	SOLICITATION AMENDMENT Solicitation No.: **RFP YH14-0001** Amendment No. **1 (One)** Solicitation Due Date: **January 28, 2013** **3:00 PM (Arizona Time)**	**AHCCCS** Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page shall be included with the proposal, which must be received by AHCCCS no later than the Solicitation due date and time.

This solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 27th **day of November, 2012,** in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date**	**Signature** **SIGNED COPY ON FILE**
Typed Name		**Typed Name** Michael Veit
Title		**Title** Contracts and Purchasing Administrator
Name of Company		**Name of Company** AHCCCS

ACUTE/CRS QUESTIONS AND RESPONSES AMENDMENT No. 1 TO RFP YH14-00014

Question #	Section	Paragraph #	Page #	Question	Response
1.				When will the Letter of Intent format be released?	Watch the AHCCCS website for major RFP decisions.
2.				Where can I find information on Duals?	Information can be found on the AHCCCS website; AHCCCS Duals Page: http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx
3.				What is the projected enrollment for next year? Do you anticipate the number to continue to decline?	AHCCCS measures Historical Enrollment numbers. Projection of future enrollment is not posted. Information may be posted to the Bidders' Library.
4.				For entities that have a traditional CMS Institutional Special Needs Plan (I-SNP), could they maintain their patient population that has both Medicare and Medicaid coverage? Or, is the intent of the AHCCCS to move the long-term care residents (SNFs/ALFs) with Medicare-Medicaid status into a current ALTCS-contracted entity?	Under the AHCCCS proposal for the Dual Demonstration, all individuals who have AHCCCS and Medicare whether they are enrolled in a Medicare Advantage plan or Medicare FFS would be passively enrolled into their current ALTCS plan for Medicare in addition to Medicaid. Members will have a choice to opt-out of the Demonstration for Medicare and AHCCCS has proposed that members can opt out to Medicare FFS only. All details of the Demonstration are subject to change and negotiation with CMS until there is a signed Memorandum or Understanding with AHCCCS and CMS. You can find all the details of the AHCCCS proposal here http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx

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5.				Is the Request for the Acute Care program of AHCCCS or is this a new program specific to CRS and Acute Services related to the CRS recipients? If it is a separate program, do you know when information for the Acute Care Program RFP will be posted? Based on the following, LOIs will not be required as part of the Acute Care RFP Process; has this been the case in the past?	Combined RFP to streamline services for our members and avoid members having to navigate multiple separate systems for care. RFP due out November 1, 2013. No LOI will be required as they have been in the past.
6.				Do plans have to be separately incorporated? Can plans be certified by AHCCCS to be a Medicare Special Needs Plan (SNP)? Is it a requirement to go through AHCCCS for certification?	Statute requires that a plan be separately incorporated for purposes of their Medicaid business with AHCCCS. Separately, statute allows AHCCCS plans to be certified through AHCCCS for their Medicare Advantage SNP business instead of licensed through DOI if they choose. This is not a requirement. AHCCCS plan SNPs are also able to receive licensure through DOI for their Medicare business instead of through AHCCCS if they choose. Although the Medicare SNP and Medicaid plans are separately incorporated, plans which offer companion AHCCCS and D-SNP plans that coordinate Medicare and Medicaid for dual eligible members meet AHCCCS requirements. The goal is for dual eligible members to be enrolled with an organization for both Medicare and Medicaid where coverage is coordinated and seamless to the member.

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7.				When is the procurement for the Duals Demonstration?	There will be no separate procurement for the Duals Demonstration. For the ALTCS population, Arizona will use its current ALTCS Contractors. For the Acute population, plan selection will be determined through the upcoming Acute RFP. There will be no separate plans who serve the dual eligible population only, thus to participate in the Duals Demonstration, bidders must bid on the entire Acute Medicaid population in Geographic Service Areas they choose. Additional information can be found on the Acute RFP page: http://www.azahcccs.gov/commercial/Purchasing/RFPInfo.aspx under Presentation/Meeting Materials AHCCCS Duals Page: http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx
8.				If AHCCCS pursues the alternative model and requires that health plans also be D-SNPs, then does that mean health plans will not need to submit documentation to CMS as specified by the CMS Duals Demonstration timeline (e.g., health plans are only required to go through the D-SNP application process)? Are timelines for the Acute Care/CRS RFP still firm despite the delayed MOU sign off from CMS? Under our umbrella of companies we have a business unit that specializes in Medicaid and a Medicare division that has been successful with Medicare Advantage, including the development of D-SNPs. Would it be acceptable for our Medicaid division to own the Medicaid contract with AHCCCS while using the expertise of our affiliated Medicare organization to	If a decision is made that AHCCCS will not be pursuing the Duals Demonstration then yes, plans would not be required to submit Demonstration required information. At this time, AHCCCS is still pursuing the Demonstration so Offerors are required to submit required information for both the Demonstration and D-SNP. See the RFP, Exhibit D, Medicare Requirements, for additional information. The delayed MOU timeframe does not impact the Acute Care/CRS RFP timeline. Yes, this is the situation with most of our current

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				meet the requirements of the Duals Demonstration? If there is a delay in securing approval from CMS of the AHCCCS Duals Demonstration Proposal, should health plans continue to move forward with the CMS 2014 Duals Demonstration data submission requirements? These include the submission of the Notice of Intent to Apply (NOIA) in November 2012 and the Duals Demonstration Application in February 2013. Please provide clarification regarding network requirements if AHCCCS moves forward with its alternative model for the Duals and requires that health plans be a D-SNP. Specifically, if a health plan's D-SNP operates with a narrow network, will the State require the health plan to enlarge the network to meet AHCCCS network requirements as well? Or, can a health plan meet AHCCCS network requirements as part of its Medicaid operations and meet Medicare/Duals requirements under its D-SNP?	health plans. However, we are aware that changes may need to be made in the future if we pursue the Demonstration. We have no further details at this time. Yes, plans should move forward with all Demonstration and D-SNP requirements until AHCCCS notifies otherwise. Health plans will be required to meet AHCCCS network requirements outlined in the RFP. In addition, health plans will be required to meet CMS Medicare network requirements outlined in the Demonstration and/or D-SNP applications.

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9.				I was hoping that we might be able to get some clarification/detail regarding the estimate that AHCCCS receives roughly a few hundred out-of-state claims per year. Specifically, my questions are: Are those few hundred out-of-state claims per year a reflection of only claims that AHCCCS pays direct? Or does it include contractors' out-of-state payments as well (based on encounter types that payors must provide AHCCCS)?	AHCCCS and our Contractors pay for out of state services when the services are emergent and when the medically necessary service was not available in-state. In addition, our contractors have out of state providers in their offered networks to provide services to members that live close to the border when it is closer for them to see a provider out of state than one in-state. We do not have the exact numbers, but would expect that there are far more than a few hundred out of state claims per year when both AHCCCS and the contractors are included.
10.				As we discussed, I would appreciate clarification regarding the "Plan B" option relative to an Acute Bidder being required to submit a Medicare-Medicaid Plan application to CMS for the Demonstration and/or a D-SNP Application to CMS in February 2013. As you are aware, The University of Arizona Health Plans (UAHP) provides management services to Maricopa Health Plan (MHP), which is owned by Maricopa Integrated Health Systems (MIHS). While MIHS is a current AHCCCS contractor, MIHS is no longer a D-SNP contractor with Medicare. Rather, their D-SNP partnership with The University of Arizona Health Plans ended in 2011. At that time, UAHP extended its D-SNP—University Care Advantage--into Maricopa County. Our question then relative to the upcoming AHCCCS RFP/dual demonstration is whether any of the following would fulfill either/both of the above SNP alignment requirements? • MHP to Partner/Align with UCA to supply the D-SNP component in Maricopa County;	Per our Oct 9th Major Decisions document we specify that: All Contractors will be required to serve dual members and to participate with Medicare as either a Dual Eligible Special Needs Plan or CMS Capitated Financial Alignment Demonstration Plan as required by AHCCCS in all GSAs awarded. Additional information about the Medicare requirement will be found in the RFP issued next week.

