SOLICITATION AMENDMENT #1		
YH19-0001 AHCCCS Complete Care	Solicitation Due Date: **January 25, 2018** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: ICRFPYH19_Questions@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

This Solicitation is amended as follows:

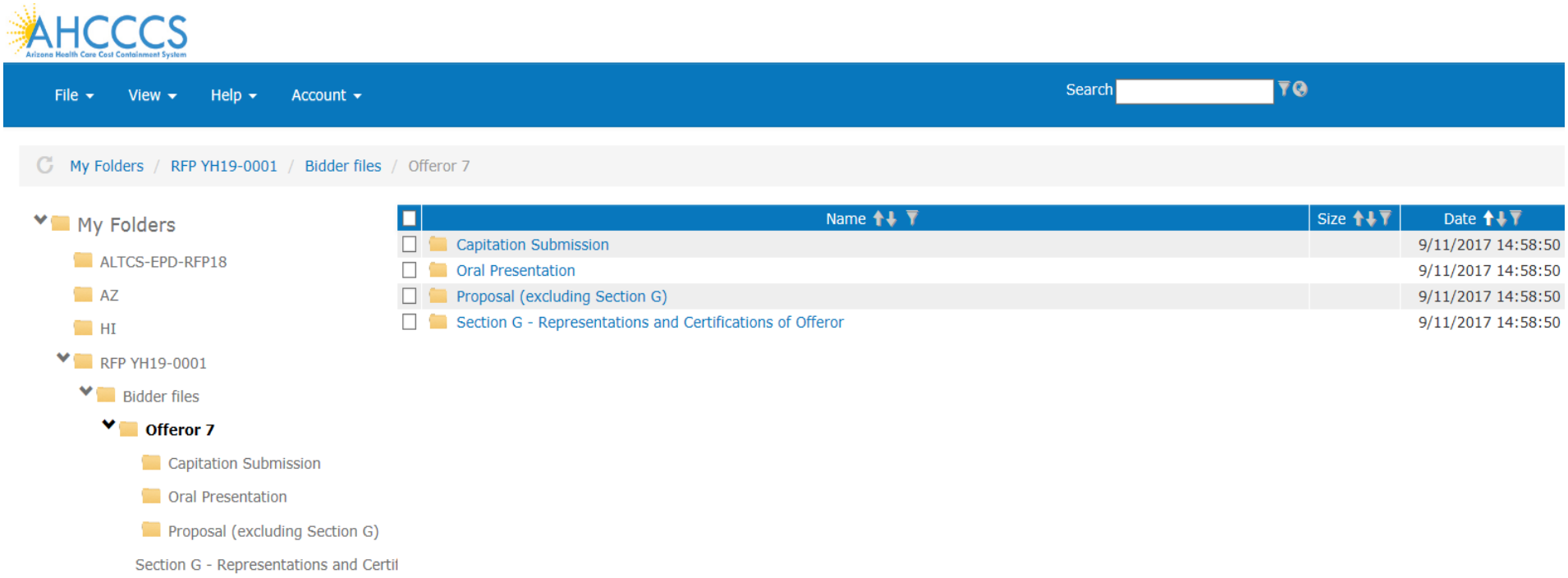
1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME:	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE:	TITLE: Chief Procurement Officer
DATE:	DATE:

AHCCCS COMPLETE CARE CONTRACTOR RFP YH19-0001 CLARIFICATIONS

1. Page 292-293 of the RFP, Section H, Instructions to Offerors, is amended as shown below:

Upon upload of the Offeror's Bid to the SFTP, the Offeror shall email notification to the Procurement Officer listed in RFP Section A, Solicitation and Offer Page. The Offeror shall include a screen print to depict the file name(s), date and time of **ALL** document(s) within each folder uploaded to the SFTP. The time stamp will display in Greenwich Mean Time (GMT). AHCCCS will provide email notification to the Offeror upon receipt of a document to the SFTP folders noted above when received within normal business hours (8am to 5pm Arizona Time). When received outside of normal business hours, email notification will be provided to the Offeror the next business day. Notification will be provided to the contact person provided on the Offeror's Proposal, Section A, Solicitation and Offer Page. The notification shall serve *only* as confirmation that a document from the Offeror was received to the SFTP. The email notification from AHCCCS does not confirm whether or not the document conforms to the material elements of the submission requirement(s) or whether or not the Offeror's Proposal qualifies as responsive.



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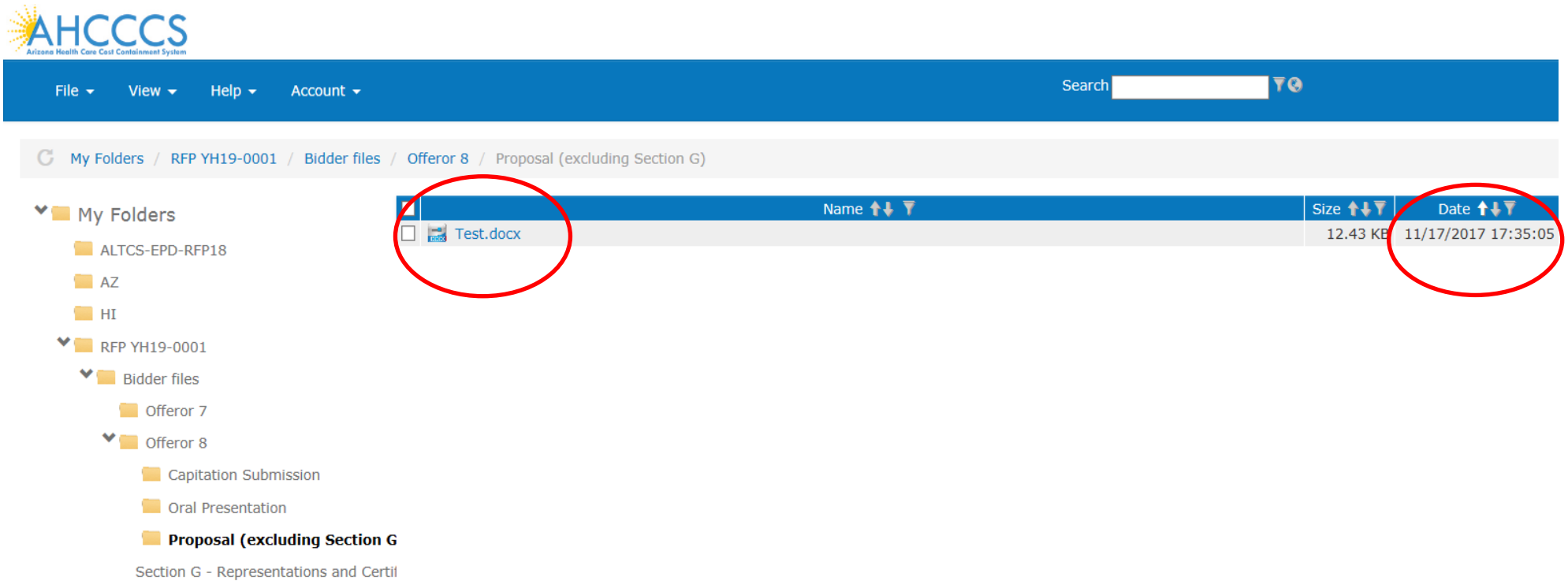

