remain in Medicare FFS. Exclusively aligned enrollment will apply only to those E/PD Full Benefit Dual Eligibles (FBDEs) that choose to enroll in a FIDE SNP available in their GSA.

For each of the following CMS FIDE SNP requirements, it is AHCCCS' expectation that Offerors awarded contracts under this procurement shall have the appropriate expertise and resources necessary for effective implementation of the CMS FIDE SNP requirements by January 1, 2025.

Further information regarding AHCCCS' current State Medicaid Agency Contract (SMAC, or MIPPA Agreement) with its contracted FIDE SNPs is available on AHCCCS' Medicare D-SNPs webpage at https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/medicareagreements.html.

FIDE SNP Exclusively Aligned Enrollment: Effective January 1, 2025, AHCCCS-contracted companion Medicare Advantage (MA) Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) will be required to implement CMS' Exclusively Aligned Enrollment (EAE) requirements to be offered and available for enrollment to AHCCCS FBDE members under the contract awarded by this procurement.

Further information can be found in the CY2023 Medicare Advantage final rule as published in the May 9, 2022 edition of the *Federal Register*, available at https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf (pages 27742-27746 and 27894, not inclusive).

Successful Offerors under this procurement shall coordinate EAE implementation activities with AHCCCS and the CMS Medicare-Medicare Coordination Office (CMS MMCO) beginning at the time of contract award through January 1, 2025. It is anticipated that CMS MMCO will be releasing further EAE technical assistance guidance for all FIDE SNPs nationally, including AHCCCS-contracted FIDE-SNPs in the period prior to the January 1, 2025, EAE effective date.

FIDE SNP Unified Grievance and Appeals Procedures: As AHCCCS-contracted FIDE SNPs will be considered "applicable integrated plans" as defined per the CY2021 Medicare Advantage final rule. To meet these requirements, FIDE SNP unified grievance and appeals procedures – that combine Medicare and AHCCCS program grievance and appeals processes and requirements – shall be implemented for AHCCCS FBDEs enrolled in an awarded Contractor's companion FIDE SNP beginning January 1, 2025. Further information regarding applicable integrated plans' unified grievance and appeals procedures is available at https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/d-snps (refer to the unified grievance and appeals section).

FIDE SNP Integrated Member Materials: In support of CMS' exclusively aligned enrollment and unified grievance and appeals requirements beginning January 1, 2025, AHCCCS-contracted companion FIDE SNPs as awarded to contract awardees through this procurement shall provide enrolled AHCCCS FBDEs with a CMS- and AHCCCS- prior approved, integrated Medicare-Medicaid:

a. Member ID card,
b. Summary of Benefits,
c. Formulary,
d. Member Handbook, and
e. Provider and Pharmacy Directory,

Further information can be found in the CY2023 Medicare Advantage final rule as published in the May 9, 2022 edition of the *Federal Register*, available at https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf (page 27773, not inclusive).

Medicare Advantage FIDE SNP Supplemental Benefits: For FIDE SNP enrolled AHCCCS FBDEs, AHCCCS will require the following Medicare Advantage (MA) supplemental benefits to be offered, at a minimum, by Contractors awarded under this procurement, effective January 1, 2025. This listing of minimum MA supplemental benefits does not preclude Offerors from proposing additional other such supplemental benefits to enrolled AHCCCS FBDEs through its companion FIDE SNP. This requirement is for the offering of these services as MA FIDE SNP supplemental benefits only. AHCCCS will not prescribe the extent and amount of each such supplemental benefit to be available per enrolled FIDE SNP FBDE.

a. Dental services,
b. Hearing services,
c. Over-The-Counter (OTC) health products catalog, and monthly or quarterly benefit maximum amount(s),
d. Telehealth services,
e. Fitness Benefits, and
f. Vision services.

Each of the above minimum MA supplemental benefits shall be offered by the FIDE SNP beginning January 1, 2025, and be available for review on CMS' Medicare Plan Finder web pages beginning October 15, 2024.

Tentative CMS CY2025 Medicare Advantage Calendar: For Offerors' consideration, to include FIDE SNPs (subject to change by CMS):

TENTATIVE DUE DATE	MILESTONE ACTIVITY
Early November 2023	Applicants submit CY2025 Notice of Intent to Apply Form (NOIA) to CMS
Early December 2023	CMS User ID form due to CMS
Early January 2024	Final MA Applications Posted by CMS
Mid-January 2024	Deadline for NOIA form submission to CMS
Mid-February 2024	Completed MA Applications due to CMS (to include AHCCCS- or AzDIFI-executed CMS "State Certification Form," either/or as applicable)
April 2024	Plan Creation module, Plan Benefit Package (PBP), and Bid Pricing Tool (BPT) available on Health Plan Management System (HPMS)
Early May 2024	PBP/BPT Upload Module available in HPMS
Early May 2024	Release of CY 2025 Formulary Submission Module
1st Monday of June 2024	Bids due to CMS
Approx. July 1, 2024	SNP Modules and AHCCCS-executed State Medicaid Agency Contract (SMAC) due to CMS
Late August 2024	CMS completes review and approval of bid data
Early to Mid-September 2024	CMS executes MA and MA-PD contracts with approved bidders
October 15, 2024	CY2025 MA Annual Election Period (AEP) begins
December 7, 2024	CY2025 MA Annual Election Period (AEP) ends
January 1, 2025	CY2025 FIDE SNP operations begin

[END OF SECTION H: INSTRUCTIONS TO OFFERORS]

EXHIBIT H: NARRATIVE SUBMISSION REQUIREMENTS

NARRATIVE SUBMISSION REQUIREMENTS		
#	**PAGE LIMIT**	**REQUIREMENT**
B1	**2**	The Offeror shall provide an Executive Summary that includes: a. An overview of the organization, b. The Offeror's relevant experience providing healthcare for the population specified in this Solicitation, and c. A high-level description of the Offeror's proposed unique approach to meet Contract requirements. This submission may be used in whole or part by AHCCCS in public communications following Contract awards. **This submission will not be scored.**
B2	**1** **Refer also to RFP Section H, Instructions to Offerors for submission format requirements**	The Offeror shall identify no more than three contracts, including Arizona Medicaid contracts, which represent its experience in managing similar healthcare delivery systems to the ALTCS E/PD Program. The Offeror shall describe all programs for the contracts selected including those from Arizona. The description shall include but is not limited to geographic coverage, population served and enrollment, behavioral health/physical health integration status, years in program, and current contractual status. In response to the Narrative Submission Requirement that asks for the Offeror's experience as well as any other responses where experience is presented, the Offeror shall refer exclusively to the experience from the identified contracts in this response, and must always include Arizona experience, if applicable. Any contracts referenced in Narrative Submission Requirement responses which are not identified in this response will not be considered. **This submission will not be scored.**
B3	**N/A**	In each response for Narrative Submission Requirements (B4-B9) the Offeror shall include in its response how the Offeror will address health inequities, health disparities, and/or structural and health-related social needs and promote equitable member care.

NARRATIVE SUBMISSION REQUIREMENTS		
#	PAGE LIMIT	REQUIREMENT
B4	5	The ALTCS E/PD member population is complex, and their care often involves a combination of services and providers to effectively meet their needs. Provide a detailed description of how the Offeror will develop and implement best practices for ALTCS Case Managers, and leverage ALTCS Case Management staff to meet the needs of individuals with complex conditions, to: a. Decrease duplication of effort and enhance coordination of care with providers of physical and behavioral health services, b. Assist members prior to, and throughout transitions, c. Improve member engagement, d. Coordinate social and community support services, e. Identify, track, and manage outcomes for members with complex needs, f. Ensure appropriate identification of members that would benefit from High Needs Case Management and provide Case Management services in alignment with identified needs and reduce burden on members and families in coordinating member care. g. Monitor Case Manager performance and respond to identified issues, at the individual and system levels.
B5	4	How will the Offeror ensure that person-centered service planning: a. Includes active engagement with ALTCS members, b. Includes all aspects of quality of life, c. Is consistent with the individual's needs and wishes, d. Promotes access to services in home and community-based settings, and e. Results in high quality, equitable, and cost-effective person-centered care. Additionally, how will the Offeror monitor and evaluate the Case Manager and the member experience and satisfaction to demonstrate the Offeror's person-centered service planning process complies with the values and principles of person-centered thinking, planning, and practice?

NARRATIVE SUBMISSION REQUIREMENTS		
#	PAGE LIMIT	REQUIREMENT
B6	6	Provide a description of the types of data, including but not limited to performance metrics and data collected in partnership with members (e.g., data from member satisfaction surveys or member focus groups), the Offeror will collect, monitor, and analyze for the purposes of improving member health outcomes and informing program initiatives. Provide a detailed description of the processes utilized by the Offeror to inform and/or initiate improvement activities, including reporting tools, monitoring technologies, and/or partnerships, as well as processes used for member and population specific data analyses and MCO decision-making processes. The Offeror shall limit its response to the submission requirement to three pages of narrative and should include up to three, one-page sample utilization reports to demonstrate the Offeror's monitoring and analysis processes.
B7	4	Describe the Offeror's network development strategy, including methods to build Home and Community Based Services (HCBS) providers and institutional capacity in rural areas and maximize available resources. Also discuss specifically how the Offeror will assist rural nursing facilities seeking to expand into community-based care. Provide action steps and a timeline for the first three years of the Contract, along with measurable outcomes to be achieved. The action steps shall illustrate how the Offeror's operational areas will work in an integrated fashion to identify and address network needs.
B8	4	Describe the Offeror's overall workforce development strategy including the Offeror's workforce development philosophy, the use of data to inform strategies and monitoring activities to determine if strategies are effective, and achievement of desired outcomes. Additionally, the Offeror shall describe how the Offeror will: a. Assist and incentivize providers to improve workforce monitoring, assessing, planning, and forecasting workforce trends so that the provider can be more strategic in their efforts to recruit, select, train, deploy, and support their staff, b. Assist providers to improve post-training coaching and supervision to ensure the skills are applied and used effectively to improve member experience and outcomes, and c. Integrate the operations of the Offeror's workforce development function within the operations of the network, medical management, and quality management departments.

NARRATIVE SUBMISSION REQUIREMENTS		
#	PAGE LIMIT	REQUIREMENT
B9	4	Recent studies have shown that social, economic, and environmental conditions, in addition to health behaviors, can determine approximately 80% of health outcomes in the U.S. Given the Offerors' role in serving people with complex clinical, behavioral health, and social needs, it is critical to address social risk factors. For each of the following populations, describe how the Offeror will provide timely access to services and supports as well as monitor outcomes. The Offeror shall also identify its strategy(ies) for addressing potential barriers to care, as well as best practices to be implemented. a. Members residing in rural communities, b. Members residing in Tribal communities, c. Members in need of community resources, and Members in need of Peer and/or Family Support services.
B10	N/A except for Non-Incumbent Offerors For Non-Incumbent Offerors: Refer to (B10c) and RFP Section H, Instructions to Offerors for submission format requirements	Pursuant to 42 CFR 438.358 (b)(iii), Medicaid agencies must conduct compliance reviews of their contracted Managed Care Organizations at least every three years. AHCCCS will evaluate compliance reviews and incorporate the Offeror's past performance as specified below: a. **Incumbent E/PD Contractors** - A submission is not required. AHCCCS will utilize the AHCCCS Calendar Year (CY) 23 ALTCS E/PD Operational Review (OR), b. **Incumbent non-E/PD Contractors** - A submission is not required. AHCCCS will utilize the most recent finalized AHCCCS Operational Review (OR), and c. **Non-Incumbent Offerors** - The Offeror shall submit its most recent review(s) that together comprise a complete evaluation. The review(s) shall be selected from one of the Medicaid Contracts cited in B2 in compliance with 42 CFR 438.358 (b)(iii) for a business line which includes provision of services that are comparable to the Scope of Services for this RFP. The Offeror shall include a description of how the services delivered in the business line for the submitted compliance review are comparable to the Scope of Services for this RFP. The Offeror's submission shall not exceed one page plus attached compliance review(s). AHCCCS reserves the right to validate the submitted review.

NARRATIVE SUBMISSION REQUIREMENTS		
#	PAGE LIMIT	REQUIREMENT
B11	Refer to RFP Section H, Instructions to Offerors for submission format requirements	The Offeror shall submit its most recent AZ Medicaid Plan D-SNP STAR rating. If the Offeror does not have a D-SNP STAR Rating in Arizona, the Offeror shall cite its most recent STAR rating with the corresponding Medicare Contract Number, from one of the states for the Medicaid contracts cited in Submission Requirement B2, using the preference order detailed below. Preference order for STAR Rating from another State: a. FIDE SNP/DSNP Plan, b. Another type of SNP, or c. Medicare Advantage Plan.

[END OF EXHIBIT H: NARRATIVE SUBMISSION REQUIREMENTS]

[END OF SECTION I: EXHIBITS]

SOLICITATION AMENDMENT #1		
SOLICITATION #: **YH24-0001** **ALTCS E/PD RFP**	**SOLICITATION DUE DATE:** **OCTOBER 2, 2023** **3:00 PM ARIZONA TIME**	**PROCUREMENT OFFICER:** **MEGGAN LAPORTE** **RFPYH24-0001@AZAHCCCS.GOV**

A signed copy of this Amendment shall be submitted with the Offeror's Proposal.

This Amendment will be posted to the Bidders Library: https://azahcccs.gov/PlansProviders/HealthPlans/YH24-0001.html.

This Solicitation is amended as follows:

A. The attached Answers to Questions are incorporated as part of this Amendment.

B. This Solicitation is also amended as follows:

SECTION	YH24-0001 AMENDMENT
SECTION G - DISCLOSURE OF INFORMATION INSTRUCTIONS AND ATTESTATION	**Revised to correct hyperlink:** 3. Once APEP access is obtained, the Offeror shall upload all appropriate information into APEP. Refer also to the AHCCCS website for MCO instructions regarding the APEP application and its use: ~~https://azahcccs.gov/PlansProviders/APEP/APEPTraining.html~~ https://azahcccs.gov/PlansProviders/APEP/Resources.html

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	**SIGNATURE:** **SIGNATURE ON FILE**
TYPED NAME:	**TYPED NAME:** **MEGGAN LAPORTE, CPPO, MSW**
TITLE:	**TITLE:** **CHIEF PROCUREMENT OFFICER**
DATE:	**DATE:**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
1.	UnitedHealthcare Community Plan	August 8, 2023	Section H, Subsection 19	5	14	May graphics, tables and charts contain font sizes smaller than 11-point?	**Graphics, tables, and charts may be in a smaller font.**
2.	Arizona Complete Health	August 8th, 2023	Section H: Instructions to Offerors	1	14	This paragraph lists what PDFS need to be submitted i.e., RFP Part B1, RFP Part B2, RFP Part B4-B10. RFP Part B11 is not included in this listing. Should RFP Part B11 be included in the same PDF as RFP Part B4 – B10 or should RFP Part B11 be in a separate PDF file.	**RFP Part B11 should be included in the same PDF as RFP Part B4. The RFP is revised as follows:** The Offeror shall submit the following electronically via the ASFS in its corresponding health plan folder by the date listed on RFP Section A, Solicitation and Offer Page: a. Capitation Agreement/Administrative Cost Bid Submission: (1) Agreement Accepting Capitation Rates [pdf] (2) Non-Benefit (Administrative and Case Management) Costs Bid Workbook [Excel] (3) Actuarial Certification [pdf], and b. One searchable PDF version of the Offeror's Executive Summary (RFP Part B1), c. One searchable PDF version of the Offeror's Contract citations (RFP Part B2), d. One searchable PDF version of the Offeror's Narrative Submission Requirements and corresponding responses (RFP Part B4-~~B10~~ B11), e. Oral Presentation participant names, titles, and resumes (RFP Part B12), and f. One searchable PDF version of the Offeror's entire Proposal.
3.	Arizona Complete Health	August 8th, 2023	Section D: Program Requirements	4	68	Community Health Worker/Community Health Representative Services: This section refers to AMPM Policy 310-W. However, AMPM Policy 310-W is not listed on the AHCCCS website. Can AHCCCS provide this referenced policy?	**AMPM Policy 310-W is under development. The RFP is revised as follows:** Certified Community Health Worker/Community Health Representative Services: A certified Community Health Worker/Community Health Representative (CHW/CHR), who obtains certification through the Arizona Department of Health Services (ADHS) as specified in A.A.C. R9-16-802, may provide AHCCCS covered member education and preventive services to eligible members. ~~Refer to AMPM Policy 310-W.~~

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4.	Arizona Complete Health	August 8th, 2023	Section D: Program Requirements	3	83	Habilitation: This paragraph states that "This includes habilitation services such as Day Treatment and Training (also known as day program) for persons with disabilities and Supported Employment." Will the following forms of habilitation be considered a covered service for the ALTCS E/PD population 10/1/2024? Habilitation – Supported Employment (T2019), Prevocational Habilitation (T2047 or T2015), Educational Habilitation (T2013), Habilitation Support/IDLA (T2017), Specialized Habilitation/Supported Community Connections	**The RFP is revised as follows:** ***Habilitation***: A service encompassing the provision of training in independent living skills or special developmental skills, sensory-motor development, orientation, and mobility, and behavior intervention. Physical, occupational, or speech therapies may be provided as a part of or in conjunction with other habilitation services. This includes habilitation services such as ~~Day Treatment and Training (also known as day program) for persons with disabilities and~~ Supported Employment.
5.	Arizona Complete Health	August 8th, 2023	Section D: Program Requirements	3	83	Habilitation: Habilitation is listed as a covered LTSS service. However, AHCCCS AMPM 1240-E states that "Habilitation provider agencies shall be certified by DDD". Is it AHCCCS' intention that a habilitation provider serving only the E/PD population would still need to be certified by DDD?	**AMPM Policy 1240-E revisions are currently in development. Habilitation providers serving the EPD population will not require DDD certification.**

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6.	Arizona Complete Health	August 8th, 2023	Section D: Program Requirements	21	123	Regarding NCQA Accreditation, for a health plan newly entering the ALTCS program to achieve NCQA LTSS Distinction, even at the Interim level, the plan must be actively serving the population for at least six-months. The Program Requirements state, "*… Must also obtain the NCQA LTSS Distinction by October 1, 2024...*" This would not be possible for new entrants to achieve. Will the state change the requirement to achievement of NCQA LTSS Distinction by October 1, 2025?	**The RFP is revised as follows:** ***National Committee for Quality Assurance Accreditation***: The Contractor shall achieve NCQA First Health Plan Accreditation, inclusive of the NCQA Medicaid Module by October 1, 2023. For successful incumbent E/PD Contractors, the Contractor shall also obtain the NCQA LTSS Distinction by October 1, 2024. For successful incumbent non-E/PD Contractors and non-incumbent Offerors, the Contractor shall also obtain the NCQA LTSS Distinction by October 1, 2025. The Contractor shall also achieve NCQA Health Equity Accreditation by October 1, 2025.
7.	Arizona Complete Health	August 8th, 2023	Section D: Program Requirements	48	196	Administrative Costs Percentage: There is a typo here, we believe the phrase should be "Total administrative expenses divided by total payments received from AHCCCS **less** Reinsurance less premium tax". Can you please confirm this?	**The RFP is revised as follows:** Total administrative expenses divided by total payments received from AHCCCS less ~~Reinsurance~~ premium tax. All components of the calculation should include annual audit adjustments.
8.	Arizona Complete Health	August 8th, 2023	Exhibit H: Narrative Submission Requirements, B7	N/A	3 of 5	For the term "community-based care" please clarify the service array that may be included in any Nursing Facility expansion activities.	**No additional information will be provided.**
9.	Arizona Complete Health	August 8th, 2023	Non-Benefit Costs Bid Requirements/ Submission	N/A	N/A	Submission Template has several tabs for the Admin Bid for varying membership assumptions. There is no distinction between GSAs on these tabs. Given there are underlying cost differences between the various GSAs, will AHCCCS adjust bid amounts for different GSA combinations that are awarded?	**AHCCCS will distribute the administrative PMPM associated with the membership tier that matches the expected enrollment for each plan across all awarded GSAs. AHCCCS may incorporate underlying cost differences in the populations between GSAs when determining the overall distribution, if such an adjustment is appropriate.**

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10.	Arizona Complete Health	August 8th, 2023	Non-Benefit Costs Bid Requirements/ Submission	N/A	N/A	The Non-Benefit Costs Bid Submission Template has one tab for the Case Management Bid with different inputs for each GSA. It does not specify which Contract Year this is for. Should this bid be for CYE 25 only, or the average for the length of the contract?	**This should be for CYE 25 only. The Offeror can provide additional information in its actuarial certification if it expects significant changes over time. For CYE 25, the only anticipated change from the bid is for adjusting member enrollment and mix percentages after awards have been set and final distribution of membership is known, unless there are changes made to AMPM Policy 1630 regarding the maximum caseloads allowed by setting. For contract years beyond CYE 25, the case management component will be modeled based on the underlying assumptions and updated for actual member mix, wage inflation, and any policy changes regarding maximum caseloads allowed for each setting.**
11.	Arizona Complete Health	August 8th, 2023	Section A: Solicitation Page and Offer – Acceptance	N/A	1	*Pre-Proposal Conference: A Pre-Proposal Conference has NOT been scheduled.* Does this mean there will not be a conference, or just that it has NOT been scheduled yet? Does AHCCCS intend to hold a bidder's conference?	**AHCCCS does not intend to hold a pre-proposal bidder's conference for this solicitation.**
12.	Arizona Complete Health	August 8th, 2023	Non-Benefit Costs Bid Requirements/Submission	N/A	N/A	What should each Offeror assume for the Dual/non-Dual mix for each GSA? There is a significant cost difference between these two populations and if each Offeror has a different assumption, it will significantly skew the scoring results.	**AHCCCS suggests using the historical information provided and stating your data, assumptions, and methodologies of the development of your bid in the actuarial certification.**
13.	Arizona Complete Health	August 8th, 2023	Exhibit H: Instructions to Offerors	20	16	Regarding B12 Oral Presentation Information: When does AHCCCS anticipate notifying offerors of oral presentations?	**AHCCCS anticipates notifying Offerors by Thursday, October 5, 2023.**
14.	BCBSAZ Health Choice	8/8/2023	B2			Could AHCCCS please confirm that the contracts listed in B2 include both is active and inactive contracts?	**Yes, the contracts listed for B2 can be active or inactive contracts.**

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15.	BCBSAZ Health Choice	8/8/2023	Section G & B2			Based on Section G of the RFP which requires Offerors to submit contract numbers can Offerors utilize experience, or a program associated with that contract number or previous contracts for the same program? (E.g., Health Choice has held an acute contract since the early 1990s. Would we be permitted to discuss experience from both the acute and ACC contracts throughout the narrative responses if we list the contract number for the current ACC in B2?)	**The RFP Submission Requirement B2 is revised as follows:** The Offeror shall identify no more than three contracts, ~~including~~ in addition to Arizona Medicaid contracts, which represent its experience in managing similar healthcare delivery systems to the ALTCS E/PD Program.
16.	BCBSAZ Health Choice	8/8/2023	B2			Could AHCCCS please confirm that the one-page limit is cumulative across all three contracts? (Or is AHCCCS requesting a discrete one-page description for each of the three contracts?	**The one-page limit is cumulative across all three listed contracts. AHCCCS is not requesting a discrete one-page description for each of the three contracts.**
17.	BCBSAZ Health Choice	8/8/2023	B2			Could AHCCCS please confirm that an offeror may discuss best practices and programs (as opposed to contract "experience") from other affiliated organizations and programs even if those contracts were not listed in B2. (E.g., If Health Choice has adopted a best practice from our BCBSAZ Medicare plan.)	**Regarding the example provided ("E.g., If Health Choice has adopted a best practice from our BCBSAZ Medicare plan"), best practices and programs that have been adopted and implemented will be considered as experience and must be from the contracts cited in B2.**
18.	BCBSAZ Health Choice	8/8/2023	B4			Could AHCCCS please confirm that "ALTCS case managers" are the offeror's case managers? (As opposed to provider case managers or AHCCCS' own internal team.)	**In RFP Narrative B4, AHCCCS is not referring to AHCCCS' own internal team.**
19.	BCBSAZ Health Choice	8/8/2023	B7			Would AHCCCS be willing to provide member PCP information and Behavioral Health Home on Member Placement Detail file?	**This information will not be provided at this time. The information may be provided to Successful Offerors during readiness and transition post-award.**

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20.	BCBSAZ Health Choice	8/8/2023	Member Placement Detail file			Would AHCCCS be willing to provide race, language preference, and ethnicity data?	**This information will not be provided.**
21.	BCBSAZ Health Choice	8/8/2023	Member Placement Detail file			Would AHCCCS be willing to provide a PRFO utilization data file?	**Assuming PRFO in this question refers to Peer or Family Run Organizations, this information will not be provided at this time. The information may be provided to Successful Offerors during readiness and transition post-award.**
22.	BCBSAZ Health Choice	8/8/2023	B10			Please confirm that an MCO currently serving in the ACC program is considered a "(b) Incumbent non-E/PD Contractor."	**An "incumbent non-E/PD Contractor" includes ACC Contractors and ACC-RBHA Contractors.**
23.	BCBSAZ Health Choice	8/8/2023	B10			Has AHCCCS published the Operational Review Contract Report for the most recently completed OR results that will be used in the bid scoring? If not, would AHCCCS be willing to provide this information?	**AHCCCS will not be providing scoring or weighting details.**
24.	BCBSAZ Health Choice	8/8/2023	B11			Will there be a difference in weight for Arizona DSNP Star Ratings versus non-Arizona DSNP Star Ratings or AZ MA Plans? If so, would AHCCCS be willing to provide the different weights?	**AHCCCS will not be providing scoring or weighting details.**

