	SOLICITATION AMENDMENT Solicitation No.: **RFP YH14-0001** Amendment No. 2 **(Two)** 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, and supersedes any information previously provided that is inconsistent:

1. Section H: Instructions to Offerors, Paragraph 16, Capitation, *Acute Care Program Capitation Resources*, page 303 is amended as follows:

   On or about December 14, 2012, AHCCCS will publish an actuarially-sound capitation rate range for the medical component for each risk group that will be bid by GSA. These ranges will be equivalent to the bottom half of the actuarially sound rate ranges, from ~~the~~ an adjusted minimum to the midpoint. The minimum of each published range was increased by 1% to account for the future Payment Reform capitation withhold of at least 1%. AHCCCS' actuaries set rate ranges based on average expenditures. The rate ranges will exclude reinsurance offsets and will not reflect any withheld amounts for payment reform initiatives.

2. The Bidders' Library, Information (IT) Technology Systems Demonstration *Provisions* and *Calendar* have been revised.

3. Section H: Instructions to Offerors, Paragraph 16, Submission Requirements, E. *Oral Presentations*, page 309, is amended as follows:

   All presentations will be scheduled to occur during the weeks of February 18 ~~and~~ through March 6, 2013.

4. 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 19th **day of December, 2012,** in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date**	**Signature** **SIGNED COPY OF 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. 2 TO RFP YH14-00014

Question #	Section	Paragraph #	Page #	Question	Response
1.	Data Supp. C			Please provide a data supplement splitting out Rx by generic, pref brand, non-pref brand and specialty. If possible, please provide the same level of detail currently in the data book. At a minimum, please provide GRD by risk group, GSA and CYE.	No additional information will be provided.
2.	Data Supp. F			Please provide a cross walk from the data book service categories to those in the capitation bid template.	Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, *Crosswalk Acute Care Service Matrix to Capitation Bid Template* posted on December 14.
3.	G	N/A	279-286 And all Excel Spreadsheet Pages	Should Offerors create a separate pdf file for Section G, Representations and Certifications of Offeror?	Yes. Create a separate .pdf file to include ALL of the required Section G documentation, including the spreadsheet information, in order for Section G to be removed from the published version of the proposal as stated on page 296, Instructions to Offerors.
4.	H			Can the state confirm that TPL offsets are incorporated into the Acute and CRS Data Book costs and will be included in the gross medical component PMPMs used to construct the rate ranges?	Expenditures included in the Data Books reflect the encounter data reported by Contractors. Data Book data is not adjusted unless the Contractor has a sub-capitated or block purchasing arrangement. If a Contractor's payment on a claim is reduced due to existence of a third party payer, the Contractor's payment should be net of the third party payment. Contractors are required to adjust previously adjudicated encounters when a post-payment recovery is made. Capitation rate ranges were developed based on the Data Book data.

Question #	Section	Paragraph #	Page #	Question	Response
5.	Instructions to Offerors			Will the same evaluators scoring this RFP also score the Maricopa behavioral health RFP?	AHCCCS is not providing any detailed information regarding evaluators scoring the Acute/CRS or Maricopa RBHA RFP.
6.	Data Supp. C			CYE12 appears to be incomplete. If possible, please provide average completion/IBNR for CYE12 and CYE11.	Refer to the Rate Setting Document in Section C of the Data Supplement for Offerors' – Acute Care/CRS which was posted to the Bidders' Library on December 14.
7.	Data Supp. F	Bid Template Tool		When using an original version of the template (i.e. unsaved) and cycling through the GSAs and Risk Groups (Select_GSA_Group tab), the template will occasionally load inputs (into the Input tab) even if the user has not stored any inputs for the selected GSA/Risk Group combination. While the inputs tab does not always clear when an un-stored combination is selected, it does not appear to impact the Summ_Bids tab. Can AHCCCS please confirm these obseravations?	The template as released to Offerors does not contain any stored inputs. Quality control testing took place before the release of the template. Subsequent testing was unable to recreate the scenario described. If you need further technical assistance please see Bidders' Library, Data Supplement, Section F, Bid Submission Information, Bid Template Overview for instructions on how to contact ISD.
8.	Data Supp. B	Attachment A		If possible, please provide general methodologies used to develop the PMPM program change estimates. For example, are the inpatient day limit PMPMs estimated using CYE11 data or projections of CYE12? Any information you can provide that will aid in the appropriate application of the program change impact estimates is greatly appreciated.	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
9.	Data Supp. C	Data Book		Based on a cursory review of certification letters, it appears as if trend factors are developed based on normalized encounter data. Would AHCCCS be willing to share encounter data normalized for program changes?	No additional information will be provided.
10.	Data Supp. C	Data Book		There are a number of large PMPM changes by service category, risk group and GSA. For example: For TANF <1 in GSA 12, the All Other Hospital Days PMPM changed from $13.21 PMPM in CYE09 to $10.10 in CYE10 to $21.89 in CYE11. For AHCCCS Care in GSA 12, the Inpatient ICU Tier PMPM decreases consistently from CYE2009 to CYE2011 (from $32.30 to $25.79 to $20.88). A similar trend exists in the IP Routine Tier service category (for this same risk group and GSA). We do not believe these year-to-year changes are fully explained by program changes. Any information you can provide to help us understand the underlying reason for these changes is greatly appreciated.	AHCCCS will not provide additional information regarding utilization or cost changes.

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11.	Data Supp. F	Pending Ranges		Does AHCCCS anticipate applying any Demonstration specific adjustments to the rate ranges? If so, please provide these adjustments and reasoning for said adjustments.	No, AHCCCS will not apply any adjustments to the rate ranges for the Duals Demonstration. 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.
12.	Round 1 Questions Amendments	General (several locations)		If a specific adjustment made to capitation rates differs from the actual financial impact of the related program change in a manner that results in losses for the contractor, will the contractor be responsible for these losses that result from this specific divergence, or will there be some limitation on contractor liability? We are concerned that single or multiple program changes that cost the contractor more than the additional revenue obtained from the related capitation rate adjustments could eliminate significant profit margin (or result in losses), even if the resulting overall revenue remains within the defined risk corridor for profit and loss.	No, there will not be a limit on Contractor liability beyond the risk corridor defined in the RFP in Sections D1 and D2, Paragraph 53, Compensation.
13.	Data Supp. I	Risk Factors	1	Can you provide the risk factor ranges (min/max) for the previous 2-3 CYEs?	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
14.	Data Supp. I	Proposed CYE14 and CYE15 Risk Adj.	1	Is AHCCCS considering changing the risk assessment tool that uses ETGs (for example, move to the federal model using Medicaid weights)?	Yes, AHCCCS plans to research risk adjustment tools and is not certain at this time if we will continue using the current tool or will switch to another risk adjustment tool.
15.	Data Supp. I	Proposed CYE14 and CYE15 Risk Adj.	1	Will AHCCCS develop new risk weights for the retrospective risk scores in CYE14? Similarly, will new prospective risk weights be recalibrated for CYE15?	Yes, AHCCCS plans to develop new retrospective risk weights for CYE 14 and new prospective risk weights for CYE 15.
16.	Document J	1	1	Are medical expenses or third party liability removed from the databook text files when a contractor is no longer active in the GSA in which the expenses were reported to be incurred (in a similar manner to Document J)?	Data was only removed from the financial statement reports if a Contractor reported medical expenses or TPL in a GSA *in a year* when they were no longer contracted in that GSA (e.g. prior period adjustments). Data Book files cannot include medical expenses in a GSA *in a year* where a Contractor is no longer contracted due to encounter edits which would reject the encounter.
17.	Document M	1	1	Please provide the necessary information to complete reinsurance amounts.	See the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section M, Reinsurance Information. No additional information will be provided regarding reinsurance. The reinsurance offsets will be determined by AHCCCS' actuaries prior to October 1, 2013. This is stated in Section H, Instructions to Offerors.

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18.	Document C – Databook Introduction	1	1	Please provide the appropriate completion factors by Category of Service for utilization and cost amounts in the databook, preferably by month, but at a minimum by year. This information is required in order to develop actuarially sound rates.	For information about completion factors used in developing the capitation rates/rate ranges, refer to the Rate Setting Document in Section C of the Data Supplement for Offerors' – Acute Care/CRS which was posted to the Bidders' Library on December 14.
19.	Document B	2	1	If the fiscal impact listed for any program change in Document B is not reflective of the population targeted in this RFP, please provide specific details for the population reflected, including membership counts by Category of Aid and GSA, total cost and utilization by GSA, Category of Aid, and Category of Service, and any other information necessary to adjust the impact of each program change.	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that states on page 1 that the fiscal impacts provided are statewide figures that are not specific to the populations addressed in this RFP. Page 1 also states that Offerors can find additional information in the Actuarial Certifications and that those impacts, too, are not specific to the populations included in the RFP. AHCCCS will not provide the requested information.
20.	Document B	1	10	Will capitation rates be adjusted by AHCCCS for the effect of the expansion of the Breast and Cervical Cancer treatment Program (effective 8/2/2012), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid.

