Janice K. Brewer, Governor
Thomas J. Betlach, Director

801 East Jefferson, Phoenix, AZ 85034
PO Box 25520, Phoenix, AZ 85002
Phone: 602-417-4000
www.azahcccs.gov

AHCCCS

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

June 3, 2011

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

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

Dear Mr. Gordon:

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

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

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

RESPONSE TO ASSERTION OF CALCULATION ERROR

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

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

Decision: No additional point is awarded.

ORGANIZATION AND STAFFING

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

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

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

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

Decision: No additional point is awarded.

Submission Number and Evaluation Item 3-5
MCP asserts that its Chief Financial Officer (CFO) satisfied the evaluation criterion for three years of experience with the elderly and physically disabled (EPD) through publicly-funded programs.

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

Decision: No additional point is awarded.

Submission Number and Evaluation Item 3-28
MCP asserts that its Provider Services Manager satisfied the evaluation criterion for three years of relevant experience through her tenure at MCP as an employee and independent consultant, and her prior positions at Sonora Quest Laboratories and Insight Health Corporation.

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

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

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

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

Decision: No additional point is awarded.

CLAIMS AND ENCOUNTERS

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

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

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

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

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

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

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

Decision: No additional point is awarded.

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

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

Submission Number and Evaluation Item 9-1

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

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

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

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

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

Decision: No additional point is awarded.

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

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

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

Decision: No additional point is awarded.

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

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

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

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

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

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

Decision: No additional point is awarded.

GRIEVANCE & APPEALS

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

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

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

Submission Number and Evaluation Items 15-1 and 15-2

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

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

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

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

---

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

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

CASE MANAGEMENT

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

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

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

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

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

---

[2] Ellipses included in original protest language.

Decision: No additional point is awarded.

Question 24 - Program - Case Management Scenarios.

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

Submission Number and Evaluation Item 24-A(4)

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

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

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

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

Decision: No additional points are awarded.

Submission Number and Evaluation Item 24-B(1)

MCP asserts that evaluators erred in not awarding a point for its discussion of respite care. MCP cites the following language from its proposal:

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

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

Decision: One additional point is awarded.

Submission Number and Evaluation Item 24-B(2)

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

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

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

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

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

Decision: No additional point is awarded.

Submission Number and Evaluation Item 24-B(3)

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

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

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

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

Decision: No additional points are awarded.

Submission Number and Evaluation Item 24-C(3)

As previously noted, the scoring methodology for case management scenarios included points for "other proposed steps/actions likely to improve members/caregivers' health,

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

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

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

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

Decision: No additional points are awarded.

Submission Number and Evaluation Item 24-D(4)

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

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

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

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

Decision: No additional points are awarded.

MEDICAL MANAGEMENT

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

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

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

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

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

Decision: No additional points are awarded.

QUALITY MANAGEMENT

Question 31 - Program - Quality Management Scenarios.

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

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

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

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

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

Decision: No additional point is awarded.

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

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

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

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

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

Decision: No additional points are awarded.

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

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

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

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

Decision: No additional points are awarded.

NETWORK DEVELOPMENT AND MANAGEMENT

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

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

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

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

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

Decision: No additional points are awarded.

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

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

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

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

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

Decision: No additional point is awarded.

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

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

Submission Number and Evaluation Item 43-B

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

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

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

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

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

Decision: No additional point is awarded.

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

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

Submission Number and Evaluation Item 44-C

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

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

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

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

Decision: No additional point is awarded.

Question 45 - Provider Network Roster Requirement

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

Submission Number and Evaluation Item 45

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

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

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

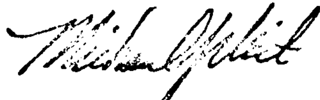
Decision: No additional points are awarded.

CONCLUSION

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

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

Sincerely,



Michael Veit
Chief Procurement Officer
AHCCCS Administration