ALABAMA MEDICAID AGENCY
REQUEST FOR PROPOSALS

RFP Number: 2019-ACHN-01	**RFP Title: Alabama Coordinated Health Network Request for Proposals**
RFP Due Date and Time: February 25, 2019 by 5:00 pm Central Time	**Number of Pages: 182**
PROCUREMENT INFORMATION	
Project Director: Varonica Wagner	**Issue Date: January 09, 2019**
E-mail Address: achnrfp@medicaid.alabama.gov **Website: http://www.medicaid.alabama.gov**	**Issuing Division: Managed Care Division**
INSTRUCTIONS TO CONTRACTORS	
Return Proposal to: **Alabama Medicaid Agency** **Attn: Varonica Wagner** **Lurleen B. Wallace Building** **501 Dexter Avenue** **Post Office Box 5624** **Montgomery, AL 36103-5624**	**Mark Face of Envelope/Package:** **RFP Number: 2019-ACHN-01** **RFP Due Date: February 25, 2019 by 5:00 pm Central Time**
VENDOR INFORMATION ***(Contractor must complete the following and return with RFP response)***	
Vendor Name/Address:	Authorized Vendor Signatory: (Please print name and sign in ink)
Vendor Phone Number:	Vendor FAX Number:
Vendor Federal I.D. Number:	Vendor E-mail Address:

Section A. RFP Checklist

1. ____ **Read the *entire* document.** Note critical items such as: mandatory requirements; supplies/services required; submittal dates; number of copies required for submittal; licensing requirements; contract requirements (i.e., contract performance security, insurance requirements, performance and/or reporting requirements, etc.).

2. ____ **Note the project director's name, address, phone numbers and e-mail address.** This is the only person you are allowed to communicate with regarding the RFP and is an excellent source of information for any questions you may have.

3. ____ **Take advantage of the "question and answer" period.** Submit your questions to the project director by the due date(s) listed in the Schedule of Events and view the answers as posted on the WEB. All addenda issued for an RFP are posted on the State's website and will include all questions asked and answered concerning the RFP.

4. ____ **Use the forms provided**, i.e., cover page, disclosure statement, etc.

5. ____ **Check the State's website for RFP addenda.** It is the Vendor's responsibility to check the State's website at www.medicaid.alabama.gov for any addenda issued for this RFP, no further notification will be provided. Vendors must submit a signed cover sheet for each addendum issued along with your RFP response.

6. ____ **Review and read the RFP document again** to make sure that you have addressed all requirements. Your original response and the requested copies must be identical and be complete. The copies are provided to the evaluation committee members and will be used to score your response.

7. ____ **Submit your response on time.** Note all the dates and times listed in the Schedule of Events and within the document, and be sure to submit all required items on time. Late proposal responses are ***never*** accepted.

8. ____ **Prepare to sign and return the Contract, Contract Review Report, Business Associate Agreement and other documents** to expedite the contract approval process. The selected Vendor's contract will have to be reviewed by the State's Contract Review Committee which has strict deadlines for document submission. Failure to submit the signed contract can delay the project start date but will not affect the deliverable date.

This checklist is provided for assistance only and should not be submitted with Vendor's

Section B. Schedule of Events

The following RFP Schedule of Events represents the Agency's best estimate of the schedule that will be followed. Except for the deadlines associated with the Vendor question and answer periods and the proposal due date, the other dates provided in the schedule are estimates and will be impacted by the number of proposals received. The Agency reserves the right, at its sole discretion, to adjust this schedule as it deems necessary. Notification of any adjustment to the Schedule of Events will be posted on the RFP website at www.medicaid.alabama.gov.

EVENT	DATE
RFP Issued	1/09/2019
Round One Questions Due by 5 pm CT	1/17/2019
Mandatory Vendor's Conference (Pre-registration required. Complete registration form (Appendix C) and return via email to the Project Director by 1/17/2019.)	1/22/2019
Round One Posting of Question and Answers	1/25/2019
Round Two Questions Due by 5pm CT	1/30/2019
Final Posting of Questions and Answers	2/08/2019
Proposals Due by 5 pm CT	2/25/2019
Evaluation Preparation (Compliance Checklist, Evaluation Material Preparation, Clarifications)	2/26/2019 - 2/28/2019
Evaluation Period (Evaluators Evaluating)	3/06/2019 - 3/27/2019
Compile Evaluator's Scores, Conduct Final Meeting, Draft Recommendation Letters, Route Letters for Signature	3/27/2019 – 4/02/2019
Contract Award Notification	4/17/2019
Technical Readiness Review	4/18/2019 - 9/20/2019
Selected Contractor Readiness Review	4/18/2019 - 7/18/2019
Contract Review Committee Meeting Date	9/05/2019
Official Contract Award/Begin Work	10/01/2019

**State law requires that all contracts must be reviewed by the Legislative Contract Review Oversight Committee. The Committee meets monthly and can at its discretion, hold a contract for up to forty-five (45) Calendar Days. The "Contract START Date" date above may be impacted by the timing of the contract submission to the Committee for review and/or by action of the Committee itself.

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I. INTRODUCTION

A. Background

The Alabama Medicaid Agency (Agency) is seeking approval of a Section 1915(b) Waiver to implement a consolidated Care Coordination system to address issues with the health status of Medicaid Eligible Individuals (EIs) and the level of quality of existing services. The majority of EIs covered by Medicaid in Alabama are children, and addressing their care is important. A significant number of EIs suffer high rates of chronic conditions such as asthma, high blood pressure, and obesity. Furthermore, maternity outcomes in Alabama are less than optimal, and preterm birth rates and infant mortality are higher than the national average.

The Agency operates statewide Patient 1st, Health Home, Maternity Care, and Plan First Programs for the state's Medicaid EIs. Care Coordination services are provided to EIs in each of these programs, linking EIs to appropriate services. The Agency desires to consolidate these separate Care Coordination programs into a single program that will allow the Agency and Providers a more effective platform for service delivery and improved quality. The background and history of the current programs is as follows:

1. Patient 1st is a traditional Medicaid Primary Care Case Management (PCCM) model. The Agency contracts directly with physicians throughout the state who have agreed to serve as Primary Medical Providers (PMP). The PMP must provide necessary medical services directly or through the referral process.

2. The Health Home Program was approved by CMS in 2012 to provide support services to EIs in twenty-one (21) counties under the Affordable Care Act Section 2703. The program expanded statewide on April 1, 2015. PMPs are contracted with the Health Homes, to provide PCCM services to Health Home enrollees. Through this program, Care Coordination is available to enrollees who have or who are at risk of having certain chronic conditions: asthma, diabetes, cancer, hepatitis C, COPD, HIV, mental health conditions, substance abuse disorders, transplants, sickle cell, BMI >25, and/or heart disease.

3. The Maternity Care Program began in 1988 under the authority of a CMS 1915(b) waiver to address Alabama's high infant mortality, the high drop-in delivery rate and the lack of Delivering Healthcare Professionals (DHCP) participating in the Medicaid Program. Currently, the Agency has fourteen (14) districts, twelve (12) of which currently have a primary contractor who contracts for maternity services and provides Care Coordination for maternity enrollees.

4. The Plan First Program was implemented in 2000 based on the need for continued family planning services to individuals who would have otherwise lost eligibility. Services under this Program are designed to reduce unintended pregnancies and improve the well-being of children and families in Alabama by extending Medicaid eligibility for family planning services to eligible women (between the ages of 19 and 55) and men (ages 21 and over) whose income is at or below one hundred forty-one percent (141%) of the Federal Poverty

Level (FPL). A standard income disregard of five percent (5%) of the FPL is applied if the individual is not eligible for coverage due to excess income. Services under the Plan First Program include Care Coordination, various types of birth control methods, office visits, HIV counseling, labs, and sterilizations. Men can receive a vasectomy, vasectomy related services, and vasectomy related Care Coordination.

B. Purpose

Using lessons learned from the process to establish Regional Care Organization's (RCOs), the Maternity Care Program, the Patient 1st program, the Patient Care Networks of Alabama (PCNA), and the Health Homes program, a new approach for improving healthcare outcomes has been designed. Improving healthcare outcomes through appropriate Care Coordination targeting high risk and/or high cost individuals has shown promise around the country. The Agency for Healthcare Research and Quality (AHRQ) has demonstrated that on average five percent (5%) of the population is associated with fifty percent (50%) of healthcare costs. By focusing on that five percent (5%) and other high-risk individuals, improvements can be made both in the quality and cost of healthcare for the Agency.

Alabama has room to improve:

1. Maternity Outcomes in Alabama are less than optimal, and preterm birth rates and infant mortality are higher than the national average.

2. Obesity is an issue across the country, but particularly in Alabama.

3. Substance Abuse is a national crisis and we have much work to do on this issue in Alabama.

The Agency proposes a system transformation that includes the establishment of a managed care system, combining Family Planning Care Coordination services, Patient 1st (State Plan Amendment(SPA)) Care Coordination services, Health Home (SPA) functions, and Maternity Care (1915(b) Waiver) functions into single, region specific Primary Care Case Management Entities (PCCM-E) throughout the state. Intended goals of the transformation include:

a. Creation of a delivery system that allows for seamless Care Coordination across eligibility categories and incentivizes quality outcomes;

b. Address statewide and regional health outcome goals;

c. Conduct outcome-focused population management activities;

d. Facilitate timeliness of key health activities (e.g., Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings, flu shots, early entry to prenatal care, care for substance use disorder);

e. Reduce barriers impacting health outcomes; and

f. Flexibility to address regional quality issues (e.g., asthma in a region due to environmental issues; substance abuse targeted in a local area where there is a high incidence of neonatal abstinence syndrome (NAS) infants).

The Agency is establishing the Alabama Coordinated Health Network (ACHN) statewide in 2019 to streamline and increase access to Care Coordination for Eligible Individuals (EIs). Seven Regions will be established as follows (See Exhibit T):

1. Central, which includes the following counties: Autauga, Butler, Chilton, Crenshaw, Dallas, Elmore, Lowndes, Marengo, Montgomery, Perry, and Wilcox.

2. East, which includes the following counties: Blount, Calhoun, Cherokee, Clay, Cleburne, Coosa, DeKalb, Etowah, Randolph, St. Clair, Talladega, and Tallapoosa.

3. Jefferson and Shelby, which includes the following counties: Jefferson and Shelby.

4. Northeast, which includes the following counties: Cullman, Jackson, Limestone, Madison, Marshall, and Morgan.

5. Northwest, which includes the following counties: Bibb, Colbert, Fayette, Franklin, Greene, Hale, Lamar, Lauderdale, Lawrence, Marion, Pickens, Sumter, Tuscaloosa, Walker, and Winston.

6. Southeast, which includes the following counties: Barbour, Bullock, Chambers, Coffee, Covington, Dale, Geneva, Henry, Houston, Lee, Macon, Pike, and Russell.

7. Southwest, which includes the following counties: Baldwin, Choctaw, Conecuh, Clarke, Escambia, Mobile, Monroe, and Washington.

Vendors must respond to this RFP by identifying the specific Region in which a proposal is being submitted. A Vendor may bid on multiple Regions but must submit a separate proposal for each individual Region.

II. SCOPE OF WORK

See Appendix B for instructions for the Scored Items and Compliance Acknowledgement.

A. Defined Terms and Acronyms

1. The definitions of terms used herein and the meaning of all acronyms can be found in Exhibit A of this RFP. The order of preference for interpreting definitions appearing in this RFP is (in descending order of priority):

    a. Express definitions in Exhibit A of this RFP;

    b. Express definitions elsewhere in this RFP;

    c. Definitions in the Alabama Medicaid Administrative Code; and

    d. Definitions in Federal law and regulations including 42 C.F.R. § 438.2.

2. For purposes of this RFP, in addition to terms defined elsewhere in this RFP, the terms found in Exhibit A have their described meanings when capitalized. If a term herein is used without capitalization in this RFP, then the context determines whether the term is intended to be used with the defined meaning.

3. Each PCCM-E shall use the same definitions outlined in this RFP in any Provider contract, Subcontract, or other agreement the PCCM-E enters into as part of the ACHN.

B. Forms, Templates and Agency Provided Data

All Forms, templates, and Agency provided data that are referenced in this RFP will be located on the Agency's website.

C. PCCM-E Organizational Requirements

1. The PCCM-E must meet all RFP guidelines and comply with all authoritative documents and any revisions thereto.

2. The PCCM-E must:

    a. Organize as a nonprofit entity under Alabama law, with an office located in the Region where the PCCM-E operates;

    b. Have an Alabama domicile;

c. Provide documentation that the PCCM-E is operating as a nonprofit entity in Alabama (or such status has been applied for), to include, providing a copy of its nonprofit articles of incorporation, and bylaws.

d. Submit the PCCM-E's governing bylaws, organization documents, policies, and procedures for review and approval by the Agency.

3. The PCCM-E must establish a Governing Board that must:

a. Meet at least once in the second (2^{nd}) quarter, and at least once in the fourth (4^{th}) quarter;

b. Keep minutes of meetings and other records to document that the Governing Board is effectively discharging its obligations. All records must be maintained for not less than ten (10) years;

c. Submit minutes and other records as requested to the Agency;

d. Notify the Agency's Managed Care Division within ten (10) Business Days of any substantial or material corrections or updates to the information provided related to the Governing Board, including but not limited to organizational or governing documents;

e. Notify the Agency within ten (10) Business Days of any vacancies or additions to the Governing Board;

f. Receive at each Governing Board meeting a verbal report from the Consumer Advisory Committee (CAC); and

g. Have the following Governing Board composition:

i. Fifty percent (50%) of the Governing Board must be primary care physicians (including at least one OB-GYN) who practice in the Region and engage in Active Participation with the PCCM-E. Up to two of these primary care physicians can be employed by a hospital; and

ii. Representative(s) from each of the following:

(1) At least two (2) representatives of In-Region hospitals representing more than one system, if more than one system exists in a Region;

(2) At least one (1) representative of a Community Mental Health Center located in the Region;

(3) At least one (1) representative of a Substance Abuse Treatment Facility located in the Region;

(4) At least one (1) Consumer Representative (e.g., EI, Parent of EI or advocacy organization representative) who lives in the Region; and

(5) At least one (1) representative of a Federally Qualified Health Center located in the Region.

4. The PCCM-E must have a CAC (see Exhibit B).

   a. The CAC shall advise the PCCM-E on ways the PCCM-E may be more efficient/effective in providing quality care to its EIs and shall carry out other functions and duties assigned to it by the PCCM-E and approved by the Agency.

   b. Meet at least once in the first (1st) quarter, and at least once in the third (3rd) quarter.

   c. The CAC must have at least six (6) members. Twenty percent (20%) of the members must be EIs and/or parent/care takers of EIs served by the PCCM-E.

   d. The PCCM-E must ensure that the CAC maintains all records for a period of ten (10) years.

   e. The Governing Board must hear at each Governing Board meeting a verbal report from the CAC.

5. The PCCM-E must also have in place the organization, management, and administrative systems necessary to fulfill all requirements of this RFP and comply with any other applicable state and federal laws and regulations. The PCCM-E must demonstrate to the Agency's satisfaction, via submission of a staffing plan and resumes, that it has the required staffing, by function and qualifications, to fulfill its obligations under this RFP.

6. The PCCM-E shall notify within ten (10) Business Days the Agency's Managed Care Division of any change within the PCCM-E's organizational structure. Key Staff positions in the organizational structure include the Executive Director, Medical Director, Quality Care Manager, Pharmacy Director, and Care Coordination Supervisor.

7. The PCCM-E shall maintain all necessary business licenses, registrations, and certifications to be able to conduct business in Alabama.

D. Primary Requirements of the PCCM-E

The PCCM-E's proposal must demonstrate its ability to meet the following requirements:

1. Coordinate Providers in the Region and ensure that best practices are being followed in relation to Care Coordination. This coordination effort must support an effective and efficient health system that minimizes duplication and cost and improves health outcomes for identified EIs.

2. Provide Care Coordination for EIs to improve maternal health, birth outcomes, and pregnancy planning.

3. Facilitate Care Coordination for EIs between Primary Care Providers (PCPs), Community Mental Health Centers (CMHCs), Substance Abuse (SA) treatment Providers, or other behavioral health Providers.

4. Coordinate care of EIs to support appropriate access to medically necessary services and treatment, including assistance with Non-Emergency Transportation (NET) services for individuals receiving Care Coordination.

5. The PCCM-E may provide a referral to a specialist for EIs who require specialty services but do not have an attributed PCP.

6. Implement quality standards to improve the overall health of the Region's EIs.

7. Develop, implement, and maintain policies, procedures and protocols related to the daily operations of the PCCM-E's Care Coordination Programs for the Agency's review and approval. The PCCM-E must review at least annually, and revise as necessary, policies, procedures, and protocols to conform to changes in the PCCM-E's program approaches, technology and federal or state law and policy.

8. Ensure that staff who are completing Care Coordination functions are operating within their professional scope of practice, are appropriate for responding to the EIs' needs, and follow the state's licensure/credentialing requirements.

9. Educate new Providers within thirty (30) Calendar Days of signing an agreement to engage in Active Participation with the PCCM-E regarding priority initiatives through orientation, training, and technical assistance.

E. PCCM-E's Readiness Assessment

1. The Agency shall conduct readiness assessments as required by 42 C.F.R § 438.66 and in accordance with Alabama Medicaid Administrative Code Chapter 37 to determine the PCCM-E's readiness and ability to provide services to its EIs and resolve any identified operational deficiencies. The Agency may require the PCCM-E to develop and implement corrective action plans (CAPs) acceptable to the Agency demonstrating the PCCM-E's readiness to satisfy the requirements of this RFP. The PCCM-E must cooperate with the Agency in the Agency's readiness assessments, including but not limited to:

    a. Providing all information, data, policies, procedures and reports the Agency requires or requests that are within the scope of the readiness assessments; and

    b. Allowing the Agency reasonable access to the PCCM-E's facilities, staff, and leadership.

2. The PCCM-E acknowledges and understands that it shall neither provide services to EIs nor be paid until the Agency has determined, in its sole discretion, that the PCCM-E has demonstrated readiness to satisfy the requirements of this RFP and until the effective date. The Agency will provide a written notice to the PCCM-E when the PCCM-E has met all requirements of the RFP to provide services.

F. Ongoing Monitoring

1. The Agency shall conduct ongoing monitoring and supervision as required by 42 C.F.R. § 438.66 to determine the PCCM-E's ability to provide services to EIs and resolve any identified operational deficiencies. The Agency may require the PCCM-E to develop and implement CAPs acceptable to the Agency demonstrating the PCCM-E's ability to satisfy the requirements of this RFP.

2. The PCCM-E must cooperate with the Agency in the ongoing monitoring and supervision, including but not limited to:

    a. Providing all information, data, or reports the Agency requires or requests under the Contract, including but not limited to the Agency's annual report to the Centers for Medicare and Medicaid Services (CMS) on the PCCM-E as required by 42 C.F.R. § 438.66(e)(1); and

    b. Allowing the Agency reasonable access to the PCCM-E's facilities, staff, and leadership.

G. Place of Business and Hours of Operation

1. The PCCM-E shall set up and maintain a central business office within the Region for the exclusive use of the PCCM-E and in a location accessible to the public. The PCCM-E may establish more than one business office within the Region but must designate one of the offices within the Region as the central business office.

2. The PCCM-E shall be responsible for all costs related to securing and maintaining the facility for interim start-up support and the subsequent operational facility, including but not limited to hardware and software acquisition and maintenance, leasehold improvements, signage, utilities, telephone service, office equipment, supplies, janitorial services, security, storage, transportation, document shredders, and insurance. The office(s) must:

    a. Be accessible in accordance with Federal and State laws and regulations;

    b. Maintain privacy and security standards in accordance with this RFP; and

    c. Have private meeting rooms to accommodate EIs who may come to the office.

3. All of the PCCM-E's documentation must reflect the address of the location identified as the PCCM-E's legal, duly licensed, central business office in the State. This business office must

be open at least between the hours of 8:00 a.m. and 5:00 p.m. CT, Monday through Friday, excluding legal holidays. The PCCM-E shall ensure that EIs and Providers receive prompt and accurate responses to inquiries.

4. The PCCM-E shall provide adequate supervision to its staff to provide quality of services and ensure they are operating within their scope of practice.

5. In accordance with Section IX.NN of this RFP, the PCCM-E shall ensure that all business offices and all employees and Subcontractors that perform functions and duties related to this RFP are located within the United States.

6. Out of State Operations

    a. The PCCM-E shall ensure the location of any staff or operational functions outside of the State does not compromise the delivery of integrated services and a seamless experience for EIs and Providers.

    b. The PCCM-E shall ensure all staff functions conducted outside of the State are readily reportable to the Agency at all times to ensure the location of staff functions does not hinder the Agency's ability to monitor the PCCM-E's performance and compliance with Contract requirements.

H. Key Staff

1. The PCCM-E must designate individuals who will serve in the Key Staff positions (see Exhibit F). Key staff include:

    a. Executive Director;

    b. Medical Director;

    c. Pharmacy Director;

    d. Care Coordination Supervisor; and

    e. Quality Care Manager.

2. The Agency must approve all Key Staff prior to hiring.

3. A Key Personnel Resume Sheet (see Appendix D), resume, documentation of education, and appropriate licensure, as applicable, must be submitted to the Agency for approval.

4. Changes to Key Staff, including individuals, job description, and/or duties, must be approved in advance by the Agency.

I. PCCM-E Program Responsibilities

1. Care Coordination Program

   a. The PCCM-E is responsible for developing and implementing a comprehensive Care Coordination Program.

   b. The PCCM-E will provide as a cost of operations, intermittent assistance for EIs requiring minimal Care Coordination services (e.g., community resource and financial assistance).

   c. The PCCM-E shall submit to the Agency for review and prior approval Care Coordination Program policies and procedures and a staffing model designed to achieve a seamless process for providing effective Care Coordination to eliminate barriers to medical care and improve health outcomes.

   d. The PCCM-E must have appropriate Care Coordination staff. Care Coordination is a professional skill that must be supported by the PCCM-E. The skills and functions employed by Care Coordination staff include community orientation, the ability to locate, augment, and develop resources including information on services offered by other agencies. Care Coordination staff includes Care Coordinators, Behavioral Health Nurses, Community Health Workers and Transitional Care Nurses.

   e. The PCCM-E must have a process to ensure that an EI or caregiver is able to request a change in his or her Care Coordinator or Community Health Worker.

   f. The PCCM-E must comply with the caseload requirements for General, Maternity, and Family Planning Care Coordination:

      i. Staff providing services in the General Care Coordination Program must not have a caseload of more than fifty (50) EIs per one (1) full time equivalent. Community Health Workers must not have a caseload of more than one hundred (100) EIs per one (1) full time equivalent.

      ii. Maternity Care Coordinators must not have a caseload of more than three hundred sixty-five (365) EIs per caseload per one (1) full time equivalent.

      iii. Family Planning Care Coordinators must not have a caseload of more than two hundred fifty (250) EIs per one (1) full time equivalent.

   g. All Care Coordination activities must be documented electronically in the Health Information Management System (HIMS) approved by the Agency. All documentation must be completed within ten (10) Business Days of the Care Coordination service (See Section II.U.

h. The PCCM-E must develop relationships with community agencies to prevent duplication of services and provide optimum Care Coordination services. The corresponding specialty Care Coordination services must be referred to the appropriate agencies and will be monitored through chart audits by the PCCM-E and the Agency. Agencies include, but are not limited to:

i. Alabama Department of Rehabilitation Services, including Children's Rehabilitation Services;

ii. Early Intervention;

iii. Community Mental Health Centers;

iv. Alabama Department of Public Health (ADPH); and

v. Alabama Department of Human Resources.

i. The PCCM-E must have policies and procedures in place to assist the EI in selecting his/her choice of a PCP and/or DHCP.

j. The PCCM-E must provide Care Coordination services, regardless of where such services are performed, to the EI.

2. Non-Emergency Transportation (NET) Coordination.

a. The PCCM-E does not provide NET services, however, the entity may assist EIs in arranging transportation or coordinating with the Agency's NET program for transportation services. An EI or his/her representative may arrange transportation for the EI receiving Care Coordination services, or request assistance through the PCCM-E by contacting their assigned Care Coordinator. Any staff member with the PCCM-E may assist with coordinating NET services.

b. The PCCM-E must:

i. Ensure the Agency does not pay for NET services if the EI has access to free transportation;

ii. Determine availability of and least costly means of transportation to include, but not limited to, free transportation, including the EI's vehicle, transportation by relative or friend, or volunteer services;

iii. Establish EI eligibility for date of service five (5) Calendar Days prior to appointments or within twenty-four (24) hours after urgent care appointments to ensure transportation is provided for Medicaid covered services only;

iv. Confirm the least expensive mode of transportation that meets the needs of the EI as:

(1) Automobile;

(2) Transporter; or

(3) Other.

v. Contact the NET Coordinator in the area or the Medicaid Recipient Call Center to arrange transportation if the EI cannot make the contact on their own;

vi. Assist EIs in submitting the necessary receipts or confirmation of expenses required for reimbursement for overnight travel;

vii. Coordinate in-state and out-of-state commercial, bus, train, or air transportation for review to Medicaid on a case-by-case basis to include but not limited to requesting and receiving necessary support documentation from the PCP for any out-of-state services to assure that such services cannot be obtained in-state; and

viii. Validate appointment with Provider by confirming the date, time, and attendance of appointment with the Medicaid Provider.

3. General Care Coordination Program. The PCCM-E is responsible for developing and implementing a General Care Coordination Program.

a. The PCCM-E shall establish processes to support Care Coordination for EIs, primarily those that are at highest risk and cost. The processes shall include, but are not limited to, the following:

i. Developing and implementing patient centered holistic plans of care;

ii. Improving health literacy, health outcomes, and self-management;

iii. Promoting effective use of the healthcare system and community resources;

iv. Reducing the potential for risks of catastrophic or severe illness;

v. Preventing disease exacerbations and complications;

vi. Reducing inappropriate utilization to decrease costs;

vii. Working to identify additional key resources and incorporate these into the strategies such as partnerships with ADPH, Alabama Department of Mental Health, and Children's Rehabilitation Services;

viii. Utilizing evidence-based clinical practice guidelines; and

ix. Promoting the importance of the Medical Home through the education of EIs.

b. EI Assignment Process

i. Each month the Agency will provide a targeted list of EIs for assignment into Care Coordination screening and assessment as well as Monitoring-Medical Review. The Agency will provide the assignment list for each PCCM-E that will be used in their Care Coordination programs. The goal will be to provide a list sufficient to reach active Care Coordination goals set by the Agency, provide fiscal stability for the PCCM-E and not overspend budgets.

ii. The assignment list will be based on the Milliman Advanced Risk Adjusters (MARA) risk assessment tool, ER claims, and total cost. The Agency will review updated data each month and can assign all EIs that meet any one criteria. If the Care Coordination program is exceeding targets and fiscal limitations, the Agency will limit assignments by only assigning EIs that meet multiple criteria, if necessary. The Agency may also change the algorithm as needed to best identify EIs. The following are the currently planned criteria:

(1) Total MARA risk score of 5 or greater;

(2) Inpatient MARA risk score of 2.5 or greater;

(3) Emergency Department (ED) MARA risk score of 0.4 or greater;

(4) Medication MARA risk score of 1 or greater;

(5) Risk score increase in past 6 months of 2 points and 25%;

(6) ED visits of 6 or more in past year and at least one in past two months; and/or

(7) Total cost greater than $20,000 for previous year.

iii. Approximately 6.9% of potential EIs meet these criteria. It is not anticipated that each of these EIs will be appropriate for Care Coordination. Each month's assignment list will include EIs who have not previously met the criteria and EIs who have not been assigned in greater than six (6) or more months.

iv. Each assignment will include a report on the clinical state of each EI. This report will include risk score data and contributing conditions, diagnosis history, hospital utilization (inpatient and ED), pharmacy history, and basic demographics. All data and reports will be provided directly to the PCCM-E through the HIMS.

c. The PCCM-E shall receive referrals for Care Coordination, which must be screened no later than five (5) Business Days from the receipt of the referral, from the following but not limited to:

   i. PCPs;

   ii. Medical or psychiatric facilities;

   iii. State or Community Agencies; and/or

   iv. EIs.

d. The PCCM-E shall use a process to screen and stratify EIs who are determined to need Care Coordination services into appropriate categories of risk which will determine the timeframe of the assessment and Care Coordination services as outlined in Exhibit G. The PCCM-E must use the results of the risk stratification to assign an initial risk level to each EI. For EIs identified as needing ongoing Care Coordination services, the PCCM-E shall stratify EIs into one of the following two (2) levels of health risks:

   i. Medium Risk; or

   ii. High Risk.

e. Once an EI who may need Care Coordination services is identified, contact must be attempted within five (5) Business Days of screening. At least three (3) attempts must be made within thirty (30) Calendar Days, including a certified letter to explain and offer Care Coordination services.

f. The EI has the right to refuse Care Coordination services. The PCCM-E will notify in writing to the EI that they may request Care Coordination services at any time.

g. EIs identified in the health risk screening and stratification as medium risk or high risk must receive a face-to-face Health Risk and Psychosocial Assessment conducted by a Care Coordinator, Behavioral Health Nurse or a Transitional Care Nurse. The required template is located on the Agency's website (see section II.B). The needs identified in this Health Risk and Psychosocial Assessment will be the basis for the EI's Care Plan (see Exhibit C).

h. As the EI's needs are identified or goals are met, the EI's risk level may change. The PCCM-E will complete a risk reassessment form to change the EI's risk level. At the minimum, a risk assessment must be completed every ninety (90) Calendar Days. The required template is located on the Agency's website (see section II.B).

i. Additional assessments required for each EI receiving general Care Coordination include:

   i. PHQ-A for EIs ages 12-17;

ii. PHQ-2 for EIs age 18 and older;

iii. PHQ-9 for EIs age 18 and older that score a four (4) or higher on the PHQ-2;

iv. Substance abuse screening tool approved by the Agency; and

v. Medication Reconciliation.

j. Actively managed EIs shall receive a Care Plan which must be patient/caregiver-centered with a team approach, including not only the PCCM-E's staff, but PCPs, state agencies, behavioral health entities, and/or other community resources, as appropriate. The Care Plan Requirements Checklist is set forth in Exhibit C.

k. Care Coordination for Children with Medical Complexity

i. Children with Medical Complexity (CMC) require the highest level of intensity of care and frequently numerous pediatric specialists are required to care for their conditions. These children are frequently medically fragile with congenital/acquired multi-system disease. Many require medical technology to sustain their activities of daily living. They also must have a qualifying diagnosis/condition and/or social assessment to meet CMC criteria for this program. PCP, in concurrence with the PCCM-E Medical Director, may also identify additional EIs for this group. The medical and social care for these children is typically more extensive than other members of the general population.

ii. The PCCM-E must have on staff, a nurse and a social worker with pediatric experience to provide training to general Care Coordination staff in the care and linking of services for children with medical complexity. A designated pharmacist will also receive training for this population. The requirements for all positions are described below:

(1) Pediatric Nurse: Must have a BSN with a minimum of two (2) years complex pediatric nursing experience or an ADN with a minimum of five (5) years complex pediatric nursing experience. Preferred experience settings include acute hospital, intensive care, Children's Rehabilitation, Children's Specialty Clinic, or a pediatric practice.

