State of California — Department of Health

Memorandum

To : William Mayer, M.D.
Director of Health
OB 8, Room 1250

Date : March 14, 1974

Subject: Statewide Medi-Cal Intermediary Selection

From : Richard P. Wilcoxon
Program Manager
Financing Operations Program

VIA: Jerry W. Green
Deputy Director
Health Financing Systems

As you know, the Statewide Medi-Cal Intermediary Selection Committee has recommended that if a contract is awarded, it should be awarded to Medi-Cal Intermediary Operations. Alternatives of not awarding a contract or issuing a new Request for Proposals (RFP) were also presented.

A new RFP would delay signing a new contract for at least a year, during which time MIO would continue to operate and would incorporate the two Medi-Cal Management System (MMS) counties upon termination of the Health Care Systems Administrators (HCSA) contract. It appears that nothing could be gained through this delay.

Therefore, the Health Financing Systems recommends that no contract be awarded. If this recommendation is implemented, the Medi-Cal Management System (MMS) prototype will cease operation on June 30, 1974, and providers in the two counties it serves will begin submitting claims to MIO. MIO will then serve as statewide intermediary under the current contract.

It is estimated that by not awarding a new contract, the costs to the State would be less than would be incurred under a new contract (see attached cost summary). MIO's system as bid is basically the system which they are now operating. The cost difference between the existing system and the proposed system is apparently justified by MIO to offset the financial risk required by the RFP. The difference between the current cost and the bid cost over the four-year term of the contract ($14.4 million) does not appear to be economical in regard to the risk assumed.

Since most of the additional costs would be incurred during the first year of a new contract, National Health Insurance (NHI) would have an especially large impact if it came about during the term of the contract. When the RFP was issued, this (NHI) did not appear to be a concern, as there were several NHI plans under consideration and there was no sign of possible compromise. Since that time, several legislators have expressed the willingness to negotiate and pass compromise legislation. It is now expected that National Health Insurance will become a reality within the next year to year and one-half.

Not awarding a contract is an alternative allowed for in the RFP and would meet the legislative intent expressed in the 1973-74 Budget Act. One intermediary system would operate statewide, reducing the higher costs associated with dual systems. Increased Federal Financial Participation (FFP) can be assured by making minor modifications to MIO's current system. MIO's subcontractor, EDS, has indicated willingness to take whatever steps are necessary for California to obtain this increase in FFP (see attached letter).

While the current MIO contract and the proposed HCSA contract are both basically open-ended contracts, the HCSA proposed contract would include ten percent profit and would limit their risk should a cost overrun occur. The estimated 1974-75 cost under the current MIO contract is $36.4 million. HCSA's estimated 1974-75 cost, which includes implementation and profit is $47.6 million, with a subsequent year normal cost of $34.3 million. It does not appear that the system features proposed by HCSA justify the first year estimated difference in costs of $11.2 million nor the estimated four-year cost difference of $4.7 million.

In view of the considerations outlined above, it is my opinion and recommendation that the most reasonable and responsible course of action for the Department of Health to take is not to award a contract but to continue our current contract with MIO as the statewide Medi-Cal intermediary.

Attachment

ESTIMATED MIO FOUR-YEAR COST
(Under Current Contract)

Estimated 1974/75 Costs	$ 31,182,900
Eligibility Subsystem (CID)	3,408,331
Benefits Review Function	104,982
Other Coverage Processing	235,000
Beneficiary Explantion of Medi-Cal Benefits	1,425,796
Total Normal Yearly Operation	$ 36,357,009
	x 4 Years
Four-Year Cost	$145,428,036

FOUR-YEAR COST COMPARISON

MIO (Current Contract)	$145,428,036
MIO (As Proposed)	159,803 525
HCSA (HCSA Eligibility)	150,146,475*
LSL	151,527,408

*The figure shown reflects the costs estimated by HCSA based upon the contract provisions submitted by HCSA.

