Department of Health and Social Services
Finance and Management Services
Grants and Contracts Support Team
333Willoughby Ave., Room 760
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RFP #170007291
Medicaid Coordinated Care Demonstration Project

Amendment #2

Amendment Issue Date: February 16, 2017

IMPORTANT NOTE TO OFFERORS: This amendment serves to answer questions submitted by interested parties. A copy of the amendment is available on the State's Vendor Self Service website.

- **Vendor Questions have been answered as follows:**

Q1: Regarding Sec. 1.02, can we assume that a service including utilization management will not run counter to your efforts to avoid administrative cost? Or is this analogous to the Medical Loss Ratio (MLR) requirements for Medicaid Managed Care under CMS regulations that defines utilization management as an administrative cost?

The answer to the first question is yes (the answer to the second question is no). The stipulation in Sec. 1.02 of the RFP is not analogous to the definition under the CMS managed care regulations regarding MLR requirements. The intent of Sec. 1.02 is to explain that the State Medicaid program will not make payments to an offeror under a contractual arrangement that would be considered a *State government* administrative cost from CMS' perspective. State Medicaid administrative cost spending is budgeted separately from Medicaid services, limited by the amount of State general funds appropriated, and is only reimbursed at 50 percent by the federal government. Coordinated Care Demonstration projects will only be paid through (possibly enhanced) reimbursement of Medicaid service, not through separate payments for administrative costs.

Q2: Re: Section 3.12, could you please define the State's insurance coverage requirements?

Evidence of insurance will not be required at the time of proposal. To the extent that insurance coverage will be required of the selected offeror(s), this will be negotiated during the contract negotiation period as described in the CCDP Initiative Timeline (see Section 2.01.02). Below is an example of the insurance typically required by the State of Alaska for the performance of professional services:

Article 1. Indemnification
The Contractor shall indemnify, hold harmless, and defend the contracting agency from and against any claim of, or liability for error, omission or negligent act of the Contractor under this agreement. The Contractor shall not be required to indemnify the contracting agency for a claim of, or liability for, the independent negligence of the contracting agency. If there is a claim of, or liability for, the joint negligent error or omission of the Contractor and the independent negligence of the Contracting agency, the indemnification and hold harmless obligation shall be apportioned on a comparative fault basis.

"Contractor" and "Contracting agency", as used within this and the following article, include the employees, agents and other contractors who are directly responsible, respectively, to each. The term "independent negligence" is negligence other than in the Contracting agency's selection, administration, monitoring, or controlling of the Contractor and in approving or accepting the Contractor's work.

Article 2. Insurance

Without limiting contractor's indemnification, it is agreed that contractor shall purchase at its own expense and maintain in force at all times during the performance of services under this agreement the following policies of insurance. Where specific limits are shown, it is understood that they shall be the minimum acceptable limits. If the contractor's policy contains higher limits, the state shall be entitled to coverage to the extent of such higher limits. Certificates of Insurance must be furnished to the contracting officer prior to beginning work and must provide for a notice of cancellation, non-renewal, or material change of conditions in accordance with policy provisions. Failure to furnish satisfactory evidence of insurance or lapse of the policy is a material breach of this contract and shall be grounds for termination of the contractor's services. All insurance policies shall comply with and be issued by insurers licensed to transact the business of insurance under AS 21.

2.1 Workers' Compensation Insurance: The Contractor shall provide and maintain, for all employees engaged in work under this contract, coverage as required by AS 23.30.045, and; where applicable, any other statutory obligations including but not limited to Federal U.S.L. & H. and Jones Act requirements. The policy must waive subrogation against the State.

2.2 Commercial General Liability Insurance: covering all business premises and operations used by the Contractor in the performance of services under this agreement with minimum coverage limits of $300,000 combined single limit per claim.

2.3 Commercial Automobile Liability Insurance: covering all vehicles used by the Contractor in the performance of services under this agreement with minimum coverage limits of $300,000 combined single limit per claim.

2.4 Professional Liability Insurance: covering all errors, omissions or negligent acts in the performance of professional services under this agreement. Limits required per the following schedule:

Contract Amount	**Minimum Required Limits**
Under $100,000	$300,000 per Claim / Annual Aggregate
$100,000-$499,999	$500,000 per Claim / Annual Aggregate
$500,000-$999,999	$1,000,000 per Claim / Annual Aggregate
$1,000,000 or over	Refer to Risk Management

Q3: Does the State intend to select a single project model or are you open to a combination of models; for instance, might the State contract with one or more MCOs *and also* carve out care management to a CME for populations requiring specialization?

It is the State's intent to demonstrate a number of different models, not to limit selection to a single model. However, it is highly unlikely that different models would be selected to serve the same population in the same community or region. For example, if an offeror proposes a model to provide comprehensive services in a region of the state, and another offeror proposes a different model to deliver a specific service to that same region and population, the one project deemed most likely to improve care and deliver the greatest level of Medicaid savings for that region/population will have the greatest chance of being selected.

Q4: Re: Section 4.01.02, is the State open to CME reimbursement models other than per member per month (PMPM)?

Yes.

Q5: When will the data be available for analysis?

The Department anticipates the Medicaid Data Book will be released on February 28th.

Q6: What level of detail will be provided in the Data Book?

Milliman is currently in the process of defining the logic for display of the data. All of the decisions about level of detail, which in part are driven by confidentiality and HIPAA privacy concerns, are currently being made.

Q7: If the Data Book is delayed will the State consider extending the deadline for proposals?

The Department anticipates the Medicaid Data Book will be released on time (by February 28).

Q8: There were many other Medicaid reform initiatives required under Senate Bill 74. How will the Coordinated Care Demonstration Projects align with those other reform efforts?

The Department is working on the plans and policies associated with each of the SB 74 initiatives to ensure compliance with all of the statutory requirements. Two other major reform initiatives of SB 74 that are related to the Coordinated Care Demonstration Project are the Behavioral Health System reforms, and implementation of the Federal Policy on Tribal Medicaid reimbursement. Those initiatives are described in Section 2.01 of the RFP, and requirements and limitations of CCDP proposals associated with those other two major reform efforts are described in Section 5.02.03 and Section 5.02.04 of the RFP.

Q9: The various federal authorities that might be required to implement a project are described in Section 2.03 of the RFP. Do you anticipate being able to meet the requirements for those federal authorities within the timeline in the RFP?

The timeline of the RFP anticipates time for request for federal approvals, if necessary. If we find that a selected project requires federal approval and the approval process will take more time than originally anticipated, the department may negotiate a different project implementation date with the offeror.

Q10: Will projects that do not require federal approval under a new federal authority be preferred?

No. Projects will be evaluated based on feasibility and overall ability to improve care and reduce Medicaid costs.

Q11: Will proposals for provision of specific services, such as high-tech imaging or musculoskeletal, be considered?

All proposals that meet the Minimum Qualifications in Section 1.04 of the RFP, and that comply with the scope of work requirements described in Section 3.01 of the RFP, will be considered. Note that a single service would still need to serve the overall intent of the program to improve coordination of care, and that the law requires that these projects include at least three from a list of nine features (listed in Section 3.01 of the RFP). Also please refer to the Definitions provided under Section 2.02 for clarification regarding the meaning of those nine potential project features.

Q12: Will you provide a breakdown of enrollment by Borough?

The Medicaid Data Book will provide a breakdown of enrollment, costs and service categories by the ten Division of Behavioral Health Regions, with the Other Southeast Region broken down by Northern Southeast and Southern Southeast (so 11 regions total).

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