Revised RFP Amendment #4

STATE OF ALASKA
Department of Health and Social Services
Division of Health Care Services
3601 C Street Suite 578
Anchorage, AK 99503

Request for Proposals

RFP **0614-075**
Date of Issue: December 24, 2013

Alaska Medicaid Coordinated Care Initiative

Vendors Are Not Required To Return This Form.

Important Notice: If you received this solicitation from the State of Alaska's "Online Public Notice" web site, you must register with the procurement officer listed in this document to receive subsequent amendments. Failure to contact the procurement officer may result in the rejection of your offer.

Lois Lemus
Procurement Officer
Department of Health and Social Services
Lois.lemus@alaska.gov

TABLE OF CONTENTS

SECTION ONE
INTRODUCTION AND INSTRUCTIONS

1.01 Return Mailing Address, Contact Person, Telephone, Fax Numbers and Deadline for Receipt of Proposals

Vendors must submit an original and four (4) unbound copies of their proposal, in writing, in a sealed envelope to the procurement officer. **Submit only one Cost Proposal in a separate, sealed envelope. No portion of the cost proposal shall be included within the body of the proposal.**

Include with your proposal packet a CD containing electronic copies of the Proposal and Cost Proposal as separate documents. Electronic documents should be no larger than 5MB each. Submissions must be addressed as follows:

Department of Health and Social Services
Division of Health Care Services
Attention: Lois Lemus
Request for Proposal (RFP) Number: ***0614-075***
Alaska Medicaid Coordinated Initiative
3601 C Street, Suite 578
Anchorage, AK 99503

Proposals must be received no later than 4:00 P.M., Alaska Time on **March 28, 2014.** Fax proposals are not acceptable. Oral proposals are not acceptable.

A Vendor's failure to submit its proposal prior to the deadline will cause the proposal to be disqualified. Late proposals or amendments will not be opened or accepted for evaluation.

PROCUREMENT OFFICER: ***Lois Lemus*** – PHONE **907*-269-3002*** - FAX ***907-269-7829***

1.02 Contract Term and Work Schedule

The contract term and work schedule set out herein represents the State of Alaska's best estimate of the schedule that will be followed. If a component of this schedule, such as the opening date, is delayed, the rest of the schedule will be shifted by the same number of days.

The length of the contract Phase I will be from the date of award through June 1, 2016 with a possible optional one year Phase II renewal at the sole discretion of the State of Alaska.

If the State of Alaska elects to exercise its' option of continuing on with Phase II, renegotiations between the State of Alaska and the Vendor will be required on all elements of the contract.

Unless otherwise provided in this RFP, the State and the successful Vendor(s) agree: (1) that any holding over of the contract excluding any exercised renewal options, will be considered as a month-to-month extension, and all other terms and conditions shall remain in full force and effect and (2) to provide written notice to the other party of the intent to cancel such month-to-month extension at least 30-days before the desired date of cancellation.

The approximate contract schedule is as follows:

- Issue RFP ***December 24, 2013***
- Deadline for Receipt of Questions ***March 19, 2014***
- Deadline for Receipt of Proposals ***March 28, 2014***
- Proposal Evaluation Committee complete evaluation by approximately ***April 15, 2014***
- State of Alaska issues Notice of Intent to Award a Contract ***May 14, 2014***

The resulting contract will be managed by the Director of the Division of Health Care Services, who will be responsible for contract oversight. The Manager of Quality Assurance or her designee(s) will be responsible for operational "day to day" activities and will be the primary contact for this contract.

1.03 Purpose of the RFP

The Department of Health and Social Services (DHSS), Division of Health Care Services (DHCS), is soliciting proposals to award up to a maximum of eight (8) contracts resulting from this RFP to provide case management and utilization review (CM/UR) services in support of Alaska Medicaid Coordinated Care Initiative (AMCCI). DHCS has identified high utilizers of emergency room services (super utilizers) whose care would be the initial focus of the AMCCI.

There is no requirement that the Vendor be a Medicare certified Quality Improvement Organization (QIO), or be fully accredited by URAC and/or the National Committee for Quality Assurance (NCQA).

The primary objective of the AMCCI is to promote high quality, cost effective outcomes by ensuring that timely and clinically appropriate medical services are provided to Alaska Medicaid members. Specifically, the AMCCI aims to reduce the number of emergency room (ER) visits, particularly those visits which are not emergent. Other goals include focusing on prevention, comprehensive care coordination, and enhanced integration of primary medical care and behavioral health services. The intended outcome of the AMCCI is to improve healthcare outcomes and access to services, as well as provide for more efficient use of services by controlling the high cost of unnecessary and wasteful health care expenditures.

The members eligible for participation in the AMCCI have been categorized in the following way:

- Region of the state,
- Native or non-Native,
- Two or more chronic conditions,
- One chronic condition, at risk for another, and
- One serious and persistent mental health condition

In the RFP, Vendor(s) are requested to select the pre-defined population they wish to serve (i.e. Anchorage Area, Non Native, with Two or more Chronic Conditions). Table 2 in Section 4.01 describes each of the populations by region, race, and medical condition. Once the contract(s) are awarded, the Division of Health Care Services (DHCS) will assign up to 200 AMCCI eligible members for each Vendor under a single proposed methodology, based on the population desired to provide services for in their bid. This number may vary depending on which population the Vendor(s) bid on. For example, Vendor(s) only bidding on Non Native members with Two or more

Chronic Conditions in South West Alaska, would have a maximum case load of 12 members (see data in Table 2, Section 4.01). The State reserves the sole right to negotiate should the vendor wish to expand their caseload if the vendor demonstrates the capacity and ability to manage a larger population.

The 200 AMCCI eligible members represent the maximum caseload DHCS would expect each Vendor(s) to maintain as an active caseload. DHCS anticipates that the Vendor(s), active case load may temporarily fluctuate slightly over time (between 85 – 100% of the maximum population the Vendor(s) bid) due to changes in eligibility or a member's 'graduation' from the program. DHCS is developing a process to maintain the Vendors caseload as members move into and out of the program.

1.04 Location of Work

The Vendor's headquarters may be located anywhere in the United States.

Case management services and direct supervision of CM/UR staff must be performed by staff based in Alaska. Vendor administrative and UR management staff will be available to DHCS 8:00 AM to 5:00 PM AST Monday through Friday. Case management services will minimally be performed between 7:00 AM to 7:00 PM Monday through Friday.

The Vendor must provide its own workspace. DHCS will not provide workspace for the Vendor.

By signature on their proposal, the Vendor certifies that all services provided under this contract by the Vendor and all subcontractors shall be performed in the United States.

If the Vendor cannot certify that all work will be performed in the United States, the Vendor must contact the procurement officer in writing to request a waiver at least ten (10) days prior to the deadline for receipt of proposals.

The request must include a detailed description of the portion of work that will be performed outside the United States, where, by whom, and the reason the waiver is necessary.

Failure to comply with this requirement or to obtain a waiver may cause the State to reject the proposal as non-responsive, or cancel the contract.

1.05 Human Trafficking

By signature on their proposal, the Vendor certifies that the Vendor is not established and headquartered or incorporated and headquartered in a country recognized as Tier 3 in the most recent United States Department of State's Trafficking in Persons Report.

The most recent United States Department of State's Trafficking in Persons Report can be found at the following website: http://www.State.gov/g/tip/

Failure to comply with this requirement will cause the State to reject the proposal as non-responsive, or cancel the contract.

1.06 Assistance to Vendors with a Disability

Vendors with a disability may receive accommodation regarding the means of communicating this RFP or participating in the procurement process. For more information, contact the procurement officer no later than ten (10) days prior to the deadline for receipt of proposals.

1.07 Required Review

Vendors should carefully review this solicitation for defects and questionable or objectionable material. Comments concerning defects and objectionable material must be made in writing and received by the procurement officer at least ten (10) days before the proposal opening. This will allow issuance of any necessary amendments. It will also help prevent the opening of a defective solicitation and exposure of Vendor's proposals upon which award could not be made. Protests based on any omission or error, or on the content of the solicitation, will be disallowed if these faults have not been brought to the attention of the procurement officer, in writing, at least ten (10) days before the time set for opening.

1.08 Questions Received Prior to Opening of Proposals

All questions must be in writing and directed to the issuing office, addressed to the procurement officer. The interested party must confirm telephone conversations in writing. **No further questions will be allowed after 1:30 pm Alaska time on date March 19, 2014.** Send questions to *lois.lemus@alaska.gov*.

Two types of questions generally arise. One may be answered by directing the questioner to a specific section of the RFP. These questions may be answered over the telephone. Other questions may be more complex and may require a written amendment to the RFP. The procurement officer will make that decision.

1.09 Amendments

If an amendment is issued, it will be provided to all who were mailed a copy of the RFP and to those who have registered with the procurement officer as having downloaded the RFP from the State of Alaska Online Public Notice web site.

1.10 Alternate Proposals

Vendor may submit only one proposal proposing one CM/UR methodology per population type. However, the Vendor may choose to submit proposal for other population types using different proposed CM/UR methodologies.

For example, the Vendor may submit one proposal for the population in Southcentral – Anchorage area, Native with two or more chronic conditions using one proposed CM/UR methodology. The Vendor then may submit another proposal for the population in the Interior, Native with one serious and persistent mental health condition using the same or different proposed CM/UR methodology. Multiple proposals on the same population will be considered non-responsive. See Section Five for further information.

1.11 Right of Rejection

Vendors must comply with all of the terms of the RFP, the State Procurement Code (AS 36.30), and all applicable local, State, and federal laws, codes, and regulations. The procurement officer may reject any proposal that does not comply with all of the material and substantial terms, conditions, and performance requirements of the RFP.

Vendors may not qualify the proposal nor restrict the rights of the State. If a Vendor does so, the procurement officer may determine the proposal to be a non-responsive counter-offer and the proposal may be rejected.

The procurement officer may waive minor informalities that:

- do not affect responsiveness;
- are merely a matter of form or format;
- do not change the relative standing or otherwise prejudice other offers;
- do not change the meaning or scope of the RFP;
- are trivial, negligible, or immaterial in nature;
- do not reflect a material change in the work; or
- do not constitute a substantial reservation against a requirement or provision.

The State reserves the right to refrain from making an award if it determines that to be in its best interest.
A proposal from a debarred or suspended Vendor shall be rejected.

1.12 State Not Responsible for Preparation Costs

The State will not pay any cost associated with the preparation, submittal, presentation, or evaluation of any proposal.

1.13 Disclosure of Proposal Contents

All proposals and other material submitted become the property of the State of Alaska and may be returned only at the State's option. AS 40.25.110 requires public records to be open to reasonable inspection. All proposal information, including detailed price and cost information, will be held in confidence during the evaluation process and prior to the time a Notice of Intent to Award is issued. Thereafter, proposals will become public information.

Trade secrets and other proprietary data contained in proposals may be held confidential if the Vendor requests, in writing, that the procurement officer does so, and if the procurement officer agrees, in writing, to do so. Material considered confidential by the Vendor must be clearly identified and the Vendor must include a brief statement that sets out the reasons for confidentiality.

1.14 Subcontractors

Subcontractors may be used to perform work under this contract. If a Vendor intends to use subcontractors, the Vendor must identify in the proposal the names of the subcontractors and the portions of the work the subcontractors will perform.

If a proposal with subcontractors is selected, the Vendor must provide the following information concerning each prospective subcontractor within five (5) working days from the date of the State's request:

(a) complete name of the subcontractor;

(b) complete address of the subcontractor;

(c) type of work the subcontractor will be performing;

(d) percentage of work the subcontractor will be providing;

(e) evidence that the subcontractor holds a valid Alaska business license; and

(f) a written statement, signed by each proposed subcontractor that clearly verifies that the subcontractor is committed to render the services required by the contract.

A Vendor's failure to provide this information, within the time set, may cause the State to consider their proposal non-responsive and reject it. The substitution of one subcontractor for another may be made only at the discretion and prior written approval of the Project Director.

1.15 Joint Ventures

Joint ventures are acceptable. If submitting a proposal as a joint venture, the Vendor must submit a copy of the joint venture agreement which identifies the principals involved and their rights and responsibilities regarding performance and payment.

1.16 Vendor's Certification

By signature on the proposal, Vendors certify that they comply with the following:

(a) the laws of the State of Alaska;

(b) the applicable portion of the Federal Civil Rights Act of 1964;

(c) the Equal Employment Opportunity Act and the regulations issued thereunder by the federal government;

(d) the Americans with Disabilities Act of 1990 and the regulations issued thereunder by the federal government;

(e) all terms and conditions set out in this RFP;

(f) a condition that the proposal submitted was independently arrived at, without collusion, under penalty of perjury;

(g) that the offers will remain open and valid for at least 90 days; and

(h) that programs, services, and activities provided to the general public under the resulting contract conform to the Americans with Disabilities Act of 1990, and the regulations issued thereunder by the federal government.

If any Vendor fails to comply with [a] through [h] of this paragraph, the State reserves the right to disregard the proposal, terminate the contract, or consider the Vendor in default.

1.17 Conflict of Interest

Each proposal shall include a statement indicating whether or not the Vendor or any individuals working on the contract has a possible conflict of interest (e.g., currently employed by the State of Alaska or formerly employed by the State of Alaska within the past two years) and, if so, the nature of that conflict. The Commissioner, Department of Health and Social Services, reserves the right to **consider a proposal non-responsive and reject it or** cancel the award if any interest disclosed from any source could either give the appearance of a conflict or cause speculation as to the objectivity of the program to be developed by the Vendor. The Commissioner's determination regarding any questions of conflict of interest shall be final.

Current grantees that propose to provide technical assistance to a group of grantees will be precluded from

submitting a proposal unless a written statement of refusal of grant funds is attached. All proposals submitted by current grantees must indicate that grant awards will not be accepted for the duration of the contract and/or any quarterly advance that has already been received will be returned upon award of contract. Proposals submitted by current grantees without this statement shall be deemed non-responsive.

1.18 Right to Inspect Place of Business

At reasonable times, the State may inspect those areas of the Vendor's place of business that are related to the performance of a contract. If the State makes such an inspection, the Vendor must provide reasonable assistance.

1.19 Solicitation Advertising

Public notice has been provided in accordance with 2 AAC 12.220.

1.20 News Releases

News releases related to this RFP will not be made without prior approval of the Project Director.

1.21 Assignment

Per 2 AAC 12.480, the Vendor may not transfer or assign any portion of the contract without prior written approval from the procurement officer.

1.22 Disputes

Any dispute arising out of this agreement will be resolved under the laws of the State of Alaska. Any appeal of an administrative order or any original action to enforce any provision of this agreement or to obtain relief from or remedy in connection with this agreement may be brought only in the Superior Court for the State of Alaska.

1.23 Severability

If any provision of the contract or agreement is declared by a court to be illegal or in conflict with any law, the validity of the remaining terms and provisions will not be affected; and, the rights and obligations of the parties will be construed and enforced as if the contract did not contain the particular provision held to be invalid.

1.24 Federal Requirements

The Vendor must identify all known federal requirements that apply to the proposal, the evaluation, or the contract.

The Vendor will comply with all Federal and State regulations as they apply to the contract.

Expenditures from this contract may involve federal funds. The U.S. Department of Labor requires all State agencies that are expending federal funds to have a certification filed in the proposal (by the

Vendor) that they have not been debarred or suspended from doing business with the federal government. Certification regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions **(included in this document) must be completed and submitted with your proposal.**
https://www.epls.gov/

SECTION TWO
STANDARD PROPOSAL INFORMATION

2.01 Authorized Signature

All proposals must be signed by an individual authorized to bind the Vendor to the provisions of the RFP. Proposals must remain open and valid for at least 90-days from the opening date.

2.02 Pre-proposal Conference

A pre-proposal conference will not be held for this solicitation. See Section 1.08 for instructions on submitting questions regarding this RFP.

2.03 Site Inspection

The State may conduct on-site visits to evaluate the Vendor's capacity to perform the contract. A Vendor must agree, at risk of being found non-responsive and having its proposal rejected, to provide the State reasonable access to relevant portions of its work sites. Individuals designated by the procurement officer at the State's expense will make site inspection.

2.04 Amendments to Proposals

Amendments to or withdrawals of proposals will only be allowed if acceptable requests are received prior to the deadline that is set for receipt of proposals. No amendments or withdrawals will be accepted after the deadline unless they are in response to the State's request in accordance with 2 AAC 12.290.

2.05 Supplemental Terms and Conditions

Proposals must comply with Section **1.11 Right of Rejection**. However, if the State fails to identify or detect supplemental terms or conditions that conflict with those contained in this RFP or that diminish the State's rights under any contract resulting from the RFP, the term(s) or condition(s) will be considered null and void. After award of contract:

a) if conflict arises between a supplemental term or condition included in the proposal and a term or condition of the RFP, the term or condition of the RFP will prevail; and
b) if the State's rights would be diminished as a result of application of a supplemental term or condition included in the proposal, the supplemental term or condition will be considered null and void.

2.06 Clarification to Vendors

In order to determine if a proposal is reasonably susceptible for award, communications by the procurement officer or the proposal evaluation committee are permitted with a Vendor to clarify uncertainties or eliminate confusion concerning the contents of a proposal. Clarifications may not result in a material or substantive change

to the proposal. The evaluation by the procurement officer or the proposal evaluation committee may be adjusted as a result of a clarification under this section.

2.07 Discussions with Vendors

The State may conduct discussions with Vendors in accordance with AS 36.30.240 and 2 AAC 12.290. The purpose of these discussions will be to ensure full understanding of the requirements of the RFP and proposal. Discussions will be limited to specific sections of the RFP or proposal identified by the procurement officer. Discussions will only be held with Vendors who have submitted a proposal deemed reasonably susceptible for award by the procurement officer. Discussions, if held, will be after initial evaluation of proposals by the PEC. If modifications are made as a result of these discussions they will be put in writing. Following discussions, the procurement officer may set a time for best and final proposal submissions from those Vendors with whom discussions were held. Proposals may be reevaluated after receipt of best and final proposal submissions.