ELECTRONIC DATA SYSTEMS CORPORATION
DALLAS, TEXAS 75235

MILLEDGE A. HART, III
PRESIDENT

January 31, 1974

Mr. Jerry W. Green
Deputy Director
State of California
Health and Welfare Agency
Department of Health
714 P Street
Sacramento, California 95814

Dear Jerry:

Now that the proposals for Medi-Cal are about to be submitted, I want to take the opportunity to thank you for the courtesies extended by you and your staff in providing some of the needed interpretations of the intent of the procurement as it relates to data processing subcontractors.

We fully understand the necessity of complying with Federal law and regulations, particularly in view of the impact of Federal funding, and once again you have our assurance that EDS and its subsidiaries will comply with the Federal requirements. The recent interpretation which you made available to me was most helpful in this regard.

Your explanation that it was not the intention of the procurement to take rights to the use of a system developed by a subcontractor at its own expense (except that at the end of the contract's four-year term the State reserved the right to use whatever system was then in place for the Medi-Cal program) is certainly a fair approach. It is also

consistent with the Federal requirements. Similarly, we fully appreciate the State's need for full and continuous access to systems information. We have no problems in that regard in view of your assurance that this will be done in a manner which will protect a subcontractor's proprietary information.

We hope that we will have the opportunity through MIO to further serve the State of California in this program.

Sincerely,

Milledge A. Hart, III
President

MAH,III/ch

cc: Charles W. Stewart

State of California — Department of Health

Memorandum

To : William Mayer, M.D.
Director of Health
OB 8, Room 1250

Date : March 14, 1974

Subject: Statewide Medi-Cal Intermediary Selection

From : Richard P. Wilcoxon, Chairman
Statewide Medi-Cal Intermediary
Selection Committee

The Statewide Medi-Cal Intermediary Selection Committee has reviewed the comparative evaluation of the proposals submitted by Health Care Systems Administrators (HCSA), Medi-Cal Intermediary Operations (MIO), and Lone Star Life Insurance Company, PAID Prescriptions, and Health Application Systems (LSL). The recommendations of the Committee are as follows:

1. Contract negotiations should not be entered into with Lone Star Life Insurance Company. The proposal submitted by LSL did not adequately demonstrate that the offeror possesses the capability to administer the Medi-Cal program statewide.

   Although the overall proposal met the minimum requirements, the implementation plan did not appear feasible, and the proposed system was judged unacceptable in the areas of processing claims for services rendered beneficiaries with a liability, file maintenance, and communication between the State and the intermediary.

2. Contract negotiations should not be entered into with Health Care Systems Administrators.

   HCSA has indicated an unwillingness to agree to the contractual provisions specified in the Request for Proposals. As the cost presented is only an estimate and not a fixed price as required, the actual cost of the HCSA proposal cannot be determined. The contract as proposed would limit HCSA's liability to 100 percent of its profits plus $500,000 in any contract year, in the event of a cost overrun. Acceptance of the HCSA contract modifications would require the Department to assume all costs in excess of HCSA's liability defined above.

In view of the foregoing discussion, if a contract is to be negotiated, the proposal submitted by Medi-Cal Intermediary Operations is the only viable alternative. The MIO system as proposed is capable of effectively administering the Medi-Cal program. Statewide implementation could be accomplished quickly and with minimal disruptive effects. Also, MIO has agreed to the contract provisions required by the Department.

However, at least two alternatives to the selection of the MIO proposal exist:

1. Reject all proposals and continue with the current MIO operation in the 56 counties and incorporate San Diego and Santa Clara Counties upon termination of the HCSA contract June 30, 1974.

2. Reject all proposals and prepare a new Request for Proposals.

It is the Committee's understanding that departmental staff will prepare a detailed analysis of these suggested alternatives for your review.