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21.	Document B	2	10	Will capitation rates be adjusted by AHCCCS for the effect of the shift to Ambulatory Surgical centers (effective 10/1/2012), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid.
22.	Document B	4	10	Will capitation rates be adjusted by AHCCCS for the effect of Out of Network QMB Duals (effective 1/5/2013), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid.
23.	D1 & D2	62	101 & 86	Has the Corporate Compliance Disclosure of Information changed?	Yes, sections D1 and D2, Paragraph 62, Corporate Compliance and Acute/CRS RFP YH14-0001 Bidders' Library, Solicitation Amendment No. 1 Q&A, Response #28 and #29 have been amended as follows: • Under the subparagraph titled, Disclosure of Ownership and Control, Contractors will no longer be required to collect ownership and control information for its subcontracted providers. Contractors will still be required to collect such information for all individuals with an ownership or control interest in the Contractor as well as the Contractor's fiscal agents. • Under the subparagraph titled, Disclosure of Information on Persons Convicted of Crimes, Contractors will no longer be required to

Question #	Section	Paragraph #	Page #	Question	Response
					determine the exclusion status of its subcontracted providers or persons associated with its subcontracted providers. Contractors will still be required to determine the exclusion status of persons which have an ownership or control interest or managing employee interest in the Contractor as well as the Contractor's fiscal agents. • Under the subparagraph titled, Disclosure of Information on Persons Convicted of Crimes, Contractors will no longer be required to query the Social Security Administration DEATH MASTER FILE or the National Plan and Provider Enumeration System (NPPES) databases when determining the exclusion status of persons which have an ownership or control interest or managing employee interest in the Contractor or the Contractor's fiscal agents. Additionally, letter "d" in this paragraph will be changed to read: "The System for Award Management (SAM) formerly known as the Excluded Parties List (EPLS)." This change will appear in a future version of the contract.

Question #	Section	Paragraph #	Page #	Question	Response
24.	D1 Section 64	6	103	Section 64 states "HIPAA Privacy and Security: The Contractor is required to have a HIPAA security audit performed by an independent third party. The initial audit must be conducted at contract award (prior to the first exchange of AHCCCS data) and annually thereafter, and must include a review of Contractor compliance with all security and privacy requirements." Considering that this provision is being reviewed by AHCCCS under the current contract, are there any additional guidelines pertaining to HIPAA Privacy and Security Audit?	As noted this provision is under review by AHCCCS and further detailed guidance will be provided.
25.	Document I	1	11	Will risk contingency be adjusted for any years other than CYE10?	Risk contingency was adjusted in the CYE 10 risk adjustment methodology to recognize the change to risk contingency that same year. If risk contingency is changed in the future, AHCCCS would anticipate that an adjustment would be necessary.
26.	Document B	2	11	Will capitation rates be adjusted by AHCCCS for the effect of Part D drug changes (effective 1/1/2013), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	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.

Question #	Section	Paragraph #	Page #	Question	Response
27.	Document B	3	11	Will capitation rates be adjusted by AHCCCS for the effect of Behavioral Health Services provider rate changes (effective 4/1/2013), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	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.
28.	Document B	4	11	Will capitation rates be adjusted by AHCCCS for the effect of Medicare Dual Demonstrations (effective 1/1/2014), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	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.

Question #	Section	Paragraph #	Page #	Question	Response
29.	Document B	5	11	Will capitation rates be adjusted for the effect of ACA Health Insurer Fee (effective 1/1/2014), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	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.
30.	Document B	6	11	Is the databook data adjusted for the effect of any other programs effective on or after 10/1/2013?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."

Question #	Section	Paragraph #	Page #	Question	Response
31.	Data Supp. B		12	We assume all MCOs were expected to modify their provider contracts to match the fee schedule changes outlined on page 12 or absorb the loss. Is this a fair assumption?	Capitation rates were developed assuming that Contractors would modify payment rates, though there was no contractual mandate to lower rates. Contractors that did not reduce rates would have to absorb losses as the capitation rates were reduced.
32.	Document B	1	12	Is the databook data adjusted to account for the fee schedule changes listed in the "Fee Schedule Changes" table?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
33.	Document B	1	12	Please provide a mapping between the service categories listed in the table of fee schedule changes and the Categories of Service in the Databook.	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
34.	Document B	1	12	Please provide total costs and utilization by Category of Aid, GSA, and the service categories listed in the "Fee Schedule Changes" table.	No additional information will be provided.
35.	Document C	1	1-2	Please provide the most current analyses performed by AHCCCS' actuaries to gauge the completeness of encounter data and to ensure the appropriateness of payment data.	No additional information will be provided.
36.	Acute Care Actuarial Certification CYE13	Appendix I	13	Are the utilization trends in Appendix I appropriate for use in CYE14?	No, the trends used to build the CYE 13 rates will not be the same trends use to build the CYE 14 capitation rate ranges. Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Rate Setting Document*.
37.	Acute Care Actuarial Certification CYE13	Appendix I	13	If the CYE13 utilization trends in Appendix I are not appropriate for use in CYE14, please quantify the amount of deviation from the CYE13 trends that AHCCCS expects in its CYE14 certification	No additional information will be provided.
38.	Acute Care Actuarial Certification CYE13	Appendix I	13	Are the unit cost trends in Appendix I appropriate for use in CYE14?	No, the trends used to build the CYE 13 rates will not be the same trends use to build the CYE 14 capitation rate ranges. Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Rate Setting Document*.
39.	Acute Care Actuarial Certification CYE13	Appendix I	13	If the CYE13 unit cost trends in Appendix I are not appropriate for use in CYE14, please quantify the amount of deviation from the CYE13 trends that AHCCCS expects in its CYE14 certification	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
40.	D-2	CRS Performance Measures	148	In the performance measure table on page 148, the language in the third and fourth rows, regarding access to a behavioral health provider (encounter for a visit) has different timeliness standards (7 days vs 23 days) and different MPS (75% vs 90%) and goals (85% vs 95%). Please clarify which standard should be used for this measure.	The Performance Measures are stated correctly in the RFP document. The Performance Measure requirements include two separate behavioral health access to care measures.
41.	DocC_Databook Introduction	9	2	The data book does not have inpatient admit information. Admit information would be very helpful to understand and project the effect of care management on admissions and the October 2014 change in hospital reimbursement from per diems to DRGs. Even though the change is not effective until October 2014, we would like to have admit information to project results from 2013 to 2014, to determine what risks may result from the change. Planning ahead will be helpful for setting our bid. Can AHCCCS please provide admit information for the same time period and rate categories as the data book?	AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Supplemental *Data Book Reports*. Please watch for updates to this Section.

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42.	Document C	1	2	Please explain the review processes that AHCCCS performs to ensure timeliness, accuracy and completeness of its encounter data.	Encounter staff review encounter submission patterns, including per member statistics, in addition to validation studies. Actuarial and finance staff analyze expenditures by month, quarter and/or year of service: • Across Contractors • Across GSAs • Across risk groups • By form type • Compared to financial statements • In total and PMPM basis
43.	Document D	All	2	Please define "Pay Code" as listed in the Outpatient Facility service category and any other service categories. Please include any relevant medical coding in this definition (ex. Bill Type) and the coding logic for assigning each pay code.	In this instance, Pay Code indicates an encounter which appears to be an inpatient claim but, using the codes provided, should be classified as an outpatient claim. No additional coding information will be provided. All information necessary to formulate a bid is posted in the Bidders' Library, Data Supplement for Offerors' – Acute care/CRS, Section D, Service Matrix/Selection Criteria for Data Book and Section E, AHCCCS Category of Service, Form Types, Provider Type List of Codes and Descriptions.

Question #	Section	Paragraph #	Page #	Question	Response
44.	Document D	All	2	Please define "Reimbursement Type" as listed in the Hospital Days service category and any other service categories. Please include any relevant medical coding in this definition (ex. Bill Type).	In this instance, Reimbursement type indicates the inpatient tier to which the claim is associated. No additional coding information will be provided. All information necessary to formulate a bid is posted in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book and Section E, AHCCCS Category of Service, Form Types, Provider Type List of Codes and Descriptions.
45.	AHCCCS Operations Manual, Section 415-Provider Network and Development Plan-DRAFT-IV. Procedure	5 (page 2) and 1-5 (page 3)	2 and 3	Is our interpretation correct in that the Acute care contractor is responsible for having HCBS providers included in its Medicaid network?	Acute Care Contractors must be able to provide HCBS services as appropriate. Section D1, Paragraph 10, Scope of Services, *Nursing Facility*, states that members requiring convalescent care may be placed in an assisted living facility, an alternative residential setting or receive home and community based services (HCBS) for up to 90 days in lieu of receiving care in a nursing facility.

46.	Prospective Offeror's conference presentation 11/8		22	How will the managed care industry fee in 2014 be considered in reimbursement rate development? Since the tax is not deductible, will the pre tax amount be reimbursed to the plans?	AHCCCS will add the full amount of the Health Insurer Fee to the capitation rates.
47.	CYE2013 Certification	Page 2, Paragraph 4 – Page 3, Paragraph 1	2-3	Please provide Co-ordination of Benefits amounts for each contract year by Category of Aid, Category of Service, and GSA	No additional information will be provided.
48.	SECTION F, Attachment A1	25	236	Item 25 ends with the incomplete sentence, "For service authorization decisions, the". Could the State please clarify whether this is a mistake or the sentence was meant to read into Item 26 on the following page?	This was a typing error, the language from page 236 will continue and the number 26 will be removed. The RFP is amended. Section F, Attachment A1, Enrollee Grievance System Standards will read as follows "…For service authorization decisions, the Contractor shall also ensure that the Notice of Action provides the enrollee with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service."
49.	SECTION G	4	278	**Section G, Question 4.b states:** "License/Certification: Attach a list of all licenses and certification (e.g. Federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper listing the license requirements and the renewal dates." **Question:** For purposes of this item, does "organization" refer to Offeror, or to Offeror and its affiliates?	For purposes of Section G, Question 4.b, the term "organization" refers to the Offeror.

