AHCCCS	**SOLICITATION AMENDMENT** Solicitation Number: RFP YH12-0001 Amendment Number 2 (Two) Solicitation Due Date: April 1, 2011 3:00 PM (MST)	Arizona Health Care Cost Containment System (AHCCCS) 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Contract Management Specialist: Jamey Schultz, CMS E-mail: Jamey.Schultz@azahcccs.gov

A signed copy of this amendment shall be included with the proposal, which must be received by AHCCCSA no later than the Solicitation due date and time. This solicitation is amended as follows:

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 11th day of March, 2011, in Phoenix, Arizona.
Signature	Date	
Typed Name and Title		Michael Veit
		Contracts and Purchasing Administrator
Name of Company		

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
1	General Question			In restating the question from AHCCCS that we are responding to in our proposal, can this be in 9pt font as opposed to 11pt font? We understand that our response must be in 11pt font.	Yes
2	Program Requirements	12/Behavioral Health		Does the psychiatric inpatient bed days benefit extend to payment for bed days once a member is transitioned to the state psychiatric hospital?	Yes, however, payment is determined by the unique factual circumstances specific to the AzSH placement.
3	Data Supplement Section C TREND AND RATE SETTING ASSUMPTIONS			General Trend and Rate Setting Assumptions of the ALTCS RFP contains historical enrollment for the Acute Care Only members for the time periods that are in the databook. It is noted in the databook supplement that the Other population includes these Acute Care Only members. Does the Acute Care expenditures associated with the Other population include expenditures that are associated with these Acute Care Only members? If so, please provide either the actual dollar amounts, or the percentage of the total acute care expenditures for the Other population that are attributable to Acute Care Only members.	Yes. The expenditures of the Other population include expenditures for Acute Care Only. Historically, the acute component in the full EPD capitation rate is used to set the acute component in the Acute Care Only population. This is done due to the small population size of the Acute Care Only members. AHCCCS plans to follow this methodology for CYE12. Thus assume the dollar amount associated with Acute Care Only members is equal to the PMPM of acute component expenses divided by all prospective member months multiplied by Acute Care Only members.
4	Data Supplement Section C Utilization and Costs			Are the databook expenditures net or gross of reinsurance amounts?	Databook expenditures are actual expenditures and have not been adjusted for reinsurance amounts.
5	Data Supplement Section C TREND AND RATE SETTING ASSUMPTIONS			Section C - General Trend and Rate Setting Assumptions contains a matrix that represents historical and prospective Fee Schedule Changes. With regard to the Provider Fee Increase (PFI) for Behavioral Health, does the 9.1% PFI effective 10/1/2007 and the 3.8% PFI effective 10/1/2008 apply to all Behavioral Health expenditures or just to Behavioral Health Inpatient expenditures?	The 10/01/07, 10/01/08 and 10/01/10 provider fee schedule changes relate to all behavioral health expenditures. The 2/1/09 provider fee schedule changes relates to all behavioral health service rates set by ADHS so they exclude the tier per diem at an acute hospital, which remained flat. The 4/1/11 provider fee schedule changes exclude behavioral health inpatient service rates set by ADHS.
6	Data Supplement Section C TREND AND RATE SETTING			Section C - General Trend and Rate Setting Assumptions contains a matrix that represents historical and prospective Fee Schedule Changes. With regard to the Free-Standing Dialysis PFI,	COS 37, Outpatient Facility Visits. Data is not available regarding the portion of expenditures of that COS impacted by the fee schedule change.