(2) Social Worker: A Licensed Independent Clinical Social Worker (LICSW) (preferred) or a Licensed Master Social Worker (LMSW) with experience in a pediatric environment. Preferred experience settings include acute hospital, intensive care, Children's Rehabilitation, Children's Specialty Clinic, Children's Mental Health, or pediatric clinic.

(3) Pharmacist: A Pharm D is required with pediatric experience preferred.

iii. Each PCCM-E will be required to identify a pediatric nurse, social worker, and pharmacist to attend an in-person training at one designated location designated by the Agency in the State during the first thirty (30) Calendar Days after the contract start date. The training will be provided by The National Center of Care Coordination Technical Assistance and will take four (4) to six (6) hours to complete. The newly trained pediatric nurse, social worker and pharmacist will subsequently be responsible for training the other PCCM-E staff designated to work with the CMC population (see Exhibit E for training modules).

iv. The PCCM-E will be responsible for its portion of the associated costs of tuition for the in-person training. The total cost for the in-person training for all PCCM-E's combined is approximately fifteen thousand dollars ($15,000.00).

l. Multidisciplinary Care Team (MCT)

i. The PCCM-E must establish MCTs. All actively managed EIs may participate in their MCT. The MCT will be person-centered, built on the EI's specific preferences, needs and input, and delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

ii. The PCCM-E is required to assign a Care Coordinator, Transitional Care Nurse, or Behavioral Health Nurse to establish and coordinate a MCT for actively managed EIs. The MCT is comprised of health care professionals including but not limited to physicians and other professionals, such as Care Coordinators, Transitional Care Nurses, Community Health Workers, Pharmacists, Behavioral Health professionals, or any professionals deemed appropriate. The EIs PCP will be an integral participant of the team.

iii. The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital, community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The MCT must:

(1) Meet regularly as outlined in Exhibit G;

(2) Include multi-disciplines;

(3) Discuss EI's needs, solutions, and potential outcomes; and

(4) Document, in detail, issues as described above and participating staff.

m. Behavioral Health Program.

i. The PCCM-E must implement a program approved by the Agency to integrate behavioral health services, including both mental health and substance abuse, and

medical services for EIs. The Behavioral Health Program must have at a minimum the following requirements:

(1) Behavioral Health Nurses on staff to support the Behavioral Health Program. Requirements for Behavioral Health Nurses are detailed in Exhibit F.

(2) PCCM-E responsibilities of the Behavioral Health Program must include:

(a) A screening and assessment for appropriateness of Care Coordination services;

(b) Education of EIs regarding services provided through the PCCM-E;

(c) Linkage of EIs to appropriate services to integrate behavioral health and medical care such as:

(a) Behavioral health and substance abuse Providers as needed.

(b) Community Mental Health Centers (CMHCs) as needed.

(d) Consultation to the MCT regarding behavioral health issues or topics and resources in the area;

(e) Transitional care for EIs requiring Care Coordination services who transition from a psychiatric facility to the community; and

(f) Integration of behavioral health and medical care including professionals such as behavioral health nurses, PCPs, Care Coordinators, community mental health center staff, and substance abuse Providers collaborating to ensure services are provided to EIs with substance use disorders, chronic illnesses, and mental health conditions.

ii. The PCCM-E will provide the following behavioral and physical health integration elements in training participating Providers and PCCM-E staff:

(1) Joint sponsorship of trainings with community stakeholders;

(2) Development and sharing of resources and tools to support participating Providers; and

(3) Prevention of substance abuse issues.

n. Transitional Care Program

i. PCCM-E must develop a Transitional Care Program to support EIs identified as needing Care Coordination services when discharged from an inpatient or residential setting to ensure continued management of care.

ii. The PCCM-E shall submit to the Agency for review and prior approval, transitional care policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to an EI's care.

iii. Transitional Care Team. The PCCM-E shall have an interdisciplinary Transitional Care Team to design and implement the Care Plan and provide oversight and management of all transitional care processes. The Transitional Care Team may be part of the MCT as described in the Care Coordination (see Section II.I.3.). The Transitional Care Team must be led by a Transitional Care Nurse and include additional staff as necessary to support EIs in their transition to a new care setting. Specific requirements for Transitional Care Nurses are detailed in Exhibit F.

iv. Transitional Care Process. The Transitional Care Nurses and/or Transitional Care Team will establish processes to assist EIs in their transition from a facility to the community setting to include, but not be limited to, the following:

(1) Reviewing daily census at inpatient or residential settings to identify EIs needing support at discharge;

(2) Collaborating with hospital or facility discharge planners, Care Coordinators, and behavioral health staff in preparation for the EIs returning to the community;

(3) Educating EIs regarding the services provided by the PCCM-E;

(4) When possible, completing the Agency provided Transitional Screening form (see Section II.B) with the EI during hospitalization to initiate services. The assessment must be face-to-face and can be completed by a Community Health Worker, Care Coordinator, or Transitional Care Nurse; and

(5) Providing transitional care services to EIs identified as needing Care Coordination services while transitioning back to the community. Transitional Care Nurse will:

(a) Complete a face-to-face Health Risk and Psychosocial Assessment within ten (10) Calendar Days of discharge to ensure appropriate home-based support and services are available;

(b) Develop a Care Plan with the EI to address identified needs. The Transitional Care Nurse/Team may consult with the PCCM-E staff and other members of the MCT to develop the Care Plan.

(c) Implement medication reconciliation in concert with the PCP and Transitional Pharmacist within ten (10) Calendar Days of discharge;

(d) Educate EIs regarding medical management, and provide referrals to needed resources within ten (10) Calendar Days of discharge;

(e) Assist with environmental adaptations, equipment, and technology the EI needs for a successful care setting transition;

(f) Provide transitional care services until all goals are met;

(g) Transfer the EI as needed to a Care Coordinator;

(h) Coordinate with the Maternity Care Coordinator to ensure a smooth transition of EIs to non-maternal health care after sixty (60) Calendar Days postpartum (as applicable); and

(i) Ensure proper transition and coordination with Alabama Department of Mental Health, the Agency and with CMHCs when EIs are moving to or from a mental health commitment.

o. Monitoring- Medical Review

i. From the list of targeted EIs referenced in Section II.I.3.b., the PCCM-E will select EIs not receiving Care Coordination services, but are high cost and/or high risk, to review claims data for cost efficiency and clinical appropriateness. Payment for each review will be based on completing a report in the HIMS used by the PCCM-E. The required template is located on the Agency's website (see Section II.B). The information required includes:

(1) Demographics – Name, Address, Contact Information;

(2) Medicaid Number;

(3) Diagnoses;

(4) Past Medical History/Significant Events such as neonatal birth, cerebrovascular accident (stroke), myocardial infarction (heart attack), extended hospitalizations, seizures;

(5) Medications for the past twelve (12) months:

(a) Compliance with medications (fill history); and

(b) Highest cost medications.

(6) Medical Appointments for the past twelve (12) months and compliance with keeping appointments, if known;

(7) Emergency Department Visits in past twelve (12) months including diagnosis/ reason for visit;

(8) Hospitalizations for the past twelve (12) months;

(9) Reason for hospitalizations;

(10) Procedures during hospitalizations;

(11) Course of current treatment;

(12) Durable Medical Equipment;

(13) Case Management Services (Targeted Case Management, Care Coordination, Waivers);

(14) Cost drivers;

(15) Next Steps; and

(16) Recommendations to the Agency, if necessary.

4. Maternity Care Coordination Program

a. The PCCM-E will implement a program approved by the Agency to integrate and manage all maternal health Care Coordination including family planning, interconception care, prenatal care, and postnatal care. The goal of the program is to reduce maternal and infant morbidity and mortality and improve birth outcomes. EIs will be notified at the time of Medicaid application of the requirement to participate and engage in the PCCM-E Maternity Care Coordination Program.

b. For the collaborative provision of maternity services, the PCCM-E Care Coordination Program will include ACHN Delivering Healthcare Professional (DHCP) Participation Agreement with the regional PCCM-E. The contract will delineate the duties and responsibilities of the DHCP. These responsibilities shall include, but are not limited to, the following:

i. Data Entry;

ii. Care Plan Participation; and

iii. Participation in the DHCP selection and referral process.

c. If the DHCP does not elect to enter into an agreement with a PCCM-E, the DHCP cannot bill Medicaid for services provided.

d. Current Pregnant EIs will be notified of the Agency's requirement to participate and engage with the PCCM-E in their Region for their Maternity Care Coordination. Pregnant Women (previously SOBRA) will be notified of this requirement at the time of Medicaid Application.

e. The PCCM-E must advise all DHCPs and include language in the ACHN DHCP Participation Agreement of the requirement for Pregnant Women to participate in the network for maternity Care Coordination for the Agency to consider the EI's maternity care a covered service.

f. The PCCM-E must have processes in place to:

i. Engage EIs in the Care Coordination Program;

ii. Assist with establishing Medicaid eligibility by providing assistance through Certified Application Assisters (referenced in Exhibit F) with the Medicaid application process;

iii. Develop and implement patient-centered holistic plans of care;

iv. Assist with accessing a DHCP;

v. Complete screenings and psychosocial assessments;

vi. Conduct face-to-face encounter visits and home visits when indicated;

vii. Reduce the potential for risks of adverse pregnancy outcomes;

viii. Assist with appointments and appointment reminders, to include making postpartum appointments and providing EIs appointment cards/appointment reminders;

ix. Collaborate with DHCPs to ensure EIs receive high-risk care as appropriate;

x. Coordinate and make appropriate referrals including, but not limited to:

(1) Plan First/family planning services;

(2) ADPH Care Coordination Collaborative Improvement and Innovation Network (CoIIN);

(3) Face-to-face tobacco cessation counseling;

(4) ADPH Quitline; and

(5) Screening, Brief Intervention and Referral to Treatment (SBIRT).

xi. Track EIs throughout pregnancy and postpartum periods;

xii. Follow-up with Providers and EIs to ensure prenatal and postpartum appointments are kept;

xiii. Transition EIs to non-maternal health Care Coordination after sixty (60) Calendar Days postpartum (if applicable);

xiv. Provide Care Coordination in versatile settings to include, but not limited to, the community (EI's home), doctor's office, public facilities (as requested by the EI), or clinics;

xv. Assist with the coordination of non-emergency transportation needs;

xvi. Improve health literacy, health outcomes, and self-management;

xvii. Promote effective use of the health care system and community resources;

xviii. Reduce potential for risks of catastrophic or severe illness;

xix. Reduce disease exacerbations and complications;

xx. Reduce inappropriate utilization and cost associated with emergency departments and hospital inpatient services;

xxi. Identify additional key resources and incorporate them (such as partnerships with ADPH and Alabama Department of Mental Health (ADMH);

xxii. Use evidence-based clinical practice guidelines;

xxiii. Promote the Medical Home through the education of EIs on its importance;

xxiv. Improve identification of individuals for possible clinical depression using PHQ-2, PHQ-9, and PHQ-A:

(1) PHQ-A for EIs age 12-17.

(2) PHQ-2 for EIs age 18 and older.

(3) PHQ-9 for EIs age 18 and older that score a four (4) or higher on the PHQ- 2.

xxv. Comply with the Agency's requirements for data collection and entry into an approved HIMS; and

xxvi. Comply with the Agency's quality, utilization and auditing processes.

g. The PCCM-E must provide maternal health Care Coordination to all EIs as outlined in Exhibit H and Exhibit I.

h. Care Coordination shall be based on the level of need and risk stratification. The risk stratification is based on the EI's maternal health severity of disease or chronic illnesses, and history of adversary pregnancy outcomes.

i. The maternal health risk assessment and screening process must:

  i. Include a maternal health risk identification strategy;

  ii. Include a maternal health screening within five (5) Business Days of contact with the EI;

  iii. Include a maternal Health Risk and Psychosocial Assessment for all EIs at the first face-to-face initial assessment.

j. Stratify all pregnant EIs to the appropriate risk level based on the risk score of the Psychosocial Assessment Tool. The risk stratification levels are:

  i. Low Risk; and

  ii. High Risk (these EIs must have a medication reconciliation review). EIs who received no prenatal care prior to the delivery date will automatically stratified as High Risk. This risk stratification requirement does not apply to individuals granted emergency Medicaid due to their non-citizen status.

k. The PCCM-E must develop a maternal health Care Plan for all pregnant EIs. The Care Plan must:

  i. Be initiated and completed by the Care Coordinator within seven (7) Business Days of the initial encounter;

  ii. Be patient/caregiver centered with a team approach; and

  iii. Include the PCPs/community agencies as appropriate.

l. The PCCM-E must have Certified Application Assisters Program. Certified Application Assisters are trained by the Agency or a Certified Trainer.

m. Certified Application Assisters will assist individuals with completing the Medicaid application process, and follow-up with the EI until a Medicaid eligibility determination is made.

n. The PCCM-E shall submit names to the Agency's Managed Care Division of all certified application assisters and the name(s) of the Certified Application Assisters trainers served by the Region at program implementation, within forty-five (45) Calendar Days of the end of the year and within thirty (30) Calendar Days of any change.

o. The PCCM-E has flexibility in determining how to perform the application assister function. Care Coordinators are not required to be Certified Application Assisters; however, the application assister function must be performed by Maternity Care Coordinators who meet the qualification to be a Care Coordinator as outlined in Exhibit F.

p. The Certified Application Assisters Eligibility Encounter must include the following:

    i. Documentation of eligibility status at screening intake.

    ii. Assistance with completing the application electronically or paper format.

    iii. Follow-up with the EI until a Medicaid eligibility determination is made.

    iv. Assistance with any other barriers to the application process.

    v. Documentation of all Care Coordination activities in the HIMS.

q. The PCCM-E must provide Care Coordination for newborns delivered with no prenatal care. Care Coordination for newborns who did not benefit from pre-natal care will receive a face-to-face inpatient delivery encounter by a Care Coordinator. The following services shall be provided to the newborn's mother:

    i. Counseling on contraception and family planning services; and

    ii. Counseling on appropriate post-partum care.

r. The PCCM-E must develop a Delivering Healthcare Professional Network and Collaborative Relationships with DHCPs. To have an effective selection and choice process for coordinating maternity care the PCCM-E has the responsibility of establishing a comprehensive network of DHCPs within fifty (50) miles of all areas in their Region that can provide prenatal, delivery and postpartum care in a coordinated care delivery system.

s. The PCCM-E must continually monitor the Provider network to ensure that the capacity is sufficient to meet the needs of all EIs to ensure that availability and accessibility to services are not hindered. The PCCM-E must submit documentation to the Agency when there are changes in its maternity Provider network.

t. Delivering Healthcare Professional Notification

i. The PCCM-E shall notify the appropriate DHCP of the EI's selection of that DHCP within five (5) Business Days of the EI's selection of the DHCP for maternity care.

ii. The PCCM-E shall provide each DHCP a monthly listing of pregnant EIs who have selected that particular DHCP for their maternity care. The PCCM-E shall provide this list prior to the first day of each month.

u. Delivering Healthcare Professional Selection Process. The PCCM-E must have policies and procedures in place to assist the EIs in selecting a DHCP of her choice for maternity care services from a list of Medicaid enrolled Providers. EIs may not in any way be influenced when selecting a DHCP:

i. The PCCM-E must inform, in writing, DHCPs who shall be involved in the EI's care.

ii. If the EI does not want to choose a DHCP on the 1st day of engaging with the PCCM-E, then the EI shall be informed that she must call back within five (5) Business Days to choose a DHCP, or the PCCM-E shall select a DHCP for her from the DHCP choice list maintained by the PCCM-E.

iii. In the event the EI refuses to choose a DHCP or fails to choose a DHCP within the designated time frame, the PCCM-E must select, for the EI, a DHCP based on equivalent distribution among the DHCPs with available openings to serve additional EIs. This process must include consideration of the distance the EI lives from the DHCP and prior relationships. The PCCM-E shall notify the EI and the DHCP of the selection.

iv. If the DHCP has no availability for additional patients, the PCCM-E must work with the EI to have a DHCP selected within two (2) Business Days of notification that the selected DHCP has no availability.

v. Changes in the Selection Process.

i. EIs must be allowed to change a DHCP once without cause within the first ninety (90) Calendar Days of selecting a DHCP and at any time for just cause, which is defined as a valid complaint submitted orally or in writing to the PCCM-E.

ii. The PCCM-E must inform the EI of the EI's rights to change DHCPs, with and without cause at the initial contact and at least once per year.

iii. The PCCM-E must provide, at the time of initial contact all required information regarding rights and responsibilities, and appropriate telephone numbers.

5. DHCP Selection Referral Process

    a. The PCCM-E must comply with the DHCP selection referral process as no maternity claims will be paid/reimbursed unless a DHCP receives a selection referral and the PCCM-E's National Provider Identifier (NPI) number is on the DHCP's claim.

    b. The PCCM-E must provide a written referral to the DHCP and the EI for the DHCP selected during the DHCP selection process.

    c. If a change in the DHCP is made by the EI as outlined in the DHCP selection process, a written referral shall be provided to the DHCP immediately by the PCCM-E, or no later than four (4) hours of the change in the DHCP.

    d. If an EI arrives at the maternity Provider's office with no DHCP selection referral and the EI has not engaged with the PCCM-E for Care Coordination, the PCCM-E may issue a one (1) time referral for the first visit and the DHCP must redirect the EI to the PCCM-E for initiation of Care Coordination. A permanent referral shall be granted after the EI engages with the PCCM-E for Care Coordination.

    e. To expedite services and to prevent barriers, the PCCM-E may generate oral DHCP selection referrals. If oral referrals are generated by the PCCM-E, written referral must be provided within twenty-four (24) hours of giving an oral referral.

    f. The PCCM-E must document all oral DHCP selection referrals and must maintain written referrals in the HIMS to assist in claim reimbursement and auditing purposes.

    g. PCCM-E shall mandate, in the ACHN DHCP Participation Agreement, for maternity Providers to maintain copies of all referrals at the Provider level for auditing purposes.

6. Family Planning Care Coordination Program

    The goal of Family Planning Care Coordination is to assist with pregnancy planning (see Exhibit J and Exhibit K for additional information). The PCCM-E must:

    a. Offer the EI freedom of choice in deciding to receive or reject family planning Care Coordination. Acceptance of any family planning service must be voluntary without any form of duress or coercion applied to gain such acceptance;

    b. Obtain written consent prior to providing family planning Care Coordination services. Written consent must be obtained at each face-to-face by individual documentation or a signature consent EI log can be maintained.

7. Pharmacy Program

   a. The PCCM-E must have a Pharmacy Program to develop, coordinate, implement, and manage education of community, transitional, and all pharmacists and PCPs within the PCCM-E and Agency pharmacy initiatives.

   b. The PCCM-E must develop, coordinate, engage within, and manage staff to implement programs that advance the Medical Home.

   c. The PCCM-E must have a Pharmacy Director, Community Pharmacist, and Transitional Pharmacist on staff to complete the Medication List and support the Medication Reconciliation Review Process (see Exhibit L for additional requirements).

   d. Completion of a Medication List must be performed by a Transitional Care Nurse, Behavioral Health Nurse, Care Coordinator, Pharmacist, Community Health Worker (CHW), or other personnel with adequate skill and competency.

   e. The Medication List shall include, but is not limited to:

      i. Discharge instruction from hospital/facility;

      ii. PCP chart or electronic health record (EHR);

      iii. Fill history (Pharmacy Home/PCCM-E's HIMS);

      iv. Information from Provider's EHR;

      v. Information from PCCM-E PCP/DHCP;

      vi. Information from any pharmacy on medication the EI has used within the last year; and

      vii. Over-the-counter/ non-legend drugs, dietary/ herbal supplements, etc. Information may need to be obtained through Medication Reconciliation.

   f. The Medication List must be reviewed by a Transitional Pharmacist for Medication Reconciliation Review within three (3) Business Days after receipt of the Medication List for transitional / discharge patients. All other Medication Lists must be reviewed by a Pharmacist within five (5) Business Days after receipt of the Medication List. Contraindications must be reviewed by a Pharmacist and the Pharmacist shall be available to the PCCM-E staff and others as needed for consultation.

   g. The Medication List shall be used during the EI interview of the Health Risk and Psychosocial Assessment to enhance drug use information gathering. The caregiver or family may be present at the interview. Medication List should also include discharge instructions, PCP chart, prescription fill history, and patient report, as appropriate.

h. Medication Reconciliation Review Process.

i. Medication Reconciliation Review is the process of gathering, organizing, and sharing with Providers drug use information from multiple sources, including the EI, medical chart, prescription fill history, and discharge instructions, to identify and resolve drug duplications, interactions, possible adverse events, contraindications, poor adherence, or other suboptimal drug-taking behaviors.

ii. Medication Reconciliation must be completed for all EIs in the general population stratified as medium or high risk, and maternity EIs stratified as high risk. In addition, medical reconciliations are to be completed on all Transitional Care EIs.

8. Transitional Plan for PCCM-E during the Implementation stage:

a. General Care Coordination. The Transitional Plan for PCCM-E during the implementation stage ensures that the process focuses on continuity of care for EIs moving from one of the ending Care Coordination programs to the PCCM-E's Care Coordination services. The PCCM-E must develop, implement, and maintain policies and procedures, subject to Agency approval, to ensure continuity of care for all EIs upon initial enrollment with the PCCM-E as follows:

i. The PCCM-E is assigned or referred a new EI for management of care; and

ii. The PCCM-E requests information from the previous organization (i.e., Health Home, ADPH) for all EIs receiving Care Coordination services. Information would include all documentation in the HIMS, demographic information and the EI's Care Plan.

b. Maternity Care Coordination:

i. The continuity of care process must include a focus on the EI's Care Coordination to and from services and programs outside of the PCCM-E's program.

ii. The PCCM-E must develop, implement, and maintain policies and procedures, subject to Agency approval, to ensure continuity of care for all EIs upon initial placement with the PCCM-E as follows:

(1) The PCCM-E is assigned a new EI for management of care;

(2) The PCCM-E requests transfer information from the previous Maternity Contractor for all EIs receiving Care Coordination services. Information would include all documentation regarding Care Coordination services;

iii. The PCCM-E must contact the EI within five (5) Business Days to initiate services and provide a referral to the transitioning maternity Provider, if indicated.

9. Transition of EIs between PCCM-E's

    a. When an EI, who is currently receiving Care Coordination services, moves out of the Region and is assigned to a new PCCM-E, the previous PCCM-E must submit within ten (10) Business Days information regarding the EI's Care Coordination services to the new PCCM-E.

    b. The continuity of care process must include a focus on the EI's Care Coordination to and from services and programs outside of the PCCM-E's program.

    c. The PCCM-E must develop, implement, and maintain policies and procedures for Agency approval to ensure continuity of care for all EIs for the following:

        i. When receiving a new EI for management of care; and/or

        ii. When requesting information from the previous PCCM-E for all EIs receiving Care Coordination services. Information would include all documentation in the HIMS.

    d. The receiving PCCM-E must contact the EI within five (5) Business Days to initiate services.

10. Transition at Expiration and/or Termination of Contract.

    a. The Agency may terminate the Contract, in accordance with the terms of this RFP, with the PCCM-E and place EIs into a different PCCM-E or provide Medicaid benefits through other state plan authority, if the Agency determines that the PCCM-E has failed to carry out the substantive terms of its contracts or meet the applicable requirements of sections 1932, 1903(m) or 1905(t) of the Act.

    b. A transition period shall begin in the event of termination of this Contract, prior to the end of the term of this Contract if the Agency and the PCCM-E do not execute a new contract or upon notice that the Agency does not intend to exercise an option to renew this Contract for any additional year.

    c. During the transition period, the PCCM-E must work cooperatively with the Agency and any organization with whom the Agency may contract for similar services to EIs in the Region.

    d. The Agency will specify a plan for the transferring PCCM-E to follow during this transition period. The length of the transition period shall be at the Agency's sole discretion. The costs relating to the transfer of materials and responsibilities must be paid by the transferring PCCM-E without additional compensation or reimbursement of expenses from the Agency. The transferring PCCM-E must be responsible for all necessary services during the transition period.

11. Post-Contract Obligations and Procedures

a. Contract termination shall not extinguish or prejudice the Agency's right to enforce its rights and remedies under this RFP or State and Federal law and regulation, including but not limited to the right to recover damages for breach of contract.

b. Continuing obligations: Termination or expiration of the Contract shall not discharge the PCCM-E of obligations with respect to services or items furnished prior to termination or expiration, including retention of records Termination or expiration shall not discharge the Agency's payment obligations, as allowed by law, to the PCCM-E or the PCCM-E's payment obligations to its Subcontractors Provider with respect to services furnished prior to termination or expiration. Upon any termination or expiration of this Contract, in accordance with the provisions in Subsections IX.J-L, the PCCM-E must provide the Agency with any and all information deemed necessary by the Agency within thirty (30) Calendar Days of the request;

c. Notice to EIs: In the event that the Contract is terminated or expires without the Agency and the PCCM-E executing a new contract, the PCCM-E must notify all EIs in writing of such termination or such expiration at least thirty (30) Calendar Days in advance of the effective date of termination or expiration. In accordance with Section II.W (Information Requirements) of this RFP, notice must be made available in an accessible format for individuals with visual impairments and in the relevant language for EIs with limited English proficiency.