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				• Enter into a joint venture relationship with an exiting D-SNP, such as UCA; or • Contract directly with CMS as a D-SNP	
11.				I am hoping for your guidance on the following points on behalf of a client that is planning to participate in the RFP. (Apologies if you covered this in last week's presentation—it was hard to hear some of the discussion for phone participants.) 1. Can Medicaid MCOs propose to sub-contract with an MA SNP to satisfy the D-SNP requirement? 2. Are there any limitations on the use of sub-contracting for care coordination?	It is the intention of AHCCCS for the Medicaid MCO to also have a Medicare product – through the CMS Capitated Financial Demonstration or as a D-SNP. See the RFP or other documents for additional details.
12.	General Inquiry			Does AHCCCS intend to adjust hospital rates and/or capitation rates based on readmission scores and/or performance outcomes in 2013 or 2014?	It is possible that hospital rates (using a DRG-methodology effective on or after October 1, 2014) could be adjusted for readmission scores or performance outcomes. It is also possible that capitation rates under this contract could be impacted by a Contractor's performance outcomes – see the discussion regarding Payment Reform – Shared Savings in Section D1, Paragraph 53, Compensation.
13.	Policy 433			What vendor does AHCCCS currently use to produce and distribute member ID cards?	The current AHCCCS Member ID Card Vendor is Custom Card Solutions.
14.	IT Demo			Will AHCCCS be sending any HIPAA transactions (820, 834, 837)? If so, which ones can the bidder expect?	Yes, as outlined in the Bidders' Library, Information Technology (IT) Systems Demonstration, *Provisions* and *Calendar*, it is AHCCCS' intent to develop and make available mock 834, 820 and 837 claims files.

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15.	IT Demo			Will a separate SFTP site be created for the IT demonstration files? If so, how will the bidder gain access to the site?	It is AHCCCS' intent to place and retrieve these files to and from specific secured folders. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Introduction* is amended to add information on these folders. Instructions to gain access to the site are found in the Data Supplement in the Bidders' Library, General, *Instructions to Electronic File Transfer - Secured File Transfer Protocol*.
16.	IT Demo			Will the bidder be required to demonstrate electronic claim attachment functionality?	No, it is not AHCCCS' intent to include electronic attachment based scenarios as a component of this process.
17.	IT Demo			Will the claims being sent be only for the members within the membership files provided by AHCCCS?	Yes, it is AHCCCS' intent to send claims only for those members within the membership files provided by AHCCCS. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Provisions* are amended to clearly reflect this intent
18.	IT Demo			Will the claim be all form types (dental, professional, institutional)?	Yes, the three form types listed are included; however, the pharmacy form type is not included. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Provisions* are amended to clearly reflect this intent.
19.	IT Demo			Should the bidder expect to receive pharmacy claims?	No, it is not AHCCCS' intent to include NCPDP/Pharmacy based scenarios as a component of this process. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Provisions* are amended to clearly reflect this intent.

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20.	IT Demo			For what pharmacies will any pharmacy claims be sent?	It is not AHCCCS' intent to include NCPDP/Pharmacy based scenarios as a component of this process. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Provisions* are amended to clearly reflect this intent.
21.	IT Demo	Provision Document		When can the bidder expect the formats and content for "processing summaries" to be provided by AHCCCS?	Processing summary layouts and required content will be provided as outlined in the IT Systems Demonstration Calendar with each related date provided by AHCCCS. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Calendar* are amended to clearly reflect this intent.
22.	H	Section H: Enrollment Information		When will reports H1, H2 and H3 be available? Will these be posted to the website or the ShareInfo folder? If the latter, can you provide the sub folder these documents will be stored in?	Reports H1, H2, H3 and H4 from the Bidders' Library, Data Supplement for Offerors'-Acute Care/CRS, Section H, *Enrollment Information*, have been available since November 1, 2012. These reports are found on the EFT server, as indicated in the Bidders' Library. See Bidders' Library, Data Supplement for Offerors'-Acute Care/CRS, Section A, *Data Supplement Instructions and Overview* for instructions on where to find data and reports that are posted to the EFT server: The data and reports will be located in a secured folder named Acute Care-CRS-RFP14. Under that folder is a secured folder named Data Supplement Files in which the Offerors will be able to download the data.
23.	IT Demo IT Calendar			The third claims scenario group is to be available to the bidders on 2/6 and the summary is due to AHCCCS on 2/8. The second encounter submission is due to AHCCCS on 2/7. Is the expectation that the second encounter submission include the third claims scenario group?	No, the second encounter submission should not include the third claims scenario group. There is not an encounter submission associated with the third set of claims scenarios.

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24.	N/A	N/A		Does AHCCCS intend to prepare and provide Offerors with template provider agreements?	No, AHCCCS will not be providing templates of provider agreements.
25.				When does AHCCCS intend to publish the Capitation Bid Templates?	The Capitation bid templates were published, along with instructions, on November 19, 2012. See the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section F, Bid Submission Information.
26.				AHCCCS has stated that the bidding entity must have actual and legal authority [over the Medicare plan]. Assume holding Company A (wholly owned by two Arizona corporations) owns two entities: Company B, a legal entity which will be an Offeror and Company C; another separate legal entity that is a licensed health care services organization under Title 20. Companies B and C are sister corporations, each of which is a separate legal entity owned by Company C. Does this organizational structure satisfy the cited requirement?	The question is unclear. The first clause states that Company A owns both Company B and Company C; the last clause of the last sentence states that Company C owns Companies B and C. Second, the question does not clearly state that either Company B or Company C are separate corporations. Third, the question does not identify which business entity holds a Medicare Advantage contract. Based on information provided, we cannot determine whether business organizations comply with A.R.S. §36-2906.01 or whether the hypothetical Offeror has actual and legal authority over the Medicare Advantage plan.
27.	Pending Data Book			If not already included in the pending data book release, please quantify TPL recovery amounts. Also, please include an estimate for copay collection rates (where applicable).	The question is unclear. Does the Offeror mean TPL recovery amounts that are included in adjudicated encounters, or TPL recovery amounts that are self-reported by Contractors? Assuming the Offeror means TPL recovery amounts that are included in adjudicated encounters, such data was not extracted and will not be provided. Copay data is available on 5010 transactions, thus this data only became available beginning with dates of service July 1, 2012. No copay collection rates are available at this time.