AHCCCS COMPLETE CARE CONTRACTOR RFP YH19-0001 CLARIFICATIONS

2. Page 285 of the RFP, Section H, Instructions to Offerors, is amended as shown below:

AHCCCS reserves the right to determine the number of AHCCCS Complete Care Contractor Contracts to be awarded in any GSA/Pima County; however, AHCCCS anticipates awarding Contracts as follows:

GSA and Corresponding Counties	Awards
North GSA Mohave/Coconino/Apache/Navajo/Yavapai ~~(excluding zip codes 85542, 85192, and 85550)~~	2
South GSA Cochise/Graham/Greenlee/ La Paz/Pima/Santa Cruz/Yuma (including zip codes 85542, 85192, and 85550)	Entire GSA - 2 At least 1 additional Award in Pima County Only
Central GSA Maricopa/Gila/Pinal (excluding zip codes 85542, 85192, and 85550)	At least 4

Additional zip code exceptions may be considered to allow for further alignment with certain tribal lands.

3. Page 261 of the RFP, Section F, Attachment F3, Contractor Chart of Deliverables is amended as shown below:

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM OPERATIONS	Annually	Value-Based Providers/Centers of Excellence Attachment to Provider Network Development and Management Plan	~~December 31st~~ 45 days after the start of the Contract year	Section D	Paragraph 72	ACOM Policy 415	DHCM Network Administrator	SharePoint

AHCCCS COMPLETE CARE CONTRACTOR RFP YH19-0001 CLARIFICATIONS

4. Page 86 of the RFP, Section D, Paragraph 11, Behavioral Health Service Delivery, is amended as shown below:

Step Therapy: The Contractor may implement step therapy for behavioral health medications used for treating anxiety, depression and ADHD disorders. The Contractor shall provide education and training for providers regarding the concept of step therapy. If the behavioral health provider provides documentation to the Contractor that step therapy has already been completed for the conditions of anxiety, depression or ADHD, or that step therapy is medically contraindicated, the Contractor shall continue to provide the medication at the dosage at which the member has been stabilized by the behavioral health provider. In the event the PCP identifies a change in the member's condition, the PCP may utilize step therapy until the member is stabilized for the condition of anxiety, depression or ADHD. The Contractor shall monitor PCPs to ensure that they prescribe medication at the dosage at which the member has been stabilized.

Medication-Assisted Treatment (MAT): The Contractor shall reimburse PCPs who are providing medication management of opioid use disorder (OUD) within their scope of practice. The PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the medication assisted treatment (MAT) model and coordinate care with the behavioral health provider. The Contractor shall include the AHCCCS preferred drugs on the Contractor's drug list for the treatment of OUD.

5. Page 61 of the RFP, Section D, Paragraph 9, Scope of Services, is amended as shown below:

In accordance with 42 CFR 438.3(e)(2)(i) through (iii), the Contractor may provide services in alternative inpatient settings that are licensed by ADHS/DLS, in lieu of services in an inpatient hospital. ~~These alternative settings must be cost effective compared to non-IMD inpatient settings.~~

6. AHCCCS clarifies that members enrolled with DES/DDD and who have a qualifying CRS Condition and who are also determined to have a Serious Mental Illness (SMI) will remain enrolled with DES/DDD for both physical and behavioral health services and will not be transitioned to a RBHA effective 10-1-18.

AHCCCS COMPLETE CARE CONTRACTOR RFP YH19-0001 QUESTIONS AND RESPONSES TEMPLATE						
	DATE SUBMITTED	**RFP SECTION**	**PARAGRAPH No.**	**PAGE No.**	**OFFEROR'S QUESTION**	**AHCCCS RESPONSE**
1.	11/14/17	Section H: **RFP states:** *"The capitation rates developed by the AHCCCS actuaries will be actuarially sound according to the applicable provisions of 42 CFR Part 438 and applicable Actuarial Standards of Practice, and will follow generally accepted actuarial principles and practices."*	19. Submission Requirements Capitation-Non Benefit Costs Bid Submission	294	As referenced in Capitation- Non Benefit Costs Bid Submission, **42 CFR 438.4 paragraph 2.3 of Actuarial Standard of practice (Number 1) states:** *Actuarial Soundness—The phrase "actuarial soundness" has different meanings in different contexts and might be dictated or imposed by an outside entity. In rendering actuarial services, if the actuary identifies the process or result as "actuarially sound," the actuary should define the meaning of "actuarially sound" in that context.* **In addition, Paragraph 2.1 of Actuarial Standard of Practice No. 49 states**: *Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs.* ***Question relating to this:*** Can AHCCCS confirm that this is the definition of "actuarially sound" it intends to use?	AHCCCS intends to use the definition of actuarial soundness from the applicable provisions of 42 CFR Part 438.
2.	11/14/17	Section H: **RFP states:** *"The capitation rates developed by the AHCCCS actuaries will be actuarially sound*	19. Submission Requirements Capitation-Non Benefit	294	As referenced in Capitation- Non Benefit Costs Bid Submission, p**aragraph 2.1 of Actuarial Standard of Practice No. 49 states**: "*Medicaid capitation rates are "actuarially sound" if, for business for*	There have been various publications by CMS and other organizations on what attainable costs are. Please refer to the following links:

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		according to the applicable provisions of 42 CFR Part 438 and applicable Actuarial Standards of Practice, and will follow generally accepted actuarial principles and practices."	Costs Bid Submission		*which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs."* **Question relating to this:** How will AHCCCS determine what "attainable" costs are?	August 2005 Health Practice Council Practice Note on Actuarial Certification of Rates for Medicaid Managed Care Programs developed by the Medicaid Rate Certification Work Group of the American Academy of Actuaries https://www.actuary.org/files/publications/Practice_Note_Actuarial_Certification_Rates_for_Medicaid_Managed_Care_Programs_aug2005.pdf Actuarial Standard of Practice 49, Medicaid Managed Care Capitation Rate Development and Certification from March 2015 http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, A Rule by the Centers for Medicare & Medicaid Services on 05/06/2016 https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