12. Quality Improvement Program

a. The PCCM-E must implement a Quality Improvement Program to improve health outcomes by:

i. Systematic data analysis to target EIs with chronic/behavioral health conditions and Providers for outreach, education, and intervention;

ii. Monitoring access to care, services, and treatment including linkage to a Medical Home;

iii. Monitoring quality and effectiveness of interventions;

iv. Facilitating quality improvement activities that educate, support, and monitor Providers regarding evidence-based care for best practices; and

v. Implementing clinical management initiatives identified as priorities by the Agency and the Quality Assurance Committee (QAC).

b. The PCCM-E will employ or contract with a Medical Director that is part time (Refer to Exhibit F for staff requirements).

c. The PCCM-E will employ a Quality Care Manager that will work with practices and community Providers in the implementation of the Quality Improvement Program. Refer to Exhibit F for staff requirements.

d. In accordance with 42 C.F.R. Part 438, Subparts D and E and the Alabama Medicaid Administrative Code Chapter 560-X-37, the PCCM-E must have an ongoing Quality Assessment and Performance Improvement Program that executes a Quality Improvement Plan to systematically monitor and evaluate the quality and appropriateness of care and services rendered to EIs and promote and improve quality of care and quality patient outcomes for its EIs.

e. The PCCM-E must develop, implement and maintain written policies and procedures which address components of effective health care management including but not limited to anticipation, identification, monitoring, measurement and evaluation of EI's health care needs, and effective action to promote quality of care.

f. The PCCM-E must develop and implement improvements in processes that enhance clinical efficiency, provide effective utilization, provide Care Coordination and focus on improved outcomes management.

g. Quality Improvement Plan

i. The PCCM-E must develop and submit a written Quality Improvement Plan (herein "Improvement Plan") to the Agency within thirty (30) Calendar Days from execution of the Contract and resubmit it to the Agency annually by October 1st of each year for written approval.

ii. The PCCM-E must annually:

(1) Measure and report to the Agency on its performance, using the Quality Measures required by the Agency; or

(2) Submit data, specified by the Agency, which enables the Agency to calculate the PCCM-E's performance using the Quality Measures identified by the Agency.

iii. The Quality Improvement Plan must:

(1) Include processes for the investigation and resolution of individual performance or quality of care issues whether identified by the PCCM-E or the Agency that:

(a) Allow for the tracking and trending of issues on an aggregate basis pertaining to problematic patterns of care;

(b) Collect and submit performance measurement data in accordance with 42 C.F.R. § 438.330(c);

(c) Implement mechanisms to detect both underutilization and overutilization of services;

(d) Monitor the delivery of Care Coordination services provided, including but not limited to, an assessment of care between care settings;

(e) An Assessment of the level of Care Coordination provided; and

(f) Health outcomes of the EIs.

h. External Quality Reviews. The PCCM-E must, as required by 42 C.F.R. Part 438, Subpart E:

i. On at least an annual basis, the PCCM-E must cooperate fully with any and all independent assessments as authorized by the Agency and/or conducted by the Agency's contracted External Quality Review Organization (EQRO) or other designee to assess the PCCM-E's performance including quality outcomes, timeliness of, and access to services.

ii. PCCM-E must provide to the EQRO all information the EQRO deems to be necessary in performing its review of the PCCM-E.

iii. Independent assessments must include, but not be limited to, validation of PCCM-E-submitted quality measure rates via an EQRO, or other designee conducted audit, any independent evaluation required by Federal or State statute or regulation, and any other independent evaluation required by the Agency.

i. Performance Monitoring and Improvement Process.

i. The PCCM-E must cooperate and participate, as requested by the Agency, in the Agency's performance monitoring and improvement process. At a minimum, this may include the following activities: the review of monthly, quarterly, and annually reported quality and Performance Measure data, including PCCM-E Quality Measures as specified in Exhibit Q, CMS-required performance standards and other measures as deemed appropriate by the Agency to manage the PCCM-E.

ii. The Agency shall track and provide PCCM-E Quality Measure results to the PCCM-E to evaluate program performance and outcomes.

iii. Upon request by the Agency, the PCCM-E shall provide all relevant information necessary to evaluate the performance and outcomes.

iv. At least quarterly and upon request by the Agency, the PCCM-E must attend a meeting with the Agency to share performance results and to discuss performance successes and challenges to aid the Agency in determining the effectiveness of the PCCM-E's quality improvement activities.

v. At least annually and upon request by the Agency, the PCCM-E must attend a meeting with the Quality Assurance Committee to discuss and review the PCCM-E Quality Measures for the upcoming calendar year.

vi. Quality Monitoring by the Agency. The Agency shall review, at least annually, the impact and effectiveness of the PCCM-E's Quality Improvement Plan. The items the Agency shall review include, but are not limited to, the PCCM-E Quality Measure performance, the PCCM-E's most current annual Quality Improvement Plan, the PCCM-E's most current Quality Improvement Plan evaluation for the previous calendar year, and the PCCM-E's Medical Management Committee minutes. At least sixty (60) Calendar Days prior to the Agency's review, the PCCM-E shall provide to the Agency:

(1) The PCCM-E's most current annual Quality Improvement Plan;

(2) The PCCM-E's most current Quality Improvement Plan evaluation for the previous calendar year; and

(3) All other information requested by the Agency to facilitate the Agency's review of the PCCM-E's compliance standards defined in the Agency's quality strategy.

j. Quality Improvement Projects

i. Quality Improvement Projects (QIPs) comprise one component of the overall PCCM-E Quality Improvement Program. The purpose of a QIP is to focus on and improve the processes and outcomes of health outcomes of the PCCM-E. Annually, the PCCM-E must submit for the Agency's approval, a description of its QIPs which it has chosen to implement to address each of the topic categories chosen by the Agency. If an additional QIP is required after the annual submission due to Agency or CMS demands, the PCCM-E will be notified as soon as possible and given appropriate time to develop the project. At a minimum, the PCCM-E must develop a QIP to address the following topics:

(1) Prevention of Childhood Obesity;

(2) Infant mortality and/or adverse birth outcomes; and

(3) Substance Use Disorders.

ii. The PCCM-E must successfully meet all requirements within each QIP category explained in detailed in Exhibit M.

iii. The PCCM-E must work with the Agency designated entities to develop, implement and evaluate the PCCM-E's annual QIPs. This includes participating in in-person meetings, conference calls, providing data to the PCCM-E, and any other required activities to implement successful QIPs. The PCCM-E must also contribute seven hundred and fifteen dollars ($715) to each lead organization that is providing technical assistance for the QIP from the funds provided by the Agency for a total annual contribution of two thousand one hundred and forty-five dollars ($2,145).

iv. The PCCM-E must submit to the Agency for approval the full plan and proposed budget for each of the QIPs annually within thirty (30) Calendar Days before the implementation of the QIP.

k. PCCM-E Quality Incentive Program

i. Beginning in year one (1) of the PCCM-E Program, the PCCM-E will have the opportunity to participate in an Incentive Program based upon the achievement of Agency determined benchmarks for each of the Quality Measures.

ii. If the PCCM-E achieves the minimum necessary of the annual benchmarks, it will be eligible to receive up to a ten percent (10%) incentive payment. See Exhibit P, Table 1 for more information on the qualifications and awarding of the Quality Incentive Payment, and see Exhibit Q for the list of Quality Measures.

l. Region Medical Management Committee

i. The PCCM-E must establish and is responsible for a Region Medical Management Committee which satisfies the following requirements:

(1) Chaired by the Medical Director, and

(2) Composed of all participating Providers who must have at least one representative (PCP, Physician Assistant, or Nurse Practitioner) from its medical practice to participate over a twelve (12) month period in at least two (2) quarterly Medical Management meetings in person and one (1) webinar/facilitation exercise with the Network(s) Medical Director.

ii. The purpose of the Region Medical Management Committee is to:

(1) Implement and supervise program initiatives centered around quality measures,

(2) Review utilization data with PCPs as needed to achieve quality goals of the PCCM-E,

(3) Review and assist the PCCM-E in implementing and evaluating its QIPs, and

(4) Discuss and when appropriate, resolve any issues the PCPs or the PCCM-E encounter in providing Care Coordination services to their EIs.

m. PCCM-E Quality Collaborative

i. The PCCM-E must participate in the Agency-led PCCM-E Quality Collaborative ("Collaborative") that is composed of the Agency, PCCM-E Programs in each Region, and other State agency representative(s) when appropriate.

ii. The Collaborative will meet quarterly, at a minimum, to develop and refine:

(1) Program measures;

(2) Utilization and management reports;

(3) Innovative health care and utilization management strategies;

(4) Quality improvement goals and measures;

(5) QIP Progress and Evaluation; and

(6) Opportunity for shared program operations and support.

13. PCP Participation with the PCCM-E

a. PCP practices will be required to sign participation agreements with the PCCM-E outlining responsibilities for the PCP to work with the PCCM-E to achieve program goals. The PCCM-E must allow requesting FQHCs and RHCs to engage in Active Participation with the PCCM-E by signing a participation agreement with the PCCM-E. The PCCM-E shall provide copies of signed participation agreements to the Agency by the 15th Calendar Day of the month to enroll the PCP for the following month. The Agency will provide a template for the participation agreement.

b. Active Participation will be a requirement for a PCP practice participating with the PCCM-E. Active Participation requirements are as follows:

i. Participates as needed in the PCCM-E's Multidisciplinary Care Team and the development of an individualized and comprehensive Care Plan;

ii. Over a twelve (12) month period, participates in person in at least two (2) quarterly Medical Management Meetings and one webinar/facilitation exercise with the

PCCM-E's Medical Director. Attendance requirements can be met by having one PCP or Nurse Practitioner/Physician Assistant from the group attend;

iii. Participates in ACHN initiatives centered around quality measures; and

iv. Reviews data provided by the PCCM-E to help achieve Agency and PCCM-E quality goals.

c. The PCCM-E must provide the Agency with a monthly report of those PCP Practices meeting the Active Participation requirements.

14. DHCP Participation with the PCCM-E

a. The DHCPs will be required to sign participation agreements with the PCCM-E outlining responsibilities for the DHCP to work with the PCCM-E to achieve program goals. The Agency will provide a template for the participation agreement. The PCCM-E shall provide copies of signed DHCP agreements to the Agency by the 15th Calendar Day of the month to enroll the DHCP for the following month.

b. Active Participation will be a requirement for a DHCP participating with the PCCM-E. Active Participation requirements are as follows:

i. Providing data to the PCCM-E;

ii. Participating in the development of the EI's care plan; and

iii. Participating in the DHCP selection and referral process.

c. The PCCM-E must provide the Agency with a monthly report of those DHCPs meeting the Active Participation requirements.

J. Financial

1. The PCCM-E shall review annually and ensure compliance with the State guidelines for nonprofit organizations receiving state funds.

2. The PCCM-E shall prepare and submit an annual operating budget to the Agency for approval at least thirty (30) Calendar Days prior to the start of each State fiscal year. The operating budget shall differentiate general and administrative expenses versus program expenses. The template for the annual budget form will be provided by the Agency.

3. The fiscal year for the PCCM-E will be the same as the State fiscal year, October 1 through September 30.

4. The PCCM-E must obtain written approval from the Agency's Managed Care Division prior to revising any budget line-item more than ten percent (10%).

5. The PCCM-E must maintain accurate records of expenditures in accordance with federal financial reporting and governmental accounting standards as defined by Generally Accepted Accounting Principles (GAAP).

6. The PCCM-E must annually submit within ninety (90) Calendar Days of the end of the state fiscal year an audit performed by an independent certified public accountant prepared in accordance with Generally Accepted Accounting Principles (GAAP) and Generally Accepted Auditing Standards. The audit must contain a "Statement of Functional Expenses" or include a functional expense analysis in the footnotes of the audited statements.

7. The PCCM-E shall carry over no more than ten percent (10%) cash derived from QIP per member per month (PMPM) payments at the close of the State fiscal year and must obtain the prior written approval of the Agency's Managed Care Division to carry over any cash funds in excess of ten percent (10%). The PCCM-E must submit a plan to the Agency by September 1st to detail how the reserve cash funds will be expended. Such cash funds must be expended or returned to the Agency within sixty (60) Calendar Days of the Agency's Managed Care Division approval of the plan.

8. The PCCM-E shall submit quarterly financial reports using a template provided by the Agency. The reports shall be due no later than the 15th Business Day following the last day of the quarter.

9. The PCCM-E shall on a monthly basis submit an accounting flash report, using a template provided by the Agency, that gives a high-level summary of monthly revenues and expenses. The flash report shall be due ten (10) Business Days following the last day of the preceding month. If the PCCM-E incurs two (2) consecutive months with expenses greater than revenues, the PCCM-E will submit to the Agency a Corrective Action Plan (CAP) that details the actions the PCCM-E will enact to enable the PCCM-E to decrease expenses below revenues. The CAP must be submitted within ten (10) Business Days following receipt of Agency notification that a CAP is required.

10. To assure full performance of all obligations imposed on a PCCM-E contracting with the State of Alabama, the PCCM-E must provide a performance guarantee in an amount equal to two hundred and fifty thousand dollars ($250,000). The performance guarantee must be submitted by the PCCM-E at least ten (10) Calendar Days prior to the Contract start date. This performance guarantee must be in force through the term of the Contract and ninety (90) Calendar Days beyond and must be conditioned on faithful performance of all contractual obligations.

11. The form of performance guarantee shall be one of the following:

    a. An irrevocable letter of credit;

b. Surety bond issued by a company authorized to do business within the State of Alabama; or

c. By maintaining at all times, a minimum capital and surplus consisting of admitted assets comprised of at least one the following:

i. Cash, including the true balance of deposits in solvent banks and trust companies;

ii. Bonds, notes, warrants, debentures, and other evidences of indebtedness which are direct obligations of the United States of America for which the full faith and credit of the United States of America is pledged for the payment of principal and interest ("U.S. Treasury Securities");

iii. Investment grade bonds or other evidences of indebtedness other than U.S. Treasury Securities, satisfying standards approved by the Medicaid Agency; or

iv. Marketable equity securities, satisfying standards approved by the Medicaid Agency.

12. Failure to perform satisfactorily shall cause the performance guarantee to become due and payable to the State. The Agency's Chief Financial Officer or his/her designee shall be custodian of the performance guarantee. The performance guarantee shall be extended in the event the Agency exercises its option to extend the Contract.

13. In accordance with the provisions of 45 C.F.R. Part 74 and paragraph 9 of OMB Circular A-102, affirmative steps shall be taken to assure that small and minority businesses are utilized when possible as sources of supplies, equipment, construction, and services.

14. The PCCM-E shall comply with Title VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Executive Order No. 11246, as amended by Executive Order No. 11375, both issued by the President of the United States, the Americans with Disabilities Act of 1990, and with all applicable federal and state laws, rules and regulations implementing the foregoing statutes with respect to nondiscrimination in employment.

15. The PCCM-E shall maintain, during the life of the Contract, Worker's Compensation insurance for all of its employees under the Contract or any subcontract thereof, if required by state law.

16. The PCCM-E shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of ten (10) years from the date of the final payment made by the Agency to the PCCM-E under the Contract. However, if audit, litigation, or other legal action by or on behalf of the State or Federal Government has begun but is not completed at the end of the ten-year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the ten-year period, the records shall be retained until resolution.

17. Subcontracts for services with a value over $10,000 per year must be prior approved in writing by the Agency.

K. Grievances and Dispute Resolution

1. Grievances

   a. The PCCM-E must have a grievance process in place to address EI's complaints regarding, but not limited to, the following:

      i. Dissatisfaction with case manager or other PCCM-E staff;

      ii. Complaints related to PCPs; and

      iii. Denial of Care Coordination services.

   b. The PCCM-E must submit a quarterly grievance log to the Agency.

   c. Grievances against the PCCM-E will be reviewed and addressed by the Agency. Grievances can be filed with the Agency in writing or verbally. EIs can request assistance with filing a grievance from the PCCM-E.

   d. Upon submitting a grievance, the Agency will investigate complaints against the PCCM-E. If necessary, the complainant will be interviewed.

   e. A summary and, if necessary, a request for a corrective action plan (CAP) will be sent from the Agency for all complaints reported within thirty (30) Calendar Days of the request for the summary or CAP. The PCCM-E must forward their CAP to the Agency. The Agency will evaluate the CAP within seven (7) Calendar Days of receipt. If the CAP is not responsive to the complaint, it will be returned to the PCCM-E within two (2) Business Days. The revised CAP will be resubmitted to the Agency within two (2) Business Days. If the summary or CAP carried out is found not to be responsive, the PCCM-E will have up to forty-five (45) Calendar Days to revise the plan and carry out the appropriate action.

   f. Appropriate parties must initiate action within twenty-four (24) hours if it appears that an EI's health and safety are at risk.

   g. The response to the Grievance by the Agency shall be in writing in a format and language that at a minimum, meets the requirements of 42 C.F.R. § 438.10, and fully explains the decision and reasons for each part of the Grievance presented.

2. The Agency, as needed, will update the PCCM-E of grievances received by the Agency and/or the status of pending grievances.

3. Dispute Resolution

    a. The Agency does operate another dispute resolution process, which is the informal conference process, which offers EIs the opportunity to appeal decisions that adversely affect their services. An informal request must be received in writing by the Agency within 30 days of the date of their Notice of Action.

    b. During this process, the EI may present the information or may be represented by a friend, relative, attorney, or other spokesperson of their choice. The Agency will provide their decision and/or recommendation within ten (10) Business Days of the date the informal conference is held.

    c. When a request for an informal conference is received by the Agency, the manager over the Region will review the request. If the request is unresolved, the manager will schedule the informal conference to include all parties involved.

    d. The Agency will notify the EI in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

L. Agency Intervention

If a problem is identified by the Agency regarding the quality of services received, the Agency will intervene as indicated below:

1. Provide education and informal mailings to EIs and PCCM-Es;

2. Initiate telephone and/or mail inquiries and follow-up;

3. Request PCCM-E's response to identified problems;

4. Refer to program staff for further investigation;

5. Send warning letters to PCCM-Es;

6. Refer to State's medical staff for investigation; or

7. Institute corrective action plans and follow-up.

M. Sanctions

1. In accordance with Alabama Medicaid Administrative Code Chapter 37, the Agency may impose Sanctions on the PCCM-E if the Agency determines, in its sole discretion, that the PCCM-E has violated any applicable federal or State law or regulation, the Alabama Medicaid State Plan, this RFP, any policies, procedures, written interpretations, or other guidance of the

Agency, or for any other applicable reason described in 42 C.F.R. Part 438, Subpart I or Alabama Medicaid Administrative Code Chapter 37, including, but not limited to, a determination by the Agency that a PCCM-E acts or fails to act as follows:

a. Acts to discriminate among EIs on the basis of their health status or need for health care services (including termination of enrollment or refusal to reenroll an EI, except as permitted under the Alabama Medicaid program, or any practice that would reasonably be expected to discourage enrollment by EIs whose medical condition or history indicates probable need for substantial future medical services);

b. Misrepresents or falsifies information that it furnishes to Agency or to CMS;

c. Misrepresents or falsifies information that it furnishes to an EI, Potential EI, or health care Provider;

d. Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved in writing by the Agency or that contain false or materially misleading information;

e. Fails to submit a Corrective Action Plan (CAP) that is acceptable to the Agency within the time period specified by the Agency's written notice or does not implement or complete the corrective action within the established time period;

f. Violates, as determined by the Agency, any requirement of sections 1932 or 1905(t) of the Social Security Act or any implementing regulations; or

g. Violates, as determined by the Agency, any applicable requirement of the Alabama Code or the Alabama Medicaid Administrative Code.

h. Unauthorized use of information.

i. Failure to safeguard confidential information of Providers, EIs or the Medicaid program.

2. The Sanctions imposed by the Agency against the PCCM-E are as follows:

a. Requiring the PCCM-E to develop and implement a CAP that is acceptable to the Agency;

b. The intermediate Sanctions described in 42 U.S.C. § 1396u-2(e)(2) and 42 C.F.R. Part 438, Subpart I, including but not limited to civil monetary penalties up to the maximum amounts set forth in 42 C.F.R. § 438.704;

c. Grant EIs the right to disenroll without cause (the Agency may notify the affected EIs of their right to disenroll);

d. Suspend all new enrollment, including auto-assignment, after the date HHS or the Agency notifies the PCCM-E of a determination of a violation of any requirement under Sections 1932 or 1905(t) of the Social Security Act;

e. Suspend payment for EIs enrolled after the effective date of the Sanction until CMS or the Agency is satisfied that the reason for the imposition of the Sanction no longer exists and is not likely to recur;

f. For acts or omissions which are not addressed by 42 C.F.R. Part 438, Subpart I, other provisions of Alabama Medicaid Administrative Code Chapter 37, or the Contract, RFP, and appendices thereto, and which, in the opinion of the Agency, constitute willful, gross, or fraudulent misconduct, the assessment of a monetary penalty amount up to $100,000 per act or omission;

g. Any other Sanction available under federal or State law or regulation, including without limitation Alabama Medicaid Administrative Code Rule 560-X-37-.01;

h. Termination of the Contract, in accordance with Section IX.K. of this RFP; and

i. Any other Sanction reasonably designed to remedy noncompliance and/or compel future compliance with the Contract or federal or State law or regulation, pursuant to the Agency's authority under 42 C.F.R. § 438.702(b), including but not limited to:

Contract Section	Performance Standard	Intermediate Sanction
Section II. M.1.e., II.M.1.f. and II.V.6.	● Distribution of unapproved marketing material or those that contain false or materially misleading information.	● Up to $25,000 for each determination
Section II. M.1.i.	● Unauthorized use of information	● Up to $25,000 for each determination
Section II. M.1.j.	● Failure to safeguard confidential information of Providers, EIs or the Medicaid program.	● Up to $25,000 for each determination
Section II. .M.1.d.	● Misrepresents or falsifies information furnished to the Agency or CMS.	● Up to $100,000 for each determination.
Section II.M.2.a.	● Failure to submit an acceptable CAP	● Up to $1,000 per instance
Section II.M.1.g.	● Failure to comply with the Agency approved CAP	● Up to $1,000 per instance

Section II.S.2.a., and Exhibit F.4.b.	● Failure to deliver quarterly reports as defined by the RFP by the date specified	● Up to $100 per day for each day delinquent per report or review
Section II.S.2.b.i.	● Failure to provide reports as required by the RFP regarding PCP and DHCP participation	● Up to $100 per day for each day delinquent
Section II. U.1.a.	● Failure to input Maternity Data for each EI with a 95% accuracy rate into the Health Information System/Database	● Up to $100 per instance
Section II. U.2.	● Failure to meet technical requirements	● Up to $1,000 per instance
Section II. I.1.f.	● Failure to maintain adequate case load levels necessary to perform the requirements of the Contract	● Up to $1,000 per instance
Section II. I.1.g.	● Insufficient or absence of Care Coordination documentation	● Up to $500 per instance
Section II.M.1.c. and II.O.1.	● Discriminate based on health status or need for health care services	● Up to $25,000 per instance
Section II.U.1.a.	● Failure to input Care Coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database	● Up to $100 per instance
Section II.V.	● Noncompliance with requirements for the EI services telephone line	● Up to $500 per instance

3. Before the Agency imposes a Sanction, with the exception of the CAP in Section II.M.2.a. above, it will give the PCCM-E timely written notice explaining:

    a. The basis and nature of the Sanction; and

    b. The PCCM-E's right to request a fair hearing under Alabama Medicaid Administrative Code Chapter 37.

4. Except as otherwise required by applicable law, in the event of an imposed Sanction in the form of a civil monetary penalty, the amount of the Sanction imposed will be reduced by thirty five percent (35%) if the PCCM-E waives, in writing, its right to a fair hearing within thirty (30) Calendar Days from the date of notice imposing the Sanction. The reduction under this

section only applies to Sanctions that could be appealed under Alabama Medicaid Administrative Code Chapter 37 and not to any other outstanding Sanctions imposed on the PCCM-E by the Agency.

5. Before terminating the Contract as a Sanction under this Section, Alabama Medicaid Administrative Code Chapter 37, and 42 C.F.R. § 438.708, the Agency will provide the PCCM-E with a pre-termination hearing to be conducted in accordance with the procedures for fair hearings set forth in Alabama Medicaid Administrative Code Chapter 3. Prior to such pre-termination hearing, the Agency will, in accordance with 42 C.F.R. § 438.710:

    a. Give the PCCM-E written notice of the Agency's intent to terminate the Contract, the reason or reasons for termination of the Contract, and the time and place of the hearing;

    b. After the hearing, give the PCCM-E written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination; and

    c. For a decision affirming the determination to terminate the Contract, give EIs of the PCCM-E notice of the termination and information, consistent with 42 C.F.R. § 438.10, on their options for receiving Medicaid services following the effective date of termination.

6. The imposition of a single Sanction by the Agency does not preclude the imposition of any other Sanction or combination of Sanctions or any remedy authorized under the Contract for the same deficiency. The Agency may impose Sanctions under this rule in addition to or in lieu of exercising any other right, remedy, or authority that the Agency may exercise under other rules promulgated by Medicaid, other applicable State and federal laws and regulations, or any contract between Medicaid and the PCCM-E. Nothing in this Section shall restrict or prevent the Agency or the State from obtaining declaratory, injunctive or equitable relief, or from recovering damages from the PCCM-E and/or any other person or entity for breach of contract or any other cause of action.

N. Included and Excluded Populations

1. The following groups of eligible Medicaid Beneficiaries shall be included for Care Coordination services under the PCCM-E (see the list on the Agency's website):

    a. Plan First recipients,

    b. Maternity Care recipients;

    c. Blind/Disabled children and adults;

    d. Aged and related populations;

    e. Children under age 19;

f. Parents or other caretaker relatives (POCR);

g. Foster children;

h. Former Foster Care;

i. Breast and Cervical Cancer; and

j. American Indians (note: may opt-out at any time).

2. The following groups of eligible Medicaid Beneficiaries shall be excluded for care coordination services under the PCCM-E:

a. Medicaid (dual eligibles);

b. Long-term institutional care;

c. Home and Community-Based Services waiver;

d. Children in the custody of the Department of Youth Services;

e. Inmates and people living in Institutions for Mental Diseases (IMDs);

f. Aged, blind or disabled individuals receiving only optional state supplements;

g. Individuals participating in the Program of All-Inclusive Care for the Elderly (PACE);

h. Individuals utilizing hospice services;

i. Individuals receiving Refugee Medical Assistance;

j. Individuals with other commercial managed care insurance or participating in the Health Insurance Premium Payment (HIPP) program; and

k. Individuals with limited or no Medicaid coverage (e.g., some non-citizens only eligible for emergency services, or individuals receiving short-term hospital presumptive eligibility).

O. Eligible Individual's (EI) Rights

1. The PCCM-E must adhere to EI rights in accordance with 42 C.F.R. §§ 438.100(a)(1), (b)(2), and (c).

2. The PCCM-E must develop, implement and maintain written policies ensuring each EI is guaranteed the right to:

a. Receive information in accordance with 42 C.F.R. § 438.10;

b. Be treated with respect and with due consideration for his or her dignity and privacy;

c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the EI's condition and ability to understand;

d. Participate in decisions regarding his or her health care, including the right to refuse treatment;

e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion; and

f. Request and receive a copy of his or her Medical Records, and request that they be amended or corrected, as specified in 45 C.F.R. §§ 164.524 and 164.526.

3. In accordance with 42 C.F.R. § 438.100(c), each EI is free to exercise his or her rights and the PCCM-E shall assure that the exercise of those rights shall not adversely affect the way the PCCM-E and its Participating Providers treat the EI.

4. The PCCM-E must further specify EI rights in the Eligible Individual Materials (EI Materials) as provided.

5. The PCCM-E must allow each EI to choose a PCP, DHCP, Care Coordinator, and a Community Health Care Worker to the extent possible and appropriate in accordance with 42 C.F.R. § 438.3(l).

6. The PCCM-E must allow EIs to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the EI to the Provider that furnished the services.

P. Enrollment

1. The PCCM-E must not, on the basis of health status or need for health care services, discriminate against Eligible Individuals (EIs). This includes but is not limited to, termination of enrollment or refusal to reenroll an EI except as permitted under this Contract, or any practice that would reasonably be expected to discourage enrollment or reenrollment by EIs whose medical condition or history indicates probable need for substantial future medical services. Violation of this requirement may result in Sanctions listed in this RFP.

2. The PCCM-E must not discriminate against individuals eligible to enroll with the PCCM-E on the basis of any protected category listed in 42 C.F.R. § 438.3(d) and must not use any policy or practice that has the effect of discriminating on the basis of any protected category listed in 42 C.F.R. § 438.3(d).

3. The PCCM-E must accept new enrollment from individuals in the order in which they apply without restriction, unless authorized by CMS, up to the limits set under the contract in accordance with 42 C.F.R § 438.3(d)(1).

Q. Disenrollment

1. In accordance with 42 C.F.R. § 438.56(b)(1), the PCCM-E may request disenrollment of an EI for the following reasons:

    a. EI loses Medicaid eligibility;

    b. EI's eligibility category changes to a category ineligible for the ACHN (e.g., EI becomes dually eligible for Medicare and Medicaid);

    c. EI otherwise becomes ineligible to participate in the ACHN

    d. EI has become incarcerated;

    e. EI has died; or

    f. EI moves out of the Region.

2. The PCCM-E may not request disenrollment because of:

    a. An adverse change in the EI's health status;

    b. The EI's utilization of medical services;

    c. The EI's diminished mental capacity; or

    d. The EI's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the PCCM-E's ability to furnish services to the EI or other EIs).

