**Amendment #7 to RFQ 20211210: Updated RFQ Appendices F and H in Word Format**

**RFQ #: 20211210 / RFx#3150003991**

**Date: February 7, 2022**

**RFQ Name: Mississippi Division of Medicaid Coordinated Care**

Provided herein are amended Microsoft Word versions of the following:

* APPENDIX F: Corporate Background and Experience, form 4.3.1.2: Corporate Experience
* APPENDIX H: Organization and Staffing, Attestation for 4.3.3.3 Administrative Requirements
* APPENDIX H: Organization and Staffing, first form for 4.3.3.5 Subcontractors

**Typographical Errors**

Additionally, the following typographical errors were corrected in the following documents included in this amendment:

**APPENDIX F Amendments**

Page 112 is amended in red, below:

**4.3.1.2: Corporate Experience**

Use the following form to provide information for any states that the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000.

If the Offeror has no current or recent clients, the Offeror must provide a narrative explanation, not to exceed three (3) pages. ~~an explanation. Offerors must submit appropriate documentation to support information provided.~~ Acceptance of the explanation provided is at the discretion of the Division.

Page 113 is amended as explained below:

**The form for APPENDIX F: Corporate Background and Experience, form 4.3.1.2: Corporate Experience (Page 113)** is amended to remove a duplicative field requesting “Geographic and population coverage requirements.”

**APPENDIX H Amendments**

Page 132 is amended as explained below:

**The header of the attestation for APPENDIX H: Organization and Staffing, 4.3.3.3 Administrative Requirements** is amended to show the correct number of points available for this section as indicated in red below, in conformance with the scoring as stated in the body of the RFQ:

4.3.3.3 Administrative Requirements (Marked) – 5~~10~~ points

**The body of the attestation for APPENDIX H: Organization and Staffing, 4.3.3.3 Administrative Requirements** is amended as indicated in red below:

**4.3.3.3 Administrative Requirements (Marked) – 5~~10~~ points**

Offeror attests to the following:

1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid’s Central Office at the Walter Sillers Building, Jackson, Mississippi 39201-1399, as required by the RFQ.
2. ~~The Offeror will Describe how and where administrative records and data will be maintained and the process and time frame for retrieving records requested by the Division or other State or external review representatives.~~

Page 133 is amended as indicated in red, below:

**4.3.3.5 Subcontractors – 20 points**

The Offeror must provide a narrative explanation no longer than three (3) pages giving an overview of its overall philosophy for subcontractor hiring and management.

Use the first provided form entitled “Subcontractor” to describe the any subcontractor the Offeror plans to use if chosen as a winning Contractor through this RFQ.

If the Offeror has worked with the subcontractor in the past three (3) years on a managed care contract, use the second form, “Prior Experience with Subcontractor” to give details about that experience.

Page 134 is amended as explained, below:

The first form in APPENDIX H: Organization and Staffing, 4.3.3.5 Subcontractors was amended to include an option for “Affiliate under the same common ownership” as a response to the question, “This entity is a:”.

**Receipt of Amendment 7 Acknowledged:**

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(Signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Title)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Company)

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Corporate Experience: Current and/or Recent Client** | | | | | | | |
| **Client’s Name:** | | | | | | | |
| **Client Location** | | | | | | | |
| **Address Line 1:** | | | | | | | |
| **Address Line 2:** | | | | | | | |
| **City:** | | **State:** | | **Zip Code:** | | **County:** | |
| **Mailing Address (P.O. Box):** | **City:** | | **State:** | | **Zip Code:** | | **County:** |
| **Direct Contact for Client** | | | | | | | |
| **Name:** | | | | | | | |
| **Title:** | | | | | | | |
| **Phone Number:** | | | | **Email Address:** | | | |
| **Work Details** | | | | | | | |
| **Number of covered lives:** | | | | | | | |
| **Time period of contract:** | | | | | | | |
| **Total number of staff hours expended during time period of contract:** | | | | | | | |
| **Personnel requirements:** | | | | | | | |
| **Geographic and population coverage requirements:** | | | | | | | |
| **Publicly funded contract cost:** | | | | | | | |
| **Description of work performed under this contract** | | | | | | | |
|  | | | | | | | |

**4.3.3.3 Administrative Requirements (Marked) – 5 points**

Offeror attests to the following:

1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid’s Central Office at the Walter Sillers Building, Jackson, Mississippi 39201-1399, as required by the RFQ.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed name of person attesting for Offeror Title of person attesting for Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of person attesting for Offeror Date**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Subcontractor** | | | | | | | |
| **Name of Subcontractor:** | | | | | | | |
| **TIN/SSN (as applicable):** | | | | **The entity is a:**  **[ ] Subcontractor**  **[ ] Wholly-Owned Subsidiary**  **[ ] Affiliate under the same common ownership** | | | |
| **Address Line 1:** | | | | | | | |
| **Address Line 2:** | | | | | | | |
| **City:** | | **State:** | | **Zip Code:** | | **County:** | |
| **Mailing Address (P.O. Box):** | **City:** | | **State:** | | **Zip Code:** | | **County:** |
| **Description of Services to be Rendered by Subcontractor for this Contract:** | | | | | | | |
| **How will the Offeror monitor and manage this Subcontractor?** | | | | | | | |
| **Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [ ] Yes [ ] No**  **If yes, fill out Prior Experience with Subcontractor for each applicable instance.** | | | | | | | |