GOLD COAST HEALTH PLAN

REQUEST FOR PROPOSAL
FOR
SERVICES RELATED TO NON-EMERGENCY MEDICAL TRANSPORTATION

RFP DATE: October 12, 2012

RFP DUE: November 2, 2012

PROVIDER CONTRACTING DEPARTMENT
2220 E GONZALES RD STE 200
OXNARD, CA 93006

CONTACT: SHERRI TARPCHINOFF BENNETT
MANAGER, PROVIDER CONTRACTING
(805) 981-5339
Sbennett@goldchp.org
SECTION I. COMPANY PROFILE

Gold Coast Health Plan (“GCHP”) proudly serves more than 96,000 Medi-Cal beneficiaries living in Ventura County, California. We are an independent public entity governed by the Ventura County Medi-Cal Managed Care Commission. The commission is comprised of locally elected officials, providers, hospitals, clinics, the county healthcare agency and consumer advocates.

SECTION II. PURPOSE OF THE RFP

GCHP has chosen your organization to participate in the procurement process for purchasing Non-Emergency Transportation services. After review of the submitted RFP responses, GCHP will notify you of our evaluation of your response and the next steps in the procurement process.

Any future business partner providing Non-Emergency Medical Transportation (NEMT) services will need to be able to operate with GCHP on a county-wide basis and, therefore, be compliant with all of the various regulations in Ventura County, California, as well as all state and federal regulations applicable to GCHP’s lines of business. GCHP provides non-emergency medical transportation services to our members and is pursuing an alliance with a business partner to improve these functions.

SECTION III. GENERAL UNDERSTANDING

Print or type responses to the Request for Proposal Questionnaire (Exhibit B) in the areas following the question. Where applicable, attach complete copies of all documents requested. Return the completed questionnaire and applicable attachments to:

SHERRI TARPCHINOFF BENNETT
MANAGER, PROVIDER CONTRACTING
(805) 981-5339
Sbennett@goldchp.org

All questions about this RFP should be directed to Sherri Bennett using the above contact information. Please be certain the questionnaire is complete and all requested attachments are enclosed at the time of submission to Gold Coast Health Care. Refer to the enclosed checklist (Exhibit “C”). Incomplete questionnaires may not qualify for final award(s).

Upon receipt of the vendor bid, GCHP will send a notice of acknowledgement.

Benefits described herein are the covered benefits as they currently exist. Such benefits are subject to change by state agency and/or GCHP, prior to and following contract implementation. Should GCHP become aware of any changes prior to the RFP submission deadline, it will immediately notify all bidders.

GCHP will request a presentation version of finalist bidders via an onsite visit. Vendor will be required to make arrangements if GCHP determines that a site visit of your facility is desirable.
The following schedule shall be followed in procurement of services described in this RFP. GCHP will attempt to perform all activities on or about the dates described, however, the dates are subject to change at our discretion. Recognize, this is an aggressive schedule.

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<tr>
<th>Procurement Schedule</th>
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<tr>
<td>1. RFP Mailing Date</td>
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<td>2. Vendor Presentations (May present refined proposal)</td>
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<td>3. Vendors Inform GCHP if they will Participate</td>
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<td>4. Vendor Questions due to GCHP</td>
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<td>5. GCHP Responses due to Vendors</td>
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<td>6. Vendor Proposals Due</td>
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<td>7. Evaluation of Proposals Completed with Finalists Selected</td>
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<td>8. Contract Award</td>
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<td>9. Finalize Contract(s)</td>
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<td>10. Implementation Date (tentative)</td>
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Vendor must be able to submit claims data or encounters in electronic batch format.

Attached to the RFP are the following exhibits for NEMT for GCHP:

**Exhibits**

x Exhibit A       GCHP Covered Benefits  
x Exhibit B       GCHP Questionnaire  
x Exhibit C       List of Required Documents

**RFP Cancellation/Non Award**

GCHP reserves the right to cancel this RFP, or to make no award of a contract pursuant to this RFP, if GCHP determines that such action would be in our best interest. Vendors shall bear all of their own costs related to the RFP.