3. The PCCM-E must not request disenrollment for reasons other than those permitted under this RFP.

4. An EI has the right to disenroll from a PCCM-E:

    a. For cause, at any time;

    b. Without cause ninety (90) Calendar Days after initial enrollment or during the ninety (90) Calendar Days following notification of enrollment, whichever is later;
    c. Without cause at least once every twelve (12) months; or

d. Without cause upon reenrollment if a temporary loss of enrollment has caused the EIs to miss the annual disenrollment period.

5. An EI has the right to disenroll from a PCCM-E without cause when the Agency imposes intermediate Sanctions on the PCCM-E.

6. An EI may request disenrollment if:

   a. The EI moves out of the Region; or

   b. The plan does not cover the service the EI seeks, because of moral or religious objections.

7. An EI may request disenrollment if the EI needs related services to be performed at the same time and not all related services are available within the Region. The EI's PCP or another Provider must determine that receiving the services separately would subject the EI to unnecessary risk.

8. An EI may request disenrollment for other reasons, including poor quality of care, lack of access to services covered under this RFP, or lack of access to Providers experienced in dealing with the EI's care needs.

9. An EI (or his or her representative) must request disenrollment by submitting an oral or written request to the Agency.

10. The PCCM-E shall refer any disenrollment request it receives to the Agency. The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the EI requests disenrollment or the PCCM-E refers the request to the Agency.

11. If the Agency fails to make a disenrollment determination within the specified timeframes (i.e., the first day of the second month following the month in which the EI requests disenrollment or the PCCM-E refers the request to the Agency), the disenrollment is considered approved for the effective date that would have been established had the Agency made a determination in the specified timeframe.

R. Reenrollment

1. An EI is automatically reenrolled if the EI is disenrolled solely because he or she loses Medicaid eligibility for a period of two (2) months or less.

2. An EI may choose to reenroll at any time.

S. Administrative Requirements

1. The PCCM-E must employ a full-time Executive Director to serve as primary administrative liaison between the PCCM-E and the Agency (the Executive Director position is a Key Staff position; additional Key Staff positions are listed in Exhibit F). The PCCM-E is required to submit resumes of all Key Staff to the Agency for review and approval as part of the RFP response. The Executive Director must have the authority to make all day-to-day program decisions. Such decisions shall be consistent with the terms of the Contract, within the policies and procedures of the PCCM-E and the budget approved by the PCCM-E's Governing Board. Duties will include hiring, firing, and financial decisions.

2. The PCCM-E must follow reporting requirements:

    a. Quarterly reports shall be submitted to the Agency's Managed Care Division within the fifteenth (15th) Business Day of the month following the end of the quarter on the standardized quarterly report templates (see Section II.B);

    b. The PCCM-E will provide the Agency with the following reports:

        i. Quarterly File. The PCCM-E will provide a listing of participating PCPs and DHCPs to the Agency on a quarterly basis. This should include all PCPs, Teaching Physicians, FQHCs, and RHCs.

        ii. Annual reports based on the state fiscal year shall be submitted by the end of the quarter following the end of the fiscal year. The reports should be in the format prescribed by the Agency.

T. Staff Training

1. The PCCM-E shall conduct professional training sessions as specified in Exhibit D. The PCCM-E must provide the Agency with an annual training plan as well as training evaluation summaries.

2. The PCCM-E staff required by the Agency will attend all training sessions provided by the Agency. The PCCM- E will ensure that designated staff are trained by Agency approved curriculum for CMC as specified in Exhibit E.

U. Health Information Management System (HIMS)

1. Functional Requirements

    a. The Agency is requiring a case management system that includes Care Coordination documentation, maternity data and the ability to accept Admission/Discharge/Transfer (ADT) feeds. Failure to input Maternity data and/or Care Coordination documentation for

each EI with a 95% accuracy rate into the Health Information System/Database will result in Sanctions (see Section II.M.2.i.).

b. The Agency will provide to the PCCM-E HIMS summary level reports for guiding quality improvement, supporting Providers, and general population health monitoring.

c. The Agency will provide data about specific EIs in the PCCM-E Region.

d. The PCCM-E may request ad-hoc research request from the Agency through the PCCM-E's primary contact with the Managed Care Division. Upon review, the Managed Care Division will forward to the Analytics Division for further review, scope development and prioritization.

e. The PCCM-E must ensure all PHI data is protected per federal laws, state laws, and Business Associates Agreement.

f. The PCCM-E must ensure that the HIMS is fully operational and tested by the PCCM-E, Agency, and/or Agency designee, prior to the completion of the Agency's readiness assessment pursuant to Section II.E. The PCCM-E must ensure prior to the completion of the Agency's readiness assessment that its HIMS be operational and have completed:

   i. Design;

   ii. Testing; and

   iii. Training of staff on the HIMS.

g. The PCCM-E HIMS must comply with the following:

   i. The system must provide the Agency a monthly extract of data in the format prescribed by the Agency.

   ii. The system must use specifications from the Agency to document user information and case management (see Section II.B).

   iii. The Agency, directly or through the HIMS, will provide to the PCCM-E the following data for EI's in the Region:

      (1) Paid claims data at least monthly or at most after each check write;
      (2) Pharmacy data daily;

      (3) Eligibility data;

      (4) Provider data; and

      (5) Reference data.

iv. The system will allow the Agency to have access to the system for reviewing case management data and to review security and management components.

2. Technical Requirements

   a. Security – The system shall meet (or comply with) federal security guidelines as (described by, laid out in, required by) FISMA, OMB A-130, FIPS 200, and NIST using the specifications provided by the current Center for Medicare and Medicaid Services Acceptable Risk Safeguards (CMS ARS).

   b. Contingency and Continuity Plan – The Contractor shall develop information systems contingency planning. Contingency plans shall include: (i) data backup plans, (ii) Disaster recovery plans, and (iii) emergency mode of operation plans. (See Exhibit R – Contingency and Continuity Requirements).

   c. Availability – The system shall have 99.0 % uptime during the hours of operations.

   d. Scalability – The Contractor shall have a scalable system and infrastructure that can process at least 125,000 EIs and related data associated with those EIs (e.g., claims).

   e. Interfaces – The system shall have the ability to process files from the Agency (e.g., Claims file, Pharmacy file, Eligibility file, Provider file, Reference file) and produce files for the Agency (e.g., Network file, Case Management audit file).

V. Services Telephone Line

1. The PCCM-E shall provide and maintain a number allowing toll-free calls from PCPs, potential and current EIs in the PCCM-E. This is to provide health related support and access. This line shall be available on Business Days, between the hours of 8:00 a.m. and 5:00 p.m. CT (central time). The PCCM-E must also have policies and procedures for handling emergency calls.

2. The PCCM-E must develop, implement, and maintain policies and procedures, which must be submitted to the Agency for prior written approval, for operating the toll-free EI services telephone line, or equivalent, that include, but are not limited to, staffing, hours of operation, call response and hold times, abandonment rate, transfer protocols and monitoring.

3. The PCCM-E shall develop, implement, and monitor performance standards for the toll-free EI services telephone line. Such standards and monitoring activities must be submitted to the Agency for approval.

4. The PCCM-E must conduct ongoing call quality assurance to ensure these minimum performance standards are met. If the Agency determines, in its sole discretion, that it is necessary to conduct onsite monitoring of the PCCM-E's EI services telephone line functions,

the PCCM-E will be responsible for all reasonable costs incurred by the Agency or its authorized designee(s) relating to such monitoring.

5. The toll-free EI services telephone line must have the capability to handle calls from any language for non-English speaking EIs, as well as EIs with communications impairment, including the use of translators, auxiliary aids such as the telecommunications relay service (TRS), and text telephone (TTY)/telecommunication device for the deaf (TDD) lines.

6. The PCCM-E shall have an automated system available every Business Day between the hours of 5:00 p.m. and 8:00 a.m. CT and during weekends and legal holidays. The automated system must include a voice mailbox for callers to leave messages. The PCCM-E shall ensure that the voice mailbox has adequate capacity to receive the reasonably anticipated maximum volume of messages. The PCCM-E must return messages on the next Business Day. This automated system must provide callers with operating instructions on what to do in case of an emergency which must include, at a minimum, the following information in accordance with 42 C.F.R. § 438.10(g)(2)(v):

    a. What constitutes an Emergency Medical Condition and Emergency Services; and

    b. The fact that the EI has a right to use any hospital or other setting for emergency care.

7. Noncompliance with requirements for the EI services telephone line may result in Sanctions.

W. Information Requirements

1. The PCCM-E shall develop, implement, and maintain policies, procedures, and forms designed to clearly and thoroughly explain, in a manner and format that may be easily understood and is readily accessible, the process to accept and decline services, the rights and responsibilities of EIs, and to help EIs understand the requirements and benefits of the ACHN program. The terms “readily accessible” and “limited English proficient” or “LEP” shall have the meanings set forth in 42 C.F.R. § 438.10(a). In addition, the PCCM-E must notify EIs that the right to free and timely language assistance services applies to translated documents and oral interpretation.

2. Prevalent Non-English Languages is defined as, at a minimum, the top fifteen (15) languages spoken in the State by individuals with LEP (see Exhibit O).

3. The PCCM-E shall provide information to potential EIs and EIs in accordance with 42 C.F.R. § 438.10 and Section 1557 of the Affordable Care Act.

4. The PCCM-E must inform EIs that interpretation service is available for any language and written translation is available in each Prevalent Non-English Language upon request. The PCCM-E shall provide, free of charge, interpreters for EIs whose primary language is any non-English language, not just those non-English languages spoken by five percent (5%) or more

of the total covered population of the Region. The PCCM-E shall also provide auxiliary aids free of charge to EIs with disabilities.

5. The PCCM-E shall at the time services are accepted by an EI, request EIs to inform the PCCM-E of primary non-English language and any language assistance requirements.

6. The PCCM-E must make all written material in a font size no smaller than twelve (12) point and in an easily understandable language that meets the requirements of this section, in English, and all other Prevalent Non-English Languages. Auxiliary aids and services must be made available at no cost to an EI upon his or her request, including toll free numbers, TTY/TDY and American Sign Language. Tag lines and large print (no smaller than eighteen (18) point font) must be used by the PCCM-E in connection with such written Materials in accordance with 42 C.F.R. § 438.10(d)(3)-(6) and 45 C.F.R. § 92.8.

7. Upon request by and at no charge to EIs, the PCCM-E must make all written material available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The PCCM-E must inform EIs that written information is available in alternative formats and how to access these formats.

8. In accordance with 42 C.F.R. § 438.10(c)(4)(i) and Section II.A.3, the PCCM-E must use the same definitions in Exhibit A in its EI Materials described in Section II.X and EI notices.

9. The PCCM-E must give each EI notice of any significant changes, as determined by the State, in the written material and the information required by this subsection and by 42 C.F.R. § 438.10, at least thirty (30) Calendar Days before the intended effective date of the change.

X. Eligible Individual Materials (EI Materials)

1. Materials for use by Eligible Individuals are to be developed in accordance with State and Federal Guidelines, including information as required in 42 C.F.R. §§ 438.10 and 438.102 and 45 C.F.R. § 147.200. When provided by the State, templates must be used.

2. On or before the first visit for Care Coordination services, EIs must be provided with Materials that describe the services provided by the PCCM-E and how to access and effectively use those services as set forth in 42 C.F.R. § 438.10(g)(2).

3. Information required by this section to be provided by the PCCM-E shall be considered properly provided if the PCCM-E:

   a. Mails a printed copy to EI’s mailing address;

   b. Provides the information by email after obtaining EI’s written consent to do so; or

   c. Provides the information in person.

4. All EI Materials, including subsequent updates and changes, must be sent to the Agency at least forty-five (45) Calendar Days prior to intended publication or dissemination to EI for review and approval.

5. The PCCM-E shall communicate to its EIs significant changes as defined by the Agency. Such changes shall be communicated to EIs no later than thirty (30) Calendar Days before the intended effective change and can be electronically transmitted.

6. Distribution of EI Materials that have not been approved or contain materially false information may result in Sanctions.

7. All EI Materials should be available in alternative formats as required by 42 C.F.R. § 438.10, including but not limited to:

    a. Information on how to access and use PCCM-E services;

    b. EI rights and responsibilities, to include the Agency's Grievance process;

    c. Participating Provider list;

    d. Privacy information (including HIPAA information);

    e. Advance Directives; and

    f. Educational documents approved by the Agency.

Y. Outreach and Education Program

1. The PCCM-E must develop and implement effective EI education and outreach programs which support health outcome initiatives and encompasses all identified populations (i.e., General, Maternity and Family Planning).

2. The PCCM-E must provide the Agency with a written description of all planned health education activities and targeted implementation dates at a frequency and in a format determined by the Agency. The PCCM-E must receive express written approval from the Agency prior to use of all educational Materials.

3. The PCCM-E must describe the requirements and benefits of the PCCM-E's services consistent with Section II.W of this RFP and 42 C.F.R. § 438.10.

4. The PCCM-E must address the prevention of illness and disease, disease management, and healthy lifestyles consistent with Section II.W of this RFP and 42 C.F.R. § 438.10.

5. The PCCM-E must specifically inform EIs about the availability of transportation services and educating EIs about how to access Non-Emergency Transportation (NET) services.

6. The PCCM-E must make PCPs, EIs, and the community aware of the purpose and the services offered by the PCCM-E. Materials identified or developed for use shall be reviewed and approved by the Agency, including, but not limited to, letters, educational Materials, programs, promotional, on-line content, and forms.

7. The PCCM-E must provide semi-annual outreach and education to DHCPs. At a minimum program guidelines, updates from the Agency and referral processes must be addressed.

8. The PCCM-E must maintain documentation to support compliance with this requirement.

Z. Community Resource Guide

1. The PCCM-E must identify community, social, and recovery support services that are available at the county level and develop a resource guide which contains a listing of the support services agencies, services provided, hours of operation, address, contact numbers, and any applicable eligibility criteria (e.g., age limitations).

2. The community resource guide must be updated at least annually and made available to the PCCM-E's Care Coordination staff who have contact with EIs.

3. Upon request, the community resource guide must be made available to EIs in hard copy form or on the PCCM-E website. Guides must be in a printer friendly format (i.e., PDF) and available via the PCCM-E website.

AA. PCCM-E Website

1. The PCCM-E must maintain a website that, at a minimum, provides public access to minimum essential information needed by EIs, including, but not limited to:

    a. Description of services available from the PCCM-E and how an EI may access or be referred for those services;

    b. Lists of Medicaid-enrolled Providers who have signed agreements to participate with the PCCM-E, specifically Primary Care Providers (PCPs), Delivering Healthcare Professionals (DHCPs), and Plan First Providers. These lists may be provided via a link to Medicaid's website;

    c. Prominent statement that EIs may see any participating PCP or DHCP for services, regardless of location, but that Care Coordination services will be provided by the PCCM-E serving the EI's county of residence;

    d. List of Care Coordinators with contact information;

    e. Copy of Community Resource Guide by County;

f. Contact information for the PCCM-E, including telephone, mailing, fax and encrypted email form;

g. Forms and instructions on how to file a complaint/grievance;

h. Instructions on how to set up and arrange for a ride through the Medicaid Non-Emergency Transportation program;

i. Commonly used forms/documents to access PCCM-E services;

j. How to update personal information with the Agency;

k. Links to recipient-related content on the Agency website, e.g., covered services, Non-Emergency Transportation, eligibility forms, educational Materials; and

l. Other items as required within this RFP.

2. The PCCM-E must ensure that the website reflects the use of modern standards to make the website readily accessible as defined in 42 C.F.R. § 438.10(a). The website also must comply with 45 C.F.R. § 92.8(f)(1)(iii) in that the notice offering language assistance must be in a conspicuous place on the home page of the website.

3. If the Agency determines that the PCCM-E's web presence will be incorporated to any degree to the Agency's or the State's web presence, the PCCM-E must conform to any applicable Agency or State standard for website structure, coding, and presentation.

4. Website content must be approved in advance by the Agency. Website content is to be accurate, current, and designed so that EIs and Providers may easily locate all relevant information. If directed by the Agency, the PCCM-E must establish appropriate links on the PCCM-E's website that direct users back to the Agency's website.

BB. Electronic Communication

1. Information required to be provided herein may not be provided electronically, unless all of the following are met in accordance with 42 C.F.R. § 438.10(c)(6):

a. The format is readily accessible;

b. The information is placed in a location on the PCCM-E's website that is prominent and readily accessible;

c. The information is provided in an electronic form which can be electronically retained and printed; and

d. The information is consistent with the content and language requirements.

2. In addition to the requirements of Section II.W Information Requirements of this RFP, the PCCM-E may only use electronic methods of communication with an EI if:

    a. The EI has provided an email address to the PCCM-E and has not requested to no longer receive electronic methods of communication;

    b. The EI has requested or approved electronic transmittal;

    c. The identical information is available in written format upon request;

    d. Language and alternative format accommodations are available; and

    e. All Health Insurance Portability and Accountability Act (HIPAA) requirements are satisfied with respect to PHI.

CC. Fraud and Abuse

1. General Requirements

    a. The PCCM-E must comply with all State and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and Children's Health Insurance Programs (CHIP).

    b. The PCCM-E must cooperate and assist the State and any State or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, Abuse, or waste. At any time during normal business hours any State or federal agency, and/or their designee(s), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules for as often as they may deem necessary during the Contract period and for a period of ten (10) years from the expiration date of the Contract (including any extensions to the Contract).

    c. The PCCM-E and its Subcontractors must make all program and financial records and service delivery sites open to the representative or any designees of the above. Each federal and State agency must have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with PCCM-E EIs, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by this RFP. The rights of access in this subsection are not limited to the required retention period but must last as long as records are retained. The PCCM-E must provide originals and/or copies (at no charge) of all records and information requested. Requests for information must be compiled in the form and the language requested.

d. PCCM-E's employees and its contractors and their employees must cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.

e. The PCCM-E must certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The PCCM-E must not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the RFP, and Agency policy.

f. The PCCM-E must report to the Agency, within three (3) Business Days, when discovered that any PCCM-E employees, Subcontractor, or Subcontractor's employees have been excluded, suspended, or debarred from any State or federal healthcare benefit program.

2. Prohibited Affiliations

a. In accordance with 42 C.F.R. § 438.608(b) and 42 C.F.R. § 438.608(c)(1)-(3), the PCCM-E must comply with all regulations regarding Provider screening and enrollment requirements, and disclosure requirements.

b. In accordance with 42 C.F.R. § 438.610 and 42 C.F.R. § 457.935, the PCCM-E must not knowingly have a relationship of the type described in this section with the following:

i. An individual or entity who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non- procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

ii. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in this section.

c. The PCCM-E must not have a relationship with an individual or entity or be controlled by an individual or entity that is excluded from participation in any Federal health care program under Sections 1128 or 1128A of the Social Security Act.

3. "Relationship," is defined as follows:

a. A director, officer, or partner of the PCCM-E;

b. A Subcontractor;

c. A person with beneficial ownership of five percent (5%) or more of the PCCM-E's equity; or

d. A Provider in the PCCM-E's network or person with an employment, consulting or other arrangement with the PCCM-E for the provision of items and services that are significant and material to the PCCM-E's obligations under this RFP Contract.

4. The PCCM-E must provide written disclosure to the Agency of any of the above prohibited affiliations.

5. If the Agency learns that the PCCM-E has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in Federal healthcare programs, the Agency:

   a. Must notify the Secretary of HHS of the noncompliance;

   b. May continue an existing agreement with the PCCM-E unless the Secretary of HHS directs otherwise; and

   c. May not renew or extend the existing Contract with the PCCM-E unless the Secretary of HHS provides to the Agency and to Congress a written statement describing compelling reasons that exist for renewing or extending the Contract despite the prohibited affiliations.

6. Nothing in this section must be construed to limit or otherwise affect any remedies available to the United States under Sections 1128, 1128A, or 1128B of the Social Security Act.

7. The PCCM-E must disclose to CMS and the Agency, and to EIs upon reasonable request, information on ownership and control, business transactions and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The PCCM-E must obtain federally required disclosures from all Participating Providers and applicants in accordance with 42 C.F.R. Part 455 Subpart B and 42 C.F.R. § 1002.3, and as specified by Medicaid including but not limited to obtaining such information through Provider enrollment forms.

8. The PCCM-E must notify the Agency within three (3) Business Days of the time it receives notice that action is being taken against the PCCM-E or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the PCCM-E or a contractor from the Medicaid or CHIP programs, or any program listed in Executive Order 12549.

9. The PCCM-E and its Subcontractors must disclose to the Agency, any persons or corporations with an ownership or control interest in the PCCM-E that:

   a. Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the PCCM-E's equity;

   b. Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the PCCM-E if that interest equals at least five percent (5%) of the value of the PCCM-E's assets;

c. Is an officer or director of a PCCM-E organized as a corporation; or

d. Is a partner in a PCCM-E organized as a partnership.

10. In accordance with 42 C.F.R. § 455.104(b), the PCCM-E must disclose the following to the Agency:

    a. The name and address of any individual or corporation with an ownership or control interest in PCCM-E and its Subcontractors. The address for corporate entities must include an applicable primary business address, every business location, and P.O. Box address;

    b. Date of birth and Social Security Number of any individual with an ownership or control interest in the PCCM-E and its Subcontractors;

    c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the PCCM-E and/or in any Subcontractor in which the PCCM-E has a five percent (5%) or more interest;

    d. Whether the individual or corporation with an ownership or control interest in the PCCM-E is related to another person with ownership or control interest in the PCCM-E as a spouse, parent, child, or sibling; or whether the individual or corporation with an ownership or control interest in any Subcontractor in which the PCCM-E has a five percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling;

    e. The name of any other disclosing entity (or the Agency's Fiscal Agent or other managed care entity) in which an owner of the PCCM-E has an ownership or control interest; and

    f. The name, address, date of birth, and Social Security Number of any managing employee of the PCCM-E.

11. In accordance with 42 C.F.R. § 455.104(c), disclosures from the PCCM-E and its Subcontractors are due at any of the following times:

    a. Upon the PCCM-E submitting a proposal in accordance with the Agency's procurement process;

    b. Upon execution, renewal, or extension of a Contract with the Agency; or

    c. Within thirty-five (35) Calendar Days after any change in ownership of the PCCM-E.

12. In accordance with 42 C.F.R. § 455.104(d), all disclosures must be provided to the Agency.

13. The Agency will review the ownership and control disclosures submitted by the PCCM-E and any of the PCCM-E's Subcontractors.

14. In accordance with 42 C.F.R. § 455.104(e), Federal financial participation (FFP) is not available in any amounts made to a PCCM-E that fails to disclose ownership or control information as required by said section. FFP is also not available for any amounts paid to the PCCM-E that could be excluded from participation in Medicare or Medicaid for any of the following reasons:

    a. The PCCM-E is controlled by a sanctioned individual;

    b. The PCCM-E has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in Section 1128(b)(8)(B) of the Social Security Act; or

    c. The PCCM-E employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

        i. Any individual or entity excluded from participation in Federal health care programs; or

        ii. Any entity that would provide those services through an excluded individual or entity.

15. The PCCM-E must maintain such disclosed information in a manner in which can be periodically searched by the PCCM-E for exclusions and provided to the Agency in accordance with this RFP and relevant Federal and State laws and regulations. In addition, the PCCM-E must comply with all reporting and disclosure requirements of 42 U.S.C. § 1396b(m)(4)(A) if the PCCM-E is not a federally qualified health maintenance organization under the Public Health Service Act. The PCCM-E must also comply with all reporting and disclosure requirements set forth in any federal or State statute or regulation.

III. PRICING

Vendors must respond to this RFP by identifying the specific Region (see Section I.B.) for which a proposal is being submitted. The maximum amount payable for direct services under this RFP is capped per Region and is the total dollar amount paid to the PCCM-E in each contract year. The PCCM-E will receive revenue based on:

1. A monthly per member per month (PMPM) for the general, maternity, and Plan First populations will be made to reimburse the PCCM-E for Quality Improvement Projects. This payment rate will vary based on the CMS classification of counties in the Region as being urban or rural. The monthly revenue received by the PCCM-E will be dependent on the number of EI's that live in the Region.

2. The Care Coordination activity payments for the general population is separated into three levels and are the same amount for all Regions. The Care Coordination activity payments for the maternity population are separated into five levels and varies for each Region. The Care Coordination activity payments for the family planning population are separated into three levels and varies for each Region (see Exhibit S).

3. The maximum amount payable per Region for PMPM payments and Care Coordination services during the term of the initial Contract is detailed in the following chart.

Region	Year One	Year Two
Central	**$ 5,561,474**	**$ 5,429,474**
East	**$ 5,732,833**	**$ 5,584,507**
Jefferson/Shelby	**$ 6,159,764**	**$ 5,988,284**
Northeast	**$ 5,594,251**	**$ 5,431,258**
Northwest	**$ 5,610,025**	**$ 5,463,943**
Southeast	**$ 5,660,416**	**$ 5,516,904**
Southwest	**$ 6,634,329**	**$ 6,455,239**

Note: Year one (1) includes the one-time one hundred dollar ($100) Maternity Care Coordination transfer fee, that will be paid to the PCCM-E, for all eligible pregnant women currently receiving maternity care coordination. Figures exclude quality incentive payments as discussed in Section III.4.

4. In addition to these maximum payable amounts, the PCCM-E will be eligible for an incentive payment if quality metrics are met. Quality metrics will be measured on a yearly basis. A PCCM-E that meets all quality metrics will be eligible to receive an incentive payment up to ten percent (10%) of the revenue received by the PCCM-E.

IV. GENERAL MEDICAID INFORMATION

The Alabama Medicaid Agency is responsible for the administration of the Alabama Medicaid Program under a federally approved State Plan for Medical Assistance. Through teamwork, the Agency strives to enhance and operate a cost-efficient system of payment for health care services rendered to low income individuals through a partnership with health care Providers and other health care insurers both public and private.

The Agency's central office is located at 501 Dexter Avenue in Montgomery, Alabama. Central office personnel are responsible for data processing, program management, financial management, program integrity, general support services, professional services, and EI eligibility services. For certain EI categories, eligibility determination is made by Agency personnel located in eleven (11) district offices throughout the state and by one hundred forty (140) out-stationed workers in designated hospitals, health departments and clinics. Medicaid eligibility is also determined through established policies by the Alabama Department of Human Resources and the Social Security Administration. In 2015, an average of 1,049,787 Alabama citizens were eligible for Medicaid benefits through a variety of programs. Services covered by the Agency include, but are not limited to, the following:

- Physician Services
- Inpatient and Outpatient Hospital Services
- Rural Health Clinic Services
- Laboratory and X-ray Services
- Nursing Home Services
- Early and Periodic Screening, Diagnosis and Treatment
- Dental for children ages zero (0) to twenty (20)
- Home Health Care Services and Durable Medical Equipment
- Family Planning Services
- Nurse-Midwife Services
- Federally Qualified Health Center Services
- Hospice Services
- Prescription Drugs
- Optometric Services
- Transportation Services
- Hearing Aids
- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Prosthetic Devices
- Outpatient Surgical Services
- Renal Dialysis Services
- Home and Community Based Waiver Services
- Prenatal Clinic Services
- Mental Health Services

Additional program information can be found at www.medicaid.alabama.gov.

V. VENDOR QUALIFICATION

This document outlines the qualifications which must be met for a Vendor to serve as Contractor. It is imperative that Vendors describe, in detail, how they intend to approach the Scope of Work specified in Section II of the RFP. The ability to perform these services must be carefully documented, even if the Vendor has been or is currently participating in a Medicaid Program.

Proposals will be evaluated based on the written information that is presented in the response. This requirement underscores the importance and the necessity of providing in-depth information in the proposal with all supporting documentation necessary.

The Vendor must demonstrate in the proposal a thorough working knowledge of program policy requirements as described, herein, including but not limited to the applicable Operational Manuals, State Plan for Medical Assistance, Administrative Code and Code of Federal Regulations (CFR) requirements.

Entities that are currently excluded under federal and/or state laws from participation in Medicare/Medicaid or any State's health care programs are prohibited from submitting bids.