If a Vendor does not submit a best and final proposal or a notice of withdrawal, the Vendor's immediate previous proposal is considered the Vendor's best and final proposal.

Vendors with a disability needing accommodation should contact the procurement officer prior to the date set for discussions so that reasonable accommodation can be made. Any oral modification of a proposal must be reduced to writing by the Vendor.

2.08 Minimum Qualifications

In order for offers to be considered responsive Vendors must provide evidence that they meet these minimum prior experience requirements. **Note: Please provide the start and end dates, including month and year, in which the minimum requirements were satisfied. Documentation should include a resume, copies of current licenses and/or professional certifications to demonstrate compliance with these requirements.**

- Provide in writing the Vendor has a minimum of three (3) years successful experience providing case management services for an active caseload using current case management standards.
- The Vendor must provide in writing the name and resume of the CM/UR direct supervisor assigned to this project. The CM/UR direct supervisor's resume must demonstrate the CM/UR direct supervisor:
    - has applicable experience for the type of CM/UR services the Vendor proposes to provide,
    - has experience managing the medical complexities of the population,
    - has a minimum of three (3) years health care supervisory experience, and
    - has a minimum of one (1) year case management experience.

A Vendor's failure to meet these minimum prior experience requirements will cause their proposal to be considered non-responsive and their proposal will be rejected. Evidence of meeting minimum prior experience must be shown in the experience section of the Vendor's proposal.

2.09 Evaluation of Proposals

The procurement officer, or an evaluation committee made up of at least three (3) State employees or public officials, will evaluate proposals. The evaluation will be based solely on the evaluation factors set out in Section SEVEN of this RFP.

After receipt of proposals, if there is a need for any substantial clarification or material change in the RFP, an amendment will be issued. The amendment will incorporate the clarification or change, and a new date and time established for new or amended proposals. Evaluations may be adjusted as a result of receiving new or amended proposals.

2.10 Vendor Tax ID

A valid Vendor Tax ID must be submitted to the issuing office with the proposal or within five (5) days of the State's request.

2.11 F.O.B. Point

All goods purchased through this contract will be F.O.B. final destination. Unless specifically stated otherwise, all prices offered must include the delivery costs to any location within the State of Alaska.

2.12 Alaska Business License and Other Required Licenses

At the time the proposals are opened, all Vendors must hold a valid Alaska business license and any necessary applicable professional licenses required by Alaska Statute. Proposals must be submitted under the name as appearing on the person's current Alaska business license in order to be considered responsive. Vendors should contact the Department of Commerce, Community and Economic Development, Division of Corporations, Business, and Professional Licensing, P. O. Box 110806, Juneau, Alaska 99811-0806, for information on these licenses. Vendors must submit evidence of a valid Alaska business license with the proposal. A Vendor's failure to submit this evidence with the proposal will cause their proposal to be determined non-responsive. Acceptable evidence that the Vendor possesses a valid Alaska business license may consist of any one of the following:

(a) copy of an Alaska business license with the correct NAICS code;

(b) certification on the proposal that the Vendor has a valid Alaska business license and has included the license number in the proposal;

(c) a canceled check for the Alaska business license fee;

(d) a copy of the Alaska business license application with a receipt stamp from the State's occupational licensing office; or

(e) a sworn and notarized affidavit that the Vendor has applied and paid for the Alaska business license.

You are not required to hold a valid Alaska business license at the time proposals are opened if you possess one of the following licenses and are offering services or supplies under that specific line of business:

- Fisheries business licenses issued by Alaska Department of Revenue or Alaska Department of Fish and Game.
- Liquor licenses issued by Alaska Department of Revenue for alcohol sales only.
- Insurance licenses issued by Alaska Department of Commerce, Community and Economic Development, Division of Insurance.
- Mining licenses issued by Alaska Department of Revenue.

2.13 Application of Preferences

Certain preferences apply to all contracts for professional services, regardless of their dollar value. The Alaska bidder, Alaska Veteran, and Alaska Vendor Preferences are the most common preferences involved in the RFP process. Additional preferences that may apply to this procurement are listed below. Guides that contain excerpts from the relevant statutes and codes, explain when the preferences apply and provide examples of how to calculate the preferences are available at the Department of Administration, Division of General Services' web site:

http://doa.alaska.gov/dgs/policy.html

Alaska Products Preference - AS 36.30.332
Recycled Products Preference - AS 36.30.337
Local Agriculture and Fisheries Products Preference - AS 36.15.050
Employment Program Preference - AS 36.30.170(c)
Alaskans with Disability Preference - AS 36.30.170 (e)
Employers of People with Disabilities Preference - AS 36.30.170 (f)

The Division of Vocational Rehabilitation in the Department of Labor and Workforce Development keeps a list of qualified employment programs; a list of individuals who qualify as persons with a disability; and a list of persons who qualify as employers with 50 percent or more of their employees being disabled. A person must be on this list at the time the bid is opened in order to qualify for a preference under this section.

As evidence of an individual's or a business' right to a certain preference, the Division of Vocational Rehabilitation will issue a certification letter. To take advantage of the employment program preference, Alaskans with Disability Preference or Employers of People with Disabilities Preference described above, an individual or business must be on the appropriate Division of Vocational Rehabilitation list at the time the proposal is opened, and must provide the procurement officer a copy of their certification letter. Vendors must attach a copy of their certification letter to the proposal. The Vendor's failure to provide the certification letter mentioned above with the proposal will cause the State to disallow the preference.

2.14 5 Percent Alaska Bidder Preference AS 36.30.170 & 2 AAC 12.260

An Alaska Bidder Preference of five percent will be applied prior to evaluation. The preference will be given to a Vendor who:

(a) holds a current Alaska business license;

(b) submits a proposal for goods or services under the name on the Alaska business license;

(c) has maintained a place of business within the State staffed by the Vendor, or an employee of the Vendor, for a period of six months immediately preceding the date of the proposal;

(d) is incorporated or qualified to do business under the laws of the State, is a sole proprietorship and the proprietor is a resident of the State, is a limited liability company organized under AS 10.50 and all members are residents of the State, or is a partnership under AS 32.05 or AS 32.11 and all partners are residents of the State; and

(e) if a joint venture, is composed entirely of entities that qualify under (a)-(d) of this subsection.

Alaska Bidder Preference Affidavit
In order to receive the Alaska Bidder Preference, proposals must include a statement certifying that the Vendor is eligible to receive the Alaska Bidder Preference.

If the Vendor is a LLC or partnership as identified in (d) of this subsection, the affidavit must also identify each member or partner and include a statement certifying that all members or partners are residents of the State.

If the Vendor is a joint venture which includes a LLC or partnership as identified in (d) of this subsection, the affidavit must also identify each member or partner of each LLC or partnership that is included in the joint venture and include a statement certifying that all of those members or partners are residents of the State.

2.15 5 Percent Alaska Veteran Preference AS 36.30.175

An Alaska Veteran Preference of five percent will be applied prior to evaluation. The preference will be given to a Vendor who qualifies under AS 36.30.170 (b) as an Alaska bidder and is a:

(a) sole proprietorship owned by an Alaska veteran;

(b) partnership under AS 32.06 or AS 32.11 if a majority of the partners are Alaska veterans;

(c) limited liability company organized under AS 10.50 if a majority of the members are Alaska veterans; or

(d) corporation that is wholly owned by individuals and a majority of the individuals are Alaska veterans.

Alaska Veteran Preference Affidavit
In order to receive the Alaska Veteran Preference, proposals must include a statement certifying that the Vendor is eligible to receive the Alaska Veteran Preference.

2.16 Formula Used to Convert Cost to Points AS 36.30.250 & 2 AAC 12.260

The distribution of points based on cost will be determined as set out in 2 AAC 12.260 (c). The lowest cost proposal will receive the maximum number of points allocated to cost. The point allocations for cost on the other proposals will be determined through the method set out below. In the **generic example below**, cost is weighted as 30% of the overall total score. The weighting of cost may be different in your particular RFP. See section SEVEN to determine the value, or weight of cost for this RFP.

EXAMPLE

Formula Used to Convert Cost to Points

[STEP 1]

List all proposal prices, adjusted where appropriate by the application of all applicable preferences.

Vendor #1 -	Non-Alaska Vendor	$40,000
Vendor #2 -	Alaska Vendor	$42,750
Vendor #3 -	Alaska Vendor	$47,500

[STEP 2]

Convert cost to points using this formula.

[(Price of Lowest Cost Proposal) x (Maximum Points for Cost)]

_____ = POINTS
(Cost of Each Higher Priced Proposal)

The RFP allotted 30% (300 points) of the total of 1,000 points for cost.

Vendor #1 receives 300 points.

The reason they receive that amount is because the lowest cost proposal, in this case $40,000, receives the maximum number of points allocated to cost, 300 points.

Vendor #2 receives 281 points.

$40,000 Lowest Cost	x	300 Max Points	=	12,000,000	÷	$42,750 Vendor #2 Adjusted By The Application Of All Applicable Preferences	=	281 Points

Vendor #3 receives 253 points.

$40,000 Lowest Cost	x	300 Max Points	=	12,000,000	÷	$47,500 Vendor #3 Adjusted By The Application Of All Applicable Preferences	=	253 Points

2.17 Alaska Vendor Preference AS 36.30.250 & 2 AAC 12.260

2 AAC 12.260(e) provides Alaska Vendors a 10 percent overall evaluation point preference. Alaska bidders, as defined in AS 36.30.170(b), are eligible for the preference. This preference will be added to the overall evaluation score of each Alaska Vendor. Each Alaska Vendor will receive 10 percent of the total available points added to their evaluation score as a preference.

EXAMPLE

Alaska Vendor Preference

[STEP 1]

Determine the number of points available to Alaska Vendors under the preference.

Total number of points available - 100 Points

1000 Total Points Available	**x**	**10%** Alaska Vendors Percentage Preference	**=**	**100** Number of Points Given to Alaska Vendors Under the Preference

[STEP 2]

Add the preference points to the Alaskan offers. There are three Vendors: Vendor #1, Vendor #2, and Vendor #3. Vendor #2 and Vendor #3 are eligible for the Alaska Vendor's Preference. For the purpose of this example presume that all of the proposals have been completely evaluated based on the evaluation criteria in the RFP. Their scores at this point are:

Vendor #1 - 890 points
Vendor #2 - 800 points
Vendor #3 - 880 points
Vendor #2 and Vendor #3 each receive 100 additional points. The final scores for all of the offers are:

*Vendor #1 - **890 points***
*Vendor #2 - **900 points***
*Vendor #3 - **980 points***

Vendor #3 is awarded the contract.

2.18 Contract Negotiation

2 AAC 12.315 CONTRACT NEGOTIATIONS After final evaluation, the procurement officer may negotiate with the Vendor of the highest-ranked proposal(s). Negotiations, if held, shall be within the scope of the request for proposals and limited to those items which would not have an effect on the ranking of proposals. If the highest-ranked Vendor fails to provide necessary information for negotiations in a timely manner, or fails to negotiate in good faith, the State may terminate negotiations and negotiate with the Vendor of the next highest-ranked proposal. If contract negotiations are commenced, they may be held in the ***Health Care Services*** conference room in ***Anchorage***, Alaska.

If the contract negotiations take place in Anchorage, Alaska, the Vendor will be responsible for their travel and per diem expenses.

During negotiations, HCS and the vendors will discuss the ramp up period and implementation dates.

2.19 Failure to Negotiate

If the selected Vendor

- fails to provide the information required to begin negotiations in a timely manner; or
- fails to negotiate in good faith; or
- indicates they cannot perform the contract within the budgeted funds available for the project; or
- if the Vendor and the State, after a good faith effort, simply cannot come to terms,

the State may terminate negotiations with the Vendor initially selected and commence negotiations with the next highest ranked Vendor.

2.20 Notice of Intent to Award (NIA) — Vendor Notification of Selection

After the completion of contract negotiation the procurement officer will issue a written Notice of Intent to Award (NIA) and send copies to all Vendors. The NIA will set out the names of all Vendors and identify the proposal selected for award.

2.21 Protest

AS 36.30.560 provides that an interested party may protest the content of the RFP.

An interested party is defined in 2 AAC 12.990(a) (7) as "an actual or prospective bidder or Vendor whose economic interest might be affected substantially and directly by the issuance of a contract solicitation, the award of a contract, or the failure to award a contract."

If an interested party wishes to protest the content of a solicitation, the protest must be received, in writing, by the procurement officer at least ten (10) days prior to the deadline for receipt of proposals.

AS 36.30.560 also provides that an interested party may protest the award of a contract or the proposed award of a contract.

If a Vendor wishes to protest the award of a contract or the proposed award of a contract, the protest must be received, in writing by the procurement officer within ten (10) days after the date the Notice of Intent to Award the contract is issued.

A protester must have submitted a proposal in order to have sufficient standing to protest the proposed award of a contract. Protests must include the following information:

a. the name, address, and telephone number of the protester;

b. the signature of the protester or the protester's representative;

c. identification of the contracting agency and the solicitation or contract at issue;

d. a detailed statement of the legal and factual grounds of the protest including copies of relevant documents; and the form of relief requested.

Protests filed by telex or telegram are not acceptable because they do not contain a signature. Fax copies containing a signature are acceptable.

The procurement officer will issue a written response to the protest. The response will set out the procurement officer's decision and contain the basis of the decision within the statutory time limit in AS 36.30.580. A copy of the decision will be furnished to the protester by certified mail, fax or another method that provides evidence of receipt.

All Vendors will be notified of any protest. The review of protests, decisions of the procurement officer, appeals, and hearings, will be conducted in accordance with the State Procurement Code (AS 36.30), Article 8 "Legal and Contractual Remedies."

SECTION THREE
STANDARD CONTRACT INFORMATION

3.01 Contract Type

This contract is a ***firm fixed price*** contract.

Department will not pay for services normally provided by any contract employee that is furloughed

3.02 Contract Approval

This RFP does not, by itself, obligate the State. The State's obligation will commence when the contract is approved by the Commissioner of the Department of Health and Social Services, or the Commissioner's designee. Upon written notice to the Vendor, the State may set a different starting date for the contract. The State will not be responsible for any work done by the Vendor, even work done in good faith, if it occurs prior to the contract start date set by the State.

3.03 Standard Contract Provisions

The successful Vendor will be required to sign and submit the attached State's Standard Agreement Form for Professional Services Contracts (form 02-093/Appendix A). The successful Vendor must comply with the contract provisions set out in this attachment. No alteration of these provisions will be permitted without prior written approval from the Department of Law. Objections to any of the provisions in Appendix A must be set out in the Vendor's proposal.

3.04 Proposal as a Part of the Contract

Part or all of this RFP and the successful proposal may be incorporated into the contract.

3.05 Additional Terms and Conditions

The State reserves the right to add terms and conditions during contract negotiations. These terms and conditions will be within the scope of the RFP and will not affect the proposal evaluations.

3.06 Insurance Requirements

The successful Vendor must provide proof of workers' compensation insurance prior to contract approval.

The successful Vendor must secure the insurance coverage required by the State. The coverage must be satisfactory to the Department of Administration, Division of Risk Management. A Vendor's failure to provide evidence of such insurance coverage is a material breach and grounds for withdrawal of the award or termination of the contract.

Vendors must review form APPENDIX B1 in the attached EXAMPLE –Standard Agreement, for details on required coverage. No alteration of these requirements will be permitted without prior written approval from the Department of Administration, Division of Risk Management.

3.07 Bid Bond - Performance Bond - Surety Deposit

N/A

3.08 Contract Funding

Payment for the contract is subject to funds already appropriated and identified.

3.09 Proposed Payment Procedures

The State will make payments based on a negotiated payment schedule. Each billing must consist of an invoice and progress report. No payment will be made until the progress report and invoice has been approved by the Project Director.

3.10 Contract Payment

No payment will be made until the contract is approved by the Commissioner of the Department of Health and Social Services or the Commissioner's designee. Under no conditions will the State be liable for the payment of any interest charges associated with the cost of the contract.

The State is not responsible for and will not pay local, State, or federal taxes. All costs associated with the contract must be Stated in U.S. currency.

3.11 Informal Debriefing

When the contract is completed, an informal debriefing may be performed at the discretion of the Project Director. If performed, the scope of the debriefing will be limited to the work performed by the Vendor.

3.12 Contract Personnel

Any change of the project team members named in the proposal must be approved, in advance and in writing, by the Project Director. Personnel changes that are not approved by the State may be grounds for the State to terminate the contract.

3.13 Inspection & Modification - Reimbursement for Unacceptable Deliverables

The Vendor is responsible for the completion of all work set out in the contract. All work is subject to inspection, evaluation, and approval by the Project Director. The State may employ all reasonable means to ensure that the work is progressing and being performed in compliance with the contract. The Project Director may instruct the Vendor to make corrections or modifications if needed in order to accomplish the contract's intent. The Vendor will not unreasonably withhold such changes.

Substantial failure of the Vendor to perform the contract may cause the State to terminate the contract. In this event, the State may require the Vendor to reimburse monies paid (based on the identified portion of unacceptable work received) and may seek associated damages.

3.14 Termination for Default

If the Project Director determines that the Vendor has refused to perform the work or has failed to perform the work with such diligence as to ensure its timely and accurate completion, the State may, by providing written notice to the Vendor, terminate the Vendor's right to proceed with part or all of the remaining work.

This clause does not restrict the State's termination rights under the contract provisions of Appendix A, attached.