50.	SECTION G	4,5 & 6	278-282	**This is a follow-up to State's response to Round 1 Question:** "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?" **State's Response from Amendment 1:** "The form boxes expand to include the narrative response as it is typed. No additional pages are necessary." **Follow-up question:** When inserting text into the current, locked word document provided for Section G, the full paragraph can be seen only by selecting text and dragging mouse down, however the text box itself will not expand. When the document is PDFd or printed, the response cuts off. Can the State release a revised word document that allows the text boxes to expand to show all text?	The RFP is Amended for the following areas: Section G Representations and Certifications of Offeror and Amendment 1, Question #39. If Offerors require additional space to answer a question, a separate Word document may be submitted with the response in its entirety. The document must clearly identify which section the response is for. Example, Section G, Offeror Representations and Certifications, #4b License/Certification.

51.	SECTION G	5	280	**Section G, Question 5.c** defines "Managing Employee" as "A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency." **Question:** For purposes of this RFP, may we understand one "who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency" to mean (i) any of the key staff positions listed in Section D, paragraph 16, together with (ii) any individuals to whom those key staff positions report either directly or indirectly?	The definition of "managing employee" in Section G, Question 5.c is a federal definition, codified at 42 C.F.R. §455.101. An Offeror should consult with its attorneys and/or other professionals if the Offeror needs additional guidance in interpreting this definition.
52.	SECTION G	5	280	**Section G, Question 5.e states:** "Long-Term Business Transactions: List any significant business transactions, as defined in 42 CFR 455.101, between the Offeror and any wholly-owned supplier or between the Offeror and any subcontractor during the five-year period ending on the Contractor's most recent fiscal year end." **Question:** Is this section intended to include the phrase "wholly-owned" before the word "subcontractor"? If not, does "subcontractor" in this instance include health care provider contracts?	No. The phrase "wholly-owned in Section G, Question 5.e was not intended to be placed before the word "subcontractor". For purposes of Section G, Question 5.e the word "subcontractor" does not include health care provider contracts.
53.	SECTION G	6	281	Question 6, subsection (a) states: a. Board of Directors: List the Names, SSN, DOB, and Addresses of the Board of Directors of the Offeror **Question**: We understand the State's need for	No. The AHCCCS Administration will receive and secure this data as we do with all other confidential and sensitive information.

				this information, however given the environment related to identity theft, would the State agree to reimburse Plan for the cost of all liabilities that may be incurred by these individuals as a result of disclosing this information?	
54.	RFP H	9	291	Please verify that Offerors should not provide separate bid rates for Pima and Santa Cruz.	The Offeror should not provide separate bid rates for Pima and Santa Cruz counties. The Offeror should bid assuming they will win both Pima and Santa Cruz. If the Offeror wins Pima only, those rates will be adjusted after award.
55.	H	15	296	Is a footnote citation required to be **outside** of the ½ inch margin or may it be included **within** the ½ inch margin?	Yes, the footnote citation is required to be outside of the ½ inch margin.
56.	AHCCCS Operations Manual, Section 415-Provider Network and Development Plan-DRAFT-IV. Procedure	13-16	3	Our question relates to iii. Is it AHCCCS' expectation that an acute care contractor have Assisted Living Facilities, alternative residential settings, or home and community based services (minimum one per listed GSA) as required by contract, providers in its network?	Acute Care Contractors must be able to provide HCBS services as appropriate. Section D1, Paragraph 10, Scope of Services, *Nursing Facility*, states that members requiring convalescent care may be placed in an assisted living facility, an alternative residential setting or receive home and community based services (HCBS) for up to 90 days in lieu of receiving care in a nursing facility.

57.	Data Supp. F		3	According to the bid template instructions, "when the Offeror chooses the Delivery Supp risk group…then only the service categories relevant to the delivery supplemental payment will appear…" A number of the hidden service categories contain data in the data book. For example, the Delivery Supp. risk group does show experience for transportation and Rx encounters. By hiding the transportation and Rx service categories in the bid template tool, is AHCCCS implying that these costs are not part of the delivery supp. and thus should be excluded (and possibly include them in cap rates)? Or, does AHCCCS intend for bidders to put these types of costs in the Misc. category?	Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, *Crosswalk Acute Care Service Matrix to Capitation Bid Template* posted on December 14.
58.	Document B	1	3	Is the databook data adjusted for the discontinuation of dental sealant coverage (effective 5/1/2009)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is

					used to populate the cost field."
59.	Document B	1	3	Do the PMPM impact amounts in Attachment A for discontinuation of dental sealant coverage represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by $1200 over the contract year. Would the table show a $1 PMPM impact to account for the cost impact over the entire contract year, or a $2.40 PMPM impact ($1200/(100 members*5 months of program in effect)) to account for the costs after the program has gone into effect.	The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be $1.00 PMPM.
60.	Document B	2	3	Is the databook data adjusted for DDD State only Transfers (effective 5/1/2009).	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is

					used to populate the cost field."
61.	Document B	2	3	Do the PMPM impact amounts in Attachment A for DDD State Only Transfers represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by $1200 over the contract year. Would the table show a $1 PMPM impact to account for the cost impact over the entire contract year, or a $2.40 PMPM impact ($1200/(100 members*5 months of program in effect)) to account for the costs after the program has gone into effect.	The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be $1.00 PMPM.

62.	Document B	3	3	Is the databook data adjusted for changes related to High Needs Children (effective 7/1/2009)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Crae/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
63.	Document B	3	3	Do the PMPM impact amounts for High Needs Children in Attachment A represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by $1200 over the contract year. Would the table show a $1 PMPM impact to account for the cost impact over the entire contract year, or a $4.00 PMPM impact ($1200/(100 members*3 months of program in effect)) to account for the costs after the program has gone into effect.	The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be $1.00 PMPM.
64.	RFP H	16	302	When checking the administrative component	When the Offeror clicks the Save Bid button on

	And Data Supp. F			(to determine if it is less than the 8% max) will AHCCCS use the rounded values produced by the Summ_Bids tab (in the bid template) or will AHCCCS use unrounded values entered into the Input tab? If rounded, please provide the rounding formula used in the bid template. Lastly, assume a bidder applies 8% admin to unrounded values. Furthermore, assume AHCCCS uses rounded values and calculates a bidder's admin component at 8.001% then will said bidder receive 0 points in this case?	the Input tab in the bid template, a warning box is produced if the value entered for admin exceeds 8% of the gross medical component. This box uses PMPM values rounded to four decimal places for admin and gross medical, but it is strictly informational. The scoring process will use the gross medical and admin component PMPM figures as shown on the Summ_Bids tab, and therefore found in the hard copy format, which are rounded to two decimal places. For scoring purposes, the ratio used to calculate if an Offeror's admin exceeds 8% of gross medical will not be rounded. The ratio will be calculated as: (admin PMPM rounded to two decimal places) / (gross medical PMPM rounded to two decimal places). If this ratio exceeds 8% the Offeror will score zero for that admin bid. For example, if an Offeror's admin component bid is $8.01 and the medical component bid is $100.00, the admin ratio would be $8.01 / $100.00 = 8.01% which is greater than 8%; thus this bid would be scored zero.
65.	Section H	E. Narrative Submissions	306 (question 3)	It is our understanding that AHCCCS is going to move to HEDIS criteria for the performance measures. Since the current reporting period is the contract year (Oct. 1 through Sept. 30) and HEDIS is Jan. 1 through Dec. 31, how does AHCCCS plan to make this change?	AHCCCS does not intend to transition from contract year to calendar year for Performance Measure purposes. Please also note that Measure methodology owners vary within the CMS measure sets being implemented. Only a portion of the measures are NCQA HEDIS measures.
66.	Section H	E-Narrative Submissions	306-307	In question 4, the scenario refers to the individual in question as a member of the Offeror's health plan. In question 5, the scenario refers to the individual as an "AHCCCS member." For the purposes of responding to the scenario, since a member is required to be a member of an AHCCCS-contracted health plan, should Offerors	Yes, the Offeror should assume the individual is currently a member of the Offeror's health plan.

				assume that individual in question is in fact a member of the Offeror's health plan?	
67.	Section H	E-Narrative Submissions	307	What is the State's definition of waste relative to this question?	"Waste" includes but is not limited to: fraud, excess administration, costs associated with failure to implement effective methods for prevention of disease, disability, or adverse health condition, and services provided to individuals which are either not medically necessary, not cost effective, or both.
68.	H (IT Demo)		308	Page 92 of Prospective Offerors' Technical Interface Meeting presentation: All Offerors will receive the same "mock" data files and scenarios ***Question: How do we get the scenarios, are they implied in the inbound 837 file per say, or do they provide an English description of the various scenarios in separate Microsoft excel/word document?***	AHCCCS will provide the Offeror with a paper claim form or an electronic 837 claim record.