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3.	11/14/17	Section H: **RFP states:** *"The capitation rates developed by the AHCCCS actuaries will be actuarially sound according to the applicable provisions of 42 CFR Part 438 and applicable Actuarial Standards of Practice, and will follow generally accepted actuarial principles and practices."*	19. Submission Requirements Capitation- Non Benefit Costs Bid Submission	294	As referenced in Capitation- Non Benefit Costs Bid Submission, will this determination vary among different AHCCCS health plans, or will it be uniform across all plans?	The determination of actuarial soundness for the capitation rate is at the rate cell level by MCO.
4.	11/14/17	Section H: **RFP states:** *"The capitation rates developed by the AHCCCS actuaries will be actuarially sound according to the applicable provisions of 42 CFR Part 438 and applicable Actuarial Standards of Practice, and will follow generally accepted actuarial principles and practices."*	19. Submission Requirements : Capitation- Non Benefit Costs Bid Submission	294	As referenced in Capitation- Non Benefit Costs Bid Submission, what process will AHCCCS use to allow the health plans to review, comment on, and provide input into the AHCCCS actuaries' capitation rate development?	Per the Rate Development Documentation located in the Section F of the Data Supplement, "It is AHCCCS' intention to provide preliminary capitation rates in July 2018 that would include the non-diagnostic based population risk adjustment based off of initial member assignment." Successful Offerors should provide comments at that time.

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5.	11/14/2017	Section D: **RFP states:** *"Access to Behavioral Health Services: Member may self-refer to a behavior health provider, or be referred by providers. Contractor shall be responsible for meeting the appointment standards found in Section D, Paragraph 33, Appointment Standards."* **Section D, Page 83-84 states:** "*Mental Health Parity: The Contractor shall submit documentation which demonstrates compliance with mental health parity as promulgated under 42 CFR Part 438 and as directed by AHCCCS."*	Contractor Responsibilities: Access to Behavioral Health Services	84	Given that members may self-refer, members may choose non-contracted providers who are not in the Offeror's contracted network. Please clarify whether the appointment availability requirements apply to only the Offeror's contracted network or whether the appointment availability requirements also apply to non-contracted providers that member's may self-refer to in the overall pool of behavioral health providers?	The requirements described in this paragraph apply to the Contractor's contracted network. Note: RFP Page 84, Paragraph 11, Behavioral Health Service Delivery, is amended as shown below: ***Access to Behavioral Health Services***: Members may self–refer to a behavioral health provider, or be referred by providers, schools, State agencies, or other parties. The Contractor shall be responsible for meeting the appointment standards found in Section D, Paragraph ~~33~~32, Appointment Standards.
6.	11/14/17	Section C, Definitions	Part 1 -Service Plan (pg 26) Part 2- Treatment Plan (pg 38)	26 & 38	Requesting clarification on the terms "individual service plan" and "treatment plan," are these terms being used interchangeably or are these terms seen as unique and separate documents?	The terms treatment plan and individual service plan are used interchangeably.

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7.	11/14/17	Section C, Definitions	Part 1 -Service Plan (pg 26) Part 2- Treatment Plan (pg 38)	26 & 38	Is AHCCCS' intention for the "Service Plan" to now be referenced as the "Individual Recovery Plan?" Under the definitions section, "Individual Recovery Plan" is listed with parenthetical reference to it being formerly known as the "Individual Service Plan." The definition says see "Service Plan." Please clarify if these are interchangeable. Does AHCCCS have a preference as to which term is used?	Although different terminology may be used throughout the RFP and policy, Individual Recovery Plan, Treatment Plan and Individual Service Plan can be used interchangeably. AHCCCS does not have a preference.
8.	11/14/17	Section I: Exhibits	Exhibit C, Narrative Submission Requirements , Question 1	302	For question one: If an Arizona Medicaid contractor also acted as an administrator for a separate Arizona Medicaid contractor, can that administrator activity also be included in the offeror's Arizona Medicaid contracts experience or would that be considered a separate Medicaid contract?	The Offeror can include the administrator activity for the separate Arizona Medicaid Contractor with the Offeror's Arizona Medicaid contract experience as a single contract.
9.	11/14/17	Section I: Exhibits	Exhibit C, Narrative Submission Requirements Question 1	302	For question one, please clarify whether the offeror's Arizona Medicaid contracts includes the offeror's Arizona D-SNP Medicare advantage contract experience	The Arizona Medicaid contract does not include the Offeror's Arizona D-SNP Medicare Advantage contract.
10.	11/14/17	Data Supplement for Offerors	Section F - Rate Development Information/Non-Benefit Costs Bid Requirement	1	Additional direction is needed with regard to the fixed component of the administrative bid for plans bidding more than one GSA. Should plans reflect 100% of their fixed costs for each GSA or should they follow a different method? Please provide an example to	An amended Non-Benefit Costs Bid Submission workbook has been provided. Additional tabs have been added as noted below. The non-benefit costs bids for the tabs labeled North, South and Central should be

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					illustrate the preferred method.	developed under the assumption that the Offeror will win that specific GSA and no other. Thus each individual GSA non-benefit costs bid stands alone. The tabs labeled North-South, North-Central, and Central-South have been added. The non-benefit costs bids for the combined GSAs should be developed under the assumption that the Offeror will win that GSA combination and no other. Page 294-295 of the RFP, Section H, Instructions to Offerors, is amended as shown below: "The Offeror will bid the administrative and underwriting gain portions of the non-benefit component of the capitation rates. The Offeror will include an administrative rate for each GSA for which the Offeror is submitting a bid. The Offeror will also include an administrative rate for each GSA combination: North-South, North-Central, and/or Central-South (as applicable to the Offeror). The Offeror will bid an underwriting gain greater than zero and less than or equal to one percent of the gross medical component for each GSA for which the Offeror is submitting a bid, for each of the first three years of the contract. The Offeror will also include an underwriting gain for each GSA

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						combination: North-South, North-Central, and/or Central-South (as applicable to the Offeror). See the updated documents in the Bidders' Library, Data Supplement for Offerors, Section F, Rate Development Information that have been revised: Non-Benefit Costs Bid Requirements document and the Non-Benefit Costs Bid Submission workbook.
11.	11/14/17	Data Supplement for Offerors	Section F - Rate Development Information/Non-Benefit Costs Bid Requirement	2	The documentation states that "The adjusted administrative PMPM will then be distributed to the risk group level by AHCCCS." What methodology will be used to distribute the administrative PMPM by risk group?	AHCCCS will distribute the adjusted administrative PMPM by developing benefit cost relativities based on projected member costs by risk group. These benefit cost relativities will then be multiplied by the total administrative PMPM. Every risk group will have the same fixed administrative PMPM. The variable administrative PMPM will be equal to the difference between the total administrative PMPM and the fixed administrative PMPM by risk group.
12.	11/14/17	Data Supplement for Offerors	Section F - Rate Development Information/Non-Benefit Costs Bid Requirement	2	Will the variable administrative bid rate for each GSA by risk group be calculated using 1) A single set of relative cost ratios, or 2) Contractor specific relative cost ratios?	The variable administrative bid rate for each GSA by risk group will be calculated using Contractor specific relative cost ratios.