VI. CORPORATE BACKGROUND AND REFERENCES

1. Vendors submitting proposals must:

   a. Provide evidence that the Vendor possesses the qualifications required in this RFP;

   b. Provide a description of the Vendor's organization, including:

      i. Date established;

      ii. Ownership (public company, partnership, subsidiary, etc.). Include an organizational chart depicting the Vendor's organization in relation to any parent, subsidiary or related organization;

      iii. Governing Board composition;

      iv. Number of employees and resources;

      v. Names and resumes of Senior Managers and Partners of the Vendor;

      vi. A list of services the Vendor intends to subcontract and the intended subcontractor;

      vii. A list of all similar projects the Vendor has completed within the last two years;

      viii. A detailed breakdown of proposed staffing for this project, including names and education background of all employees that will be assigned to this project as explained in Section II of this RFP;

      ix. A list of all Medicaid agencies or other entities for which the Vendor currently performs similar work;

      x. Vendor's acknowledgment that the State will not reimburse the Vendor until: (a) the Project Director has approved the invoice; and (b) the Agency has received and approved all deliverables covered by the invoice; and

      xi. Details of any pertinent judgment, criminal conviction, investigation or litigation pending against the Vendor or any of its officers, directors, employees, agents or Subcontractors of which the Vendor has knowledge, or a statement that there are none. The Agency reserves the right to reject a proposal solely on the basis of this information.

c. Have all necessary business licenses, registrations and professional certifications at the time of the contracting to be able to do business in Alabama. Alabama law provides that a foreign corporation (a business corporation incorporated under a law other than the law of this state) may not transact business in the state of Alabama until it obtains a Certificate of Authority from the Secretary of State. To obtain forms for a Certificate of Authority, contact the Secretary of State, (334) 242-5324, www.sos.state.al.us. The Certificate of Authority or a letter/form showing application has been made for a Certificate of Authority must be submitted with the bid.

d. Document the resources and capability for completing the work necessary to implement the Network. The Vendor's proposal must include a chart outlining the proposed tasks needed to complete the implementation by the readiness assessment deadline, as well as outline follow-up and routine reporting deliverables and staff needed to complete the proposed tasks.

2. The State reserves the right to use any information or additional references deemed necessary to establish the ability of the Vendor to perform the conditions of the Contract.

VII. SUBMISSION REQUIREMENTS

A. Authority

This RFP is issued under the authority of Section 41-16-72 of the Alabama Code (1975) and 45 C.F.R. §§ 74.40 through 74.48. The RFP process is a procurement option allowing the award to be based on stated evaluation criteria. The RFP states the relative importance of all evaluation criteria. No other evaluation criteria, other than as outlined in the RFP, will be used.

In accordance with 45 C.F.R. § 74.43, the State encourages free and open competition among Vendors. Whenever possible, the State will design specifications, proposal requests, and conditions to accomplish this objective, consistent with the necessity to satisfy the State's need to procure technically sound, cost-effective services and supplies.

B. Single Point of Contact

From the date this RFP is issued until a Contractor is selected and the selection is announced by the Project Director, all communication must be directed to the Project Director in charge of this solicitation. Vendors or their representatives must not communicate with any State staff or officials regarding this procurement with the exception of the Project Director. Any unauthorized contact may disqualify the Vendor from further consideration. Contact information for the single point of contact is as follows:

Project Director: Varonica Wagner

Address: Alabama Medicaid Agency

Lurleen B. Wallace Building

501 Dexter Avenue

Post Office Box 5624

Montgomery, Alabama 36103-5624

E-Mail Address: achnrfp@medicaid.alabama.gov

C. RFP Documentation

All documents and updates to the RFP including, but not limited to, the actual RFP, questions and answers, addenda, etc., will be posted to Medicaid's website at www.medicaid.alabama.gov.

D. Questions Regarding the RFP

Vendors with questions requiring clarification or interpretation of any section within this RFP must submit questions and receive formal, written replies from the State. Each question must be submitted to the Project Director via email. Questions and answers will be posted on the Medicaid website as described in the Schedule of Events.

E. Mandatory Vendor Conference

There will be a mandatory in-person conference to discuss the Scope of Work and proposal response requirements, with all Vendors interested in submitting a proposal in response to this RFP. The Vendor submitting the Proposal or its representative must register in-person as required at the site of this mandatory conference.

A Proposal submitted by a Vendor which failed to attend the mandatory conference and register as required will be rejected upon receipt.

The mandatory conference will be held at the Alabama Department of Archives and History, 624 Washington Ave., Montgomery, AL 36104, 10:00 AM CT on 01/22/2019. Vendors will have the opportunity to ask questions during the conference. The Agency may respond to questions during the conference, and will post written responses.

THE VENDOR MUST COMPLETE APPENDIX C - MANDATORY VENDOR CONFERENCE NOTIFICATION AND SUBMIT TO THE PROJECT DIRECTOR VIA EMAIL BY THE DATE SPECIFIED IN THE SCHEDULE OF EVENTS.

F. Acceptance of Terms and Conditions

Vendor must submit a statement stating that the Vendor understands and will comply with the terms and conditions as set out in this RFP. Additions or exceptions to the standard terms and

conditions are not allowed. Any addition or exception to the terms and conditions are considered severed, null and void, and may result in the Vendor's proposal being deemed non-responsive.

G. Adherence to Specifications and Requirements

Vendor must submit a statement stating that the Vendor understands and will comply with the specifications and requirements described in this RFP.

H. Order of Precedence

In the event of inconsistencies or contradictions between language contained in the RFP and a Vendor's response, the language contained in the RFP will prevail. Should the State issue addenda to the original RFP, then said addenda, being more recently issued, would prevail against both the original RFP and the Vendor's proposal in the event of an inconsistency, ambiguity, or conflict.

I. Vendor's Signature

The proposal must be accompanied by the RFP Cover Sheet signed in ink by an individual authorized to legally bind the Vendor. The Vendor's signature on a proposal in response to this RFP guarantees that the offer has been established without collusion and without effort to preclude the State from obtaining the best possible supply or service. Proof of authority of the person signing the RFP response must be furnished upon request.

J. Offer in Effect for 90 Days

A proposal may not be modified, withdrawn or canceled by the Vendor for a 90-day period following the deadline for proposal submission as defined in the Schedule of Events, or receipt of best and final offer, if required, and Vendor so agrees in submitting the proposal.

K. State Not Responsible for Preparation Costs

The costs for developing and delivering responses to this RFP and any subsequent presentations of the proposal as requested by the State are entirely the responsibility of the Vendor. The State is not liable for any expense incurred by the Vendor in the preparation and presentation of their proposal or any other costs incurred by the Vendor prior to execution of a contract.

L. State's Rights Reserved

Issuance of this RFP in no way constitutes a commitment by the State to award and execute a contract. Upon a determination such actions would be in its best interest, the State, in its sole discretion, reserves the right to:

- Cancel or terminate this RFP;

- Reject any or all of the proposals submitted in response to this RFP;

- Change its decision with respect to the selection and to select another proposal;

- Waive any minor irregularity in an otherwise valid proposal which would not jeopardize the overall program and to award a contract on the basis of such a waiver (minor irregularities are those which will not have a significant adverse effect on overall project cost or performance);

- Negotiate with any Contractor whose proposal is within the competitive range with respect to technical plan and cost;

- Adopt to its use all, or any part, of a Contractor's proposal and to use any idea or all ideas presented in a proposal;

- Amend the RFP (amendments to the RFP will be made by written addendum issued by the State and will be posted on the RFP website);

- Not award any contract.

M. Price

Vendors must respond to this RFP by identifying the specific Region (see Section I.B.) for which a proposal is being submitted. The maximum amount payable for direct services under this RFP is capped per Region and is the total dollar amount paid to the PCCM-E in each contract year. The PCCM-E will receive revenue based on:

1. A monthly per member per month (PMPM) for the general, maternity, and Plan First populations will be made to reimburse the PCCM-E for Quality Improvement Projects. This payment rate will vary based on the CMS classification of counties in the Region as being urban or rural. The monthly revenue received by the PCCM-E will be dependent on the number of EI's that live in the Region.
2. The Care Coordination activity payments for the general population is separated into three levels and are the same amount for all Regions. The Care Coordination activity payments for the maternity population are separated into five levels and varies for each Region. The Care Coordination activity payments for the family planning population are separated into three levels and varies for each Region (see Exhibit S).

3. The maximum amount payable per Region for PMPM payments and Care Coordination services during the term of the initial Contract is detailed in the following chart:

Region	Year One	Year Two
Central	**$ 5,561,474**	**$ 5,429,474**
East	**$ 5,732,833**	**$ 5,584,507**
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Southwest	**$ 6,634,329**	**$ 6,455,239**

Note: Year one (1) includes the one-time one hundred dollar ($100) Maternity Care Coordination transfer fee, that will be paid to the PCCM-E, for all eligible pregnant women currently receiving maternity care coordination. Figures exclude quality incentive payments as discussed in Section VII.M.4.

4. In addition to these maximum payable amounts, the PCCM-E will be eligible for an incentive payment if quality metrics are met. Quality metrics will be measured on a yearly basis. A PCCM-E that meets all quality metrics will be eligible to receive an incentive payment up to ten percent (10%) of the revenue received by the PCCM-E.

N. Submission of Proposals

Vendors must respond to this RFP by identifying the specific Region in which a proposal is being submitted. A Vendor may bid on multiple Regions but must submit a separate proposal for each individual Region.

Proposals must be sealed and labeled on the outside of the package to clearly indicate that they are in response to 2019-ACHN-01. Proposals must be sent to the attention of the Project Director and received at Medicaid as specified in the Schedule of Events. It is the responsibility of the Vendor to ensure receipt of the Proposal by the deadline specified in the Schedule of Events.

O. Copies Required

Vendors must submit one original Proposal with original signatures in ink, one additional hard copy in binder form, plus two electronic copies of the Proposal on CD/DVD or jump drive clearly labeled with the Vendor name. One electronic copy (Word and searchable PDF format) MUST be a complete version of the Contractor's response and the second electronic (searchable PDF format) copy MUST have any information asserted as confidential or proprietary removed. Vendor must identify the original hard copy clearly on the outside of the proposal.

P. Late Proposals

Regardless of cause, late proposals will not be accepted and will automatically be disqualified from further consideration. It shall be the Vendor's sole risk to assure delivery at Medicaid by the designated deadline. Late proposals will not be opened and may be returned to the Vendor at the expense of the Vendor or destroyed if requested.

Q. Proposal Format

Proposals must be prepared on standard 8 ½" x 11" paper and must be bound. All proposal pages must be numbered unless specified otherwise. All responses, as well as, any reference material presented, must be written in English.

The Vendor must structure its response in the same sequence, using the same labeling and numbering that appears in the RFP section in question. For example, the proposal would have a major section entitled "Scope of Work." Within this section, the Vendor would include their response, addressing each of the numbered sections in sequence, as they appear in the RFP. The response to each section must be preceded by the section text of the RFP followed by the Vendor's response.

Proposals must not include references to information located elsewhere, such as Internet websites. Information or materials presented by the Vendor outside the formal response or subsequent discussion/negotiation, if requested, will not be considered, and will have no bearing on any award.

This RFP and its attachments are available on Medicaid's website. The Vendor acknowledges and accepts full responsibility to ensure that no changes are made to the RFP. In the event of inconsistencies or contradictions between language contained in the RFP and a Contractor's response, the language contained in the RFP will prevail. Should Medicaid issue addenda to the original RFP, then said addenda, being more recently issued, would prevail against both the original RFP and the Contractor's proposal.

R. Proposal Withdrawal

The Vendor may withdraw a submitted proposal at any time before the deadline for submission. To withdraw a proposal, the Vendor must submit a written request, signed by a Vendor's representative authorized to sign the resulting contract, to the RFP Project Director. After withdrawing a previously submitted proposal, the Vendor may submit another proposal at any time up to the deadline for submitting proposals.

S. Proposal Amendment

The Agency will not accept any amendments, revisions, or alterations to proposals after the deadline for submitting proposals unless the Agency formally requested in writing.

T. Proposal Errors

The Vendor is liable for all errors or omissions contained in their proposals. The Vendor will not be allowed to alter proposal documents after the deadline for submitting proposals. If the Vendor needs to change a previously submitted proposal, the Vendor must withdraw the entire proposal and may submit the corrected proposal before the deadline for submitting proposals.

U. Proposal Clarifications

The Agency reserves the right to request clarifications with any or all Vendors if they are necessary to properly clarify compliance with the requirements of this RFP. The Agency will not be liable for any costs associated with such clarifications. The purpose of any such clarifications will be to ensure full understanding of the proposal. Clarifications will be limited to specific sections of the proposal identified by Medicaid. If clarifications are requested, the Vendor must put such clarifications in writing within the specified time frame.

V. Disclosure of Proposal Contents

Proposals and supporting documents are kept confidential until the evaluation process is complete, a Vendor has been selected, and the Contract has been fully executed. The Vendor should be aware that any information in a proposal may be subject to disclosure and/or reproduction under Alabama law. Designation as proprietary or confidential may not protect any materials included within the proposal from disclosure if required by law. The Vendor should mark or otherwise designate any material that it feels is proprietary or otherwise confidential by labeling the page as "CONFIDENTIAL". The Vendor must also state any legal authority as to why that material should not be subject to public disclosure under Alabama open records law and is marked as Proprietary Information. By way of illustration but not limitation, "Proprietary Information" may include trade secrets, inventions, mask works, ideas, processes, formulas, source and object codes, data, programs, other works of authorship, know-how, improvements, discoveries, developments, designs and techniques.

Information contained in the Pricing Section may not be marked confidential. It is the sole responsibility of the Vendor to indicate information that is to remain confidential. The Agency assumes no liability for the disclosure of information not identified by the Vendor as confidential. If the Vendor identifies its entire proposal as confidential, Medicaid may deem the proposal as non-compliant and may reject it.

VIII. EVALUATION AND SELECTION PROCESS

A. Initial Classification of Proposals as Responsive or Non-responsive

All proposals will initially be classified as either "responsive" or "non-responsive." Proposals may be found non-responsive at any time during the evaluation process or contract negotiation if any of the required information is not provided; or the proposal is not within the plans and specifications described and required in the RFP. If a proposal is found to be non-responsive, it will not be considered further.

Proposals failing to demonstrate that the Vendor meets the mandatory requirements listed in Appendix A will be deemed non-responsive and not considered further in the evaluation process (and thereby rejected).

B. Determination of Responsibility

The Project Director will determine whether a Vendor has met the standards of responsibility. In determining responsibility, the Project Director may consider factors such as, but not limited to, the Vendor's specialized expertise, ability to perform the work, experience and past performance. Such a determination may be made at any time during the evaluation process and through contract negotiation if information surfaces that would result in a determination of non-responsibility. If a Vendor is found non-responsible, a written determination will be made a part of the procurement file and mailed to the affected Vendor.

C. Opportunity for Additional Information

The Agency reserves the right to contact any Vendor submitting a proposal for the purpose of clarifying issues in that Vendor's proposal. Vendors should clearly designate in their proposal a point-of-contact for questions or issues that arise in the Agency's review of a Vendor's proposal.

D. Evaluation Committee

An Evaluation Committee appointed by the Project Director will read the proposals, conduct corporate and personal reference checks, score the proposals, and make a written recommendation to the Commissioner of the Alabama Medicaid Agency. The Agency may change the size or composition of the committee during the review in response to exigent circumstances.

E. Scoring

The Evaluation Committee will score the proposals using the scoring system shown in the table below. The highest score that can be awarded to any proposal is 100 points.

Evaluation Factor	Highest Possible Score
Corporate Background	10
References	10
Scope of Work	80
Total	100

F. Determination of Successful Proposal

The Vendor whose proposal is determined to be in the best interest of the Agency will be recommended as the Vendor. The Project Director will forward this Vendor's proposal through

the supervisory chain to the Commissioner, with documentation to justify the Committee's recommendation.

When the final approval is received, the Agency will notify the selected Contractor. If the Agency rejects all proposals, it will notify all Vendors. The Agency will post the award on Medicaid website at www.medicaid.alabama.gov. The award will be posted under the applicable RFP number.

IX. GENERAL TERMS AND CONDITIONS

A. General

This RFP and Vendor's response thereto shall be incorporated into a contract by the execution of a formal agreement. The Contract and amendments, if any, are subject to approval by the Governor of the State of Alabama.

The Contract shall include the following:

1) Executed Contract;

2) RFP, attachments, and any amendments thereto;

3) Vendor's response to the RFP, and shall be construed in accordance with and in the order of the applicable provisions of:

    a) Title XIX of the Social Security Act, as amended and regulations promulgated hereunder by HHS and any other applicable federal statutes and regulations;

    b) The statutory and case law of the State of Alabama;

    c) The Alabama State Plan for Medical Assistance under Title XIX of the Social Security Act, as amended;

    d) The Alabama Medicaid Administrative Code; and

    e) The Agency's written response to prospective Vendor questions.

B. Compliance with State and Federal Regulations

Vendor shall perform all services under the contract in accordance with applicable federal and State statutes and regulations, including:

1) Title VI of the Civil Rights Act (CRA) of 1964;

2) The Age Discrimination Act of 1975;

3) The Rehabilitation Act of 1973;

4) Title IX of the Education Amendments of 1972 (regarding education programs and activities);

5) The Americans with Disabilities Act; and

6) Section 1557 of the Patient Protection and Affordable Care Act (ACA).

Vendors agrees to comply with any and all applicable federal and State laws that pertain to Enrollee rights and ensure that its employees and contracted Providers observe and protect those rights. The Agency retains full operational and administrative authority and responsibility over the Alabama Medicaid Program in accordance with the requirements of the federal statutes and regulations as the same may be amended from time to time.

C. Term of Contract

The initial contract term shall be for two (2) years effective October 1, 2019, through September 30, 2021. The Agency shall have the option of unilaterally extending the Contract by exercising three one-year options, after review by the Legislative Contract Review Oversight Committee. At the end of the Contract period, the Agency may at its discretion, exercise the extension option and allow the period of performance to be extended at the rate indicated on the RFP Cover Sheet.

Vendor acknowledges and understands that this Contract is not effective until it has received all requisite state government approvals, and Contractor shall not begin performing work under this Contract until notified to do so by the Agency. Contractor is entitled to no compensation for work performed prior to the effective date of this Contract.

D. Contract Amendments

No alteration or variation of the terms of the Contract shall be valid unless made in writing and duly signed by the parties thereto. The Contract may be amended by written agreement duly executed by the parties. Every such amendment shall specify the date its provisions shall be effective as agreed to by the parties.

The Contract shall be deemed to include all applicable provisions of the State Plan and of all state and federal laws and regulations applicable to the Alabama Medicaid Program, as they may be amended. In the event of any substantial change in such Plan, laws, or regulations, that materially affects the operation of the Alabama Medicaid Program or the costs of administering such Program, either party, after written notice and before performance of any related work, may apply in writing to the other for an equitable adjustment in compensation caused by such substantial change.

E. Subcontracts

Notwithstanding any relationship(s) it may have with any Subcontractor, the Vendor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this RFP, but may enter into Subcontracts for the performance of work required under this Contract. No Subcontract which the Vendor enters into with respect to performance under the Contract shall in any way relieve the Vendor of any responsibility for the performance of duties under this Contract. The Vendor shall assure that all tasks related to the Subcontract are performed in accordance with the terms of this RFP. The Vendor shall identify in its Subcontracts any aspect of service that may be further subcontracted by the Subcontractor.

Each Subcontract shall be a written agreement between Vendor and Subcontractor which specifies the activities or obligations, and related reporting responsibilities, delegated to the Subcontractor, and shall provide the conditions for terminating the Subcontract or imposing other Sanctions if the Subcontractor's performance is inadequate. Contracts between the Vendor and the Subcontractor must require the Subcontractor to agree to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.

Each Subcontract must require the Subcontractor to agree to the following audit requirements:

1) The Agency, CMS, the DHHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's Vendor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Vendor's Contract with the Agency.

2) The Subcontractor will make available, for purposes of an audit, evaluation, or inspection under this section of the RFP, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid EIs.

3) The right to audit under this section of this RFP will exist through ten (10) years from the final date of the Contract term or from the date of completion of any audit, whichever is later.

4) If the Agency, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Agency, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

F. Confidentiality

Contractor shall treat all information, and in particular information relating to individuals that is obtained by or through its performance under the Contract, as confidential information to the extent confidential treatment is provided under State and Federal laws including 45 CFR §

§160.101 – 164.534. Contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and rights under this Contract.

Contractor shall ensure safeguards that restrict the use or disclosure of information concerning individuals to purposes directly connected with the administration of the Plan in accordance with 42 CFR § Part 431, Subpart F, as specified in 42 CFR § 434.6(a)(8). Purposes directly related to the Plan administration include:

1) Establishing eligibility;

2) Determining the amount of medical assistance;

3) Providing services for EIs; and

4) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan.

Pursuant to requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191), the successful Contractor shall sign and comply with the terms of a Business Associate agreement with the Agency (Appendix E).

G. Security and Release of Information

Contractor shall take all reasonable precautions to ensure the safety and security of all information, data, procedures, methods, and funds involved in the performance under the Contract, and shall require the same from all employees so involved. Contractor shall not release any data or other information relating to the Alabama Medicaid Program without prior written consent of the Agency. This provision covers both general summary data as well as detailed, specific data. Contractor shall not be entitled to use of Alabama Medicaid Program data in its other business dealings without prior written consent of the Agency. All requests for program data shall be referred to the Agency for response by the Commissioner only.

H. Federal Nondisclosure Requirements

Each officer or employee of any person to whom Social Security information is or may be disclosed shall be notified in writing by such person that Social Security information disclosed to such officer or employee can be only used for authorized purposes and to that extent and any other unauthorized use herein constitutes a felony punishable upon conviction by a fine of as much as $5,000 or imprisonment for as long as five years, or both, together with the cost of prosecution. Such person shall also notify each such officer or employee that any such unauthorized further disclosure of Social Security information may also result in an award of civil damages against the officer or employee in an amount not less than $1,000 with respect to each instance of unauthorized disclosure. These penalties are prescribed by IRC Sections 7213 and 7431 and set forth at 26 CFR § 301.6103(n).

Additionally, it is incumbent upon the Contractor to inform its officers and employees of penalties for improper disclosure implied by the Privacy Act of 1974, 5 USC § 552a. Specifically, 5 USC § 552a (i) (1), which is made applicable to contractors by 5 USC § 552a (m) (1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position, has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established there under, and who knowing that disclosure of the specific material is prohibited, willfully discloses that material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

I. Contract a Public Record

Upon signing of this Contract by all parties, the terms of the Contract become available to the public pursuant to Alabama law. Contractor agrees to allow public access to all documents, papers, letters, or other Materials subject to the current Alabama law on disclosure. It is expressly understood that substantial evidence of Contractor's refusal to comply with this provision shall constitute a material breach of contract.

J. Termination for Bankruptcy

The filing of a petition for voluntary or involuntary bankruptcy of a company or corporate reorganization pursuant to the Bankruptcy Act shall, at the option of the Agency, constitute default by Contractor effective the date of such filing. Contractor shall inform the Agency in writing of any such action(s) immediately upon occurrence by the most expeditious means possible. The Agency may, at its option, declare default and notify Contractor in writing that performance under the Contract is terminated and proceed to seek appropriate relief from Contractor.

K. Termination for Default

The Agency may, by written notice, terminate performance under the Contract, in whole or in part, for failure of Contractor to perform any of the Contract provisions. In the event Contractor defaults in the performance of any of Contractor’s material duties and obligations, written notice shall be given to Contractor specifying default. Contractor shall have ten (10) Calendar Days, or such additional time as agreed to in writing by the Agency, after the mailing of such notice to cure any default. In the event Contractor does not cure a default within ten (10) Calendar Days, or such additional time allowed by the Agency, the Agency may, at its option, notify Contractor in writing that performance under the Contract is terminated and proceed to seek appropriate relief from Contractor.

L. Termination for Unavailability of Funds

Performance by the State of Alabama of any of its obligations under the Contract is subject to and contingent upon the availability of state and federal monies lawfully applicable for such

purposes. If the Agency, in its sole discretion, deems at any time during the term of the Contract that monies lawfully applicable to this agreement shall not be available for the remainder of the term, the Agency shall promptly notify Contractor to that effect, whereupon the obligations of the parties hereto shall end as of the date of the receipt of such notice and the Contract shall at such time be cancelled without penalty to the Agency, State or Federal Government.

M. Proration of Funds

In the event of proration of the funds from which payment under this Contract is to be made, this Contract will be subject to termination.

N. Termination for Convenience

The Agency may terminate performance of work under the Contract in whole or in part whenever, for any reason, the Agency, in its sole discretion determines that such termination is in the best interest of the State. In the event that the Agency elects to terminate the Contract pursuant to this provision, it shall so notify the Contractor by certified or registered mail, return receipt requested. The termination shall be effective as of the date specified in the notice. In such event, Contractor will be entitled only to payment for all work satisfactorily completed and for reasonable, documented costs incurred in good faith for work in progress. The Contractor will not be entitled to payment for uncompleted work, or for anticipated profit, unabsorbed overhead, or any other costs.

O. Force Majeure

Contractor shall be excused from performance hereunder for any period Contractor is prevented from performing any services pursuant hereto in whole or in part as a result of an act of God, war, civil disturbance, epidemic, or court order; such nonperformance shall not be a ground for termination for default.

P. Nondiscriminatory Compliance

Contractor shall comply with Title VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Executive Order No. 11246, as amended by Executive Order No. 11375, both issued by the President of the United States, the Americans with Disabilities Act of 1990, and with all applicable federal and state laws, rules and regulations implementing the foregoing statutes with respect to nondiscrimination in employment.

Q. Conflict of Interest

The parties acknowledge and agree that the Contractor must be free of conflicts of interest in accordance with all federal and state regulations while performing the duties within the

Contract. The Contractor agrees that it has no conflict of interest preventing the execution of this Contract, and the Contractor will abide by applicable state and federal regulations.

R. Open Trade

In compliance with Section 41-16-5 Code of Alabama (1975), the contractor hereby certifies that it is not currently engaged in, and will not engage in, the boycott of a person or an organization based in or doing business with a jurisdiction with which this state can enjoy open trade.

S. Small and Minority Business Enterprise Utilization

In accordance with the provisions of 45 CFR § Part 74 and paragraph 9 of OMB Circular A-102, affirmative steps shall be taken to assure that small and minority businesses are utilized when possible as sources of supplies, equipment, construction, and services.

T. Worker's Compensation

Contractor shall take out and maintain, during the life of this Contract, Worker's Compensation Insurance for all of its employees under the Contract or any subcontract thereof, if required by state law.

U. Employment of State Staff

Contractor shall not knowingly engage on a full-time, part-time, or other basis during the period of the Contract any professional or technical personnel, who are or have been in the employment of the Agency during the previous twelve (12) months, except retired employees or contractual consultants, without the written consent of the Agency. Certain Agency employees may be subject to more stringent employment restrictions under the Alabama Code of Ethics, §36-25-1 et seq., Code of Alabama 1975.

V. Immigration Compliance

Contractor will not knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama. Contractor shall comply with the requirements of the Immigration Reform and Control Act of 1986 and the Beason- Hammon Alabama Taxpayer and Citizen Protection Act (Ala, Act 2012- 491 and any amendments thereto) and certify its compliance by executing Attachment G. Contractor will document that the Contractor is enrolled in the E-Verify Program operated by the US Department of Homeland Security as required by Section 9 of Act 2012-491. During the performance of the Contract, the Contractor shall participate in the E-Verify program and shall verify every employee that is required to be verified according to the applicable federal rules and regulations. Contractor further agrees that, should it employ or contract with any subcontractor(s) in connection with the performance of the services pursuant to this Contract, that the Contractor will secure from

such subcontractor(s) documentation that subcontractor is enrolled in the E-Verify program prior to performing any work on the project. The subcontractor shall verify every employee that is required to be verified according to the applicable federal rules and regulations. This subsection shall only apply to subcontractors performing work on a project subject to the provisions of this section and not to collateral persons or business entities hired by the subcontractor. Contractor shall maintain the subcontractor documentation that shall be available upon request by the Alabama Medicaid Agency.

Pursuant to Ala. Code §31-13-9(k), by signing this Contract, the contracting parties affirm, for the duration of the agreement, that they will not violate federal immigration law or knowingly employ, hire for employment, or continue to employ an unauthorized alien within the state of Alabama. Furthermore, a contracting party found to be in violation of this provision shall be deemed in breach of the agreement and shall be responsible for all damages resulting therefrom.

Failure to comply with these requirements may result in termination of the agreement or subcontract.

W. Share of Contract

No official or employee of the State of Alabama shall be admitted to any share of the Contract or to any benefit that may arise there from.

X. Waivers

No covenant, condition, duty, obligation, or undertaking contained in or made a part of the Contract shall be waived except by written agreement of the parties.

Y. Warranties Against Broker's Fees

Contractor warrants that no person or selling agent has been employed or retained to solicit or secure the Contract upon an agreement or understanding for a commission percentage, brokerage, or contingency fee excepting bona fide employees. For breach of this warranty, the Agency shall have the right to terminate the Contract without liability.