69.	H (IT Demo)		308	Page 93 of Prospective Offerors' Technical Interface Meeting presentation: Encounter submissions will be based upon claims adjudicated by the Offeror as part of the claims scenarios exercises *Question: Assuming this means submissions from Offerer to AHCCCS?*	Correct, AHCCCS will expect encounter submissions based upon approved/paid claims scenarios.
70.	H (IT Demo)		308	Page 93 of Prospective Offerors' Technical Interface Meeting presentation: First and second eligibility and claims status inquires will not exceed 5 records per iteration. *Question: Assuming this means the HIPAA transaction inbound and outbound data files?*	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. Additionally, note that AHCCCS will not, as a component of the demonstration, be asking for eligibility or claims status inquiries on more than 5 members or claims.
71.	Section H	E-Narrative Submissions	308	With respect to the IT Demonstration, will CRS eligibility and benefits data be part of the 834 file the Offeror will receive from AHCCCS?	No, CRS scenarios will not be included for purposes of this demonstration.
72.	Section H	E-Narrative Submission	308	Will we be expected to provide a paper provider remittance advice as part of the IT Demonstration?	No remittance advice will be required for purposes of this demonstration.
73.	Section H	E-Narrative Submissions	308	Can you confirm from an encounters perspective, will an 837 file be required or will the response be in the form of a summary template as all others?	AHCCCS will supply the Offeror with an 837 Template for purposes of encounter submission and will require that the Offeror submit the completed 837 Template and Summary of Encounters Processing. Refer to the revised Information Technology (IT) Systems Demonstration *Calendar* for additional information posted December 19.

74.	Section H	E-Narrative Submissions	308	Will the encounter initial cycle results be provided in a 277 format or in a spreadsheet? Will corrected encounters from initial cycle be permissible or expected in the second encounter cycle submission?	The cycle results were incorrectly included in the Final 10/29 version of the Information Technology (IT) Systems Demonstration *Calendar*. The revised IT Systems Demonstration *Calendar* posted on 11/27 and revised again on 12/19 is correct and supersedes the 10/29 version.
75.	Section H	E-Narrative Submissions	308	For reference data extracts will this include a sample of reference files or a complete set of reference files, such as transition of care, COB, provider and fee schedule?	The reference data extract will include the full set of Reference and Provider data exchanges as outlined in the AHCCCS Encounter Manual.
76.	Section H	E-Narrative Submissions	308	If Encounter Submissions Response Files are required in an 837 format, are new TSNs required for system demonstrations?	No, new TSN's will not be required for purposes of this Demonstration.
77.	Section H	E-Narrative Submission	308	What is the earliest date/time that all the Offeror's will be able to view the Process Summary Templates for the each transaction	This information is included in the Information Technology (IT) Systems Demonstration *Calendar*.
78.	Section H	E-Narrative Submission	308	Will the summary of the initial 820 be inclusive of the first two daily 834 files only?	Yes, the information in the initial 820 will be inclusive of the enrollment information in the 834 files.
79.	SECTION H	E (Oral Presentation)	309	During the Oral Presentations, will AHCCCS pose "solutions to health care situations and operational challenges" for Acute Care, CRS populations or a combination of both groups?	AHCCCS is not providing assistance or clarification related to the submission requirements or the oral presentations.
80.	Document B	All	3-26	Please provide the impact to utilization and charge for each fee schedule and program change adjustment based on actual historical data.	No additional information will be provided.

81.	D1	10	38	It is our understanding that AHCCCS will assume responsibility for determining CRS eligibility. Please verify this will be effective as of 10/1/2013.	AHCCCS will assume CRS eligibility determination processes as of 10/1/2013.
82.	Arizona Medical Policy Manual, 520 Member Transitions	4 and 5	4	In section D.1 it discusses transition from an ALTCS to an acute care contractor. The paragraphs referenced imply that an acute care contractor does not have to cover attendant care or home delivered meals as a part of its network or benefits? Our understanding was that an acute care contractor has to provide for necessary HCBS as a part of its network. Does an acute care contractor have to have attendant care, meals on wheels and other types of LTSS in its network? Please clarify this.	Acute Care Contractors must be able to provide HCBS services as appropriate, including those specifically identified (e.g. attendant care, home delivered meals). Section D1, Paragraph 10, Scope of Services, *Nursing Facility*, states that members requiring convalescent care may be placed in an assisted living facility, an alternative residential setting or receive home and community based services (HCBS) for up to 90 days in lieu of receiving care in a nursing facility. .
83.	AHCCCS Operations Manual, Section 415-Provider Network and Development Plan-DRAFT-IV. Procedure	7	4	Please clarify the following: After number 15, there is a bold statement-"(For ALTCS EPD and DDD Contractors Only)" prior to number 16. Does this statement only apply to Number 16 or does it apply to items 16 through 23 which seem to apply to ALTCS contractors.	Yes, items 16 through 23 apply only to ALTCS Contractors.

84.	Document B	1	4	Is the databook data adjusted for changes related to Transition Age Youth (effective 7/1/2009).	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
85.	Document B	1	4	Do the PMPM impact amounts in Attachment A for transition Age Youth represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by $1200 over the contract year. Would the table show a $1 PMPM impact to account for the cost impact over the entire contract year, or a $4.00 PMPM impact ($1200/(100 members*3 months of program in effect)) to account for the costs after the program has gone into effect.	The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be $1.00 PMPM.

86.	Document B	2	4	Please provide a breakout of the $2.5 million increase (CYE09 to CYE10) and $2.5 million decrease (CYE10 to CYE11) caused by H1N1 Influenza by category of service, category of aid and GSA.	No additional information will be provided.
87.	Document B	3	4	Is the databook data adjusted for changes related to outlier hospital reimbursement rates (effective 10/1/2009)? Please provide the adjustment?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
88.	Document B	3	4	Which contract year of capitation rates was originally updated with the impact of changes for outlier hospital reimbursement rates?	CYE 08, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes.
89.	Document B	3	4	Please define "extraordinary operating costs per day"	Outliers are claims with extraordinarily high costs per day that exceed thresholds established by AHCCCS

90.	Document B	4	4	Is the databook data adjusted for changes related to dental service changes (effective 10/1/2009)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
91.	Document B	4	4	Which contract year of capitation rates was originally updated with the impact of changes for dental service changes?	CYE 10, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 10.

92.	Document B	5	4	Is the databook data adjusted for medical management changes (effective 10/1/2009)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
93.	Document B	5	4	Which contract year of capitation rates was originally updated with the impact of medical management changes?	CYE 10, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 10.
94.	CYE13 Acute Care Actuarial Certification	Section IV	4	Please provide a list of experience adjustments made to capitation rates for the CYE13 contract year.	No additional information will be provided.

95.	Document I	1	5	How frequently will risk weights be recalibrated? Please describe the recalibration process.	AHCCCS plans to develop new retrospective risk weights for CYE 14 and also new prospective risk weights for CYE 15. See Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section I, Risk Adjustment Information, *CYE 09 Risk Adjustment Whitepaper* for a brief description on the recalibration process.
96.	Document B	1	5	Is the databook data adjusted for changes in ADHS regulated transportation rates (effective 10/1/2009)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."

97.	Document B	3	5	Is the databook data adjusted for the KidsCare Freeze (effective 10/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."

98.	Document B	4	5	Is the databook data adjusted for changes regulations related to the HPV Vaccine (effective 7/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
99.	Document B	4	5	Do the PMPM impact amounts for HPV Vaccine administration in Attachment A represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by $1200 over the contract year. Would the table show a $1 PMPM impact to account for the cost impact over the entire contract year, or a $4.00 PMPM impact ($1200/(100 members*3 months of program in effect)) to account for the costs after the program has gone into effect.	The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be $1.00 PMPM.

100.	Document B	4	5	Is the databook data adjusted for the benefit redesign change (effective 10/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
101.	Document B	4	5	Which contract year of capitation rates was originally updated with the impact of the benefit redesign change?	CYE 11, as stated in Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 11.
102.	D1	16	51	Will the State consider the CRS awarded Contractor's contract for both CRS and Acute services as one line of business for the purposes of Key Staff?	The CRS contract for both CRS specialty and acute services (and behavioral health services) is considered one line of business for purposes of Key Staff.

103.	Prospective Offeror's conference presentation 11/8		52	What does "current rate setting methods" mean? If a dual eligible demonstration is approved, what savings rate will the state assume – either 1, 3, or 5% versus fee for service as preliminarily proposed by CMS?	For the Medicaid portion of the Dual Demonstration rate AHCCCS is proposing to use the same capitation rate setting methodology used for the Acute population. This methodology is subject to CMS approval. See the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Rate Setting Document* for more information regarding the Acute rate setting methodology. AHCCCS and CMS have not finalized the savings target percentages.
104.	D1 & D2	18	55-56 (D1) 141-142 (D2)	Is the CRS Contractor permitted to develop one set of member materials for Acute and CRS that highlight differences in procedures and network (similar to DDD information); or must the CRS members receive a separate set of CRS specific materials?	The CRS contract and the Acute Care contract are separate lines of business. Each line of business requires unique member materials.
105.	D1 & D2	21	57-58 (D1) 143 (D2)	For the purposes of care coordination, records may be shared with care team members. Will there be a definition of care team and what are the requirements for member/guardian acknowledgement/authorization?	Care teams are unique to the needs of each individual member. Participants in a care team for a member with cleft lip would be different than those needed in a care team for a member diagnosed with cystic fibrosis. AHCCCS is not anticipating establishing specific requirements for the composition of the care team at this time. The CRS Program is designed to include the member and the member's parent/guardian as part of the team with the ability to participate in the health care decision making process.