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28.	A through B	N/A	100-101	Are bidders required to disclose ownership and managing employee information for subcontractors?	For purposes of the RFP, an Offeror will be considered to be in compliance with Section D1, 62, (A through B) if Offeror submits a completed and accurate Section G, Representations and Certifications of Offerors. Section D1, Paragraph 62, Corporate Compliance Bullet A, pertains to the Disclosure of Ownership and Control of the Contractor. Bullet B, requires the Contractor to obtain the information in 1 through 4 from its subcontracted providers and fiscal agents. Once an Offeror is awarded a contract they must meet these requirements.
29.	D1 and D2	62	101 & 86	The health plans have been having discussions with AHCCCS on the Corporate Compliance Requirements as specified in Paragraph 62. Will there be changes to this paragraph based on the outcome of these discussions?	At this time, the section should be considered amended by removing the requirement to routinely check the a. Social Security Administration DEATH MASTER FILE and b. The National Plan and Provider Enumeration System (NPPES) in the section regarding Disclosure of Information on Persons Convicted of Crimes. Future amendments may be included at a later date.
30.	D1	75	108-109	"AHCCCS also anticipates establishing minimum standards, goals and requirements related to operational areas where improved efficiencies or effectiveness could be achieved." Please provide adjustments applied to the rate ranges (if any) to account for anticipated technology efficiencies.	AHCCCS will not adjust the rate ranges to account for anticipated technological efficiencies.

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31.	D1	75	109	Proposition 204 was not passed. Please provide an estimate of the impact of KidsCare II enrollees transitioning to Medicaid.	AHCCCS' member month projections assumed that Proposition 204 would not pass, thus no revisions to the member month projections are necessary. See the Bidders' Library, Data Supplement for Offerors'- Acute Care/CRS, Section H, Enrollment Information, *Introduction* and *H-3 Enrollment by Month (Historical and Projected)* for more information.
32.	D-2-CRS	3	117	To ensure continuity of care, can existing ALTCS EPD/CRS members be grandfathered into the CRS Fully Integrated Coverage Type on 10/1/13 should they choose to?	No. ALTCS EPD members that have CRS eligible conditions will be fully integrated into their ALTCS EPD Contractor. ALTCS EPD Contractors are encouraged to contract with or authorize services with providers that have been providing services to the member for their CRS covered condition.
33.	D-2-CRS	Covered Services	124	Currently, there are services that have not been covered through CRS such as: ventilator services; chronic or acute infections related to a CRS condition; cancers related to a CRS condition; diapers/toileting items and dialysis. These services are not clearly written as out of scope in the RFP Section D2 or in the AMPM draft for a partially integrated CRS member. Can you confirm that these services will continue to be covered by the member's primary coverage, or will they be carved-in to the CRS capitation?	All covered services <u>related to the member's CRS condition</u> are the responsibility of the CRS Contractor currently and under the RFP.

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34.	D-2-CRS	Performance Measures	148	Currently, the AHCCCS performance measure for Initiation of First CRS Service is within the date specified on the member's ISP or within 90 days of positive CRS eligibility (Att J, CYE13, pg. 22). In the RFP, the Performance Measure is stated as "Initiation of Services (within 30 days)". We interpret this to mean that the initiation of services should be within 30 days of development of the ISP. Please confirm.	No, services for a CRS member will be measured based on an appointment completed within 30 days from the date of enrollment with the CRS Contractor.
35.	Sections E1 and E2 Contract Terms and Conditions	Paragraph #8	199 & 217	Under the Changes paragraph an amendment is deemed accepted 60 days after the date of the mailing by AHCCCS even if the amendment has not been signed by the Contractor. Paragraph 45 Term of Contract and Option to Renew states that an amendment will be deemed accepted 30 days after the mailing date. Which is correct?	Section E1 and Section E2, Paragraph 8, Changes, is amended to state "When AHCCCS issues an amendment to modify the contract, the provisions of such amendment will be deemed to have been accepted 30 days after the date of mailing by AHCCCS, even if the amendment has not been signed by the Contractor, unless within that time the Contractor notifies AHCCCS in writing that it refuses to sign the amendment." This change will appear in a future version of the contract.
36.	Sections E1 &E2	Paragraph 50	207 & 225	Is the "Type of Contract" language correct on page 207?	No, the language has been amended to "Fixed-Price, stated as capitated per member per month, except as otherwise provided." This change will appear in a future version of the contract

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37.	Sections E1 & E2, & Section I, Exhibit B, Minimum Subcontract Provisions	Attachments E-1 & E-2, Paragraph F, and Attachment E-1, Item F. - Subcontractors and Attachment E-2 Item F.- Subcontractors	210, 214, 228, 232 322, 326	Should the Offeror furnish to the State of Arizona separate certificates and endorsements of each subcontractor?	No, Item F. *Subcontractors*, is amended to read, "Contractors' certificate(s) shall include all subcontractors as insureds under its policies **or** upon request, the Contractor shall furnish to the State of Arizona separate certificates and endorsements for each subcontractor upon request." This change will appear in a future version of the contract and the Minimum Subcontract Provisions.
38.	Sections E1 & E2 and Section I, Exhibits, Exhibit B, Minimum Subcontract Provisions	Attachments E-1 & E-2	210, 214, 228, 232, 322, 326	Where should the insurance verifications, for both Offerors and providers, be submitted?	Section E1 & E2 and Minimum Subcontract Provisions are amended to clarify that insurance verifications of the Contractor shall be sent to AHCCCS Contracts Unit, Mail Drop 5700, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034. Additionally, all subcontractors are required to maintain appropriate insurance per the RFP and Minimum Subcontract requirements and to provide verification upon request. These changes will appear in a future version of the contract and the Minimum Subcontract Provisions.
39.	Section G	4,5 & 6	278-282	When completing SECTION G, can responses requiring narrative (for example 4.c - Accessibility Assurance) be attached as a separate document if it is longer than the space provided on the form?	The form boxes expand to include the narrative response as it is typed. No additional pages are necessary.
40.	G	Item 5.b.	280	Please define "subcontractor" as it applies to this question? Does "subcontractor" by definition include a bidding entity's network providers? Please clarify	The definition of a subcontractor is defined in G-1, 42 CFR 455.101 Definitions, pages283-284. Section G, Item 5.b. pertains to the Offeror's ownership or control

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				whether AHCCCS wants the Offeror to submit this information, including social security numbers for all subcontractors (including providers) with submission of the bid.	interest in any subcontractor in which they have direct or indirect ownership of more than 5%. If the Offeror has ownership or controlling interest of 5% or more in a subcontractor then it must submit all the required information including social security numbers.
41.	G	Item 6.b.	281	Please define "disclosing entity" and "Offeror" as both terms apply to this question?	Disclosing entity means any Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent. "Disclosing entity" and "Offeror" are synonymous as they pertain to this question. Refer to Section G, G-1, 42 CFR 455.101 Definitions, pages 283-284.

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42.	H	N/A	287	This section states that all acute care Offerors, if awarded a contract, are required to be organizations that contract with CMS to provide and manage Medicare benefits for dual eligible member. However, this appears to conflict with the Arizona requirements that the AHCCCS Contractor be a separately organized entity whose only business is the AHCCCS contract. Please clarify the required legal relationship between the AHCCCS Contractor and the CMS-contracted entity for dual eligibles.	There is no conflict. A.R.S. 36-2906.01(A) provides that "Entities, including insurers as defined in section 20-104, hospital, medical, dental and optometric service corporations defined in title 20, chapter 4, article 3 and health care services organizations as defined in section 20-1051, are prohibited from contracting with the administration as a system contractor unless the entity establishes an affiliated corporation whose only authorized business is to provide services or coverage pursuant to a contract with the administration to persons defined as eligible in section 36-2901, paragraph 6, subdivisions (a), (f) and (g)." Thus, the legal entity that is an Offeror in response to this RFP can be an entity that contracts with CMS as a Medicare Advantage Special Needs plan and can also establish an affiliated corporation whose only authorized business is to provide Title XIX services pursuant to Title 36, Chapter 29, Article 1 of the Arizona Revised Statutes.
43.	Section H	7	289	How will the scoring be weighted for: • The narrative submissions • The IT demonstration • The Oral Presentations • Capitation Distribution	AHCCCS is not providing the actual weighting of the four components.