3.15 Liquidated Damages

N/A

3.16 Contract Changes - Unanticipated Amendments

During the course of this contract, the Vendor may be required to perform additional work. That work will be within the general scope of the initial contract. When additional work is required, the Project Director will provide the Vendor a written description of the additional work and request the Vendor to submit a Vendor time schedule for accomplishing the additional work and a Vendor price for the additional work. Cost and pricing data must be provided to justify the cost of such amendments per AS 36.30.400.

The Vendor will not commence additional work until the Project Director has secured any required State approvals necessary for the amendment and issued a written contract amendment, approved by the Commissioner of the Department of Health and Social Services or the Commissioner's designee.

3.17 Contract Additions - Anticipated Amendment

At the State's sole option and contingent upon available funding, DHSS may invoke a second phase of this contract for additional professional services that fall within the general scope of the original contract. If opted for, work under Phase II may not progress until the Procurement Officer of record determines in writing that Phase II is necessary and in the State's best interest.

3.18 Contract Invalidation

If any provision of this contract is found to be invalid, such invalidation will not be construed to invalidate the entire contract.

3.19 Nondisclosure and Confidentiality

Vendor agrees that all confidential information shall be used only for purposes of providing the deliverables and performing the services specified herein and shall not disseminate or allow dissemination of confidential information except as provided for in this section. The Vendor shall hold as confidential and will use reasonable care (including administrative, physical and technological security) to prevent unauthorized access by, storage, disclosure, publication, dissemination to and/or use by third parties of, the confidential information. "Reasonable care" means compliance by the Vendor with all applicable federal and State law, including the Social Security Act, the Health Insurance Portability and Accountability Act ("HIPAA"), the Health Information Technology for Economical and Clinical Health Act ("HITECH Act"), and 45 C.F.R. Parts 160 and 164 ("Privacy and Security Rule"). The Vendor must promptly notify the State in writing if it becomes aware of any storage, disclosure, loss, unauthorized access to or use of the confidential information.

The Vendor shall comply with the business associate requirements set forth in HIPAA, the HITECH Act, and the Privacy and Security Rule if the Vendor will be using or will have access to the protected health information (as defined in 45 C.F.R. 160.103) of DHSS, as part of the services performed by the Vendor. The Vendor shall be required to agree to the terms of, and sign, the HIPAA Business Associate Agreement as a condition of this contract if the Vendor will be using or will have access to the protected health information of DHSS, as part of the services performed by the Vendor.

Confidential information, as used herein, means any data, files, software, information or materials (whether prepared by the State or its agents or advisors) in oral, electronic, tangible or intangible form and however stored, compiled or memorialized that is protected health information (as defined in 45 C.F.R. 160.103); or classified confidential as defined by State of Alaska classification and categorization guidelines (i) provided by the State to the Vendor or a Vendor agent or otherwise made available to the Vendor or a Vendor agent in connection with this contract, or (ii) acquired, obtained or learned by the Vendor or a Vendor agent in the performance of this contract. Examples of confidential information include, but are not limited to: technology infrastructure, architecture, financial data, individually identifiable health information, trade secrets, equipment specifications, user lists, passwords, research data, and technology data (infrastructure, architecture, operating systems, security tools, IP addresses, etc).

Additional information that the Vendor shall hold as confidential during the performance of services under this contract include:

- Member participation in the Alaska Medicaid Coordinated Care Initiative (AMCCI) project
- Individual member medical and social service information
- Alaska Medicaid Claims data
- Medical records as required by 7 AAC 105.230 (e)

If confidential information is requested to be disclosed by the Vendor pursuant to a request received by a third party and such disclosure of the confidential information is required under applicable State or federal law, regulation, governmental or regulatory authority, the Vendor may disclose the confidential information after providing the State with written notice of the requested disclosure (to the extent such notice to the State is permitted by applicable law) and giving the State opportunity to review the request. If the Vendor receives no objection from the State, it may release the confidential information within 30 days. Notice of the requested disclosure of confidential information by the Vendor must be provided to the State within a reasonable time after the Vendor's receipt of notice of the requested disclosure and, upon request of the State, shall seek to obtain legal protection from the release of the confidential information.

The following information shall not be considered confidential information: information previously known to be public information when received from the other party; information freely available to the general public; information which now is or hereafter becomes publicly known by other than a breach of confidentiality hereof; or information which is disclosed by a party pursuant to subpoena or other legal process and which as a result becomes lawfully obtainable by the general public.

SECTION FOUR
BACKGROUND INFORMATION

4.01 Care Management Program (CMP)

The current Care Management Program (CMP), formerly known as the 'Lock-in' Program, was established in 2006 by the Alaska Department of Health and Social Services under the authority of the Alaska Administrative Code 7 AAC 105.600 to combat harmful and costly inappropriate use of Alaska Medicaid-covered services. The Care Management Program restricts a member to a Primary Care Provider and a single Pharmacy to reduce misuse of the Alaska Medicaid program, encourage continuity of care and promote communication between the member's Primary Care Provider and pharmacy. Providers eligible to serve as a primary care provider under the Care Management Program include:

- Physicians
- Advanced Nurse Practitioners
- Physician Assistants
- Health Professional Groups that include any or all of the above Provider types

Members who could benefit from the CMP are most often identified by the Department or Xerox State Healthcare, LLC (Xerox), the Department's current contracted fiscal agent, although medical providers or other concerned individuals may also refer members to CMP. A utilization review of the most recent 12 months of all medical and pharmacy records is then conducted to determine if the individual meets criteria for CMP. If CMP placement is determined to be appropriate, the member is sent a notice explaining the reason for, and the date of placement into the program. The notice includes reports describing in detail the area(s) the member has overused medical services. The notice explains that participation is mandatory. Members are explained their fair hearing rights and procedures in order to assure due process are available to all members selected for participation.

Care Management Program participation generally lasts for 12 months. With the exception of emergency services, a member is able to seek treatment from other providers only after receiving an advance written referral from their assigned primary care provider.

The Fiscal Agent provides limited special assistance to CMP members during contract business hours. These CMP coordinators monitor and assist CMP members during their 12 month placement period. Coordinators are able to troubleshoot and resolve issues that CMP members may encounter such as finding new doctors, assistance getting into drug rehabilitation programs, obtaining referrals, pharmacy overrides, and problem solving other challenges that the CMP member may encounter.

Each year the Care Management Program receives more than 100 referrals from physicians and pharmacies within Alaska. These referrals affirm that the Alaska medical community views the Care Management Program as a valuable tool in reducing fraud, waste and abuse of Alaska Medicaid services. The end result of this effort is increased prescription oversight, a reduction in unnecessary health care encounters, increased coordination of care, better health outcomes and cost savings to the Alaska Medicaid program.

Prudent fiscal stewardship requires that Alaska Medicaid detect and minimize wasteful health care expenditures. The current Care Management Program is able to manage about 300 top utilizers but lacks sufficient resources and expertise to address the complex and layered problems of this super utilizer group. Additionally, members of the AMCCI program may not require the severe limits applied to members in the Care Management Program.

4.02 Alaska Medical Assistance Care Coordination Program (AMCCI)

4.02.1 National Governors Association Participation

The State of Alaska applied and was chosen by the National Governors Association (NGA) to participate in Developing State-level Capacity to Support Super Utilizers Policy Academy. The goal of this Policy Academy is to assist Governors in designing and improving systems at the State level to ensure better provision of coordinated and targeted services for people who are high-utilizers of health care services. On average a small percentage of Alaska Medicaid population accounts for a large share of Alaska Medicaid spending. These individuals face extremely complex challenges and often use hospital services when their health issues could be addressed through lower cost interventions. Preventing the incorrect use of emergency room services by over utilizing members requires a level of care coordination, support and insight that does not exist in the Care Management Program today.

Alaska has been selected as one of five States to work with the NGA who will assist these States in designing a State action plan. The plans will lay the ground work for and strategy around how each State will move forward to strengthen systems and processes to support better care delivery for members, specifically within the target populations. Through participation in the Policy Academy and under the leadership of the Governors' Office, teams of senior-level advisors and other State policymakers from different parts of State Government will work together with external stakeholders to determine how individual States can leverage existing resources.

A typical Super Utilizer intervention model identifies high utilizers of care through data analytics and addresses both the clinical and non-clinical needs of these members by administering intensive and personalized care interventions over the course of a specific time period. Through such models, members receive one on one, consistent care management and support from professionals such as nurses, health coaches or health navigators. In addition to helping members navigate the health care system, these models are designed to promote a member's access to health coverage and human services as needed.

NGA is a resource to State staff to develop policy and an effective implementation policy. The Vendor(s) will not be required to interact with or report to NGA. DHCS' work with NGA is ongoing as we finalize an internal work plan to establish key timelines, milestones, and project deliverables. DHCS meets monthly with NGA to discuss project progress and provides written updates as requested.

4.02.2 AMCCI Overview

The primary objective of the AMCCI is to promote high quality, cost effective outcomes by ensuring that timely and clinically appropriate medical services are provided to Alaska Medicaid members. Specifically, the AMCCI aims to reduce the number of emergency room (ER) visits, particularly those which are not emergent. Other goals include focusing on prevention, comprehensive care coordination, and enhanced integration of primary medical care and behavioral health services. The intended outcome of the AMCCI is to improve healthcare outcomes and access to services, as well as provide for more efficient use of services by controlling the high cost of unnecessary and wasteful health care expenditures.

In this pilot project, the Division of Health Care Services (DHCS) has identified a group of members whose frequency of emergency room utilization meets the criteria for AMCCI selection (see AMCCCI Participation Selection at 4.02.03). Participating members will have their care guided throughout twelve consecutive months. By following these members, DHCS will develop an informed sense of the challenges of providing appropriate, medically necessary health care to these members. Those members that do not meet the AMCCI selection criteria will continue to be monitored by DHCS through the traditional CMP or other processes.

Unlike the CMP, the AMCCI will be a primarily voluntary program. Members meeting AMCCI criteria as defined in the RFP will be contacted and offered the opportunity to voluntarily participate. However, CMP potential

candidates may be moved into the AMCCI program at the sole discretion of the DHCS. Members who choose not to voluntarily participate in the AMCCI will be re-evaluated by the fiscal agent to see if they meet statutory criteria for potential placement in the CMP set forth in 7 AAC 105.600. Once assigned, a member placed in either the AMCCI or the CMP will not be permitted to move between programs. A member may however, complete their twelve consecutive months in one program and then be assigned to the other program.

This pilot project will include integration of behavioral health services when necessary. The proposed model will include assignment of a primary care provider, a pharmacy, hospital, and a behavioral health provider as appropriate.

Members may not be arbitrarily terminated by the vendor from participation in this project; only DHCS has sole authority to terminate or approve a request for transition out of the program.

4.02.3 AMCCI Member Selection

The AMCCI serves eligible members receiving benefits from some of Alaska's Medical Assistance programs. These programs include Alaska Medicaid and Children's Health Insurance Program (CHIP), known in Alaska as Denali KidCare (DKC), and other programs administered by the Department. The AMCCI has identified Alaska Medicaid eligible members whose utilization of ER services is exceptionally high (referred to as super utilizers). These members will be the focus of the CM/UR activities.

Paid Alaska Medicaid claims data was used for analysis. Members within the target population were identified based on who:

- met AMCCI criteria[1] i.e. used the emergency room five or more times a year and who were not in the current Care Management Program; or
- met CMP criteria for potential candidates as defined at 7 AAC 105.600[2]

Additional AMCCI criteria for selection will include a primary and/or secondary diagnosis of health care conditions such as: Diabetes, COPD, Asthma, CHF, Depression, Pain Management, Addictions, Heart Disease, Heart Attack, Pneumonia, Obesity (BMI>25), and Substance Abuse.

Individuals will be placed in the Alaska Medicaid Coordinated Care Initiative (AMCCI) program in the following order:

- Individuals who have two or more chronic conditions
- Individuals with one chronic condition but are at risk for developing another
- Individuals with at least one serious and persistent mental health condition

At this time dual eligible (Medicare and Alaska Medicaid) members will be excluded. However this may be reconsidered in the future.

The universe of members meeting AMCCI criteria, used for the analysis below, is comprised of 6,512 members based on claims paid by Alaska Medicaid Program between January 1, 2012 and September 17, 2013. The number of members by region is displayed below.

[1] AMCCI criteria were based on CMS Informational Bulletins dated July 24, 2013 and January 16, 2014 entitled, "Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality" and "Reducing Nonurgent Use of Emergency Rooms and Improving Appropriate Care in Appropriate Settings.

[2] The DHCS CMP Vendor does not have the capacity currently to service the large volume of members who are potential candidates for placement in the AMCCI.

The Division of Health Care Services makes every effort to ensure that reported numbers are as accurate as possible. However, due to possible defects in the new Health Enterprise MMIS claims processing system (including converted historical records) the data provided in this RFP is to be considered a draft and may be updated in future iterations.

Members by Region and Condition

Region	Two or more Chronic Conditions		One chronic condition at risk for another		One Serious and persistent Mental Health Condition		**Totals**
	Non Native	AK Native	Non Native	AK Native	Non Native	AK Native	
Southcentral – Anchorage Area	156	104	1,059	590	167	194	**2,270**
Southcentral – Mat-Su and North South Central	58	25	369	200	119	23	**794**
Southcentral – Kenai Peninsula	48	19	271	135	89	26	**588**
Southcentral – Mt. View	84	30	521	229	99	106	**1,069**
Interior	62	18	319	172	85	76	**732**
Inside Passage (Southeast)	74	21	291	161	51	76	**674**
Far North	14	6	136	60	1	77	**294**
South West	12	2	30	20	4	23	**91**
						TOTAL	**6,512**

Table 2. Members by Region and Condition

Members by Age and Gender

	Age in Years				Gender	
Members	0-12	13 to 20	21 - 64	65+	Male	Female
6512	1832	959	3672	49	2164	4348

Table 3. Members by Age and Gender

The average number of emergency room visits during the review period for the members meeting AMCCI criteria is 12.41. The visit range is between 5 and 79 visits. None of the members considered for participation in this project have fewer than five (5) emergency room visits in the 18 month review period. The estimated average cost to Alaska Medicaid for an emergency room visit is $1,300. The frequency distribution of visits is as follows:

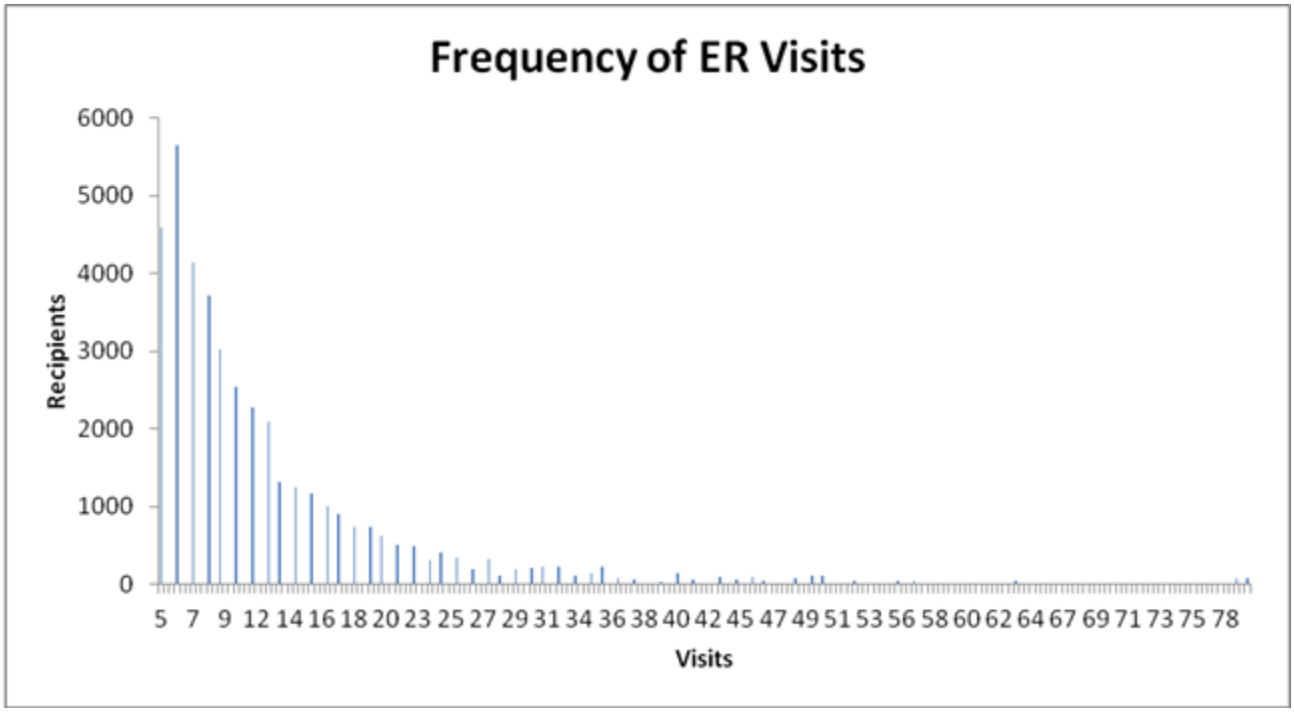

Figure 1. Frequency of ER Visits

4.03 Challenges Posed by Alaska's Rural Nature

Alaska's vast size, rural/frontier nature and arctic climate add a unique level of complexity in providing health care services to our residents. Alaska is the largest State in the United States at more than 570,000 square miles. However, Alaska's population, approximately 752,000 in July 2012, ranks 47th in the United States. Slightly more than half of the State's population resides in the Anchorage/Matanuska-Susitna region of the State, while 40% reside in rural and remote towns and villages with fewer than 2,500 residents. Distances between medical services in Alaska are extreme. While medical care may be only minutes away in our larger communities, it is not uncommon for those living in remote areas to travel hundreds of miles to the nearest provider.