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25.	BCBSAZ Health Choice	8/8/2023	Solicitation. (Page 8, Section H: Instruction to Offerors		8	We recognize that AHCCCS is requiring that offerors who are owned by the same parent organization must submit a single proposal in response to the Solicitation. (Page 8, Section H: Instruction to Offerors.) Does this mean that the single offeror will be limited to using the experience and performance of the actual legal entity submitting the bid (e.g., Operating Review score under Narrative Submission B10 and contract experience under Narrative Submission B2) or will the offeror be given credit for the higher experience and/or performance of the two organizations?	**AHCCCS will not be providing scoring or weighting details.**
26.	BCBSAZ Health Choice	8/8/2023	ASFS Data Files			We noted that the Member Months in the Detail File do not appear to match the Member Count in the Member Placement Detail File. Would AHCCCS be willing to please identify the difference between the two data sets. Which one would AHCCCS prefer bidders to use for PMPM calculations?	**AHCCCS suggests bidders use member months for PMPM calculations. The difference between the member months file and the member placement file is the member months will count partial enrollment, while the member placement file provides information on member counts as of a specific point in time.**

	CYE 20	CYE 21	CYE 22	CYE 23
Member Months	349,239	321,368	315,085	78,977
Placement Total	349,113	320,560	312,745	78,393
Difference	**126**	**808**	**2,340**	**584**

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27.	BCBSAZ Health Choice	8/8/2023	ASFS Data Files			There are a total of 32,201 members labeled as "Not Placed" in the Member Placement Detail File. How would AHCCCS prefer that we treat these during the rate development process? Should they be classified as HCBS or institutional? Eighty percent HCBS and twenty percent institutional? CYE 20 / CYE 21 / CYE 22 / CYE 23 Not Placed 10,485 / 9,586 / 9,644 / 2,486	**The "Not Placed" members in the Placement Detail File are excluded when calculating the HCBS mix percentage, as described in the rate development documentation. The "Not Placed" members would be included in Member Months which are used to calculate the PMPMs and can be allocated based on the calculated HCBS mix percentage as a proxy for placement.**
28.	BCBSAZ Health Choice	8/8/2023	ASFS Data Files			Health Choice has reviewed prior year rate setting documents and have identified the Nursing Facility total dollars provided in the ASFS data look to be substantially lower than the base data in previous rate setting cycles. Would AHCCCS be willing to identify what components are not included in the data book that would account for this difference?	**The question is unclear regarding what exactly is being compared from previous rate setting documents to the ASFS data. All components are included in the data book.**
29.	BCBSAZ Health Choice	8/8/2023	ASFS Data Files			Would AHCCCS be willing to provide member data on the use of self-directed care versus non-self-directed care, including county, race, ethnicity, and language data?	**Offerors may refer to the AHCCCS CYE2022 HCBS Annual Report on the AHCCCS website for additional information:** https://www.azahcccs.gov/Resources/Reports/federal.html
30.	Mercy Care	08/08/2023	Section H, 19. Contents of Offeror's Proposal	6	13	Please advise if there is a file size limit for uploads to AHCCCS Secure File Share (ASFS)?	**There is no official document size limit for the ASFS, but excessively large documents may time out when loading. Additionally, the file name has a limit of 32 characters.**
31.	Mercy Care	08/08/2023	Section H, 19. Contents of Offeror's Proposal	5	14	Please advise if Bidders can exclude signed forms, attachments, cover, tables of content, etc. from the sequential numbering requirement?	**Yes, Offerors may exclude these items from the sequential page numbering requirements but please refer to the instructions to determine if these items count toward maximum page limits. Also, see answer to Question #39.**

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32.	Mercy Care	08/08/2023	Section I, Exhibit H, B9	1.c.	4	Considering that a member will be enrolled with Tribal ALTCS if he/she lives on or lived on a reservation prior to admission into an off-reservation facility, please provide clarification regarding "Members residing in tribal communities." Please confirm if these tribal communities are on a reservation and/or off-reservation?	**The RFP Submission Requirement B9 is revised as follows:** Recent studies have shown that social, economic, and environmental conditions, in addition to health behaviors, can determine approximately 80% of health outcomes in the U.S. Given the Offerors' role in serving people with complex clinical, behavioral health, and social needs, it is critical to address social risk factors. For each of the following populations, describe how the Offeror will provide timely access to services and supports as well as monitor outcomes. The Offeror shall also identify its strategy(ies) for addressing potential barriers to care, as well as best practices to be implemented. a. Members residing in rural communities, b. ~~Members residing in Tribal communities~~ Tribal members, c. Members in need of community resources, and d. Members in need of Peer and/or Family Support services.
33.	Mercy Care	08/08/2023	Section I, Exhibit H, B2	2	1	Is it expected if a Bidder wants to reference current ALTCS E/PD work, an ALTCS E/PD contract must be cited?	**In response to the Narrative Submission Requirements that ask for the Offeror's experience as well as any other responses where experience is presented, the Offeror shall refer exclusively to the experience from the identified contracts submitted for B2. Additionally, the RFP Submission Requirement B2 is revised as follows:** The Offeror shall identify no more than three contracts, ~~including~~ in addition to Arizona Medicaid contracts, which represent its experience in managing similar healthcare delivery systems to the ALTCS E/PD Program.
34.	Mercy Care	08/08/2023	Section I, Exhibit H, B2	2	1	Please confirm that AHCCCS Complete Care contractors whose contract was expanded to include integrated services for Title XIX/XXI eligible individuals with Serious Mental Illness (SMI) are permitted to respond to the full scope of this contract as a single cited contract.	**The RFP Submission Requirement B2 is revised as follows:** The Offeror shall identify no more than three contracts, ~~including~~ in addition to Arizona Medicaid contracts, which represent its experience in managing similar healthcare delivery systems to the ALTCS E/PD Program.

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35.	Mercy Care	08/08/2023	Section I, Exhibit H, B2 and B11	1	1 and 5	Non-incumbent bidders will be allowed to select contracts from markets with disparate characteristics from Arizona. How will AHCCCS evaluate "similar healthcare delivery systems to the ALTCS E/PD Program" and ensure equity in the evaluation process of experience and DSNP STAR Rating?	**AHCCCS will not be providing scoring or weighting details.**
36.	Mercy Care	08/08/2023	Section I, Exhibit C, B6	1	3	Considering there are multiple types of data included but not limited to performance metrics and data collected in partnership with members, in lieu of utilization reports are other one-page samples allowable to demonstrate the Offeror's monitoring and analysis process?	**Yes, Offerors may submit other one-page samples, in addition to or in lieu of utilization reports, to demonstrate their monitoring and analysis processes. The RFP Submission Requirement B6 is revised as follows:** The Offeror shall limit its response to the submission requirement to three pages of narrative and should include up to three, one-page sample utilization reports or other sample data to demonstrate the Offeror's monitoring and analysis processes.
37.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Part D, D4	RFP Section D, Moral or Religious Objections	59	The Offeror's Checklist, Part D, Section D4, requires bidders to identify Moral or Religious Objections. If bidders have no religious or moral objections, is a document required? If "yes," should bidders create their own?	**If bidders do not have religious or moral objections to submit for AHCCCS notification, the Offeror is not required to submit a document. The RFP is revised as follows:** **Moral or Religious Objections**: The ~~Contractor~~ Offeror shall notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. The ~~Contractor~~ Offeror may submit a Proposal addressing members' access to the services. AHCCCS does not intend to offer the services on a Fee-For-Service basis to the ~~Contractor~~ Offeror's members. The Proposal shall be submitted to AHCCCS in writing as part of this submission. This submission will not be scored. If the Offeror does not have a Moral or Religious Objection, the Offeror is not required to submit a document for this submission requirement.

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38.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Section H: Instructions to Offerors	Section 19. Contents of Offeror's Proposal	14	The instructions indicate that all proposals shall be in Calibri 11-point font or larger with borders no less than ½". Will AHCCCS allow a smaller, readable font size for graphics, callouts, and tables?	**Graphics, tables, and charts may be in a smaller font.**
39.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Section H: Instructions to Offerors	Section 19. Contents of Offeror's Proposal	14	The instructions indicate that all pages of the Offeror's Proposal shall be numbered sequentially, and that numbering of pages shall continue in sequence through each separate section. If we use Section Cover Sheets, are those excluded from the page limit and numbering?	**Yes, Offerors may exclude these items from the sequential page numbering requirements. Section Cover sheets do not count toward page limits. Also, see answer to Question #31.**

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40.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Exhibit H: Narrative Submission Requirement	B7	3	With the depth and accuracy required to thoroughly answer question B7, and page limits, would AHCCCS consider adding one page to the page limit?	**The page limit for submission requirement B7 will remain unchanged.**

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41.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Exhibit H: Narrative Submission Requirement	B6	3	Given the number of questions and subparts to each question in B6, would AHCCCS consider increasing the page limit for the response to 4 pages of narrative?	**The page limit for submission requirement B6 will remain unchanged.**
42.	Banner-University Care Advantage dba Banner-University Family Care	August 8, 2023	Exhibit H: Narrative Submission Requirement	B4	2	Question B4 identifies seven objectives. Are Offeror's asked to identify both best practices and Case Management (CM) initiatives related to the seven objectives? Or should these be treated as two separate questions to respond to? Give the number of objectives and subparts to the question, would AHCCCS consider adding an additional one or two pages?	**Offerors shall respond as needed to provide a comprehensive response to the question and meet the requirements of the RFP. The page limit for submission requirement B4 will remain unchanged.**
43.	EMAIL	N/A	N/A	N/A	N/A	Can you share any details about plans for CAHPs surveys in the future? Is there a timeframe when the 2023 ACC CAHPS will be completed?	**AHCCCS is currently in the process of conducting statewide CAHPS surveys for the adult population, child population, and the KidsCare program for 2023. The statewide CAHPS surveys do not include the ALTCS-EPD population; it is AHCCCS' expectation that results will be reported at the statewide level as well as at the ACC and DCS CHP population/line of business level. AHCCCS anticipates the 2023 statewide CAHPS surveys to be completed in March/April 2024.**

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44.	EMAIL	N/A	N/A	N/A	N/A	Can you confirm that AHCCCS did not conduct an Adult CAHPs survey for 2022?	**AHCCCS is confirming that a CAHPS survey was not conducted for the adult population in 2022; however, AHCCCS conducted a 2022 CAHPS survey for the KidsCare program.**

SOLICITATION AMENDMENT #2		
SOLICITATION #: **YH24-0001** **ALTCS E/PD RFP**	**SOLICITATION DUE DATE:** **OCTOBER 2, 2023** **3:00 PM ARIZONA TIME**	**PROCUREMENT OFFICER:** **MEGGAN LAPORTE** **RFPYH24-0001@AZAHCCCS.GOV**

A signed copy of this Amendment shall be submitted with the Offeror's Proposal.

This Amendment will be posted to the Bidders Library: https://azahcccs.gov/PlansProviders/HealthPlans/YH24-0001.html.

This Solicitation is amended as follows:

A. The attached Answers to Questions are incorporated as part of this Amendment.

B. This Solicitation is also amended as follows:

SECTION	YH24-0001 AMENDMENT
Exhibit A: Offeror's Checklist	

PART B	SUBMISSION REQUIREMENTS	
B1	Executive Summary 2-page limit	
B2	Cite Contracts 1-page limit - Utilize Template	
B3	Health Equity Requirement No submission required	
B4	5-page limit	
B5	~~4~~5-page limit	
B6	6-page limit 3 pages of narrative and up to 3, one-page sample utilization reports or other sample data	
B7	4-page limit	
B8	4-page limit	
B9	4-page limit	
B10	Compliance Reviews No submission required unless a Non-Incumbent Offeror Non-Incumbent Offerors - Utilize Template	
B11	D-SNP STAR Rating Utilize Template	
B12	Oral Presentation Information Participant Names, Titles, and Resumes	

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	**SIGNATURE:** **SIGNATURE ON FILE**
TYPED NAME:	**TYPED NAME:** **MEGGAN LAPORTE, CPPO, MSW**
TITLE:	**TITLE:** **CHIEF PROCUREMENT OFFICER**
DATE:	**DATE:**

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#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
1.	N/A	August 22, 2023	Exhibit H, B11	N/A	-	What year D-SNP STAR rating should be reported by the Offeror?	**RFP B11 is revised as shown below:** The Offeror shall submit its ~~most recent~~ 2023 AZ Medicaid Plan D-SNP STAR rating. If the Offeror does not have a D-SNP STAR Rating in Arizona, the Offeror shall cite its ~~most recent~~ 2023 STAR rating with the corresponding Medicare Contract Number, from one of the states for the Medicaid contracts cited in Submission Requirement B2, using the preference order detailed below. Preference order for STAR Rating from another State: a. FIDE SNP/DSNP Plan, b. Another type of SNP, or c. Medicare Advantage Plan.
2.	N/A	August 23, 2023	Section H, Part C, Cost Bid	N/A	-	The Capitation Agreement (C1) does not appear to include the accurate Underwriting gain for CYE24. Additionally, the Capitation Agreement (C1) requirements do not stipulate if/how an Offeror should account for moral or religious obligations.	**Section H Instructions to Offerors C1 is revised as follows:** C1 - Agreement to Accept Capitation Rates: The Offeror shall submit an agreement that the Offeror will accept the actuarially sound capitation rates computed prior to October 1, 2024. The agreement shall be signed by the Offeror's Chief Executive Officer. This is a required submission. For the CYE 24 rating period, AHCCCS set the ALTCS-EPD underwriting gain percentage equal to 1.45% of the

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#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
							capitation rates, excluding premium tax. AHCCCS may revise the applicable underwriting gain percentage as part of capitation rate development each year. ~~AHCCCS intends to set the underwriting gain equal to one percent of the capitation rate for each risk group excluding premium tax.~~ Administrative and case management cost components will be bid by the Offerors. AHCCCS may use these bids in developing capitation rates; however, AHCCCS reserves the right to adjust the capitation rates, including the administrative and case management cost components, to maintain compliance with the Medicaid and CHIP Managed Care Final Rule and additional guidance from CMS published annually in the Medicaid Managed Care Rate Development Guides. If any moral or religious objections were submitted as part of the RFP, the Offeror shall include in its Capitation Agreement a statement attesting that the Offeror did not exclude from the administrative and case management bid submission(s) any related administrative and case management costs.

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
3.	UnitedHealthcare Community Plan	August 22, 2023	Section I, Exhibit H	B2	1	Given the current requirement for all incumbent ALTCS Contractors to offer a FIDE-SNP under a SMAC with AHCCCS, please confirm that offerors may write to the companion FIDE-SNP experience and best practices in their response under their current AHCCCS Medicaid contract number and need not separately list their companion FIDE-SNP agreement in response to B2.	**The Offeror must list the FIDE-SNP in B2 if the Offeror writes to experience related to the FIDE-SNP contract.**
4.	UnitedHealthcare Community Plan	August 22, 2023	Section H	B12	19	If an oral presentation participant identified in our response becomes unavailable to attend, may we substitute another individual after our proposal is submitted?	**Yes, if an oral presentation participant becomes unavailable another individual may be substituted; however, the information for the newly added individual must be submitted to AHCCCS (i.e., name, title, and resume) as required by the RFP.**
5.	UnitedHealthcare Community Plan	August 22, 2023	Section H	N/A	N/A	The RFP does not specify whether AHCCCS will accept electronic or digital signatures. Please confirm that AHCCCS will accept a digital or electronically placed signature in place	**Yes, AHCCCS will accept a digital/electronically placed signature in place of a written signature for RFP documents requiring signature.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
						of a written signature for all documents requiring signature.	
6.	Arizona Complete Health	8/22/23	Section I: Exhibits Exhibit H	B7	3	Please advise if the action steps and timeline for the first three years of the contract begin on execution of the contract or contract go-live, I.e., Day One of member coverage.	**In reference to B7 submission requirement where it states: "Provide action steps and a timeline for the first three years of the Contract, along with measurable outcomes to be achieved," the action steps should focus on the contract start (execution) date.**
7.	Arizona Complete Health	8/22/23	Section D: Program Requirements	3	83	As a response to the first round of questions, in Amendment 1, AHCCCS made the following revisions: **Habilitation:** A service encompassing the provision of training in independent living skills or special developmental skills, sensory motor development, orientation, and mobility, and behavior intervention. Physical, occupational, or speech therapies may be provided as a part of or in conjunction with other habilitation services. This includes habilitation	**AHCCCS suggests the Offeror refer to AHCCCS policies and other materials as needed.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
						services such as ~~Day Treatment and Training (also known as day program) for persons with disabilities and~~ Supported Employment. The phrase "such as" implies that Supported Employment is just one example. What other types of habilitation will be included beyond Supported Employment?	
8.	Arizona Complete Health	8/22/23	Section D: Program Requirements	11	60	Does your policy allow for an ALTCS Tribal Member that lives on a reservation to be served by a non-Tribal ALTCS Contractor?	**No, per A.A.C. R9-28-415 Tribal members living on-reservation shall be enrolled with the tribe participating as an ALTCS Tribal program in the member's service area.**
9.	Arizona Complete Health	8/22/23	Non-Benefit Costs Bid Requirements/Submission	N/A	N/A	In response to Amendment 1 Questions and Responses Number 9, AHCCCS stated they "may incorporate underlying cost differences in the populations between GSAs when determining the overall distribution, if such an adjustment is appropriate." What about adjusting the overall total	**AHCCCS does not intend to adjust the overall total administrative cost bid itself as described in this question. If an Offeror believes that their admin costs would be impacted by being awarded a different GSA combo, they are welcome to include additional detail in their actuarial certification of the administrative rates. Offerors should bid based on their projected administrative need, whatever the Offeror determines that to be.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
						administrative cost bid itself? For example, the PMPM for 100,000 member months is likely to be different for the Central + South GSAs vs the Central + North GSAs. An Offeror would likely bid differently under those two scenarios. How does AHCCCS intend to adjust for this situation?	
10.	Arizona Complete Health	8/22/23	Section I: Exhibits Exhibit H	B2	1	The RFP submission requirement was revised as follows: The Offeror shall identify no more than three contracts in addition to Arizona Medicaid contracts, which represents its experience in managing similar healthcare delivery systems to the ALTCS E/PD Program. Given the one-page length and design of the form submission is it the intent of AHCCCS for bidders to not include AZ information, and only include that of three contracts which represent	**The Offeror shall list only the three contracts that are not Arizona Medicaid Contracts that it wishes to cite throughout its RFP response; the Offeror does not need to include Arizona Medicaid Contracts in its list.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
						its experience in managing similar healthcare delivery systems, or will AHCCCS provide a new form?	
11.	Mercy Care	08/22/2023	Section I, Exhibit H, B2	B2	1	The current B2 template allows for only three contracts to be cited. Amendment 1 infers that more than three contracts may be cited – Arizona contracts and other state contracts. Please provide clarification if Offerors can list all Arizona contracts and up to three additional non-Arizona contracts. If so, will a new B2 template be provided? If not, please clarify which contracts and how many are to be cited in the B2 template.	**The Offeror shall list only the three contracts that are not Arizona Medicaid Contracts that it wishes to cite throughout its RFP response; the Offeror does not need to include Arizona Medicaid Contracts in its list.**
12.	Mercy Care	08/22/2023	Section I, Exhibit H, B2	B2	1	Please confirm that, in response to B2, Offerors may cite data and experience of other plans also administered by Offeror's administrator.	**Any experience cited must be related to one of the three contracts listed, or Arizona Medicaid Contracts.**
13.	Mercy Care	08/22/2023	Section I, Exhibit A, Offeror's Checklist and		1 and 3	Please clarify the page limit requirement for narrative submission question B7. Section I,	**The page limit for B7 is 4 pages. The RFP Offeror's Checklist is revised to indicate a 4-page limit for item B7. The Offeror's Checklist will also be reposted to the**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
			Section I, Exhibit H, B7			Exhibit A, Offeror's Checklist indicates 5 pages and Section I, Exhibit H, B7 indicates 4 pages.	**Bidders' Library with the post of this RFP Amendment with this correction included.**
14.	BCBSAZ Health Choice	8/22/2023	B2			Thank you for the response to our questions regarding B2. Based on the revised language of the Narrative Submission Requirement, is an Offeror required to identify and describe their Arizona Medicaid contracts (both active and inactive) *plus* allowed to identify and describe up to three additional non-Arizona Medicaid contracts within the prescribed one-page limit? Or, instead, is the Offeror expected to identify and describe *only* the three additional non-Arizona Medicaid contracts (but the Offeror is allowed to cite and receive credit for their Arizona Medicaid experience in other narratives without	**The Offeror shall list only the three contracts that are not Arizona Medicaid Contracts that it wishes to cite throughout its RFP response; the Offeror does not need to include Arizona Medicaid Contracts in its list.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
						identifying and describing them in B2)?	
15.	BCBSAZ Health Choice	8/22/2023	B2			If the answer to the previous question is that Arizona Medicaid contracts must be identified and described, please clarify whether each Medicaid contract number is considered a separate contract, i.e., each individual contract number represents one of the three contract limit (e.g., ACC Contract YH19-0001 and Acute Care Contract YH14-0001 = 2 contracts) or whether continuing contracts are considered as one contract (e.g., ACC Contract YH19-0001 and Acute Care Contract YH14-0001 = 1 contract).	**The Offeror shall list only the three contracts that are not Arizona Medicaid Contracts that it wishes to cite throughout its RFP response; the Offeror does not need to include Arizona Medicaid Contracts in its list.**
16.	BCBSAZ Health Choice	8/22/2023	B2			Is an incumbent AHCCCS contractor's affiliated DSNP contract considered an "Arizona Medicaid contract" or should the DSNP be identified and described as one of the	**The Offeror must list the affiliated DSNP contract in B2 if the Offeror writes to experience related to the DSNP contract.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
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						three additional non-Arizona Medicaid contracts?	
17.	Banner-University Care Advantage dba Banner-University Family Care	August 22, 2023	Part B, B11	Exhibit H, Narrative Submission Requirements, B11	Exhibit H, Page 5, and Page 18 in the Instructions to Offerors	Given that projected STAR ratings for measurement year 2022 have been released, and the final ratings will be released in early October, would AHCCCS consider accepting the 2022 projected STAR ratings for B11, and validate the STAR rating using publicly available information? This would ensure the most current data is utilized.	**RFP B11 is revised as shown below:** The Offeror shall submit its ~~most recent~~ 2023 AZ Medicaid Plan D-SNP STAR rating. If the Offeror does not have a D-SNP STAR Rating in Arizona, the Offeror shall cite its ~~most recent~~ 2023 STAR rating with the corresponding Medicare Contract Number, from one of the states for the Medicaid contracts cited in Submission Requirement B2, using the preference order detailed below. Preference order for STAR Rating from another State: a. FIDE SNP/DSNP Plan, b. Another type of SNP, or c. Medicare Advantage Plan.
18.	Banner-University Care Advantage dba Banner-University Family Care	August 22, 2023	Exhibit H: Narrative Submission Requirement	Exhibit H, Narrative Submission Requirements, B6	3	Given the number of questions and size of utilization reports necessary to answer B6, would AHCCCS consider allowing Offerors to submit utilization reports as 3 attachments rather than 3 one-page screen shots of reports, which may be more difficult to read?	**The requirements for submitting sample reports for B6 will remain unchanged.**

RFP #YH24-0001 QUESTIONS AND RESPONSES TEMPLATE							
#	OFFEROR'S NAME	DATE OF SUBMISSION	RFP SECTION	PARAGRAPH NO.	PAGE NO.	OFFEROR'S QUESTION	AHCCCS RESPONSE
19.	Banner-University Care Advantage dba Banner-University Family Care	August 22, 2023	Section H: Instructions to Offerors	Instructions Section 19. Contents of Offeror's Proposal, related to Exhibit H: B7	14	The instructions indicate that the submission be provided in 8 ½" x 11" page size. Would AHCCCS allow an 8 ½" x 11" page in landscape orientation to be used for the action steps and timeline portion of B7?	**Yes.**

EXHIBIT A: OFFEROR'S CHECKLIST

The Offeror shall complete and submit the Offeror's Checklist as the initial pages of the Proposal. It is the Offeror's responsibility to ensure it has submitted all requirements in the RFP notwithstanding the items included in the Offeror's Checklist.