This memo has been reviewed and approved by the following SMISC members:

Richard P. Wilcoxon
Program Manager
Financing Operations Program
Department of Health

Fulton Smith
State Data Processing Officer
Department of Finance

Chuck Farrell, Chief
Data Processing Division
Employment Development Department

Jack R. Brown, Chief
Program Implementation Section
Department of Health

Winston Hickox
Program Manager
Management Systems and Computer Services
Department of Health

Sam W. Jennings
Legal Counsel
Department of General Services

Tom Warriner
Deputy Director
Legal Affairs
Department of Health

Tom Elkin
Health Assistant to the Secretary
Health and Welfare Agency

Stewart Barnes
Senior Data Processing Systems Analyst
Department of Finance

EVALUATION OF PROPOSALS

STATEWIDE MEDI-CAL INTERMEDIARY

Prepared By

Program Implementation Section
Health Financing System
Department of Health
March , 1974

PREFACE

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Preface

I. The California Medicaid (Medi-Cal) program was established in 1966, based upon Title XIX of the Social Security Act which had been passed by Congress the previous year. The Department of Health Care Services contracted with California Blue Shield, Hospital Service of California (Blue Cross-North), and Hospital Service of Southern California (Blue Cross-South) to act as the Department's fiscal intermediary in the processing and payment of Medi-Cal claims. Although the contract was to run through calendar year 1966, it has been renewed monthly to the present.

In 1968, a Governor's task force recommended that the Department conduct a study of the administration of the Medi-Cal program. This recommendation resulted partially from early problems the "Blues" experienced in claims payment. In 1969, Lockheed performed the study which culminated in the development of an alternative claims processing system, to be owned by the State, which was called the Medi-Cal Management System (MMS).

The MMS was implemented by Health Care Systems Administrators, (HCSA) a joint venture of Occidental, Cal-West, and Pacific Mutual Life Insurance Companies on August 1, 1972, as a prototype operation in Santa Clara and San Diego Counties. The design of MMS combined claims processing, eligibility, and management reporting into a single system. Major MMS innovations were: model treatment profiles which relate the normal treatment pattern to medical diagnosis; on-line beneficiary eligibility information via terminals in county welfare departments; and improved State, federal, and management reports.

Concurrently, the "Blues" upgraded their claims processing systems and formed a single management structure to administer their Medi-Cal activities. This single structure is referred to as Medi-Cal Intermediary Operations (MIO). The new system integrated computer processing for institutional and non-institutional claims and offered a wide variety of management and program reports.

House Resolution 129, approved in 1972, directed the Secretary of the Health and Welfare Agency to form a Blue Ribbon Panel task force to conduct a comparative evaluation of the MMS and the MIO. In June 1973, the Blue Ribbon Panel made the recommendations that (1) the MIO contract be renegotiated and (2) MMS and MIO continue their current operational status through Fiscal Year 1973-74.

The 1973-74 Budget Act provided full-year funding for MIO and MMS; however, its language limited the MMS prototype expenditures to 75 percent of the MMS budgeted expenditures unless the Department executed a contract for a statewide fiscal intermediary system by April 1, 1974. The Department elected to seek a statewide intermediary system at this time because the operation of two fiscal intermediary systems was not cost-effective and because of this budget language. It was determined that only limited additional information could be gathered from continued operation of the MMS prototype.

Three choices were identified in reviewing the fiscal intermediary options available to the Department. The options were a statewide

claims processing system through:

1. Operation of the MMS system (either by the State or a private contractor).

2. Continuance of the MIO system (either under the current or a new contract).

3. A new system based upon criteria developed by the Department.

Through the development and prototype operation of MMS and the subsequent evaluations comparing MMS and MIO, the Department had the opportunity to measure the desirability of various administrative and design features of each for inclusion in a statewide fiscal intermediary system. MMS and MIO each have demonstrated unique attributes that are desirable to the Department, as well as shortcomings the Department should avoid.

Comparative analysis of these two systems suggested that the selection of one over the other had serious disadvantages. First, this approach would not allow the Department to readily capitalize on those unique desirable features of the system not chosen. Analysis of the MMS and MIO indicated that, depending on the subjective weighting of the factors considered, either system could be judged superior. There is no clear-cut superiority of either system. Additionally, there could be desirable features relative to a fiscal intermediary system not contained in either MIO or MMS. An

entirely separate system could exist, superior to both, which the Department has not had the opportunity to consider.