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13.	11/14/17	Data Supplement for Offerors	Section F - Rate Development Information/Non-Benefit Costs Bid Requirement	2	Underwriting gain is to be bid on as a percent of the gross medical component for each GSA for each of the first three years. Will the medical component be available to the offeror before the final submission of the proposal is due?	No, the medical component will not be available to the Offerors before the final submission of the proposal is due.
14.	11/14/17	Data Supplement for Offerors	Section F - Rate Development Information/Non-Benefit Costs Bid Requirement	2	The documentation states that "…AHCCCS may adjust the non-benefit cost components of the capitation rates in future years in order to maintain compliance with the Medicaid Managed Care Rules and Rate Setting Guidelines." We have reviewed the rate setting guidelines and don't see anything about trend/inflation adjustments for non-benefit costs. Will AHCCCS consider an adjustment of this type? This has greater relevance than in the past due to the extended length of the overall contract term.	AHCCCS will not speculate as to the nature of any such adjustments.
15.	11/14/17	Section D	1 - Purpose and Applicability	40	On Page 39 of the RFP, Section D.1, it states that the Complete Care Contractor shall be responsible for the provision of *integrated care addressing physical health and behavioral health needs* for various populations. Among the list of populations are "Members determined to have SMI who opt to transfer to the Contractor for the provision of *physical health services* as outlined in ACOM Policy 442." These	ACC Contractors will only be responsible for physical health services for members with SMI who opt out of the RBHA consistent with ACOM Policy 442. Page 39 of RFP, Section D, Paragraph 1, Purpose, Applicability and Introduction is amended as shown below: The purpose of the Contract between AHCCCS and the Contractor is to implement and operate the AHCCCS Complete Care

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					two sentences appear to contradict themselves. Will the Complete Care Contractors be responsible for the provision of ***both*** physical health and behavioral health services for members determined to have SMI who opt to transfer from the RHBA to a Complete Care Contractor or will the Complete Care Contractor only be responsible for physical health services for these members?	Program pursuant to A.R.S. §36-2901 et seq. The AHCCCS Complete Care Contractor (Contractor) shall be responsible for the provision of integrated care addressing physical health and behavioral health needs for the following Title XIX/XXI populations: 1. Adults who are not determined to have a Serious Mental Illness excluding DES/DDD enrolled members, 2. Children, including those with special health care needs; excluding DES/DDD and DCS/CMDP enrolled members, and ~~3. Members determined to have SMI who opt to transfer to the Contractor for the provision of physical health services as outlined in ACOM Policy 442.~~ The Contractor shall be responsible for the provision of physical health services for members determined to have SMI who opt to transfer to the Contractor as outlined in ACOM Policy 442.

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16.	11/14/17	Section D	1 - Purpose and Applicability	40	If the Contractor will be responsible for *integrated physical and behavioral health services* for members determined to have SMI who opt to transfer to the Contractor, will the contractor be required to follow the same staffing ratios as outlined for these members today in the RHBA contracts? Also, can AHCCCS estimate the number of opt-outs expected for each Complete Care Contractor?	ACC Contractors will only be responsible for physical health services for members with SMI who opt out of the RBHA consistent with ACOM Policy 442.
17.	11/14/17	Section D	8 – Covered Services	62	How will AHCCCS notify the plans of new members with CRS qualifying conditions? Will the original CRS ID number be present in the 834? Is the requirement to accept the original CRS ID number for transition purposes only or do plans need to continue to be able to house the original CRS ID in the system for extended period of time?	Contractors will receive a corresponding CRS segment on the 834. Post 10/1/2018, CRS ID numbers will no longer be assigned, however historical CRS ID numbers will be maintained in PMMIS as alternate IDs. Currently alternative IDs, including CRS IDs, are included on the 834. In order for the ACC Contractor to comply with the requirements outlined in RFP Page 62, Paragraph 9: Scope of Services, the Contractor is expected to maintain the original CRS ID for claims processing purposes. This applies for the term of the Contract.
18.	11/14/17	Section D	11- Behavioral Health Service Delivery	79	Is the designated Behavioral Health Professional referenced in item #5 a member of the MCO's staff such as a BH care manager	The designated Behavioral Health Professional is not a member of the MCO's staff. Refer to A.A.C. R9-10-101 for definition of Behavioral Health Professional.

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19.	11/14/17	Section D	6 – Centers for Excellence	83	The RFP includes a requirement that Contractors contract with Centers of Excellence that implement evidence based practices and track outcomes for children with specialized healthcare needs. Is there a specific date when these contract are required to be in place?	No date is being provided at this time; however, AHCCCS would expect contracts to be in place by the end of the first contract year. The Offeror is required to submit a deliverable with the Provider Network Development and Management Plan as described in RFP Section D, Paragraph 72, Value-Based Purchasing addressing contracts or contract status with Centers of Excellence.
20.	11/14/17	Prospective Offerors' Conference Power Point	Technical Interface Meeting Discu ssion	101	What is the earliest date that AHCCCS anticipates the implementation of Multiple Line Encounter Submissions?	AHCCCS is targeting implementation by the first quarter of calendar year 2019. This date will be further discussed with the Technical Consortium which includes the Contractors and AHCCCS staff.
21.	11/14/17	Prospective Offerors' Conference Power Point	Technical Interface Meeting	116	If AHCCCS excludes NCPDP claims/encounters due to additional complexities with the PBM vendor, will AHCCCS consider excluding dental claims/encounters due to similar complexities with the dental vendor?	Dental claims/encounters will be included in the IT Demonstration. Dental differs from pharmacy in that the dental benefit package differs for adults and children. AHCCCS intends to test the ability to apply benefit rules.
22.	11/14/17	Section D	50 – Compensatio n	158	With the change in the risk groups, does AHCCCS anticipate changing rate codes or will it just be a remapping of the existing rate codes?	AHCCCS does not anticipate changing or adding new rate codes but will be remapping the existing rate codes.