OFFEROR'S CHECKLIST ALTCS EPD RFP #YH24-0001		
	SUBMISSION REQUIREMENT	**OFFEROR'S PROPOSAL PAGE NO.**
PART A		
A1	Offeror's Checklist	
A2	Completed and Signed Offeror's Intent to Bid	
A3	Completed and Signed Solicitation Offer and Acceptance Offer Page	
A4	Completed and Signed Offeror's Bid Choice Form	
A5	Completed and Signed Solicitation Amendment(s)	
PART B	**SUBMISSION REQUIREMENTS**	
B1	Executive Summary 2-page limit	
B2	Cite Contracts 1-page limit - Utilize Template	
B3	Health Equity Requirement No submission required	
B4	5-page limit	
B5	4-page limit	
B6	6-page limit 3 pages of narrative and up to 3, one-page sample utilization reports or other sample data	
B7	4-page limit	
B8	4-page limit	
B9	4-page limit	
B10	Compliance Reviews No submission required unless a Non-Incumbent Offeror Non-Incumbent Offerors - Utilize Template	
B11	D-SNP STAR Rating Utilize Template	
B12	Oral Presentation Information Participant Names, Titles, and Resumes	
PART C	**CAPITATION AGREEMENT/ADMINISTRATIVE AND CASE MANAGEMENT COST COMPONENTS BID**	
C1	Agreement Accepting Capitation Rates	
C2	Administrative Cost Component Bid	
C3	Case Management Cost Component Bid	
C4	Actuarial Certification	
PART D		
D1	Intent to Provide Insurance	
D2	Representations and Certifications of Offeror and Disclosure of Information Instructions and Attestation	
D3	Boycott of Israel Disclosure	
D4	Moral or Religious Objections	
D5	State Only Pregnancy Terminations Agreement	

SOLICITATION AMENDMENT #3 ISSUED 9/8/2023		
SOLICITATION #: **YH24-0001** **ALTCS E/PD RFP**	**SOLICITATION DUE DATE:** **OCTOBER 2, 2023** **3:00 PM ARIZONA TIME**	**PROCUREMENT OFFICER:** **MEGGAN LAPORTE** **RFPYH24-0001@AZAHCCCS.GOV**

A signed copy of this Amendment shall be submitted with the Offeror's Proposal.

This Amendment will be posted to the Bidders Library:
https://azahcccs.gov/PlansProviders/HealthPlans/YH24-0001.html.

This Solicitation is amended as follows:

SECTION	YH24-0001 AMENDMENT
SECTION H: INSTRUCTIONS TO OFFERORS – DEFINITIONS	• Adding: ***Unsuccessful Offeror***: An Offeror that is not awarded a Contract under this RFP. • Revising: ***Unsuccessful Incumbent Offeror*:** An Incumbent Contractor that is not awarded a Contract for a specific GSA under this RFP where the Incumbent Contractor holds a Contract through September 30, 2023, in one or more of the same counties comprising the specific GSA(s) established for October 1, 2024.
SECTION H: INSTRUCTIONS TO OFFERORS	Correcting all references to Section G "Representations and Certifications of Offeror Instructions and Attestation" to the following: Section G "Disclosure of Information Instructions and Attestation"
SECTION H: INSTRUCTIONS TO OFFERORS – 20. Submission Requirements	**PART D** D1 Intent to Provide Insurance (Refer to information below) D2 ~~Representations and Certifications of Offeror and Disclosure of Information Instructions and Attestation~~ Disclosure of Ownership and Control and Disclosure of Information (RFP Section G and RFP Section I, Exhibit I) D3 Boycott of Israel Disclosure (RFP Section I, Exhibit E) D4 Moral or Religious Objections (Refer to information below) D5 State Only Pregnancy Terminations Agreement (RFP Section I, Exhibit F) ~~D6 Disclosure of Information (RFP Section I, Exhibit I)~~

SECTION H: INSTRUCTIONS TO OFFERORS – 20. Submission Requirements (page 20)	***D2 - ~~Representations and Certifications of Offeror and~~ Disclosure of Ownership and Control, and Disclosure of Information Instructions and Attestation:*** The Offeror shall complete requirements outlined in ~~and submit~~ RFP Section G "Disclosure of Information Instructions and Attestation." Please note all submitted documentation shall align with the Offeror's submitted Exhibit D: Offeror's Intent to Bid "Company Name". AHCCCS reserves the right to reject an APEP application should an Offeror's Company Name not match to the information (e.g., Tax ID) used for the APEP application.
EXHIBIT A: OFFEROR'S CHECKLIST	PART D D2 ~~Representations and Certifications of Offeror and~~ Disclosure of Information Instructions and Attestation A revised Exhibit A will be uploaded to the Bidders' Library for use by the Offeror with this Amendment. This revised Exhibit A shall be the version utilized by the Offeror when submitting its RFP Proposal.
SECTION G: DISCLOSURE OF INFORMATION INSTRUCTIONS AND ATTESTATION	1. Removed reference to *Representations and Certifications of Offeror and Disclosure Information* and replaced with *Disclosure of Ownership and Control*. 2. Added submission requirements for Exhibit I, Disclosure of Information. A revised Section G will be uploaded to the Bidders' Library for use by the Offeror with this Amendment. This revised Section G shall be the version utilized by the Offeror when submitting its RFP Proposal.

INCORPORATED in this Solicitation Amendment:

REVISED SECTION I EXHIBIT A: Offeror's Checklist
REVISED SECTION G: Disclosure of Information Instructions and Attestation

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	**SIGNATURE:** **SIGNATURE ON FILE**
TYPED NAME:	**TYPED NAME:** **MEGGAN LAPORTE, CPPO, MSW**
TITLE:	**TITLE:** **CHIEF PROCUREMENT OFFICER**
DATE:	**DATE:** **9/8/2023**

EXHIBIT B

REQUEST FOR PROPOSAL (RFP) EXECUTIVE SUMMARY
YH24-0001 – ALTCS E/PD

December 1, 2023

The Request for Proposals (RFP) commenced in accordance with A.R.S. § 36-2906.

Timeline

1. Procurement Disclosure Statements were signed by individuals involved in the solicitation between March 09, 2022, and September 20, 2023.
2. RFP was written and reviewed by internal subject matter experts from AHCCCS and approved for publishing by Procurement Management on July 12, 2023.
3. The RFP was published on the AHCCCS website on August 1, 2023.
4. RFP notification was sent to potential interested vendors on August 1, 2023, with a link to the AHCCCS website where the RFP was published.
5. Evaluator Training and Scoring Methodology meeting convened on October 3, 2023
6. Solicitation amendment one response to Offerors' questions was published on the AHCCCS website on August 15,2023.
7. Solicitation amendment two response to Offerors' questions was published on the AHCCCS website on August 30, 2023 .
8. Solicitation amendment three response to Offerors' questions was published on the AHCCCS website on September 8, 2023.
9. No Pre-Offer conference was held.
10. The RFP closed on October 2, 2023, and five Proposals were received.

Award Recommendation

The Scope Team recommends a Statewide contract award be made to two MCOs: *Health Net Access, Inc. dba Arizona Complete Health-Complete Plan* [ranked 1 based on total score] *and Arizona Physicians IPA, Inc. (dba UnitedHealthcare Community Plan)* [ranked 2 based on total score]. *Refer to Overall Final Score by Offeror attached.*

A history of the RFP development process and proposal evaluation process is provided below.

History of RFP Development and Release

The development of the RFP took place during the timeframe of August 2, 2022 – June 12, 2023. The Request for Proposals was published publicly on the AHCCCS website on August 1, 2023. Notice of the future RFP was advertised publicly in the Record Reporter on June 17, 2022. Approximately 326 vendors/potential Offerors were notified through email of the RFP publication. A list of the notified vendors/potential Offerors is contained in the procurement file. The Proposal Due Date was August 1, 2023.

The Solicitation Amendments were posted publicly on the AHCCCS website with the RFP and are made available in the procurement file. Solicitation Amendment one was released August 15, 2023, and consisted of 44 detailed questions and answers and amended the RFP as necessary. Solicitation

Amendment #2 was released August 30, 2023, and consisted of 19 detailed questions and answers and amended the RFP as necessary. Solicitation Amendment #3 was released September 8, 2023 and amended Instructions to Offerors, Offeror's Checklist, and Disclosure of Information Instructions and Attestation the RFP as necessary.

Scoring Methodology

The Scope Team met October 2, 2023, through November 15, 2023, to determine the scoring methodology and came to an agreement to apply the scoring methodology detailed in the *Evaluation Process Overview* document available in the procurement file.

Receipt of Proposals

A total of five proposals were submitted to AHCCCS by the due date of October 2, 2023. The Offerors were: Arizona Physicians IPA, Inc. (dba UnitedHealthcare Community Plan); Banner-University Care Advantage dba Banner-University Family Care; BCBSAZ Health Choice; Health Net Access, Inc. dba Arizona Complete Health-Complete Plan; and Mercy Care (Administered by Aetna Medicaid Administrators). Proposals were received and publicly opened on October 2, 2023, in accordance with the RFP instructions:

Evaluation Process

Each submission requirement was evaluated by an Evaluation Team. The five proposals were evaluated pursuant to the submission evaluation considerations contained in the procurement file. The proposals and scoring tools were distributed to all Evaluation Team members. The following individuals served as Evaluation Team members:

1. Melissa Arzabal 2. Danielle Ashlock 3. Gini Britton 4. Georgette Chukwuemeka 5. Rachel Conley 6. Dr. Melissa Del-Colle 7. Jay Dunkleberger 8. Tom Heiser 9. Michelle Holmes 10. Cynthia Hostetler 11. Brandi Howard 12. Dara Johnson	13. Bill Kennard 14. Susan Kennard 15. Jakenna Lebsock 16. Pam McMillian 17. Samantha O'Neal 18. Christina Quast 19. Bobbi Schmidt 20. Matt Varitek 21. Dr. Megan Woods 22. Jenna Girdosky

Scope and Evaluation Team members were required to sign a Procurement Disclosure Statement/Confidentiality Statement at the commencement of the development of the RFP. Additional subject matter experts were used on an as needed basis.

Evaluation Meetings

Scoring Training was held on October 2, 2023. The Evaluation Teams' first consensus meeting was held on October 12, 2023. At this meeting the Evaluation Team started to develop strengths and weaknesses for

each proposal for their assigned submission requirement. The teams continued this process through November 15, 2023.

AHCCCS requested Best and Final Offers (BAFO) for the Cost Bid portion of the RFP. The Cost Bid Evaluation Team reviewed the BAFO submissions and final rankings were assigned to each Offer.

Conclusion

After giving the proposals serious consideration and after examining the facts related to the submission evaluation considerations, the Scope Team recommended two statewide contracts be awarded: one Statewide Contract to *Arizona Physicians IPA, Inc. (dba UnitedHealthcare Community Plan)* and one Statewide Contract to *and Health Net Access, Inc. dba Arizona Complete Health-Complete Plan*. It is determined that each of these Offerors submitted a proposal that was responsible and responsive. It was further determined that this award will be the most advantageous to AHCCCS and the State of Arizona based on the evaluation factors set forth in the solicitation.

The final scoring sheet is incorporated into this Executive Summary as shown on the following page.

AHCCCS Procurement Office

I, AHCCCS Chief Procurement Officer, Meggan LaPorte, agree with the Scope Team's award recommendation.

Sincerely,

Meggan LaPorte (Nov 29, 2023 09:34 MST)

Meggan LaPorte
AHCCCS Chief Procurement Officer

Overall Final Score by Offeror

Best and Final Offer

Statewide Number of AHCCCS E/PD Offerors Statewide = 5		
Maximum Points 1,000	Total Score	Rank Based on Total Score
HEALTH NET ACCESS	715.00	1
ARIZONA PHYSICIANS IPA, INC.	668.00	2
MERCY CARE	557.50	3
BCBSAZ HEALTH CHOICE	537.00	4
BANNER-UNIVERSITY CARE ADVANTAGE	522.50	5

Ranking Summary for Offerors by Submission Requirement

Best and Final Offer

Measure #	Measure Name	ARIZONA PHYSICIANS IPA, INC.	BANNER-UNIVERSITY CARE ADVANTAGE	BCBSAZ HEALTH CHOICE	HEALTH NET ACCESS	MERCY CARE
B1	Executive Summary					
B2	Contract Citations					
B3	Health Equity					
B4	Complex Conditions & Member Transitions	3	5	4	2	1
B5	Person-Centered Service Plan	2	1	5	3	4
B6	Data	3	3	5	1	2
B7	Network Development	2	5	4	1	3
B8	Workforce Development	2	3	5	4	1
B9	Access to Services & Supports (Peer Supports)	4	2	1	3	5
B10	Past Performance - Compliance Review	2	1	5	4	3
B11	Past Performance - Star Rating	1	2	4	5	2
OP 1	Family Caregiver Support	2	4	1	3	5
OP 2	Abuse and Neglect Prevention	3	4	2	1	4
C1-C4	Non-Benefit Cost Bid	4	4	3	1	2

OVERVIEW OF RFP EVALUATION PROCESS

For the ALTCS E/PD Contractor RFP YH24-0001, AHCCCS will use a scoring methodology using a Consensus Evaluation Process comprised of an evaluation of:

- Programmatic Submission Requirements
  - B4-B11 Narrative Submission requirements
  - Oral Presentations (Oral Presentation 1 and Oral Presentation 2)

- Financial Submission Requirements
  - C1 – Agreement Accepting Capitation Rates (RFP Section H Instructions to Offerors)
  - C2 – Administrative Cost Component Bid (RFP Section H Instructions to Offerors)
  - C3 – Case Management Cost Component Bid (RFP Section H Instructions to Offerors)
  - C4 – Actuarial Certification(s) (RFP Section H Instructions to Offerors)

Additional submissions required of Offerors that are not separately scored items:

Part B:

- B1 – Executive Summary (RFP Section H Instructions to Offerors)
- B2 – Cite Contracts (RFP Section H Instructions to Offerors)
- B3 – Health Equity Requirement (RFP Section H Instructions to Offerors)
- B12 – Oral Presentation Information (RFP Section H Instructions to Offerors)

Part D:

- D1 – Intent to Provide Insurance (RFP Section H Instructions to Offerors)
- D2 – Disclosure of Information Instructions and Attestation (RFP Section H Instructions to Offerors)
- D3 – Boycott of Israel Disclosure (RFP Section H Instructions to Offerors)
- D4 – Moral or Religious Objections (RFP Section H Instructions to Offerors)
- D5 – State Only Pregnancy Terminations Agreement (RFP Section H Instructions to Offerors)

All Scoring documents were locked down prior to October 2, 2023.

Consensus Evaluation

The general steps in the consensus evaluation process are described below:

Each submission requirement will be evaluated by an Evaluation Team. These individuals are referred to as team members. A Facilitator will be assigned to each Team to assist the Team in discussions of the submission requirement and to assist the Team in reaching consensus. Each team member will first individually evaluate the Offeror's response to the designated Programmatic or Financial Submission requirement. All team members will then be convened to participate in a consensus evaluation meeting(s) for the particular submission requirement, led by a Facilitator. Through the consensus evaluation meeting(s), the Team will establish a consensus ranking for each submission requirement which is approved by each and every member of the Team and incorporated into a consensus ranking document. The consensus ranking documents represent the rank of each submission requirement for each Offeror. Once the consensus ranking documents are completed, they will be submitted to the Finance Team for

inclusion in the overall scoring methodology. A Consensus Rationale document will also be completed which specifies the ranking of each Offeror and reason(s) for the ranking of each submission requirement. All working documents used in the evaluation process will be destroyed.

During the Consensus Evaluation Process, team members shall only consider the information submitted by the Offeror for the specific submission requirement. Information that is not received as part of the Offeror's bid submission for that specific requirement shall not be considered. For a specific submission requirement, team members shall only consider information that is provided in accordance with the Instructions to Offerors. When reviewing a specific response to an individual submission requirement, team members will not consider information that is outside the allotted page limit and permitted attachments and any information elsewhere in the Proposal. 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. An Offeror's use of contingent language such as "exploring" or "taking under consideration" will not be given any weight during the scoring evaluation process.

OVERVIEW OF OVERALL SCORING TOOL

This document describes the process whereby the ALTCS E/PD RFP #YH24-0001 submission requirements are scored.

Scoring Process

Each Offeror will be scored based on required submissions for the Programmatic and Financial submissions detailed in RFP Section H, Instructions to Offerors. The Programmatic and Financial submissions are scored on a statewide basis.

Each Offeror can earn points as follows:

STATEWIDE	
SUBMISSION	**MAXIMUM POINTS**
Narrative Submission Requirements	610
Oral Presentations	290
Capitation Agreement/Administrative and Case Management Cost Components Bid	100
Total	**1000**

Each of these submission requirements can be awarded a maximum of the following points:

PROGRAMMATIC SUBMISSION REQUIREMENTS	
NARRATIVE SUBMISSION	**MAXIMUM**
B1	0 (Not Scored)
B2	0 (Not Scored)
B3	0 (Not Scored)
B4	75
B5	145
B6	40
B7	75
B8	145
B9	75
B10	35
B11	20
Total	**610**

ORAL PRESENTATION	MAXIMUM
Oral Presentation 1	145
Oral Presentation 2	145
Total	**290**

FINANCIAL SUBMISSION REQUIREMENTS	
COST BID	**MAXIMUM**
Part C C1 Agreement Accepting Capitation Rates; C2 Administrative Cost Component Bid; C3 Case Management Cost Component Bid; C4 Actuarial Certification	100
Total	**100**

The most favorable rank (1) is given to the best submission the next most favorable rank (2) is given to the second most favorable submission. The ranking process continues in this same manner until all Offerors are ranked.

The ranks are provided to the DBF Finance Team from the DHCS Contract and Policy Administrator for each submission requirement for input into the Ranking Summary tab in the ALTCS E/PD Overall Scoring Tool file. If an Offeror failed to submit a requirement, "X" is entered into the table to identify the omitted requirement. If an Offeror withdraws from the bidding process, the Offeror's name will be replaced with "OFFEROR WITHDREW." In addition, for the Non-Benefit Cost Bid, a drop-down menu has been provided to indicate if a Best and Final Offer (BAFO) process was utilized.

The ALTCS E/PD Overall Scoring Tool file utilizes an Excel model for computing overall RFP scores and contains the Ranking Summary, and a Scores Statewide worksheet. The worksheet has a column for each Offeror and a series of rows for each submission requirement. The rows for each submission requirement are programmed to retrieve and display each Offeror's rank from the Ranking Summary tab and calculate the score for the specific submission requirement.

The formula that calculates the score for each submission requirement is as follows:
*Maximum Points / Number of Offerors * Offeror's Inverse Rank = Score*

The formula counts the number of Offerors. The maximum points for each submission requirement are then divided by the number of Offerors. The quotient is multiplied by the Offeror's inverse rank resulting in each Offeror receiving a proportion of the points. All points are rounded to the second decimal place. For example, if there were 10 Offerors and a particular question was worth 900 points, points would be awarded as follows:
900 points / 10 Offerors = 90

RANK		INVERSE RANK	DISTRIBUTION OF POINTS
1	First best ranked response	10	10 * 90 = 900
2	Second best ranked response	9	9 * 90 = 810
3	Third best ranked response	8	8 * 90 = 720
4	Fourth best ranked response	7	7 * 90 = 630
5	Fifth best ranked response	6	6 * 90 = 540
6	Sixth best ranked response	5	5 * 90 = 450
7	Seventh best ranked response	4	4 * 90 = 360
8	Eighth best ranked response	3	3 * 90 = 270

RANK		INVERSE RANK	DISTRIBUTION OF POINTS
9	Ninth best ranked response	2	2 * 90 = 180
10	Tenth best ranked response	1	1 * 90 = 90

In the event of a tie in the rank scores, points are awarded equal to the average points of all impacted ranks. For example, in the event of a two-way tie for the second best ranked response, the points for the second and third best ranked responses, 810 and 720, respectively, would be added together and divided by two resulting in an award of 765 points to each Offeror for this particular submission requirement. In the event of a three-way tie for the eighth best ranked response, the points for the eighth, ninth and tenth best ranked responses, 270, 180 and 90, respectively, would be added together and divided by three resulting in an award of 180 points to each Offeror for this particular submission requirement. In an extreme case for illustration purposes, all Offerors can be tied for first place. The total points for all ranks combined, 4,950, are divided by 10 resulting in 495 points being awarded to each Offeror for this particular submission requirement.

The formula also tests for omitted submission requirements. If, in the example above, an Offeror fails to submit a submission requirement, the Offeror will receive zero points for that submission requirement (this is indicated by entering a value of "X" on the Ranking Summary tab for that Offeror). The other Offerors will receive their scores without adjustment to the distribution of points as follows:

RANK		INVERSE RANK	DISTRIBUTION OF POINTS
1	First best ranked response	10	10 * 90 = 900
2	Second best ranked response	9	9 * 90 = 810
3	Third best ranked response	8	8 * 90 = 720
4	Fourth best ranked response	7	7 * 90 = 630
5	Fifth best ranked response	6	6 * 90 = 540
6	Sixth best ranked response	5	5 * 90 = 450
7	Seventh best ranked response	4	4 * 90 = 360
8	Eighth best ranked response	3	3 * 90 = 270
9	Ninth best ranked response	2	2 * 90 = 180
10	Tenth best ranked response	Not ranked	0

The worksheet calculates a total for its respective submission by Offeror by summing the points for all submission requirements.

In the event an Offeror withdraws from the bidding process, the formula adjusts to count the Number of Offerors to the number of Offerors remaining. If, in the example above, an Offeror withdraws, the Offeror will receive zero points for all submission requirements (this is indicated by replacing the Offerors name with "OFFEROR WITHDREW" on the Ranking Summary tab). The other Offerors will receive their scores with an adjustment to the distribution of points as follows:

900 points / 9 Offerors = 100

RANK		INVERSE RANK	DISTRIBUTION OF POINTS
1	First best ranked response	9	9 * 100 = 900
2	Second best ranked response	8	8 * 100 = 800
3	Third best ranked response	7	7 * 100 = 700
4	Fourth best ranked response	6	6 * 100 = 600
5	Fifth best ranked response	5	5 * 100 = 500
6	Sixth best ranked response	4	4 * 100 = 400
7	Seventh best ranked response	3	3 * 100 = 300
8	Eighth best ranked response	2	2 * 100 = 200
9	Ninth best ranked response	1	1 * 100 = 100
10	OFFEROR WITHDREW	Not ranked	0

Best and Final Offer

If the BAFO process is utilized, the Offerors will be re-evaluated and re-ranked by the Evaluation Team(s). The revised ranks will be provided to the DBF Finance Team from the DHCS Contract and Policy Administrator for entry into the ALTCS E/PD Overall Scoring Tool file.

Total Score

A worksheet in the ALTCS E/PD Overall Scoring Tool file labeled Overall Points All Offerors retrieves the submission totals statewide by Offeror from the Scores Statewide worksheet in the ALTCS E/PD Overall Scoring Tool file and calculates a Total Score statewide by Offeror. The Offerors and ranks for each submission requirement are also electronically populated in the Ranking Summary All Offerors worksheet of the ALTCS E/PD Overall Scoring Tool file. The Overall Final Score worksheet retrieves the total points by Offeror from the Overall Points All Offerors worksheet and a formula arranges the total points by Offeror in descending order.

EPO RFP 1H24-0001 SCORING TOOL
FINAL RANKING AND RATIONALE - B4

SUBMISSION REQUIREMENT B4: The ALTCS E/PD member population is complex, and their care often involves a combination of services and providers to effectively meet their needs. Provide a detailed description of how the Offeror will develop and implement best practices for ALTCS Case Managers, and leverage ALTCS Case Management staff to meet the needs of individuals with complex conditions, to:
a.)Decrease duplication of effort and enhance coordination of care with providers of physical and behavioral health services.
b.)Assist members prior to, and throughout transitions.
c.)Improve member engagement.
d.)Coordinate social and community support services.
e.)Identify, track, and manage outcomes for members with complex needs.
f.)Ensure appropriate identification of members that would benefit from High Needs Case Management and provide Case Management services in alignment with identified needs and reduce burden on members and families in coordinating member care, and
g.)Monitor Case Manager performance and respond to identified issues, at the individual and system levels.