In order to avoid the limitations of selecting either MMS or MIO, proposals were solicited for a statewide fiscal intermediary system. The Request for Proposal (RFP) outlined the desirable features of a fiscal intermediary, including, but not limited to, those identified in MIO and MMS. The terms of the RFP were broad enough to allow both HCSA and MIO to submit proposals, as well as other interested companies. The requirements, however, were specific enough to preclude systems not sophisticated enough to handle the Medi-Cal program.

The Request for Proposal elicited proposals from Medi-Cal Intermediary Operations, Health Care Systems Administrators and a group consisting of Lone Star Life Insurance Company, PAID Prescriptions and Health Application Systems. The selection criteria and evaluation of these three proposals constitute the substance of this report.

EVALUATION APPROACH

EVALUATION APPROACH

Evaluation Approach

The Department of Health has made every effort to ensure that each offeror was given full and impartial consideration. A competent and dedicated staff, following a rigorous evaluation approach and utilizing extensive consultation by outside sources, objectively and thoroughly evaluated every aspect of each proposal. In the following paragraphs, the key steps in the evaluation approach are described.

Several weeks prior to receipt of the proposals, members of the staff in the Program Implementation Section of the Health Financing Systems, Department of Health, developed an evaluation plan that was designed to lead to the selection of the most effective proposed Medi-Cal intermediary system at the most reasonable cost to the State. Medi-Cal providers, California taxpayer representatives, experts from other State departments, and Department of Health personnel experienced in the day-to-day operation of the Medi-Cal program were consulted during the evaluation planning process. Four independent consulting firms were retained by the Department to review the evaluation approach, criteria, and process. Additionally, a Statewide Medi-Cal Intermediary Selection Committee, consisting of representatives from the State Health and Welfare Agency, Department of Health, and control agencies, served in an advisory capacity to the Department during the development of the RFP and the evaluation criteria.

Three weeks prior to receipt of the proposals, teams of three or more analysts, selected on the basis of their pertinent experience with the Medi-Cal program, were assigned to evaluate sections of the proposed systems. Each analyst was thoroughly familiar with the requirements of the RFP, Medi-Cal rules, regulations, and policies in those areas to which

he was assigned. Several training sessions covering evaluation techniques and an intensive review class in interpretation of decision logic tables, flow charts, and critical path charts were held to refresh evaluation skills. A five-member control team, made up of staff members who had been instrumental in the development of the RFP, assisted the evaluation teams in coordination and reporting requirements.

As proposals were received from the offerors, they were logged in and assigned a unique control number. When the deadline for submitting proposals had passed, a validation team checked each proposal against a detailed list of all items requested in the RFP. With only minor exceptions (as noted elsewhere in this report), all proposals were found to be responsive to the RFP as submitted.

Following validation, proposals were assigned to teams of analysts. To ensure that the evaluation of a proposed system's merit would not be influenced by its cost (and vice versa), cost proposals were detached from systems proposals prior to their review by analyst teams. As a result, the analysts who were reviewing systems had no knowledge of the attendant costs until their evaluation of the systems was complete.

Sections of each bidder's proposal (e.g., professional review, eligibility) were distributed to evaluation teams in a way that guaranteed that the sections of no one offeror's proposal would consistently be evaluated first or last.

During the development of the evaluation plan, weights[1] were assigned to the various sections to reflect the relative importance of each section in the overall system. However, the weights of individual sections were not

(1) See Page 6, Appendix 4 for weight distribution.

disclosed to the analysts at the time they were evaluating them; thus, their evaluation could not be influenced by the section's relative importance in the overall evaluation.

Each analyst independently awarded points and fully documented his evaluation before consensus opinions and point assignments were formed by his team. Each analyst's opinion had equal weight in the formation of the team's evaluation and consensus point award. Evaluation teams were instructed not to discuss their evaluations with other teams to prevent preconceptions being formed on sections prior to their review.

In parallel with the evaluation of each system's proposal, an independent team conducted an analysis of the cost proposals.

The cost estimates included in each proposal were first reviewed for reasonableness; that is, individual cost elements were examined to establish that the offeror had realistically provided for the staff, equipment, facilities, and support to adequately carry out each proposed function.