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	ASSUMPTIONS			what COS does this PFI impact? And what portion of expenditures of that COS is impacted by this PFI?	
7	Forms- Network Summary Form			The second column of the Network Summary form (PC ID#) requires a Contractor Identification Number. How do new bidders obtain this number?	New Offerors are not required to fill out the second column.
8	Section I. Instruction to Offerors	14. CONTENTS OF OFFEROR'S PROPOSAL SECTION B.		AHCCCS will publish actuarially sound rate ranges by GSA for the medical component of the capitation rates prior to March 1, 2011. Where are these rates published?	These rates are available in the Data Supplement portion of the Bidders' Library in the Data Supplement, under Section F, Bid Submission Tools.
9	Section C - General Trend and Rate Setting Assumptions, "Table I: Fee Schedule Changes"			This section lists the historical and prospective fee schedule changes for HCBS (home only) providers as 5% and 2.5% rate decreases on 10/1/2009 and 10/1/2010, respectively, and a 2.5% reduction on 4/1/2011. In the databook, there are 14 categories of service that are listed as HCBS home services. Do these fee schedule changes for HCBS (home only) apply to all 14 categories of services associated with HCBS home services? If not, could you please indicate which categories of service that these rate decreases apply to?	The changes for HCBS apply to all 14 categories of service.
10	Capitation			Please provide the actuarial memorandum for the development of the rate ranges for this RFP.	No actuarial memorandum will be provided for the rate ranges. AHCCCS will provide an actuarial certification to CMS at the time the final rates are submitted for approval, no later than September 1, 2011.
11	Capitation			If actuarial memorandum is not available, which factors were adjusted to determine the endpoints of the rate ranges? Examples might be improvements in medical management of acute services, improvements in the HCBS mix, etc. Can you provide those adjustments?	All of the assumptions for developing each mid-point of the range are provided in the Data Supplement, including a discussion of the HCBS mix. The ranges were then developed by computing appropriate deviations from the means.
12	Data Supplement			Pima County claims totals as found in the data supplement files are significantly lower than costs found in the unaudited financials. Were the ranges based on the supplemental files alone, or were adjustments made to account for the differences	The base data used for Pima GSA was the CYE10 encounters which, when adjusted by a completion factor, fall within a reasonable range when compared to the financials. Trends for Pima GSA were based on statewide trends without Pima GSA

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				between the supplemental files and the financials?	data due to the encounter issues for Pima in CYE08 and CYE09.
13	Data Supplement			GSA 44 and GSA 50 consistently show much smaller historical reinsurance offsets than the other GSAs. This differential is not consistent with acute costs in those GSAs relative to other GSAs. Are these reinsurance costs representative of the catastrophic acute costs experienced in these GSAs, or were there extenuating circumstances that led to unusually low reinsurance offsets?	GSA 50 has had historical encounter issues. AHCCCS attributes the low reinsurance payments in CYE08 to the fact that the Contractor did not adjudicate encounters on time and thus missed reinsurance timely filing deadlines. GSA 44 has lower TBI/BEH cases as well as lower regular RI cases. No extenuating circumstances that AHCCCS knows about led to the low reinsurance payments in that GSA.
14	RFP Amendment Number 1	Q&A #2	1	Please clarify- The response to this question also appears as the response to Q#103 regarding the Instructions to Offerors section 14.C.7. Is this the same answer to the question posed by the Offeror: "Is inclusion of the questions being addressed required as part of the narrative responses?" If the Offeror repeats the RFP Bid Requirement, will AHCCCS consider only the space utilized by the response to the requirement?	Inclusion of the question being addressed is not required. The total response (including any restatement) must be within the page limit specified.
15	RFP Amendment Number 1	Q&A #80	20	When the Offeror is required to provide a list as a part of its response to a disclosure requirement in Schedule G (e.g., items 7d and 8), may the Offeror include this as an exhibit/attachment to Schedule G within the General Matters section of the bid response, providing all disclosure information is included in the exhibit and the two parts are fully cross-referenced?	Yes
16	RFP Amendment Number 1	Question 90	22	When using Visio (standard flow charting software), the template shapes generally do not provide adequate spacing for 9 point font in certain shapes. Would a smaller font be acceptable if it can be clearly read within the lines of the template shape or will AHCCCS consider allowing more pages for flow charts given the font size limitation?	A minimum of 8 point font is acceptable for flowcharts only.
17	Program Requirements	19/Pre-Admission Screening and Resident	42	What is the difference between the Preadmission Screening and Resident Review (PASRR) mentioned on page 42 and the Pre-admission Screening (PAS) tool referenced in Sections 2	In order to qualify for ALTCS all applicants must meet both financial and medical eligibility. The PAS is conducted to determine if the person meets medical eligibility for ALTCS. The PASRR is