PAGE LIMIT (5)

Submission Evaluation Considerations:
- Health Equity
- Use of Data
- Care Management/Care Coordination
- Addresses Specific Population Needs
- Other Notable Considerations

ARIZONA PHYSICIANS IPA, INC.	BANNER-UNIVERSITY CARE ADVANTAGE	BCBSAZ HEALTH CHOICE	HEALTH NET ACCESS	MERCY CARE
RATIONALE AND MAJOR OBSERVATIONS				
Offeror provided a detailed description of its approaches to support health equity through identification of health-related social needs, person-centered service planning and engagement. Offeror generally described its approaches for educating members and encouraging engagement in care. Offeror described its data collection and analysis platforms; Offeror indicated that it is capturing additional data to support health equity, including race, ethnicity and language, to supplement the RFI. data from AHCCCS.	Offeror identified approaches that support health equity, but did not clearly describe how its processes advance health equity. Offeror generally described its approaches for educating members and encouraging engagement in care. Offeror described types of data to be collected and used to support health equity.	Offeror provided a detailed description of its approaches for identifying and promoting health equity, including: targeted training, outreach and engagement approaches. Offeror described its approaches for educating members and encouraging engagement in care, including members who are hard-to-reach, have specific conditions or are withdrawing from participation in their care. Offeror described types of data to be collected and used to support health equity.	Offeror identified approaches that support health equity, including its process for assigning case managers and its goal to recruit case managers with culturally diverse backgrounds. Offeror provided a detailed description of approaches for educating members and encouraging engagement in care. Offeror provided a detailed description of the types of data to be collected and how data is used to support health equity.	Offeror identified approaches that support health equity, but did not clearly describe how its processes advance health equity. Offeror described its approaches for educating members and encouraging engagement in care. Offeror provided a detailed description of the types of data to be collected and how data is used to support health equity.
Offeror described how data is used to identify gaps and address member needs. Offeror provided a detailed description of how data is used to monitor outcomes. Offeror provided a detailed description of its use of data to monitor program performance.	Offeror described how data is used to identify gaps and address member needs. Offeror described how data is used to monitor outcomes. Offeror described its use of data to monitor program performance.	Offeror described how data is used to identify gaps and address member needs. Offeror described how data is used to monitor outcomes. Offeror described its use of data to monitor program performance.	Offeror described how data is used to identify gaps and address member needs. Offeror described how data is used to monitor outcomes. Offeror provided a detailed description of its use of data to monitor program performance.	Offeror described how data is used to identify gaps and address member needs. Offeror described in detail how data is used to monitor outcomes and described its process for leadership's use of data to drive policy changes. Offeror provided a detailed description of its use of data to monitor program performance.
Offeror described its process for developing and implementing case management best practices. Offeror described how case management activities and resources support access to, and coordination of, physical and behavioral health services. Offeror described its approaches for supporting case managers and monitoring case management performance, including assessment and adherence tools, member record reviews, inter-rater reliability testing and case manager observation. Offeror described its approaches for training case managers and developing case managers' skills.	Offeror described the role of case managers and its case manager training approach. Offeror described how case management activities and resources support access to, and coordination of, physical and behavioral health services. Offeror described its approaches for supporting case managers and monitoring case manager performance, including audits, inter-rater reliability reviews and review of aggregated data. Offeror described its approaches for training case managers, but did not clearly describe its approach for continual skill building for case managers.	Offeror clearly described its case management training approach and described how guiding principles, in accordance with AHCCCS requirements, are included within the training program. Offeror described how case management activities and resources support access to, and coordination of, physical and behavioral health services. Offeror described its approaches for supporting case managers, including the monitoring of case manager job satisfaction. Offeror described its approaches for monitoring case manager performance, including monitoring tools, inter-rater reliability testing, data analysis, supervisor reviews, and continuous coaching. Offeror described role of leadership regarding oversight and monitoring of case management performance. Offeror described its case manager training process, but did not clearly describe its approach for continual skill building for case managers.	Offeror described the role of case managers and its case manager training approach. Offeror described how case management activities and resources support access to, and coordination of, physical and behavioral health services. Offeror described its approaches for supporting case managers, including its approach for supporting case managers in the field. Offeror described its approaches for monitoring case manager performance, including data analysis, audits, supervisor reviews, and in-field supervision. Offeror described role of leadership regarding oversight and monitoring of case management performance. Offeror clearly described its process for training, skill development, and supporting case managers, including innovative case manager training initiatives and approaches to improve case manager retention rates.	Offeror described the role of case managers and its case manager training approach. Offeror clearly described how case management activities and resources support access to, and coordination of, physical and behavioral health services. Offeror described its approaches for supporting case managers and monitoring case management performance, including report reviews, supervisor reviews, in-field supervision, inter-rater reliability testing. Offeror described its case manager training process and identified approaches for building case managers' skills.
Offeror provided a detailed description of its approach for supporting members with complex needs and identifying members who would benefit from high needs case management. Offeror described strategies for integrating physical health and behavioral health services within its case management approach. Offeror described its approach for identifying, tracking and managing outcomes for members with complex needs. Offeror described its approaches for assisting members during transitions, including new members, fee-for-service Tribal members, members transitioning from acute settings and nursing facilities, and members transitioning to adulthood.	Offeror provided a description of its approach for assisting members with complex needs and identifying members who would benefit from high needs case management. Offeror identified the importance of integrated care and described strategies for integrating physical health and behavioral health services within its case management approach. Offeror described its approach for identifying, tracking and managing outcomes for members with complex needs. Offeror described its approaches for assisting members during transitions, including new members, fee-for-service Tribal members, members who moved from other service areas, members transitioning from correctional facilities, members with an IMH designation, members changing providers, members transitioning to/from acute and non-acute facilities, and members transitioning to adulthood.	Offeror provided a description of its approach for assisting members with complex needs and identifying members who would benefit from high needs case management. Offeror described strategies for integrating physical health and behavioral health services within its case management approach. Offeror described its approach for identifying, tracking and managing outcomes for members with complex needs. Offeror described its approaches for assisting members during transitions, including new members, member transitions involving ALTCS Tribal providers, members transitioning between residential and community settings, transition of members living with SMI, members transitioning from another plan, members transitioning to/from other service areas, transition of ALTCS "acute only" members to HCBS or institutional settings, and members transitioning to adulthood.	Offeror provided a description of its approach for assisting members with complex needs and identifying members who would benefit from high needs case management. Offeror described strategies for integrating physical health and behavioral health services within its case management approach. Offeror described its approach for identifying, tracking and managing outcomes for members with complex needs. Offeror provided a detailed description of its process for assisting members during transitions, including new ALTCS members, members transferring from other health plans, fee-for-service members, and members transitioning to and from facilities, and end of life transitions.	Offeror provided a description of its approach for assisting members with complex needs and identifying members who would benefit from high needs case management. Offeror provided a detailed description of its strategies for integrating physical health and behavioral health services within its case management approach, including children's behavioral health in alignment with AHCCCS policies Offeror described its approach for identifying, tracking and managing outcomes for members with complex needs; Offeror provided a detailed description of its process for assisting members during transitions, including members transitioning to and from facilities, members transitioning to new housing programs, members transitioning to adulthood, and members transferring from other plans.
RANKING				
3	5	4	2	1

EVALUATOR FULL NAME (FIRST AND LAST):	Brandi Howard
EVALUATOR TITLE:	Medical Management Manager DHCS
DATE:	Nov 13, 2023
SIGNATURE:	Brandi Howard

EVALUATOR FULL NAME (FIRST AND LAST):	Dr. Megan Woods
EVALUATOR TITLE:	Integrated Care Administrator-DGI
DATE:	Nov 14, 2023
SIGNATURE:	Megan Woods

EVALUATOR FULL NAME (FIRST AND LAST):	Samantha O'Neal
EVALUATOR TITLE:	Medical Management Supervisor DHCS
DATE:	Nov 14, 2023
SIGNATURE:	Samantha O'Neal Samantha O'Neal (Nov 14, 2023 09:20 MST)

FACILITATOR FULL NAME (FIRST AND LAST):	Scott Wittman
DATE:	Nov 16, 2023
SIGNATURE:	Scott Wittman Scott Wittman (Nov 16, 2023 09:33 CST)

EPD RFP TH24-0001 SCORING TOOL FINAL RANKING AND RATIONALE - BS				
SUBMISSION REQUIREMENT BS: How will the Offeror ensure that person-centered service planning: **a.)Includes active engagement with ALTCS members.** **b.)Includes all aspects of quality of life.** **c.)Is consistent with the individual's needs and wishes.** **d.)Promotes access to services in home and community-based settings, and** **e.)Results in high quality, equitable, and cost-effective person-centered care.** **Additionally, how will the Offeror monitor and evaluate the Case Manager and the member experience and satisfaction to demonstrate the Offeror's person-centered service planning process complies with the values and principles of person-centered thinking, planning, and practice?** **[PAGE LIMIT 4]**				
Submission Evaluation Considerations: **- Health Equity** **- Implementable** **- Addresses Person-Centered Service Planning** **- Addresses Ongoing Monitoring and Oversight** **- Strategies that Improve Member Experience and Outcomes** **- Other Notable Considerations**				
ARIZONA PHYSICIANS IPA, INC.	**BANNER-UNIVERSITY CARE ADVANTAGE**	**BCBSAZ HEALTH CHOICE**	**HEALTH NET ACCESS**	**MERCY CARE**
RATIONALE AND MAJOR OBSERVATIONS				
Offeror described how health equity is addressed as part of its approach to person-centered service planning, including through alignment of case managers with members based on language/cultural preferences, consideration of health equity-related needs when matching members to case managers, use of AHCCCS standardized tools to promote consistency in service planning, and use of multiple qualitative and quantitative data sources to identify potential areas of underutilization by demographic group. Offeror provided an example of monitoring and follow-up through a disparity evaluation of HCBS service use by tribal members in Maricopa County and offeror's efforts to address.	Offeror described how health equity is addressed as part of its approach to person-centered service planning, including through recruitment of locally-based case managers with diverse backgrounds (e.g., persons with disabilities) and language skills, consideration of health equity-related needs when matching members to case managers, use of a social vulnerability index score, in combination with community resources to address health related social needs in a standardized manner, and use of a population health platform (innovaccer) to inform the person-centered planning process through identification of potential health disparities and continuous monitoring of outcomes.	Offeror discussed health equity as part of its person-centered service planning, including through case manager training on cultural competency, tribal initiatives (e.g., sweat lodge healing programs) and using data to inform health equity plan. Offeror did not describe clearly how it incorporates health equity when matching members with case managers in performing its assessment process, or conducting outcomes follow-up.	Offeror discussed health equity as part of its person-centered service planning, including through inclusion of peers/families and individuals with lived experience and diverse backgrounds as case managers, consideration of health equity-related needs when matching members to case managers, and use of a health equity dashboard to identify opportunities for reducing disparities in outcomes. Offeror discussed assessments and closed loop referrals but did not describe clearly its process for outcomes follow-up.	Offeror described how health equity is addressed as part of its approach to person-centered service planning, including through recruitment of locally-based case managers with diverse backgrounds, consideration of health equity-related needs when matching members to case managers, and availability of multiple digital tools (e.g., Thrive and Social Scape) to evaluate equitable access to services and social risk. Offeror discussed use of a variety of evidence-based assessments (e.g., InterRAI and SASI), as well as outcomes monitoring and follow-up. Offeror provided an example of a disparity evaluation in which mammography screening rates were found to be lower than average in two zip codes with significant Latino populations.
Offeror discussed its case management staffing infrastructure but did not describe clearly its systems to support case managers and to facilitate supervision of case manager activities. Offeror did not describe clearly new initiatives for which there would be an associated implementation timeframe. Offeror discussed use of chart audits to monitor case manager performance but did not describe clearly its support plan for case managers based on varying levels of demonstrated competencies.	Offeror discussed its approach to implementing person centered service planning, including its systems to support case managers. Offeror discussed evaluating case manager performance but did not describe clearly a system for performing oversight through multiple methods. Offeror did not describe clearly its timeframe for implementing systems or processes not currently in place. Offeror discussed using member surveys to monitor case manager performance but did not describe clearly its support plan for case managers based on varying levels of demonstrated competencies.	Offeror described its approach to implementing person centered service planning, including its systems to support case managers, as well as multiple methods for performing oversight of case manager performance. Offeror did not describe clearly its timeframe for implementing systems or processes not currently in place. Offeror did not describe clearly its support plan for case managers based on varying levels of demonstrated competencies.	Offeror described its approach to implementing person centered service planning, including its systems to support case managers and to facilitate supervision activities, as well as multiple methods for performing oversight of case manager performance. Offeror discussed its timeframe for obtaining PCSP certification but did not describe clearly other implementation milestone dates. Offeror did not describe clearly its support plan for case managers based on varying levels of demonstrated competencies.	Offeror described its approach to implementing person centered service planning, including its systems to support members and case managers and to facilitate supervision activities. Offeror discussed its timeframe for implementing systems or processes not currently in place. Offeror described multiple methods for performing oversight of case manager performance, and its support plan for case managers based on varying levels of demonstrated competencies.
Offeror's response addressed case management principles, person-centered case management and its strategy for recognizing individual strengths and needs, including through adoption of the evidence-based ME program (for which offeror provided examples of ME resource team activities). Offeror described multiple methods for encouraging and supporting active member participation in the planning process. Offeror mentioned provider participation on the planning team but did not describe clearly how it encourages and supports their active participation.	Offeror's response presented an overview of case management principles and discussed person-centered case management. Offeror described its strategy for recognizing individual strengths and needs, including through an emphasis on member preferences. Offeror described its approach for encouraging and supporting active member participation in the planning process. Offeror committed to making case managers available to their members 24/7, although it did not describe clearly how that policy would be implemented. Offeror discussed the importance of provider participation in the planning process but did not describe clearly how it encourages and supports their active participation.	Offeror's response presented an overview of case management principles, person-centered case management and its strategy for recognizing individual needs and strengths. Offeror described its approach for encouraging and supporting active member participation in the planning process. Offeror did not describe clearly how it encourages and supports their active participation. Offeror mentioned updating the PCSP with the member at a minimum annually. However, the AHCCCS requirement is for more frequent updates. Offeror also mentioned providing budget management assistance to members in the consumer direct program. However, the ALTCS program does not include member-specific budgets. Offeror mentioned provider participation on the PCSP but did not describe clearly how it encourages and supports their active participation.	Offeror's response addressed case management principles, person-centered case management and its strategy for recognizing individual needs and strengths, including for members with dementia. Offeror described multiple methods for encouraging and supporting active member participation in the planning process, including through inclusion of a peer support specialist, distribution of tablet computers, and implementation of the mandated community intervener initiative. Offeror did not describe clearly how it encourages and supports active participation by providers in the planning process.	Offeror's response presented an overview of case management principles. Offeror discussed case manager interaction with members but did not describe clearly its strategy for recognizing individual strengths and needs. Offeror described its approach for encouraging and supporting active member participation in the planning process, including through frequent calls and visits. Offeror discussed provider participation in the planning process but did not describe clearly how it encourages and supports their active participation.
Offeror discussed monitoring program-level performance (e.g., member surveys) but did not describe clearly how individual case manager performance is monitored and addressed. Offeror mentioned chart audits and supervision of case managers but did not describe clearly its process for either activity.	Offeror described its approach to monitoring program-level performance with respect to attainment of PCSP goals (e.g., member surveys) but did not describe clearly how individual case manager performance is monitored and addressed. Offeror did not describe clearly a process for conducting case file audits.	Offeror described its approach to conducting ongoing monitoring and oversight, including through: use of multiple tracking and trending tools and reports (e.g. NCAPCPS key performance indicators, adoption of the case management performance fidelity process developed by BCBS Minnesota), and case file audits. Offeror discussed supervisory coaching and monitoring activities (e.g., case manager scorecards and interrater reliability) but did not describe clearly how supervisory staff would perform ongoing oversight and address problems when identified. Offeror stated that member advocacy support "is made available" through the LTC Ombudsman when "immediate issues" are identified. However, the office of LTC Ombudsman is a State function and not responsible for ALTCS Contractor monitoring and oversight.	Offeror described its approach to conducting ongoing monitoring, including through: use of multiple tracking and trending tools and reports, e.g., Electronic Visit Verification, interrater reliability reviews, annual "day in the life of a case manager" participation by senior staff, random calls to members, and quarterly case file audits. Offeror described how supervisory staff perform oversight of case manager performance.	Offeror described its approach to conducting ongoing monitoring, including through: use of multiple tracking and trending tools and reports, e.g., PCSP performance monitoring measures and interrater reliability reviews, an annual analysis of case management strategy, and monthly case file audits (sample for established case managers and 100 percent audit of new case managers). Offeror described how supervisory staff perform hands on oversight of case manager performance.
Offeror described its strategy for addressing member experience, quality-of-life and outcomes, including through use of a quality-of-life (4-I) assessment to document member goals/preferences, support of unpaid caregivers and integration of housing specialist into case management team to assist in removing barriers to home/community placement.	Offeror described its strategy for addressing member experience, quality-of-life and outcomes, including through use of quality-of-life/health appraisal assessments to document member goals, promotion of HCBS with institutionalized members, strategies for addressing loneliness, and support of caregivers through hiring of caregiver advocates.	Offeror described its strategy for addressing member experience, quality-of-life and outcomes, including through use of quality-of-life/health appraisal assessments to document member goals (with detailed examples provided) and HRSN and use of D-SNP supplemental benefits to support home placement.	Offeror described its strategy for addressing member experience, quality-of-life and outcomes, including through use of whole life assessment and steps to promote HCBS through its Community Engagement Team and D-SNP supplemental benefits.	Offeror described its strategy for addressing member experience, quality-of-life and outcomes, including through use of quality-of-life/health appraisal assessments, strategies for addressing loneliness (e.g., Meezy Pets program), and support of members with SMI at risk of eviction.
RANKING				
2	1	5	3	4

EVALUATOR FULL NAME (FIRST AND LAST):	Danielle Ashlock
EVALUTOR TITLE:	ALTCS Project Manager
DATE:	Nov 15, 2023
SIGNATURE:	Danielle Ashlock (Nov 15, 2023 08:21 MST)

EVALUATOR FULL NAME (FIRST AND LAST):	Dara Johnson
EVALUTOR TITLE:	Program Development Officer - DHCS
DATE:	Nov 15, 2023
SIGNATURE:	

EVALUATOR FULL NAME (FIRST AND LAST):	Melissa Arzabal
EVALUTOR TITLE:	ALTCS Case Management Program Manager
DATE:	Nov 15, 2023
SIGNATURE:	

FACILITATOR FULL NAME (FIRST AND LAST):	Andrew Cohen
DATE:	Nov 15, 2023
SIGNATURE:	Andrew Cohen

EPD RFP 9H24-0001 SCORING TOOL
FINAL RANKING AND RATIONALE - B6

SUBMISSION REQUIREMENT B6: Provide a description of the types of data, including but not limited to performance metrics and data collected in partnership with members (e.g., data from member satisfaction surveys or member focus groups), the Offeror will collect, monitor, and analyze for the purposes of improving member health outcomes and informing program initiatives.

Provide a detailed description of the processes utilized by the Offeror to inform and/or initiate improvement activities, including reporting tools, monitoring technologies, and/or partnerships, as well as processes used for member and population specific data analyses and MCO decision-making processes.

The Offeror shall limit its response to the submission requirement to three pages of narrative and should include up to three, one-page sample utilization reports or other sample data to demonstrate the Offeror's monitoring and analysis processes.

[PAGE LIMIT 6 with 3 pages of narrative and up to 3, one-page sample utilization reports or other sample data]

Submission Evaluation Considerations:
- Health Equity
- Use of Data
- Improves Outcomes
- Member Experience
- Other Notable Considerations

ARIZONA PHYSICIANS IPA, INC.	BANNER-UNIVERSITY CARE ADVANTAGE	BCBSAZ HEALTH CHOICE	HEALTH NET ACCESS	MERCY CARE
RATIONALE AND MAJOR OBSERVATIONS				
Offeror discussed NCQA accreditation and being awarded NCQA LTSS distinction but did not address clearly NCQA Health Equity accreditation. Offeror described its Quality Solutions platform and identified multiple examples of performance data stratification relevant to analysis of health disparities, including race, ethnicity, language, gender and geography among others. Offeror described a collaborative approach to engaging members for the purpose of collecting data to improve outcomes, including through meetings with its Member Advisory Council and member surveys. Offeror mentioned use of HIE but did not describe clearly how either the HIE or CURS would be used in addressing health disparities.	Offeror discussed being in full compliance with NCQA LTSS care plan and assessment requirements but did not address clearly NCQA Health Equity accreditation. Offeror described its data analysis platforms (e.g., Innovaccer) and identified multiple examples of performance data stratification (e.g., behavioral health, SHCN known and unknown rising risk) but did not describe clearly stratification based on factors relevant to analysis of health disparities (e.g., race, ethnicity and language, among others). Offeror described a collaborative approach to engaging members for the purpose of collecting data to improve outcomes, including through meetings with its Member Advisory Council, member surveys and caregiver studies conducted by the University of Arizona. Offeror mentioned use of HIE but did not describe clearly how either the HIE or CURS would be used in addressing health disparities.	Offeror discussed NCQA MA accreditation and its intent to achieve NCQA Health Equity accreditation. Offeror identified multiple examples of performance data stratification relevant to analysis of health disparities, including race, ethnicity, language, Z-codes and geography, among others. Offeror provided sample reports depicting stratification of performance data by demographic characteristics. Offeror described a collaborative approach to engaging members for the purpose of collecting data to improve outcomes, including through meetings with its Member Advisory Council and Member Experience Committee, tribal consultations and member surveys. Offeror included the term HIE within an exhibit but did not describe clearly how either the HIE or CURS would be used in addressing health disparities.	Offeror holds NCQA Health Equity accreditation. Offeror described its LTSS KPI dashboard and identified multiple examples of performance data stratification relevant to analysis of health disparities, including race, ethnicity, language, social risk factors and Z-codes, among others. Offeror provided examples of health disparity data analysis among members with diabetes and members with hypertension. Offeror described a collaborative approach to engaging members for the purpose of collecting data to improve outcomes, including through meetings with individual tribal councils and use of LTSS Quality of Life surveys. Offeror mentioned use of CURS and the HIE, but did not describe clearly how either would be used in addressing health disparities.	Offeror discussed NCQA accreditation in general but did not address clearly NCQA Health Equity accreditation. Offeror described its Health Equity dashboard and identified multiple examples of performance data stratification relevant to analysis of health disparities, including race, ethnicity, language, HRSN, LBTQ status and Z-codes, among others. Offeror provided a sample report depicting stratification of performance data by demographic characteristics. Offeror described use of multiple data tools (e.g., Pyx Health and Thrive Health Mobile) for engaging members and improving health experience and outcomes. Offeror mentioned use of HIE but did not describe clearly how either the HIE or CURS would be used in addressing health disparities.
Offeror described monitoring its members' and providers' performance and quality of care through its Quality Solutions platform and SMART data warehouse. Offeror included a sample clinical intervention and adherence report stratified by member placement type. Offeror stated it uses the PDSA cycle to assess the effectiveness of interventions. Offeror provided an example involving implementation of its LTSS CM university. Offeror described drawing from a wide variety of data sources, including, among others, claims, surveys and the HIE, although it did not specify clearly what HIE data elements are used. Offeror described its QMPI structure, including staffing and CQI process.	Offeror described monitoring its members' and providers' performance and quality of care through its Innovaccer population health platform and component modules (utilization dashboard, frail and elderly dashboard and patient 360). Offeror included sample reports depicting trended utilization data and a sample quality performance report stratified by provider. Offeror stated it uses the PDSA cycle to deploy focused interventions and evaluate performance improvement project outcomes. Offeror provided an example involving prevalence of chronic kidney disease. Offeror described drawing from a wide variety of data sources, including, among others, claims, surveys and the HIE, although it did not specify clearly what HIE data elements are used. Offeror described its QMPI structure, including staffing and CQI process.	Offeror described monitoring its members' and providers' performance and quality of care through detailed Monthly Management Reports that contain approximately 350 metrics across all aspects of the organization. Offeror included a sample report depicting HbA1c non-compliance rates stratified by demographic and provider subgroups; offeror also included a sample report presenting trended inpatient utilization data. Offeror stated it uses the Institute for Healthcare Improvement (IHI) model of improvement based on PDSA rapid-cycle intervention framework for continuous improvement, including elements of Lean model. Offeror provided an example of its PDSA process for the HEDIS FUH 7 Day measure. Offeror described drawing from a wide variety of data sources, including claims, surveys, the HIE and national sources, although it did not specify clearly what HIE data elements are used. Offeror described its QMPI structure, including staffing and CQI process.	Offeror described monitoring its members' and providers' performance and quality of care through its LTSS Key Performance Indicator dashboard that contains 150 performance metrics. Offeror included a sample report depicting trended safety and quality metrics stratified by skilled nursing facility. Offeror presented an exhibit of its continuous quality improvement process that included PDSA as a component of its implement and evaluate step. Offeror noted that the PDSA cycle is used to evaluate, expand, and refine interventions. Offeror described drawing from a wide variety of data sources, including claims, surveys, the HIE and national sources, among others. Offeror described its QMPI structure, including staffing and CQI process.	Offeror described monitoring its members' and providers' performance and quality of care through multiple data analytic platforms, including CORE, health equity dashboards, utilization dashboards and Healthmine, among others. Offeror included a sample report with stratified trending and outcomes data. Offeror discussed use of the FOCUS model for conducting the PDSA quality improvement cycle. Offeror discussed its approach to sharing results and outcomes with members, families, providers, the State, and other stakeholders to obtain feedback and inform identification of best practices. Offeror described drawing from a wide variety of data sources, including claims, surveys, the HIE and national sources, among others. Offeror described its QMPI structure, including staffing and CQI process.
The offeror discussed use of data to inform development and measurement of evidence-based initiatives. Offeror provided a cervical cancer screening program example and its use of data to inform development and measurement of an evidence-based initiative. Offeror described its SMART data warehouse and Health Plan Scorecard employed by staff to track and evaluate performance/delivery system changes. The platforms (as supported by sample reports) capture data encompassing all member health needs, including physical health, behavioral health, LTSS and HRSN.	The offeror discussed use of Innovaccer to support evidence-based initiatives and presented a PIP related to chronic kidney disease, but did not describe clearly the use of data to inform development and measurement of evidence-based initiatives. Offeror identified multiple analytic platforms employed by staff to track and evaluate performance/delivery system changes, including Innovaccer, Primary Care Quality Dashboard and Patient 360. The platforms capture data encompassing all member health needs, including physical health, behavioral health, LTSS and HRSN.	The offeror described how it monitors 350 data metrics through monthly management reports and uses data to drive PDSA-informed remediation strategies in response to negative trends. Offeror did not provide clear examples of using data to inform development and measurement of evidence-based initiatives. Offeror described its structure for tracking and evaluating performance/delivery system changes. Offeror discussed capturing data encompassing member physical health, behavioral health and HRSN needs but did not address clearly LTSS data/health needs.	The offeror described how it monitors 150 data metrics across all lines-of-business and uses data to inform development and measurement of evidence-based initiatives. Offeror provided examples, including for HbA1c control and fall prevention. Offeror described its proposed LTSS KPI dashboard for tracking and evaluating performance/delivery system changes. The dashboard will capture data encompassing all member health needs, including physical health, behavioral health, LTSS and HRSN.	The offeror described how it uses data to inform development and measurement of evidence-based initiatives. Offeror provided examples, including programs for colorectal cancer screening and fall prevention. Offeror identified multiple analytic platforms employed by staff to track and evaluate performance/delivery system changes. The platforms capture data encompassing all member health needs, including physical health, behavioral health, LTSS and HRSN.
Offeror described how data is used to improve member experiences and provided an example of developing an ACO VBP pilot based on CAHPS data. Offeror described how it engages members and families, beyond surveys, through the MAC. Offeror did not describe clearly other methods. Offeror described its broader community connections, including its Manzanita Outreach Initiative to address food insecurity and its partnership with the American Heart Association.	Offeror described its collection of relevant data, including through surveys and its Member Advisory Council, but did not provide clear examples of its use of the data to improve member experiences. Offeror described how it engages members and families, beyond surveys, through the MAC, community listening sessions, participation on the governance advisory committee and a University of Arizona caregiver study. Offeror described its broader community connections, including partnerships with FoodSmart and the American Cancer Society.	Offeror described its collection of relevant data, including through surveys, but did not provide clear examples of its use of the data to improve member experiences. Offeror described how it engages members and families, beyond surveys, through the MAC. Offeror did not describe clearly other methods. Offeror described its community outreach, including tribal summits and collaboration with provider associations, but did not provide clear examples of forming partnerships to improve member experiences.	Offeror described how data is used to improve member experiences and provided an example, based on CAHPS provider communication data, to have Provider Quality Liaisons encourage training focused on doctor/member relationships. Offeror stated it tracks member, family and stakeholder feedback from over 90 input sources. Offeror described how it engages with members and families, beyond surveys, including through post-visit evaluations and its Community Consensus Collaborative. Offeror described its broader community connections with multiple associations/organizations, including a partnership with the American Heart Association and its Adopt-a-Clinic program.	Offeror described how data is used to improve member experiences and provided an example of using population health monitoring technology to provide ALTCS case managers with ADT alerts from the HIE to support care transition encounters and refer members to the Area Agency on Aging Transition program. Offeror described how it engages with members and families, beyond surveys, including through real-time member engagement tools (e.g., Pyx Health, Healthmine, Thrive Health Mobile, and Cognitopia) and sharing of data by CMPI staff with member/family councils and stakeholder groups. Offeror described its broader community connections, including a partnership with Sonora Quest to improve
RANKING				
3	3	5	1	2