Many transportation services that other States consider basic, such as mass public transportation and an extensive interstate/intrastate system, are limited or unavailable in Alaska. In remote areas not accessible via the State's road system, long-distance travel is available only by small aircraft and the most common modes of ground transportation are ATVs and snow machines. A few larger coastal communities are served by the Alaska Marine Highway System.

Alaska also encounters extreme weather conditions. During the months of Alaska's long winters, travel to medical care is often delayed or impeded. Severe spring storms are not uncommon and can result in the inability to use the modes of transportation necessary to obtain appropriate health care.

4.04 Administration and Organization

DHSS is the federally-defined Alaska Medicaid Single State Agency (SSA) for Alaska. The Commissioner of DHSS is the Director of the SSA. The Department is organized into four functional units. Two of these units are each headed by a Deputy Commissioner. The Director of Health Care Services is the Executive Sponsor for this project.

Two Deputy Commissioners oversee seven Divisions and related Boards and Commissions:

- Division of Health Care Services (DHCS),
- Division of Public Assistance (DPA),
- Division of Behavioral Health (DBH),
- Division of Juvenile Justice (DJJ),
- Division of Public Health (DPH),
- Division of Senior and Disabilities Services (DSDS), and
- Division of Alaska Pioneer Homes

All of the above Divisions have involvement in the administration of Alaska Medical Assistance programs. A second Deputy Commissioner is responsible for the Office of Children's Services (OCS).

The Department administers the Alaska Medicaid program primarily through four Divisions:

- Health Care Services,
- Behavioral Health Services,
- Senior and Disabilities Services, and
- Office of Children's Services

Alaska's Alaska Medicaid program affects the service delivery of every division within the Department of Health and Social Services, as well as six other departments within the State government.

Alaska Medical Assistance Benefit Programs by Division

Health Care Services	Hospitals, physician services, pharmacy, transportation, dental, vision, physical/occupational/speech therapy, chiropractic, medical equipment, home health, hospice, laboratory, X-ray, State-only medical assistance, premium assistance, third party recoveries, supplemental hospital payments, and Alaska Medicaid administrative management
Behavioral Health	Mental health, substance abuse, residential psychiatric treatment centers, and inpatient psychiatric facilities
Senior and Disabilities Services	Nursing homes, personal care, and four home and community based waiver programs
Children's Services	Behavioral rehabilitation

Table 4. Alaska Medical Assistance Benefit Programs by Division

DHSS medical programs include Title XIX Alaska Medicaid; Title XXI S-Children's Health Insurance Program (SCHIP) which is now referred to as Denali KidCare (DKC); the Permanent Fund Dividend Hold Harmless (PFDHH) Program; and the Alaska Longevity Bonus Hold Harmless (ALBHH) Program. DHSS also a State-

funded medical assistance program called the Chronic and Acute Medical Assistance Program (CAMA). The Alaska Medicaid program is annually funded from appropriations authorized by the Alaska State Legislature and matched, in part, by federal funds.

Alaska's Alaska Medicaid program, like that of other States, is continually evolving to meet new requirements, including but not limited to:

- Changing State and Federal requirements
- Changing populations eligible for the program
- HIPAA
- Changing State funding priorities
- Legislative or Departmental Initiatives

Alaska Medicaid provides health coverage for approximately 154,000 individuals, 20.5% of Alaska's 752,000 residents. Eligibility for Alaska Medicaid and other medical assistance programs is determined by the Division of Public Assistance (DPA). Although the majority of program members are clustered around Anchorage, Fairbanks, and the towns in southeast Alaska, program members are scattered throughout the interior and northern coastal area. Some of these members are Alaska Natives who receive medical care through the Alaska Native Regional Corporations under Section 638 agreements with the Indian Health Service (IHS).

In addition to mandated coverage, services also reimbursable by Alaska Medicaid include but are not limited to prescription drugs, eyeglasses and hearing aids, organ transplants, dental services, physical, occupational and speech therapy, rehabilitative services, case management, hospice, non-emergency transportation services, prosthetic devices, and adult personal care.

As the fiscal agent, Xerox's primary functions include maintaining and upgrading Alaska's Alaska Medicaid Management Information System known as Alaska Medicaid Health Enterprise (Enterprise), enrolling providers and maintaining provider files, processing and paying claims, provider training and outreach, and fulfilling various reporting requirements. Xerox also performs certain authorization functions, including but not limited to travel, specific medical services, certain maternal and newborn stays, and services in excess of pre-set program limitations.

Alaska's MMIS processes an average of 7.5 million claims annually, totaling $1.4 billion in payments to providers.

The following sections describe the governmental organizations and their agents within the State of Alaska that are involved in the administration of the Alaska Medical Assistance programs or that interface with these programs.

4.04.1 Department of Health and Social Services

http://www.hss.State.ak.us

The following divisions within DHSS are involved in the administration of health care programs for the State:

4.04.1.1. Division of Health Care Services

http://www.hss.State.ak.us/dhcs/

DHCS administers the Alaska Medicaid core services including hospitals, physician services, pharmacy, dental services, and transportation. Other Alaska Medicaid core services managed by the division include physical,

occupational, and speech therapy; laboratory; radiology; durable medical equipment; hospice; and, home health care. On a department-wide basis, DHCS administers the following:

- State Children's Health Insurance Program (SCHIP)
- Alaska Medicaid Management Information System (MMIS)
- Claims payments and accounting
- Third-party liability collections and recoveries
- Federal reporting
- Alaska Medicaid financing
- Chronic and Acute Medical Assistance Program

The Division is primarily located in Anchorage and is organized as follows.

- Director's Office of Division of Health Care Services
- Pharmacy and Ancillary Services Unit
- Facility Relations Unit
- Practitioner Relations Unit
- Program Integrity Unit
- Accounting and Recovery Unit
- Member Services Unit

4.04.1.2. Division of Public Assistance (DPA)

http://www.hss.State.ak.us/dpa/

DPA administers programs that provide temporary economic support to needy families and individuals; financial assistance to the elderly, blind, and disabled; benefits to supplement nutrition; medical benefits; and supportive services that enable and encourage welfare members to pursue economic independence and self-sufficiency.

The Division provides services to help Alaskans remain safe and healthy by:

- Providing temporary financial assistance to low-income Alaskan families with children working towards self-sufficiency to help them meet their basic needs.
- Providing employment assistance to low-income Alaskan families with children to help them become more self-sufficient and increase stability through employment.
- Providing financial assistance to low-income aged, blind, or disabled Alaskans to help them meet their basic needs.
- Providing food assistance to low-income Alaskans to decrease their incidence of food insecurity.
- Providing home heating assistance to low-income Alaskans to reduce their disproportionate burden of home heating costs.
- Providing child care subsidies to families who need child care to work or participate in approved training activities.
- Licensing child care providers to increase the safety and quality of child care in Alaska.
- Making eligibility determinations for medical assistance programs.

Alaska Medicaid Eligibility AS 47.07.020
Alaska Medicaid, an entitlement program created by the Federal government, is the primary public program financing basic health and long-term care services for low-income Alaskans. DHCS is responsible for provider payments. DPA is responsible for eligibility policy and access to the program and determining the eligibility of individuals and families in need of Alaska Medicaid benefits, including children and pregnant women under the Denali KidCare Program. The majority of Alaska Medicaid members are beneficiaries of other programs and services administered and delivered by DPA. Most members on the Alaska Temporary Assistance Program

receive family Alaska Medicaid benefits. Many children, young adults, and elderly or disabled persons receiving Alaska Medicaid also receive food stamps or adult public assistance benefits.

Chronic and Acute Medical Assistance Eligibility AS 47.08.150
The Chronic and Acute Medical Assistance (CAMA) program is a State-funded program designed to help needy Alaskans who have specific illnesses get the medical care they need to manage these illnesses. It is a program primarily for people age 21 through 64 who do not qualify for Alaska Medicaid benefits, have very little income, and have inadequate or no health insurance. DHCS is responsible for provider payments. DPA is responsible for eligibility policy and access to the program.

SeniorCare Program AS 47.300
SeniorCare helps low-income seniors who are at least 65 years of age remain independent in the community by providing a cash benefit or paying the premiums and deductibles for Medicare Part D or similar prescription drug coverage. Effective January 2006, responsibility for determining eligibility for the SeniorCare program transferred from the Division of Alaska Pioneer Homes to the DPA. DHCS is responsible for premium and deductible payments. DPA is responsible for cash benefit payments, eligibility determination, policy development, and access to the program.

4.04.1.3. Division of Behavioral Health (DBH)

http://www.hss.State.ak.us/dbh/

DBH is responsible for the State's public behavioral health system, which includes the community mental health and substance disorder programs. DBH administers the Statewide system of community behavioral health programs for delivery of residential and community-based treatment and recovery services; manages Alaska Psychiatric Institute (API), the State's only public psychiatric hospital; administers grants to the State's network of local community mental health and substance abuse programs; and coordinates with other government, tribal and private providers of behavioral health services to ensure the provision of comprehensive behavioral health services to Alaska residents. DBH works closely with the Alaska Mental Health Board (AMHB), the State's mental health and substance abuse planning councils, and provider organizations (Alaska Behavioral Health Association and Alaska's Substance Abuse Directors) on system planning and evaluation. (Note: The Division of Alcohol and Drug Abuse was reorganized and combined with other services to form the Division of Behavioral Health.)

4.04.1.4. Division of Juvenile Justice (DJJ)

http://www.hss.State.ak.us/djj

DJJ is responsible for juveniles adjudicated under the criminal justice system in Alaska, including juveniles in parole status. DJJ operates 8 regional juvenile correctional facilities.

Juvenile Detention and Treatment Facilities
Youth facilities in Alaska perform two primary functions:

(a) Detention Units designed as short-term secure units for youth who are awaiting court hearings; and

(b) Treatment Units designed for youth who have been ordered by the courts into long-term secure treatment.

Juveniles in parole status are usually eligible for Alaska Medicaid if they meet income guidelines. Juveniles incarcerated in juvenile correctional facilities are not eligible for Alaska Medicaid while residents of the facilities but may have Alaska Medicaid eligibility from previous community status. Claims for medical services provided to DJJ members in regional correctional facilities are scheduled to be processed through the MMIS as part of the future MMIS development.

4.04.1.5. Division of Public Health (DPH)

http://www.hss.State.ak.us/dph

DPH operates programs that are primarily population-based and focus on protecting and promoting the health of entire communities and of all Alaskans. DPH conducts disease surveillance and investigation and provides treatment consultation, case management, and laboratory testing services to prevent epidemics and control outbreaks of communicable diseases. Many of the services and programs delivered by the DPH serve the population as a whole, rather than individuals, so statistics on individual services do not complete the picture of the Division's work. Activities such as disease outbreak response, preparation and dissemination of epidemiology bulletins to all health practitioners in the State, planning and development of health systems, and educational campaigns such as those designed to influence children not to smoke are a few examples of DPH efforts to protect, promote, and improve the health of hundreds of thousands of Alaskans every day.

Public Health Nursing - Public health services are provided by nursing staff in public health centers in 23 communities and by itinerant public health nurses serving more than 250 communities. Grantees in four areas of Alaska – Norton Sound Health Corporation, Maniilaq Association, the North Slope Borough, and the Municipality of Anchorage are supported through grant funding and technical assistance to assure that public health nursing services are available Statewide.

Women's, Children's and Family Health (WCFH) - Services and programs delivered Statewide include Breast and Cervical Health Check; Family Planning; Perinatal Health; Oral Health for Children and Adults; Newborn Metabolic Screening; Early Hearing Detection, Treatment, and Intervention; Pediatric Specialty Clinics; and Genetics and Metabolic clinics. In addition, the WCFH Epidemiology unit collects, analyzes, and reports maternal and child health indicator data to provide an accurate picture of the health status of Alaskan women, children and their families.

Chronic Disease Prevention and Health Promotion Epidemiology Section - The Section of Epidemiology provides surveillance for reportable health conditions to accurately assess the health of Alaskans, to detect disease outbreaks requiring intervention, and to assess the effectiveness of prevention strategies, such as immunization programs. It also detects, investigates, and controls disease outbreaks through defining causal factors and by identifying and directing prevention and control measures.

Bureau of Vital Statistics - The Bureau of Vital Statistics oversees the registration of vital events in Alaska and is responsible for the preservation and security of records. Bureau staff work in partnership with hospitals, funeral directors, physicians, and the court system to ensure all vital events are properly recorded, that they satisfy the legal requirements of Alaskans and their families, and that the information contained in vital records meet the statistical needs of researchers or health officials at the State and national level.

Information from vital records is used to monitor and assess the health status of Alaskans and help guide health policy issues affecting the State. The Bureau publishes an annual report of vital events in Alaska and provides public health statistics on its web site. These reports include statistics on births, fetal and infant deaths, induced terminations, adoptions, marriages and divorces, and deaths. Teen birth rates, chronic disease mortality, leading causes of death, infant mortality, pregnancy and fertility rates, local health profiles, and Healthy Alaskans 2010 statistics are examples of information published on the Bureau's web site.

Community Health and Emergency Medical Services- This section provides services and outreach training to reduce human suffering and economic loss to society resulting from disability and premature death from injuries and to assure access to community-based emergency medical services.

State Medical Examiner -The State Medical Examiner's Office is responsible for investigating and certifying all deaths that occur within the State of Alaska that are the result of violence, suspected violence, deaths due to accidental causes, deaths that occur during incarceration, deaths that are associated with conditions that pose a hazard to public safety or health, and all unattended or unexplained deaths.

Public Health Laboratories - The Section of Laboratories provides analytical and technical laboratory testing and information to support disease prevention programs, services, and activities. The Anchorage laboratory provides testing for microbial, parasitic, and fungal infectious agents, as well as testing for disease antibodies in the blood and for chemical and toxic agents. The Fairbanks lab provides virology testing. In addition to laboratory testing, this section provides technical consultation and continuing education to clinical laboratories throughout Alaska, as well as quality assurance and reference testing for Alaska's clinical laboratories to ensure the safety and efficacy of their services.

DPH administers a number of programs for prevention and treatment. They also are responsible for the EPSDT tracking system, including the interface with the EPSDT subsystem in the MMIS.

DPH programs generally cover individuals who are not eligible for Alaska Medicaid or services not covered by Alaska Medicaid. The Breast and Cervical Health Check and Family Planning grant programs provide screening and preventive services to women. The Health Care Program for Children with Special Needs provides specialty services to disabled children. Some of these DPH sections receive information from the MMIS on a regular basis. Others such as the Laboratories submit claims for Alaska Medicaid covered services. The Division also operates and uses the RPMS application for tracking services to members.

4.04.1.6. Division of Senior and Disabilities Services (DSDS)

http://hss.State.ak.us/dsds/

DSDS provides institutional, home and community-based services for older Alaskans and persons with disabilities, as well as protection of vulnerable adults. The Division administers four Alaska Medicaid Waiver and Senior Services and Community Developmental Disabilities Grants programs: Alaskans Living Independently (ALI), Adults with Physical and Developmental Disabilities (APDD), Intellectual and Developmental Disabilities (IDD), and Children with Complex Medical Conditions (CMCC).

In addition to the four Alaska Medicaid waivers above, the Division operates the Personal Care Assistance and Nursing Home Authorization (Alaska Medicaid) programs. DSDS is responsible for the initial admitting authorizations of Alaska Medicaid eligible members to Skilled Nursing Facilities. Reauthorizations are completed every three to six months for those consumers staying in these facilities (depending on level of care) throughout the State of Alaska and in other States if the appropriate care is not available in this State. The Division is also responsible for authorizing Await and Swing beds for hospitals, in-State and out-of-State, while Alaska Medicaid members are waiting for admittance to a skilled nursing facility or if a skilled nursing facility is not available in the community. This responsibility includes approval for all services on the member care plans and transmittal of these approvals to the MMIS fiscal agent through a proprietary software program called Cost Sheet Interface (COSI). DSDS also authorizes all admissions to nursing homes using the COSI software and administers the Personal Care Attendant service.

There are 14 skilled nursing facilities around the State. The average yearly cost for a member in a nursing home in FY05 was approximately $164,742.

The Adult Protective Services Unit within DSDS protects adults over the age of 18 from abuse, neglect, and exploitation. APS staff investigates reports of harm and takes appropriate action (up to and including removal from the member's home) to ensure that vulnerable adults are safe. The APS Unit also administers the General Relief Program which pays for temporary assisted living home costs for members who need "emergency placement" and may qualify for but are not currently approved to receive services under an Alaska Medicaid waiver.

4.04.1.7. Division of Alaska Pioneer Homes

http://hss.State.ak.us/dalp/

The Division of Alaska Pioneer Homes provides residential and pharmaceutical services in Sitka, Fairbanks, Anchorage, Ketchikan, Palmer, and Juneau for qualified Alaska seniors. Services are designed to maximize independence and quality of life by addressing the physical, emotional, and spiritual needs of Pioneer Home residents. The Pioneer Home system served 573 Alaskan seniors during FY05. During FY 2005, all six Pioneer Homes and the Pioneer Home central Pharmacy became licensed Alaska Medicaid providers and Pioneer Home residents became eligible to apply for and receive Alaska Medicaid benefits. This significant change allows the Division access to federal funding thereby reducing general funds expended to operate the homes and subsidize residents who are unable to pay the full monthly charges. As of November 2004, 58 percent of Pioneer Home residents were subsidized by the State through the division's Payment Assistance Program.

The following paragraphs highlight other offices within the Alaska State Government that interface with DHSS.