Costs then were analyzed for any elements or unique accounting conventions that would preclude legitimate comparisons between proposals.

The cost data then was examined on four bases:

1. First year total costs (including implementation costs and all other costs to the State such as cost of phasing out the current intermediary).
2. One-year operating costs (other than first year).
3. Four-year costs (including implementation costs and all other costs to the State such as the cost of phasing out the current

fiscal intermediary).

4. Fiscal year pro forma budget costs for FI expense over four-year life of contracts.

After the systems and costs of each proposal were independently evaluated, a cost/benefit analysis was performed to select that proposal which offered the best combination of systems approach and cost.

The Program Implementation Section's recommendation will be reviewed by the Chief of the Financing Operations Division and the Statewide Medi-Cal Intermediary Selection Committee which he chairs. Then it will be reviewed by the Chief of the Health Financing System who will present it to the Director of Health for his review and final selection and announcement.

The following schedule represents events occurring during the process of requesting and evaluating the proposals for a statewide Medi-Cal fiscal intermediary.

December 3, 1973	RFP Released
December 17, 1973	Offerors' Conference
December 28, 1973	Last Date to Protest RFP
January 15, 1974	Last Date to Submit Questions for Guaranteed Answer
February 1, 1974	Delivery of Proposals to the Department
March 15, 1974	Announce Selected Proposal
May 15, 1974	Sign Contract * April 1?
July 1, 1974	Contractor Begins Operation

VALIDATION

VALIDATION

On February 1, 1974, the Department of Health received responses to its Request for Proposal (RFP) from:

1. Medi-Cal Intermediary Operations (MIO)
2. Lone Star Life (LSL)
3. Health Care Systems Administrators (HCSA)

These proposals were validated on February 2 and found to be responsive to the RFP except as noted below.

The following items either were omitted or required clarification or correction:

MIO: Explanation of the phrase "dollarized Claim Volume" (Pages 4 and 5 of their Volume XXI).

Explanation of the use of two methods to allocate costs of institutional claims processing.

- Definition and method of calculation of "imputed interest" (Page 10 of their Volume XXI).

Correction of the volume of claims used in determining the cost of Other Coverage processing. ERRATA Notice Number 5 requires the offeror to bid on the basis of 792,000 claims per year with a total of 4.5 million services; MIO's proposal was based on the costs of processing 980,000 claims.

HAS: Failed to submit a positive statement that they had processed 50,000 health claims per month for six months, including hospital (inpatient and outpatient) and medical (physician) claims.

Failed to submit a list by volume and type of health claims processed for each client and for what period.

Failed to submit a listing of the names, titles, and professional, technical and managerial qualifications of key personnel to be assigned to implementation and operation of the system. In addition, failed to submit an indication of the percentage of time that key individuals would be assigned to the intermediary operation (if assigned less than 100% of the time).

Failed to submit a unit cost for processing claims transferred from previous fiscal intermediary operations (as required by ERRATA Notice Number 4).

HCSA: Failed to submit a unit cost for processing claims transferred from previous fiscal intermediary operations (as required by ERRATA Notice Number 4).

All offerors responded promptly to the requests for additional information and were deemed to have met the requirements for validation.

SUMMARIES OF PROPOSALS

SUMMARIES OF PROPOSALS

HCSA

The Health Care Systems Administrator's (HCSA's) proposed system is currently operational in 2 of the 58 counties, Santa Clara and San Diego, on a prototype basis. Prototype operations began August 1972. The system features extensive computer processing procedures utilizing the Medi-Cal Management System (MMS). HCSA proposes to operate as a general partnership by Occidental Life Insurance Company of California, Pacific Mutual Life Insurance Company, and California-Western States Life Insurance Company. The proposal features a centralized computer site in Los Angeles for the automated review of claims for pricing, medical necessity, and compliance with Title 22 regulations and Department policy. An additional feature is the use of model treatment profiles (MTP's) which applies an automated medical policy criteria by diagnosis to assure medical necessity of the health care services provided the Medi-Cal beneficiary.