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44.	H.7 Acute Scoring	All	290	The proposal states, "The following four components will be evaluated and weighted in the order listed: - Capitation and Program (Program includes Oral presentations) - Access to Care/Network and Organization What is the actual weighting of each of these four components?	AHCCCS is not providing the actual weighting of the four components.
45.	Section H, Number 7. EVALUATION FACTORS AND SELECTION PROCESS	Paragraph 1 "Acute Scoring"	290	Will AHCCCS please describe in more detail how will weights be assigned to the four RFP response sections? For example, if the four sections are weighted in decreasing order: 1) Capitation; 2) Program and oral presentations; 3) Access to Care/Network; 4) Organization, what are the weights assigned to each section, i.e. 30% for Capitation, 25% for Program, etc. Is each question within the four sections weighted equally, if not, how is each question weighted with respect to the section? What weight will the oral presentation receive in comparison to the written responses within the Program section?	AHCCCS is not providing the actual weighting of the four components.
46.	H	7	290	There are four components that will be evaluated and weighted for the Acute care bid. Can AHCCCS describe the scoring methodology and relative weights of the four components?	AHCCCS is not providing the actual weighting of the four components.
47.	H, Acute Scoring	4-5	290	Regarding the Acute Scoring process, please provide the percentages regarding how each of the four scoring components will be weighted. Will they be equally weighted at 25% each or differentially weighted? Or will each of the ten Acute Care questions be weighted 10%?	AHCCCS is not providing the actual weighting of the four components.

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48.	H	9	292	Will a capped Contractor be required to be a Medicare Special Needs Plans (SNP) or participate in the Duals Demonstration? If a capped Contractor wants to participate in the Duals Demonstration, can they?	No, a capped Contractor will not be required to be a Medicare Special Needs Plans (SNP) or participate in the CMS Capitated Financial Alignment Demonstration. Dual eligible members will be disenrolled from the Contractor. Section H, Instructions to Offerors, Paragraph 9, Award of Contract, *Capped Contract Awards* is amended to disenroll dual eligible members from the capped Contractor.
49.	Section H	10	293	At the 11/19 meeting, it was stated that AHCCCS would not assign members to a plan that was unprepared to receive membership yet section H uses a more liberal phrasing of "may not." Please confirm whether the decision to assign to an unprepared contractor is at the discretion of AHCCCS.	The RFP document prevails. Responses given during the Offerors' Conference are not binding. The decision to assign members is at AHCCCS' discretion based on Readiness Reviews.
50.	H	12	294	The current RFP schedule includes only one round of questions after the data book is released and this 2nd and final round is prior to the rate ranges being released. Will AHCCCS consider having another round of questions for any follow up data or rate range questions?	Due to the release of the capitation rates/rate ranges currently anticipated for December 14, 2012, AHCCCS will permit a third set of Technical Assistance and RFP Questions which will be limited to the published capitation rates/rate ranges. AHCCCS will not respond to any other questions. Questions will be due by 3:00 p.m. Arizona time Friday December 21st, 2012. AHCCCS will issue the third RFP amendment on or around January 4th, 2013.
51.	Section H	15	296	Does the offeror need to identify Section G as proprietary or will AHCCCS automatically deem it proprietary?	AHCCCS has automatically deemed Section G, Representations and Certifications of Offeror, as proprietary.
52.	Section H	15	296	Can offeror logos be included on the page outside of the ½" margin?	Yes, the Offeror's logo can be included in the margins.

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53.	Section H	Number 16. SUBMISSION REQUIREMENTS, E. Narrative Submission	296	This section provides that responses to each submission requirement must be limited to five pages and permitted attachments. Can AHCCCS confirm that no attachments are permitted to the Narrative submissions outlined in Section H, Number 16. SUBMISSION REQUIREMENTS, E. Narrative Submission?	No attachments are permissible unless specifically noted. There are no Narrative Submission Requirements outlined in Section H, Instructions to Offerors, which allow attachments.
54.	H	15	296	AHCCCS will only consider the information provided within the allotted page limit and permitted attachments. What are the permitted attachments?	No attachments are permissible unless specifically noted.
55.	H-15	3	296	The instruction states: "Unless otherwise specified, responses to each submission requirement must be limited to five (5) 81/2" x 11" one sided, single spaced, type written pages". Narrative Submissions in section E are not identified as separate submission requirements. Is each "narrative submission" subject to a 5 page minimum (for a total of 45 page minimum for the 9 questions) or is the combined submission subject to the 5 page minimum?	Each individual submission requirement is preceded by a number (e.g. 1.) and each number is limited to five pages, unless otherwise noted. There are 10 narrative submissions for Acute Care plus 5 additional for CRS.
56.	H.	15. Contents of Proposal, 16. Submission Requirements, and E. Narrative Submissions	296 and 305	Please provide clarification regarding page limits for each response section. This RFP section states, "Unless otherwise specified, responses to each submission requirement must be limited to five (5) 8½" x 11" one sided, single spaced, type written pages." In Section E. Narrative Submission, AHCCCS asks for responses to several sub-questions in each section. Does the five page limit apply to each sub-question, i.e. Access to Care/Network number 1-five page maximum, number 2, five page maximum, etc. or does the five page limit apply to the overall major section?	Each individual submission requirement is preceded by a number (e.g. 1.) and each number is limited to five pages, unless otherwise noted. There are 10 narrative submissions for Acute Care plus 5 additional for CRS.

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57.	Section H	15	296	Is the Offeror required to include the question from the RFP in the response, or is it acceptable to reference the question number from the RFP without repeating the question in the proposal?	The Offeror is not required to include the question from the RFP in the response; however, the response must clearly identify which question is being answered.
58.	Section H	15	297	Can the page numbering fall within the ½" margin?	Yes, the page numbering can be included in the margins.
59.	H	5	297	Use of contingent language such as "exploring" or "taking under consideration" will not be given any weight during the scoring evaluation process. Narrative submission # 7 asks the bidder to describe any initiatives it will pursue to deal with waste and would pursue to improve quality. How should the bidder present future driven initiatives that will be favorably scored?	AHCCCS will not provide suggestions on how to write a proposal that will be favorably scored.
60.	H-15 and I-A	15 A	297 and 311	In Section H-15 it states that "each section shall begin with a table of contents" In Section I-A: Offeror's Checklist, opening paragraph it states the "Offeror's Checklist must be submitted with the proposal and shall be the first pages in the binder". Given that the table of contents is required to begin each section, is the table of contents to not be included in the sequential page numbering?	Yes, the Table of Contents for each section must be included in the sequential page numbering. The Offeror's Checklist (Exhibit A) must be submitted as the first pages in the binder and only appears at the start of the binder. The Table of Contents, however, accompanies each section and shall be sequentially numbered