106.	CYE12 Cert Letter		6	The cert letter indicates a savings of $28.2 million for hospital outliers. What is the basis year for this savings estimate? In addition, please provide the detailed adjustments applied to the CYE12 rates to account for this change.	This savings was estimated by using CYE 09 (10/01/08 - 09/30/09) outlier encounter data and CYE 09 member months. A PMPM was calculated and trended forward to estimate the savings. The CYE 12 actuarial certification explains that capitation rates would have increased by approximately $28.2 million if AHCCCS had not made this change to outlier. AHCCCS did not apply an adjustment factor to the CYE 12 rates for this change, but assumed the future outlier trend would stay at the CYE 11 levels rather than growing as it had in the past.
107.	Document B	1	6	Is the databook data adjusted for changes in copay amounts (effective 10/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."

108.	Document B	2	6	Is the databook data adjusted for the shift to Ambulatory Surgery Centers (effective 10/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
109.	Document B	2	6	Which contract year of capitation rates was originally updated with the impact of the shift to Ambulatory Surgery Centers?	CYE 11, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 11.

110.	Document B	3	6	Is the databook data adjusted for the change in first 72 hours coverage (effective 10/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
111.	Document B	3	6	Which contract year of capitation rates was originally updated with the impact of the change in first 72 hours coverage?	CYE 11, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 11.

112.	Document B	4	6	Is the databook data adjusted for the change in Behavioral Health Services prior period coverage (effective 10/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
113.	Document B	4	6	Which contract year of capitation rates was originally updated with the impact of the change in Behavioral Health Services prior period coverage?	CYE 11, as stated in the Data Supplement for Offerors'– Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 11.

114.	Document B	5	6	Is the databook data adjusted for the change in Cochlear Implants coverage (effective 10/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
115.	Document B	5	6	Which contract year of capitation rates was originally updated with the impact of the change in Cochlear Implants coverage?	CYE 11, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the CRS Actuarial Certification for CYE 11.

116.	Document B	6	6	Does the databook contain data for MED program enrollees prior to the elimination of the program (effective 10/1/2011)?	No, data for MED members is not contained in the Data Book files. This information is stated in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Layout/File Description*: "All Data Book Files exclude utilization, cost and member information for those populations that will no longer be covered by Acute Care Contractors, and by the CRS Contractor, as of October 1, 2013. For additional information on the excluded populations please refer below to "Data Book Files Exclusions" section." **"**Data Book Files Exclusions Acute Care Bid All Data Book Files and member information exclude the following populations…. Those members in the HIFA or MED risk groups which are no longer covered."
117.	Document B	6	6	If the databook does contain data for MED program enrollees, please provide the volume of utilization and cost data by Category of Service, Category of Aid, and GSA associated with the MED program.	Data for MED members is not contained in the Data Book files.

118.	Document B	7	6	Is the databook data adjusted for the transition of pediatric costs (effective 6/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
119.	Document B	7	6	Which contract year of capitation rates was originally updated for the transition of pediatric costs?	CYE 12, as stated in both the Acute Care Actuarial Certification for CYE 12 and the CRS Actuarial Certification for CYE 12.

120.	Document B	7	6	Do the PMPM impact amounts for transition of pediatric costs in Attachment A represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by $1200 over the contract year. Would the table show a $1 PMPM impact to account for the cost impact over the entire contract year, or a $3.00 PMPM impact ($1200/(100 members*4 months of program in effect)) to account for the costs after the program has gone into effect.	The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be $1.00 PMPM.
121.	D1	23	60	Credential Verification Organization Contract: Is AHCCCS able to provide information regarding the Alliance? We are having difficulty in learning about the Alliance and its costs and because using it will entail cancelling other contracts potentially and additional work in switching to the Alliance any assistance on pricing, structure etc would be helpful.	AHCCCS does not have a copy of the AzAHP Credentialing Alliance contract nor the terms of the contract. Information may be available through the Executive Director of the Arizona Association of Health Plans, Deb Gullett, Gallagher & Kennedy P.A. Law Offices, Senior Government Relations Specialist, deb.gullett@gknet.com.
122.	D	23	60	"The CVO is also responsible for conducting annual delegated entity site visits to ensure compliance with AHCCCS requirements." Our understanding is that the AzAHP credentialing alliance does not include providers that plans have delegated credentialing to – but the above sentence refers to 'annual delegated entity site visits'. Can you please clarify?	The RFP has been amended and the word "delegated" has been removed. The CVO is required to conduct annual entity site visits. The sentence now reads, "The CVO is also responsible for conducting annual entity site visits to ensure compliance with AHCCCS requirements." This change will appear in a future version of the contract.

123.	D	23	60	"The AHCCCS Contractor must utilize the contracted CVO as part of its credentialing and recredentialing process regardless of membership in the AzAHP." Does this mean that the Contractor must participate in the AzAHP credentialing alliance or simply utilize the same CVO that AzAHP uses for its credentialing alliance?	Contractors shall be required to participate in the AzAHP credentialing alliance.
124.	D1 & D2	23	60 (D1) 146 (D2)	The CVO is a delegated entity that will oversee the credentialing process for Acute Care contractors. Please verify that each contractor will not be required to evaluate the CVO in accordance with AHCCCS guidelines for delegated entities.	The AzAHP Credentialing Alliance has contracted with a Credential Verification Organization (CVO) to conduct primary source verification and site visit requirements related to the required credentialing processes. Contractors are required to use the information provided by the CVO and complete the credentialing process which includes a review of quality, utilization, performance data, etc. As is required for all delegated functions, Contractors are required to validate that the delegated entity is meeting the AHCCCS requirements. AHCCCS anticipates that the AzAHP will establish a collaborative process to meet this requirement.
125.	D1 & D2	23	63-64 (D1) 148-149 (D2)	Please clarify if AHCCCS will determine separate performance measures for CRS and Acute Care members. It is our understanding that CRS and Acute Care membership will be segregated for the purpose of determining responsiveness to the performance measures. Is this correct?	AHCCCS has established a separate performance measures set for each line of business. The CRS and the Acute Care programs are separate lines of business. Performance Measures for each of these lines of business contain measures specific to the population served. The results for each population will be calculated independently.

126.	D1	27	68	Regarding paragraph 27 "In accordance with the requirements specified in the ACOM Draft Policy, Acute Network Standards the network shall be sufficient to provide covered services within designated time and distance limits. This includes a network such that 90% of its members residing Pima and Maricopa counties do not have to travel more than 15 minutes or 10 miles to visit a PCP, dentist or pharmacy, unless accessing those services through a Multi-Specialty Interdisciplinary Clinic (MSIC). The Contractor must obtain hospital contracts as specified in ACOM Draft Policy, Acute Network Standards." Please validate that Offerors are not required to submit GeoAccess reports with the proposal to document that network responsibility and availability criteria have been met. Also, please validate that Offerors will not be required to submit a listing of their contracted network of providers with the proposal.	Offerors are not required to submit GeoAccess reports or a listing of their contracted network of providers with their offer. Adherence to network sufficiency standards will be assessed during the readiness review process.
127.	Data Supp. B		7	Please provide the methodology used to develop the estimated percentage impact for the Childless Adult Freeze change. In particular, what assumptions were used to convert an enrollment freeze into a PMPM impact?	As stated in the Bidders Library, Data Supplement, Section B, Program and Fee Schedule Changes, as part of the freeze, the elderly and individuals meeting the federal definition of disability (including SMI members) were transitioned to either the SSI with or without Medicare risk groups. In order to account for this movement, AHCCCS analyzed historical encounter and member data for those individuals who were transitioning to SSI with or without Medicare. The data for those members was moved to the appropriate groups to calculate the percentage impact by comparing the PMPM before the move to the PMPM after the move.

128.	Document B	1	7	Is the databook data adjusted for changes to the Best for Babies program (effective 7/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
129.	Document B	1	7	Which contract year of capitation rates was originally updated for changes in the Best for Babies Program?	While this behavioral health program was effective July 2011, the capitation rates were not adjusted until July 2012, thus impacting the CP (contract period) 13 capitation rates. Refer to the Behavioral Health Actuarial Certification for CYE 13 found in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section K, Capitation Rates.
130.	Document B	1	7	Do the PMPM impact amounts for changes in the Best for Babies Program in Attachment A represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100	The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be $1.00 PMPM.

				members and costs will increase by $1200 over the contract year. Would the table show a $1 PMPM impact to account for the cost impact over the entire contract year, or a $4.00 PMPM impact ($1200/(100 members*3 months of program in effect)) to account for the costs after the program has gone into effect.	
131.	Document B	1	7	Please define the "CMDP Child Population" and provide enrollment counts for historical contract years.	Children Enrolled in the Comprehensive Medical and Dental Program (CMDP).
132.	Document B	1	7	Please provide a list of members involved in the "Best for Babies" program in the same format as any detailed claims, encounter, or membership data provided.	No additional information will be provided.