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23.	11/14/17	Section D and Prospective Offerors' Conference Power Point	50 – Compensation	158	Will there also be a notification for SMI members who elect to receive care from an ACC contractor versus a RBHA contractor? Also, will there be an indicator present in the 834?	Placement of an indicator for non-Integrated SMI members is still under evaluation. It will either be placed on the 834 if it can be accommodated in a compliant manner or on the existing Unique Eligibility Population file. Note that the only option for a member who is determined SMI to receive care from an ACC Contractor is via a formal "opt-out" of the RBHA contractor. This activity occurs infrequently
24.	11/14/17	Section D	50 - Compensation	165	For purposes of calculating the amount of community reinvestment, may the Contractor include the cost of activities it undertakes to benefit the community (by way of example only, literacy classes) in addition to any cash contributions it may make to community organizations?	The Contractor may include the cost of activities it undertakes to benefit the community, provided that those activities are not covered by Medicaid. AHCCCS does not specify the mechanisms for dispersing the Community Reinvestment funds; nor does AHCCCS stipulate how the funds should be directed except to say that the funds should benefit the local community.

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25.	11/14/17	Section D	53 – Reinsurance	168	We sincerely appreciate the change to include PPC in reinsurance. We request that AHCCCS also take under consideration contract year splits that currently exclude a claim from reinsurance. We realize that AHCCCS makes every effort to account for these in the reinsurance offsets but there are material claims that are infrequent enough that they would not be taken into consideration in the offset. In addition, claims that span contract years are split for recons. What is the rationale for treating reinsurance differently? In lieu of a system change, we believe that there are ways to accommodate this change that would place the majority of the obligation on the plan versus AHCCCS.	Reinsurance cases do not include encounters that span contract years due to system limitations. However, since claims which cross contract years are not eligible for reinsurance, they are also not included in the reinsurance offset. Rather, these specific encounter costs will be included in the capitation rates without an offset. AHCCCS would be happy to engage in conversations with Successful Offerors regarding other opportunities prior to CYE 19.
26.	11/14/17	Section H	8 – RBHA Contractor Option…	280	What is the timeframe for RBHA contractors to elect the option to become a RBHA/ACC contractor?	RBHA Contractors will be notified of this process and timeframe which will occur immediately after ACC Contract award. AHCCCS anticipates election decisions to be made by mid-March 2018.
27.	11/14/17	Section H	10 – Evaluation Factors and Selection Process	283	Does AHCCCS intend to publish the weighting of scoring between the non-benefit costs and the narrative submission requirements in advance of the bid submission? If so, when?	AHCCCS will not be publishing the scoring weights.

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28.	11/14/17	Section H	11 – Readiness Review	283	Will AHCCCS please consider providing the specific month for the IT Demo prior to the end of the year so plans can lock in resources?	AHCCCS intends to conduct the IT Demo during May or June 2018. A more specific month is not available at this time. AHCCCS has reviewed the timeline for the IT Demonstration and has determined that the demo will exceed 30 days. Successful Offerors should plan for at least 5-6 weeks to complete the IT Demonstration. Page 283 of the RFP, Section H, Instructions to Offerors, is amended as shown below: AHCCCS intends to incorporate an Information Technology (IT) demonstration, in May or June 2018, as part of the readiness review where Successful Offerors will be required to participate in the IT demonstration utilizing mock data running through PMMIS. The IT demonstration will take five to six weeks to complete and will encompass a ~~30 day~~ minimum of a 45 day cycle in order to incorporate a full month of PMMIS activity. The IT demonstration will be scored solely for the purpose of use in the auto-assignment algorithm effective October 1, 2018.
29.	11/14/17	Section H	11 – Readiness Review	283	As part of the full month of PMMIS activity, will the 30 day cycle for the IT Demo include Reinsurance, the Magic File and Blind Spot Data?	AHCCCS will not be providing details about the IT Demo at this time.

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30.	11/14/17	Section H	12 – Award of Contract	285	Will any additional awards in Pima County and Maricopa County beyond the minimum number of awards stated for each GSA on page 285, Section H of the RFP, be available to an ACC contractor or only limited to RHBA contractors electing to expand their services?	Additional awards in Pima County and the Central GSA may include awards to ACC Contractors regardless of the, RBHAs electing to expand services.
31.	11/14/17	H.18	7	293	Will the contents of Section G be automatically accorded confidential treatment or does the Offeror need to formally request it? If so, where in the proposal should the request be provided?	RFP Section G, Certifications of Offeror and Disclosure Information Template, is considered confidential information without any request from the Offeror.
32.	11/14/17	H.19	8	294	Offerors are required to submit with the proposal an agreement signed by the CEO to accept the rates computed by AHCCCS prior to October 1, 2018. Offerors are not able to evaluate rates before they know what they are. Please confirm that this requirement is related to the timing of the response. In other words, the agreement will indicate that the Offeror will evaluate and either accept or reject the computed rates prior to October 1, 2018.	The CEO is signing this agreement to acknowledge that it is understood that AHCCCS will compute actuarially-sound rates, and that rates will not be negotiated.

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33.	11/14/17	Section H	19 – Submission Requirements	294	In light of the communication at the Prospective Offerors' Conference that the medical rates will not be published until after contract awards, is AHCCCS going to publish any additional guidance related to non-benefit expenses in order to provide the plans a reference point similar to the upper and lower bounds provided for the CY14 RFP?	No, AHCCCS does not plan to publish medical rates or ranges.
34.	11/14/17	Section H	19 – Submission Requirements	295	When does AHCCCS anticipate receiving direction from CMS regarding the ability to bid/not bid the underwriting component?	AHCCCS has had multiple communications with CMS over the past several months with regard to capitation bidding and is hopeful this will be resolved in the next couple months.
35.	11/14/17	G.5.a	Disclosure Template	N/A	Please confirm that Column J (related to another person with ownership or control interest) applies only to natural persons. In other words a parent company is not "related to" its subsidiary for purposes of Column J.	Confirming that Column J applies to natural persons.