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61.	B	All	3	Should the bid amount include the cost of paying PCPs 100% of Medicare allowable in 2013/2014?	No, the capitation bid should not include the cost increase necessary to pay PCPs 100% of the Medicare rates. The Bidders' Library, Section B of the Data Supplement for Offerors – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.
62.	H.	16. Submission Requirements, B. Attestation, Access to Care, number 28.	301	This section states, " A comprehensive network that complies with all Acute Care network sufficiency standards as outlined in RFP YH14-0001 and ACOM Draft Policy, Acute Network Standards, no later than August 1, 2013 RFP, Section D, Paragraph 27, Network Development." In addition to this attestation and the narrative description described in Section E.1 and 2, does AHCCCS expect the bidder to submit additional documentation relative to its network build out with the bid submittal? i.e. Do bidders have to submit a list of actual contracts and/or LOIs by network area as outlined in the RFP?	No additional documentation related to the Offeror's network build out, including LOIs, is required with the proposal.
63.	H	16	302	Can you please list what is included in the administrative fee limit of 8%? For example, is care management, health insurer fees, etc. included in this amount?	Funding for all administrative functions is included in the administrative fee limit. This includes non-encountered functions like care management. The Health Insurer Fee should **not** be included in the administrative component. This Fee will be handled outside the administrative component, similar to the

Question #	Section	Paragraph #	Page #	Question	Response
					Premium Tax.
64.	Section H	16-C	302/303	AHCCCS indicates that bids submitted with a medical component outside of the published range will receive zero points (page 302). AHCCCS indicates it will publish an actuarially sound rate range equivalent to the bottom half of the rate ranges from the minimum to the midpoint (page 303). Does this mean that a bid that is above the dollar value of the stated/published midpoint but yet still within the rate range will receive a score of 0?	Yes, a capitation bid outside (above or below) the **published** rate range will receive a score of 0.
65.	H	16	303	When the rate ranges are released, please indicate if any adjustments were made to account for generic launches. If so, please provide the adjustments applied.	AHCCCS did not make any adjustments for generic launches.
66.	Section H	E. Narrative Submissions	305	When responding to Section E or other sections requesting Offeror experience, is it acceptable for an Offeror to include information related to the experience its Management Services Subcontractor and its affiliate companies have owning and administering health plans, provided that the State prior approves the Management Services Subcontractor in advance?	Yes, this would be acceptable if the Offeror clearly identifies which organization's experience they are presenting.
67.	H	16	305	The additional 180,000 to 430,000 new members eligible for Medicaid will likely have pent-up demand. Does AHCCCS anticipate adjusting the rate ranges for this pent-up demand? If so, please provide the adjustments applied.	AHCCCS will not adjust the rate ranges for assumptions like pent-up demand.
68.	H	16	305	This may be addressed in the yet unreleased risk adjustment information but given the overall Medicaid population is expected to increase significantly (additional 180,000 to 430,000 new members eligible), how does AHCCCS anticipate risk adjusting for these	Information on risk adjustment is now available in the Bidders' Library, Data Supplement for Offerors'- Acute Care/CRS, Section I, Risk Adjustment Information.

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				members? Will their risk scores be based on demographics only?	
69.	H	16E	305-309	AHCCCS does not appear to be differentiating bidders based on their approaches to meeting contract requirements, but is using "value-adds" to distinguish among bidders. What types of "value-adds" are of most importance or how will AHCCCS consider them?	AHCCCS will not provide suggestions on how to write a proposal that will be favorably scored.
70.	H-16-E	6	307	Narrative Submission 6 states in part "….Describe processes that will be utilized to enhance and maximize care coordination and improve member experience for members being served for both Medicare and Medicaid services by the Offeror and for members who will only be served for Medicaid by the Offeror…." Does the last section of this sentence (underlined) refer to dual members who are in the Offeror's Medicaid plan and another entities Medicare plan or utilizing Medicare FFS?	Yes, the underlined section refers to a Contractor's members that are dual (Medicare and Medicaid) that are enrolled with the Contractor for Medicaid but another entity for their Medicare benefits.
71.	H-16-E	5	307	Narrative submission #5. In the response to this case scenario, is it acceptable to add information to fill in the gaps of why and how certain circumstances came about and then use that information as the basis for parts of the response.	AHCCCS will not provide suggestions on how to write a proposal that will be favorably scored.
72.	H	Question 6	307	Assume Arizona Corp A and Arizona Corp B own (50/50 interest each) in Corp C, which is a holding company that owns the Offeror (Arizona Entity D). Is the Offeror in this question inclusive of the experiences of C as well as of A and B and any subcontractor that provides operational support to the Offeror; such as utilization management?	The Offeror may provide experience for Corp A, Corp B Corp C and entity D. The Offeror must specify which entity's experience they are describing when providing the narrative response.

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73.	H	E – Narrative Submissions	307	Submission 6 states, "What strategies will be used to increase and maintain aligned Medicaid and Medicare enrollment" Can we assume that the question mark was left off and that this is the end of this submission requirement.	Submission requirement number six is complete and has been amended to include a question mark at the end of the sentence. The amended sentence reads as follows: "What strategies will be used to increase and maintain aligned Medicaid and Medicare enrollment?"
74.	H	16	307-308	Each Offeror must "provide specific initiatives and efforts… [they] will pursue to deal with 'waste' that exists within the existing system and improves outcomes." Is AHCCCS planning on adjusting the rate ranges to account for such initiatives? If so, please provide the assumptions/adjustments used.	AHCCCS will not adjust the rate ranges for initiatives the Offeror will describe in its Proposal.
75.	H	E	307-308	Since the RFP states that there will be no points awarded for future strategies, how will your Narrative questions that are specifically soliciting future strategies be addressed/scored?	The RFP does not state that there will be no points awarded for future strategies. Future strategies will indeed be scored; however, use of contingent language such as 'exploring' or 'taking under consideration' will not be given any weight during the scoring evaluation process. Furthermore, the Offeror will be held to initiatives and strategies presented in their proposal.
76.	H	E. Narrative Submissions (Question 10)	308	Where are the user guides and manuals located, mentioned on page 308?	User Guides and Manuals are located in the Bidders' Library, under the heading *Current Reporting Guides and Manuals*.
77.	H	E. Narrative Submissions (Question 10)	308	For existing SFTP access- Will the mock files/data for the scenarios be housed in the State's current SFTP site or will there be a different access point or requirement?	It is AHCCCS' intent to place and retrieve these files to and from specific secured folders. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Introduction* is amended to add information on these folders. Instructions to gain access to the site are found in the Data Supplement in the Bidders' Library, General, *Instructions to Electronic File Transfer - Secured File Transfer Protocol*.

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78.	Section H	16-E	309	At the 11/19 meeting, it was stated that an offeror's subcontractor could participate in the oral presentations. Will AHCCCS require any specific documentation supporting that the individual is employed by a subcontractor as opposed to being a consultant?	No specific documentation will be required beyond the resumes of the staff participating in the oral presentation. AHCCCS reserves the right to request additional documentation.
79.	H.	15. Contents of Proposal and E. Oral Presentations	309	AHCCCS states the following relative to the Oral Presentation: "The Offeror shall bring no more than six individuals to the meeting. All participants must be employees of the Offeror; no consultants may participate." If the Offeror plans to subcontract several of these functions, is it permissible to bring personnel who will be administering these operations who are not employees of the offeror to the Oral Presentation?	Yes, staff as you have described would be allowed to participate in the Oral Presentation. However, refer to D1 and D2, ¶16, Staff Requirements and Support Services and ¶37, Subcontracts for specific staffing/subcontract Contract Requirements.
80.	Section H	Number 16. SUBMISSIO N REQUIREME NTS, E. Oral Presentations Paragraph 3	310	This section provides that the offeror may not be permitted to bring laptops, tablets or any prepared handouts to the Oral presentations, but will be able to utilize hard copy material "including copies of policies and procedures as they prepare for the presentation." Can AHCCCS confirm that bidders may bring prepared background material for their own use, in addition to copies of policies and procedures?	The Offeror may bring prepared background material, policies and procedures to assist in preparing for the oral presentation. These materials will not be provided to or utilized by AHCCCS in the scoring process.
81.	H	Instructions to Offerors	312	The Instructions require the Bid Response to be in Times New Roman, 11 point font. Should the Capitation Bid Template also be in Times New Roman, 11 point font? How do we address page numbers as required by the Checklist?	No. The Capitation Bid Template is already formatted. Page numbers for the template and the Certification will have to be added manually.