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		Review (PASRR)		(Introduction / ALTCS Eligibility: Medical Eligibility section on page 17) and 3 (Enrollment Disenrollment / Disenrollment to Acute Care Program section on page 18)?	conducted prior to a member's admission to a nursing facility and is used to determine whether a member has any diagnosis or other presenting evidence that suggests the potential of mental illness or mental retardation and whether a member requires the level of care provided in a nursing facility and/or needs specialized services.
18	Program Requirements	31/Provider Registration	59	Will AHCCCS provide new offerors a database or other resource to look up provider AHCCCS ID numbers prior to bid submission? If so, when can new offerors expect to receive this information?	No database will be provided to new Offerors prior to bid submission.
19	Program Requirements	32/Network Summary	59	Do non-emergency Transportation Providers (i.e. ITM) require AHCCCS Numbers?	Yes, all providers require AHCCCS Provider Identification numbers.
20	GENERAL QUESTION: D. Program Requirements	44. Claims Payment/ Health Information System	70	In Amendment 1 issued by AHCCCS on 2/25/11, AHCCCS' response to Question 46 indicated that "Any claim that does not meet the standardized claim requirements of R9-22-719 is considered roster billing." Please verify the reference to R9-22-719 is correct, as we believe the correct reference may be R9-22-705.	This reference should be corrected to reflect R9-22-710 as stated in RFP Section D, Paragraph 44, Claims Payment/Health Information System.
21	D- Program Requirements	53 – Separate Incorporation	76	The RFP states: "Within 60 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." AHCCCS previously clarified that it is acceptable to have a single corporate entity that is authorized to provide services under multiple contracts with AHCCCS (e.g., one corporate entity that holds separate contracts with AHCCCS for both the acute and long term care programs). Contractor also administers benefits for AHCCCS dual eligible Medicaid/Medicare members, and maintains a Medicare Advantage contract with	It is acceptable for the Contractor to use the same corporate entity for Medicaid and Medicare contracts.

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				CMS. Contractor understands that it will continue to be acceptable to use the corporate entity that is authorized to provide services under the multiple AHCCCS contracts for the Medicare Advantage program. Please advise if this is not correct.	
22	D- Program Requirements	59 – Capitation Adjustments	83	The RFP states: "In these instances the adjustment and assumptions will be discussed with the Contractor prior to modifying capitation rates." AHCCCS previously responded that Contractor is always given a contract amendment for signature, and has the option not to sign. Will the contract be revised to incorporate language establishing that: 1. Modification of the capitation rates will not be effective without a contract amendment? and 2. Contractor is not obligated to sign any contract amendment?	No capitation rate change can be made without a contract amendment. Per response to Question #60 in Amendment #1: (i) Contractor is always given the contract amendment for signature. Contractor has the option not to sign. (ii) Contract language already stipulates the terms for notification to AHCCCS of intent not to renew or continue as an AHCCCS Contractor. See Section E, Paragraph 25, Term of Contract and Option to Renew for further information..
23	E – Contract Terms and Conditions	29 -- Contract	110	The RFP states: "AHCCCS reserves the right to clarify any contractual relationship in writing, and such written clarification shall govern in case of conflict with the applicable requirements stated in the RFP or the Contractor's proposal." AHCCCS previously responded that not all clarifications will require an amendment to the contract. Will the contract be revised to incorporate language establishing that any such clarification that materially, adversely affects Contractor's compensation, reimbursement, or scope of services will not be effective without being adopted pursuant to a contract amendment?	Change will be considered for possible future amendment.
24	Provider Network	Section H	142	The second paragraph describes that **"network development portion of Provider Network"** will be scored by GSA. The remaining submission	The "network development portion" refers to the Network Summary, Submission #45. The "network management portion" refers to all other