HCSA proposes to utilize ten Local Input and Review Centers (LIRC's) which will be located in the major population centers. Professional and clerical review, provider relations, and the receipt and input of claims will be the major function of the LIRC's. The local nature of the LIRC's facilitates contact with providers and the application of local medical standards in professional review.

HCSA also proposed an eligibility system which is currently operational in the prototype counties and will provide for the Medi-Cal card issuance, Federal, State, and county eligibility reporting. The system will also act as an interface with the PHP and Pilot Project programs.

MIO

The Medi-Cal Intermediary Operations' (MIO's) proposed system is currently operational in 56 of the 58 counties. The system is highlighted by a combination of manual and computer processing at three regional sites. Blue Cross North, Blue Cross South, and California Blue Shield, with a liaison office for coordination. The data processing effort is by subcontract with Electronic Data Systems-Federal (EDSF) with a computer center located in San Francisco. Extensive manual and computer editing and auditing is performed on claims to assure appropriate pricing, medical necessity, and compliance with Title 22 regulations and Department policy. MIO utilizes the background and the health care knowledge of the corporate Blue Cross and Blue Shield plans in the development of automated medical policy and utilization control programs.

Professional review is conducted at the regional centers and at the thirteen Foundations which are regional medical societies and are under subcontract to perform peer review activities. Provider relations is handled by staff at the three regional centers and at the Foundations.

LSL

The proposal by LSL, a consortium of Lone Star Life Insurance Company, PAID Prescriptions, and Health Application Systems, provides for a computer processing system which will utilize the Medi-Cal Management System (MMS). LSL proposes to assume the management and operation of the claims processing system now performed by Health Care Systems Administrators, with a few alterations. LSL proposes to utilize automated procedures for appropriate pricing, medical necessity testing, and compliance to Title 22 regulations and Department policy. LSL also proposes to implement the Model Treatment System (MTS) which is similar to the Model Treatment Profile (MTP) application developed by HCSA. The MTS was developed by Health Applications System with Federal funding, and provides for automated claims review for medical necessity and utilization by applying developed treatment patterns in the claims review activity.

LSL proposes a computer site to be located in Burlingame and five Local Input and Review Centers (LIRC's). The LIRC's will be located regionally throughout the State and will provide for claims receipt, input, and review, and provider relations activities. Professional review will utilize the PSRO concept. PSRO's (Professional Standards and Review Organizations) are federally developed systems for Medicaid and Medicare medical review activities in various regional settings throughout the State.

LSL proposes to utilize the existing equipment, facilities, and personnel currently under the HCSA management. LSL also proposes to manage and operate the eligibility system currently operational under HCSA with some modifications.

SUMMARY OF STATE OPTIONS

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Summary of State Options

Offerors were asked to present proposals on the following options in conjunction with their claims processing system:

A. Providing a Beneficiary Explanation of Medi-Cal Benefits (BEOMBs) to beneficiaries.

B. To follow-up on claims containing other coverage to recover funds due the Medi-Cal program.

C. To Review Medically Needy Only and Medically Indigent claims to determine if liability has been satisfied.

D. To issue checks to providers.

E. To provide and maintain an eligibility subsystem.

The State's proposals for options were evaluated using the same criteria and methods applied to the bidders' responses.

The most effective manner to provide the options on which the offerors were asked to present a proposal was selected. This selection took into consideration the effectiveness and cost of each proposal as compared to the effectiveness and cost of the State proposed option. In other words, cost was not the only factor in selecting who would provide each of the options.

If HCSA is the successful offeror, they will perform all the options requested. However, HCSA's costs are also shown with the State providing the eligibility subsystem.

If LSL is the successful offeror, they will provide the check write function and the State will provide the other options.

If MIO is the successful offeror, they will provide the beneficiary explanation of Medi-Cal benefits, other coverage processing, and the check write function. The State will provide the MNO and MI review function and the eligibility subsystem.