133.	Document B	1	7	Please provide a detailed list of services provided within the "Best for Babies" Program.	The same services are available for all populations; however, the timeline is more structured for children in CPS custody and enrolled in CMDP. The difference for children in CPS custody and enrolled in CMDP is that timelines for certain services, primarily behavioral health (BH) are written into the CPS protocols. For example, children taken into custody must have a BH assessment within 72 hours. A follow-up full BH assessment must be completed within 30 days and services initiated based on those assessments. The CRS Contractor will need to meet those requirements. All other physical health needs should be consistent with other AHCCCS populations. Best For Babies does also have the tendency to have active judicial involvement. Judges overseeing the custody cases often order and expect care to be delivered in a specific manner, frequency and volume. The CRS Contractor would be responsible for considering the judge's order, but must only approve services that are medically necessary (not necessarily because it was ordered by the judge). Those care/services ordered by the judge that are not determined to be medically necessary would become the responsibility of the State (CPS).
134.	Document B	1	7	Is the databook data adjusted for changes to the Best for Babies program (effective 7/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-

					capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
135.	Document B	1	7	Which contract year of capitation rates was originally updated for changes in the Best for Babies Program?	Duplicate question: #159
136.	Document B	2	7	Is the databook data adjusted for the AHCCCS Care freeze (effective 10/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is

					used to populate the cost field."
137.	Document B	3	7	Is the databook data adjusted for the effect of the inpatient day limit (effective 10/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."

138.	Document B	1	8	Is the databook data adjusted for the effect of changes related to hospital outliers (effective 10/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
139.	Document B	1	8	Please provide hospital outlier cost thresholds before and after the changes effective 10/1/2011	Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section N, Hospital Rate Overview, *Outlier Cost Thresholds* posted December 18.

140.	Document B	2	8	Is the databook data adjusted for the effect of changes related to transportation services (effective 10/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
141.	Document B	4	8	Is the databook data adjusted for the effect of new drug approvals for Hepatitis C (effective 10/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used

					in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
142.	D1 & D2	51	86 (D1) 172 (D2)	Section D1 and D2, Paragraph 51 of the RFP originally stated: "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." The State has agreed to revise to state: "Within 120 days of 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 or other contracts with AHCCCS." Would the State consider further revising the end of this sentence so that it reads: "Within 120 days of 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 or other contracts with or approved by AHCCCS"?	No, the amended language stands. No further revisions will be made.
143.	D-1-acute	53	88	Is the 4.5% profit cap on a pretax or after tax basis?	Income tax is not considered in reconciliations. Please refer to ACOM draft Policy 311 - Acute Program Tiered Prospective Reconciliation in the Bidders' Library for a detailed explanation of the reconciliation calculation, as well as the example provided.

144.	Sections D1 and D2 and Section H	55, and C respectively	89 and 175; and 303 ("Acute Care Program Capitation Adjustments After Award) and 305 ("CRS Program Capitation Adjustments After Award")	Will AHCCCS provide the Contractor with detailed information to determine if the adjusted rates or rate range offered meet the requirements of the Social Security Act § 1903(m)(2)(A); 42 CFR §438.6(c)(1)(i)(2009); Pub. L. No 111-3, 123 Stat.8, 103; and the American Academy of Actuaries practice note on guidance for certifying Medicaid managed care rates?	With the exception of hospital admits and length of stay data, all information regarding capitation rates/ranges has been posted to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.
145.	Sections D1 and D2 and Section H	55, and C respectively	89 and 175; and 303 ("Acute Care Program Capitation Adjustments After Award) and 305 ("CRS Program Capitation Adjustments After Award")	Will AHCCCS fully disclose its actuarial assumptions, including justification for why these assumptions were not included in the RFP capitation rate ranges published?	With the exception of hospital admits and length of stay data, all information regarding capitation rates/ranges has been posted to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.

146.	Sections D1 and D2 and Section H	55, and C respectively	89 and 175; and 303 ("Acute Care Program Capitation Adjustments After Award) and 305 ("CRS Program Capitation Adjustments After Award")	Will amendments, clarifications or program changes expressly require the consent of the Plan (at least if they have a material, adverse effect on compensation or scope of work)?	The Contractor has the choice to sign or not sign contract amendments that include clarifications or program changes within a specified time period. No other express consent will be granted.
147.	Data Supp. B		9	KidsCare II program change – it appears as if the CYE13 rates were not adjusted for the KidsCare II program expansion. Please verify this is correct. Also, please provide cost and utilization relativities for those enrolled under the expansion (compared to those already in the program).	For CYE 13 rates, AHCCCS analysis indicated that the impact of additional KidsCare II members would not materially impact the rates. No additional information will be provided.

148.	Document B	1	9	Is the databook data adjusted for the effect of changes to claims processing standards (effective 1/1/2012)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
149.	Document B	2	9	Is the databook data adjusted for the effect of increased reimbursements for family planning devices (effective 2/1/2012)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used

					in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
150.	Document B	3	9	Is the databook data adjusted for the effect of changes in taxi copays (effective 2/1/2012)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."

151.	Document B	4	9	Is the databook data adjusted for the effect of changes to 340B pharmacy pricing (effective 4/1/2012)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
152.	Document B	5	9	Is the databook data adjusted for the effect of changing responsibility for psychiatric consultations (effective 7/1/2012)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used

					in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
153.	Document B	5	9	Will capitation rates be adjusted by AHCCCS for the effect of changing responsibility for Emergency Room transportation (effective 7/1/2012), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid.
154.	Document B	5	9	Will capitation rates be adjusted by AHCCCS for the effect of the KidsCare II expansion (effective 5/1/2012), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid. Please note that, for CYE 13 rates, AHCCCS analysis indicated that the impact of additional KidsCare II members would not materially impact the rates.

155.	Document D/Document E-3 – Provider Types	All	All	Please provide coding criteria for grouping services by provider type. For example, the Physical Therapy section in Document D includes the selection criteria "Select all HCPCS that meet Provider Type requirements". A list of the HCPCS codes referenced and the logic used to assign provider type would assist in our analysis of the data.	No additional coding information will be provided. All information necessary to formulate a bid is posted in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D**,** Service Matrix/Selection Criteria for Data Book and Section E, AHCCCS Category of Service, Form Types, Provider Type List of Codes and Descriptions.
156.	IT SYSTEM DEMONS-TRATION CALENDAR	DATA FROM AHCCCS	Calendar	The IT Systems Demonstration Calendar Final 10/29 included the 277U – Encounter Adjudication; Pend and Encounter Cycle Results' Initial Cycle Results on Monday, February 4th and Second Cycle Results on Friday, February 8th. However the encounter cycle results for both the initial and second cycles were excluded from the Information Technology Systems Demonstration Calendar Final 11/27. Was the exclusion from the 11/27 Calendar deliberate? Adjudication/pend files and reports from each encounter cycle automatically provides feedback to Offerors. In addition, the pend correction files allow us to revise encounter submissions for a second cycle.	The revised Information Technology (IT) Systems Demonstration *Calendar* posted on 11/27 (and revised again on 12/19) is correct and supersedes the 10/29 version.

157.	Document J	General	General	Does the data in Document J include claims for all services to be covered in the contract year?	Section J of the Data Supplement contains Contractors' unaudited financial statement data. This data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted. See the Introduction for Section J for more information about these reports. For questions regarding the data contained in Contractors' self-reported statements, see the *Financial Reporting Guide for Acute Health Care Contractors* in the Bidders' Library, Current Reporting Guides and Manuals.
158.	Document C	General	General	Does the data in the databook text files include claims for all services to be covered in the contract year?	Yes, the Data Book files contain all adjudicated encounters for covered services submitted to AHCCCS for the years included in the Data Books.
159.	Document A-Document O	General	General	Were there any significant issues regarding existing health plan data?	There were no significant issues regarding existing health plan data for the Acute Care data. Refer to the Rate Setting Document in Section C of the Data Supplement for Offerors' – Acute Care/CRS, which was posted to the Bidders' Library on December 14 to read about the true-up factors AHCCCS used to develop the CRS rates.
160.	Document C, Document J	General	General	Please provide a list of the adjustments made for any anomalies present in the databook text files and Document J.	Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-

					capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field." Contractors' self-reported financial statement data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted.
161.	Document J	General	General	Are the PMPM amounts in Document J gross or net of copays?	For questions regarding the data contained in Contractors' self-reported financial statements, see the *Financial Reporting Guide for Acute Health Care Contractors* in the Bidders' Library, Current Reporting Guides and Manuals. This data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted.
162.	Document C	General	General	Are the total cost amounts in the databook text files gross or net of copays?	Data Books reflect expenditures using encounter data as reported by Contractors. If payments were reduced due to copays, the Contractor should have reported paid amounts net of copays.

163.	Document C, Document J	General	General	Please provide the dollar amount of the beneficiary copayments and cost sharing associated with total cost amounts in Document J and the Databook text files by fiscal year, region, rate cell, and covered service.	No additional information will be provided.
164.	Document C	General	General	Are third party liability payments included in the databook text files?	TPL payments are not separately reported in the Data Book text files. Expenditures included in the Data Books reflect the encounter data reported by Contractors. Data Book data is not adjusted unless the Contractor has a sub-capitated or block purchasing arrangement. If a Contractor's payment on a claim is reduced due to existence of a third party payer, the Contractor's payment should be net of the third party payment. Contractors are required to adjust previously adjudicated encounters when a post-payment recovery is made.
165.	Document C, Document J	General	General	Please provide the dollar amount of any other adjustments made to the claims experience included in the databook text files and Document J for reasons other than third party liability by fiscal year, region, rate cell, and covered service.	Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then

					the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field." Contractors' self-reported financial statement data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted.
166.	Document C	General	General	Please provide the number of inpatient claim outliers and the associated utilization and cost in the development of the databook text files by fiscal year, region, and rate cell.	No additional information will be provided.
167.	Document C, Document J	General	General	Did the state do any smoothing of large claims in the development of the data?	No, the data provided was not smoothed.
168.	Document C	General	General	Were there significant changes (such as a noted increase or decrease) to utilization since the data period ended?	AHCCCS has not noticed significant changes to utilization since the data period provided ended.
169.	Document J	General	General	Please provide completion factors by Category of Aid, Category of Service and GSA for utilization and expenditures in Document J.	Document J reports are self-reported financial statements submitted by AHCCCS Contractors. Completion factors are not included in this data. For questions regarding the data contained in Contractors' self-reported statements, see the *Financial Reporting Guide for Acute Health Care Contractors* in the Bidders' Library, Current Reporting Guides and Manuals.
170.	Document C	General	General	Please provide the experience period paid-through date.	The Data Book files were run after the first July 2012 encounter cycle. Paid dates could include any date up to the deadline date for encounter submissions for this cycle, which was July 5, 2012.