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36.	11/14/17	D: Program Requirements	3. Member Choice of Contractor	45	Will integrated contractors be responsible for physical health only (and the RBHA responsible for BH only) in the case of members who are determined to have a serious mental illness who opt out and transfer from the RBHA to an AHCCCS Complete Care Contractor as consistent with ACOM Policy 442. In the prospective offerors' conference on Nov. 8, 2017, slide 32 where it states that the MCOs will be responsible for the provision of integrated care addressing physical and behavioral health needs for the following populations: Adults determined SMI that opt out of a RBHA.	ACC Contractors will only be responsible for physical health services for members with SMI who opt out of the RBHA consistent with ACOM Policy 442. ACC Contractors will only be responsible for physical health services for members with SMI who opt out of the RBHA consistent with ACOM Policy 442. Page 39 of RFP, Section D, Paragraph 1, Purpose, Applicability and Introduction is amended as shown below: The purpose of the Contract between AHCCCS and the Contractor is to implement and operate the AHCCCS Complete Care Program pursuant to A.R.S. §36-2901 et seq. The AHCCCS Complete Care Contractor (Contractor) shall be responsible for the provision of integrated care addressing physical health and behavioral health needs for the following Title XIX/XXI populations: 1. Adults who are not determined to have a Serious Mental Illness excluding DES/DDD enrolled members, 2. Children, including those with special health care needs; excluding DES/DDD and DCS/CMDP enrolled members, and 3. ~~Members determined to have SMI who opt to transfer to the Contractor for the provision of physical health services as outlined in ACOM Policy 442.~~

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						The Contractor shall be responsible for the provision of physical health services for members determined to have SMI who opt to transfer to the Contractor as outlined in ACOM Policy 442.
37.	11/14/17	D Program Requirements	71	199	Will the incoming Complete Care plan be required to submit demographic information post 10/1/2018 like the RBHAs will continue to do so?	As the RFP describes, this issue is pending and AHCCCS is in the process of paring down the required data set elements as well as determining what services, providers, and Contractors the DUG will apply. In order to make informed decisions, AHCCCS is obtaining stakeholder feedback regarding continued required use of DUG reporting through a request for information.
38.	11/14/17	D Program Requirements	71	199	Will the incoming Complete Care plan receive historic demographics from the previous RBHA for transitioning members?	Yes, AHCCCS will provide RBHA demographic information to incoming Complete Care Contractors.
39.	11/14/17	H	Table 1	285	Please clarify zip code exclusions 85550, 85542, 85192—listed zip codes are excluded from the North GSA, but are Pinal/Gila County zip codes.	The Major Decision posting and the Instructions to Offerors were incorrect. Zip codes 85550, 85542 and 85192 are all in Gila County and are excluded from the Central GSA and included in the South GSA for the ACC Contract.

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40.	11/14/17	D	4	89	Paragraph states that "The Contractor is not responsible for payment of BH services provided to American Indian members by an IHS or 638 tribal facility, even if the member is enrolled with the Contractor." And in Section D, Scope of Services (page 57, Paragraph 4), it states "The Contractor is responsible for reimbursement (including physical and BH services) to IHS or tribal facilities for services provided to Title XXI American Indian members enrolled with the Contractor. Please clarify if the first statement refers only to Title XIX members.	The first statement, found on page 89, Section D, Paragraph 11, refers only to Title XIX members as stated on page 57.
41.	11/14/17	D	5	57	Clarify the definition of an "Indian Health Care Provider" if this provider type does NOT include Indian Health Service and 638 tribal facilities (as stated in this paragraph)	Indian Health Care Provider includes Urban Indian Health Programs only. Refer to the AHCCCS website for a list of Urban Indian Health Programs https://www.azahcccs.gov/AmericanIndians/AmericanIndianHealthFacilities/ITUsList.html
42.	11/14/17	D	50	159	Under "Reconciliation of Costs to Reimbursement," it states that the reconciliation will apply to prospective and PPC medical costs and capitations. Are delivery supplemental payments included in the reconciliation?	Yes, delivery supplemental payments are included in the reconciliation.

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43.	11/14/17	D	50	159	Under "Reconciliation of Costs to Reimbursement," what is included in and excluded from medical cost expenses and total net capitation paid in order to calculate profit and loss? For example, will statutory filings be used to identify the non-encounterable claim payments to be included in medical cost expense?	The ACC ACOM Reconciliation Policy draft is not yet available. However, AHCCCS expects the definitions of Medical Expense and Net Capitation to be consistent with previous ACOM policies. See ACOMs 311, 312, and 323 for example definitions. Initiatives such as Access to Professional Services Initiative (APSI) will be appropriately addressed in the ACC ACOM Reconciliation Policy definitions. However, regardless of final definitions, in keeping with historical practice, AHCCCS does not intend to include any non-encounterable medical expenses for the purposes of reconciliation.
44.	11/14/17	D	50	159	Under "Reconciliation of Costs to Reimbursement," please explain how the profit and loss percentages may change after CYE19.	AHCCCS is only providing CYE 19 profit and loss percentages at this time.
45.	11/14/17	D	50	160-161	The sections discussing Withholds, Incentives, and Access to Professional Services Initiative (APSI) refer to policy documents ACOM 306, 307, and 325 respectively. When will these policies be finalized, and will the State share draft documents with the bidders?	Policies will likely be open to public comment by mid-December.
46.	11/14/17	D	50	165	Regarding the Community Reinvestment, is this an extension of the current RBHA program?	Community Reinvestment is defined as its own requirement for ACC Contractors.

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47.	11/14/17	H	10	283	To optimize transparency in the scoring process and thus giving Offerors the same playing field, can you answer the following questions about how the Administrative Bid Component and the Underwriting Gain Component will be scored? 1. Will the fixed and variable administrative components be scored separately or in total? 2. If the Underwriting Gain Component differs in years 1-3, how will the different bids be weighted? 3. How will the Administrative and Underwriting Gain Components be combined?	Scoring information will not be provided.
48.	11/14/17	H	10	283	The final sentence of this section states that "scores for each of the submission requirements, including Capitation – Non-Benefit Costs and Programmatic submissions" will be weighted separately. Are there other submission requirements that will be scored besides the two items identified?	Capitation-Non-Benefit Costs and Programmatic submissions (including narrative and oral presentations) are the only submissions to be scored.

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49.	11/14/17	H	12	284	The document says "A contract is formed… and the Offeror accepts any special provisions to the Contract and the final rates awarded." Please describe what is meant by "special provisions".	RFP Page 284, Section H, Instructions to Offerors is amended as shown below: A Contract is formed when the AHCCCS Chief Procurement Officer signs the award page and provides to the Successful Offeror(s) written notice of the award(s). ~~to the Successful Offeror(s), and the Offeror accepts any special provisions to the Contract and the final rates awarded.~~ All Offerors will be promptly notified of Contract award.
50.	11/14/17	H	19	294	Regarding Administrative bids, does the state expect to use the PMPM bids over the life of the contract? Does this include or exclude contract extension periods?	Per the Non-Benefit Costs Bid Requirements document, AHCCCS may adjust the non-benefit cost components of the capitation rates in future years in order to maintain compliance with the Medicaid Managed Care Rules and Rate Setting Guidelines.
51.	11/14/17	H	19	294	The section states that Underwriting Gain is applied to the "gross medical component". Please define "gross medical" – for example, does this mean gross of reinsurance? To ensure consistency of bids, will the state provide the projected CYE 2019 gross medical component by rate cell and GSA?	Gross medical is before any reinsurance offset is deducted. AHCCCS will not provide the projected CYE 19 gross medical component rates in the RFP bid process.