Z. Novation

In the event of a change in the corporate or company ownership of Contractor, the Agency shall retain the right to continue the Contract with the new owner or terminate the Contract. The new corporate or company PCCM-E must agree to the terms of the original Contract and any amendments thereto. During the interim between legal recognition of the new PCCM-E and the Agency execution of the novation agreement, a valid contract shall continue to exist between the Agency and the original Contractor. When, to the Agency's satisfaction, sufficient

evidence has been presented of the new owner's ability to perform under the terms of the Contract, the Agency may approve the new owner and a novation agreement shall be executed.

AA. Employment Basis

It is expressly understood and agreed that the Agency enters into this agreement with Contractor and any subcontractor as authorized under the provisions of this Contract as an independent contractor on a purchase of service basis and not on an employer-employee basis and not subject to State Merit System law.

BB. Disputes and Litigation

Except in those cases where the proposal response exceeds the requirements of the RFP, any conflict between the response of Contractor and the RFP shall be controlled by the provisions of the RFP. Any dispute concerning a question of fact arising under the Contract which is not disposed of by agreement shall be decided by the Commissioner of the Agency.

The Contractor's sole remedy for the settlement of any and all disputes arising under the terms of this Contract shall be limited to the filing of a claim with the board of Adjustment for the State of Alabama. Pending a final decision of a dispute hereunder, the Contractor must proceed diligently with the performance of the Contract in accordance with the disputed decision.

For any and all disputes arising under the terms of this Contract, the parties hereto agree, in compliance with the recommendations of the Governor and Attorney General, when considering settlement of such disputes, to utilize appropriate forms of non-binding alternative dispute resolution including, but not limited to, mediation by and through private mediators.

Any litigation brought by the Agency or Contractor regarding any provision of the Contract shall be brought in either the Circuit Court of Montgomery County, Alabama, or the United States District Court for the Middle District of Alabama, Northern Division, according to the jurisdictions of these courts. This provision shall not be deemed an attempt to confer any jurisdiction on these courts which they do not by law have, but is a stipulation and agreement as to forum and venue only.

CC. Records Retention and Storage

Contractor shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of ten years from the date of the final payment made by the Agency to Contractor under the Contract. However, if audit, litigation, or other legal action by or on behalf of the State or Federal Government has begun but is not completed at the end of the ten (10) year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the three year period, the records shall be retained until resolution.

DD. Inspection of Records

Contractor agrees that representatives of the Comptroller General, HHS, the General Accounting Office, the Alabama Department of Examiners of Public Accounts, and the Agency and their authorized representatives shall have the right during business hours to inspect and copy Contractor's books and records pertaining to Contract performance and costs thereof. Contractor shall cooperate fully with requests from any of the agencies listed above and shall furnish free of charge copies of all requested records. Contractor may require that a receipt be given for any original record removed from Contractor's premises.

EE. Use of Federal Cost Principles

For any terms of the Contract which allow reimbursement for the cost of procuring goods, Materials, supplies, equipment, or services, such procurement shall be made on a competitive basis (including the use of competitive bidding procedures) where practicable, and reimbursement for such cost under the Contract shall be in accordance with 48 CFR, Part 31. Further, if such reimbursement is to be made with funds derived wholly or partially from federal sources, such reimbursement shall be subject to Contractor's compliance with applicable federal procurement requirements, and the determination of costs shall be governed by federal cost principles.

FF. Payment

1) The PCCM-E shall receive monthly, an assignment list of EIs from the Agency from which the PCCM-E will prioritize their screening and assessment work. The PCCM-E payment model is based on monthly payments that reflect Care Coordination activities occurring in a given month. Payments would be for the entire month (as opposed to each individual activity) and payments would not occur for months in which there is no documented activity. Payments for case management services are limited to the months when services are provided. (See Exhibit N for additional details).

2) General Care Coordination: In the Care Coordination general population, payments will be made when a contact is documented in a given calendar month.

3) Family Planning Care Coordination: In the family planning population, payments also will be made when a contact is documented in a given calendar month.

4) Maternity Care Coordination: The maternity population will have specific Care Coordination milestones that would trigger a payment based on actual contact.

5) QIP payment: There will also be a monthly payment for all EIs in the general population, Maternity Population, and Family Planning population to fund quality improvement projects. Medicaid will determine the percentage of EIs to be care coordinated in the General Population, Maternity population, and Plan First population. Each population will have an average target percentage range based on the average population per Region as

listed below (averages may vary on a monthly basis based on changes in population). (See Exhibit S for additional information).

6) General Population: The Agency will identify EIs in need of screening for possible Care Coordination and forward on a monthly basis, to PCCM-E, the identified EIs for prioritization. The PCCM-E will also receive Care Coordination referrals from physicians, other Providers, community agencies, etc. The PCCM-E must evaluate the identified and referred EIs and provide Care Coordination services to those in need based on their prioritization.

   a) The PCCM-E will be responsible to provide services to one-point five percent (1.5%) of the general Care Coordination population. Statewide, this population is approximately 651,000 EIs currently. It is understood that the number of this population varies from month to month.

   b) Beginning after the second quarter of PCCM-E operations, if the PCCM-E fails to provide the above stated level of Care Coordination services to EIs, the Agency will require the PCCM-E to submit a CAP within fifteen (15) Business Days of the end of the quarter in which the PCCM-E failed to care coordinate the required percent of EIs.

7) Maternity Population: The PCCM-E will be responsible to provide services to ninety-five percent (95%) of the maternity population. This population is approximately 33,000 EIs. It is understood that the number of this population varies from month to month. Beginning after the second quarter of PCCM-E operations, if the PCCM-E fails to provide the above stated level of Care Coordination services to EIs, the Agency will require the PCCM-E to submit a CAP within fifteen (15) Business Days of the end of the quarter in which the PCCM-E failed to care coordinate the required percent of EIs.

8) Family Planning Services: The Agency will identify EIs in need of screening for possible Care Coordination services and forward on a monthly basis, to the PCCM-E. The PCCM-E will be responsible to provide services to four and one-half percent (4.5%) of the Plan First population per month. The Plan First population is approximately 73,000 EIs statewide. It is understood that the number of this population varies from month to month. Beginning after the second quarter of PCCM-E operations, if the PCCM-E fails to provide the above stated level of Care Coordination services to EIs, the Agency will require the PCCM-E to submit a CAP within fifteen (15) Business Days of the end of the quarter in which the PCCM-E failed to care coordinate the required percent of EIs.

GG. Notice to Parties

Any notice to the Agency under the Contract shall be sufficient when mailed to the Project Director. Any notice to Contractor shall be sufficient when mailed to Contractor at the address given on the return receipt from this RFP or on the Contract after signing. Notice shall be given by certified mail, return receipt requested.

HH. Disclosure Statement

The successful Contractor shall be required to complete a financial disclosure statement with the executed Contract.

II. Debarment

Contractor hereby certifies that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this Contract by any Federal department or agency.

JJ. Not to Constitute a Debt of the State

Under no circumstances shall any commitments by the Agency constitute a debt of the State of Alabama as prohibited by Article XI, Section 213, Constitution of Alabama of 1901, as amended by Amendment 26. It is further agreed that if any provision of this Contract shall contravene any statute or Constitutional provision or amendment, whether now in effect or which may, during the course of this Contract, be enacted, then that conflicting provision in the Contract shall be deemed null and void. The Contractor's sole remedy for the settlement of any and all disputes arising under the terms of this agreement shall be limited to the filing of a claim against the Agency with the Board of Adjustment for the State of Alabama.

KK. Qualification to do Business in Alabama

Should a foreign corporation (a business corporation incorporated under a law other than the law of this state) be selected to provide professional services in accordance with this RFP, it must be qualified to transact business in the State of Alabama and possess a Certificate of Authority issued by the Secretary of State at the time a professional services contract is executed. To obtain forms for a Certificate of Authority, contact the Secretary of State at (334) 242-5324 or www.sos.state.al.us. The Certificate of Authority or a letter/form showing application has been made for a Certificate of Authority must be submitted with the proposal.

LL. Choice of Law

The construction, interpretation, and enforcement of this Contract shall be governed by the substantive contract law of the State of Alabama without regard to its conflict of laws provisions. In the event any provision of this Contract is unenforceable as a matter of law, the remaining provisions will remain in full force and effect.

MM. Alabama Interchange Interface Standards

Contractor hereby certifies that any exchange of MMIS data with the Agency's fiscal agent will be accomplished by following the Alabama Interchange Interface Standards Document, which will be posted on the Agency website.

NN. Operations Outside the United States

The Vendor shall ensure that all business offices and all employees and Subcontractors that perform functions and duties related to this Contract are located within the United States. The Vendor and all Subcontractors shall perform the services to be provided under this Contract entirely within the boundaries of the United States and shall not provide any payments for items or services (including telemedicine) provided under the Contract to any financial institution or entity located outside of the United States. This includes, but is not limited to:

1) All services, including but not limited to information technology services, processing, transmission, storage, archiving, data center services, Disaster recovery sites and services, customer support), and covered services; or

2) All custom software prepared for performance of this RFP, and all modifications of custom, third party, or vendor proprietary software, must be performed within the United States.

   Exceptions to this Section are limited to:

   a) Commercial Off-The-Shelf (COTS) Software. The foregoing requirements will not preclude the acquisition or use of COTS software that is developed outside the United States or hardware that is generically configured outside the United States.

   b) Foreign-made Products and Supplies. The foregoing requirements will not preclude Vendor from acquiring, using, or reimbursing products or supplies that are manufactured outside the United States, provided such products or supplies are commercially available within the United States for acquisition or reimbursement by the Agency.

   c) Agency Approved Waiver. The foregoing requirements will not preclude Vendor from performing work outside the United States provided the Vendor first acquires a written waiver from the Agency in accordance with Section IX.X of this RFP.

   If the Vendor or its Subcontractor performs services, or uses services, in violation of this subsection, the Vendor shall be in material breach of this RFP and shall be subject to Sanctions under this RFP, including but not limited to, payment to the Agency for any costs, fees, damages, claims, or expenses it may incur.

EXHIBIT A – DEFINITIONS AND ACRONYMS

A. Definitions

Active Participation – For Primary Care Physicians, is defined as:

a) Participates as needed in the PCCM-E's Multidisciplinary Care Team and the development of an individualized and comprehensive Care Plan;

b) Over a twelve (12) month period, participates in person in at least two (2) quarterly Medical Management Meetings and one webinar/facilitation exercise with the PCCM-E's Medical Director. Attendance requirements can be met by having one PCP or Nurse Practitioner/Physician Assistant from the group attend;

c) Participates in ACHN initiatives centered around quality measures; and

d) Reviews data provided by the PCCM-E to help achieve Agency and PCCM-E quality goals.

Acute – A condition, diagnosis or illness with a sudden onset and that is of short duration.

Advance Directive – A written instruction, such as a living will or durable power of attorney for health care, recognized under Alabama law (whether statutory or as recognized by the courts of Alabama), relating to the provision of health care when the individual is incapacitated.

Agency – The Alabama Medicaid Agency or any successor agency of the State designated as the "single state agency" to administer the Medicaid program described in Title XIX of the Social Security Act.

Alabama Coordinated Health Network – A statewide program to streamline and increase access to Care Coordination for Eligible Individuals.

Alabama Medicaid State Plan or State Plan – The Alabama Medicaid Agency agreement filed with and approved by the Centers for Medicare and Medicaid Services (CMS) that describes the Alabama Medicaid program.

Annual Improvement Target – Beginning in CY18, Annual Improvement Targets for each PCCM-E and each measure will be based on a linear improvement in each measure from the regional baseline to the Final Rate Target with each PCCM-E projected to meet or exceed the Final Rate Target by CY22.

Behavioral Health Program – A component of the PCCM-E's Care Coordination activities devoted to address behavioral health needs.

Business Day – Any day except Saturday, Sunday or a holiday recognized by the Agency. The word "day" not qualified as Business Day means Calendar Day.

Calendar Day – All seven (7) days of the week. NOTE: When a deadline or timeframe provided herein ends on a Calendar Day, the last day of the designated period shall be included unless it is a Saturday, Sunday or a holiday recognized by the agency, in which event the designated period shall run until the end of the next day which is not a Saturday, Sunday or a holiday recognized by the Agency.

Care Coordination – Management of care including recruitment, outreach, psychosocial assessment, service planning, assisting the EI in arranging for appropriate services, including but not limited to, resolving transportation issues, education, counseling and follow-up and monitoring to ensure services are delivered and continuity of care is maintained.

Care Plan – Refer to Exhibit C of this Contract. A plan developed by the Care Coordinator or other appropriate PCCM-E staff with the EI to include goals and interventions based on identified needs.

Certified Application Trainer – An individual who has completed the Agency's Train the Trainer course and is certified to train application assisters.

Certified Preceptor – A practicing, Alabama licensed pharmacist who provides educational supervision and evaluation to pharmacy students and holds an active Alabama Preceptor Certification issued by the Alabama Board of Pharmacy.

Children with Medical Complexity (CMC) – Those children identified for enhanced Care Coordination who are medically fragile with congenital/acquired and/or frequently multi-system disease. Many require medical technology to sustain their activities of daily living. They also must have a qualifying diagnosis/condition and/or social assessment to meet CMC criteria. Primary Care Physicians, in concurrence with the Regional Medical Director, may also identify individuals for this group.

Compliance Plan – A written proposal for the Contractor's policies and procedures for monitoring and preventing fraud, waste and/or abuse developed by the Contractor and submitted to the Agency in advance for review and/or written approval.

Contract – The written agreement between the Agency and the Contractor, and includes the Contract, the RFP, any Exhibits, addenda, appendices, attachments, or amendments thereto.

Contractor – The PCCM-E that contracts hereunder with the Agency for the provision of comprehensive Care Coordination to EIs.

Corrective Action Plan (CAP) – a step by step plan of action that is developed to achieve targeted outcomes for resolution of identified errors, non-compliance or other concerns.

Covered Services – All those Medically Necessary health care services covered under the PCCM-E and that the PCCM-E has been contracted to deliver under this RFP.

Debarment – Exclusion from participation as a Medicare/Medicaid Provider.

Delivering Healthcare Professional (DHCP) – A licensed physician or nurse midwife who is qualified to perform deliveries, prenatal care, and postpartum care.

Disaster – An occurrence of any kind that severely inhibits the Contractor's ability to conduct daily business or severely affects the required performance, functionality, efficiency, accessibility, reliability or security of the Contractor's system. Disaster may include natural disaster, fire, vandalism, system failure, human error, computer virus or malfunctioning hardware or electrical supply.

Durable Medical Equipment – Equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness of injury, and is suitable for use in any setting in which normal life activities take place, as defined in 42 C.F.R. § 440.70(c)(1).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – Comprehensive diagnostic and preventative program for Medicaid recipients under age twenty-one (21) in accordance with Sections 1905(a) and 1905(r) of the Social Security Act.

Electronic Health Record (EHR) – an electronic version of a patient's medical history, that is maintained by the Provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular Provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports The EHR automates access to information and has the potential to streamline the clinician's workflow. The EHR also has the ability to support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management, and outcomes reporting.

Eligible Individual (EI) – A person who has been assigned one or more Medicaid identification numbers and is qualified due to their aid category to receive Care Coordination services under the Alabama Medicaid 1915(b) Waiver. Eligible individuals include Plan First recipients, Maternity Care recipients, Disabled children and adults, Children under age 19, Parents or other caretaker relatives (POCR), and foster children. Recipients on Medicaid with dual eligibility (dual eligibles) and those in long-term institutional care or on a Home and Community-Based Services waiver are excluded.

Eligible Individual Materials (EI Materials) – A source of information to EIs regarding Covered Services and process for obtaining services (including transportation), Emergency Services, PCPs, policies and procedures, EI rights and responsibilities, telephone access and any special requirements to help EI understand the PCCM-E's requirements and benefits. The EI Materials shall describe all services covered by the PCCM-E, exclusions or limitations on

coverage, the correct use of the Contractor's plan, and other relevant information including at a minimum, requirements set forth in Section II.X of this RFP.

Emergency Medical Condition – A medical condition manifesting itself by Acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An Emergency Medical Condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.

Emergency Medical Transportation – Ground or air transportation in a vehicle specifically designed and equipped for transporting the wounded, injured, ill, or sick for an Emergency Medical Condition.

Emergency Services – Covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish these services under 42 C.F.R. § 438.114 and needed to evaluate or stabilize an Emergency Medical Condition.

Encounter – The basic unit of service used in accumulating utilization data and/or a face-to-face contact between an EI and a Provider resulting in a service to the EI.

Enrollee - A person who has been assigned one or more Medicaid identification numbers and has been certified by the Agency as eligible for Medicaid under the Alabama Medicaid State Plan and who is enrolled with the Contractor under this RFP.

External Quality Review Organization (EQRO) - An organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354 and performs external quality review and other related activities.

Family Planning – Family Planning services are those services described in Alabama Medicaid Administrative Code Chapter 560-X-14 and Appendix C of the Alabama Medicaid Provider Manual. They are also services provided to prevent or delay pregnancy and may include coverage of supplies, including birth control pills, the Depo-Provera shot, vaginal ring and contraceptive patch, doctor/clinic visits (for Family Planning only) and tubal ligations.

Family Planning Eligible Individuals:

a) Family Planning Eligible – Females of childbearing age, 8 through 55, and males of any age who may be sexually active and meet the criteria for full Medicaid eligibility.

b) Plan First Eligible – Eligible women, ages 19 through 55, and men age 21 or older (for vasectomy/vasectomy related services and Care Coordination) who meet the criteria for

Waiver eligibility. Plan First EIs are only eligible for family planning services certified under the 1115(a) Waiver Demonstration.

Final Rate Target – The regional and State baselines will be compared to national benchmarks where they exist, and the Agency will select an appropriate Final Rate Target for the State that reflects an achievable and meaningful level of quality for the measure. For measures where baseline rates cannot be calculated, the Agency will select a Final Rate Target for the State that reflects an achievable and meaningful level of quality for the measure.

Fiscal Agent – The company designated by the Agency, through contract, to maintain the Agency's Claims processing system.

Fiscal Year – October 1 through September 30. The Fiscal Year for a PCCM-E must be the same as the State of Alabama—October 1 through September 30.

Governing Board – Pursuant to the PCCM-E's bylaws, the board that is responsible for the overall operation of the PCCM-E.

Grievance – An expression of dissatisfaction about any matter. Grievances may include, but are not limited to, the quality of care or Covered Services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the EI's rights regardless of whether remedial action is requested.

Health Information Management System (HIMS) – Refer to Section II.U of this RFP. The system that will be used by the PCCM-Es to document Care Coordination activities and other EI care information.

Health Risk and Psychosocial Assessment – An evaluation of a person's medical history, current medical conditions, mental health, social status, and functional capacity within the community.

HIPAA – Shall mean the Standards for Privacy of Individually Identifiable Health Information and the Security Standards for the Protection of Electronic Protected Health Information (45 C.F.R. Parts 160 and 164) promulgated by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 or the Health Information Technology for Economic and Clinical Health Act (HITECH), as in effect on the Effective Date of this Agreement and as may be amended, modified, or renumbered.

Hospital Outpatient Care – Preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a Physician or dentist at a licensed hospital.

Hospitalization – Admission to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient with the expectation that he or she will remain in the hospital at least overnight and occupy a bed.

Indian – Any individual defined at 25 U.S.C. §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian under 42 C.F.R. § 136.12 and this individual meets the criteria under 42 C.F.R. § 438.14(a)(i)-(iv).

Indian Health Care Provider (IHCP) – A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

Key Staff – Refer to Exhibit F of this RFP. The positions required of the PCCM-E that will allow the PCCM-E to operate and perform all required Care Coordination activities.

Limited English proficient (LEP) – means potential EIs and EIs who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English.

Maternal Health – The health of women during pregnancy, childbirth and the Postpartum period.

Maternity Care Coordination Plan – Refer to Exhibit C of this RFP. The Plan by which the PCCM-E provide Care Coordination services to maternity EIs.

Maternity Health Care Coordinator – The professional staff responsible for meeting Care Coordination requirements for pregnant EIs as defined in Exhibit F of this RFP.

Medicaid – The joint Federal/State program of medical assistance established by Title XIX of the Social Security Act, 42 U.S.C. § 1396, et seq., which in Alabama is administered by the Agency.

Medical Home – A patient centered care delivery model whereby quality focused care is coordinated through the EI's Primary Care Provider (PCP)

Medical Management Meeting – In Region activity with the intent to foster the primary professional development and networking opportunities for the PCCM-E and the primary care Providers (as well as other agencies and/or Providers who may have roles, responsibilities, and interests related to the regional PCCM-E); and a platform to address challenges and develop successful strategies for meeting regional and Agency goals.

Medicare – The program providing hospital and medical benefits under Title XVIII of the Social Security Act.

Medication List – The full list of medications an EI is currently prescribed by any licensed prescriber.

Medication Management – The monitoring of medications to avoid potentially dangerous drug interactions and other complications.

Medication Reconciliation – Process of gathering, organizing and sharing drug use information from multiple sources, including the EI, medical record, prescription fill history and discharge instructions, with Providers in order to identify and resolve urgent and emergent drug-drug duplications, interactions, possible adverse events, poor adherence or other suboptimal drug-taking behaviors.

Mental Illness Rehabilitative Services – Services provided by Community Mental Health Centers (CMHCs) who are 310 Boards that are certified and under contract with the Department of Mental Health (DMH).

Non-Emergency Transportation (NET) – Transportation to or from a medical Covered Service which is not urgent or emergent in nature.

Patient Health Questionnaire-A (PHQ-A) – Patient Health Questionnaire (PHQ-9 for Adolescents). This is used as a tool determine the severity of depression specific to the adolescent age range.

Patient Health Questionnaire-2 (PHQ-2) – This questionnaire is used as the initial screening test for major depressive episode.

Patient Health Questionnaire-9 (PHQ-9) – a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression. The PHQ-9 incorporates Diagnostic and Statistical Manual for Mental Disorders IV (DSM-IV) depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool.

PCCM-E Payment – The payment made by the Agency to reimburse PCCM-Es for provided services.

Performance Measure – A consistent measurement of service, practice, and governance of a health care organization. Measurements must produce solid, statistically-based measurement of critical processes that, in turn, must permit the PCCM-E to make solid decisions about improvements. Quality Measures are defined later in this section.

Physician – Physician shall mean:

a) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she renders services.

b) A doctor of dentistry or of dental or oral surgery licensed to practice dentistry or dental or oral surgery by the state in which he or she renders services but only with respect to:

   i) Surgery related to the jaw.

   ii) The reduction of any fracture relating to the jaw or facial bone.

iii) Surgery within the oral cavity for removal of lesions or the correction of congenital defects.

iv) Fabrication of a prosthesis for closure of a lesion, or congenital defect such as cleft palate.

Plan First Program – Family planning services provided under a Centers for Medicare and Medicaid Services (CMS) approved Section 1115 Research and Demonstration waiver that extends Medicaid eligibility for Family Planning services to women ages 19 – 55 and men ages 21 and older who would not otherwise qualify for Medicaid.

Postnatal – Care issues that include recovery from childbirth, concerns about newborn care, nutrition, breastfeeding and Family Planning.

Postpartum – Care which includes inpatient hospital visits, office visits, outpatient hospital visits, and/or home visits by a Physician, midwife or registered nurse following delivery for routine care through the end of the month of the sixtieth (60th) day Postpartum period.

Potential EI – A Medicaid Recipient and/or Medicaid eligible individual (EI) who may voluntarily elect to receive Care Coordination services with a PCCM-E, but is not yet receiving Care Coordination services from a specific PCCM-E.

Preconception – Care that may include education, health promotion, screening and other interventions among women of reproductive age to reduce risk factors that might affect future pregnancies.

Pregnant Women – Category of assistance formerly known as SOBRA coverage.

Prenatal – Care that is provided to detect any potential complications of early pregnancy, to prevent them if possible and to direct the woman to an appropriate medical services Specialist as appropriate.

Prescription Drugs – Drugs and medications that, by law, require a prescription by a health care professional licensed to prescribe such drugs.

Prevalent – Means a non-English language determined to be spoken by a significant number or percentage of potential EIs and EIs that are limited English proficient.

Preventive Services – Services rendered to prevent or delay the onset of disease. Examples of preventive services include:

a) for adults: pap smears; vaccines for the prevention of pneumonia, diphtheria-tetanus, and influenza; mammograms; and

b) for children under 21 years: EPSDT screening and age-appropriate immunizations; urinalysis; lead screening; and hematocrit.

Primary Care Case Management Entity (PCCM-E) – An organization that meets the definition of PCCM entity in 42 C.F.R. § 438.2 and is contracted with the Agency to provide services described in this RFP.

Primary Care Physician (PCP) – A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) that practices in the specialty designation of family medicine, general internal medicine, pediatrics, or general medicine.

Privacy Rule – The Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E.

Provider – An institution, facility, agency, person, partnership, corporation or association which is approved and certified by the Agency as authorized to provide the EIs the services specified in the State Plan at the time services are rendered.

Psychosocial Assessment – an evaluation of a person's mental health, social status, and functional capacity within the community.

Quality Improvement – The process of continuously finding ways to improve and provide better patient care and services, including assuring that health care services are appropriate, timely, accessible, medically necessary and high quality.

Quality Improvement Plan – Refer to Subsection II.H.13 of this Contract and 42 C.F.R. § 438, Subpart E. The Plan developed by the PCCM-E and approved by the Agency that guides the PCCM-E to provide services that are consistent with Agency standards.

Quality Improvement Project (QIP) – An initiative that focuses on one or more clinical or non-clinical area(s) with the aim of improving health outcomes and EI satisfaction. The statutory and regulatory requirements for PCCM-Es to implement and maintain a QIP are outlined in 42 CFR § § 438, Subpart E. QIPs should not only enumerate the targeted quality measures and expected performance improvement, but also the costs to the PCCM-E required to implement the project and the process of evaluation.

Quality Incentive Payment – The payment that may be earned by the PCCM-E for achieving quality metrics or measures.

Quality Measures – Determined by the Agency and the Quality Assurance Committee, Quality Measures help the Agency measure and assess the PCCM-E's health care processes, outcomes, EI perceptions, and organizational structure and/or systems that are associated with the PCCM-E's ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable and timely care.

Readily Accessible – electronic information and services which comply with modern accessibility standards such as Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

Recipient – A person who has been assigned one or more Medicaid identification numbers and has been certified by the Agency as eligible for medical assistance under the Alabama Medicaid State Plan.

Region – The defined geographic area within which the PCCM-E and the Agency have agreed that the PCCM-E shall coordinate the provision of Covered Services needed by Target Population through participating Providers or referral arrangements.

Rehabilitation Services and Devices – Rehabilitative services are specialized services of a medical or remedial nature delivered by uniquely qualified practitioners designed to treat or rehabilitate persons with mental illness or substance abuse diagnoses.

Risk Stratification – A decision-making process using a combination of medical and social data to determine the EIs' Care Coordination needs. The EI's needs are identified using a compilation of activities to include, but are not limited to: maternal history, history of chronic illnesses, history of adverse pregnancy outcomes and history of social determinants. Upon review and assessment of the data, EIs may be classified as High, Medium or Low Risk. The classification status determines the degree of Care Coordination that is needed to address current, and preventive healthcare concerns.

Rural – Sparsely populated area outside of the limits of a city or town or a designated commercial, industrial, or residential center.

Sanction – In accordance with Alabama Medicaid Administrative Code Chapter 560-X-37 an adverse action taken against the Contractor for failure to demonstrate compliance in one or more areas of contractual responsibility.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) – SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. It provides opportunities for early intervention with at-risk substance users before more severe consequences occur. It includes:

a) A screening to quickly assesses the severity of substance use and identifies the appropriate level of treatment.

b) A brief intervention focused on increasing insight and awareness regarding substance use and motivation toward behavioral change.

c) A referral to treatment providing those identified as needing more extensive treatment with access to specialty care.

Social Security Act – The legislation, signed in 1965, which authorized Medicare, under Title XVIII, and Medicaid, under Title XIX, as amended.

Special Terms and Conditions (STCs) – The terms that set forth in detail the operation of the 1115(a) demonstration, including the nature, character and extent of federal involvement in the demonstration and the State's obligations to CMS during the life of the demonstration.

State – The State of Alabama.

Subcontract – Any written agreement between the Contractor and any other individual, entity, facility or organization not in the Provider Network and/or considered to be a Participating Provider that relates directly or indirectly to the performance of the Contractor's obligations under this Contract.

Subcontractor – Any individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligation under this Contract. A Participating Provider is not a Subcontractor by virtue of the Participating Provider's agreement with the Contractor.