**Rejection of Proposals**

Proposals which do not conform to the requirements outlined in this RFP may be rejected by GCHP. Proposals may be rejected for reasons, which include, but are not limited to, the following:

x The proposal is received after the submission deadline.  
x The proposal is not signed by an authorized representative of the Vendor.  
x The Vendor submits more than one proposal.
EXHIBIT A
COVERED BENEFITS

Non-Emergency Medical Transportation Services are covered benefits of the Medi-Cal program only if the following requirements are met:

A. The transportation is a covered benefit under Title 22, California Code of Regulations section 51323, the Medi-Cal program, and the California Department of Health Care Services contract with GCHP under which Ventura County Medi-Cal beneficiaries are assigned to GCHP;

B. Transportation by ordinary means of public or private conveyance is contraindicated;

C. Transportation is required for the purpose of obtaining medically necessary Medi-Cal covered services;

D. A physician, dentist, or podiatrist issued a written prescription for the GCHP Medi-Cal beneficiary to receive non-emergency medical transportation necessary for Medi-Cal program covered services;

E. GCHP prior authorized the non-emergency medical transportation or the transportation is to transfer a Medi-Cal patient from an acute care hospital immediately following a stay as an inpatient at the acute level of care to a skilled nursing facility or an intermediate care facility licensed pursuant to Cal. Health and Safety Code §1250;

F. Transportation is only to the nearest facility capable of meeting the patient's medical needs;

G. The lowest cost type of medical transportation that is adequate for the patient's medical needs, and is available at the time transportation is required, is utilized as follows:

   a. LITTER VAN SERVICES
      
      i. The patient's medical and physical condition requires that the patient be transported in a prone or supine position, because the patient is incapable of sitting for the period of time needed to transport;

      ii. The patient's medical and physical condition requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance; and

      iii. The patient's medical and physical condition does not require the specialized services, equipment and personnel provided in an ambulance because the patient is in stable condition and does not need constant observation.

   b. WHEELCHAIR VAN SERVICES

      i. The patient's medical and physical condition renders the patient incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport;
ii. The patient's medical and physical condition requires that the patient be transported in a wheelchair or assisted to and from residence, vehicle and place of treatment because of a disabling physical or mental limitation;

iii. The patient's medical and physical condition requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance; and

iv. The patient's medical and physical condition does not require the specialized services, equipment and personnel provided in an ambulance, because the patient is in stable condition and does not need constant observation.

c. AMBULANCE TRANSPORTATION

i. The patient's medical condition contraindicates the use of other forms of medical transportation.

d. AIR TRANSPORTATION

i. Transportation by air is necessary because of the medical condition of the patient or practical considerations render ground transportation not feasible; and

ii. The necessity for transportation by air is substantiated by the content of a written order of a physician, podiatrist or dentist.
EXHIBIT B
REQUEST FOR PROPOSAL QUESTIONNAIRE

Print or type responses to the questionnaire in the areas following the question. Please provide your full response via electronic mail.

I. MANAGEMENT

A. Ownership

1. Provide a list of the majority owners of your organization, the form of ownership, their respective percentage of ownership, and a brief description of their experience. Include a current top-level organizational chart with a list of all your management personnel. Provide your employee turnover rate for the last 12 months, and list any senior management turnover in the last six months. Briefly describe the functional responsibilities, interactions and reporting requirements of each organizational unit.

2. Describe any “joint ventures,” partnerships or other joint ownership relationships you are a part of with any other healthcare provider(s) for the provision of transportation services. Include the percentage of ownership held by your organization, a short description of the operation, and a list of major customers. List any preferred or exclusive arrangements you have with any other third party payer in the service area. Include the length and terms of these contracts and their expiration date.

3. If any change of ownership of the company is anticipated during 12 months following the proposal due date, describe the circumstances of such change and indicate when the change is likely to occur.

B. History

1. List all acquisitions of transportation companies, in California, that your organization has completed in the last two years.

2. Has your company had a contract terminated by a client for cause within last three years? If so, by whom and under what circumstances?

3. State the length of time you have been doing business as a non-emergent transportation provider in California.

C. Insurance, License & Certifications

1. Describe your current liability insurance policies for your organization
and professional liability for your principal owners and corporate officers. Include their financial limits, underwriter terms, and description of coverage, exclusions and other limitations. Include a description of all current and pending lawsuits or any actions, or any matters that you believe may lead to a claim regarding any of the services you provide for your organization or its principle owners. Also, include a description of any action you are involved with concerning any license or accreditation, you as an organization or your principles hold.

2. Describe other current insurance coverage relevant to your organization or services, including workers’ compensation and vehicle coverage.

3. Describe any licenses or certifications your organization holds. Include for each state or service area.

4. List any law suits or settlement judgments in the past five (5) years; provide details.

D. Fiscal Responsibility

1. Provide copies of all state, federal and local government agency performance evaluations conducted in the last year. Include your most recent review if none in the last year and all relevant comments.

2. Provide copies of your current financial statement (Income Statement, Balance Sheet and Statement of Cash Flows, Statement of Retained Earnings and Notes to Financial Statements), plus your two most previous fiscal year ended audited financial reports. If you are a publicly held multidivisional organization, provide your divisional statements as well.

II. EXPERIENCE

A. Network Management

1. Please list the California counties in which your company is currently providing non-emergent medical transportation services, by vehicle type.