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52.	11/14/17	H	19	295	Does the State plan to use the Year 3 Underwriting Gain bid for years 4+ if the contract is extended?	At the end of the initial three years, unless CMS requirements dictate otherwise, AHCCCS plans to use the Year 3 Underwriting Gain bid for years 4+. As noted in the Non-Benefit Costs Requirement document, AHCCCS may adjust the non-benefit cost components of the capitation rates in future years in order to maintain compliance with the Medicaid Managed Care Rules and Rate Setting Guidelines.
53.	11/14/17	H	19	295	How will the State determine the Administrative Component and Underwriting Gain applied to delivery supplemental payments? Please provide the expected values.	Underwriting gain percentage will be the same for all risk groups including delivery supplemental payments. AHCCCS does not intend to apply an administrative rate to the delivery supplemental payments, but will account for the administrative component associated with these costs in other rate cells.
54.	11/14/17	H	19	295	When did the State submit its request to CMS for determination on the Underwriting Gain Component requirements, and when is a response expected? How soon after CMS' response will the State deliver a decision to the Offerors?	AHCCCS has had multiple communications with CMS over the past several months with regard to capitation bidding and is hopeful this will be resolved in the next couple months.
55.	11/14/17	Section B – Data Supplement	Program Changes and Fee Schedule Changes	8	Can the State provide the percentage impact of the program changes by service category (i.e., similar to the information provided for fee schedule changes on page 9)?	See the actuarial certifications posted on the AHCCCS website for more information.

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56.	11/14/17	Section C – Data Supplement	Data Book Introduction	1	The section states that the Services Data Book file does not have completion factors added. Please provide the completion factors so that the Offerors can complete the data.	The completion factors listed below are not what AHCCCS will be using for capitation rate development next year, but should be reasonable for the Offerors' purpose of completing the data. FFY 16 Completion Factor: 97.4% FFY 15 Completion Factor: 99.8% FFY 14 Completion Factor: 100.0%
57.	11/14/17	Section F – Data Supplement	Non-Benefit Costs Bid Requirements	2	To ensure consistency across cost proposals, will the State provide the projected membership by rate cell and by GSA for CYE 2019?	Projected membership by rate cell and by GSA for CYE 2019 will not be provided.
58.	11/14/17	Section F – Data Supplement	Non-Benefit Costs Bid Requirements	2	Is the detailed administrative PMPM breakout (e.g. compensation, occupancy, etc.) just for informational purposes, or will the detailed components be used for scoring of the Cost Bid?	Scoring information will not be provided.
59.	11/14/17	Section F – Data Supplement	Rate Development Documentation	2	Can you please provide the formula and an example for developing the historical encounter PMPM data as referenced in regard to the non-diagnostic based risk adjustment? Will you also include non-encounter data in the calculation?	Only fully adjudicated/approved encounter data will be included in the calculation. AHCCCS will not provide a formula/example for developing the non-diagnostic based risk adjustment.

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60.	11/14/17	D	50	159	Under "Reconciliation of Costs to Reimbursement," it states that the reconciliation will apply to prospective and PPC medical costs and capitations. Are delivery supplemental payments included in the reconciliation?	Duplicate question from the same organization. See answer to question 42.
61.	11/14/17	D	50	159	Under "Reconciliation of Costs to Reimbursement," what is included in and excluded from medical cost expenses and total net capitation paid in order to calculate profit and loss? For example, will statutory filings be used to identify the non-encounterable claim payments to be included in medical cost expense?	Duplicate question from the same organization. See answer to question 43.
62.	11/14/17	D	50	159	Under "Reconciliation of Costs to Reimbursement," please explain how the profit and loss percentages may change after CYE19.	Duplicate question from the same organization. See answer to question 44.
63.	11/14/17	D	50	160-161	The sections discussing Withholds, Incentives, and Access to Professional Services Initiative (APSI) refer to policy documents ACOM 306, 307, and 325 respectively. When will these policies be finalized, and will the State share draft documents with the bidders?	Duplicate question from the same organization. See answer to question 45.
64.	11/14/17	D	50	165	Regarding the Community Reinvestment, is this an extension of the current RBHA program?	Duplicate question from the same organization. See answer to question 46.

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	DATE SUBMITTED	**RFP SECTION**	**PARAGRAPH No.**	**PAGE No.**	**OFFEROR'S QUESTION**	**AHCCCS RESPONSE**
65.	11/14/17	H	10	283	To optimize transparency in the scoring process and thus giving Offerors the same playing field, can you answer the following questions about how the Administrative Bid Component and the Underwriting Gain Component will be scored? 4. Will the fixed and variable administrative components be scored separately or in total? 5. If the Underwriting Gain Component differs in years 1-3, how will the different bids be weighted? 6. How will the Administrative and Underwriting Gain Components be combined?	Duplicate question from the same organization. See answer to question 47.
66.	11/14/17	H	10	283	The final sentence of this section states that "scores for each of the submission requirements, including Capitation – Non-Benefit Costs and Programmatic submissions" will be weighted separately. Are there other submission requirements that will be scored besides the two items identified?	Capitation-Non-Benefit Costs and Programmatic submissions (including narrative and oral presentations) are the only submissions to be scored.
67.	11/14/17	H	12	284	The document says "A contract is formed… and the Offeror accepts any special provisions to the Contract and the final rates awarded." Please describe what is meant by "special provisions".	Duplicate question from the same organization. See answer to question 49.

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68.	11/14/17	H	19	294	Regarding Administrative bids, does the state expect to use the PMPM bids over the life of the contract? Does this include or exclude contract extension periods?	Duplicate question from the same organization. See answer to question 50.
69.	11/14/17	H	19	294	The section states that Underwriting Gain is applied to the "gross medical component". Please define "gross medical" – for example, does this mean gross of reinsurance? To ensure consistency of bids, will the state provide the projected CYE 2019 gross medical component by rate cell and GSA?	Duplicate question from the same organization. See answer to question 51.
70.	11/14/17	H	19	295	Does the State plan to use the Year 3 Underwriting Gain bid for years 4+ if the contract is extended?	Duplicate question from the same organization. See answer to question 52.
71.	11/14/17	H	19	295	How will the State determine the Administrative Component and Underwriting Gain applied to delivery supplemental payments? Please provide the expected values.	Duplicate question from the same organization. See answer to question 53.
72.	11/14/17	H	19	295	When did the State submit its request to CMS for determination on the Underwriting Gain Component requirements, and when is a response expected? How soon after CMS' response will the State deliver a decision to the Offerors?	Duplicate question from the same organization. See answer to question 54.