4.04.1.8. Office of Children's Services (OCS)

http://hss.State.ak.us/ocs/

OCS is responsible for administering child protective services. Since most children under protective services are eligible for Alaska Medicaid, OCS supports DHCS in administering services for this population. These activities include monitoring the eligibility process for children in protective services, monitoring medical services, and developing specialty services for these children. OCS also acts as the billing agent for behavioral rehabilitation services, which are long term mental health services for children placed with OCS community providers.

4.04.1.9. Office of Finance and Management Services (FMS)

http://www.hss.State.ak.us/das/default.htm

The core services of this Office are to assist and be responsible for all the administrative service and management functions of the Department. These responsibilities range from managing Department policy to insuring that all DHSS external and internal customer needs are met in an effective and efficient manner.

Hearings and Appeals Unit
The Office of Hearings and Appeals is within the Office of Finance and Management Services (FMS) and is responsible for member case hearings and provider rate appeals. Unit responsibilities include:

(a) Scheduling hearings and coordinating pre-hearing arrangements
(b) Holding pre-hearing and other conferences
(c) Presiding over formal hearings
(d) Analyzing and evaluating facts and pertinent laws
(e) Preparing reports and findings
(f) Recommending orders and decisions for consideration by the Commissioner

4.04.1.10. Certification and Licensing Unit(C&L)

This unit is responsible for Medicare and Alaska Medicaid certification of healthcare facilities. Unit responsibilities include:

(a) Licensing of all health facilities in Alaska accordance with State law.
(b) Under contract with CMS, certifying of all facilities that wish to participate in Medicare and Alaska Medicaid in Alaska.
(c) Investigating complaints and reports of harm made against the facilities it licenses.

4.04.1.11. Commissioner's Office

The Commissioner's Office is responsible for upper-level management and policy development for the Department. (AS 18.05: Health, Safety and Housing)

4.04.1.12. Office of Program Review

The Office of Program Review ensures that DHSS programs accomplish their goals and helps Divisions identify and maintain funding for continued service delivery. (AS 37.10: Financial Management)

4.04.1.13. Rate Review

The Rate Review component establishes efficiency in rate-setting functions throughout the Department. (AS 47.07: Medical Assistance for Needy Persons).

4.04.1.14. Assessment and Planning

The Assessment and Planning component is tasked with planning, assessment, and forecasting improvements for the Alaska Medicaid program. (AS 47.07: Medical Assistance for Needy Persons).

4.04.1.15. Administrative Support Services

The Administrative Support Services component funds financial, budget, procurement, grant, and professional service contract administration, information services, as well as human resource liaison functions. (AS 37.10: Financial Management; AS 37.07: Budget Section; AS 36.30 Procurement Section, 7 AAC 78 and 81 Grant Regulations; Audit Section PL 98-502 Single Audit Act Amendments of 1996, PL 104-156 and OMB Circular A-133).

4.04.1.16. Hearings and Appeals

The Hearings and Appeals component conducts appeals for Alaska Medicaid, Chronic and Acute Medical Assistance, and Division of Public Assistance regarding rates and member benefit appeals. (AS 47.07; AS 47.08 and AS 47.25)

4.04.1.17. Facilities Management

The Facilities Management component includes the management of the Department's capital programs. (AS 37.07.062 Capital Projects - Responsible for preparation, submission and competent management of annual capital budget requests)

4.04.1.18. Health Planning and Infrastructure

The Health Planning and Infrastructure component core services include community health needs assessments, health indicators tracking, data analyses and reporting, technical assistance, health plan development, community health grants, and Certificate of Need (CON) (AS 18.07 and AS 18.20 – Health, Safety and Housing, Certificate of Need).

4.04.1.19. Alaska Medicaid School Based Claims

The Alaska Medicaid School Based Claims component improves health services access and availability for Alaska Medicaid-eligible children and families. (AS 18.05 Health, Safety and Housing)

4.04.1.20. Information Technology

The Information Technology component's focus is to improve the efficiency and effectiveness of IT services and develop a more capable IT organization for the Department.

The Office uses MMIS data to prepare the HCFA-64 report, request Federal fund draw downs, validate accounts receivable collections, and prepare cost allocation plans and audit responses. The Office is the liaison with AKSAS (State accounting system). In this capacity they assign collocation, ledger, and program codes for the MMIS accounting interface.

This Office also provides guidance to DHSS staff in procuring professional services contracts and reviewing Requests for Proposals.

4.04.1.21. Office of Program Review and Rate Review Executive Director of MRAC

Office of Rate Review (ORR) - Alaska Medicaid Rate Advisory Committee. The Alaska Medicaid Rate Advisory Commission (MRAC), authorized under AS 47.07, advises DHSS on facility rate setting and related policy issues. FMS Office of Rate Review (ORR) - The Executive Director is responsible for the operations of the Alaska Medicaid Rate Advisory Committee. The Alaska Medicaid Rate Advisory Commission (MRAC), authorized under AS 47.07, advises DHSS on facility rate setting and related policy issues.

4.04.1.22. Project Director (Special Projects Manager)

This position is responsible for management of the procurement and implementation processes associated with the new MMIS and Data warehouse/Decision Support contract.

4.04.1.23. Department of Administration (DOA)

http://www.State.ak.us/local/akpages/ADMIN/home.htm

The following Divisions within DOA are involved in administration of DHSS medical assistance programs:

- Enterprise Technology Services (ETS)
- Division of General Services (DGS)
- Division of Finance (DOF)

4.04.1.24. Enterprise Technology Services (ETS)

http://www.State.ak.us/admin/info/home.html

ETS regulates the infrastructure (Wide Area Network or WAN) tying the State agencies together. The fiscal agent must connect the MMIS to the network of users through this WAN. The ETS also sets policy for procurement of computer services, system security and confidentiality, connectivity to the State's backbone, and hardware and

software standards. A copy of the Comprehensive Telecommunications Service Agreement is provided in the Bidder's Library and is also available on the Internet at the above-referenced site.

4.04.1.25. Division of General Services (DGS)

http://www.State.ak.us/local/akpages/ADMIN/dgs/home.htm

DGS regulates purchasing (such as this professional services contract), provides office leasing for State agencies and provides mailroom and surplus property management services. This procurement process and resulting contract must be approved by this agency.

4.04.1.26. Division of Finance (DOF)

http://fin.admin.State.ak.us/dof/main/index.jsp

DOF manages the Alaska State Accounting System (AKSAS). AKSAS incorporates files for accounting transactions, check write, and electronic funds transfer EFT transactions. The DOF also authorizes release of the payments for each fiscal agent payment cycle.

4.04.2 Department of Commerce, Community and Economic Development (DCCED)

http://www.dced.State.ak.us/occ/DCBPLAlaska

Within the DCCED, the Division of Corporations, Business and Professional Licensing (DCBPL) http://www.dced.State.ak.us/occ is the primary occupational licensing agency for Alaska professional licenses. DCBPL regulates entry into professions and enforces performance standards for each professional licensing area. The Fiscal Agent must support an interface with DCBPL to verify status of professional licenses for Alaska Medicaid providers.

4.04.3 Department of Law (DOL)

http://www.law.State.ak.us

4.04.3.1 Alaska Medicaid Fraud Control Unit (MFCU)

http://www.law.State.ak.us/department/criminal/mfcu.html

The MFCU has been part of the State Attorney General's Office within the Department of Law since January 1992. The Unit is located in Anchorage and has statewide jurisdiction. It has the responsibility for investigating and prosecuting Alaska Medicaid fraud and abuse, neglect, or financial exploitation of members in any health care facility that accepts Alaska Medicaid funds. The Fiscal Agent will be requested to provide claim records and other information to support ongoing investigations of MFCU.

Additionally, the Collections and Support section of the Department of Law provides legal advice to and represents the Alaska Child Support Services Division in local and interstate child support actions. These include actions to establish or disestablish paternity, establish and modify child support orders, obtain and enforce medical support orders, and enforce support obligations through civil process.

4.04.4 Department of Revenue (DOR)

http://www.revenue.State.ak.us

The following Divisions within DOR are involved in administration of DHSS medical assistance programs:

- Child Support Enforcement Division (CSED)
- Division of Treasury

4.04.4.1 CSED

http://www.csed.State.ak.us

CSED is responsible for establishing child support orders, including orders for medical support, collecting child support payments, and disbursement of the payments. The automated interface between CSED and the MMIS needs to be reestablished. Currently, information on child support assignments is generated through manual look-up on the CSED case tracking system or secondhand through automated matches performed by the TPL Vendor.

4.04.4.2 Division of Treasury

http://www.revenue.State.ak.us/treasury

The Division of Treasury is located in Juneau. This Division provides cash management, investment management, debt management, and accounting services for the State's General Fund, the Constitutional Budget Reserve Fund, various retirement funds, and other funds and trusts. Treasury maintains necessary payment and collection bank accounts for the Alaska Medicaid program. The rules for establishing electronic fund transfer payments and payment procedures are controlled by Treasury.

4.04.5 Department of Labor and Workforce Development (DOL/WD)

This Department works with DHSS to determine disability and return members to work. The Divisions of Vocational Rehabilitation and Disability Determination Services (DDS) are 100% federally funded by the Social Security Administration. DDS operates as a federally-regulated agency, and Federal funds are used solely to provide medical determinations for persons alleging disability. DDS adjudicates claims for the Social Security Administration for Title II (Social Security) and Title XVI (Supplemental Security Income) applicants for disability benefits. Referrals are made, when appropriate, to the vocational rehabilitation program for job training and placement.

4.04.6 Department of Education and Early Development (DE&ED)

Generally, children who have been determined to be eligible for Alaska Medicaid may be able to obtain these services in the school setting. School-Based Alaska Medicaid Administrative Claiming (MAC) is administered by DE&ED.

SECTION FIVE
SCOPE OF WORK

5.01 Scope of Work

The Department of Health and Social Services (DHSS), Division of Health Care Services (DHCS), is issuing this RFP to obtain specialized case management and utilization review (CM/UR) services for members identified as eligible for participation in the AMCCI. The scope of work described in this section identifies the requirements, responsibilities, and expectations associated with CM/UR activities, deliverables, and general requirements, all of which must be met throughout the duration of the contract. DHCS reserves the right to adopt regulatory, policy, or business process changes including changes to the Alaska Medicaid Coordinated Care Initiative (AMCCI) program. While AMCCI program changes may take place, there will be no changes to the Vendor's costs and it is anticipated there will be no additional services required. However, services from the original first year of Phase I may be modified. If contract changes do occur, DHCS and the Vendor will follow the processes outlined in Section 3.16.

DHCS is seeking to avail itself of CM/UR activities to identify barriers, coordinate care, and facilitate appropriate use of health care services, with emphasis on emergency room services, to improve member health outcomes and reduce costs. It is important that proposals present the best solution to satisfy all the functional and technological requirements and to provide a CM/UR model that will be usable for the Alaska Medicaid programs well into the future. As part of the successful vendor's proposal DHCS expects a comprehensive management approach.

The Vendor must provide a comprehensive and detailed narrative that describes its proposed methodologies and costs for meeting all requirements of, and providing all services described in, Section 5, Scope of Work. The proposal must describe in detail the scope, type, and frequency of CM/UR services to be provided in support of the AMCCI. The narrative must describe how the Vendor will meet DHCS' project schedule. A projected timeframe for completion of all requirements must be included.

The Vendor is expected to propose rendering CM/UR services for the population(s) they wish to serve. If the proposal is accepted and a contract awarded, members meeting the criteria of the specific proposed population will be assigned to the Vendor(s) using a random sample methodology. For example, if a Vendor proposes to provide CM/UR services for the non-Native population in Interior Alaska with two or more chronic conditions, the Vendor would not be assigned members residing in the Anchorage area. DHCS, solely at its discretion, will assign AMCCI members to the Vendor in order to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) regarding the disclosure of protected health information (PHI). Therefore, due to HIPAA regulations, vendors will not be allowed to determine the specific individual identified recipients to serve, but instead, must select a population to serve as defined by section 4.02.3.

As part of the UR services, the Vendor(s) would retrospectively review outpatient room visits to determine if the service meets the definition of an "emergency service" as defined at 7 AAC 105.610(e)(2), which states:

> (e) In this section, "emergency service" means
>
> (2) outpatient services and physician services provided to a member in response to the sudden and unexpected onset of an illness or accidental injury that requires immediate medical attention to safeguard the member's life; in this paragraph "immediate medical attention" means medical care that the department determines cannot be delayed for 24 hours or more after the onset of the illness or occurrence of the accidental injury.

Inappropriate utilization as defined in 7 AAC 105.600 (b)(3) is:

the member, during a period of not less than three consecutive months, uses a medical item or service with a frequency that exceeds two standard deviations from the arithmetic mean of the frequency of us of the medical item or service by members of medical assistance programs administered by the department who have used the medical item or service as shown in the department's most recent statistical analysis of usage of that medical item or service

For purposes of this RFP, the peer group is all utilizers of emergency room services, regardless of age, between January 1, 2012 and September 17, 2013.

5.02 Phase I

During the first year of Phase I the Vendor will perform the services as required in the Scope of Work. Three (3) months prior to the end of Phase I, year one, the Vendor and DHCS will discuss lessons learned and evaluate program strengths and/or weaknesses.

5.02.1 Second Year

During the second year of Phase I DHCS anticipates incorporating strategies to address lessons learned and program strengths and/or weaknesses. Outcome measures will be introduced as well as expansion of data analytics and use of the Health Information Exchange (HIE). Review of additional payment methodologies will occur during Phase I, year two.

5.03 Phase II

Phase II will focus heavily on outcome measures. The State would also like to increase the use of data analytics and the Health Information Exchange (HIE), review payment methodologies, and assess this program as a possible model of care for the entire Alaska Medicaid program.

Below are the Scope of Work and related Requirements and Deliverables.

5.04 General Requirements

1. All work completed under any resulting contract must be performed in consideration of the health care delivery system in Alaska, as described in Section 4.02.

2. The Vendor must coordinate the member’s care with providers who are enrolled and in good standing with Alaska Medical Assistance.

3. The AMCCI services may not duplicate services provided to members through Alaska Medical Assistance or any other medical program.

4. The Vendor must maintain qualified CM/UR staff, as defined in this Section and meet the organization’s training and experience requirements, at a level sufficient to assure access to case management and utilization review services for the number of members the Vendor proposes to serve. DHCS reserves the right to request the Vendor provide additional Vendor staffing to provide CM/UR services for this project if DHCS feels the Vendor's staffing level is inadequate.

5.04.1. Management

1. DHCS will provide oversight of the entire program, but the Vendor must provide overall management for the tasks under this contract, including the day-to-day management of its staff. The Vendor must exert control to assure completion of all tasks according to the approved schedule.

2. The Vendor must notify the DHCS Manager of Quality Assurance, or their designee, immediately of all member complaints of harm or concerns regarding quality of care.

5.04.2. Customer Service

1. The Vendor must provide and maintain a CM/UR dedicated toll-free telephone and facsimile numbers by which members, providers, and other agencies can contact the Vendor at no cost.

2. The Vendor must receive and respond to CM/UR related inquiries from customers, providers, members, and DHSS staff, including other DHSS vendors.

3. The Vendor must log, track, and monitor customer service activities, requests, and complaints in an electronic format and make this informational data available to the DHCS on a monthly basis.

4. The Vendor must have written internal and external procedures for all services provided. These materials must be made available to DHCS upon request within five (5) business days.

5. The Vendor must provide educational publications, outreach, and identify methods the Vendor will use to provide education and training to members. This program should include materials related to, but not limited to, medically appropriate health care services, appropriate use of the ER and other utilization, and managing chronic conditions with emphasis on preventive health. These materials must be made available to DHCS upon request within five (5) business days.

6. Collaboration is strongly encouraged with the Alaska State Hospital and Nursing Home Association (ASHNHA) and the Alaska State Medical Association, State Travel Office, the fiscal agent, first responders, such as Anchorage Police Department, Anchorage Fire Department, and Emergency Medical personnel, and other applicable organizations to establish and maintain a good working relationship. The winning bidder(s) will be provided with a list of contact names and telephone numbers for these agencies.

5.04.3. Communications

1. The Vendor may be required to arrange, facilitate, and attend a one hour monthly WebEx or telephonic status meeting with DHCS staff. These meetings are one-on-one meetings with the individual Vendor and DHCS. The Vendor must make the project supervisor and at least one (1) CM/UR staff available to attend these meetings.

   The purpose of these monthly meetings is for the Vendor to provide a status update of their ongoing case management and utilization review activities. These meetings will provide a forum for discussion of various topics related to ongoing activities of DHCS and the Vendors, identification and resolution of problems, issues, process changes/improvements, constructive feedback, individual case status, treatment recommendations, service responsibilities, and on-going contract monitoring and management items. At DHCS' discretion, a written progress report may be authorized in lieu of a monthly meeting. The meetings must be conducted during standard business hours of 8am to 5pm Alaska Standard Time.

2. At DHCS' sole discretion, DHCS may request joint meetings with all Vendors on a quarterly basis. These meetings may be conducted by WebEx or telephonically. The quarterly meetings must be attended by the project supervisor and at least one (1) CM/UR staff. In the event DHCS requests a quarterly meeting, the requirement for a monthly meeting during that month will be waived for all Vendors participating in the quarterly meeting. The purpose of these meetings is to share best practices and provide constructive feedback. The meetings will be conducted during standard business hours of 8am to 5pm Alaska Standard Time.

3. Written communications that are general updates on the program or outline specific changes must be pre-approved by DHCS and, although it may contain the Vendor's logo and appropriate address and telephone number, the communications must always contain the Department's address and the Project Director's name and telephone number.

5.04.4. Personnel

1. The Vendor's clinical CM personnel must be licensed professionals who have at least two (2) years' experience in case management. The Vendor must provide a resume for each clinical CM staff member and copies of professional license(s) and/or certification(s).