2. How would you maintain a network that will assure all GCHP members have sufficient and appropriate access to the services? Please provide access standards/locations in Ventura County California based on GCHP’ current membership of approximately 96,000.

3. Discuss how you would establish and maintain a provider network which meets the following requirements:
a. Employs safe, quality strategies in the delivery of transportation and ensures a culturally diverse provider network that is responsive to the varied needs of the consumers.

b. Utilizes current providers in the community to the extent possible without limiting efficiency or program design.

c. Provides sufficient transport carrier capacity.

d. Includes public transportation carriers.

e. Addresses special needs including but not limited to members who utilize wheelchairs, walkers, canes, gurneys, etc., for their mobility.

f. Ensures the provision of service delivery to meet the needs of members for routinely scheduled trips and non-recurrent on-demand trips.

g. Ensures that non-English speaking members can access transportation services.

5. Do you utilize services of any subcontracted providers? If so, please describe.

6. How do you monitor and ensure services provided by subcontracted transportation providers meet contractual requirements?

   a. What oversight of providers do you perform to ensure their compliance with applicable State and Federal laws, regulations and permit requirements?

7. How do you promote and maximize mileage reimbursement options, public transportation, and ensure appropriate access to Ambulate transportation?

8. What is your experience providing in-person functional assessments to determine recipient’s level-of-need for transportation mode and how do you make the determination that such an assessment is necessary?

9. What is your experience managing the prior authorization process for non-emergent transportation services?

B. Access

1. Discuss how you would schedule, assign and dispatch service, including procedures to handle last minute request, scheduling changes, vendor and member “no-shows” and late running vehicles.

2. Can you handle customer mileage reimbursement when participants use their own transportation? How is this accomplished?

3. Transportation of Minors:

GCHP Transportation RFP - 2012
Depending on state or federal regulations, you may from time to time be required to transport minors. Appointments for minors include but are not limited to (1) dialysis appointments (2) family planning; or (3) minor children transporting their children to and from appointments. It is the expectation of GCHP that anyone transporting minor children has been pre-screened and is free from any criminal convictions. Show how you are able to meet these expectations. In addition to your attestation of compliance, please submit your policies and procedures on transportation of minor age children.

4. Procedures to assure ninety-percent (90%) of shared-ride trips take no more than 30 minutes more than the time required to accomplish the same trip, at the same time of day, under the same weather and traffic conditions, as on a non-shared basis.

5. What are your phone service center staffing ratios and do they result in responding to trip requests and questions from consumers about available NEMT services within your performance standards and those of GCHP listed below. What are your Service Level standards?

   x Average Speed of Answer – 30 seconds
   x Abandonment Rate – 5% or less.
   x Provide your call center statistics for the last 12 (twelve) months.

6. Do you provide a functioning local and toll-free telephone number equipped with voice mail, TTY/TDD and facsimile number?

7. During what hours do you have customer service staff available to respond to member calls?

8. How does your call center address the special service needs of non-English speaking and deaf customers?

9. Please provide the contact names and addresses of your local administrative service centers and call centers.

10. Can you provide same-day transportation? What is your procedure for this type of request?

11. Do you have any distance limitations on transportation trips (i.e. will you transport members to another county if necessary)? If yes, please explain.

12. How would you work with GCHP to encourage members utilize services in closer vicinity to their residence, thus decreasing transportation costs and more strongly encouraging care within their community?
C. **Quality Improvement**

1. How do you track and report incoming calls, wait times, call times, number of abandoned calls? What software do you use? Provide sample reports.

2. Describe your complaint monitoring and response program.

3. Discuss how you will ensure your company promptly report accidents that have occurred if a GCHP member was present in the vehicle.

4. How often do you conduct member satisfaction surveys? Please provide copies of past two (2) years’ survey results. If provider satisfaction surveys are performed, also provide survey results of the past two (2) years.


6. Do you currently provide management reports to any other health plan? Are you able to submit accurate and complete management reports to GCHP at requested intervals? These reports shall include but not be limited to levels of transport, numbers of trips, cost, and utilization by customer, complaint log, and customer satisfaction survey information. Please attach sample reports.

7. How will you safeguard and protect unauthorized disclosure of member PHI?

8. What is your process to coordinate after-hour hospital discharges and handle transportation problems that may arise during non-office hours?

9. Do you have any performance based incentive or disincentive programs with your contracted and subcontracted vendors? Please describe.

10. Do you provide ongoing training for your staff? Please describe.

11. Do you provide ongoing education and training for contracted and subcontracted transportation vendors? If so, please describe and provide samples as applicable.

12. Do you have a Quality Management Plan in place? Please provide a copy.

13. What measures do you employ to prevent, detect, investigate, and address fraud and abuse?

14. Describe Patient Safety and Risk Management Program description you have in place and provide copy.
15. List the number and type of complaints you have received within the last six months concerning all forms of services and products you provide.