EVALUATOR FULL NAME (FIRST AND LAST):	Cynthia Hostetler
EVALUTOR TITLE:	Medical Management Specialist
DATE:	NOV 14, 2023
SIGNATURE:	Cynthia Hostetler

EVALUATOR FULL NAME (FIRST AND LAST):	Georgette Chukwuemeka
EVALUTOR TITLE:	Strategic Performance Administrator
DATE:	Nov 14, 2023
SIGNATURE:	

EVALUATOR FULL NAME (FIRST AND LAST):	Dr. Megan Woods
EVALUTOR TITLE:	Integrated Care Administrator-DG
DATE:	Nov 14, 2023
SIGNATURE:	Megan Woods

FACILITATOR FULL NAME (FIRST AND LAST):	
DATE:	
SIGNATURE:	

FACILITATOR FULL NAME (FIRST AND LAST):	Andrew Cohen
DATE:	NOV 14, 2023
SIGNATURE:	Andrew Cohen Andrew Cohen (Nov 14, 2023 08:57 PST)

EPD RFP YH24-0001 SCORING TOOL FINAL RANKING AND RATIONALE - B7				
SUBMISSION REQUIREMENT B7: Describe the Offeror's network development strategy, including methods to build Home and Community Based Services (HCBS) providers and institutional capacity in rural areas and maximize available resources. Also discuss specifically how the Offeror will assist rural nursing facilities seeking to expand into community-based care. **Provide action steps and a timeline for the first three years of the Contract, along with measurable outcomes to be achieved. The action steps should focus on the contract start (execution) date and shall illustrate how the Offeror's operational areas will work in an integrated fashion to identify and address network needs.** **[PAGE LIMIT 4]**				
Submission Evaluation Considerations: **- Health Equity** **- Network Development Strategies** **- Other Notable Considerations**				
ARIZONA PHYSICIANS IPA, INC.	**BANNER-UNIVERSITY CARE ADVANTAGE**	**BCBSAZ HEALTH CHOICE**	**HEALTH NET ACCESS**	**MERCY CARE**
RATIONALE AND MAJOR OBSERVATIONS				
Offeror identified specific access issues in rural areas and cited comparative data (e.g., primary care visits, inpatient hospital stays, behavioral health services, emergency room visits) to support its findings. Offeror described in detail its approaches for addressing capacity for HCBS and institutional services in rural areas, including its Health Equity Program incentive within VPB contracts, HCBS workforce investments, and technical/financial supports for Skilled Nursing Facilities. Offeror described innovative approaches for supporting caregivers, including grants to improve access to caregiver support groups and peer support resources for Hispanic families, and the use of caregiver coaches. Offeror described its experience in supporting SNFs to expand services and described its approaches for assisting rural nursing facilities seeking to expand into community-based care, including technical assistance and financial supports.	Offeror described its approach that considers the community and cultural uniqueness of each GSA. Offeror provided an example of a service shortage in the North GSA (Assisted Living Facilities) and its approach for addressing it. Offeror described its approaches for addressing capacity for HCBS and institutional services in rural areas, including provider partnerships, a VBP to incentivize whole-person care, telehealth and virtual clinics. Offeror described methods to increase providers' knowledge and skills, but did not describe clearly innovative approaches. Offeror generally described its approach for assisting rural nursing facilities seeking to expand into community-based care, including collaboration with the Arizona Health Care Association and technical assistance.	Offeror identified the need for additional direct care workers in rural areas and provided examples of programs to address access, including Northern Arizona Dementia Care Center of Excellence and the Northern Arizona BH "Alliance ACO, but did not clearly describe the unique aspects of service areas. Offeror addressed the need for capacity for HCBS and institutional services in rural areas, including assignment of "in-network" status to preserve existing provider and facility relationships for at least one year, workforce development, VBP strategies, and financial supports. However, Offeror did not clearly describe how approaches address the needs of members in rural areas. Offeror described an innovative approach for addressing health equity and service capacity through scholarships for residents in rural communities and minority students. Offeror generally described its approaches for assisting rural nursing facilities seeking to expand into community-based care, including the Blue ALTCS Academy for education/training, investments and creation of NF Centers of Excellence for facilities that expand into community-based services.	Offeror described its approach that considers the community and cultural uniqueness of each GSA. Offeror provided examples of GSA-specific initiatives to address member needs, including a SNF-in-home pilot in the South GSA and specialized care for Hispanic members with dementia in Southeast Maricopa County. Offeror provided a detailed description of its approaches for addressing capacity for HCBS and institutional services in rural areas, including investments, technology-based tools, caregiver supports, transportation enhancements, and strategies for serving members with dementia, and strategies for supporting SNFs to provided specialized care. Offeror provided a detailed description it Network Development and Management Plan. Offeror described innovative approaches for addressing care gaps, including a hotline for members and caregivers to request backup coverage and a dashboard that enables providers to track VBP targets. Offeror clearly described its approaches for assisting rural nursing facilities seeking to expand into community-based care, including collaboration with SNFs , technical support for SNFs to build respite service capacity, and development of a rural AZ SNF Center of Excellence that has expanded to community-based care.	Offeror described its network development strategy to address the needs of members across all settings and services but did not clearly describe unique aspects of service areas. Offeror described its approaches for addressing capacity for HCBS and institutional services in rural areas, including caregiver supports, specialty programs in SNFs/ALFs, community health worker supports, and provider supports/training. Offeror described innovative approaches for addressing health disparities and care gaps, including a bariatric program for SNF/ALF residents and supports for LGBTQ members. Offeror described its approaches for assisting rural nursing facilities seeking to expand into community-based care, including collaboration with SNFs and other stakeholders, and investments to support SNF efforts to expand to HCBS.
Offeror described strategies to monitor and address access to care and network adequacy, including stakeholder feedback and continuous network monitoring. Offeror identified data sources and analysis tools for monitoring access to care and network adequacy, including member/provider feedback, Quest Cloud analysis, Zeills Network 360°, state file review and competitive analysis. Offeror described strategies to address access to care in rural areas, including workforce development, In-Home Primary Care, mobile tools, econsults, caregiver supports, and a SNF at Home pilot. Offeror described strategies to maximize available resources, including a pilot to divert avoidable ambulance and ER use, econsults and the SNF at Home pilot. Offeror provided a three-year plan that included action steps and measurable outcomes, such as increases in the number of providers delivering new services and improvement in health disparities.	Offeror generally described strategies to monitor and address access to care and network adequacy, including community participation and governance and review of proactive/retrospective data sources. Offeror identified data sources and analysis tools for monitoring access to care and network adequacy, including member/provider feedback, and proactive/retrospective data sources and tools, such as the Rovicare customized HCBS capacity tracker. Offeror generally described strategies to address access to care in rural areas, including workforce development, investment in health-related service needs of rural members, mobile tools and telehealth. Offeror generally described strategies to maximize available resources, including expansion of service delivery for existing providers, increasing mobile health, offering virtual clinics and contracting with providers in bordering states. Offeror provided a three-year plan that included action steps and measurable outcomes, such as contracting with additional providers and implementation of identified initiatives) but identified outcomes do not clearly address quality of care or systemic improvement.	Offeror indicated that it gathers and analyzes data as part of its approach for developing and maintaining its network but did not clearly describe how data is used. Offeror did not clearly describe data sources or analysis tools used to monitor access to care and network adequacy. Offeror described strategies to address access to care in rural areas, including workforce development, investments, mobile tools, and health insurance coverage for Self-Directed Attendant Care and other DCWs. Offeror described strategies to maximize available resources, including enhanced transportation reimbursement for providers, mobile tools and telehealth options. Offeror provided a three-year plan that included action steps and measurable outcomes, including metrics related to additional contracting, improved health outcomes and advancing health equity.	Offeror provided a detailed description of its plan to monitor and address access to care, that includes community collaboration, data analysis, review of AHCCCS program requirements, evaluation of its current network and other MCO networks. Offeror fully described data sources and analysis tools for monitoring access to care and network adequacy, such as: feedback from members, the community, providers, and internal departments: geo-mapping; utilization data, health disparities data; appointment availability data, provider grievances and member grievances. Offeror described strategies to address access to care in rural areas, including workforce development, investments, mobile tools, caregiver supports, initiatives to address timely access to non-emergency transportation, and initiatives to provide care for members with specialized treatment needs, such as dementia, Substance Use Disorder and Traumatic Brain Injury. Offeror described strategies to maximize available resources, including initiatives to support provision of specialized care, mobile tools and caregiver supports. Offeror provided a three-year plan that included action steps and measurable outcomes, including metrics related to additional contracting, improved health outcomes and advancing health equity.	Offeror described strategies to monitor and address access to care and network adequacy, including community collaboration, extensive analysis of data and internal collaboration. Offeror identified data sources and analysis tools for monitoring access to care and network adequacy, including stakeholder feedback, utilization data, disparity data, electronic visit verification (EVV) information, member grievance data, satisfaction data, and social risk factor data. Offeror described strategies to address access to care in rural areas, including workforce development, caregiver and family supports, and development of SNF capacity to serve members with specialized needs. Offeror described strategies to maximize available resources, including a "Hospital and SNF at Home" program, virtual in-home care for members with complex conditions, mobile tools, and development of SNF capacity to serve members with specialized needs. Offeror provided a summary that generally described action steps in the first three years of the contract. Offeror identified measurable outcomes that it will monitor over the three-year period but Offeror did not clearly describe how outcomes relate to specific action steps.
RANKING				
2	5	4	1	3

EVALUATOR FULL NAME (FIRST AND LAST):	Christina Quast
EVALUTOR TITLE:	Deputy Assistant Director of Managed Care Operations
DATE:	Nov 9, 2023
SIGNATURE:	Christina Quast

EVALUATOR FULL NAME (FIRST AND LAST):	Gini Britton
EVALUTOR TITLE:	Operations Complianc officwe
DATE:	Nov 9, 2023
SIGNATURE:	Gini Britton

EVALUATOR FULL NAME (FIRST AND LAST):	Jay Dunkleberger
EVALUTOR TITLE:	Network Administrator
DATE:	Nov 13, 2023
SIGNATURE:	Jay Dunkleberger Jay Dunkleberger (Nov 13, 2023 08:03 MST)

FACILITATOR FULL NAME (FIRST AND LAST):	Scott Wittman
DATE:	Nov 13, 2023
SIGNATURE:	Scott Wittman Scott Wittman (Nov 13, 2023 10:35 CST)

EPD RFP YH24-0001 SCORING TOOL
FINAL RANKING AND RATIONALE - BB

SUBMISSION REQUIREMENT 8.B: Describe the Offeror's overall workforce development strategy including the Offeror's workforce development philosophy, the use of data to inform strategies and monitoring activities to determine if strategies are effective, and achievement of desired outcomes. Additionally, the Offeror shall describe how the Offeror will:
a. Assist and incentivize providers to improve workforce monitoring, assessing, planning, and forecasting workforce trends so that the provider can be more strategic in their efforts to recruit, select, train, deploy, and support their staff.
b. Assist providers to improve post-training coaching and supervision to ensure the skills are applied and used effectively, to improve member experience and outcomes, and
c. Integrate the operations of the Offeror's workforce development function within the operations of the network, medical management, and quality management departments.

PAGE LIMIT [4]

Submission Evaluation Considerations:
- Health Equity
- Workforce Strategy and Philosophy
- Provider Functions of Workforce Development
- Provider Competency Development
- Interdependent Workforce Operations
- Other Notable Considerations

ARIZONA PHYSICIANS IPA, INC.	BANNER-UNIVERSITY CARE ADVANTAGE	BCBSAZ HEALTH CHOICE	HEALTH NET ACCESS	MERCY CARE
RATIONALE AND MAJOR OBSERVATIONS				
Offeror described an approach to matching its workforce to the members being served and the communities in which they live, including through its direct care referral program, tribal internship program and creation of a workforce development analytics dashboard to inform workforce development initiatives. Offeror discussed use of technology/innovative techniques to extend/enhance the workforce and increase member access, including through tablet-based DCW skills assessment and training and its DCW transportation program. Offeror described collection and use of demographic data to address health equity and disparities, including through the HWEQ, AHRQ SAS and direct care referral program data sharing (member language and gender preferences). Offeror described workforce development initiatives to address underrepresentation by younger and Spanish-speaking caregivers.	Offeror discussed its commitment to addressing health inequities through workforce development and its investments in programs to address health-related social needs. Offeror did not describe clearly an approach to matching its workforce to the member s being served and the communities in which they live. Offeror discussed use of technology/innovative techniques to extend/enhance the workforce and increase member access, including through deployment of RoviCare platform (e.g., to identify and address caregiver service gaps) and partnering with ASU to offer scholarships to CHW candidates upon completion of training and again upon placement. Offeror discussed collection and use of data but did not describe clearly the use of demographic data to inform workforce recruitment efforts. Offeror committed to finding CHW apprenticeship placements in tribal areas and among Spanish-speaking populations experiencing significant health inequities.	Offeror described an approach to matching its workforce to the members being served and the communities in which they live, including through BCBSAZ diversity scholarships and its AZ Blue ALTCS Academy initiative to promote entry of peer/family and other local supports into the workforce. Offeror discussed use of technology/innovative techniques to extend/enhance the workforce and increase member access, including through quarterly DCW training to promote use of technology/platforms (e.g., Pyx and BlueCare Anywhere telehealth) and implementation of Blue Caregiver Cafe 24-hour online caregiver support. Offeror discussed collection and use of data but did not describe clearly the use of demographic data to inform workforce recruitment efforts. Offeror committed to offering AHCCCS-like, no cost ALA product to encourage low income caregivers to accept greater hour s/higher wages without risking loss of health coverage.	Offeror described an approach to matching its workforce to the members being served and the communities in which they live, including through funding of Spectrum Training Academy in partnership with Havasupai Tribe and Tohono O'odham Nation, to pilot a Training Academy cohort with participants residing in or near the Havasupai and Tohono O'odham Reservations. Offeror discussed funding a caregiver technical assistance center for technology-focused education of paid caregivers but did not describe clearly how it promotes use of technology/innovative techniques to extend the workforce and increase member access. Offeror described collection and use of data under its current contract and how this will be expanded for ALTCS. Offeror described how its Health Equity Administrator tracks member demographic data, including through the use of Ethnic Technologies (a component of its HEDIS dashboard), to inform workforce recruitment efforts.	Offeror described an approach to matching its workforce to the members being served and the communities in which they live, including through funding of collaboration with tribal nations and its partnership with AZCHCW to perform a provider needs/gaps assessment in rural areas to inform workforce development. Offeror discussed use of technology/innovative techniques to extend/enhance the workforce and increase member access, including through its Trualta virtual engagement/learning platform and partnerships with United Way of Southern AZ and Pima Council on Aging to develop a DCW recruitment, training, and placement program in Pima County. Offeror discussed the importance of data in workforce development, as well as future workforce needs. Offeror also mentioned pairing case managers with CHWs, although it did not describe clearly how it uses data to address health equity and disparities or how health equity will be incorporated into the pairing process.
Offeror committed to meeting/exceeding the requirements of ACOM 407 and described its approach to operationalizing through integration of the workforce development office across the organization. Offeror described a workforce development vision that aligned with AHCCCS goals and included both proactive (e.g., funding of pathway pilot programs) and reactive (e.g., initiatives launched in response to 2015 workforce survey) strategies. Offeror provided an example of using quantitative and qualitative data to identify the need for more Spanish-speaking caregivers, resulting in a partnership with Dust CBO. Offeror did not present a formal plan for implementation but did describe multiple initiatives with specific targets to be achieved during the upcoming contract period (e.g., recruiting and retaining up to 2,000 DCWs through grant funding, with no commitment to a minimum number). Offeror described its use of data to inform strategies and monitoring activities, including through use of multiple internal and external data sources and its RoviCare platform. Offeror acknowledged the importance of less traditional workforces and pr ovided initiatives to expand their numbers (e.g., paid scholarships for younger adults ages 18 - 24 and the Dust CBO partnership for Spanish-speaking caregivers).	Offeror described a plan aligned with ACOM 407. Offeror described its approach to operationalizing through its WFD administrator and team. Offeror discussed its goal to build a more cohesive and effective healthcare system through workforce development but did not describe clearly a vision that aligned with AHCCCS goals and described both proactive and reactive strategies for workforce development (e.g., various funding initiatives) but did not provide clear examples of reactive strategies. Offeror discussed several new initiatives (e.g., ALTCS WFD toolkit) but did not describe clearly a plan for implementation of a strategy with multiple action steps, timelines and/or measurable outcomes. Offeror described its use of data to inform strategies and monitoring activities, including through use of multiple internal and external data sources and the RoviCare platform. Offeror acknowledged the importance of less traditional workforces (e.g., Promotores de Salud) and discussed various methods for supporting caregivers (e.g., respite and peer support).	Offeror described a plan aligned with ACOM 407. Offeror described its approach to operationalizing through development of a workforce development operations team with ten FTEs. Offeror described a workforce development vision that aligned with AHCCCS goals and included both proactive (e.g., expanding peer/family caregiver participation) and reactive (e.g., PDSA to evaluate/modify) strategies. Offeror described its plan for implementation through presentation of four team discrete initiatives. Offeror described its use of data to inform strategies and monitoring activities, including through use of multiple internal and external data sources to forecast needs and evaluate performance. Offeror acknowledged the importance of less traditional workforces for HCDS through its strategy for expanding use of peer/family and other community supports.	Offeror committed to meeting/exceeding the requirements of ACOM 407 and described its approach to operationalizing by building upon its existing workforce development office. Offeror described a workforce development vision that aligned with AHCCCS goals and included both proactive (e.g., funding of CHW certificate program) and reactive (e.g., proposed creation of caregiver technical assistance center in response to drop in average length of employment) strategies. Offeror described its plan for implementation through presentation of multiple initiatives with timelines. Offeror described its use of data to inform strategies and monitoring activities, including through multiple internal and external data sources. Offeror acknowledged the importance of less traditional workforces through its partnership with the Peer and Family Career Academy.	Offeror committed to meeting/exceeding the requirements of ACOM 407 and described its approach to operationalizing through integration of the workforce development office across the organization. Offeror described a workforce development vision that aligned with AHCCCS goals and included both proactive (e.g., funding of pathway pilot programs) and reactive (e.g., initiatives launched in response to 2015 workforce survey) strategies. Offeror described its plan for implementation through presentation of a three-year schedule with multiple action steps and measurable outcomes. Offeror described its use of data to inform strategies and monitoring activities, including through use of multiple internal and external data sources to forecast needs and evaluate performance. Offeror acknowledged the importance of less traditional workforces through its "Supporting Family Members in Becoming Professional Direct Care Givers" initiative.
Offeror demonstrated its approach to engaging providers and their workforce operations, including through a grant to Consumer Direct to fund a WFD leader and through facilitation or technical assistance for providers by promoting an EVV Hard Edit Interactive Guide. Offeror described its evaluation of provider workforce plans for member and network needs, including through in-person provider audits to observe direct skills application and offer real-time coaching and supervision. Offeror discussed integration of the provider workforce plans into operations through leadership of the WFDO by the CEO and COO and meetings between the WFD Administrator and other operations leaders. Offeror described an incentive program for MEI/IT drivers who complete cultural competency training. Offeror also discussed an EVV WIP initiative for Personal Care Attendants in its Tennessee plan but did not state clearly whether the incentive program would be replicated in Arizona.	Offeror demonstrated its approach to engaging providers and their workforce operations, including through its commitments to offering incentives for completion of WFD plans and meeting competency continuum goals, and through provision of 1:1 technical assistance. Offeror described its evaluation of provider workforce plans, including through monitoring of utilization within RoviCare and tracking member satisfaction with access to care and cultural competency. Offeror provided an example of identifying an issue with caregiver training on Hoyer lifts based on utilization trends. Offeror discussed integration of the provider workforce plans into operations through placement of the WFD team within network operations and coordination with quality and medical management teams, among others. Offeror described several types of provider incentive programs, including bonuses to CHWs for completion of training and certification and the previously-noted WFD plan incentives.	Offeror demonstrated its approach to engaging providers and their workforce operations, including through its commitments to offering incentives for completion of WFD plans and meeting competency continuum goals, and through provision of 1:1 technical assistance. Offeror described its evaluation of provider workforce plans, including through monitoring of utilization within RoviCare and tracking member satisfaction with access to care and cultural competency. Offeror provided an example of identifying an issue with caregiver training on Hoyer lifts based on utilization trends. Offeror discussed integration of the provider workforce plans into operations through placement of the WFD team within network operations and coordination with quality and medical management teams, among others. Offeror described several types of provider incentive programs, including bonuses to CHWs for completion of training and certification and the previously-noted WFD plan incentives.	Offeror demonstrated its approach to engaging providers and their workforce operations, including through its commitments to create a comprehensive training program for ALTCS Peer/Family Advocates and to offer 1:1 technical assistance to providers. Offeror described its evaluation of provider workforce plans through a combination of internal, external and stakeholder data. Offeror provided an example of identifying a decrease in average length of employment and developing a strategy to address. Offeror discussed integration of WFD into operations through its committee structure but did not describe clearly how it will integrate provider workforce plans into operations. Offeror discussed recognizing providers through an Excellence in WFD award. Offeror noted that it requires agencies to share a portion of VBP incentives with their frontline staff but did not describe clearly its proposed VBP structure for ALTCS.	Offeror demonstrated its approach to engaging providers and their workforce operations, including through its provision of 1:1 technical assistance and its centers-of-excellence initiative. Offeror described its monitoring and evaluation of provider workforce plans to assess achievement of expected outcomes. Offeror discussed the role of its WFD taskforce in reviewing progress toward achievement of expected outcomes. Offeror discussed integration of the provider workforce plans into operations through the WFD Advisory Board and Taskforce, which includes medical management, network and QM, among others. Offeror described several types of provider incentive programs, including value-based incentive contracts for centers-of-excellence and RISE awards based on WFD innovations and results.
Offeror discussed providing a tablet-based electronic self-evaluation tool to providers for assessing skills after participating in DCW supervision/in-care trainings, as well as conducting audits, as noted above. Offeror also mentioned providing training to psychiatry leadership staff but did not describe clearly an approach to offering supervisory development training. Offeror discussed measuring provider competency through the self-evaluation tool and in-person audits. Offeror also stated it is incorporating member experience and outcomes questions in conjunction with Heightened Scrutiny to assess provider training efficacy. Offeror discussed promoting the Healthcare Hub for career advancement and described its funding of tribal internships at a local FQHC.	Offeror described an approach to offering supervisory development training that included creation of an ALTCS-specific WFD toolkit and apprenticeships to support providers in Pima and Yuma Counties to sustain coaching for their workforce post-training. Offeror discussed measuring provider competency through pre-hire assessments, 30/60/90 day post-hire check-ins and proposed incentive payments for meeting competency continuum goals. Offeror discussed including career advancement templates and training guides in the ALTCS WFD toolkit but did not describe clearly a strategy for promoting career advancement.	Offeror described an approach to offering supervisory development training that included commitments to provide coaching and mentoring training to 500 provider supervisors, offering 20 Blue Academy slots per year to high-potential supervisors and sponsoring 20 organizations per year to send leaders via wellbeing training. Offeror discussed multiple data sources for its monitoring activities but did not describe clearly any direct methods for measuring provider competency. Offeror discussed supporting up to 1,000 scholarships to assist residents in rural communities to enter or pursue promotion in the workforce (no commitment to a minimum number) and mentioned that Blue ALTCS Academy participation will in part be for career advancement.	Offeror committed to supporting supervisory activities by funding key provider supervisor positions, offering training on supportive supervision, establishing provider coaching programs and modeling a coaching approach. Offeror discussed initiatives for entry level workers and for career enrichment but did not describe clearly its proposed methods to fulfill the supervisory development commitments. Offeror discussed multiple data sources for its monitoring activities but did not describe clearly any direct methods for measuring provider competency. Offeror described an approach for fostering career advancement that included multiple strategies (e.g., investment in the AZ Western College CHW Certificate Program, investment in Education Unidos and creating AzCHI Community Transformation Scholarship Fund with a $400,000 endowment). Offeror also committed approximately $2 million in new WFD initiatives if operating as an ALTCS plan.	Offeror described an approach to offering supervisory development training that included mentoring and train-the-trainer programs. Offeror documented the value of the programs as reported by participants. Offeror discussed identifying high-performing providers through member survey data but did not describe clearly any direct methods for measuring provider competency. Offeror described an approach for fostering career advancement that included multiple strategies (e.g., offering caregiver education and support through Trualta and providing funding for internships and other initiatives). Offeror committed to specific hiring and certification targets for direct care workers.
Offeror presented a reporting structure in which the CEO and COO lead the WFDO, while the WFD Administrator interacts with other operations leaders.	Offeror presented a reporting structure that addressed integration of workforce development with other components through inclusion in network operations and reporting to plan committees, although it did not specify clearly which committees. WFD Administrator reports to executive leadership through the network operations senior director.	Offeror presented a reporting structure that addressed integration of workforce development with other components through internal committee participation but did not describe clearly how workforce development reports to executive leadership.	Offeror presented a reporting structure that addressed integration of workforce development with other components through internal committee participation but did not describe clearly how workforce development reports to executive leadership, other than indirectly through the Network Oversight Committee.	Offeror presented a reporting structure that addressed integration of workforce development with other components through internal committee participation but did not describe clearly how workforce development reports to executive leadership.
RANKING				
2	3	5	4	1

EVALUATOR FULL NAME (FIRST AND LAST):	William Kennard
EVALUATOR TITLE:	Administrator, Office of Health Care Workforce Development
DATE	Nov 8, 2023
SIGNATURE:	WK Kennard

EVALUATOR FULL NAME (FIRST AND LAST):	Jay Dunkleberger
EVALUATOR TITLE:	Network Administrator
DATE	Nov 13, 2023
SIGNATURE:	Jay Dunkleberger Jay Dunkleberger (Nov 13, 2023 08:05 MST)

EVALUATOR FULL NAME (FIRST AND LAST)	Jenna Girdosky
EVALUATOR TITLE:	Operations Compliance Officer
DATE	Nov 13, 2023
SIGNATURE:	JG

FACILITATOR FULL NAME (FIRST AND LAST)	Andrew Cohen
DATE	Nov 13, 2023
SIGNATURE:	Andrew Cohen Andrew Cohen (Nov 13, 2023 07:56 PST)

EPD RFP YH24-0001 SCORING TOOL
FINAL RANKING AND RATIONALE - B9

SUBMISSION REQUIREMENT B9: Recent studies have shown that social, economic, and environmental conditions, in addition to health behaviors, can determine approximately 80% of health outcomes in the U.S. Given the Offerors' role in serving people with complex clinical, behavioral health, and social needs, it is critical to address social risk factors. For each of the following populations, describe how the Offeror will provide timely access to services and supports as well as monitor outcomes. The Offeror shall also identify its strategy(ies) for addressing potential barriers to care, as well as best practices to be implemented.
a. Members residing in rural communities,
b. Tribal members,
c. Members in need of community resources, and
d. Members in need of Peer and/or Family Support services.