Target Population – Group of individuals enrolled, assigned, or otherwise contracted to be managed by the PCCM-E.

Transitional Care – Services and supports to facilitate an EI shift from an inpatient or residential setting to a community setting.

Transitional Care Team – An interdisciplinary group which must include Transitional Care Nurses to design and implement the EI's transition of Care Plan and provide oversight and management of all transition of care processes including the Transitional Care Program.

Urban Area – Any county other than a county designated as "micro," "rural," or "County with Extreme Access Considerations" in the Medicare Advantage Health Services Delivery Reference file for the applicable calendar year.

Urgent Care Services – Health services that are medically appropriate and immediately required to prevent serious deterioration of an EI's health that are a result of unforeseen illness or injury.

B. Acronyms

ADA	Americans with Disabilities Act
ADPH	Alabama Department of Public Health
ADT	Admission/Discharge/Transfer
AHRQ	Agency for Healthcare Research and Quality
BA	Bachelor of Arts
BAA	Business Associate Agreement
BS	Bachelor of Science
BSN	Bachelor of Science in Nursing

BSW	Bachelor of Social Work
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMC	Children with Medical Complexity
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CoIIN	Collaborative Improvement and Innovation Network
CT	Central Time
CY	Calendar Year
DHCP	Delivering Healthcare Professional
DMH	Department of Mental Health
DO	Doctor of Osteopathic Medicine
DUR	Drug Utilization Review
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EI	Eligible Individual
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
FFP	Federal Financial Participation
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAAS	Generally Accepted Auditing Standards
GED®	General Educational Development
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	United States Department of Health and Human Services
HIE	Health Information Exchange
HIMS	Health Information Management System
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health Act
IT	Information Technology
MARA	Milliman Advanced Risk Adjusters
MCT	Multidisciplinary Care Team
MD	Medical Doctor
MMIS	Medicaid Management Information System
MSW	Master of Social Work
NET	Non-Emergency Transportation
NF	Nursing Facility
NP	Nurse Practitioner
PCCM-E	Primary Care Coordination Management Entity
PCP	Primary Care Provider
P&T	Pharmacy and Therapeutics
PA	Physician Assistant
Pharm. D.	Doctor of Pharmacy

PHI	Protected Health Information
PHQ-A	Patient Health Questionnaire for Adolescents
PHQ-2	Patient Health Question-2
PHQ-9	Patient Health Question-9
PMP	Primary Medical Provider
PMPM	Per Member Per Month
QAC	Quality Assurance Committee
QIP	Quality Improvement Project
SA	Substance Abuse
SBIRT	Screening, Brief Intervention and Referral to Treatment
SCHIP	State Children's Health Insurance Program
SSA	Social Security Administration
STC	Special Terms and Conditions
TRS	Telecommunications Relay Service
TTY/TTD	Text Telephone/Telecommunication Device for the Deaf
UM	Utilization Management
USC	United States Code

EXHIBIT B – CONSUMER ADVISORY COMMITTEE

Each PCCM-E shall have Consumer Advisory Committee. This committee shall advise the PCCM-E on ways to improve care provided to Medicaid beneficiaries. In addition, this committee shall carry out other functions and duties assigned to it by a PCCM-E and approved by the Agency. The committee shall meet all of the following criteria:

a) Be selected in a method established by the PCCM-E and approved by the Agency;

b) Consist of at least six (6) members;

c) At least twenty (20) percent of its members shall be Medicaid beneficiaries or a parent/care-giver of beneficiaries residing in the Region and are served by the PCCM-E. It shall be PCCM-E's sole responsibility to obtain all necessary approvals, consents or waivers from Medicaid beneficiaries and to comply with all applicable laws regarding privacy and confidentiality related to such information before providing it to the Agency;

d) Include members who are representatives of patient or low-income advocacy organizations;

e) Include only persons who live in the Region the PCCM-E plans to serve; and

f) Elect a chair.

EXHIBIT C – GENERAL CARE COORDINATION CARE PLAN REQUIREMENTS

1) All Care Plans for EIs receiving General Care Coordination must be documented in the HIMS designated by the Agency.

2) The Care Plan must be reviewed and updated no less than every ninety (90) Calendar Days. Care Plans must also be updated when there is a change in the EI's health status or needs, change in diagnosis, change in caregiver status, change in functional status, a significant health care event (e.g., hospital admission or transition between care settings), or as requested by the EI's caregiver or his or her Provider.

3) The Care Plan must apply evidence-based guidelines or best practices when developing and implementing goals and interventions.

4) At a minimum, the EI Care Plan must include:

   a) Identified needs;

   b) Goals to address identified needs;

   c) Interventions to achieve goals;

   d) Frequency of follow-up/ monitoring to achieve goals;

   e) Opportunity for EI participation and an opportunity for input from the PCP, other Providers, a legal representative, and the EI's family and caregiver if appropriate during the development, implementation and ongoing assessment of the EI Care Plan;

   f) Identification and evaluation of risks associated with the EI's care;

   g) A provision to refer the EI, if applicable, to a community or social services agency, assist the EI in contacting the agency and validate the EI received the service;

   h) A communication plan developed with the EI, including the method of preferred contact and a contact schedule that is based on the EI's needs;

   i) If applicable, an aggressive strategy for effective and comprehensive transitions of care between care settings which includes obtaining the discharge/ transition plan, conducting timely follow up with the EI and his/ her Providers as appropriate, performing medication reconciliation, and ensuring the timely provision of formal and informal supports;

   j) Continuous evaluation of the appropriateness of the EI 's current assignment to the risk stratification level;

k) The EI's personal or cultural preferences, such as types or amounts of services;

l) The EI's preference of Providers and any preferred characteristics, such as gender or language;

m) The EI's living arrangements;

n) Actions and interventions necessary to achieve the EI's objectives;

o) Collaborative approaches to be used;

p) Desired outcome and goals, both clinical and non-clinical;

q) Status of the EI's goals;

r) Barriers or obstacles;

s) Responsible parties;

t) Community resources;

u) Informal supports;

v) Timeframes for completing actions;

w) Back-up plan arrangements for critical services; and

x) Crisis plans for an EI with behavioral health conditions.

EXHIBIT D – TRAINING REQUIREMENTS FOR CARE COORDINATORS

The PCCM-E must record written attestations that it has provided all of the required training. Upon hiring, the PCCM-E must provide training on the following topics:

a) Federal and State laws and program requirements;

b) Americans with Disabilities Act (ADA) requirements;

c) Initial contact and information referral;

d) Health Risk and Psychosocial Assessment;

e) Person-centered Care Planning process;

f) Medicaid Eligibility;

g) PCCM-E Enrollment Process;

h) Risk stratification;

i) Care Planning (goals, objectives, outcomes and service planning);

j) Agency and PCCM-E Grievance procedures;

k) Documentation requirements; and

l) Community resources including an explanation of the resources available and training on how to access the services.

Upon hiring and annually thereafter, the PCCM-E must provide training for its Care Coordinators (to include Maternity), Transitional Care Nurses, Behavioral Health Nurses, and staff who participate in the MCT on, at a minimum, the following topics:

Motivational Interviewing	STD's/HIV	Person Centered Language
Domestic Violence	Assessment skills	Breastfeeding
Abuse, neglect and exploitation and all other incident reporting	Cultural competency/ diversity training that is specific to the Region and	Substance Use Disorders, including identifying warning signs, screening

	addresses the culture/ diversity in that Region	and assessment, and resources available
Independent living and recovery	Accessibility and accommodations	Smoking, alcohol or other substance cessation
Wellness principles	Customer service	Medication management
Medication management	Risk stratification	Risk and safety planning
Safe Sleep	Documentation	PT+3 Teaching Methodology
Cultural diversity	Postpartum depression	Birth Control Option
Maternal Health (nutrition, mother and infant bonding, etc.)	Psychosocial barriers to medical management of chronic conditions	Suicide and the wrong way to respond to suicidal statements
Health Insurance Portability and Accountability Act (HIPAA)		Other topics as defined by the Agency

EXHIBIT E – TRAINING REQUIREMENTS FOR STAFF WHO PROVIDE CARE COORDINATION SERVICES FOR IDENTIFIED CHILDREN WITH MEDICAL COMPLEXITY (CMC)

The Agency shall provide special training for staff providing Care Coordination services to Children with Medical Complexities. The basis of this training will be modules produced by The National Center of Care Coordination Technical Assistance. A description of these modules are as follows:

1) Introduction to New Models of Care and Healthcare Trends
   a) Overview of the U.S. Healthcare System
   b) Introduction to Care Coordination
   c) New models of care

2) Interdisciplinary Teams
   a) Working on interdisciplinary teams
   b) Building positive relationships on a team
   c) Communication with team members
   d) Participating in team huddles
   e) Dealing with team conflicts

3) Person-centered and Communication
   a) Defining person-centered Care Planning
   b) Recognizing family and patient needs
   c) Communication and patient engagement techniques (part 1)
   d) Communication and patient engagement techniques (part 2)
   e) Health literacy

4) Complex Medical Conditions
   a) Overview of complex medical conditions (part 1)
   b) Overview of complex medical conditions (part 2)
   c) Social determination of health
   d) Self-management

5) Cultural Competence
   a) Recognizing patients' families' cultural needs/factors that may affect their choices or engagement
   b) Communicating with patients and families in a culturally competent manner

6) Ethics and Professional Boundaries
   a) Ethical and professional responsibilities
   b) Professional boundaries

7) Quality Improvement
   a) The quality improvement process

b) Quality improvement methods and processes

8) Community Orientation
   a) Connecting patients and families to community resources
   b) Supporting families as they seek resources in the community

9) Health Information Technology, Documentation and Confidentiality
   a) Basic technology skills and electronic health records
   b) Documentation
   c) Confidentiality and guidelines

EXHIBIT F – REQUIREMENTS FOR KEY STAFF AND OTHER POSITIONS

1) Administrative Staff Requirements. The PCCM-E(s) must:

   a) have sufficient and appropriate staff;

   b) ensure staff are properly licensed and credentialed;

   c) ensure staff operates within their professional scope;

   d) ensure staff responds to needs of EIs;

   e) provide appropriate training to all staff; and

   f) submit potential staff resumes for review by the Agency to ensure appropriate experience requirements are met.

2) Executive Director:

   a) Possess a Bachelor of Science (BS) or Bachelor of Arts (BA) degree from an accredited college or university (preferred);

   b) Have a minimum of three (3) years management experience in managed health care and experience working with low income populations; or

   c) In lieu of a BS or BA degree, the individual may have ten (10) years management experience in managed health care;

   d) The authority to make all day to day program decisions including hiring, firing, financial, contract agreements, policies and procedures, and the budget approved by the PCMM-E Governing Board; and

   e) Maintain a full-time office in the PCCM-E Region.

3) Medical Director:

   a) Be a practicing Primary Care Physician within the Region for which he or she serves as Medical Director. If the Medical Director practices in more than one Region, he or she will only be eligible to serve (as Medical Director) in the Region of his or her main practice site;

   b) Be a licensed physician in the State of Alabama (required);

c) Have three (3) years' experience with low income populations;

d) Is part-time.

e) Primary responsibilities include, but are not limited to:

i) Maintain contact with local Providers;

ii) Represent the PCCM-E in person at select meetings as required by the Agency and/or the PCCM-E;

iii) Address local issues at the community level;

iv) Lead quarterly Medical Management Meetings in the Region; and

v) Approve the Quality Initiatives and Quality Improvement Plan of PCCM-E.

4) Quality Care Manager:

a) Possess at least one of the following qualifications:

i) Master of Public Health (MPH) in Epidemiology (preferred);

ii) Master of Science (MS) in Health Services or Public Health, or Master of Health Administration (MHA) with minimum of one (1) year experience in managing population health;

iii) Master of Social Work (MSW) degree with appropriate license with one (1) year experience in managing population health; or

iv) Bachelor of Science in Nursing (BSN) degree with current license and minimum of one (1) year experience in managing population health.

b) Primary responsibilities include, but are not limited to:

i) Oversees the Quality Improvement Plan and submits quarterly reports to the Agency on the progress made and plans to address any issues identified;

ii) Ensures the PCCM-E completes the required Quality Improvement Projects (QIPs) and meets required benchmarks;

iii) Reviews and reports data to the Medical Director, Region Medical Management Committee, and the PCCM-E information related to Quality Measures, QIPs, and any Agency directed quality initiatives adopted by the Agency;

iv) Support the Care Coordination activities of those in the Region that are at the highest risk and cost along with other areas of focus as chosen by the PCCM-E;

v) Work with existing Care Coordinators to meet transformation goals (listed in I. B. Purpose transformation Goals) or initiatives as defined by the PCCM-E or the Agency;

vi) Assist the Region Medical Management Committee by providing data and assistance in implementing health initiatives;

vii) Ensure quality of services are provided in accordance with state and federal regulations;

viii) Population Health Management - Oversees the PCCM-E Quality Improvement Plan by:

(1) Systematic data analysis to target EIs and Providers for outreach, education, and intervention to improve health outcomes;

(2) Monitoring system access to care, services, and treatment including linkage to a Medical Home;

(3) Monitoring quality and effectiveness of interventions to the population;

(4) Facilitating quality improvement activities that educate, support, and monitor Providers regarding evidence-based care for best practice; and

(5) Implement clinical management initiatives identified as priorities by the Agency, Quality Assurance Committee, and the PCCM-E.

5) Pharmacy Director (See Exhibit L below for additional information):

a) Current Alabama pharmacy license in good standing;

b) Work within the Region; live within the Region (preferred);

c) Holds at a minimum a B.S. degree in Pharmacy;

d) Must have a minimum of five (5) years of pharmacist experience within the past six (6) years; supervisory experience preferred; and

e) Possess excellent organizational and administrative skills.

6) Care Coordinator Supervisor:

   a) Minimum of three (3) years' experience in Care Coordination or case management;

   b) Possess at least one of the following qualifications:

      i) Master of Social Work (MSW) degree from an accredited school of Social Work, and minimum Licensed Graduate Social Worker (LGSW); or

      ii) Minimum of a Bachelor of Science in Nursing (BSN) degree with appropriate license.

7) General Care Coordinators:

   a) Possess at least one of the following qualifications:

      i) Minimum of Bachelor of Science in Nursing (BSN) degree with appropriate license; or

      ii) Minimum of Bachelor of Social Work (BSW) or MSW from an accredited school of Social Work and appropriate license.

8) Maternity Care Coordinators:

   a) Possess at least one of the following qualifications:

      i) Minimum of Bachelor of Science in Nursing (BSN) degree with appropriate license;

      ii) Minimum of Bachelor of Social Work (BSW) or MSW from an accredited school of Social Work and appropriate license;

      iii) Maternity Care Coordinators may also be a licensed registered nurse with an Associate of Science degree or diploma in nursing, with one (1) year experience in Care Coordination with low-income populations; or

      iv) Maternity Care Coordinators may be comprised of 20% licensed practical nurses with at least two (2) years of clinical experience and one (1) year experience in Care Coordination, accessing resources, and coordinating care with low-income populations.

   b) Application Assister – an Application Assister is a Maternity Care Coordinator that has received training from the Agency to assist in Medicaid applications.

9) Family Planning Care Coordinators:

   a) Possess at least one of the following qualifications:

      i) Minimum of Bachelor of Science in Nursing (BSN) degree with appropriate license; or

      ii) Minimum of Bachelor of Social Work (BSW) or MSW from an accredited school of Social Work and appropriate license.

10) Community Health Workers:

   a) Minimum of a high school diploma or GED; and

   b) Have a valid driver's license.

11) Transitional Care Nurses:

   a) Maintain appropriate licensure;

   b) At least 50% of transitional care nurses on staff must:

      i) Possess BSN degree; and

      ii) Have experience in a hospital or Home Health setting;

   c) The remainder of transitional care nurses on staff may:

      i) Possess an Associate Degree in Nursing (ADN) or Diploma in Nursing;

      ii) Within last three (3) years, have a minimum of two (2) years of direct patient care experience in a health care setting (preferably hospital, home health agency, or PCCM-E).

12) Behavioral Health Nurses:

   a) An individual with a BSN must meet the following:

      i) Minimum of a BSN degree with appropriate license; and

      ii) Within the last three (3) years have a minimum of two (2) years nursing experience in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program, or other outpatient psychiatric services; or

   b) An individual with an ADN must meet the following:

i) Possess an ADN degree or Diploma of Nursing degree with appropriate license; and

ii) Within last four (4) years have a minimum of three (3) years nursing experience in an acute treatment unit within a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program, or other outpatient psychiatric services

13) Community Pharmacist:

a) Must hold a current Alabama Pharmacy license in good standing;

b) Must hold a current Alabama Preceptor certification (at the time of or within six (6) months of start of the Contract);

c) Must work and preferably live within the PCCM-E Region;

d) Must hold at a minimum a B.S. in Pharmacy with a Pharm.D. preferred;

e) Must have three (3) years of community pharmacy experience within the past four (4) years preferably with supervisory experience preferred;

f) Must possess excellent organizational and administrative skills; and

14) Transitional Pharmacist:

a) Must hold a current Alabama Pharmacy license in good standing;

b) Must hold a current Alabama Preceptor certification;

c) Must work and preferably live within the PCCM-E Region;

d) Must hold at a minimum a B.S. in Pharmacy with a Pharm.D. preferred;

e) Must have formal residency training or equivalent clinical inpatient experience (minimum of three (3) calendar years within the past four (4) years preferably with supervisory experience preferred; and

f) Must possess excellent organizational and administrative skills.

EXHIBIT G – CONTACT REQUIREMENT SCHEDULE FOR GENERAL CARE COORDINATION

Minimum Contact and Requirement Schedule for General Care Coordination: The PCCM-E must establish a contact schedule that is based on the EI's needs and interventions as agreed upon in the Care Plan. The approach to General Care Coordination is individualized and will vary from case to case to meet the needs of the EI, and reflect changes to the Care Plan. At a minimum, the PCCM-E must adhere to the following contact and requirement schedule as specified below for each stratification level.

At a minimum, the PCCM-E must make three (3) documented attempts to contact the EI within thirty (30) Calendar Days, to conduct a health risk screening and assessment. One attempt must include outreach via certified mail. Other attempts may include telephone calls and home visits.

Risk Stratification Level	Minimum Contact and Requirement Schedule	
	First six (6) months of enrollment in the risk stratification level (note: visit is an in-person contact)	Month seven (7) until conclusion of the EI Care Plan (note: visit is an in-person contact)
High	• Within twenty-one (21) Calendar Days of initial health risk screening and stratification: Health Risk and Psychosocial Assessment completed • Within twenty-five (25) Calendar Days of Health Risk and Psychosocial Assessment: Care Plan developed • Per week: At least one documented goal in place with at least one (1) task or more documented and completed • Months 0-1: Two (2) face-to-face visits. Maximum of fifteen (15) Calendar Days between visits • Months 2-3: One (1) visit per month. Maximum of thirty (30) Calendar Days between visits	• Per week: At least one documented goal in place with at least one (1) task or more documented and completed • One (1) visit every two (2) months. Maximum of sixty (60) Calendar Days between visits • Monthly telephonic contact • MCT meeting held, at a minimum, monthly

	• Months 4-6: Two (2) visits in ninety (90) Calendar Days. Maximum of forty-five (45) Calendar Days between visits • Telephonic contact, as needed • MCT meeting held, at a minimum, monthly	
Medium	• Within twenty-one (21) Calendar Days of initial health risk screening and stratification: Health Risk and Psychosocial Assessment completed • Within twenty-five (25) Calendar Days of Health Risk and Psychosocial Assessment: Care Plan developed • Per month, but less than one (1) per week: At least one documented goal in place with at least one (1) or more documented and completed tasks • Months 0-2: One (1) face-to-face visit • Months 3-6: Two (2) visits. Maximum of sixty (60) Calendar Days between visits • Telephonic contact, as needed • MCT meeting held, at a minimum, quarterly	• Per month, but less than one (1) per week: At least one documented goal in place with at least one (1) or more documented and completed tasks • One (1) visit every three (3) months. Maximum of ninety (90) Calendar Days between visits • Monthly telephonic contact • MCT meeting held, at a minimum, quarterly

EXHIBIT H – MATERNITY CARE COORDINATION AND CONTRACT REQUIREMENTS

1) Maternal Health Screening:

    a) Required for all pregnant EIs;

    b) Must be completed via telephone or face-to-face;

    c) Must make contact with EI within five (5) Business Days;

    d) Must use the Agency's approved tool; and

    e) Must be documented in HIMS.

2) Maternal Health Screening Administrators must be:

    a) Maternal Care Coordinators; or

    b) Other Contractor staff knowledgeable of enrollment requirements, screening tool instruments and competent to complete the task.

3) The Maternal Health Risk and Psychosocial Assessment Tool determines the EIs risk stratification level. The PCCM-E must:

    a) Use the Agency's approved tool;

    b) Complete the psychosocial assessment face-to face; and

    c) Use the psychosocial assessment as a basis to determine high risk referrals and risk stratification.

4) The Maternal Health Risk and Psychosocial Assessment must be completed at the pregnant EI's initial face-to-face initial assessment by the Maternity Care Coordinator.

5) A Maternal Health Care Plan is required of all pregnant EIs regardless of risk stratification level.

6) A Maternal Health Care Plan must be completed within seven (7) Calendar Days of the pregnant EI's psychosocial assessment.

EXHIBIT I – MATERNITY RISK STRATIFICATION LEVELS AND CONTRACT GUIDELINES

Risk Stratification Level	**High Risk** **EIs must meet a risk score of eight (8) or above on the Psychosocial Assessment Tool to be stratified as High Risk**	**Low Risk** **EIs must meet a risk score of seven (7) or below on the Psychosocial Assessment Tool to be stratified as Low Risk**
Encounters	**Description for High Risk**	**Description for Low Risk**
Face to Face Eligibility Assistance Encounter	Pregnant Women EIs may receive assistance with establishing eligibility in the first trimester. This encounter must be completed by a certified application assister.	Pregnant Women EIs may receive assistance with establishing eligibility in the first trimester
First Face-to-face Encounter	First encounter for all Pregnant Women which must include completion of the psychosocial assessment and the Care Plan	First encounter for all Pregnant Women which must include completion of the psychosocial assessment and the Care Plan
First follow-up Face-to-face Encounter	First follow-up encounter for EIs. stratified as High Risk. This Encounter must occur within the second trimester.	Second Encounter for EIs stratified as Low Risk. This Encounter can occur within the second or third trimester.
Second follow-up Face-to-face Delivery Encounter	Second follow-up encounter for EIs stratified as High Risk. This Encounter must occur within the third trimester.	N/A
In-Patient Face-to-face Delivery Encounter	Hospital Delivery encounter for all eligible EIs including those who receive no prenatal care. If this encounter is missed in the hospital, an In-Home face-to-face encounter must be conducted within twenty (20) Calendar Days of the delivery date. Individuals granted emergency Medicaid due to their non-citizen status will not receive a home visit within twenty (20) Calendar Days of the delivery if the visit is missed in the hospital.	Hospital Delivery encounter for all eligible EIs including those who receive no prenatal care. If this encounter is missed in the hospital, an In-Home face-to-face encounter must be conducted within twenty (20) Calendar Days of the delivery date except for individuals granted emergency Medicaid due to their non-citizen status.

In-Home Face-to-face Post-Partum Encounter	In-home post-partum encounter for EIs stratified as High Risk, including EIs who receive no prenatal care prior to the delivery date. This encounter must occur at or between four (4) and eight (8) weeks of the delivery date. Individuals granted emergency Medicaid due to their non-citizen status will not receive a home visit between four (4) and eight (8) weeks of the delivery date.	N/A

EXHIBIT J – FAMILY PLANNING PROGRAM REQUIREMENTS

1) The Agency will provide a monthly list including, but not limited to EIs newly eligible for Plan First or family planning, EIs who have previously been on birth control and recently stopped to the PCCM-E.

2) Components of Care Coordination for family planning EIs include, but are not limited to:

   a) Face to face risk screenings which shall be completed on male and female family planning EIs using the risk screening form provided by the Agency (see section II.B)The risk screening will determine the EI's need for Care Coordination. The screening shall be completed at the initial encounter.

      i) Risk stratification. Care Coordination shall be provided according to the identified risk stratification needs. See Exhibit K for additional information on risk stratification. EIs may be stratified as:

         (1) High risk; or

         (2) Low risk

   b) Completion of Psychosocial Assessments and Care Plans which must be completed, face-to-face, on all EIs stratified as needing high risk or low risk Care Coordination using Agency approved forms (see section II.B).

   c) If any change in risk stratification is indicated, an additional face-to-face risk screening and Psychosocial Assessment is required. The Care Plan must be updated with new goals and objectives.

   d) To be stratified as High Risk. EIs MUST meet at least one (1) of the primary criteria and may have any of the secondary criteria:

   e) Primary Criteria –

      i) Awaiting sterilization procedure (tubal ligation or vasectomy);

      ii) First time birth control user with complications;

      iii) Multiple unplanned pregnancies;

      iv) A history of abortions;

      v) Language/communication barriers that interfere with the EI's ability to understand and/or implement family planning methods; or

vi) Lack of compliance with the chosen family planning contraceptive methods (consecutive months of missed refills of contraceptives, etc.).

f) Secondary Criteria –

i) Domestic violence in the home or environment;

ii) History of mental health problems;

iii) History of substance abuse;

iv) Impaired cognitive functioning;

v) Tobacco products user; or

vi) Needs assistance with establishing Medicaid eligibility.

g) To be stratified as low risk EIs MUST meet at least one (1) of the criteria listed below:

i) Change in prescription for family planning contraceptives in the last three (3) months;

ii) History of missed appointments and need frequent appointment reminders; or

iii) Needs assistance with establishing Medicaid eligibility.

3) To receive family planning Care Coordination continuously (greater than twelve (12) consecutive months) the EI must have at least one of the following:

i) Had a contraceptive prescription filled in the last twelve (12) months;

ii) Been seen by a doctor in the last twelve (12) months;

iii) Had a pregnancy in the last twenty-four (24) months; or

iv) Had multiple missed appointments in the last twelve (12) months.

4) If there is no contact with the EI after six (6) months, the case must be closed.

5) Only face-to-face and successful telephone contacts constitute active encounters with the EI that qualify for payment.

6) EIs who are sterilized by a tubal ligation or vasectomy cannot receive family planning Care Coordination.

7) Plan First Female Care Coordination includes:

a) Counseling, coordinating services, medical and social resources;

b) Providing assistance with establishing Medicaid eligibility. Assistance with establishing Medicaid eligibility shall include assistance with completing the Medicaid application process;

c) Providing EIs with a list of Medicaid enrolled Providers for completion of the sterilization procedure;

d) Coordinating services with the EI's Provider of choice;

e) Making Provider appointments for the initial consultation;

f) Developing individualized Care Plans for each EI addressing identified needs;

g) Promote pre-pregnancy health;

h) Provide counseling regarding sexuality, family planning, HIV/AIDS, STDs, and psychosocial issues identified in the assessment, such as substance abuse or domestic violence;

i) Encourage EIs to continue with pregnancy spacing plans and assist with the mitigation or removal of barriers to successful pregnancy planning;

j) Make referrals based on Care Plan directives;

k) Assist EIs with obtaining access to medically necessary primary care services;

l) Conduct follow-up to ensure appointments are kept, including subsequent family planning visits;

m) Provide answers to general questions about family planning;

n) Maintain a low-literacy family planning education program based on the PT+3 teaching method described below;

o) Consult with Providers regarding problems with the selected family planning method;

p) Maintain and provide EIs a list of all Medicaid enrolled family planning Providers in the PCCM-E; and

q) Provide face-to-face tobacco cessation counseling, and make referrals to the ADPH Quitline.

7) Plan First Males Care Coordination. Plan First Males Care Coordination includes:

a) Providing assistance and resources to male EIs in efforts of overcoming barriers to receiving a vasectomy procedure;

b) Counseling, coordinating services, medical and social resources;

c) Providing assistance with establishing Medicaid eligibility. Assistance with establishing Medicaid eligibility shall include completing the Medicaid application process;

d) Providing EIs with a list of Medicaid enrolled Providers (i.e., Urologists) for completion of the sterilization procedure;

e) Coordinating services with the EI's Provider of choice;

f) Making Provider appointments for the initial consultation;

g) Developing individualized Care Plans for each EI addressing identified needs;

h) Provide face-to-face tobacco cessation counseling, and make referrals to the ADPH Quitline;

i) Make referrals based on Care Plan directives; and

j) Assist EIs with obtaining access to medically necessary primary care services.