16. What type of measures/action plans would your company take if there are repetitive/consistent complaints against one particular vendor/subcontractor with which your company is contracted? (e.g. misconduct or unprofessional behavior)

17. Are you accredited by any independent quality accrediting organizations? If so, please list and provide proof of accreditation.

18. What are your policy and process and experience conducting vehicle inspections and on-street observations of your owned, contracted and subcontracted vehicles?

19. Drivers of vehicles equipped with wheelchair ramps or lifts must by CPR and 1st Aid certified; do your drivers all meet this requirement?

D. HIPAA Compliance

1. Describe your privacy and security program to ensure the confidentiality, integrity and availability of customer information. Describe any actions that you have taken to update your program to comply with the HITECH Act.

2. Describe your administrative, physical and technical safeguards to protect against unauthorized use or disclosure of personally identifiable information (PII) and protected health information (PHI).

3. Describe your security incident reporting and management process to handle any suspected or known breaches of PII or PHI. List all breaches that you have experienced in the last five (5) years.

4. Describe how you train your workforce members regarding privacy and security of customer information.

5. Describe how you ensure that any subcontractors or agents protect the confidentiality of customer information.

6. Describe any Internet portals or similar technology used by patients to schedule transportation services. Include all security measures

7. Describe your business continuity and disaster recovery plan. When was your plan last tested?
III. PRICING

A. GCHP is interested in entering into a multi-year contract with a Transportation company. Please indicate your proposed guaranteed rates for two, three and five-year term contracts. You may use any combination of rate components in the grid provided or a variation thereof. GCHP will consider proposed rates and rate structure as part of the greater RFP response. Decisions will not be based solely on rates and rates will be negotiated with the winning respondent(s).

Medicaid Members / Bid: Non Emergent Medical Transportation Services.

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<tr>
<th>Number of Years</th>
<th>Per Member/Per Month Amount</th>
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<td>2 year</td>
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<td>3 year</td>
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<td>4 year</td>
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B. Should GCHP membership increase during the term of this contract, would it affect your proposed contract rates? If so, describe.

C. Would proposed rates fluctuate with Gasoline changes? Please describe.

D. Describe your experience managing under a capitated model of reimbursement for states, counties and managed care entities.

E. Billing and Encounter Information

1. Describe your billing process including file format.

2. Describe your process to submit encounter information to health plans and file formats supported. Describe the data transmission process used.

3. Describe how you verify eligibility prior to providing transportation services.
IV. ADDITIONAL INFORMATION REQUESTED

A. Please provide copies of your following policies:
   2. Specimen Subcontractor Agreement
   3. Business Continuity and Disaster Recovery Plan
   4. Grievance and Complaint Resolution

B. Please provide contact information for your five highest volume customers. A minimum of (3) references from the list may be contacted by GCHP concerning your past performance.

C. Do you provide reports to referring providers? What is the turnaround time for such reports? Provide a sample.

D. Describe your trip scheduling/routing software in detail; what is the accuracy of the mileage determinations and on what basis is it made? Describe your information technology capabilities, staff, and ratios.

E. How do you propose to partner with GCHP on an on-going basis to ensure exemplary service to its members and your subcontracted providers? Meetings, oversight, problem solving, etc?

F. Other comments.

Upon completion of this questionnaire, please review and sign the following statement and return it with your responses:

***** SIGNATURE PAGE TO FOLLOW *****
I, ____________________________, attest that I have the authority to answer these questions by the organization submitting the bid and that the information enclosed herein is the complete and the whole truth. I also attest that any information provided herein that is not true and complete would constitute grounds for termination of any contract between GCHP and my organization to provide services. I understand and agree that GCHP is entitled to wholly rely upon the responses submitted in this questionnaire.

__________________________________________
Vendor/Company Name

__________________________________________
Signature/Title

__________________________________________
Print

__________________________________________
Date
Exhibit C - List of Required Documents

1. Top-level organizational chart with a list of all your management personnel.
2. Copies of all most recent state, federal and local government agency performance evaluations.
3. Current financial statement with:
   a. Income Statement
   b. Balance Sheet
   c. Statement of Cash Flows
   d. Statement of Retained Earnings and Notes to Financial Statements
   e. Two most previous fiscal years ended audited financial reports. If you are a publicly held multidivisional organization, provide your divisional statements as well
4. Contact names and addresses of your local administrative service centers and call centers
5. Member Satisfaction survey results for past two years
6. Provider Satisfaction survey results for past two years
8. Copy of Provider/Subcontractor Manual
9. Sample management reports
10. Sample subcontractor training tools
11. Copy of Quality Management Plan
12. Copy of Patient Safety and Risk Management Program description
13. Sample of reports provided to referring providers