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73.	11/14/17	H	8	280	The RFP states on page 285 that, "AHCCCS does not intend to award Contracts for all GSAs to a single Offeror. Pima County-only awards are counted as an award of a GSA for this purpose." Please clarify whether or not a single Offeror can be awarded a contract In the Central GSA, the North GSA, and Pima County.	As this section states, AHCCCS does not intend to award Contracts for all GSAs to a single Offeror. Pima County-only awards are counted as an award of a GSA for this purpose. A single Offeror cannot be awarded a contract in the Central GSA, the North GSA and Pima County.
74.	11/14/17	D	Under: "At a minimum, the MOUs shall include the following Contractor care coordination requirements: (3)	121	Page 121: Question- should there be a "not" as in "are (not) used to treat substance use disorders"? Seems like this as written is not consistent with 42 CFR; "3. Utilize data sharing agreements and administrative orders that permit the sharing of written, verbal and electronic information at the time of admission into the facility and at the time of discharge. The data may be shared without the permission of the member if the medications are used to treat substance use disorders and data may consist of: "	RFP Page 121, Paragraph 23, Medical Management is amended as shown below: To the extent permitted by State and federal laws regarding privacy and confidentiality, the data may be shared without the permission of the member ~~if the medications are used to treat substance use disorders~~ and ~~data~~ may consist of:

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75.	11/14/17	Section H; 19	1	294-295	In the Data Book, Section F, page 2 paragraph 1 it is noted that "AHCCCS will adjust administrative bids after award and when preliminary membership has been determined through initial assignment and member choice" in the first year of the contract. Will each of the subsequent years include adjustments to the administrative bids as well?	Per the Non-Benefit Costs Requirement document, AHCCCS may adjust the non-benefit cost components of the capitation rates in future years in order to maintain compliance with the Medicaid Managed Care Rules and Rate Setting Guidelines.
76.	11/14/17	Section D; 50	7	157	The staffing levels and ratios vary by acuity and expected utilization patterns of different ages (TANF Under Age 1 vs. TANF 1-20 vs. TANF 21+) , programs (TANF vs. Medicaid Expansion vs. SSI w/ Medicare vs. SSI w/o Medicare) and rates (base rates vs. Maternity Kick). How will the administrative bids be applied to each base capitation rate? How will the administrative load be adjusted once the population risk adjustment is applied?	AHCCCS will distribute the adjusted administrative PMPM by developing benefit cost relativities based on projected member costs by risk group. These benefit cost relativities will then be multiplied by the total administrative PMPM. Every risk group will have the same fixed admin PMPM. The variable administrative PMPM will be equal to the difference between the total administrative PMPM and the fixed administrative PMPM by risk group. AHCCCS intends that the population risk adjustment will be part of the benefit cost relativities. These relativities will be reviewed and may be adjusted if population risk adjustments occur throughout the contract year. At the same time, the fixed administrative PMPM will be reviewed and may be adjusted.

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77.	11/14/17	Section H; 19	1	295	Based on the information in the Data Book, Section F, page 2 paragraph 1, how will the administrative expense load be adjusted in years 2+ of the contract to account for inflation, programmatic changes such as changes to staffing level requirements or legislative changes that would create an increase to administrative expenses?	AHCCCS will not speculate as to the nature of any such adjustments.
78.	11/14/17	Section H; 19	7	294	When setting the CYE 19 capitation rates, AHCCCS anticipates applying completion factors along with any other adjustments necessary to develop actuarially sound capitation rates. Will AHCCCS be applying an under-reporting adjustment as part of the "other adjustments" to bridge the gap between the MCO reported financial statements and the encounter data?	AHCCCS will not speculate as to the application of under-reporting adjustments.
79.	11/14/17	Section H; 19	9	294	If it is determined that AHCCCS will not use the MCO's underwriting gain bid and use a uniform 1.00% underwriting gain load, will the points associated with that component be rolled into the administrative bid score or removed in its entirety from the scoring?	Scoring information will not be provided.
80.	11/14/17	Section D;11	4	82	Will MCO's be covering the cost of training providers on the Early Childhood Service Intensity Instrument (ECSII)?	AHCCCS will be amending these sections to remove the requirement to utilize the ECSII at this time. Pages 82 and 83 of RFP Section D, Paragraph

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						11 Behavioral Health Service Delivery, are amended as shown below: **Page 82** *Standardized validated instruments to assess member behavioral health service intensity needs* The Contractor shall implement the following validated service intensity instrument~~s~~ for all children accessing behavioral health services: ~~a. Early Childhood Service Intensity Instrument (ECSII): Children birth through five years of age, and~~ ~~b.~~ a. Child and Adolescent Service Intensity Instrument (CASII): Children six through 17 years of age. **Page 83** *Fidelity Monitoring* a. Implement AHCCCS' method for in-depth quality review of Children's System of Care Practice Reviews, including necessary practice improvement activities as directed by AHCCCS b. Implement protocols for Child and Family Team training/supervision and fidelity monitoring as directed by AHCCCS, c. Implement AHCCCS-approved methodology for fidelity review of Generalist Direct Support Services (MMWIA), and

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						d. ~~Implement AHCCCS approved methodology for fidelity review of ECSII and CASII completion and scoring.~~
81.	11/14/17	Section D; Definitions	1	35	Is the "no cost to the member" in this definition correct?	This definition is based on A.A.C. R9-28-101: "Home" means a residential dwelling that is owned, rented, leased, or occupied by a member, at no cost to the member, including a house, a mobile home, an apartment, or other similar shelter. 'No cost to the member' in this definition modifies the term 'occupied.' The wording "no cost to the member" refers only to those settings that are occupied by the member when not otherwise owned, leased, or rented.
82.	11/13/17	H: Instructions to Offerors	18	292	Will there be file size limitations for each file uploaded to the SFTP site?	There is no file size restriction.
83.	11/13/17	D: Program Requirements	50	158	There is a material difference in acuity between CRS and non-CRS members in the <1 and 1-20 risk groups. MCOs with a disproportionate share of CRS members would be adversely impacted without an appropriate risk adjustment to account for this. As there is no CRS-specific Risk Group, how does AHCCCS intend to address potential variation in CRS enrollment between the MCOs?	Population Risk Adjustments will be applied for this purpose. For more information see Rate Development Documentation in Section F of the Data Supplement.