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82.	Section I	Exhibit B – Minimum Subcontract Provisions – Attachment E-1	320	A reference to a new attachment E-1 was added to the insurance section within the minimum subcontract provisions (#17). Please explain the general purpose of this new attachment specifically, the requirement on page 321 for policies to be endorsed to include the additional language of: *"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor*". What actions, if any, does AHCCCS anticipate to be required by the provider and/or contractor to meet the requirement? Please address both existing contracts and newly contracted providers.	This requirement applies to all awarded contracts under this RFP. It is the responsibility of the Contractor (MCO) to ensure that each of its subcontractors (providers) are in compliance with the applicable insurance requirements as described in the contract, in addition to holding the State and its officers harmless. Each subcontractor shall have appropriate liability insurance and workman's compensation coverage as evidenced by an insurance certificate which should be sent to the Contractor and compliance shall be monitored by the Contractor.
83.	I	Exhibit C, Item #10	329	"Change Control" can have many different meanings. In the context of this attestation, how does AHCCCS define "change control" as well any parameters regarding "change control"?	Change control is defined as a systematic approach to managing all changes made to a system, the purpose of which is to ensure that no unnecessary changes are made, that all changes are documented, that services are not unnecessarily disrupted and that resources are used efficiently.

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84.	Section I, Exhibit D	General	333	The Offeror is required to pursue its Medicare bid through a dual process: the normal bid process and the Demo bid process. What role will AHCCCS play in the CMS bid approval process, and how will AHCCCS validate or verify the Offeror's CMS application?	Under the Medicare Advantage SNP application process, AHCCCS will work with CMS when possible, but ultimate authority of approval is done by CMS. AHCCCS will work with CMS to verify submissions. Under the CMS Capitated Financial Alignment Demonstration, there is no bid process as there is in the Medicare Advantage process. Offerors are required to submit an Application to CMS in February as well as additional CMS required documents. AHCCCS will work with CMS to verify and review these documents.
85.	Section I, Exhibit D	General	333	Since the Offeror will be submitting its Network through the HSD table process with CMS, what is the timeline and process that AHCCCS will be using to evaluate the adequacy of the Offeror's Medicare Network?	Under the CMS Capitated Financial Alignment Demonstration process, AHCCCS will work with CMS, to evaluate the Offeror's Medicare network.
86.	Section D1	10	38	With regard to CRS eligibility – section D1 states that an acute plan would refer a member for CRS through notification to AHCCCS Division of Member Services but members are determined eligible by the CRS contractor. The 11/19 presentation, slide 106, stated that AHCCCS would determine medical eligibility for the CRS program. Which is accurate?	Section D1, Paragraph 10, Scope of Services, page 38 is amended to clarify that the Contractor is responsible for care of members until those members are determined eligible by AHCCCS, Division of Members Services. This change will appear in a future version of Section D of the contract.
87.	Section D1 and D2	16	50 and 135	Paragraph 16 states that Contractor shall "employ" certain Key Personnel. May the Contractor also arrange for the provision of these personnel through a Contractor's Management Services Subcontractor provided that the State prior approves the Management Services Subcontractor in advance?	Yes, the Key Personnel requirements may be fulfilled through a management services agreement subject to prior approval by AHCCCS.

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88.	D.1.	Paragraph 5	51	Please define "multiple lines of business." For example, may a Key Staff member, such as the Dispute and Appeal Manager position, serve the bidding entity's affiliated entities depending upon work load?	AHCCCS considers multiple lines of business as a company/corporation/ organization that provides healthcare coverage under several product lines, among several markets, or multiple contracts. For example a company/ corporation/organization that provides Medicaid services in Arizona, New Mexico and Utah and also operates a commercial business and/or Medicare product. The Dispute and Appeals Manager could serve the Offeror's affiliated entities, as long as all staffing requirements are met.
89.	D.1.	Paragraph 6, Key Staff Positions	51	Must each of the key staff positions be employees or can the bidder use contractors to fill these roles? Can the Contractor use employees of a parent company or affiliated company to fill these roles? Can these individuals share more than one role, either within the Contractor or between related entities?	Yes, the Key Staff positions must be employees of the Offeror, or contracted/employed under an administrative service subcontract, as outlined in Section D1, Paragraph 37 Subcontracts. Yes, under Section D1, Paragraph 37, Subcontracts of the RFP administrative services subcontracts includes all Service Level Agreements with any Division or Subsidiary of a corporate parent owner. However, all staffing requirements outlined in Section D1, Paragraph 16, Staff Requirements and Support Services must be met. Yes, an individual can occupy a maximum of two of the Key Staff Positions.

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90.	H, Key Staff Positions and Corporate Compliance	N/A	51 and 99	Regarding Page 51, item "Key Staff Positions" and page 99, item "Corporate Compliance;" If the Corporate Compliance Officer can be shared with a related organization as indicated on page 51, please explain the requirement that the Compliance Officer must be "onsite" per page 99. Does "onsite" refer to part of the time, all of the time; presence in Arizona or presence in the office location of the contractor?	The Corporate Compliance Officer can be shared with a related organization; however, this position must be physically located in Arizona to conduct business during business hours.
91.	Section D1 and D2	Paragraph 23	59 and 144	RFP states: "The contractor must ensure that the QM/PI unit within the org structure is separate & distinct from any other units of departments such as Medical Management or Case Management...." "QM/QI Positions performing work functions related to the contract mush have a direct reporting relationship to the CMO and the local CEO...." **Question**: Is State requiring the contractor to have two separate QM/PI units within the organization - 1 unit that is specific to Acute and 1 unit that is specific to CRS? Or is it permissible to have one QM/PI unit that supports both Acute and CRS Quality Management & Performance Improvement?	It is permissible to have one QM/PI unit that supports both Acute and CRS. Key staff members are limited in the number of key staff positions they may hold (see Section D1 and D2, Paragraph 16, Staff Requirements and Support Services.)

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92.	Section D1	Paragraph 23, QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI),	61	When does AHCCCS anticipate releasing the "next generation" of quality performance measures?	The next generation of Performance Measures has been included in the RFP. AHCCCS will continue to monitor CMS quality measure expectations, review the availability of additional data sources such as Health Information Exchange, Electronic Health Records, etc. and consider implementing additional measures from the CMS measure sets based on penetration and use of these technologies within Arizona health care systems in future contract years.
93.	Section D1	23	62-64	When does AHCCCS expect to develop or release more specifics on the new Performance Measure methodologies and how it established or will establish Minimum Performance Standards for some of them?	Performance Measures were selected from NCQA HEDIS measure sets and from the CMS measure sets being established for CHIPRA, Well Child, Adult, Dual, and LTC. The methodologies are publically available on the measure set developers' websites and through links on the CMS website. For those Performance Measures listed with a TBD for the Minimum Performance Standard (MPS), national Medicaid rate data is not currently available. AHCCCS will utilize national Medicaid rate data should it become available. If not available, AHCCCS will establish the MPS based on a stated CMS goal or where data is already available to the Agency, AHCCCS will analyze historical encounter data as part of the rate determination.
94.	D1	23	62-64	Please provide performance measures by GSA and risk group for the base period as well as the most current measurement period.	AHCCCS will not provide additional data related to performance measures by GSA or risk group. Offerors may reference the Performance Measure results published on the AHCCCS website.