2. The Vendor's CM/UR direct supervisor must be a full time professional employee.

3. The Vendor will maintain and provide a list of all employee names, phone numbers and email addresses. An updated list must be provided to DHCS monthly.

4. The Vendor must describe the ongoing methods they will use to ensure and attest that any person providing services under this contract, including subcontractors are not excluded from participation in federal programs 42 U.S.C. 1320a-7 (2009). This includes certifying that none of the vendor's employees, contract employees, or any person with ownership or a controlling interest, has ever:

    - been sanctioned or excluded by the Office of Inspector General (OIG), Medicare, Alaska Medicaid, or other federal program

    - been convicted of a criminal offense related to Alaska's Medical Assistance programs, the Alaska Medicaid program in another state or territory, the Medicare program, or any other federally funded health or social service program [42 CFR 455.106]

5. The vendor certifies it is fully responsible for all health care services provided by itself, its employees, its subcontractors and its Vendors. The vendor certifies that the qualifications and credentials of persons providing and billing for health care services through the providers practice/business are appropriate and in accordance with Occupational Licensing, Alaska Medicaid and Federal regulations, statutes, and program rules.

6. Case management services may be provided by a combination of non-clinical and clinical staff. All staff must perform services within the scope of their license and/or training in accordance with Alaska State Law. As an example, Vendors may propose non-clinical staff perform case management support services, such as facilitating access to service, transportation facilitation, eligibility verification, eligibility related assistance, and other non-clinical support services.

5.05 Cost

The Vendor must determine the payment methodology by which CM/UR services provided under the contract will be reimbursed. DHCS is open to innovative and creative strategies for reimbursing case management and utilization review services, such as shared savings and risk adjusted strategies. DHCS welcomes any additional payment methodologies the Vendor may wish to propose.

However, in the absence of an alternative proposed payment methodology, DHCS has described some common payment methodologies for the Vendor's consideration below:

- Fee for service
- Per member per month (base care coordination fee)
- Hourly rate (for clinical and non-clinical staff)

Regardless of the payment methodology selected by the Vendor, the cost proposal must contain specific rates at which the Vendor wishes to be reimbursed.

If the Vendor's case management services reduce emergency room visits by more than 25% threshold for decreasing ER visits, DHCS may consider an incentive payment of the additional savings based on the following:

- Reduction of ER usage between 30% - 40% — incentive payment is 5% of additional savings
- Reduction of ER usage by more than 50% — incentive payment is 7.5% of additional savings

5.06 Case Management Requirements

1. The Vendor must describe in detail the proposed case management model, including scope, type, and frequency of case management services to be provided in support of members eligible for the AMCCI. Include in the case management model how the model will support and integrate behavioral health and substance abuse assistance.

2. Vendors must describe system/tools to assure timely interaction and coordination with physicians, hospitals and other providers when a member is admitted as an inpatient. The proposal must include and explanation of how the vendor will coordinate with hospitals to assure case management interventions will occur in a timely manner prior to discharge.

3. The Vendor must describe and maintain operational case management service procedures that clearly define the processes, internal policy, and roles, including defining which activities are performed by clinical versus non-clinical staff. This documentation must be made available to DHCS upon request within five (5) business days.

4. The Vendor is required to describe its case management methodology in sufficient detail to understand the personalized interaction and interventions being offered. Case management may be provided face-to-face, telephonically, through home telehealth technologies, via telemedicine or real-time video imaging, including Skype. Inter-periodic supports may be delivered via text messaging and/or email. However, documentation of inter-periodic supports conducted by text messaging and/or email must be contained in the member's chart. DHCS welcomes innovative strategies for effective person-centered case management delivery.

5. The Vendor will perform an **initial health screening**. DHCS will provide an initial health screening tool. The purpose this initial health screening is to determine the member's initial level of acuity. This will assist the Vendor in identifying and prioritizing the member's most critical needs so those services are made available as soon as possible.

6. In addition, the Vendor will develop and implement a **comprehensive health needs assessment** based upon clinical and psychosocial histories and individual member preferences to create a person-centered written care plan that is shared with the member and his/her family, the primary care physician, pharmacy, hospital, behavior management providers and others that may be identified by the member. The care plan will also address psychosocial risk factors of substance abuse, partner violence, homelessness, and mental illness. Item 7 below identifies the components of the comprehensive health needs assessment.

7. Case Management services must minimally include, but are not limited to, the following intervention components:

    a. Intake and assessment

        I. Initial Health Screening (must use standardized screening tool provided by State for initial health screening)

        II. Illness/Disease Impact

        III. Self-determination/self-efficacy assessment (i.e. guardianship, caregiver)

        IV. Quality of life assessments

        V. Behavior change

        VI. Ongoing assessments and screening

    b. Psycho-social assessment

    c. Environment assessment

    d. Care Planning

    e. Care Coordination

    f. Education and self-management skill development

    g. Medical Management (including medication reconciliation and management)

        I. Report new or worsening symptoms, abnormal findings, psychosocial issues

        II. Coordinate on regular follow-up and on-going treatment planning and routine prevention

        III. Assess compliance and understanding of medications

        IV. Timely access to care

    h. Health promotion (i.e. nutrition, physical activity/exercise, weight management, tobacco cessation, stress management, etc.)

    i. Care transition

    j. Population specific risk assessments and interventions (example: for elderly and disabled, fall prevention, advance directives, advanced care planning, etc.)

k. Literacy Assessment

8. The Vendor will be required to deliver specialized case management methodologies so that members receive thorough and timely health care for chronic care conditions in accordance with best practices standards. Vendors are required to:

    - Collaborate with health care professionals in support of tobacco use cessation
    - Assure members have access to appropriate care from a preferred primary care health care provider, pharmacy, hospital, behavioral health provider as appropriate, and other providers as required,
    - Demonstrate health care practice satisfaction through a customer satisfaction survey.

9. The Vendor is required to provide case management and certain utilization review services within the scope of this RFP including providing referral and facilitating access to appropriate community resources. As an example: Identification of a member's social needs is a required component of the case management assessment within this RFP. DHCS expects the Vendor to identify the member's housing needs and provides direction and guidance to appropriate local resources (i.e. subsidized housing programs, etc.). The Vendor is not required to provide housing and would not incur associated housing costs.

10. The AMCCI Vendor(s) and members must comply with all applicable AK Medical Assistance program rules and processes. DHCS anticipates some of the AMCCI members will require more extensive services than they are currently receiving and/or seeking. The Vendor is required to comply with established AK Medical Assistance program rules and processes when referring or otherwise facilitating access to service. For example, if the Vendor(s) identified a need for a member that may be addressed by personal care attendant (PCA) services, DHCS expects the Vendor to contact the Division of Senior and Disabilities Services to coordinate an assessment to determine the need for PCA services. Managing the member's plan of care or service authorization is not within the scope of this contract. The Vendor is not required to assume management of PCA or waiver services.

11. Case Management is available only to Alaska Medicaid-eligible members. Prior to commencement of CM services, and monthly thereafter, the Vendor must review eligibility records for current eligibility status. If ineligibility is found, the Vendor must notify DHCS immediately and suspend all CM services except administrative/clerical services to assist the member with re-establishing eligibility.

12. The Vendor must maintain complete and comprehensive documentation of each case managed member including all contacts, visits, and related activities. An electronic format is the preferred method. These records should comply with case management standard practices, AK Alaska Medicaid program rules and processes, and should include:

    - profile reflective of member's current status,
    - screening and assessment documentation,
    - reasons for all emergency room visits incurred after the implementation date of the contract,
    - identify whether or not the member has a primary care provider upon entering the program and the name of that provider,
    - identify why the member does not have a primary care provider, if appropriate,

- interventions planned and performed,
- reviewers' notations,
- referrals made,
- case summaries,
- decisions and recommendations made,
- evidence of collaboration with health care professionals and entities to coordinate health care and manage transitions of member's care,
- evidence of collaboration with Community Mental Health Centers to manage behavioral health issues, reinforce the treatment plan and/or mitigate the effects of partner violence or depression,
- evidence of collaboration with social services such as housing assistance, food distribution centers, and local transportation options,
- comprehensive transition plan to ensure continuity of appropriate medical and social supports for all members including, but not limited to, written instructions regarding obtaining prescriptions and follow up appointments. The comprehensive transition plan must be initiated at the beginning of the Vendors case management services and updated routinely until discharge, and
- other appropriate documentation.

DHCS reserves the right to conduct site visits for the purpose of reviewing this documentation and/or request records for audit purposes to assure continued compliance with the contract. Records must be made available upon request by the DHCS and be provided within five (5) business days of DHCS' request.

13. A minimum of two times per month, Case Managers must initiate contact with medical providers of each member. The communication should minimally include:
    - ensuring compliance with the member's medical regime,
    - keeping appointments,
    - unscheduled appointments for problems,
    - new symptoms or problems,
    - compliance with medications, and
    - any new prescriptions written.
14. Vendor expenses related to required travel for Vendor staff or Vendors, including time, mileage, and accommodations are not separately billable and should be included in the proposed reimbursement methodology.

15. After the member signs the Election to Participate in Case Management, the Vendor will coordinate with the member on selection and/or placement with one primary care provider, one pharmacy, one hospital, and one behavioral health provider as appropriate.

16. The Vendor will communicate with providers to request acceptance of members as a primary provider.

17. The Vendor must provide copies of reviewers' notations, case summaries, and any other documentation deemed necessary by DHCS' hearing staff to support DHCS in hearings or appeals. Records must be provided within five (5) business days of DHCS' request.

NOTE: To accomplish the objectives in Section 5.03, with the exception of the Initial Health Screening tool provided by DHCS, the Vendor may use the standardized tools provided by DHCS or their own tool so long as the Vendor's tool captures standard data elements required by DHCS. In addition, the Vendor may choose to use any combination of their own tool(s) and tools provided by DHCS. The type of tool utilized will be agreed upon by the Vendor and DHCS during contract negotiation. DHCS is currently developing screening tools for health literacy, depression, domestic violence, medication knowledge and compliance, and a customer satisfaction survey.

5.07 Utilization Review Requirements

1. The Vendor will be required to perform retrospective reviews for outpatient emergency room (ER) visits to determine if the service meets the definition of an "emergency service" as defined at 7 AAC 105.610(e)(2), which states:

   > (e) In this section, "emergency service" means
   >
   > (2) outpatient hospital services and physician services provided to a member in response to the sudden and unexpected onset of an illness or accidental injury that requires immediate medical attention to safeguard the member's life; in this paragraph "immediate medical attention" means medical care that the department determines cannot be delayed for 24 hours or more after the onset of the illness or occurrence of the accidental injury.

2. It is the Vendor's responsibility to request medical records of outpatient emergency room visits to conduct the retrospective reviews. At least one time per month, DHCS will provide the Vendor with claims history identifying outpatient emergency room visits.

3. Emergency room medical necessity reviews will be on services rendered after the implementation date of the contract.

4. The Vendor is responsible for making a determination as to whether or not the ER visit documentation supports an emergency service. The Vendor must categorize each ER visit into one of three categories: emergent, non-emergent, and undetermined. ER visits categorized as emergent meet the definition of an emergency service as defined by 7 AAC 105.610(e) (2). Non-emergent ER visits do not meet the definition of an emergency service as defined by 7 AAC 105.610(e) (2). If the Vendor is not able to determine if the ER visit documentation meets the definition of an emergency service, that ER visit is categorized as undetermined.

5. The Vendor will not be responsible for performing service authorization activities.

6. The Vendor must provide copies of reviewers' notations, case summaries, and any other documentation deemed necessary by DHCS' hearing staff to support DHCS in hearings or appeals. Records must be provided within five (5) business days of DHCS' request.

5.08 Information and Data Requirements

The Vendor must operate and maintain processes and/or systems to support the collection, maintenance, and submission of required information, data, and reports. These functions may encompass both automated and manual processes required to provide standard information, data, and reporting to the Division of Health Care Services (DHCS).

DHCS recognizes that the Vendor's solution for meeting these requirements may include alternative reporting methods, content, and formatting for presentation of data. Within the Vendor's proposal, the Vendor should present the information, data, and reporting conceptual equivalency of the Vendor's solution.

Preference will be given to those Vendor proposals that provide automation solutions. The State has undertaken several projects to promote automation and interoperability i.e. HIT, HIE, EHR, etc.

1. The Vendor will:

    a. track, collect, document, and maintain administrative, operational and performance information and data necessary to support all activities required by this RFP;

    b. compile, format, and submit reports, data, and information to the State in an electronic format as specified by the State, i.e. Microsoft Office Excel 2007;

    c. store copies of all submitted reports, data, and information with the ability to recreate information, data, or reports upon the State's request ;

    d. generate ad-hoc reports in both electronic and hard copy formats, upon the State's request;

    e. have capacity to perform data analysis; and

    f. deliver to the State all required reports, information, and data within the specified time periods.

2. Information, data, and reports submitted must comply with State specifications.

3. The Vendor will be responsible for the submission or transmission of information, data, and reports in electronic format to the State's specified site at the frequency required by the State.

4. All Vendor's information, data, and reports must be maintained in compliance with HIPAA Security and Privacy rules including, but not limited to, protecting the storage of, access to, and dissemination of protected health information.

    The DHCS will provide vendors with one year of Medicaid claims data and member demographics data for those members assigned. The information will be made available to vendors after negotiations are complete. New claims data will be made available periodically.

5. The Vendor must submit information, data, and reports to DHCS via methods determined by the Department including, but not limited to Direct Secure Messaging (DSM), SharePoint posting, or other method as determined by the State. The State is working on developing a secured SharePoint site to exchange data. The State is exploring the option to provide Vendors with secure access to a State maintained SharePoint site. On this site, the Vendor will be able to:

    a. obtain certain claims data for participants in their active caseload;

b. submit information, reports, and data required by this RFP;
c. exchange other information with the State as approved by the State

6. The Vendor must maintain and make available to the State upon request all records in support of this RFP including but not limited to, both UM and CM patient records, either electronically or hardcopy, in accordance with Alaska State Statute and Administrative Code record retention requirements. Currently, records must be maintained a minimum of 7 years from the most recent action.

7. The Vendor is responsible to provide the necessary computer hardware, software, phone lines, modems, and other connectivity equipment necessary to fulfill the scope of this contract.

5.09 Reporting

The Alaska Medicaid Coordinated Care Initiative is a pilot project during which the State will identify successful practices and those requiring improvement. Reporting requirements are necessary to assist the State to perform program analysis and improvement. The information, data, and reporting required will assist the State in its review of utilization, efficiency, policy, costs, and other program functions.

1. The Vendor will be expected to produce and deliver to Department monthly and annual reports of CM/UR activity and costs based on Department specifications. All reports are due 15 business days after the end of the specified period or from the date mutually agreed for ad-hoc reports.

2. The Vendor will identify recipients by the Medicaid identification number in all reports.

3. The Vendor will provide to DHCS a monthly Administrative Report on all active CM/UR activity. This report will include, for the most recent month, at a minimum:

    a. the start date of CM/UR services,

    b. total CM/UR hours

    c. total CM hours

    d. total UR hours

    e. total administrative CM hours

    f. total administrative UR hours

    g. total non-administrative CM hours

    h. total non-administrative UR hours

    i. the ratio of the number of case managers to the number recipients assigned to the Contractor's caseload

    j. the average number of recipients assigned per case manager

    k. the average number of hours per case manager per recipient

    l. the average number of hours for all activity per recipient

4. On a monthly basis, the Vendor must provide the State an Operational report or data detailing the total number of retrospective reviews for outpatient emergency department visits. Each outpatient emergency department visit, after Vendor review, must be categorized as either emergent, non-emergent, or undetermined. The Vendor must also provide the number of reviews falling into each category. At a minimum the following data will be provided:

    a. Total number of recipients whose ER visit documentation has been reviewed

    b. Total number of ER visits reviewed

    c. Number of ER visits meeting the State definition of “emergency service”

    d. Number of ER visits not meeting the State definition of “emergency service”

    e. Number of ER visits the Vendor could not determine if the State definition of “emergency service” was met, categorized as “undetermined”.

1. On a monthly basis, the Vendor must provide the State with Case Management Activity reports or data. The reports or data need to include primary data elements reflective of CM/UR detail activities. At a minimum the following data will be provided:

    a. Number of active cases

    b. Total number of contacts made with recipients

    c. Total number of contacts with others (i.e. medical professionals, family, etc,)

    d. Number of telephone contacts with recipients

    e. Number of face to face contacts with recipients

    f. Number of contacts made through home telehealth with recipients

    g. Number of contacts made via telemedicine with recipients

    h. Number of contacts made by Skype with recipients

    i. Number of contacts made by email or text message with recipient

    j. Number of unsuccessful contact attempts to recipients

    k. Number of recipients graduated from program

    l. Number of recipients that left program (other reasons)

    m. Other data elements and data as defined by the State as shown in Attachment TBD

5. The Vendor will compile and provide the State the data collected during the Initial Health Screening as shown in Attachment TBD.

6. The Vendor will compile and provide the State the data collected during the Comprehensive Needs Health Assessment as shown in Attachment TBD.

7. The Vendor will compile and provide the State the Performance Metrics data collected as shown in Attachment TBD.

8. Other ad hoc reports may be requested as specified by DHCS. In addition to the printed reports, all data contained in the reports must be available in current, Department compatible Microsoft ® Office software products, for use on Department enterprise computers.

9. The State is currently developing the Vendor required final reporting and data specifications; draft specifications are included in Attachment TBD.

5.10 Survey Requirements

1. The Vendor must mail paper customer satisfaction surveys within two months of a member's anticipated end date in the AMCCI. A copy of the customer service satisfaction survey can be found in Attachment TBD.