PAGE LIMIT [4]

Submission Evaluation Considerations:
- Health Equity
- Strategies that Support Access to Care
- Collaboration and Engagement
- Other Notable Considerations

ARIZONA PHYSICIANS IPA, INC.	BANNER-UNIVERSITY CARE ADVANTAGE	BCBSAZ HEALTH CHOICE	HEALTH NET ACCESS	MERCY CARE
RATIONALE AND MAJOR OBSERVATIONS				
Offeror discussed its data collection and analysis tools, as well as data sources, to monitor timely access and outcomes. Offeror cited comparative health utilization statistics (urban v. rural) and health-related social needs (HRSN) measures to support its findings. Offeror described how it uses data to support program evaluation and policy development. Offeror described initiatives, including CareBridge and Spectrum Anywhere Care, to provide physical and behavioral health services for members at high risk and promote access in rural areas. Offeror provided examples (food insecurity, social isolation) of how it used data to identify SDOH-related barriers and its development of partnerships/investments to address barriers.	Offeror generally described data sources and tools used, as well as community input, to monitor timely access and assess community needs. Offeror described how it uses data to support program evaluation and policy development. Offeror acknowledged the importance of physical and behavioral health and provided examples of initiatives (e.g., mobile apps, telehealth, providing psychiatric and dementia training to non-psychiatrists) to address barriers. Offeror described how it used data analytics to identify SDOH-related barriers; Offeror described partnerships/investments to address barriers.	Offeror described its data collection and analytics approach, including the use of local data sources, such as the NAU/ASU Center for Health Equity Research study. Offeror clearly described how it uses data to support program evaluation and policy development; Offeror described its four-step approach for identifying, addressing and monitoring health-related social needs. Offeror described its efforts to collect and analyze data related to physical and behavioral health care, including care for dementia. Offeror described its efforts to support caregivers and families. Offeror described how it used data analytics to identify SDOH-related barriers; Offeror described partnerships/investments to address barriers.	Offeror discussed data sources as well as its efforts to solicit stakeholder feedback, but did not clearly describe its data collection and analysis approach to monitor timely access and outcomes. Offeror described how it uses data to support program evaluation and policy development Offeror described its efforts to work with stakeholders to implement initiatives and remove barriers to physical and behavioral health services. Offeror described how it used data analytics to identify SDOH-related barriers; Offeror described partnerships/investments to address barriers.	Offeror described its proprietary tools for monitoring and promoting timely access and outcomes, but did not clearly describe the functionality of these tools. Offeror described how it uses data to support program evaluation and policy development. Offeror described initiatives, including CareBridge, Spectrum Anywhere Care and Terros, to provide physical and behavioral health services for members at high risk and promote access in rural areas. Offeror described how it used data analytics to identify SDOH-related barriers; Offeror described partnerships/investments to address barriers.
Offeror described its approach for monitoring and addressing network adequacy; Offeror indicated that it adheres to Plan-Do-Study-Act (PDSA) methods to assess and adjust initiatives. Offeror identified examples of potential barriers, solutions and outcomes for members residing in rural communities, including technology-based solutions, supports for using technology (Cyber Seniors), and provider supports (eConsults). Offeror discussed its approach for supporting Tribal members that includes collaboration with Tribal partners, cultural awareness training and Tribal workforce development. Offeror identified unique characteristics of certain service areas and provided examples of strategies to ensure timely access, including approaches in response to natural disasters, food insecurity and social isolation.	Offeror generally described how it monitors network adequacy and provided a proactive plan for addressing network adequacy. Offeror identified examples of potential barriers, solutions and outcomes for members residing in rural communities, including a Home-Based Primary Care Pilot, technology-based solutions, telehealth, transportation and provider supports. Offeror discussed its approach for supporting Tribal members that includes collaboration with Tribal partners, cultural awareness training and targeted initiatives to address barriers. Offeror identified unique characteristics of certain service areas and provided examples of strategies to ensure timely access, including telehealth and provider training.	Offeror described its approach for monitoring and addressing network adequacy; Offeror indicated that it adheres to Plan-Do-Study-Act (PDSA) methods to assess and adjust initiatives. Offeror identified examples of potential barriers, solutions and outcomes for members residing in rural communities, including supporting member-directed options, technology-based solutions, telehealth, transportation and provider supports. Offeror discussed its approach for supporting Tribal members that includes collaboration with Tribal partners, cultural awareness training and targeted initiatives to address barriers. Offeror identified unique characteristics of certain service areas and described strategies to address specific barriers, including food insecurity, housing, workforce shortages and access to specialized care (including care for members with neurological disabilities, spinal cord injuries and dementia).	Offeror generally described its approach for monitoring its network, including data review and communications with partners. Offeror identified examples of barriers, solutions and outcomes for members residing in rural communities, including technology-based solutions and transportation. Offeror discussed its approach for supporting Tribal members that includes collaboration with Tribal partners, creation of a dedicated case management team to serve ALTCS AI members, and targeted initiatives to address barriers. Offeror generally discussed unique characteristics of certain service areas and provided examples of strategies to ensure timely access, including food insecurity in Southern Arizona.	Offeror described its approach for monitoring network adequacy that includes data analysis and feedback; Offeror indicated that Find-Organize-Clarify-Understand-Specify and Plan-Do-Study Act methods to evaluate improvement efforts. Offeror identified examples of barriers, solutions and outcomes for members residing in rural communities, including technology-based solutions and transportation. Offeror discussed its approach for supporting Tribal members that includes collaboration with Tribal partners, development of a tribal specialty community health worker program, and targeted initiatives to address barriers. Offeror generally discussed unique characteristics of certain service areas and provided examples of strategies to ensure timely access, including initiatives to address disparities in the South Mountain neighborhood in Phoenix.
Offeror described the tools is uses to monitor outcomes; Offeror provided examples of how it collaborated with the Tribal community to improve outcomes; Offeror provided an example of a potential telehealth barrier identified through surveying Tribal representatives, providers and stakeholders and its response to address the barrier. Offeror discussed its approach for identifying barriers through an array of tools related to member and provider outcomes. Offeror provided examples of responses to identified barriers. Offeror provided examples of initiatives to promote and expand peer and family supports, including its partnership with Gellert Health to offer an Intensive Peer Support program and its credentialed peer support training program.	Offeror described the tools is uses to monitor outcomes and described its engagement with community partners, including the Tribal community and providers. Offeror described a proactive approach for identifying and addressing barriers. Offeror provided examples of responses to identified barriers. Offeror indicated that it contracts with 9 of 10 Community Service Agencies that are designated as peer run organizations; Offeror provided an example of identifying and implementing the daily living activities-20 (DLA-20) assessment tool as a best practice.	Offeror described the tools is uses to monitor outcomes; Offeror provided examples of how it collaborated with community agencies to improve outcomes. Offeror described in detail a proactive approach for identifying and addressing barriers. Offeror provided examples of responses to identified barriers. Offeror provided a detailed and proactive description of its plan to promote and expand peer and family supports, including peer and family programs, enhanced communications initiatives, and training programs.	Offeror described the tools is uses to monitor outcomes; Offeror provided examples of how it collaborated with the Tribal community to improve outcomes. Offeror described a proactive approach for identifying and addressing barriers. Offeror provided examples of responses to identified barriers. Offeror provided examples of targeted initiatives to promote and expand peer and family supports, including access to peer supports in Skilled Nursing Facilities and Assisted Living Facilities, its Hospital Engagement and Linkage Peer Program (HELPP), and partnering with a Center for Independent Living (CIL) to develop its Peer and Family Advocacy Project.	Offeror described the tools is uses to monitor outcomes; Offeror provided examples of how it collaborated with the Tribal community to improve outcomes. Offeror discussed its approach for identifying and addressing barriers; Offeror provided examples of responses to identified barriers. Offeror provided examples of initiatives it has undertaken to promote and expand peer and family supports, including its partnership with a peer-run organization, mobile tools, access to respite, and family supports.
RANKING				
4	2	1	3	5

EVALUATOR FULL NAME (FIRST AND LAST):	Rachel Conley
EVALUTOR TITLE:	Tribal ALTCS Administrator
DATE:	Nov 13, 2023
SIGNATURE:	Rachel Conley Rachel Conley (Nov 13, 2023 14:28 PST)

EVALUATOR FULL NAME (FIRST AND LAST):	Dr. Melissa Del-Colle
EVALUTOR TITLE:	Adult System of Care Program Administrator
DATE:	Nov 14, 2023
SIGNATURE:	Melissa DelColle (Nov 14, 2023 06:51 MST)

EVALUATOR FULL NAME (FIRST AND LAST):	Susan Kennard
EVALUTOR TITLE:	Administrator Office of Individual and Family Affairs
DATE:	Nov 14, 2023
SIGNATURE:	Susan Kennard

FACILITATOR FULL NAME (FIRST AND LAST):	
DATE:	
SIGNATURE:	

FACILITATOR FULL NAME (FIRST AND LAST):	Scott Wittman
DATE:	Nov 14, 2023
SIGNATURE:	Scott Wittman Scott Wittman (Nov 14, 2023 09:18 CST)

EPD RFP YH24-0001 SCORING TOOL FINAL RANKING AND RATIONALE - B10				
SUBMISSION REQUIREMENT B10: Pursuant to 42 CFR 438.358 (b)(iii), Medicaid agencies must conduct compliance reviews of their contracted Managed Care Organizations at least every three years. AHCCCS will evaluate compliance reviews and incorporate the Offeror's past performance as specified below: **a. Incumbent E/PD Contractors - A submission is not required. AHCCCS will utilize the AHCCCS Calendar Year (CY) 23 ALTCS E/PD Operational Review (OR),** **b. Incumbent non-E/PD Contractors - A submission is not required. AHCCCS will utilize the most recent finalized AHCCCS Operational Review (OR), and** **c. Non-Incumbent Offerors - The Offeror shall submit its most recent review(s) that together comprise a complete evaluation. The review(s) shall be selected from one of the Medicaid Contracts cited in B2 in compliance with 42 CFR 438.358 (b)(iii) for a business line which includes provision of services that are comparable to the Scope of Services for this RFP. The Offeror shall include a description of how the services delivered in the business line for the submitted compliance review are comparable to the Scope of Services for this RFP. The Offeror's submission shall not exceed one page plus attached compliance review(s). AHCCCS reserves the right to validate the submitted review.** **PAGE LIMIT: N/A except for Non-Incumbent Offerors** **For Nonincumbent Offerors: Refer to (B10c) and RFP Section H, Instructions to Offerors for submission format requirements**				
Submission Evaluation Considerations: **- AHCCCS OR Report Review [Incumbent]** **- Other Notable Considerations**				
ARIZONA PHYSICIANS IPA, INC.	**BANNER-UNIVERSITY CARE ADVANTAGE**	**BCBSAZ HEALTH CHOICE**	**HEALTH NET ACCESS**	**MERCY CARE**
RATIONALE AND MAJOR OBSERVATIONS				
In its most recent operational review, issued in April 2023, offeror was found to be in full (95 - 100%) compliance on 138 standards.	In its most recent operational review, issued in May 2023, offeror was found to be in full (95 - 100%) compliance on 145 standards.	In its most recent operational review, issued in October 2022, offeror was found to be in full (95 - 100%) compliance on 125 standards.	In its most recent operational review, issued in May 2021, offeror was found to be in full (95 - 100%) compliance on 129 standards.	In its most recent operational review, issued in July 2023, offeror was found to be in full (95 - 100%) compliance on 142 standards.
Operational review categories in which standards with substantial non-compliance (under 80% full compliance) were documented included, among others: case management (four standards), adult/EPSDT/MCH (three standards), medical management (two standards), quality management (five standards) and integrated system of care (six standards). (Offeror had no findings of substantial non-compliance within the quality improvement category.)	Operational review categories in which standards with substantial non-compliance (under 80% full compliance) were documented included, among others: case management (five standards), medical management (four standards), quality management (three standards) and integrated system of care (two standards). (Offeror had no findings of substantial non-compliance within the adult/EPSDT/MCH category.)	Operational review categories in which standards with substantial non-compliance (under 80% full compliance) were documented included, among others: adult/EPSDT/MCH (one standard), medical management (one standard), quality management (seven standards), quality improvement (three standards) and integrated system of care (one standard). (Case management was not an operational review category.)	Operational review categories in which standards with substantial non-compliance (under 80% full compliance) were documented included, among others: adult/EPSDT/MCH (five standards), medical management (one standard) and quality management (one standard). (Offeror had no findings of substantial non-compliance within the quality improvement category.) (Case management and integrated system of care were not operational review categories.)	Operational review categories in which standards with substantial non-compliance (under 80% full compliance) were documented included, among others: case management (ten standards), adult/EPSDT/MCH (four standards), medical management (two standards), quality management (four standards) and integrated system of care (one standard). (Offeror had no findings of substantial non-compliance within the quality improvement category.)
Offeror's operational review was for the ALTCS E/PD program, which includes a comprehensive LTSS benefit package.	Offeror's operational review was for the ALTCS E/PD program, which includes a comprehensive LTSS benefit package.	Offeror's operational review was for the AHCCCS Complete Care program.	Offeror's operational review was for the ACC-RBHA program.	Offeror's operational review was for the ALTCS E/PD program, which includes a comprehensive LTSS benefit package.
RANKING				
2	**1**	**5**	**4**	**3**

EVALUATOR FULL NAME (FIRST AND LAST):	Christina Quast
EVALUTOR TITLE:	Deputy Assistant Director of Managed Care Operations
DATE	Nov 8, 2023
SIGNATURE:	Christina Quast

EVALUATOR FULL NAME (FIRST AND LAST):	Jakenna Lebsock
EVALUTOR TITLE:	Assistant Director, Division of Health Care Services
DATE	Nov 8, 2023
SIGNATURE:	Jakenna L Lebsock

EVALUATOR FULL NAME (FIRST AND LAST):	Michelle Holmes
EVALUTOR TITLE:	Operations Manager, Division of Health Care Services
DATE	Nov 8, 2023
SIGNATURE:	Michelle Holmes

FACILITATOR FULL NAME (FIRST AND LAST):	Andrew Cohen
DATE	Nov 8, 2023
SIGNATURE:	Andrew Cohen Andrew Cohen (Nov 8, 2023 08:36 PST)

EPD RFP YH24-0001 SCORING TOOL
FINAL RANKING AND RATIONALE - B11

SUBMISSION REQUIREMENT B11: The Offeror shall submit its 2023 AZ Medicaid Plan D-SNP STAR rating. If the Offeror does not have a D-SNP STAR Rating in Arizona, the Offeror shall cite its 2023 STAR rating with the corresponding Medicare Contract Number, from one of the states for the Medicaid contracts cited in Submission Requirement B2, using the preference order detailed below. Preference order for STAR Rating from another State:
a. FIDE SNP/DSNP Plan,
b. Another type of SNP, or
c. Medicare Advantage Plan.

PAGE LIMIT: Refer to RFP Section H, Instructions to Offerors for submission format requirements.

Submission Evaluation Considerations:
-Comprehensive Response
-Verification
-Other Notable Considerations

ARIZONA PHYSICIANS IPA, INC.	BANNER-UNIVERSITY CARE ADVANTAGE	BCBSAZ HEALTH CHOICE	HEALTH NET ACCESS	MERCY CARE
RATIONALE AND MAJOR OBSERVATIONS				
Offeror provided its 2023 Star rating for its Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) in Arizona.	Offeror provided its 2023 Star rating for its Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) in Arizona.	Offeror provided its 2023 Star rating for its Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) in Arizona.	Offeror provided its 2023 Star rating for its Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) in Arizona.	Offeror provided its 2023 Star rating for its Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) in Arizona.
Offeror cited Contract Number H0321, which is a current AHCCCS-contracted FIDE and HIDE SNP CMS contract number.	Offeror cited Contract Number H4931, which is a current AHCCCS-contracted FIDE and HIDE SNP CMS contract number.	Offeror cited Contract Number H5587, which is a current AHCCCS-contracted HIDE SNP CMS contract number.	Offeror cited Contract Number H5590, which is a current AHCCCS-contracted HIDE SNP CMS contract number.	Offeror cited Contract Number H5580, which is a current AHCCCS-contracted FIDE and HIDE SNP CMS contract number.
Offeror provided its 2023 Star rating, equal to 4.0 Stars.	Offeror provided its 2023 Star rating, equal to 3.0 Stars.	Offeror provided its 2023 Star rating, equal to 4.0 Stars.	Offeror provided its 2023 Star rating, equal to 3.5 Stars.	Offeror provided its 2023 Star rating, equal to 3.0 Stars.
Offeror's reported Star rating was confirmed using Medicare Plan Compare website on October 3, 2023.	Offeror's reported Star rating was confirmed using Medicare Plan Compare website on October 3, 2023.	Offeror's reported Star rating was confirmed using Medicare Plan Compare website on October 3, 2023.	Offeror's reported Star rating was confirmed using Medicare Plan Compare website on October 3, 2023.	Offeror's reported Star rating was confirmed using Medicare Plan Compare website on October 3, 2023.
RANKING				
1	**2**	**4**	**5**	**2**

EVALUATOR FULL NAME (FIRST AND LAST):	Christina Quast
EVALUTOR TITLE:	Deputy Assistant Director of Managed Care Operations
DATE	Nov 8, 2023
SIGNATURE:	Christina Quast

EVALUATOR FULL NAME (FIRST AND LAST):	Tom Heiser
EVALUTOR TITLE:	Project Development Officer
DATE	Nov 13, 2023
SIGNATURE:	Thomas Heiser Thomas Heiser (Nov 13, 2023 10:55 MST)

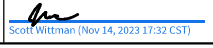
FACILITATOR FULL NAME (FIRST AND LAST):	Scott Wittman
DATE	Nov 14, 2023
SIGNATURE:	 Scott Wittman (Nov 14, 2023 17:32 CST)

EXHIBIT C

December 1, 2023 THIS NOTICE BEING SENT EXCLUSIVELY VIA EMAIL

Health Net Access, Inc. dba Arizona Complete Health-Complete Care Plan
James Stover
Medicaid Plan President
James.V.Stover@azcompletehealth.com

Subject: Notification of Contract Awards ALTCS E/PD RFP YH-0001

Dear Mr. James Stover,

This letter is to inform you that AHCCCS is awarding *Health Net Access, Inc. dba Arizona Complete Health-Complete Care Plan* an ALTCS E/PD Statewide Contract under RFP number YH24-0001 in the following Geographic Service Area(s) (GSAs):

GSA	COUNTY
CENTRAL	Maricopa, Gila, Pinal (excluding zip codes 85542, 85192, and 85550)
NORTH	Mohave, Coconino, Apache, Navajo, Yavapai
SOUTH	Pima, Cochise, Graham, Greenlee, La Paz, Santa Cruz, Yuma (including zip codes 85542, 85192, and 85550)

As stipulated in the YH24-0001 RFP Section H: Instructions to Offerors: For the CYE 24 rating period, AHCCCS set the ALTCS-EPD underwriting gain percentage equal to 1.45% of the capitation rates, excluding premium tax. AHCCCS may revise the applicable underwriting gain percentage as part of capitation rate development each year. Administrative and case management cost components were bid by the Offerors. AHCCCS may use these bids in developing capitation rates; however, AHCCCS reserves the right to adjust the capitation rates, including the administrative and case management cost components, to maintain compliance with the Medicaid and CHIP Managed Care Final Rule and additional guidance from CMS published annually in the Medicaid Managed Care Rate Development Guides.

Additionally, as stated in the RFP, Section H: Instructions to Offerors, the Offeror shall meet all AHCCCS requirements, irrespective of what is requested and evaluated through this Solicitation. The Proposal submitted by the Offeror will become part of the Contract with AHCCCS and the Offeror shall comply with all commitments and statements included in its RFP submission.

Your assigned Contract Number is YH24-0001-02, please include this number in contract communications going forward.

Please find your fully executed Offer and Acceptance Page attached to this letter.

Please countersign and return this contract award letter as soon as possible. This information must be emailed to Meggan LaPorte at RFPYH24-0001@azahcccs.gov.

www.azahcccs.gov
602-417-4000
801 East Jefferson Street, Phoenix, AZ 85034

Per RFP Section H: Instructions to Offerors, Contractor changes will be effective October 1, 2024. AHCCCS will notify Contractors of the transition process and timelines as soon as possible after Contract awards.

The public will be notified of the awards when the RFP YH24-0001 Procurement File is made available for public inspection on the AHCCCS website on December 1, 2023. The Offeror may refer to the Procurement File for information regarding contract awards.

If you have any questions regarding this letter please contact Meggan LaPorte, AHCCCS Chief Procurement Officer via RFPYH24-0001@azahcccs.gov.

The Offeror must acknowledge receipt of this letter via email response to this notification.

AHCCCS	
MEGGAN LAPORTE	Meggan LaPorte (Nov 29, 2023 10:13 MST)
PRINTED NAME	**SIGNATURE**
AHCCCS CHIEF PROCUREMENT OFFICER	Nov 29, 2023
TITLE	**DATE**

HEALTH NET ACCESS, INC. DBA ARIZONA COMPLETE HEALTH-COMPLETE CARE PLAN	
PRINTED NAME	**SIGNATURE**
TITLE	**DATE**

www.azahcccs.gov
602-417-4000
801 East Jefferson Street, Phoenix, AZ 85034

EXHIBIT D

December 1, 2023 THIS NOTICE BEING SENT EXCLUSIVELY VIA EMAIL

Arizona Physicians IPA, Inc. (dba UnitedHealthcare Community Plan)
Jean Kalbacher
Chief Executive Officer
Jean_Kalbacher@uhc.com

Subject: Notification of Contract Awards ALTCS E/PD RFP YH-0001

Dear Ms. Jean Kalbacher,

This letter is to inform you that AHCCCS is awarding *Arizona Physicians IPA, Inc. (dba UnitedHealthcare Community Plan)* an ALTCS E/PD Statewide Contract under RFP number YH24-0001 in the following Geographic Service Area(s) (GSAs):

GSA	COUNTY
CENTRAL	Maricopa, Gila, Pinal (excluding zip codes 85542, 85192, and 85550)
NORTH	Mohave, Coconino, Apache, Navajo, Yavapai
SOUTH	Pima, Cochise, Graham, Greenlee, La Paz, Santa Cruz, Yuma (including zip codes 85542, 85192, and 85550)

As stipulated in the YH24-0001 RFP Section H: Instructions to Offerors: For the CYE 24 rating period, AHCCCS set the ALTCS-EPD underwriting gain percentage equal to 1.45% of the capitation rates, excluding premium tax. AHCCCS may revise the applicable underwriting gain percentage as part of capitation rate development each year. Administrative and case management cost components were bid by the Offerors. AHCCCS may use these bids in developing capitation rates; however, AHCCCS reserves the right to adjust the capitation rates, including the administrative and case management cost components, to maintain compliance with the Medicaid and CHIP Managed Care Final Rule and additional guidance from CMS published annually in the Medicaid Managed Care Rate Development Guides.