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95.	Section D1	23	64	For those performance measures that are in a TBD status, what time period does AHCCCS anticipate using for the baseline data?	Data from the first six months of operation of CYE 2014 will be reviewed to determine the appropriate Minimum Performance Standards and Goals. In instances where data is already available to the Agency, AHCCCS will analyze historical encounter data as part of the rate determination.
96.	D.1	27. Network Development	69	The RFP states, "The Contractor must pay all AHCCCS registered Arizona Early Intervention Program (AzEIP) providers, regardless of their contract status with the Contractor, when Individual Family Service Plans identify and meet the requirement for medically necessary EPSDT covered services." Please provide a listing of the AzEIP providers or advise where it can be obtained.	Arizona Early Intervention Program (AzEIP) provider (vendor) information is available on the Department of Economic Security, Arizona Early Intervention website.
97.	D.1	27. Network Development	69	The RFP states, "Homeless Clinics: Contractors in Maricopa and Pima County must contract with homeless clinics at the AHCCCS Fee-for-Service rate for Primary Care services." Please provide a listing of the Homeless Clinics in Maricopa County.	AHCCCS will provide a list of Homeless Clinics in Maricopa and Pima County upon award of the contract.
98.	D.1.	Homeless Clinics, Item Number 2.	69	What is the definition of "needed specialty services?" Does this requirement apply when such services are available in-network?	Contractors must utilize in-state, contracted network providers. If the needed specialty services are not available in-network, the Contractor must make the services available through an out-of-network provider. In Section D1, Paragraph 27, Network Development, "needed specialty services" refers to services considered outside of standard medical-surgical services because of the specialized knowledge required for service delivery and management.

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99.	Section C, Definitions	Day – Business/ working	8	Is the word "day" left out of the first sentence?	Yes, the definition is amended to read "A business day means a Monday, Tuesday…". This change will appear in a future version of the contract.
100.	D1	42	82	Will the data book include amounts for physician incentive payments (assuming such programs existed)?	The Data Books include expenditures by category of service, including several for physician services. If physician incentive payments were incorporated in adjudicated encounter data, then such payments are included.
101.	D.1	43. Management Services Agreement and Cost Allocation Plan	83	The RFP states, "If a Contractor has subcontracted for management services, the management service agreement must be approved in advance by AHCCCS, Division of Health Care Management." Does AHCCCS expect a new contractor to submit the management services agreement with its proposal?	Administrative services contracts will not be submitted with proposals. Once awards are made, any Administrative Services Agreements meeting the criteria in D1, ¶ 37 Subcontracts, pages 76 will be submitted for approval.
102.	D1	50-Financial Viability	86	This paragraph references ACOM Draft Policy 305. Is this the correct Policy reference? Should this be Policy 313?	Both ACOM Draft Policy 305 and ACOM Policy 313 should be included. D1 is amended to include ACOM Policy 313 in Paragraph 50, Financial Viability Standards. This change will appear in a future version of Section D of the contract.
103.	D1	51	86	Regarding the separate incorporation requirement, will the establishment of a limited liability corporation satisfy the separate corporation requirement?	No, a limited liability company is not a corporation. A.R.S. §36-2906.01 requires the establishment of an "affiliated corporation."
104.	D.1.	51. Separate Incorporation	86	The RFP states that, "Contractor shall establish a separate corporation for the purposes of this contract." Please clarify whether the requirement permits a bidder to establish a separate entity that is a limited liability company (LLC) rather than a corporation.	No, a limited liability company is not a corporation. A.R.S. §36-2906.01 requires the establishment of an "affiliated corporation."

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105.	Section D1 and D2	51	86 and 172	Paragraph 51 states: "Within 120 days contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract." Would the State consider adding "or other contracts with CMS, AHCCCS, and/or another State regulatory agency," to accommodate a plan offering multiple programs (e.g., ALTCS, Medicare, etc.) through AHCCCS and/or CMS?	AHCCCS will add "or other contracts with AHCCCS" at the end of this sentence. The statute does not allow the addition of CMS or another State regulatory agency. Section D1 and D2, Paragraph 51, Separate Incorporation, are amended to include this additional language. This change will appear in a future version of Section D of the contract.
106.	D.1. and H		86, 302	*Administrative Expense Limits:* We note an apparent conflict between RFP Sections D.1. and H regarding the issue of limitation on administrative expenses. Section D.1. page 86: "Administrative Cost Percentage = Total administrative expenses divided by the sum of total PPC and prospective capitation + Delivery Supplement + All Reconciliation Settlements + Reinsurance less premium tax. Standard: No greater than 10%." Section H page 302: "Acute Care Program Capitation Bid Submission; item #2 – Offerors will submit an administrative component PMPM bid for each risk group by GSA. The administrative component is limited to a maximum of 8%. The administrative component percentage shall be calculated as: Administration/Gross Medical Component. Capitation bids submitted with an administrative component exceeding 8% will earn an administrative component score of zero points." Does this mean that the standard for actual	There is no conflict. There is one methodology to compute the administrative expense standard, and at this time AHCCCS allows a Contractor to report up to 10% according to the formula contained in D1, paragraph 50, Financial Viability Standards. Despite this, it is correct that an Offeror with an administrative component bid exceeding 8% according to the formula provided in Section H, Instructions to Offerors, Paragraph 16.C. will receive a score of zero points. Premium Tax is not considered an administrative expense; however, because it is included in the capitation paid, it is subtracted in the denominator according to the formula contained in D1, Paragraph 50, Financial Viability Standards. Premium Tax should not be included in the administrative component bid.

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				administrative expenses is 10% of total revenue, but that if a carrier bids more than 8%, they score zero points on the administrative component of the bid score? In addition, when determining the measure of administrative expense is premium tax considered part of administrative expense or is it not considered part of administrative expense?	
107.	Section D1	50	86/86	Excluding the equity per member requirement, will AHCCCS consider an MA plan certified by AHCCCS out of compliance if the ratios for the contractor's Medicare line of business fall outside of the guidelines listed for the acute care ratios?	No, AHCCCS will not apply the AHCCCS Acute Care standards to the financial viability ratios for the Contractor's Medicare line of business. AHCCCS will review the ratios included in D1, Paragraph 50, Financial Viability Standards but will only consider the Contractor out of compliance for the standards explicitly described for the Medicare Advantage Plan Certified by AHCCCS.
108.	Section D1	Paragraph 53, COMPENSATION,	87	Which national episodic/diagnostic risk adjustment model does AHCCCS use to establish prospective capitation rates?	AHCCCS has used the Optum (formerly Ingenix) Symmetry Episode Risk Groups (ERG) tool. More information on risk adjustment is now available in the Bidders' Library, Data Supplement, Section I, *Risk Adjustment Information*.