2. DHCS will provide the questions for the customer satisfaction survey.

3. Paper customer satisfaction surveys must be mailed to members by the Vendor with a return stamped envelope addressed to DHCS. The costs associated with conducting this survey, including cost of postage and supplies, should be itemized and included in the Vendor's proposal. When the Vendor begins mailing paper customer satisfaction surveys, the Vendor must provide the number of surveys mailed on a monthly basis.

4. All survey results will be returned directly to DHCS. In the event a member inadvertently returns the survey to the Vendor, the Vendor will forward the unopened survey directly to DHCS.

5. CM/UR surveys must be made available to every member in active CM during the contract year. Documentation of at least two unsuccessful attempts by the Vendor to make the survey available to members will be considered satisfactory evidence of this requirement.

6. The Vendor must assure members are aware of the ability to participate in the customer satisfaction survey.

5.11 Performance Requirements

DHCS requires all members served by case management be supported and guided through the health care and social service system by the Vendor to reduce and eliminate the unnecessary use of emergency room visits and shift the emphasis of care to appropriate preventive and chronic care management. In order to measure the effectiveness of the case management services, Vendors are required to report on the following performance measures:

1. 25% reduction in overall ER utilization.

2. In 100% of ER visits rendered after the implementation date of the contract, documentation will be reviewed retrospectively to determine if the visit was emergent or non-emergent. The Vendor will not be held responsible for a member's non-emergent ER utilization. The Vendor will report to DHCS on the following:

    - Total number of ER visits reviewed
    - Number of emergent ER visits

- Number of non-emergent ER visits
- Number of undetermined ER visits

3. In approximately 25% of the cases where a non-emergent ER visit has occurred, the Vendor will contact the member to provide education and outreach regarding appropriate use of the ER, and urgent versus emergent conditions. Documentation of at least three unsuccessful attempts by the Vendor to contact a member for this outreach will be considered satisfactory evidence of meeting this metric.

4. Members will complete an Initial Health Screening on the standardized screening tool provided by DHCS.

5. Members will complete a health literacy assessment. Documentation of at least three unsuccessful attempts by the Vendor to obtain a completed health literacy assessment from a member will be considered satisfactory evidence of meeting this metric.

6. Members will have a comprehensive health needs assessment as described in Section 5.03. Documentation of at least three unsuccessful attempts by the Vendor to obtain the comprehensive health needs assessment will be considered satisfactory evidence of meeting this metric.

7. Members who have completed a comprehensive health needs assessment and are identified as taking at least one prescription medication will complete a Medication Knowledge Assessment Form. Documentation of at least three unsuccessful attempts by the Vendor to obtain a completed Medication Knowledge Assessment Form will be considered satisfactory evidence of meeting this metric.

8. At least monthly, members who have completed a comprehensive health needs assessment and are identified as taking at least one prescription medication, during the case management contact will be asked:

    - If they are compliant with their medications,
    - If there have been any changes in dosage since the last visit,
    - If they have started any new medications since the last visit, and
    - If any medications have been discontinued since the last visit

    Responses to these questions may be documented on the Medication Compliance form provided by DHCS. Documentation of at least three unsuccessful attempts by the Vendor to obtain this information will be considered satisfactory evidence of meeting this metric.

9. Reasons for medication non-compliance will be documented and possible side effects will be discussed. Documentation of at least three unsuccessful attempts by the Vendor to obtain the information related to medication non-compliance listed above will be considered satisfactory evidence of meeting this metric in the even a member does not provide responses.

10. Members will be asked if they have a primary care provider. If a member does not have a primary care provider, the Vendor will document the reason the member does not have a primary care provider. Documentation of the Vendor's efforts to reach the member to obtain this information will be considered satisfactory evidence of meeting this metric.

11. Members with a completed comprehensive health needs assessment will be assigned a primary care provider, a pharmacy, a hospital, and a behavioral health provider (as appropriate). Documentation of at least three unsuccessful attempts by the Vendor to secure and assign a member to a primary care provider, pharmacy, hospital, and behavioral health provider (as appropriate) will be considered satisfactory evidence of meeting this metric. Inability to assign a

member to a primary care provider, a pharmacy, a hospital, and a behavioral health provider (as appropriate) must be reported to DHCS immediately.

12. Members with an identified tobacco use disorder have been referred to receive tobacco cessation counseling and appropriate education from their assigned primary care provider. Documentation of at least three unsuccessful attempts by the Vendor to obtain a referral for tobacco cessation counseling is considered satisfactory evidence of meeting this metric.

13. Members with identified social service needs have obtained appropriate social service information and a referral to agencies such as housing assistance, food distribution centers, and local transportation. Documentation of at least three unsuccessful attempts by the Vendor to refer the member to social service agencies will be considered satisfactory evidence of meeting this metric.

14. 95% - 100% of members have been provided the *opportunity to participate* in a customer satisfaction survey developed by DHCS.

15. 50% of members initially assigned during implementation to the Vendor for case management will have a completed comprehensive health needs assessment with thirty (30) calendar days after the date of the assignment. The remaining 50% of members initially assigned during implementation to the Vendor will have a completed comprehensive health needs assessment within sixty (60) calendar days after the date of the assignment.

16. Members subsequently assigned to the Vendor for case management services will have a completed comprehensive health needs assessment within ten (10) calendar days after the date of the assignment. Subsequent assignments to the Vendor would be those assignments made to ensure the Vendor maintains an active caseload of 85% - 100% of the population they bid on (i.e. replacing a member who has lost eligibility or exited the program for any reason).

17. Member records will contain evidence of a monthly progress note. DHCS may make periodic onsite visits to ensure compliance with this metric. Progress notes should include the member's progress, compliance with medication and health care provider recommendations, medical progress, and any education performed. Documentation of at least two unsuccessful attempts by the Vendor to reach the member to complete a monthly progress note will be considered satisfactory evidence of meeting this metric.

SECTION SIX
PROPOSAL FORMAT AND CONTENT

6.01 Proposal Format and Content

DHCS discourages overly lengthy and costly proposals, however, in order for DHCS to evaluate proposals fairly and completely, Vendors must follow the format set out in this RFP and provide all information requested.

6.02 Introduction

Proposals must include the complete name and address of the Vendor's firm and the name, mailing address, and telephone number of the person DHCS should contact regarding the proposal.

Proposals must confirm that the Vendor will comply with all provisions in this RFP; and, if applicable, provide notice that the Vendor qualifies as an Alaskan bidder. Proposals must be signed by a company officer empowered to bind the company. A Vendor's failure to include these items in the proposals may cause the proposal to be determined to be non-responsive and the proposal may be rejected.

6.03 Understanding of the Project

Vendors must provide comprehensive narrative statements that illustrate their understanding of the requirements of the project and the project schedule.

6.04 Methodology Used for the Project

Vendors must provide comprehensive narrative statements that set out the methodology they intend to employ. Additionally, Vendors must submit a work plan which illustrates how the methodology will serve to accomplish the work and meet DHCS' project schedule.

Vendor must provide estimated ramp-up period needed to perform the services described in Section 5.

- the reason the ramp up period requested is necessary
- if the Vendor will be able to perform limited or no CM/UR activities during the ramp up period.

Vendor must provide estimated implementation start date for the services described in Section 5.

Vendor must provide and explanation on processes that will be utilized when barriers exist preventing the recipient from be available during the vendor's usual case management business hours.

6.05 Management Plan for the Project

Vendors must provide comprehensive narrative statements that set out the management plan they intend to follow and illustrate how the plan will serve to accomplish the work and meet DHCS' project schedule.

6.06 Experience and Qualifications

Vendors must provide an organizational chart specific to the personnel assigned to accomplish the work called for in this RFP; illustrate the lines of authority; designate the individual responsible and accountable for the completion of each component and deliverable of the RFP. Preference is given to those Vendors whose CM/UR direct supervisor is a licensed professional.

Vendors must provide a narrative description of the organization of the project team and a personnel roster that identifies each person who will actually work on the contract and provide the following information about each person listed:

a. title,

b. resume, and

c. location(s) where work will be performed

Vendors must include detailed narrative descriptions demonstrating their experience in completing projects similar to the one defined in this RFP. The description should include general statements regarding the Vendor's ability to successfully complete the projects described on time and within budget.

Vendors must provide at least three (3) letters of reference from previous members demonstrating evidence of successful case management, including names and phone numbers.

Vendors must provide a detailed narrative description of recent successful quality improvement activities. If applicable, please describe how the outcomes and lessons learned from these quality improvement activities have been applied to this project.

Vendors must include a detailed description as required by Section 1.14 if the Vendor intends to use a subcontractor for work on this project.

Vendor must provide in writing a detailed narrative the requested information in Section 5.04.4.

Vendors must provide evidence within their proposal that they meet the minimum requirements specified in Section 2.08 Minimum Qualifications along with any certifications and credentials referenced in the resume or their proposal may be found non-responsive and may be rejected.

6.07 Cost Proposal

The completed cost proposal, along with any reference to pricing, is to be **excluded** from the body of the Vendor’s proposal. Instead, it should accompany the proposal in a separate, sealed envelope. Failure to comply with this requirement will result in a proposal rejected as non-responsive.

6.08 Evaluation Criteria

All proposals will be reviewed to determine if they are responsive. They will then be evaluated using the criterion that is set out in Section SEVEN.

An evaluation may not be based on discrimination due to the race, religion, color, national origin, sex, age, marital status, pregnancy, parenthood, disability, or political affiliation of the Vendor.

A proposal shall be evaluated to determine whether the Vendor responds to the provisions, including goals and financial incentives, established in the request for proposals in order to eliminate and prevent discrimination in State contracting because of race, religion, color, national origin, sex, age, marital status, pregnancy, parenthood, or disability.

SECTION SEVEN
EVALUATION CRITERIA AND VENDOR SELECTION

THE TOTAL NUMBER OF POINTS USED TO SCORE THIS PROPOSAL IS 1,000

7.01 Understanding of the Project (10 Percent)

Proposals will be evaluated against the questions set out below:

[a] Has the narrative comprehensively demonstrated a thorough understanding of the purpose, scope, requirements, and deliverables of the project?

[b] How well does Vendor understand and describe their capacity for behavioral health integration?

[c] How well has the Vendor identified pertinent risks, issues, and potential challenges related to the project?

[d] Has the Vendor demonstrated an understanding of the challenges of providing care in Alaska?

7.02 Methodology Used for the Project (30 Percent)

Proposals will be evaluated against the questions set out below:

[a] How comprehensive is the methodology and does it depict a logical approach to fulfilling the requirements of the RFP?

[b] How well does the methodology match and achieve the objectives set out in the RFP?

[c] Did the work plan submitted illustrate who the methodology interface with the time schedule in the RFP?

[d] Does the proposal describe in detail proposed methods for communicating with members and coordinating member care after normal business hours?

[e] Does the Vendor's proposal include automation solutions that align with the goal of interoperability?

[f] Does the Vendor provide cost methodology?

[g] Did the Vendor provide estimated ramp-up period, and can the vendor provide limited or no CM/UR activities during the ramp up period

[h] Did the Vendor provide estimated implementation date?

[i] Did the Vendor provide a processes that will be utilized when barriers exist preventing the recipient from being available during the vendor’s usual case management business hours?

[j] Did the Vendor provide how they will coordinate with hospitals to assure case management interventions will occur in a timely manner prior to discharge?

7.03 Management Plan for the Project (10 Percent)

Proposals will be evaluated against the questions set out below:

[a] How well does the management plan support all of the project requirements and logically lead to the deliverables required in the RFP?

[b] How well does the management plan illustrate the lines of authority and communication?

[c] To what extent does the Vendor already have the hardware, software, equipment, and licenses necessary to perform the contract?

[d] Has the Vendor gone beyond the minimum tasks necessary to meet the objectives of the RFP?

[e] To what degree is the proposal practical and feasible?

[f] Does the project proposal provide an opportunity for project growth and sustainability?

7.04 Experience and Qualifications (10 Percent)

Proposals will be evaluated against the questions set out below:

Questions regarding the personnel:

[a] Do the individuals assigned to the project have experience on similar projects and CM/UR activities?

[b] Are resumes complete and do they demonstrate backgrounds that would be desirable for individuals engaged in the work the project requires?

[c] Is there sufficient evidence that the CM/UR direct supervisor is a professional who:

- has applicable experience for the type of CM/UR services the Vendor proposes to provide,
- has experience managing the medical complexities of the population,
- has a minimum of three (3) years health care supervisory experience, and
- has a minimum of one (1) year case management experience.

[d] How well is accountability completely and clearly defined?

[e] Is the organization of the project team clear?

[f] How extensive is the applicable education and experience of the personnel designated to work on the project?

[g] Is there a sufficient number of qualified CM/UR staff as defined in the RFP who meet the organization's training and experience requirements to assure access to case management services, depending on the number of members the Vendor chooses to serve?

[h] Are the roles and responsibilities of clinical versus non-clinical staff appropriately delineated?

[i] Are case management services provided by a combination of non-clinical and clinical staff? Are those staff performing services within the scope of their license and/or training in accordance with Alaska State Law?

[j] Is the CM/UR direct supervisor a licensed professional? Is a copy of the CM/UR direct supervisor's license(s) and/or certification(s) attached?

Questions regarding the Vendor:

[a] Does the structure of the personnel in the organizational chart provided support the ability to accomplish the work called for in this RFP?

[b] Does the Vendor provide a narrative description of the organization of the project team and including a personnel roster that identifies each person who will actually work on the contract and provide the following information about each person listed:

a. title,

b. resume, and

c. location(s) where work will be performed

[c] How well has the Vendor demonstrated experience in successfully completing similar projects on time and within budget?

[d] Has the Vendor provided at least three (3) letters of reference from previous members, including contact names and phone numbers?

[e] Has the Vendor provided evidence of recent quality improvement activities? Are previous QA lessons learned applied to this project?

[f] If a subcontractor will perform work on the contract, how well do they measure up to the evaluation used for the Vendor?

[g] Has the Vendor included a description of the ongoing methods they will use to ensure and attest that any person providing services under this contract, including subcontractors, are not excluded from participation in federal programs as specified in 42 U.S.C. 1320a-7 (2009)? The Vendor(s) must ensure staff and subcontractors *are* ***not*** excluded (i.e. not on the List of Excluded Individuals/Entities (LEIE) or the State exclusion list). If a person *is* listed on the LEIE or State exclusion list, the Vendor(s) is not eligible to receive federal funds while the excluded individual is working for the Vendor(s).

[h] Is the Vendor a Medicare certified Quality Improvement Organization (QIO), or fully accredited by URAC and/or the National Committee for Quality Assurance (NCQA)?

7.05 Contract Cost (30 Percent)

Overall, **30**% of the total evaluation points will be assigned to cost. The cost amount used for evaluation may be affected by one or more of the preferences referenced under Section 2.13.

Converting Cost to Points

The lowest cost proposal will receive the maximum number of points allocated to cost. The point allocations for cost on the other proposals will be determined through the method set out in Section 2.15.

7.06 Alaska Vendor Preference (10 Percent)

If a Vendor qualifies for the Alaska Bidder Preference, the Vendor will receive an Alaska Vendor Preference. The preference will be 10 percent of the total available points. This amount will be added to the overall evaluation score of each Alaska Vendor.

SECTION EIGHT
ATTACHMENTS

8.01 Attachments

Included in this RFP document

1. Vendor's Checklist
2. Cost Proposal
3. Proposal Evaluation Form
4. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions

Attached Separately

5. Standard Agreement Form
   a. Appendix A
   b. Appendix B1 or B2
   c. Appendix C
   d. Appendix D
   e. Appendix E - HIPAA Business Associate Agreement
6. Notice of Intent to Award
7. NGA Super Utilizer Grant
8. Generic Sample CMP Placement Letter

VENDOR'S CHECKLIST

IMPORTANT NOTE TO VENDORS: This checklist is provided to assist Vendors and the Procurement Officer in addressing and/or locating specific requirements identified in the RFP for the Vendor's proposal. **Vendors are to complete and return this form**. Completion of this form does not guarantee a declaration of responsiveness.

Vendor: _____

1. Per section 1.16, provide a statement regarding Vendor's Certification.

   Evidence is provided on page # _____.

2. Per section 1.16, proposal has been **signed** by an individual authorized to bind the Vendor to the provisions of the RFP.

   Evidence is provided on page #_____.

3. Per section 1.17, provide a Conflict of Interest Statement.

   Evidence is provided on page # _____.

4. Per section 1.24, Vendor has signed and returned the *Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions* form.

   Evidence is provided on page #_____.

5. Per section 2.08, evidence that the Vendor meets the minimum prior experience requirements.

   - Provide in writing the Vendor has a minimum of three (3) years successful experience providing case management services for an active caseload using current case management standards,

     Evidence is provided on page # _____.

   - The Vendor must provide in writing the name and resume of the CM/UR direct supervisor assigned to this project. The CM/UR direct supervisor's resume must demonstrate the CM/UR direct supervisor:

     - has applicable experience for the type of CM/UR services the Vendor proposes to provide,
     - has experience managing the medical complexities of the population,
     - has a minimum of three (3) years health care supervisory experience, and
     - has a minimum of one (1) year case management experience.

     Evidence is provided on page # _____.

6. Per section 2.12, evidence that the Vendor holds a valid Alaska business license.

   Evidence is provided on page #____.

7. Per section 7.01, how comprehensive is the narrative and how well has the Vendor demonstrated a thorough understanding of the purpose, scope and requirements of the project?

   Evidence is provided on page # _____.

8. Per section 7.01, how well does Vendor understand and describe their capacity for behavioral health integration?

   Evidence is provided on page # _____.

9. Per section 7.01, how well has the Vendor identified pertinent risks, issues and potential challenges related to the project?

   Evidence is provided on page # _____.