171.	Document J	General	General	Please indicate whether PMPM expenditures in Document J have completion factors applied.	Contractors' self-reported financial statement data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted. For questions regarding the data contained in Contractors' self-reported statements, see the *Financial Reporting Guide for Acute Health Care Contractors* in the Bidders' Library, Current Reporting Guides and Manuals.
172.	Document C	General	General	What flexibility does the MCO have in developing the formulary?	Refer to AMPM, Chapter 300 Medical Policy for Covered Services, Policy 310-V, Prescription Medication/Pharmacy Services.
173.	Document C	General	General	Are there any services provided to members through other departments or programs that have been cut this year or expect to be cut in the near future causing the services to be pushed into this program?	Information regarding known program changes is provided in various sections of the RFP and supplemental documents.
174.	Document C	General	General	If there are services provided to members through other departments or programs that have been cut this year or expect to be cut in the near future causing the services to be pushed into this program, how is the base experience data adjusted to take into account these changes in services since the base period?	AHCCCS rebases the capitation years every five years as part of the RFP process. Program changes that occur after a rate rebase result in adjustments to the capitation rates.

175.	General	General	General	How will the State account withhold for quality incentives in the risk sharing arrangement calculation?	The question is unclear. Assuming the Offeror is asking how AHCCCS will account for the Payment Reform/Shared Savings withhold in the risk sharing calculations, the withheld capitation revenue will be excluded from the reconciliation. For example, if capitation is $100 and AHCCCS withholds $1, revenue equal to $99 would be used for the reconciliation.
176.	General	General	General	Will withhold for quality incentives be excluded from the gain sharing calculations?	The question is unclear.
177.	General	General	General	Please provide an estimate of reimbursement as a percentage of Medicaid allowable reflected in the dataset, by service category.	No additional information will be provided.
178.	General	General	General	How are Medicaid fee schedule increases developed for hospital, physician, emergency room and pharmacy rates?	Generally, when setting the capitation rates, the unit cost trend will be based on changes to the AHCCCS fee schedule for the categories of service which are impacted by these fee schedule changes. Categories that are not impacted by the AHCCCS fee schedule, include, but are not limited to: Pharmacy, Hospice and CRS Clinic Fees. The AHCCCS fee schedule rates are based primarily on changes to Medicare fee schedules, national trends, access to care and budgetary decisions.
179.	Document C, Document J	General	General	Are there other payments/settlements made outside of the claims system that will be the responsibility of the plans?	All expenditures for covered medical services are required to be submitted as encounters to AHCCCS. However, AHCCCS cannot speak to any Contractor-specific arrangements or circumstances which could result in payments/settlements outside of the claims' system.

180.	Document C, Document J	General	General	If other payments/settlements made outside of the claims system are the responsibility of the plans, will these be built into the rates?	No, payments outside of the claim's system will not be built into the medical component of the capitation rates. This component is developed based on adjudicated encounter data. Payments/settlements made outside the claims' system may be reflected in the Contractor's administrative expenditures and therefore may be accounted for in the administrative component.
181.	Document I	General	General	How many times per year will the Average MCO risk score be updated?	AHCCCS anticipates updating the risk scores one time per year.
182.	Document I	General	General	Please provide additional detail on how members who have enough months of enrollment to be scored, but who have no claim experience will be included in the risk adjustment process.	No additional information will be provided regarding risk adjustment. All information necessary to formulate a bid is posted in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section I, Risk Adjustment Information.
183.	Document I	General	General	If risk adjustment is designed to be budget neutral to the state, will the budget neutrality be on a statewide or regional basis?	Yes, risk adjustment is designed to be budget neutral to the state on both a statewide and GSA basis.
184.	General	General	General	Is premium tax included in the administrative expense level (excluding gain) in the actuarially sound rate ranges rate ranges that will be used for scoring purposes?	This question is unclear. The rate ranges developed by AHCCCS are for the medical component of the capitation rates. There is no administrative expense in the rate ranges. The administrative component bid excludes premium tax. For more information, see the RFP, Section H, Instructions to Offerors, and Acute/CRS RFP YH14-0001 Bidders' Library, Solicitation Amendment No. 1 Q&A, Response # 106.
185.	General	General	General	Please explain how the actuarially sound rate range will be developed by the state	Refer to the Rate Setting Document in Section C of the Data Supplement for Offerors' – Acute

				actuaries.	Care/CRS which was posted to the Bidders' Library on December 14.
186.	General	General	General	Please specify all assumptions including, but not limited to the experience period, trend assumptions, managed care saving assumptions, program changes considered (retrospective and prospective), and non-medical loads in the development of actuarially sound rates by the state actuaries.	Refer to the *Rate Setting Document* in Section C of the Data Supplement for Offerors' – Acute Care/CRS which was posted to the Bidders' Library on December 14. Also see the Bidders' Library, Section B, Program and Fee Schedule Changes. No additional information regarding assumptions will be provided.
187.	Document C, Document J	General	General	Are there any pass-through payments reflected in the data? If so, please quantify these payments.	Data Books reflect expenditures using encounter data as reported by Contractors. To the extent encounter data includes pass-through payments, those payments would be reflected in the data. Likewise, if Contractors' financial statement data include pass-through payments, those payments would be reflected in the self-reported financial data. AHCCCS cannot quantify these payments.
188.	Databook, Document J	General	General	Please provide a reconciliation of membership and PMPM costs for all available years between the Databook and the financial summaries in Document J, including a summary of any data that is only included in one of these items.	AHCCCS will not provide a reconciliation. The Offeror may perform the requested reconciliation based on the data provided.
189.	Databook	General	General	We've observed significant negative changes in inpatient utilization across contract years. Please explain and quantify the primary factors driving these changes.	AHCCCS will not provide additional information regarding utilization changes.

190.	Databook	General	General	We've observed consistent reductions in Emergency Room utilization across contract years. Are there any Emergency Room avoidance measures in place beyond the change in copayments (effective 10/1/2010) that could be driving this change. If so, please quantify them.	The Offeror has access to information on program changes and AHCCCS initiatives across the years included in the Data Books. AHCCCS will not provide additional information regarding utilization changes.
191.	Databook	General	General	Please provide the utilization and charge trends used to develop the actuarially sound rate ranges for CYE14 by Category of Service for each category of aid and GSA.	Refer to the *Rate Setting Document* in Section C of the Data Supplement for Offerors'– Acute Care/CRS which was posted to the Bidders' Library on December 14. No additional information will be provided.
192.	Databook	General	General	We've observed consistently negative and dramatic changes in utilization for Physician/OBGYN services across contract years	Observation noted.
193.	Databook	General	General	Please explain the significant decrease in utilization rates for Hospital days by Maternity Tier between CYE10 and CYE11. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.

194.	Databook	General	General	Please explain the significant decrease in utilization rates for Hospital days by NICU Tier between CYE10 and CYE11. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.
195.	Databook	General	General	Please explain the significant decrease in utilization rates for Hospital days by ICU Tier over all contract years. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.
196.	Databook	General	General	Please explain the significant decrease in utilization rates for Hospital days by Surgery Tier between CYE09 and CYE10. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.

197.	Databook	General	General	Please explain the significant decrease in utilization rates for Hospital days by Nursery Tier between CYE10 and CYE11. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.
198.	Databook	General	General	Please explain the significant decrease in utilization rates for Hospital days by Routine Tier over all contract years. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.
199.	Databook	General	General	Please provide coding criteria and a list of prominent services for the "Hospital Days by Routine Tier" service line.	Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section N, Hospital Rate Overview, *Introduction*.
200.	Databook	General	General	Please provide coding criteria and a list of prominent services for the "All Other Hospital Days" service line.	Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, *Acute Care/CRS Service Matrix*, and Section N, Hospital Rate Overview, *Introduction*.
201.	Databook	General	General	Please explain the spike in utilization rates for All Other Hospital Days in CYE10 within the TANF program, and overall. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted increases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.

202.	Databook	General	General	Please explain the decreasing utilization rate trend over contract years for Physician Surgery.	AHCCCS will not provide additional information regarding utilization changes.
203.	Databook	General	General	Please provide coding criteria and a list of prominent services for the "Physician Other" service line.	Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, *Acute Care/CRS Service Matrix*.
204.	Databook	General	General	Please provide coding criteria and a list of prominent services for the "Other Professional" service line.	Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, *Acute Care/CRS Service Matrix*.
205.	Databook	General	General	Please explain the spike in utilization rates for Other Professional Services in CYE10.	AHCCCS will not provide additional information regarding utilization changes.
206.	Databook	General	General	The utilization rate trend for Other professional services from CYE11 to CYE12 appears to be significantly positive. Because of the timing of the data release, we assume that the CYE12 data is relatively incomplete. This would suggest that the CYE11 to CYE12 utilization trend for Other Professional services could be quite high after completion. Please explain the implied high utilization rate trend for this service category.	AHCCCS will not provide additional information regarding utilization changes.
207.	Databook	General	General	Please explain the significant decrease in utilization rates for Laboratory and Radiology Services between CYE09 and CYE10.	AHCCCS will not provide additional information regarding utilization changes.