Additionally, as stated in the RFP, Section H: Instructions to Offerors, the Offeror shall meet all AHCCCS requirements, irrespective of what is requested and evaluated through this Solicitation. The Proposal submitted by the Offeror will become part of the Contract with AHCCCS and the Offeror shall comply with all commitments and statements included in its RFP submission.

Your assigned Contract Number is YH24-0001-01, please include this number in contract communications going forward.

Please find your fully executed Offer and Acceptance Page attached to this letter.

Please countersign and return this contract award letter as soon as possible. This information must be emailed to Meggan LaPorte at RFPYH24-0001@azahcccs.gov.

www.azahcccs.gov
602-417-4000
801 East Jefferson Street, Phoenix, AZ 85034

Per RFP Section H: Instructions to Offerors, Contractor changes will be effective October 1, 2024. AHCCCS will notify Contractors of the transition process and timelines as soon as possible after Contract awards.

The public will be notified of the awards when the RFP YH24-0001 Procurement File is made available for public inspection on the AHCCCS website on December 1, 2023. The Offeror may refer to the Procurement File for information regarding contract awards.

If you have any questions regarding this letter please contact Meggan LaPorte, AHCCCS Chief Procurement Officer via RFPYH24-0001@azahcccs.gov.

The Offeror must acknowledge receipt of this letter via email response to this notification.

AHCCCS	
MEGGAN LAPORTE	Meggan LaPorte (Nov 29, 2023 10:43 MST)
PRINTED NAME	**SIGNATURE**
AHCCCS CHIEF PROCUREMENT OFFICER	Nov 29, 2023
TITLE	**DATE**

ARIZONA PHYSICIANS IPA, INC. (DBA UNITEDHEALTHCARE COMMUNITY PLAN)	
PRINTED NAME	**SIGNATURE**
TITLE	**DATE**

www.azahcccs.gov
602-417-4000
801 East Jefferson Street, Phoenix, AZ 85034

EXHIBIT E

OFFER AND ACCEPTANCE

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and final proposal revisions (if any). Signature also certifies Small Business Status.

Arizona Transaction (Sales) Privilege Tax License No.:				For clarification of this offer, contact:
N/A			Name:	James Stover
Federal Employer Identification No.:				
46-2616037			Title:	Medicaid Plan President
E-Mail Address:	james.v.stover@azcompletehealth.com		Phone:	520-343-8004
Health Net Access, Inc. d/b/a Arizona Complete Health-Complete Care Plan			JVS	
Company Name			Signature of Person Authorized to Sign Offer	
1850 E. Rio Salado Pkwy, Suite 211			James Stover	
Address			Printed Name	
Tempe	Arizona	85281	Medicaid Plan President	
City	State	Zip	Title	

CERTIFICATION

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

1. The submission of the offer did not involve collusion or other anti-competitive practices.
2. The Offeror shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 2009-09 or A.R.S. §§ 41-1461 through 1465.
3. The Offeror 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.
4. The Offeror _____is / __**X**___ is **not** a small business with less than 100 employees or has gross revenues of $4 million or less.
5. The Offeror is in compliance with A.R.S. § 18-132 when offering electronics or information technology products, services, or maintenance; and
6. The Offeror certifies that it is not debarred from, or otherwise prohibited from participating in any contract awarded by federal, state, or local government.

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

Your offer, including all exhibits, amendments, and final proposal revisions (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.

The Contractor is cautioned not to commence any billable work or to provide any material or service under this contract until Contractor receives purchase order, contact release document or written notice to proceed.

This contract shall henceforth be referred to as

Contract No. YH24-0001-02

Contract Service Start Date: 10/01/2024

Award Date: 12/01/2023

MEGGAN LAPORTE, AHCCCS CHIEF PROCUREMENT OFFICER

EXHIBIT F

OFFER AND ACCEPTANCE

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and final proposal revisions (if any). Signature also certifies Small Business Status.

Arizona Transaction (Sales) Privilege Tax License No.:

N/A

Federal Employer Identification No.:

86-0813232

E-Mail Address: jean_kalbacher@uhc.com

Arizona Physicians IPA, Inc. dba UnitedHealthcare Community Plan
Company Name

1 E. Washington Street, Suite 900
Address

Phoenix | AZ | 85004
City | State | Zip

For clarification of this offer, contact:

Name: Jean Kalbacher

Title: Chief Executive Officer

Phone: (602) 255-8457

Signature of Person Authorized to Sign Offer

Jean Kalbacher
Printed Name

Chief Executive Officer
Title

CERTIFICATION

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

1. The submission of the offer did not involve collusion or other anti-competitive practices.
2. The Offeror shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 2009-09 or A.R.S. §§ 41-1461 through 1465.
3. The Offeror 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.
4. The Offeror _____is / _X_____ is **not** a small business with less than 100 employees or has gross revenues of $4 million or less.
5. The Offeror is in compliance with A.R.S. § 18-132 when offering electronics or information technology products, services, or maintenance; and
6. The Offeror certifies that it is not debarred from, or otherwise prohibited from participating in any contract awarded by federal, state, or local government.

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

Your offer, including all exhibits, amendments, and final proposal revisions (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.

The Contractor is cautioned not to commence any billable work or to provide any material or service under this contract until Contractor receives purchase order, contact release document or written notice to proceed.

This contract shall henceforth be referred to as

Contract No. YH24-0001-01
Contract Service Start Date: 10/01/2024
Award Date: 12/01/2023

MEGGAN LAPORTE, AHCCCS CHIEF PROCUREMENT OFFICER

EXHIBIT G

AHCCCS Arizona Health Care Cost Containment System	DATE OF MEETING	TOPIC	PROJECT	FACILITATOR	CO-FACILITATOR
	09/21/23	SCOPE TEAM MEETING	ALTCS EPD RFP	SANDI BORYS	JULIE AMBUR

CONTRACT TEAM		SCOPE TEAM MEMBERS						GUEST PRESENTERS			
☒	Sandi Borys	☒	Christina Quast	☐	Kari Price	☒	Stephanie Elzenga	☒	Kenneth Hoser	☐	
☒	Kris Gill	☒	Cynthia Layne	☐	Megan Woods	☐		☒	Bobbi Schmidt	☐	
☐		☐	Daniella Ashlock	☐	Meggan LaPorte	☐		☐		☐	
☐		☐	Dara Johnson	☐	Melissa Arzabal	☐		☐		☐	
☐		☐	Jakenna Lebsock	☐	Pam Sullivan	☐		☐		☐	
☐		☐	Julie Ambur	☐	Rachel Conley	☐		☐		☐	

MINUTES		
PRESENTER	**TOPIC**	**UPDATE**
Sandi Borys	**Start Meeting**	APEP Update
PRESENTER	**TOPIC**	**NOTES/TAKEAWAY**
Julie Ambur	**Review Scoring Methodology Document**	Overview of evaluation process and overall scoring tool **Approved**
Bobbi Schmidt	**Cost Bid Scoring Tool(s)**	**Approved**
Kenneth Hoser	**Overall Scoring Tool**	**Approved**
Julie Ambur	**Other Docs to Lock Down**	All Tools Scoring Training Oral Presentation Script

EXHIBIT H

From: Jakenna Lebsock
To: Gina Relkin
Subject: Fwd: URGENT: Oral Presentation Script
Date: Wednesday, December 27, 2023 12:20:15 PM

FYI... may be relevant for public records?

Jakenna

Jakenna L. Lebsock, MPA

(she/her/hers)

Assistant Director

Division of Health Care Services

Exec. Asst.: Tamra Rothenburger (Tamra.Rothenburger@azahcccs.gov)

801 E. Jefferson, MD 6100

Phoenix, AZ 85034

602.417.4229 (Office)

520.461.7468 (Cell)

"For me, I am driven by two main philosophies: know more today about the world than I knew yesterday and lessen the suffering of others." — **Neil deGrasse Tyson**

---------- Forwarded message ---------
From: **Sandi Borys** <sandi.borys@azahcccs.gov>
Date: Thu, Sep 28, 2023 at 6:43 AM
Subject: URGENT: Oral Presentation Script
To: Lebsock, Jakenna <jakenna.lebsock@azahcccs.gov>

Hello Jakenna,

Please review and make any changes to the Oral Presentation Script. https://ahcccs-my.sharepoint.com/personal/julie_ambur_azahcccs_gov/_layouts/15/onedrive.aspx?csf=1&web=1&e=6GF4Js&cid=4d7d1ca1%2D983d%2D4b8c%2D9fe5%2D2b8c667803a1&FolderCTID=0x012000A4FA3018CE437F468CDD172120C94519&id=%2Fpersonal%2Fjulie%5Fambur%5Fazahcccs%5Fgov%2FDocuments%2F1%2DPROJECTS%2FEPD%20RFP%20YH24%2D0001%2FScoring%2FScoring%20Tools%2FScoring%20Tools%20%2D%20Oral%20Presentations

I have to lock this down today.

We have received a bid already but I don't think that we can work on it until all documents are locked down.

Thank you,

Sandi Borys

Contract and Policy Administrator

801 W. Jefferson, Phoenix, AZ 85034

602-417-4055

sandi.borys@azahcccs.gov

NOTICE: This e-mail and any attachments to it may contain information that is PRIVILEGED and CONFIDENTIAL under State and Federal law and is intended only for the use of the specific individual(s) to whom it is addressed. This information may only be used or disclosed in accordance with law, and you may be subject to penalties under law for improper use or further disclosure of the information in this e-mail and its attachments. If you have received this e-mail in error, please immediately notify the person named above by reply e-mail, and then delete the one you received

EXHIBIT I

ALTCS E/PD RFP YH24-0001
SCORING TRAINING

October 3, 2023

Sandi Borys, DHCS Contract and Policy Administrator

AHCCCS

PURPOSE OF TODAY'S MEETING

- To ensure everyone is familiar with the ALTCS E/PD Evaluation and Consensus Ranking process *(also referred to as scoring).*
- To learn your responsibilities regarding the Evaluation and Ranking process.
- To understand the role of the Consultants in the Consensus process.

REFRESHER OF THE ALTCS E/PD RFP

- The ALTCS E/PD procurement was issued on August 1, 2023
- The Contract will be in effect for a total of seven years the first part starts on October 1, 2024 through September 30, 2027
  - There will be two additional options for two two-year extensions with an ending date of September 30, 2031.
- As of August 2023, ALTCS E/PD currently serves approximately 26,000 members.
- The ALTCS E/PD Contract Award is estimated to be around $15,463,100.00.

ALTCS EP/D REFRESHER

- Bids are solicited from Managed Care Organizations (i.e., health plans; Offerors) for the delivery and oversight of services to qualified members.

- AHCCCS will be awarding a total of three contracts:
  - Two in the North GSA consisting of Mohave, Coconino, Apache, Navajo, and Yavapai Counties.
  - Three in the Central GSA including Maricopa, Gila, and Pinal Counties.
  - Two in the South GSA consisting of Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties.

- There is a potential for 0, 1, or 2 statewide contracts being awarded.

THE ALTCS E/PD SERVICES

- ALTCS E/PD Contractors serve members who are Elderly and/or who have a Physical Disability (E/PD) including:
  - Children with special health care needs,
  - Individuals with general mental health needs, and
  - Individuals with a Serious Mental Illness (SMI) designation.

- When members qualify for ALTCS E/PD services; the program coordinates and provides the integrated care for this population including:
  - Acute Care *(physical health),*
  - Behavioral Health,
  - Case Management Services (*at the Contractor-level*), and
  - Services and supports to all ages who have functional limitations and/or chronic illnesses, helping to support the ability for members to live or work in setting of their choice.

ALTCS E/PD TIMELINE

ALTCS E/PD YH24-0001 ANTICIPATED PROCUREMENT TIMELINE			
Issued the ALTCS E/PD RFP	08/01/23	**Cost Bid Narrative scoring is due by**	**10/10/23**
First set of technical questions were due by	08/08/23	**All other Narrative scoring is due by**	**10/11/23**
First Amendment was issued on	08/15/23	**Consensus Meetings Begin**	**10/12/23**
Second set of technical questions was due by	08/15/23	**Oral Presentations**	**10/24-11/02**
Second Amendment was Issued on	08/30/23	**Best And Final Offer (BAFO) is due by**	**10/19/23**
Intent to Bid was due by 3:00 pm AZ time	08/31/23	**Scoring ends**	**11/15/23**
Third Amendment was issued on	09/08/23	**Present findings to Exec and Scope**	**11/16/23**
Proposals were due by 3:00 pm AZ time	10/02/23	**Send to the Governors Office**	**11/21/23**
Scoring Begins	**10/03/23**	**Award**	**12/13/23**

NOTE: All dates above are subject to change

ALTCS E/PD OFFERORS

LIST OF OFFERORS FOR THE ALTCS E/PD YH24-0001	
1.	**Arizona Physicians IPA, Inc** (dba United Healthcare Community Plan)
2.	**Banner-University Care Advantage** dba Banner-University Family Care
3.	**BCBSAZ Health Choice**
4.	**Health Net Access, Inc** dba Arizona Complete Health-Complete Plan
5.	**Mercy Care** (Administered by Aetna Medicaid Administrators)

CONFIDENTIALITY

- You have all signed the Procurement Disclosure Statement (PDS)
- You hold a Significant Procurement Role (SPR) and will be scoring your assigned RFP Submission Requirement(s) *(Narrative/Oral Presentations/Cost Bid)*
- **Keep materials and Discussions Confidential including but not limited to:**
  - Contractor responses,
  - All documentation,
  - Discussions should only be with your assigned team.
- **The scoring process remains confidential even after award.**

Questions?

NARRATIVES

B1 – EXECUTIVE SUMMARY

This is not a scored aspect of the submission

The Offeror shall provide an Executive Summary that includes:

a. An overview of the organization,
b. The Offeror's relevant experience providing healthcare for the population specified in this Solicitation, and
c. A high-level description of the Offeror's proposed unique approach to meet Contract requirements.

This submission may be used in whole or part by AHCCCS in public communications following Contract awards.

B2 – SUBMISSION FORMAT

This is not a scored aspect of the submission however, they do need to address in each Narrative

The Offeror shall identify no more than three contracts, *The Offeror shall list only the three contracts that are not Arizona Medicaid Contracts that it wishes to cite. Throughout its RFP the Offeror does not need to include Arizona Medicaid Contracts in its list, which represent its experience in managing similar healthcare delivery systems to the ALTCS E/PD Program. *The Offeror must list the FIDE-SNP in B2 if the Offeror writes to experience related to the FIDE-SNP contract. The Offeror shall describe all programs for the contracts selected including those from Arizona. The description shall include but is not limited to geographic *coverage*, population served and enrollment, behavioral health/physical health integration status, years in program, and current contractual status. In response to the Narrative Submission Requirement that asks for the Offeror's experience as well as any other responses where experience is presented, the Offeror shall refer exclusively to the experience from the identified contracts in this response, and must always include Arizona experience, if applicable. Any contracts referenced in Narrative Submission Requirement responses which are not identified in this response will not be considered.

*** RFP Amendment 2 Clarifications**

B3 – ALL NARRATIVE SUBMISSIONS SHOULD INLCUDE

Built into each Narrative Scoring Tool as Broad Category

In each response for Narrative Submission Requirements (B4-B9) the Offeror shall include in its response how the Offeror will address health inequities, health disparities, and/or structural and health-related social needs and promote equitable member care.

B4 – MEMBER POPULATION *(5 PAGES)*

Scoring Team includes Brandi Howard, Dr. Megan Woods, and Samantha O'Neal

The ALTCS E/PD member population is complex, and their care often involves a combination of services and providers to effectively meet their needs. Provide a detailed description of how the Offeror will develop and implement best practices for ALTCS Case Managers, and leverage ALTCS Case Management staff to meet the needs of individuals with complex conditions, to:

a. Decrease duplication of effort and enhance coordination of care with providers of physical and behavioral health services,
b. Assist members prior to, and throughout transitions,
c. Improve member engagement,
d. Coordinate social and community support services,
e. Identify, track, and manage outcomes for members with complex needs,
f. Ensure appropriate identification of members that would benefit from High Needs Case Management and provide Case Management services in alignment with identified needs and reduce burden on members and families in coordinating member care.
g. Monitor Case Manager performance and respond to identified issues, at the individual and system levels.

B5 – PERSON CENTERED SERVICE PLANNING *(4 PAGES)*

Scoring Team includes Danielle Ashlock, Dara Johnson, and Melissa Arzabal

How will the Offeror ensure that person-centered service planning:

a. Includes active engagement with ALTCS members,
b. Includes all aspects of quality of life,
c. Is consistent with the individual's needs and wishes,
d. Promotes access to services in home and community-based settings, and
e. Results in high quality, equitable, and cost-effective person-centered care.

Additionally, how will the Offeror monitor and evaluate the Case Manager and the member experience and satisfaction to demonstrate the Offeror's person-centered service planning process complies with the values and principles of person-centered thinking, planning, and practice?

B6 – DATA AND PERFORMANCE METRICS

(6 Pages Consisting of 3-Narrative and 3-Sample Data)

Scoring Team includes Georgette Chukwuemeka, Dr. Megan Woods and Cindy Hostetler

- Provide a description of the types of data, including but not limited to performance metrics and data collected in partnership with members (e.g., data from member satisfaction surveys or member focus groups), the Offeror will collect, monitor, and analyze for the purposes of improving member health outcomes and informing program initiatives.
- Provide a detailed description of the processes utilized by the Offeror to inform and/or initiate improvement activities, including reporting tools, monitoring technologies, and/or partnerships, as well as processes used for member and population specific data analyses and MCO decision making processes.
- The Offeror shall limit its response to the submission requirement to three pages of narrative and should include up to *three pages of narrative and up to three, one-page sample utilization reports or other sample data or other sample data to demonstrate the Offeror's monitoring and analysis processes.

*[PAGE LIMIT 6 *with 3 pages of narrative and up to 3, one-page sample utilization reports or other sample data]*

**Revised with RFP Amendment 2*

B7 – NETWORK DEVELOPMENT *(4 Pages)*

Scoring Team includes Christina Quast, Gini Britton, and Jay Dunkleberger

- Describe the Offeror's network development strategy, including methods to build Home and Community Based Services (HCBS) providers and institutional capacity in rural areas and maximize available resources. Also discuss specifically how the Offeror will assist rural nursing facilities seeking to expand into community-based care.

- Provide action steps and a timeline for the first three years of the Contract, along with measurable outcomes to be achieved. The action steps *should focus on the contract start (execution) date and shall illustrate how the Offeror's operational areas will work in an integrated fashion to identify and address network needs.

***RFP Amendment 2 Clarification -**

B8 – WORKFORCE DEVELOPMENT *(4 Pages)*

Scoring Team includes Bill Kennard, Jay Dunkleberger, and Jenna Girdosky

Describe the Offeror's overall workforce development strategy including the Offeror's workforce development philosophy, the use of data to inform strategies and monitoring activities to determine if strategies are effective, and achievement of desired outcomes. Additionally, the Offeror shall describe how the Offeror will:

a. Assist and incentivize providers to improve workforce monitoring, assessing, planning, and forecasting workforce trends so that the provider can be more strategic in their efforts to recruit, select, train, deploy, and support their staff,
b. Assist providers to improve post-training coaching and supervision to ensure the skills are applied and used effectively to improve member experience and outcomes, and
c. Integrate the operations of the Offeror's workforce development function within the operations of the network, medical management, and quality management departments.

B9 – SOCIAL DETERMINANTS OF HEALTH *(4 pages)*

Scoring Team includes Dr. Melissa Del-Colle, Rachel Conley, and Susan Kennard

Recent studies have shown that social, economic, and environmental conditions, in addition to health behaviors, can determine approximately 80% of health outcomes in the U.S. Given the Offerors' role in serving people with complex clinical, behavioral health, and social needs, it is critical to address social risk factors. For each of the following populations, describe how the Offeror will provide timely access to services and supports as well as monitor outcomes. The Offeror shall also identify its strategy(ies) for addressing potential barriers to care, as well as best practices to be implemented.

a. Members residing in rural communities,
b. Members residing in Tribal communities,
c. Members in need of community resources, and Members in need of Peer and/or Family Support services.

B10 – COMPLIANCE REVIEWS

Scoring Team includes Christina Quast, Jakenna Lebsock, and Michelle Holmes

Pursuant to 42 CFR 438.358 (b)(iii), Medicaid agencies must conduct compliance reviews of their contracted Managed Care Organizations at least every three years. AHCCCS will evaluate compliance reviews and incorporate the Offeror's past performance as specified below:

a. **Incumbent E/PD Contractors** - A submission is not required. AHCCCS will utilize the AHCCCS Calendar Year (CY) 23 ALTCS E/PD Operational Review (OR),

b. **Incumbent non-E/PD Contractors** - A submission is not required. AHCCCS will utilize the most recent finalized AHCCCS Operational Review (OR), and

c. **Non-Incumbent Offerors** - The Offeror shall submit its most recent review(s) that together comprise a complete evaluation. The review(s) shall be selected from one of the Medicaid Contracts cited in B2 in compliance with 42 CFR 438.358 (b)(iii) for a business line which includes provision of services that are comparable to the Scope of Services for this RFP. The Offeror shall include a description of how the services delivered in the business line for the submitted compliance review are comparable to the Scope of Services for this RFP. The Offeror's submission shall not exceed one page plus attached compliance review(s). AHCCCS reserves the right to validate the submitted review.

B11 - DSNP

Scoring Team includes Christina Quast and Tom Heiser

The Offeror shall submit its *2023 AZ Medicaid Plan D-SNP STAR rating. If the Offeror does not have a D-SNP STAR Rating in Arizona, the Offeror shall cite its *2023 STAR rating with the corresponding Medicare Contract Number, from one of the states for the Medicaid contracts cited in Submission Requirement B2, using the preference order detailed below. Preference order for STAR Rating from another State:

a. FIDE SNP/DSNP Plan,
b. Another type of SNP, or
c. Medicare Advantage Plan.

**Revised with RFP Amendment 2*

ORAL PRESENTATIONS

B12 - ORAL PRESENTATIONS

Scoring Team includes:
Danielle Ashlock, Dara Johnson, Jakenna Lebsock, and Melissa Arzabal

Offerors shall participate in a scheduled oral presentation pertaining to key areas of the ALTCS E/PD Program. Oral presentations will be in-person.

Presentations may be audio-taped by AHCCCS for the Agency's use in the evaluation process. Audio-taped oral presentations will be published on the AHCCCS website once the Contract awards have been made. AHCCCS will notify each Offeror of its scheduled 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 individuals with expertise in:

- Medical Management,
- Case Management, and
- Quality Management

*** RFP Amendment 1 Clarification -** AHCCCS anticipates notifying Offerors by Thursday, October 5, 2023.

B12 - ORAL PRESENTATIONS

Scoring Team includes:
Danielle Ashlock, Dara Johnson, Jakenna Lebsock, and Melissa Arzabal

The Offeror will not be permitted to distribute previously prepared presentations or materials to AHCCCS. The Offeror **may bring a laptop** for accessing and referencing materials including but not limited to policies and procedures. The Offeror will not be permitted to utilize a laptop for presenting Oral Presentations. Additionally, the Offeror shall supply its own internet connection. **Cell phones are not allowed in the room**; therefore, the Offeror shall not rely on utilization of a cell phone for internet connection. Outside communication (e.g., cell phones, instant messaging, email, text messaging) is prohibited for the duration of the oral presentations. The Offeror is also permitted to utilize any hard copy reference material brought with them. AHCCCS will provide a whiteboard or flip charts and markers for Offeror use in preparing for the Oral Presentation.

AHCCCS may have staff in the room at all times for the oral presentation process including during presentation preparation, whether in-person or virtual, to ensure compliance with these requirements.

The Offeror shall submit with its Proposal a list of names and titles along with resumes of the participating individuals.

COST BID

COST BID

Scoring Team includes Bobbi Schmidt, Matt Varitek, Pam Sullivan

The Offeror shall submit the following:

- C1 – Agreement to Accept Capitation Rates - The Offeror shall submit an agreement that the Offeror will accept the actuarially sound capitation rates computed prior to October 1, 2024. The agreement shall be signed by the Offeror's Chief Executive Officer.

  *For the CYE 24 rating period, AHCCCS set the ALTCS-EPD underwriting gain percentage equal to 1.45% of the capitation rates, excluding premium tax. AHCCCS may revise the applicable underwriting gain percentage as part of capitation rate development each year.

  Administrative and case management cost components will be bid by the Offerors. AHCCCS may use these bids in developing capitation rates; however, AHCCCS reserves the right to adjust the capitation rates, including the administrative and case management cost components, to maintain compliance with the Medicaid and CHIP Managed Care Final Rule and additional guidance from CMS published annually in the Medicaid Managed Care Rate Development Guides.