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109.	D.1.	53, Question 1.	87, 2nd paragraph under Compensation.	"AHCCCS provides the following data to its actuaries for the purposes of rebasing and/or updating the capitation rates... d. AHCCCS fee-for-service schedule pricing adjustments…" In its range of capitation rates expected to be released on December 14, 2012, has AHCCCS taken into account the recently released CMS ruling that Medicaid PCP reimbursement would be increased to at least the same as Medicare? If not, will there be an adjustment to capitation rates for this at a later date? Should carriers assume an increase in the PCP reimbursement from prior experience to account for this increase?	No, the rate ranges provided will not consider PCP rate parity. Additionally, the capitation bid should not include the cost increase necessary to pay PCPs 100% of the Medicare rates. Section B of the Data Supplement for Offerors – Acute Care/CRS, includes a Program and Fee Schedule Changes document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.
110.	D.1.	53, Question 2.	87, 2nd to last paragraph under Compensation.	The second to last paragraph notes, "In instances in which AHCCCS has specialty contracts of legislation/policy limits the allowable reimbursement for certain services or pharmaceuticals, the amount to be used in the capitation rate setting process and reconciliations will be the lesser of the contracted/mandated amount or the Contractor paid amount." Do bidders have information on all specialty contracts and all legislation/policy limits AHCCCS has so we may create a bid which appropriately reflects these limits? If bidders do not, when will they become available?	AHCCCS did not provide Offerors with information on specialty contracts or legislation/policy limits, but intends to provide such information prior to the start date of the contract. The encounter data in the Data Books is reflective of Contractors' costs for related services and is the base data for the AHCCCS rates and/or rate ranges.

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111.	D.1.	53, Compensation - Payment Reform – Shared Savings	88, 2nd to last paragraph.	The second to last paragraph states, "AHCCCS anticipates that capitation rates will be reduced by a withhold of no less than 1% in CYE14, 100% of which will be paid to one or more Contractors according to relative Contractor performance." Is this program an incentive program for Contractors who do the right thing based on what AHCCCS wants them to do? Or is this an incentive arrangement for Contractors to pass on to providers? Does AHCCCS assume that additional revenue to Contractors will be based on innovative arrangements between the Contractor payer and the providers, with this payment meant to be shared with providers of the awarded Contractor?	AHCCCS is currently developing the payment reform policy with the intent to drive innovative arrangements that will further enhance cost control and result in quality improvements, while also offering providers incentive to participate in these arrangements. AHCCCS will release the policy no later than six months prior to the start date of the contract.
112.	D1	57- Reinsurance	91	Why is the Reinsurance language different between D1 and D2 (p. 178)? The language regarding Catastrophic Reinsurance case notification states that the Contractor must notify Medical Management Unit of cases identified 'within 30 days of initial diagnosis and/or enrollment with the Contractor, and annually within 30 days of the beginning of each contract year,' but D1 language refers to the Chart of Deliverables.	The Chart of Deliverables referenced in D1, Acute Care Program Requirements, ¶57 Reinsurance, contains the same notification requirements as the language in D2, CRS Program Requirements, ¶57 Reinsurance. D1, ¶57 is amended to include the notification information and to delete the reference to the Chart of Deliverables. This change will appear in a future version of Section D of the contract. Notification/reporting requirements for both Programs are the same.

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113.	D.1.	58, Coordination of Benefits/Third Party Liability	96, Retroactive Recoveries, Paragraphs 1 and 2.	Paragraphs 1 and 2 state, "The Contractor shall engage in retroactive third party recovery efforts for members for which a claim was paid, for up to two years from the date of service…After two years from the service date, AHCCCS will direct recovery efforts…Any recoveries obtained by AHCCCS through its recovery efforts will be retained exclusively by AHCCCS…The total recovery period…is limited to three years after the date of service…" We understand there currently is a three year retroactive recovery period. Does this section change the current period from a full Contractor recovery period of 3 years to only 2 years, and then AHCCCS gets the value of recoveries in the third year? This issue will be important to understand as we develop our medical expense bid.	Yes, current policy (ACOM Policy 412, Claims Reprocessing) permits Contractors to engage in retroactive third party recovery for three years after the date of service. Effective October 1, 2013, in accordance with Section D1, Paragraph 58, Coordination of Benefits/Third Party Liability and ACOM Draft Policy, Coordination of Benefits/Third Party Liability, the Contractor is required to engage in retroactive third party recovery for up to two years from the date of service.
114.	Exhibit D-Medicare Requirements	General Question	n/a	General Question about CMS/DOI regulatory oversight going forward. If a Plan currently has a DOI reporting relation for Medicare, with the dual integration proposal, will AHCCCS take over the oversight (i.e. NAIC DOI financial reporting requirements)?	No, AHCCCS does not intend to take over the oversight of the NAIC DOI financial reporting requirements or any other DOI requirements.
115.	D.1 Attachment B.1. Deliverables	37. Subcontracts Administrative Services subcontracts	pp. 75-76 and 252	The RFP states, "All subcontracts entered into by the Contractor are subject to prior review and written approval by AHCCCS, Division of Health Care Management, and shall incorporate by reference the applicable terms and conditions of this contract. The following types of Administrative Services subcontracts shall be submitted to AHCCCS, Division of Health Care Management for prior approval as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. Administrative Services Subcontracts: 1. Delegated agreements that subcontract;	Administrative services contracts will not be submitted with proposals. Once awards are made, any administrative services contracts meeting the criteria in D1, ¶ 37 Subcontracts, page 76 will be submitted for approval. The Chart of Deliverables requires Administrative Service Agreements to be submitted to AHCCCS for approval 60 days prior to the start date of the Agreement.

Question #	Section	Paragraph #	Page #	Question	Response
				a. Any function related to the management of the contract with AHCCCS, b. Claims processing, including pharmacy claims, c. Credentialing including those for only primary source verification (CVO). 2. All Management Service Agreements; 3. All Service Level Agreements with any Division or Subsidiary of a corporate parent owner." Does AHCCCS expect a new contractor to submit any administrative services subcontracts, i.e. Medical Management, Quality Assurance, etc. with the proposal or are these to be submitted after contract award for AHCCCS prior approval? The chart of deliverables is not clear regarding this requirement for new contractors (page 252).	
116.	IT Systems Demonstration Provision and Calendar	6TH Bullet under provisions and 4th Row Under Calendar AHCCCS to Offeror	Provisions and Calendar	Will initial and subsequent claims scenarios include retail pharmacy drug (NCPDP) claims? The calendar suggests only paper and electronic 837 claims. Retail pharmacy drug claims are processed and adjudicated via point of sale by pharmacy benefit manager. It would be administratively burdensome to process and adjudicate retail pharmacy drug test claims manually for the IT Systems Demonstration.	No, it is not AHCCCS' intent to include NCPDP/Pharmacy based scenarios as a component of this process. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Provisions* are amended to clearly reflect this intent.

Question #	Section	Paragraph #	Page #	Question	Response
117.	IT Systems Demonstration Provision and Calendar	8TH Bullet under provisions and 5th Row Under Calendar AHCCCS to Offeror	Provisions and Calendar	Trading partner set-ups and interface systems are often idiosyncratic for each trading partner. Currently we do not exchange 270/271 and 276/277 transactions with AHCCCS. Are we allowed to test with AHCCCS prior to the IT Systems Demonstration start date? If so, would that include testing with Transaction Insight?	No, the Offeror will not perform any testing with AHCCCS prior to the IT Demonstration start date. It is not AHCCCS intent that Offerors develop a process to exchange 270/271 or 276/277 transactions with AHCCCS. Offerors may exchange this data utilizing an automated system or a manual process. The intent of these demonstrations is to mimic key data exchanges related to eligibility and claims status inquiries that would occur between the Offeror and a provider or clearinghouse.