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				areas: the **network management portion of Provider network…."** are anticipated to be scored statewide, not specific to any GSA". Please clarify your definition of "network development" versus "network management" and where would the **network summary** fall between these two categories?	network submission requirements, #36 through 44.
25	Instructions to Offerors B. Capitation	Capitation Bid Submission	151	Each capitation bid will encompass three components; a medical component, a case management component, and an administrative component. Each component will be scored separately. Please provide additional details on how these components will be scored. Will each component have a maximum point level? Will the weighting for the three components be different than 33.3% each?	No further information will be provided regarding the scoring of the capitation bid.
26	Instructions to Offerors B. Capitation	Capitation Bid Submission	151	Will the rate bid for case management remain static, regardless of changes in the underlying case mix over the term of the contract, or will it be adjusted in the annual rate setting meeting to reflect the change in mix for a contractor?	The case management component is reviewed each year for necessary adjustments due to mix change or other factors.
27	RFP Section I; Instructions to Offerors	B. Capitation	152	Please clarify the name of the folder located on the FTP/SFTP server to be used for offeror's bid submissions. Specifically, should bid materials be submitted directly to "/EFPRFP12" or will a subfolder be created for offeror bid submissions (such as an "IN" folder)?	Each Offeror has an available folder listed by the Offeror's name that can be used for the bid submission. The folders can be located when logged on to the AHCCCS sftp. https://sftp.statemedicaid.us/ EPDRFP12 >Data SupplementFiles > (offeror folder name) use tab UPLOAD
28	Section I. Instruction to Offerors	14. CONTENTS OF OFFEROR'S PROPOSAL SECTION B.	152	Is the actuarial certification of the rates for the overall rate (the sum of the three components), a separate certification for each component of the rate that is being bid or only the medical component of the rate?	The actuarial certification is for the total rate bid.
29	Section I	C. Organization, Question 5	153	Regarding the requirement to provide functional organizational charts of the key program areas and responsibilities are Offerors allotted the three page limit per functional area?	The standard page limit of 3 applies to the total submission.
30	I (Instructions to Offerors)	Information Services	154	Regarding the sentence underneath Question 14 (which states: *Reference: Section D, Paragraphs*	The sentence is in reference to Questions 11 through 14.

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				44, Claims Payment/Health Information System; 73, Data Exchange Requirements. Question: is this sentence in reference to Question 14 - or is it in reference to Questions 11 through 14?	
31	I. Instructions to Offerors; #14, Contents of Offeror's Proposal	35	159	The reference for the submission requirement cites Paragraph 26 for Quality Management and Attachment H(1) for Enrollee Grievance System Standards and Policy. Are these correct?	The correct references for Submission Requirement #35 is: *Section D, Paragraphs 20, Quality Management, 22, Grievance System; Section F, Attachments, B(1), Enrollee Grievance System; ACOM, 406 Enrollee Grievance Policy; AMPM Chapter 900; 42 CFR 438.240; 42 CFR 438.408; 42 CFR 438.414*
32	I. Instructions to Offerors; #14, Contents of Offeror's Proposal	45	160	What GSAs have Zone requirements?	Two GSAs have Zone requirements – GSA 50, Pima County and GSA 52 – Maricopa. See ACOM Policy 419 Network Standards.
33	Section I	E.45	160	The RFP states: LOIs and contracts should NOT be included with the Offeror's proposal. Please confirm that this statement also indicates that LOIs and Contracts need not be provided electronically via the EFT site.	LOIs and contracts should not be provided via the EFT, however, they must be available for review if requested by AHCCCS.
34	Instructions to Offerors	14. E. Provider Network Submissions	160	Specifically to the provider network, are DD Group Homes a requirement of the ALTCS network? Previously they have been included in the DES program at AHCCCS, but the current requirements for each GSA include "DD Group Home" in the "HCBS Community" provider section. Is this correct for each GSA's requirements?	DD Group Homes are a covered service (see Section D, paragraph 10) and must be available when appropriate.
35	Provider Network		160	On the network summary - will you make a distinction between contracted providers and providers solicited through a Letter of Intent(LOI)? Furthermore, will you consider adopting a similar methodology utilized by Medicare Advantage whereby a random sample of providers is selected to determine if they truly are contracted or if providers actually agreed to contract (via LOI)? If not, what alternative methodology might you consider employing to ensure that providers listed in a network disk, in fact agreed to enter into a contract with a health plan or are currently	There will be no distinction between contracts and Letters of Intent. AHCCCS will not reveal its scoring or verification methodologies.

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				contracted?	
36	Provider Network	Question 45	160	How will the network summary be scored beyond meeting the minimum network standards?	AHCCCS will not reveal its scoring or verification methodologies.
37	ALTCS Bidders Library/ACOM	Chapter 300 – Financial	310-1	In the Bidder's Library link to the ACOM, the delivery supplemental policy indicates that it applies to all Acute contractors. Under the ALTCS program, is this policy also applicable? If so, what is the method of transmitting delivery information to AHCCCS for the delivery supplemental payments?	There is no delivery supplemental payment for the ALTCS program. This payment only applies to Acute contracts as the policy describes.