  If any moral or religious objections were submitted as part of the RFP, *the Offeror shall include in its Capitation Agreement a statement attesting that the Offeror did not exclude from the administrative and case management bid submission(s) any related administrative and case management costs.

**Revised with RFP Amendment 2*

COST BID

Scoring Team includes Bobbi Schmidt, Matt Varitek, Pam Sullivan

- C2 – Administrative Cost Component Bid - The Offeror shall bid on the administrative cost component of the capitation rates. The Offeror shall include an administrative bid for each membership tier.

- C3 – Case Management Cost Component Bid - The Offeror shall bid on the case management cost component of the capitation rates. The Offeror shall include a case management bid for each GSA where the Offeror is submitting a bid.

COST BID

Scoring Team includes Bobbi Schmidt, Matt Varitek, Pam Sullivan

- C4 – Actuarial Certification - The Offeror shall ensure that an actuary who is a member of the American Academy of Actuaries certifies that the Administrative and Case Management Cost Bid Submissions meets the requirements of 42 CFR 438.5(e) by submitting a signed actuarial certification of all rates submitted with the submission.

BEST AND FINAL OFFER (BAFO)

Scoring Team includes Bobbi Schmidt, Matt Varitek, Pam Sullivan

AHCCCS reserves the right to request Best and Final Offers. In the event AHCCCS exercises this right, all Offerors that submitted a Proposal that is susceptible to award may be asked to provide a Best and Final Offer. The State reserves the right to award a Contract on the basis of initial Proposals received; therefore, the Offeror is encouraged to submit its most competitive bid.

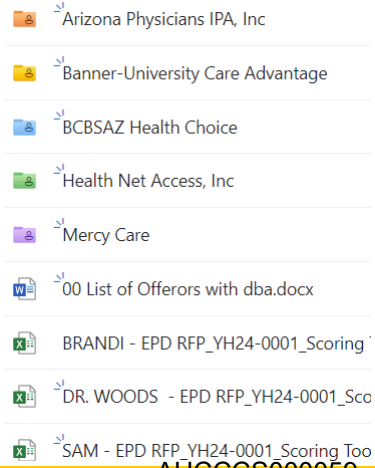
- **RFP Definition - Best and Final Offer** - A revision to an Offer submitted after negotiations are completed that contains the Offeror's most favorable terms for price, service, and products to be delivered. Sometimes referred to as a Final Proposal Revision



INDIVIDUAL EVALUATION PROCESS

INDIVIDUAL EVALUATION PROCESS

- **You will receive an email providing you with a link to where you will find the following documents:**
  - Each Offeror's response to the assigned narrative and/or cost bid,
  - Each Offeror's submission related to B2 listing no more than three contracts that are not Arizona Medicaid Contracts that they will utilize to reference their experience in managing similar healthcare delivery systems, and
  - Individual scoring tool *(Use only the tool with your name on it).*



YOUR RESPONSIBILITIES IN THE SCORING PROCESS

- Your evaluation teams met to agree on the Broad Categories and the Criteria Considerations that now make up the Scoring Tool.

DO NOT SAVE ANYTHING TO YOUR COMPUTER AND ONLY WORK WITHIN THE ASSIGNED LINK.

- Utilize only your assigned scoring tool.
- You will be performing your individual initial review based on **your** interpretation of what has been submitted by the Offerors.
- **DO NOT** be concerned with what anyone else may think or how anyone else may interpret the submission.
- Remember the purpose of doing an individual review is for your perspective.
- Enter your notes *(strengths/weaknesses)* of each Offerors response within their column of the Tool.
- Utilize the "Other" area for items that may not fit under a Broad Categories - Criteria Consideration.
- Provide your ranking based on YOUR interpretation *(ties are ok but try to rank 1-5).*

INDIVIDUAL EVALUATION PROCESS

- Do not give any consideration to ***contingent language*** such as ‘we are exploring….’ or ‘we are taking under consideration….’
- Do not give any consideration to any references to various policies and/or manuals these references do not constitute an adequate response to the submission requirement.
- Do not consider your personal knowledge or experience of a particular Offeror.
- Do not consider information outside the allotted page limit *(indicated within the Submission Requirement of the Scoring Tool)* or any other information provided elsewhere in the bid.

YOUR RESPONSIBLITY

REMEMBER

- **Your** notes are based on **your** unique perspective. **You** have been chosen because of **your** subject matter expertise and **your** knowledge. Do not worry what someone else may think or how they may interpret the response.
- Rank each of the offerors how **you** believe they scored 1-5 *(1 being the best)*.
- All areas will be discussed during your Consensus Meeting(s).
- It is strongly suggested that you do not print any documents related to the offerors or the scoring documents themselves. If you do **YOU** must ensure that the documents are shredded. Do Not put them into the shredding can in your office. You must physically put them into the locked shredding bin yourself.

DUE DATES

Cost Bid individual scoring is due NO LATER THAN 10/10.

B4-B11 are due NO LATER THAN 10/11.

INDIVIDUAL EVALUATION PROCESS

Evaluation Team:
Scorer:
Consultants:

OFFERORS	ARIZONA PHYSICIANS IPA, INC.	BANNER-UNIVERSITY CARE ADVANTAGE	BCBSAZ HEALTH CHOICE	HEALTH NET ACCESS	MERCY CARE
Contract Identified in Narrative B2 (1 OF 3):	Enter Contract 1 Here When Responses Received	Enter Contract 1 Here When Responses Received	Enter Contract 1 Here When Responses Received	Enter Contract 1 Here When Responses Received	Enter Contract 1 Here When Responses Received
Contracts Identified in Narrative B2 (2 OF 3):	Enter Contract 2 Here When Responses Received	Enter Contract 2 Here When Responses Received	Enter Contract 2 Here When Responses Received	Enter Contract 2 Here When Responses Received	Enter Contract 2 Here When Responses Received
Contracts Identified in Narrative B2 (3 OF 3):	Enter Contract 3 Here When Responses Received	Enter Contract 3 Here When Responses Received	Enter Contract 3 Here When Responses Received	Enter Contract 3 Here When Responses Received	Enter Contract 3 Here When Responses Received
BROAD CATEGORY					
Criteria Consideration - [Enter Consideration Here]	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration
Criteria Consideration - [Enter Consideration Here]	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration
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Criteria Consideration - Other	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration
DRAFT RANKING	[After reading all Contractor's responses, enter your individual Draft Ranking here for the Plan identified above]	[After reading all Contractor's responses, enter your individual Draft Ranking here for the Plan identified above]	[After reading all Contractor's responses, enter your individual Draft Ranking here for the Plan identified above]	[After reading all Contractor's responses, enter your individual Draft Ranking here for the Plan identified above]	[After reading all Contractor's responses, enter your individual Draft Ranking here for the Plan identified above]

Questions?




CONSENSUS EVALUATION PROCESS CONSULTANT'S ROLE

Andy Cohen and Scott Wittman with
Pacific Health Policy Group (PHPG)

CONSULTANT ROLE

- Reviews and synthesizes all individual notes
- Facilitates virtual *(in-person for oral presentations)* team evaluation meetings to come to consensus agreement
- Makes sure all voices are heard
- Ensures all team members endorse the final ranking and rationale write up
- Documents Offerors commitments
- Finalizes documentation for signature and award

TEAM CONSENSUS SCORING PROCESS

- **Meet virtually with your assigned Team and Consultant *(facilitator)***
- **Consensus Ranking process – as a Team**
  - Review all individual notes and have discussions
  - Reminder do not take into account your personal opinions of an Offeror
  - Rate the strengths of each submission
  - Rank the comparative position of each submission
  - Compare strength of a response relative to the responses submitted by other Offerors
  - Determine single Ranking for each offeror for each requirement
  - Identify Contractor commitments
- **Finalize**
- **Sign**

TEAM CONSENSUS SCORING MEETINGS

MEETINGS CONSIST OF THREE SEPARATE MEETINGS

- First meeting is a four-hour meeting
- Second meeting is a 1.5-hour meeting
- Third meeting is a .5-hour meeting *(if needed)*

CONSENSUS MEETINGS

B4=MEMBER POPULATION 5 pages	
Brandi, Sam, Megan	
4-hour meet	10/20 @ 9-1
1.5-hour meet	11/6@8-9:30
.5 meet	11/13 @ 12-12:30

B5=PERSON CENTERED SERVICE PLAN 4 pages	
Dara, Danielle, Melissa	
4-hour meet	10/19 @9-1
1.5-hour meet	10/23 @ 9-10:30
.5 meet	11/9 @ 11-11:30

B6=DATA AND PERFORMANCE 3/3 = 6 pages	
Cindy, Georgette, Megan	
4-hour meet	10/18 @ 1-5
1.5-hour meet	11/9 @ 1-2:30
.5 meet	11/13 @ 2-2:30

B7-NETWORK DEVELOPMENT 4 pages	
Christina, Gini, Jay	
4-hour meet	10/18 @ 8-12
1.5-hour meet	11/7@12:30-2
.5 meet	11/14@8-8:30

B8=WORKFORCE DEVELOPMENT 4 pages	
Bill, Jay, Jenna	
4-hour meet	10/17 @ 8-11 am
1.5-hour meet	11/07 @ 8-9:30
.5 meet	11/13 @ 11-11:30

B9=SOCIAL DETERMINANTS OF HEALTH 4 pages	
Dr. Del-Colle, Rachel, Susan	
4-hour meet	10/16 @ 1-5
1.5-hour meet	11/6 @12:30-2:00
.5 meet	11/14 @2-2:30

B10=COMPLIANCE REVIEW	
Chrstina, Michelle, Jakenna	
4-hour meet	10/13 @ 8-11
1.5-hour meet	10/30 @ 9-10:30
.5 meet	11/13 @ 9-9:30

B11=D-SNP	
Christina, Tom	
4-hour meet	10/16 @ 8-12
1.5-hour meet	10/27 @ 10-11:30
.5 meet	11/8 @ 9-9:30

COST BID		
Bobbi, Matt, Pam		
4-hour meet	10/12 @ 8-12	
3-hour meet	10/26 @ 9-12 pm	
.5 meet	11/1 @ 1-2:30pm	
BOBBI	**MATT**	**PAM**

Oral Presentations 2 presentations			
Jakenna, Dara, Danielle, Melissa			
Oral presentation 10/24, 10/25, 10/26, 11/1, & 11/2 Discussion – 1-4			
1.5-hour meet	11/8 @ 1-2:30 pm		
.5	11/14 @ 11-11:30 am		
JAKENNA	**DARA**	**DANIELLE**	**MELISSA**

Examples of ALTCS E/PD Commitments

General statement in ALTCS EPD Contract:

The Contractor specified various actions it committed to take to enhance the ALTCS E/PD program in its Response to Request for Proposal YH24-0001. Consistent with RFP YH24-0001 Instructions to Offerors which provides: "The Proposal submitted by the Offeror will become part of the Contract with AHCCCS," the Contractor shall ensure they effectuate all such commitments and report compliance in a manner determined by AHCCCS (e.g., deliverable submission, operational review). The list below is not intended to be an all-inclusive compilation of action items for the Contractor. However, the list is provided as a summary to identify many of the actions committed to be performed by the Contractor as part of its contractual obligations.

Examples of Our Current ALTCS E/PD Commitments

- **Banner-University Care Advantage Commitment example:**
  Establish Case Management processes to include utilization of a Priority System to evaluate if the timing of a member's initial Case Management visit requires less than the AHCCCS standard of within 12 business days.

- **Mercy Care Commitment example:**
  Establish mercy Care Paws Program including veterinarian care and boarding when the member's hospitalized.

- **United Healthcare Community Plan Commitment example:**
  Establish Case Management processes to include utilization of a Priority System to evaluate if the timing of a member's initial Case Management visit requires less than the AHCCCS standard or within 12 business days.

Questions?

HELPFUL INFORMATION AND LINKS

Any questions do not hesitate to reach out to:
Sandi Borys, Julie Ambur, or Kristina (Kris) Gill

SCORING TRAINING POWERPOINT PRESENTATION

RFP H24-0001 – ALTCS E/PD BIDDERS' LIBRARY

SCORING TOOLS FOR B4 - BEST COST BID [illegible]
PRESENTATION

AHCCCS000074

Questions?


Thank
You
Merci
Gracias
TerimaKasih
Spacibo
Danke
KamSahHamnida
Arigatô
Hvala
Mèsi
Xièxie
Dziakuju
Chokrane
Grazie
aDank
Takk
ThintKo
Rahmat
BarakAllahuFilk
Blagodaram
Matondo
Mercé
Taiku
Dakujem
Tanemirt
Tenki
Gràcies
Faleminderit
Efharisto
NäjisTuke
Grandmercé
Nirringrazzjak
Bayarlalaa
Obrigado
Salamat
Saha
Multumesc
CámOn
Gracie
KopKhunKha
GratiasAgo
Tak
Sagolun
Motashakkeram
Dankie
TänanVäga
Chnorakaloutioun
Gratzias
GratiasAgimus
Barkal
Aciū
Kiitos
Mauruuru
Buznyg
TapadhLeat
Köszönöm
Murakoze
WaadMahadsantahay
Grazzi
Aabhar
Dhanyavaad
KhobChaiDeu
Shukriya
TapadhLeibh
AsanteSana
Waita
FaafetaiLava
Ngiyabonga
Enkosi
M-Sapo
Bedankt
Zikomo
Nouari
Trugarez
GoRaibhMaithAgat
KyayTzuTinPaTe
Mochchakkeram
TeşekkürEderim
Sobodi
AabhariAahe
KurreSumanga
Yakeniele
Dhanyabaad
KopKhunKrap
Tau
Nanni
Welalin
TangioTumas
Dhanyavad
Mamnun
Tänan
Sukriya
TesekkurEdirem
KeYaLeboha
Vinaka
Dankon
Barka
aNiKié
Toda
Mersi
Nizzik ajr
Aguyjé
Dhanyavadagalu
Dhanyavadalu
Sulpáy
Blagodaria
Nandri
Merkzi
Akun
ÇoxSagOlun
Meharbani
Mahalo
Gracinas
DankJuWel
Marahaba
Diky
TakkFyri
Wado
Spas
Asante
Miigwetch
EskerrikAsko Dankewol
Dankje
Diolch
Paldies
DjereDieuf
ANiKié
Rahmat
Trugéré
Misaotra
Akpe
Mieiskerr
Tanmirt
Akiba
MaloTeOfa
Graçie

EXHIBIT J

EPD RFP YH24-0001 SCORING TOOL
DRAFT NOTES - CONFIDENTIAL

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SUBMISSION REQUIREMENT B10: COMPLIANCE REVIEWS
Pursuant to 42 CFR 438.358 (b)(iii), Medicaid agencies must conduct compliance reviews of their contracted Managed Care Organizations at least every three years. AHCCCS will evaluate compliance reviews and incorporate the Offeror's past performance as specified below:
a. Incumbent E/PD Contractors - A submission is not required. AHCCCS will utilize the AHCCCS Calendar Year (CY) 23 ALTCS E/PD Operational Review (OR),
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PAGE LIMIT: N/A except for Non-Incumbent Offerors
For NonIncumbent Offerors: Refer to (B10c) and RFP Section H, Instructions to Offerors for submission format requirements

EVALUATION TEAM: The Personally Identifying Information of the Individual Evaluators Has Been Redacted Herein
SCORER: The Personally Identifying Information of the Individual Evaluators Has Been Redacted Herein
CONSULTANT FACILITATOR: Andy Cohen and Scott Wittman

OFFERORS	ARIZONA PHYSICIANS IPA, INC.	BANNER-UNIVERSITY CARE ADVANTAGE	BCBSAZ HEALTH CHOICE	HEALTH NET ACCESS	MERCY CARE
Contract Identified in Narrative B2 (1 OF 3):	UnitedHealthcare® Dual Complete® ONE (Arizona)	Banner Medicare Advantage DSNP (Arizona)	Medicare Dual Special Needs Plan (Arizona)	MIPPA (Arizona)	Mercy Care Advantage HMO SNP (Arizona)
Contracts Identified in Narrative B2 (2 OF 3):	MyCare Ohio (Medicare-Medicaid Plan [MMP]) (Ohio)	Medicare Shared Savings Program (MSSP) (Arizona)	ACA Marketplace Plan (Bronze, Silver, Gold Plans) (Arizona)	STAR+PLUS (Texas)	N/A
Contracts Identified in Narrative B2 (3 OF 3):	TennCare (Tennessee)	MA Prescription Drug (MAPD) Plan HMO (Arizona)	Blue Advantage Senior Care Plus (Minnesota)	KanCare 2.0 Medicaid Care (Kansas)	N/A
BROAD CATEGORY - AHCCCS OR REPORT REVIEW [INCUMBENT]					
Criteria Consideration - Most Recent AHCCCS OR Results Contractor name and Line of business Reviewed (link provided):	**UnitedHealthcare Community Plan LTC OR 2023**	**Banner-University Family Care LTC OR 2023**	**Health Choice Arizona ACC OR 2022**	**Arizona Complete Health-Complete Care Plan RBHA OR 2020**	**Mercy Care Plan LTC OR 2023**
Criteria Consideration - # Total Standards:	**173**	**173**	**152**	**154**	**173**
Criteria Consideration - # Standards Full Compliance (full compliance is equal to or greater than 95%):	**138**	**145**	**125**	**129**	**142**
Criteria Consideration - Compliance Considerations / Findings					
Criteria Consideration - LTSS-specific experience	LTSS specific OR considered	LTSS specific OR considered			LTSS specific OR considered
Criteria Consideration - [Enter Consideration Here]					
Criteria Consideration - Other					
BROAD CATEGORY - OTHER NOTABLE CONSIDERATIONS					
Criteria Consideration - Use of cited contracts					
Criteria Consideration - [Enter Consideration Here]					
DRAFT RANKING	3	1	5	4	2

EPD RFP YH24-0001 SCORING TOOL
DRAFT NOTES - CONFIDENTIAL

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SCORER:
CONSULTANT FACILITATOR: Andy Cohen and Scott Wittman

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Criteria Consideration - # Total Standards:	**173**	**173**	**152**	**154**	**173**
Criteria Consideration - # Standards Full Compliance (full compliance is equal to or greater than 95%):	**138**	**145**	**125**	**129**	**142**
Criteria Consideration - Compliance Considerations / Findings	79.8% of metrics were in full compliance; concerns noted with case management policies and procedures (numerous aspects), provider manual, EPSDT services, monitoring of ED utilization, member transition processes, quality of care/onsite monitoring, provisional credentialing, AzSH coordination, BH treatment coordination/service delivery, and SUD services	83.8% of metrics were in full compliance; concerns noted with care coordination and needs assessment planning, service plan monitoring, BH service delivery, provider manual, peer supports, concurrent review, discharge planning, ED utilization monitoring, discharge planning, transitions, PCP changes, onsite monitoring, QM, and AzSH coordination	82.2% of metrics were in full compliance; concerns noted with peer support, medical records, NOAs, EPSDT periodicity schedules, ED utilization monitoring, social networking, QM, onsite montiring, seclusion/restraint reporting, QI program elements, community initiatives, BH medical records,	83.8% of metrics were in full compliance; concerns noted with corporate compliance, claims interest payments, provider manuals, access to care, material change monitoring, grants, claims disputes, pregnancy/postpartum SUD care, EPSDT community coordination and screenings, preventive care, timely medical record review for PA/CR,	82.1% of metrics were in full compliance; concerns noted include case management policies re: service planning and care coordination, CATS, BH services, NF service monitoring, CM caseloads, timely initiation of services, timely claims decisions, provider manual, EPSDT services, ED utiliztaion monitoring, member transitions, timely pCP changes, QM, AzSH coordination,
Criteria Consideration - LTSS-specific experience	Yes, although there were some concerns with LTSS areas (e.g. Case management, especially around member planning aspects) - LTSS has heavy emphasis on care coordination, which generally appears to be a concern for United, based on their OR	Yes, although a few concerns with LTSS, especially around care planning and transitions	No LTSS experience in AZ; one plan noted in MN for LTSS but scoring detail not supplied as part of this RFP structure	No LTSS experience in AZ (in terms of OR reviews); history of service in AZ generally. Two plans noted for LTSS (TX and KS) - timely/accurate claims payments are a big concern for LTSS providers who generally have less overhead to cover delays/inaccuracies	Yes; biggest area of concerns was case management, which is concerning
Criteria Consideration - [Enter Consideration Here]			Mostly "member care issues" vs. business issues.	Mostly "business" issues vs. issues that impaact member care (e.g. QM, QI, MM, ISOC).	
Criteria Consideration - Other					
BROAD CATEGORY - OTHER NOTABLE CONSIDERATIONS					
Criteria Consideration - Use of cited contracts	n/a	n/a	n/a	n/a	n/a
Criteria Consideration - [Enter Consideration Here]					
DRAFT RANKING	2	1	5	3	4

EPD RFP YH24-0001 SCORING TOOL
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SCORER:
CONSULTANT FACILITATOR: Andy Cohen and Scott Wittman

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Contract Identified in Narrative B2 (1 OF 3):	UnitedHealthcare® Dual Complete® ONE (Arizona)	Banner Medicare Advantage DSNP (Arizona)	Medicare Dual Special Needs Plan (Arizona)	MIPPA (Arizona)	Mercy Care Advantage HMO SNP (Arizona)
Contracts Identified in Narrative B2 (2 OF 3):	MyCare Ohio (Medicare-Medicaid Plan [MMP]) (Ohio)	Medicare Shared Savings Program (MSSP) (Arizona)	ACA Marketplace Plan (Bronze, Silver, Gold Plans) (Arizona)	STAR+PLUS (Texas)	N/A
Contracts Identified in Narrative B2 (3 OF 3):	TennCare (Tennessee)	MA Prescription Drug (MAPD) Plan HMO (Arizona)	Blue Advantage Senior Care Plus (Minnesota)	KanCare 2.0 Medicaid Care (Kansas)	N/A
BROAD CATEGORY - AHCCCS OR REPORT REVIEW [INCUMBENT]					
Criteria Consideration - Most Recent AHCCCS OR Results Contractor name and Line of business Reviewed (link provided):	UnitedHealthcare Community Plan LTC OR 2023	Banner-University Family Care LTC OR 2023	Health Choice Arizona ACC OR 2022	Arizona Complete Health-Complete Care Plan RBHA OR 2020	Mercy Care Plan LTC OR 2023
Criteria Consideration - # Total Standards:	**173**	**173**	**152**	**154**	**173**
Criteria Consideration - # Standards Full Compliance (full compliance is equal to or greater than 95%):	**138**	**145**	**125**	**129**	**142**
Criteria Consideration - Compliance Considerations / Findings	80% overall compliance based on Standard scoring, CY2023. CM scored 87%. P/P placement/svs planning, p/p needs assessment/care planning, svs plan monitoring/asessment, CM caseload monitoring	84% overall compliance based on Standard scoring, 2023. CM scored 93%. Hosp dc, p/p needs assessment/care planning, svs plan monitoring/assessment, provide/monitor BH svs	82% overall compliance based on Standard scoring, CY 2022	84% overall compliance based on Standard scoring, CY 2020	82% overall compliance based on Standard scoring, 2023. CM scored 77%. P/P placement/svs planning, hosp dc, p/p needs assessment/care planning, CATS, providing/monitoring BH svs, providing/monitoring
Criteria Consideration - LTSS-specific experience	UnitedHealthcare Dual Complete ONE - FIDE SNP, covered area aligned with ALTCS E/PD central and north GSA, 4,960 members, 8 years since 1/1/15. MyCare Ohio - 'similar' to ALTCS E/PD pop, NCQA medicaid and	Banner University Care Advantage dba Banner Medicare Advantage Dual (BMA Dual), noted to be a FIDE SNP, 15 years experience, CMS contract in Central and Southern GSA, 13,724 members. Refers to	Health Choice Pathway DSNP, first in Az to achieve NCQA MA and DSNP accreditation. One of two 4 STAR DNSPs in Az, 12,000 Az members in North and Central GSAs. Providers and assisted living network serves	Operates/serves 20,806 DNSP members in Az, 16 yrs. Doesn't mention areas served. STAR+PLUS serves 50,197 adults with disabilities or age 65+, 16 yrs in Texas (Bexar, Lubbock and Nueces counties). KanCare in	State wide SNP, 13,503 members, 100% score on CMS NCQA Model of Care evaluation, noted to be a HIDE and FIDE SNP, operating 17 years (eff 1/1/06), Maricopa, Pinal, Gila and Pima. Also notes for medicaid is
Criteria Consideration - [Enter Consideration Here]	Incumbant is an E/PD Contractor.	Incumbant is an E/PD Contractor.	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	Notes they are a current Az LTC program.
Criteria Consideration - Other	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration
BROAD CATEGORY - OTHER NOTABLE CONSIDERATIONS					
Criteria Consideration - Use of cited contracts	Describes contracts.	Describes contracts	Describes contracts	Describes contracts	Describes contracts
Criteria Consideration - [STAR and/or NCQA Rating]	Ohio and Tennessee programs noted to have NCQA medicaid accreditation and health equity accreditation. Tennesee also has LTSS accreditation.	Star Rating of 3.5 noted, VIBD full approval of Health Equity Plan for the DSNP and MAPD.	Notes NCQA MA and DNSP accreditation and one of two four STAR DSNPs in Az, only DSNP with five STAR Part D pharmacy program.	After reading Contractor's response, enter your individual notes here for this Broad Category and Criteria Consideration	Notes 100% score on recent CMS NCQA Model of Care Evaluation
DRAFT RANKING	1	2	3	5	4