10. Per section 7.01, how well has the Vendor demonstrated an understanding of the challenges of providing care in Alaska?

    Evidence is provided on page # _____.

11. Per section 7.02, how comprehensive is the methodology and does it depict a logical approach to fulfilling the requirements of the RFP?

    Evidence is provided on page # _____.

12. Per section 7.02, how well does the methodology match and achieve the objectives set out in the RFP?

    Evidence is provided on page # _____.

13. Per section 7.02, does the work plan submitted illustrate the methodology interface with the time schedule in the RFP?

    Evidence is provided on page # _____.

14. Per section 7.02, does the proposal describe in detail the proposed methods for communicating with members and coordinating member care after normal business hours?

    Evidence is provided on page # _____.

15. Per section 7.02, does the Vendor's proposal include automation solutions that align with the goal of interoperability?

Evidence is provided on page # _____.

16. Per section 7.02, does the Vendor provide a cost methodology?

Evidence is provided on page # _____.

17. Per section 7.02, did the Vendor provide estimated ramp-up period, and can the vendor provide limited or no CM/UR activities during the ramp up period

Evidence is provided on page # _____.

18. Per section 7.02, did the Vendor provide estimated implementation date?

Evidence is provided on page # _____.

19. Per section 7.02, Did the Vendor provide a processes that will be utilized when barriers exist preventing the recipient from being available during the vendor's usual case management business hours?

Evidence is provided on page # _____.

20. Per section 7.02, Did the Vendor provide how they will coordinate with hospitals to assure case management interventions will occur in a timely manner prior to discharge?

Evidence is provided on page # _____.

21. Per section 7.03, how well does the management plan support all of the project requirements and logically lead to the deliverables required in the RFP?

Evidence is provided on page # _____.

22. Per section 7.03, how well does the management plan illustrate the lines of authority and communication?

Evidence is provided on page # _____.

23. Per section 7.03, to what extent does the Vendor already have the hardware, software, equipment, and licenses necessary to perform the contract?

Evidence is provided on page # _____.

24. Per section 7.03, has the Vendor gone beyond the minimum tasks necessary to meet the objectives of the RFP?

Evidence is provided on page # _____.

25. Per section 7.03, to what degree is the proposal practical and feasible?

Evidence is provided on page # _____.

26. Per section 7.03, does the project proposal provide an opportunity for project growth and sustainability?

Evidence is provided on page # _____.

27. Per section 7.04, do the individuals assigned to the project have experience on similar projects and CM/UR activities?

Evidence is provided on page # _____.

28. Per section 7.04, are resumes complete and do they demonstrate backgrounds that would be desirable for individuals engaged in the work the project requires?

Evidence is provided on page # _____.

29. Per section 7.04, Is there sufficient evidence that the CM/UR direct supervisor is a professional who:

- has applicable experience for the type of CM/UR services the Vendor proposes to provide,
- has experience managing the medical complexities of the population,
- has a minimum of three (3) years health care supervisory experience, and
- has a minimum of one (1) year case management experience.

Evidence is provided on page # _____.

30. Per section 7.04, how well is accountability completely and clearly defined?

Evidence is provided on page # _____.

31. Per section 7.04, is the organization of the project team clear?

Evidence is provided on page # _____.

32. Per section 7.04, how extensive is the applicable education and experience of the personnel designated to work on the project?

Evidence is provided on page # _____.

33. Per section 7.04, is there a sufficient number of qualified CM/UR staff as defined in the RFP who meet the organization's training and experience requirements to assure access to case management services depending on the number of members the Vendor chooses to serve?

Evidence is provided on page # _____.

34. Per section 7.04, are the roles and responsibilities of clinical versus non-clinical staff appropriately delineated?

Evidence is provided on page # _____.

35. Per section 7.04, are case management services provided by a combination of non-clinical and clinical staff? Are those staff performing services within the scope of their license and/or training in accordance with Alaska State Law?

Evidence is provided on page # _____.

36. Per section 7.04, Is the CM/UR direct supervisor a licensed professional? Is a copy of the CM/UR direct supervisor's license(s) and/or certification(s) attached?

Evidence is provided on page # _____.

37. Per section 7.04, did the Vendor provide detailed narrative the requested information in Section 5.04.4.

Evidence is provided on page # _____.

38. Per section 7.04, does the structure of the personnel in the organizational chart provided support the ability accomplish the work called for in this RFP?

Evidence is provided on page # _____

39. Per section 7.04, has the Vendor provided a narrative description of the organization of the project team and include a personnel roster that identifies each person who will actually work on the contract and provide the following information about each person listed:

    a. title,

    b. resume, and

    c. location(s) where work will be performed

Evidence is provided on page # _____.

40. Per section 7.04, how well has the Vendor demonstrated experience in successfully completing similar projects on time and within budget?

Evidence is provided on page # _____.

41. Per section 7.04, has the Vendor provided at least (3) letters of reference from previous members, including names and phone numbers?

Evidence is provided on page # _____.

42. Per section 7.04, has the Vendor provided evidence of recent quality improvement activities? Are outcomes and lessons learned from those activities applied to this project?

Evidence is provided on page # _____.

43. Per section 7.04, if a subcontractor will perform work on the contract, how well do they measure up to the evaluation used for the Vendor?

Evidence is provided on page # _____.

44. Per section 7.04, has the Vendor included a description of the ongoing methods they will use to ensure and attest that any person providing services under this contract, including subcontractors, are not excluded from participation in federal programs as specified in 42 U.S.C. 1320a-7 (2009).

Evidence is provided on page # _____.

45. Per section 7.04, Is the Vendor a Medicare certified Quality Improvement Organization (QIO), or fully accredited by URAC and/or the National Committee for Quality Assurance (NCQA)?

Evidence is provided on page # _____.

COST PROPOSAL

Note: The Vendor must provide a comprehensive and detailed narrative that describes its proposed methodologies and costs for meeting all requirements of, and providing all services described in, Section 5, Scope of Work.

Payment for contract services are based upon firm fixed price. The fixed rate are inclusive of all direct, indirect, travel related cost and other cost incurred by the Vendor in the delivery of services.

The purpose of the cost formula below is to provide a mechanism for Vendors to submit a cost to complete an Initial Health Screening Tool for one member. This will allow DHCS to evaluate and score all proposals in an equitable manner. The rate indicated below does not necessarily represent the actual payment methodology by which the successful Vendor will be reimbursed. The Initial Health Screening Tool will be published as an Amendment to come to this RFP.

Cost to complete an Initial Health Screening Tool per member ($_____) X 1 = $_____
(This is the only cost that will be used to determine the lowest cost proposal)

The Vendor must select an option below that will be used as the mechanism for payment.

Option 1

_____ The Vendor proposes an innovated and creative strategy for reimbursing case management services.

Option 2

_____ The Vendor wishes to be reimbursed on a fee for service basis. The narrative description below includes the Current Procedural Terminology (CPT) and/or Healthcare Common Procedure Coding System (HCPCS) code(s) the Vendor would like to use and the desired reimbursement amount for each code.

Option 3

_____ The Vendor wishes to be reimbursed on a per member per month (PMPM) basis or at a base care coordination fee. The Vendor must provide a proposed member reimbursement rate. The narrative description below details the services included in the proposed reimbursement rate, the services not included in the proposed reimbursement rate, and the methodology used to set the proposed reimbursement rate.

Option 4

_____ The Vendor wishes to be reimbursed at an hourly rate. The Vendor must provide separate proposed hourly rates for services performed by clinical staff versus non-clinical staff. The narrative description below includes an explanation of how time will be calculated (i.e. in increments of 6 minutes (0.1 is equal to 6 minutes), in increments of 15 minutes) and the methodology used to determine the hourly rates.

PROPOSAL EVALUATION FORM

All proposals will be reviewed for responsiveness and then evaluated using the criteria set out herein.

Person or Vendor Name _____

Name of Proposal Evaluation (PEC) Member _____

Date of Review _____

RFP Number _____

EVALUATION CRITERIA AND SCORING

THE TOTAL NUMBER OF POINTS USED TO SCORE THIS PROPOSAL IS 1000

7.01 Understanding of the Project—10 Percent

Maximum Point Value for this Section - 100 Points
1000 Points x 10 Percent = 100 Points

Proposals will be evaluated against the questions set out below.

[a] How comprehensive is the narrative and how well has the Vendor demonstrated a thorough understanding of the purpose, scope and requirements of the project?

EVALUATOR'S NOTES _____

_____

[b] How well does Vendor understand and describe their capacity for behavioral health integration?

EVALUATOR'S NOTES _____

_____

[c] How well has the Vendor identified pertinent risks, issues and potential challenges related to the project?

EVALUATOR'S NOTES _____

_____

[d] How well has the Vendor demonstrated an understanding of the challenges of providing care in Alaska?

EVALUATOR'S NOTES _____

_____

EVALUATOR'S POINT TOTAL FOR 7.01 _____

7.02 Methodology Used for the Project—30 Percent

Maximum Point Value for this Section - 300 Points
1000 Points x 30 Percent = 300 Points

Proposals will be evaluated against the questions set out below.

[a] How comprehensive is the methodology and does it depict a logical approach to fulfilling the requirements of the RFP?

EVALUATOR'S NOTES _____

_____

[b] How well does the methodology match and achieve the objectives set out in the RFP?

EVALUATOR'S NOTES _____

_____

[c] Does the work plan submitted illustrate the methodology interface with the time schedule in the proposal?

EVALUATOR'S NOTES _____

_____

[d] Does the proposal describe in detail the proposed methods for communicating with members and coordinating member care after normal business hours?

EVALUATOR'S NOTES _____

_____

[e] Does the Vendor's proposal include automation solutions that align with the goal of interoperability?

EVALUATOR'S NOTES _____

_____

[f] Does the Vendor provide cost methodology?

EVALUATOR'S NOTES _____

_____

[g] Did the Vendor provide estimated ramp-up period, and can the vendor provide limited or no CM/UR activities during the ramp up period

EVALUATOR'S NOTES _____

_____

[h] Did the Vendor provide estimated implementation date?

EVALUATOR'S NOTES _____

_____

[i] Did the Vendor provide a processes that will be utilized when barriers exist preventing the recipient from being available during the vendor's usual case management business hours?

EVALUATOR'S NOTES _____

_____

[j] Did the Vendor provide how they will coordinate with hospitals to assure case management interventions will occur in a timely manner prior to discharge?

EVALUATOR'S NOTES _____

_____

EVALUATOR'S POINT TOTAL FOR 7.02 _____

7.03 Management Plan for the Project—10 Percent

Maximum Point Value for this Section - 100 Points
1000 Points x 10 Percent = 100 Points

Proposals will be evaluated against the questions set out below.

[a] How well does the management plan support all of the project requirements and logically lead to the deliverables required in the RFP?

EVALUATOR'S NOTES _____

_____

[b] How well does the management plan illustrate the lines of authority and communication?

EVALUATOR'S NOTES _____

_____

[c] To what extent does the Vendor already have the hardware, software, equipment, and licenses necessary to perform the contract?

EVALUATOR'S NOTES _____

_____

[d] Has the Vendor gone beyond the minimum tasks necessary to meet the objectives of the RFP?

EVALUATOR'S NOTES _____

_____

[e] To what degree is the proposal practical and feasible?

EVALUATOR'S NOTES _____

_____

[f] Does the project proposal provide an opportunity for project growth and sustainability?

EVALUATOR'S NOTES _____

_____

EVALUATOR'S POINT TOTAL FOR 7.03 _____

7.04 Experience and Qualifications—10 Percent

Maximum Point Value for this Section - 100 Points
1000 Points x 10 Percent = 100 Points

Proposals will be evaluated against the questions set out below.

Questions regarding the personnel.

[a] Do the individuals assigned to the project have experience on similar projects and CM/UR activities?

EVALUATOR'S NOTES _____

_____

[b] Are resumes complete and do they demonstrate backgrounds that would be desirable for individuals engaged in the work the project requires?

EVALUATOR'S NOTES _____

_____

[c] Is there sufficient evidence that the CM/UR direct supervisor is a professional who:

- has applicable experience for the type of CM/UR services the Vendor proposes to provide,
- has experience managing the medical complexities of the population,
- has a minimum of three (3) years health care supervisory experience, and
- has a minimum of one (1) year case management experience.

EVALUATOR'S NOTES _____

_____

[d] How well is accountability completely and clearly defined?

EVALUATOR'S NOTES _____

_____

[e] Is the organization of the project team clear?

EVALUATOR'S NOTES _____

_____

[f] How extensive is the applicable education and experience of the personnel designated to work on the project?

EVALUATOR'S NOTES _____

_____

[g] Is there a sufficient number of qualified CM/UR staff as defined in the RFP who meet the organization's training and experience requirements to assure access to case management services, depending on the number of members the Vendor chooses to serve?

EVALUATOR'S NOTES _____

_____

[h] Are the roles and responsibilities of clinical versus non-clinical staff appropriately delineated?

EVALUATOR'S NOTES _____

_____

[i] Are case management services provided by a combination of non-clinical and clinical staff? Are those staff performing services within the scope of their license and/or training in accordance with Alaska State Law?

EVALUATOR'S NOTES _____

_____

[j] Is the CM/UR direct supervisor a licensed professional? Is a copy of the CM/UR direct supervisor's license(s) and/or certification(s) attached?

EVALUATOR'S NOTES _____

_____

[k] Did the Vendor provide detailed narrative the requested information in Section 5.04.4.

EVALUATOR'S NOTES _____

_____

Questions regarding the Vendor.

[a] Does the structure of the personnel in the organizational chart provided support the ability to accomplish the work called for in this RFP?

EVALUATOR'S NOTES _____

_____

[b] Does the Vendor provide a narrative description of the organization of the project team and including a personnel roster that identifies each person who will actually work on the contract and provide the following information about each person listed:

a. title,

b. resume, and

c. location(s) where work will be performed

EVALUATOR'S NOTES _____

_____

[c] How well has the Vendor demonstrated experience in successfully completing similar projects on time and within budget?

EVALUATOR'S NOTES _____

_____

[d] Has the Vendor provided at least (3) letters of reference from previous members, including names and phone numbers?

EVALUATOR'S NOTES _____

_____

[e] Has the Vendor provided evidence of recent quality improvement activities? Are previous QA lessons learned applied to this project?

EVALUATOR'S NOTES _____

_____

[f] If a subcontractor will perform work on the contract, how well do they measure up to the evaluation used for the Vendor?

EVALUATOR'S NOTES _____

_____

[g] Has the Vendor included a description of the ongoing methods they will use to ensure and attest that any person providing services under this contract, including subcontractors, are not excluded from participation in federal programs as specified in 42 U.S.C. 1320a-7 (2009)?

EVALUATOR'S NOTES _____

[h] Is the Vendor a Medicare certified Quality Improvement Organization (QIO), or fully accredited by URAC and/or the National Committee for Quality Assurance (NCQA)?

EVALUATOR'S NOTES _____

_____

EVALUATOR'S POINT TOTAL FOR 7.04 _____

7.05 Contract Cost — 30 Percent

Maximum Point Value for this Section - 300 Points
1000 Points x 30 Percent = 300 Points

Overall, 30 percent of the total evaluation points will be assigned to cost. The cost amount used for evaluation may be affected by one or more of the preferences referenced under Section 2.13.

Converting Cost to Points

The lowest cost proposal will receive the maximum number of points allocated to cost. The point allocations for cost on the other proposals will be determined through the method set out in Section 2.15.

EVALUATOR'S POINT TOTAL FOR 7.05 _____

7.06 Alaska Vendor Preference — 10 Percent

Alaska bidders receive a 10 percent overall evaluation point preference.
Point Value for Alaska bidders in this section -- 100 Points
1000 Points x 10 Percent = 100 Points

If a Vendor qualifies for the Alaska Bidder Preference, the Vendor will receive an Alaska Vendor Preference. The preference will be 10 percent of the total available points. This amount will be added to the overall evaluation score of each Alaska Vendor.

EVALUATOR'S POINT TOTAL FOR 7.06 (either 0 or 100) _____

EVALUATOR'S COMBINED POINT TOTAL FOR ALL SECTIONS _____

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION LOWER TIER COVERED TRANSACTIONS

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, 29 CFR Part 98, Section 98.510, Member's responsibilities. The regulations were published as Part VII of the May 26, 1988 Federal Register (pages 19160-19211).

(BEFORE COMPLETING CERTIFICATION, READ THE INSTRUCTIONS ON THE FOLLOWING PAGE WHICH ARE AN INTEGRAL PART OF THE CERTIFICATION)

(1) The prospective member of Federal assistance funds certifies, by submission of this bid, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

(2) Where the prospective member of Federal assistance funds is unable to certify to any of the statements in this certification, such prospective member shall attach an explanation to this Proposal.

_____
Name and Title of Authorized Representative

_____
Signature Date

Instructions for Certification

1. By signing and submitting this Proposal, the prospective member of Federal assistance funds is providing the certification as set out below.

2. The certification in this class is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective member of Federal assistance funds knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the Department of Labor (DOL) may pursue available remedies, including suspension and/or debarment.

3. The prospective member of Federal assistance funds shall provide immediate written notice to the person to whom this Proposal is submitted if at any time the prospective member of Federal assistance funds learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "member," "person," "primary covered transaction," "principal," "Proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this Proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective member of Federal assistance funds agrees by submitting this Proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the DOL.

6. The prospective member of Federal assistance funds further agrees by submitting this Proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A member in a covered transaction may rely upon a certification of a prospective member in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A member may decide the method and frequency by which it determines the eligibility of its principals. Each member may but is not required to check the List of Parties Excluded from Procurement or Non-procurement Programs.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a member is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a member in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the DOL may pursue available remedies, including suspension and/or debarment