[redacted]

SUMMARY OF COMPARATIVE EVALUATION

SUMMARY OF COMPARATIVE EVALUATION

COMPARATIVE EVALUATION

Introduction

On December 3, 1973, the California Department of Health requested proposals for implementation and operation of a statewide Medi-Cal intermediary system which would meet the needs of the Department in the most effective and economical manner. Proposal requirements included the ability to:

Process Medi-Cal claims according to regulations and policies established by the State.

Provide an effective means of detecting potential abuses of the Medi-Cal program.

Obtain appropriate information through production of timely, accurate reports by the fiscal intermediary.

Inform Medi-Cal providers of policies, regulations, and billing procedures; explain fully to providers the disposition of all claims submitted by them for payment.

If the proposer opted to propose eligibility, establish and maintain a centralized eligibility file and issue Medi-Cal identification to beneficiaries.

On February 1, 1974, three proposals were submitted in response to the Department's Request for Proposals (RFP).

A. A proposal from Medi-Cal Intermediary Operations, an organization composed of California Blue Shield, Hospital Service of California (Blue Cross-North), and Hospital

Service of Southern California (Blue Cross-South), based on their current 56-county operation. This proposal was designated MIO.

B. A proposal based on the State-owned Medi-Cal Management System, submitted by Lone Star Life Insurance Company, PAID Prescriptions, and Health Application Systems. This proposal was designated LSL.

C. A proposal based on the State-owned Medi-Cal Management System (MMS) submitted by Health Care Systems Administrators, a general partnership of Pacific Mutual, Occidental, and California-Western States Life Insurance Companies, an organization which currently operates the MMS as a two-county prototype. This proposal was designated HCSA.

The three proposals were found to be responsive to the RFP, and could, with minor modification, meet its minimum requirements. The proposal submitted by LSL, however, was not submitted in sufficient detail in many sections to allow full evaluation and assure adequate performance on a statewide basis.

Both MIO's and HCSA's proposals were judged to be capable of meeting the needs of the Medi-Cal program and the Department of Health. Although MIO's proposal was judged superior to HCSA's in the areas of forms, security, accounting, and professional review, HCSA was rated higher overall, chiefly because of its greater use of computer capability. This capability allows

the Medi-Cal regulations to be applied to all providers accurately and consistently.

	Point Range	MIO		LSL		HCSA (HCSA Eligibility)		HCSA (CID Eligibility)	
		Points Received Out of 100	Converted Points	Points Received Out of 100	Converted Points	Points Received Out of 100	Converted Points	Points Received Out of 100	Converted Points
Offeror's Qualifications	Pass/Fail	Pass	-0-	Pass	-0-	Pass	-0-	Pass	-0-
Implementation	10	72	7.2	22.8	2.28	73	7.3	73	7.3
Change Control	Pass/Fail	Pass	-0-	Pass	-0-	Pass	-0-	Pass	-0-
Claim Review	45	58.8	26.46	37.8	17.01	64.3	28.93	64.3	28.93
Administrative Subsystem	12	62.9	7.64	34	4.08	69.3	8.31	69.3	8.31
Equipment and Facilities	Pass/Fail	Pass	-0-	Pass	-0-	Pass	-0-	Pass	-0-
Communications Between Fiscal Intermediary and State	2	60	1.2	12	.24	68	1.36	68	1.36
Professional Review	20	56	11.2	50	10	40	8.0	40	8.0
Eligibility	8	48.9	3.91	46.5	3.72	77.4	6.19	51.1	4.09
Other Coverage	3	60	1.8	40	1.2	60	1.8	60	1.8
Total	100		59.41		38.53		61.89		59.79

POINT AWARD AND COST SUMMARY

	MIO	LSL	HCSA (As Bid)	HCSA (SOES)
Total Points (Raw Score)	59.41	38.53	61.89	59.79
Total Points (Reference Evaluation Criteria, Page 21)	137,678	1,695	212,747	140,571
Normal Year Costs (In Millions)	$39.4	$34.4	$34.2	$34.3
First Year Costs (In Millions)	$40.9	$48.3	$47.5	$46.7
Four-Year Contract Costs (In Millions)	$159.7	$151.5	$150.1	$149.6