208.	Databook	General	General	Please explain the significant increases and decreases for rentals and purchases of DME and Medical Supplies over contract years. For example, has there been an effort to shift DME and Medical Supplies expenses from purchases to rentals?	The Offeror has access to information on program changes and AHCCCS initiatives across the years included in the Data Books. AHCCCS will not provide additional information regarding utilization changes.
209.	Databook	General	General	Please explain the significant decrease in utilization rates for Dental Services between CYE10 and CYE11.	AHCCCS will not provide additional information regarding utilization changes.
210.	Databook	General	General	Please explain the significant increase in utilization rates for Non-Emergency Transportation between CYE09 and CYE10.	AHCCCS will not provide additional information regarding utilization changes.
211.	Databook	General	General	Please explain the significant decrease in unit cost for Non-Emergency Transportation between CYE09 and CYE10. The list of program changes in Document B specifies a 5% reduction in rates between these years; we observe a much more significant negative trend.	AHCCCS will not provide additional information regarding unit cost changes.
212.	Databook	General	General	Please explain the significant decrease in utilization rates for Pharmacy Encounters between CYE10 and CYE11.	AHCCCS will not provide additional information regarding utilization changes.
213.	Databook	General	General	The databook groups membership and claims for members age 14-44 by gender only. Because there are variations in coverage for children and adults within this population, utilization and cost patterns may be substantially different between these two groups. Please provide databook data, enrollment counts and enrollment projections broken out between adults and children for these groups.	No additional information will be provided.

214.	Acute Care Actuarial Certifications CYE09-CYE12	General	General	Please provide a list of experience adjustments made to capitation rates in CYE09-CYE12,	No additional information will be provided.
215.	Acute Care Actuarial Certifications CYE09-CYE13	General	General	Please provide a list of all adjustments other than experience adjustments made to capitation rates after bids had been made, for each contract year.	No additional information will be provided.
216.	Databook	General	General	Does AHCCCS anticipate any difference in utilization trend rates from the utilization trends apparent in the current databook based on emerging experience?	No, AHCCCS does not anticipate any difference in trends based on emerging experience. Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Rate Setting Document*.
217.	Databook	General	General	Does AHCCCS anticipate any difference in unit cost trend rates from the unit cost trends apparent in the current databook based on emerging experience?	No, AHCCCS does not anticipate any difference in trends based on emerging experience. Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Rate Setting Document*.
218.	Databook	General	General	Please provide a definition for "Pharmacy Encounters" (ex. prescriptions, or 30 day equivalents)	Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section D**,** Service Matrix/Selection Criteria for Data Book.
219.	Databook	General	General	The utilization rate trend for TANF < 1 overall appears to be slightly positive between CYE11 and CYE12. Because of the timing of the data release, we assume that the CYE12 data is relatively incomplete. This would suggest that the CYE11 to CYE12 utilization trend for TANF < 1 could be quite high after completion. Please explain the implied high utilization trend for this category of aid.	AHCCCS will not provide additional information regarding utilization changes.

220.	Document H-3	General	General	Which category of aid will the members in the "PPACA Child Expansion" column be included in?	PPACA child expansion members are included in the column labeled "ACA Child Expansion" on H-3, Enrollment by Month (Historical and Projected), which can be found in the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section H, Enrollment Information.
221.	Document H-3	General	General	It appears that the enrollment projections include the assumption that Arizona will participate in the PPACA Medicaid expansion. Please verify this assumption.	The Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section H, Enrollment Information includes an Introduction document which states on page 1: "The projected member months assume the following: • Child expansion is mandatory beginning January 1, 2014 • Restoration of the AHCCCS Care (Childless Adults) population beginning January 1, 2014 • Some categorical woodwork beginning July 1, 2013 • Increase due to streamlined redetermination beginning January 1, 2014 • Kidscare II will end December 31, 2013, but it is anticipated that half of the population will move to child expansion"

222.	Document H-3	General	General	If the state's position on adopting the PPACA Medicaid expansion changes, will AHCCCS publish adjusted enrollment projections, or adjust capitation rates in any way?	As stated in the RFP, Sections D1 and D2, Paragraph 75, Pending Legislation/Other issues: "Governor Brewer and State lawmakers have yet to determine the course for the Medicaid program as it relates to options under the ACA." If something changes before the proposal due date, AHCCCS may choose to publish adjusted enrollment projections, if available. Also as stated in the RFP, Sections D1 and D2, Paragraph 55, Capitation Adjustments, "AHCCCS may, at its option, review capitation rates to determine if a capitation adjustment is needed for reasons including, but not limited to, the following: • Program changes • Legislative requirements…"
223.	N/A	N/A	N/A	We want to make sure we provide appropriate bids for the populations covered, and want to be clear on which populations are to be included in the Dual SNP or Pilot program. There is a category of dual eligible called SSI with Medicare. These members and this category seem to continue to be included in the acute bid. Will these members be moved to the Dual SNP or Pilot? Should we include a bid for them in the acute bid?	Yes, include a bid for members who are in the SSI with Medicare risk group. If the Dual SNP continues, these members will be paid a Medicaid rate based on the bid. If the Dual Demo is implemented, the members are permitted to opt out of the Demo, thus the Medicaid rate paid for these members will be based on the bid.

224.	N/A	N/A	N/A	In addition, we understand that members in the SMI category have been removed from the data book for the acute population. Are there any SMI members with dual eligibility also included in the SSI with Medicare? If so, have they been removed from the data book also?	Only County 13 (Maricopa) SMI members have been removed from the Data Book for the acute population. However, the Acute Care Data Book will contain minimal County 13 SMI services, costs and member months for those members accounting for the transition window from the Acute Care program to the Maricopa RBHA. Example: If a member is in County 13 and determined SMI, there is a 14 day window to move the member from the Acute Care program to the Maricopa RBHA. During that 14 day period the member will still be on the Acute Care program, thus that data was not removed from the Data Book.
225.	Supplemental Data Book Reports	N/A	N/A	The data book does not break out prescription drug information into generic, brand, retail or mail. Can utilization and cost information be broken out by these additional categories and provided to bidders?	No additional information will be provided.
226.	Document F – Capitation Bid Template Acute Care and Document C – Data Book Files Acute Care Delivery Supplement Cost and Utilization.txt	N/A	N/A	When Delivery Supplement is selected as the risk group in the bid template (Data Book file 'Document F – Capitation Bid Template Acute Care.xlsm'), only limited service categories are shown; however, the Data Book file 'Document C- Data Book Files Acute Care Delivery Supplement Cost and Utilization.txt' includes Delivery Supplement utilization and costs in other service categories (e.g., Pharmacy). Should costs in those additional categories be included in Miscellaneous in the bid?	Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, *Crosswalk Acute Care Service Matrix to Capitation Bid Template* posted on December 14.

227.	Document G – CrosswalkAcuteCare CRS Service Matrix Financial Statements	N/A	N/A	Document G provides a crosswalk between most service categories, but does not specifically show how Physician OB/GYN Services, Physician Surgery, and Physician Other map to Primary Care Physician and Referral Physician, which are service categories in the bid template. Is there a direct mapping for these categories, or can you provide additional information on primary care vs. referral physician utilization?	Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, *Crosswalk Acute Care Service Matrix to Capitation Bid Template* posted on December 14.
228.	Document C – Databook Introduction	N/A	N/A	We understand that the data book contains services provided through 3/31/12, and is not adjusted for completion factors. DocC_DatabookIntroduction.pdf indicates that the Data Book Files were run after the first July 2012 encounter cycle. Can you provide a specific "paid-through" date?	The Data Book files were run after the first July 2012 encounter cycle. Paid dates could include any date up to the deadline date for encounter submissions for this cycle, which was July 5, 2012.
229.	Document C – Databook Introduction	N/A	N/A	Is there information available on Third Party Liability (TPL) recoveries, beyond the PMPM values in Section J? Can lag tables be provided? Are TPL recoveries included in the data book?	Expenditures included in the Data Books reflect the encounter data reported by Contractors. Data Book data is not adjusted unless the Contractor has a sub-capitated or block purchasing arrangement. If a Contractor's payment on a claim is reduced due to existence of a third party payer, the Contractor's payment should be net of the third party payment. Contractors are required to adjust previously adjudicated encounters when a post-payment recovery is made. Capitation rate ranges were developed based on the Data Book data. No additional information will be provided.

230.	Amendment 1	N/A	N/A	Please confirm that the entity awarded a contract must be a c corporation. Please also confirm that a successful incumbent bidder that is currently organized as an LLC would be required to reorganize as a corporation. If so, what is the deadline for such reorganization?	Within 120 days of contract award, a non-governmental Contractor shall have established a separate corporation. This corporation does not have to be a c corporation. A successful incumbent that is currently an LLC would be required to become a corporation within the same timeline.
231.	Databook	Utilization Data	Utilization Data	Please explain the large drop in utilization for AHCCCS Care between 2010 and 2011	AHCCCS will not provide additional information regarding utilization changes.