8) PT+3 Teaching Method

a) All family planning counseling must utilize the PT+3 teaching method. The Agency will provide initial training for a representative from the PCCM-E. Thereafter the PCCM-E will be responsible for training its staff. The acronym, PT+3, means:

P = Personalize the PROBLEM,
T = "TAKLE" the problem,
T = Set a Therapeutic Tone,
A = Assess the knowledge level of the EI,
K = Provide Knowledge,
L = Listen for feedback,
E = Elaborate or reeducate as needed.
+3 = Summarize the teaching session into three essential points.

b) At all points during the counseling and education process, the EI must be given the information in such a way as to encourage and support the exercise of choice. To support informed choice, certain informational elements should be offered. Due to the constraint of time, the topics are listed in order of priority.

i) Priority one includes those topics that must be discussed with the EI. At a minimum, these include:

(1) EI expressed needs or problems;

(2) Contraception;

(3) Listing of the various options;

(4) How to use;

(5) Side effect management;

(6) Prevention of STDs including HIV; and

(7) Breast self-exam or testicular self-exam.

ii) Priority two includes those topics that can be presented to the EI in a written document, with verbal follow-up. At a minimum, these include:

(1) Explanation of any screening or lab testing done;

(2) Services offered;

(3) Telephone number of office or instructions about accessing emergency care; and

(4) Folic Acid.

iii) Priority three includes those topics that can be presented in written format only, with follow-up occurring should the EI need/desire further clarification. At a minimum, these include:

(1) Need for mammogram; and

(2) Anatomy and physiology.

c) At all times, the PT+3 method of teaching/counseling should be used so that time is targeted toward individual EI need.

EXHIBIT K – FAMILY PLANNING RISK STRATIFICATION LEVELS AND CONTACT GUIDELINES

Risk Stratification Level	Guidelines
High Risk	• One (1) initial face-to-face encounter in an eligibility period to complete risk screening, Psychosocial Assessment, and a Care Plan. • One (1) follow-up face-to-face encounter in a twelve (12) month period. • Two (2) successful telephone calls in a twelve (12) month period. Sending emails, writing letters, mailing postcards, checking eligibility, documenting in records, and unsuccessful phone calls do not constitute successful contacts. • One (1) additional face-to-face risk screening and Psychosocial Assessment in a twelve (12) month period is allowed if documentation supports the need for a reassessment.
Low Risk	• One (1) initial face-to-face encounter in an eligibility period to complete a risk screening, Psychosocial Assessment, and implement a Care Plan. Two (2) successful telephone contacts in a twelve (12) month period. Sending emails, writing letters, mailing postcards, checking eligibility, documenting in records, and unsuccessful telephone calls do not constitute successful contacts. • One (1) additional face-to-face risk screening and Psychosocial Assessment in a twelve (12) month period is allowed if documentation supports the need for a reassessment.

EXHIBIT L – PHARMACY PROGRAM REQUIREMENTS

The Pharmacy Director must hold developed clinical, administrative, analytical, and leadership skills to create, implement, manage, and retrospectively provide quality assurance on all aspects of the Pharmacy Program. The Pharmacy Director may also simultaneously serve as either the Transitional Pharmacist or Community Pharmacist. The person holding the Pharmacy Director position will be the primary point of contact with the Agency for all meetings and coordination.

1) Pharmacy Director

   a) Provide leadership and oversight of the Pharmacy Program for the PCCM-E, including supervision of the Community Pharmacist, Transitional Pharmacist, and any pharmacy staff (pharmacists or certified pharmacy technicians) within the Region;

   b) Serve as the primary point of contact for Agency coordination and meetings;

   c) Develop, coordinate, implement, and manage education of community, inpatient, transitional, and all pharmacists and PCPs within the PCCM-E and Agency pharmacy initiatives;

   d) Develop, coordinate, engage within, and manage staff to implement programs that advance the Medical Home;

   e) Work with the PCCM-E's management team to determine ways to support pharmacists and prescribers with management of drug costs and policies;

   f) Create and manage programs that address new policies as the Agency implements them;

   g) Attend and present at various local PCCM-E and Agency meetings as requested, such as Steering Committee meetings, Medical Management Committee meetings, Alabama Medicaid Pharmacy and Therapeutics (P&T) and Drug Utilization Review (DUR) meetings, and PCCM-E Director's Meetings;

   h) Serve as a resource to PCPs and care managers on general drug information and Agency pharmacy policy issues;

   i) Develop and implement a Medication Reconciliation standard for both Community and Transitional Pharmacists to follow and maintain. Implementing medication reconciliation in concert with the PCP and Pharmacists to assure continuation of needed therapy following inpatient discharge to ensure a seamless transition back into the community;

   j) Educate and train, or coordinate the education and training of staff on processes to be developed, such as Medication Reconciliation;

k) Coordinate efforts with the Alabama Medicaid Academic Detailing program on administrative detailing to PCCM-E PCPs;

l) Participate in regular status calls with Agency Pharmacy Program staff;

m) Educational/Professional Criteria:

i) Current Alabama pharmacy license in good standing;

ii) Work within the Region; live within the Region preferred;

iii) Holds at a minimum a B.S. degree in Pharmacy;

iv) Must have a minimum of five (5) years of pharmacist experience within the past six (6) years; supervisory experience preferred; and

v) Possesses excellent organizational and administrative skills.

n) Complete, oversee, be responsible for, and submit all reports for the PCCM-E Pharmacy Program. Example reporting include, but are not limited to, quarterly goals such as:

i) Perform five (5) physician educational visits (to be performed by a pharmacist);

ii) Perform five (5) pharmacy educational visits (to be performed by a pharmacist);

iii) Perform one (1) home visit with PCCM-E Program EI(to be performed by a pharmacist);

iv) Provide one (1) inservice training on various clinical topics for care managers (to be performed by a pharmacist);

v) Run report on high utilizers. Review the top ten (10) by costs and identify any possible EI to be referred to the Care Coordinator for enrollment into the PCCM-E;

vi) Medication Reconciliations for inpatient/discharge patients receiving Care Coordination services must be performed by a pharmacist for all discharge patients; and

vii) Medication Reconciliations for community patients must be conducted by a pharmacist for all medium/high risk EIs in the General Population and for all high risk EIs on prescription medications in the Maternity Population:

(1) Perform and submit Medication Reconciliations for PCCM-E Program EIs within five (5) Business Days after receipt of Medication List;

(2) Perform and submit Medication Reconciliations for transitional/ discharge patients within three (3) Business Days after receipt of Medication List;

(3) Ensure that any pharmacist working or contracted within the PCCM-E, and any pharmacist that conducts Medication Reconciliation, successfully complete a Medication Therapy Management Certification Course. The course must be approved in advance by the Agency. One course approved by the Agency is provided by Power-Pak C.E.® (http://www.powerpak.com/mtm/);

o) Work with both schools of pharmacy within the state (McWhorter and Harrison Schools of Pharmacy) to implement a Student Advanced Practice Experience Program. Each Region may determine what specialty best suits the practice type (i.e., Drug Information, Community, Inpatient, Elective). The Agency is anticipating an advanced practice program to be developed for the Inpatient/Transitional program, and a separate program for the Community arm. Each PCCM-E must offer to take pharmacy students, and provide a good faith effort to have a minimum of two (2) students per year in the Community and Inpatient Programs (i.e., minimum of four (4) students per year). The PCCM-E may take on additional students as the Region determines; and

p) Pharmacy Director may also serve as the Transitional or Community Pharmacist, but not both. If the Pharmacy Director also serves as the Transitional or Community Pharmacist, the Educational/Professional Criteria must be met for all positions held.

2) Community Pharmacist

a) Coordinate and support outpatient pharmacy initiatives, such as dispensing of ninety (90) day supply for maintenance medications, pharmacist vaccine administration, opioid use and abuse, smoking cessation, and other programs as outlined by the Agency or PCCM-E;

b) Assist prescribers in creating and managing drug regimens of EIs with chronic disease (e.g., diabetes, asthma, congestive heart failure). This may include, but shall not be limited to, activities such as meeting with EIs, adjusting medication dosages in concert with PCP;

c) Assist prescribers and dispensing pharmacists within the Region for patients needing assistance with prior authorizations, management of drug therapy, prescription limit concerns, and any other pharmacy-related patient challenges;

d) Implement pharmacy management programs for those receiving multiple medications, complex drug regimens, and/or specialty pharmacy products. The following goals should be considered, but additional criteria may be added by the Agency:

i) Improve medication adherence;

ii) Prevent and reduce potential medication-related errors;

iii) Reduce ‘doctor shopping’; and

iv) Cost-effectiveness;

e) Perform Medication Reconciliation assessments as requested by PCPs, Maternity Care Program staff, and/ or Care Coordinators to optimize the EI's drug regimen;

f) Educate community pharmacists within the Region on the PCCM-E and Agency pharmacy initiatives;

g) Coordinate with the Agency on the Patient Controlled Substances Lock-In Program Medication Reconciliations and must be conducted by a pharmacist for all medium/high risk EIs in the General Population;

h) Serve as a resource to PCCM-E's PCPs and Care Coordinators on general drug information and Agency drug policy issues;

i) Educational/Professional Criteria:

i) Current Alabama Pharmacy license in good standing;

ii) Must hold a current Alabama Preceptor certification (at the time of or within six (6) months of start of contract or employment);

iii) Works within the PCCM-E Region; live within the Region preferred;

iv) Holds at a minimum a B.S. in Pharmacy; Pharm.D. preferred;

v) Must have three (3) years of community pharmacy experience within the past four (4) years; supervisory experience preferred; and

vi) Possesses excellent organizational and administrative skills;

j) Serve as the Preceptor for the Pharmacy Student Advance Practice Experience;

k) Successfully complete a Medication Therapy Management Certification Course. The course must be approved in advance by the Agency. One course approved by the Agency is provided by Power-Pak C.E.® (http://www.powerpak.com/mtm/); and

l) Manage any additional pharmacy staff (pharmacists, certified pharmacy technicians, etc.) hired by the Region to work on Community Pharmacy program tasks.

3) Transitional Pharmacist

a) Develop, establish, and oversee an organizational process and policy on EI transition of care from inpatient to the community. Aspects of the transitional care should include, but are not limited to:

i) Medication reconciliation on patients from pre-, during inpatient stay, and post-discharge within three (3) days of receiving the patient medication list;

ii) Transitional medication management to include face-to-face visits, calls, and any other means necessary;

iii) Obtain and review discharge information (e.g., discharge summary or continuity of care documents);

iv) Prior authorization assistance;

v) Reduction of readmission rates related to medication issues/errors;

vi) Coordination with the Care Coordinator to ensure appointments for post-discharge appointments are made, needed prescriptions are obtained;

vii) Review need for or follow-up on pending diagnostic tests related to the medications and treatments;

viii) Interact with other health care professionals who will assume or reassume care of the EI's system-specific problems;

ix) Provide education to the EI, family, guardian, and/or caregiver;

x) Refer EI to the Community Pharmacy Program if continued services are needed; and

xi) Monitor compliance with standardized forms, tools, and methods for transitions of care. Use post-discharge surveys and data collection to find root causes of ineffective transitions and to identify patient and caregiver understanding of transitions and the Care Plan;

b) Coordinate and support EIs as they transition to the community or outpatient on Agency pharmacy initiatives, such as dispensing of ninety (90) Calendar Day supply for maintenance medications, pharmacist vaccine administration, smoking cessation, and other programs as outlined by the Agency or PCCM-E;

c) Assist prescribers in creating and managing drug regimens of EIs with chronic disease upon discharge (e.g., diabetes, asthma, congested heart failure). This may include, but shall not be limited to, activities such as meeting with EIs, adjusting medication dosages in concert with PMP;

d) Assist prescribers and dispensing pharmacists within the Region for patients needing assistance with prior authorizations, management of drug therapy, prescription limit

concerns, and any other pharmacy-related patient challenge as they transition to the community setting;

e) Medication Reconciliations for inpatient/discharge patients must be performed by a pharmacist for all discharge patients;

f) Perform Medication Reconciliation assessments as requested by PCPs and/ or Care Coordinators to optimize the EI's drug regimen;

g) Educate inpatient prescribers and pharmacists within the Region on the PCCM-E and Agency pharmacy initiatives;

h) Educational/Professional Criteria:

i) Current Alabama Pharmacy license in good standing;

ii) Must hold a current Alabama Preceptor certification;

iii) Works within the PCCM-E Region; live within the Region preferred;

iv) Holds at a minimum a B.S. in Pharmacy; Pharm.D. preferred;

v) Must have formal residency training or equivalent clinical inpatient experience (minimum of three (3) calendar years within the past 4 years; supervisory experience preferred; and

vi) Possesses excellent organizational and administrative skills;

i) Serve as the Preceptor for the Pharmacy Student Advance Practice Experience;

j) Successfully complete a Medication Therapy Management Certification Course. The course must be approved in advance by the Agency. One course approved by the Agency is provided by Power-Pak C.E.® (http://www.powerpak.com/mtm/); and

k) Manage any additional pharmacy staff (pharmacists, certified pharmacy technicians, etc.) hired by the Region to work on Inpatient/Transitional Pharmacy program tasks.

EXHIBIT M – QUALITY IMPROVEMENT PROJECT REQUIREMENTS

Each Quality Improvement Project (QIP) must contain the following sections:

1) Targeted Quality Measure(s): Each of the submitted QIPs must target improvement in one of the three areas the Agency has selected to focus on, including: prevention of childhood obesity, substance use disorders, and infant mortality and/or adverse birth outcome. It is expected that the PCCM-E will submit a minimum of three QIPs, a separate QIP for each targeted area of focus, for the Agency to review and approve. The measure must be appropriate to effectively evaluate the outcomes of the QIP, align with the PCCM-E and/or Provider incentive metrics, and should be nationally recognized or validated whenever possible.

2) Project Goal(s): The project goal(s) must be clear, concise, and answerable. The project goal(s) identifies the focus of the QIP and sets the framework for data collection, analysis and interpretation. Potential sources of information to help form the project goal include:

    a) State data relevant to the measure and/or outcome;

    b) PCCM-E data relevant to the measure and/or outcome; and

    c) Relevant clinical literature;

3) Project variable(s): A study variable is a measurable characteristic, quality, trait or attribute of a particular individual, object or situation being studied.

4) Expected cost of project: The PCCM-E must submit detailed budget and expected cost to implement the project and savings expected due to the improved performance. The projected budget should not exceed approximately one-third of the total Quality Improvement PMPM to be received by the PCCM-E. The PCCM-E should expect to spend all of the Quality Improvement PMPM funds on the implementation of the QIPs. If the proposed budget exceeds the expected total PMPM funds, use of other funds including external funding sources must be identified and approved by the Agency.

5) Representative and generalizable sample: Measurement and improvement efforts must be system-wide. The QIP must clearly identify the ‘“system” or study population, also referred to as the universe. Once the population is identified, the PCCM-E will determine whether to study data for the entire population or a sample of that population. A representative sample of the identified population is acceptable.

6) Sound sampling methods (if sampling is used): Proper sampling methods are necessary to provide valid and reliable (generalizable) study results. Healthcare Effectiveness Data and Information Set (HEDIS®) measures and HEDIS® sampling methodology are generally considered valid and reliable;

7) Reliable data collection: Data collection procedures must ensure that the data used to measure an indicator of performance are valid and reliable. A valid measure is one that measures what it intends to measure, while a reliable measure that provides consistent results is an indication that the data will produce consistent, repeatable or reproducible measurements. Potential sources of data include:

   a) Administrative data (e.g., membership, enrollment, claims, encounters);

   b) Medical records;

   c) Tracking logs;

   d) Results of any Provider interviews; and

   e) Results of any EI interviews and surveys.

8) Measurement of performance using objective quality indicators: Real, sustained improvements result from a continuous cycle of measuring and analyzing performance and developing and implementing system-wide improvements. Actual improvements depend on thorough analysis and implementation of appropriate solutions.

9) Implementation of system interventions to achieve improvement in quality: Data analysis begins with examining the performance on the selected clinical or non-clinical indicators, including the collection and calculation of baseline rates and ongoing remeasurement. The examination should be initiated using statistical analysis techniques defined in a data analysis plan.

10) Evaluation of the effectiveness of the interventions: It is important to determine if a reported change represents "real" change or is an artifact of a short-term event unrelated to the intervention or random chance. The PCCM-E must demonstrate whether the cause for improvement was due to the interventions and improvement strategies implemented.

11) Planning and initiation of activities for increasing or sustaining improvement: Real change is the result of changes in the fundamental processes of health care delivery and is most valuable when it offers demonstrable sustained improvements. In contrast, a spurious "one-time" improvement can result from unplanned accidental occurrences or random chance. The PCCM-E must demonstrate whether the interventions and improvement strategies implemented are likely to achieve sustained improvement.

EXHIBIT N – PCCM-E PAYMENT METHODOLOGY TABLE

The PCCM-E will be paid once a month. The total payment will be derived from the following (See Exhibit S for additional information):

Category	Definition
GENERAL CARE COORDINATION	
Monitoring	High-cost EIs currently not receiving Care Coordination services will be monitored through claims and data review for cost efficiency and clinical appropriateness.
Intensely Managed	At least one face-to-face encounter with the EI, which may include the Health risk assessment, is completed in a month. The encounter may occur at the home, PCP office, hospital, community agency, or other public setting.
Moderately Managed	At least four non-face-to-face activities completed in a month to receive the moderately managed monthly payment. A successful phone call to the EI must be one of the four activities. Other activities may include: a. Successful phone calls on behalf of the EI b. Multidisciplinary Care Team (MCT) Meetings c. Professional Encounter with PCP d. Other Professional Encounters. e. Community Resources Assistance. f. Transportation Request Activities **that will not receive a moderately managed monthly payment** include, but are not limited to: unsuccessful phone calls, unsuccessful home visits, checking eligibility, or documentation.
MATERNITY CARE COORDINATION	
One-time transfer payment	There will be a one-time Maternity Care Coordination transfer payment, to the PCCM-E, for one hundred dollars ($100.00) to ensure continuity of care for each Pregnant Woman that transfers from an existing Medicaid maternity contractor.
Face-to-Face Eligibility Assistance	To assist EIs with establishing Medicaid eligibility in the first trimester (Pregnant Women EIs only). This encounter must be completed by a Certified application assister.
First Face-to-face Encounter	First Encounter for all Pregnant Women EIs. This encounter includes but is not limited to completion of psychosocial assessment and Care Plan.
Follow-up Face-to-face Encounter	Second and third Encounter for EIs stratified as High Risk. The second encounter must occur within the second trimester and the third encounter must occur within the third trimester. Second encounter for EIs stratified as Low Risk. This encounter can occur within the second or third trimester.
In-Patient Face-to-face Delivery Encounter.	Hospital Delivery Encounter for all Pregnant Women EIs including those with no prenatal care. If this Encounter is missed in the hospital, an in-home face-to-face Encounter must be conducted within twenty (20) Calendar Days of the delivery date. Individuals granted emergency Medicaid due to their non-citizen status will not receive a

	home visit within twenty (20) Calendar Days of the delivery if the visit is missed in the hospital.
In-Home Face-to-face Post-Partum Encounter	In-home post-partum Encounter for EIs stratified as High Risk. This Encounter must occur at or between four (4) and eight (8) weeks of the delivery date. Individuals granted emergency Medicaid due to their non-citizen status will not receive a home visit between four (4) and eight (8) weeks of the delivery date.
FAMILY PLANNING CARE COORDINATION	
Face to Face Risk Screening only	This payment is only made if a risk screening is completed and it is determined that the EI does not need Care Coordination.
Intensely Managed	A payment is made for the provision of Care Coordination services to include either of the following activities: a. Face-to-face initial encounter in an eligibility period to complete risk screening, Psychosocial Assessment, and a Care Plan. b. Face-to-face follow up Care Coordination visit. c. If a change in risk stratification is indicated, one additional face-to-face risk screening and Psychosocial Assessment within a twelve (12) month period is allowed.
Moderately Managed	Successful telephone contact
QUALITY IMPROVEMENT PROJECTS	
Monthly PMPM payment for Quality Improvement Projects	There will be a monthly capitation payment for all EIs to fund quality improvement.
PCCM-E QUALITY INCENTIVE PAYMENTS	
Annual Incentive Payment	There will be an annual incentive payment up to ten percent (10%) for PCCM-Es meeting quality measures.

EXHIBIT O – PREVALENT NON-ENGLISH LANGUAGES

The following languages are defined as Prevalent Non-English Languages:

1) Spanish or Spanish Creole
2) Korean
3) Chinese
4) Vietnamese
5) Arabic
6) German
7) French
8) Gujarati
9) Tagalog
10) Hindi
11) Laotian
12) Russian
13) Portuguese
14) Turkish
15) Japanese

EXHIBIT P – QUALITY INCENTIVE PAYMENT METHODOLOGY

1) Overview

   a) Ensuring quality outcomes for Medicaid recipients is one of the primary goals of the ACHN program. Quality efforts should reflect a partnership between the PCCM-E, the Providers, and the Agency. To promote quality improvement within the ACHN program, the Agency has implemented a Quality Incentive Payment, whereby the PCCM-E may earn an incentive payment up to ten percent (10%) of the total revenues received in the quality metrics evaluation year if the PCCM-E meets quality targets set by the Agency.

   b) Beginning in year one (1) of the ACHN Program, the PCCM-E will have the opportunity to participate in an incentive program based upon the achievement of Agency determined benchmarks for each of the Quality Measures. If the PCCM-E achieves the minimum necessary of the annual benchmarks, it will be eligible to receive up to a ten percent (10%) incentive payment. For details related to incentive payments see Table 1 below.

2) Key Features

   a) The Agency will select ten (10) incentive measures to assess the PCCM-E quality performance. Each of the ten (10) measures will be equally weighted when assessing the PCCM-E's performance. If any measure has any sub-components, the total of the sub-components will equal any one incentive measure. The measures are listed in Exhibit Q.

   b) Any PCCM-E that fails to submit the required performance reports to facilitate a related measure calculation or is in a sanctioned status that the Agency determines would preclude the PCCM-E from obtaining the Quality Incentive Payment, the PCCM-E will be ineligible to participate in the Quality Incentive Program.

   c) Starting in FY21 and going forward, the Agency will distribute earned incentive funds based on the PCCM-E's performance for the incentive measures of the previous calendar year (CY). For the first year of implementation, if the PCCM-E is operational for a minimum of ten (10) months or more, the PCCM-E's performance will be evaluated on the full calendar year's outcomes.

3) Methodology

   a) Setting Final Rate and Annual Improvement Targets. The Agency will identify ten (10) incentive measures. The Agency will calculate baseline rates using CY13-17 data in each Region. The average of the rates over these five (5) years will be used as the baseline for each Region. The Agency will determine a final rate and Annual Improvement Targets for each measure as follows:

i) Final Rate Target: The regional and State baselines will be compared to national benchmarks where they exist, and the Agency will select an appropriate Final Rate Target for the State that reflects an achievable and meaningful level of quality for the measure. For measures where baseline rates cannot be calculated, the Agency will select a Final Rate Target for the State that reflects an achievable and meaningful level of quality for the measure.

ii) Annual Improvement Target: Beginning in CY20, Annual Improvement Targets for each PCCM-E and each measure will be based on a linear improvement in each measure from the regional baseline to the Final Rate Target with each PCCM-E projected to meet or exceed the Final Rate Target by CY24.

b) Calculating the Quality Incentive Score. Each of the ten (10) incentive measures will be worth ten (10) points, for a maximum quality incentive score of one hundred (100) points. As described above, for each measure, the Agency will set a Final Rate Target and an Annual Improvement Target. If the PCCM-E's rate meets the Final Rate Target, the PCCM-E will earn ten (10) points for the measure. If the PCCM-E fails to meet the Final Rate Target, the PCCM-E will still earn ten (10) points for the measure if it achieves the Annual Improvement Target. If the PCCM-E fails to meet either target, it will receive zero (0) points for the measure.

c) Composite Measures. Some of the incentive measures may be composite measures. Composite measures are measures that consist of two (2) or more components (i.e., sub-measures). For example, the Child Access to Care measure is one incentive measure that consists of four (4) components: 1) Child Access to Care 12 -24 months old, 2) Child Access to Care 25 months to 6 years old, 3) Child Access to Care 7 – 11 years, and 4) Child Access to Care 12 – 19 years. The Agency will divide composite measures into equally weighted components. For example, a composite incentive measure with two (2) components will have two (2) rate targets and two (2) Annual Improvement Targets. Each component will be worth five (5) points, and the maximum points for the composite incentive measure will be ten (10) points.

d) The Agency will sum the points from all ten (10) incentive measures to calculate a total Quality Incentive Payment score for the PCCM-E. The Agency will distribute the earned withhold funds as follows:

Table 1: **Quality Incentive Payment Methodology**

Total Quality Incentive Program Score	Percentage of Incentive Earned
Less than 20 points	0%
Between 20 points and 30 points	25%
Between 31 points and 50 points	50%
Between 51 points and less than 80 points	75%
80 or more points	100%

4) Ongoing Monitoring and Performance Improvement Activities. At the end of each FY, the PCCM-E must meet with the Agency to review the quality measures and share best practices. Additionally, the Agency will meet at least quarterly with each PCCM-E to review preliminary data, review measure specifications, plan for data gathering, and share early successes and challenges.

EXHIBIT Q – QUALITY MEASURES

PCCM-E Quality Incentive Program Measures		
CMS Measure Designation		**PCCM-E Measure Description**
1	W15-CH	Well-Child Visits in the First 15 Months of Life
2	ABA-AD	Adult BMI Check
3	WCC-CH	Child BMI
4	CCS-AD	Cervical Cancer Screen
5a	AMR-CH	Asthma Medication Ratio (Child Measure)
5b	AMR-AD	Asthma Medication Ratio (Adult Measure)
6	AMM-AD	Antidepressant Medication Management
7	LBW-AD	Live Births less than 2500
8a	CAP-CH	CAP-CH 12-24 months
8b		CAP-CH 25-mos - 6-years
8c		Child Access to Care 7-years to 11-years
8d		Child Access to Care 12-years to 19-years
9	PPC-CH	Prenatal and Postpartum: Timeliness of Prenatal Care
10	IET-AD	Initiation and Engagement of Treatment for AOD [Initiation]
		Initiation and Engagement of Treatment for AOD [Continuation]

EXHIBIT R – CONTINGENCY AND CONTINUITY REQUIREMENTS

Contingency and Continuity Plan

Continuity Planning. Continuity planning and execution shall encompass all activities, processes and resources necessary for the Contractor to continue to provide mission-critical business functions and processes during a Disaster. Continuity planning shall be coordinated with information system contingency planning to ensure alignment. Continuity planning shall address processes for restoring critical business functions at an existing or alternate location. Continuity activities shall include coordination with the Agency and its designees to ensure continuous eligibility, enrollment and delivery of services.

General Responsibilities. In any readiness assessments or ongoing monitoring required by Subsections II.E and II.F of this Contract, the Vendor/Contractor shall develop and submit contingency and continuity planning documents acceptable to the Agency. In addition, the Vendor/Contractor shall ensure on–going maintenance and execution of the Agency accepted contingency and continuity plans. The Vendor's/Contractor's contingency and continuity planning responsibilities include, but are not limited to:

- Notifying the Agency of any disruptions in normal business operations that affects the access and use of the Vendor's/Contractor's MIS by an EI, Provider, or the Agency for any duration longer than one (1) hour with a plan for resuming normal operations.

- Ensuring users continue to receive services with minimal interruption.

- Ensuring data is safeguarded and accessible in the same manner that complies with federal security guidelines as (described by, laid out in, required by) FISMA, OMB A-130, FIPS 200, and NIST 800-53 and requirements from Agency IT.

- Training Contractor staff and appropriate Subcontractors on the requirements of the information system contingency and continuity plans.

- Developing plans for system problem resolution that do not rise to the level of Disaster. The plans shall include notification of the Agency immediately upon identification of network hardware or software failures and sub–standard performance that affects the access and use of the system for any duration longer than six (6) hours and triage with the Agency to determine the severity level or deficiencies or defects and determine timelines for fixes.

Information Systems Contingency Planning and Execution.

The Vendor shall develop information systems contingency planning in accordance with 45 CFR § 164.308(a)(7). Contingency plans shall include: (i) data backup plans, (ii) Disaster recovery plans, and (iii) emergency mode of operation plans. Application and data criticality

analysis and testing and revisions procedures shall also be addressed within the required contingency plans. The Contactor shall execute all activities needed to recover and restore operation of information systems, data and software at an existing or alternate location under emergency conditions within six (6) hours of the identification or a declaration of a Disaster. The Contractor shall maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back–ups, and Disaster recovery.

Back–Up Requirements.

The Contractor shall maintain full and complete back-up copies of data and software in accordance with the following timelines: weekly back-ups, daily back-ups sufficient to cover eight (8) days, incremental daily back-ups sufficient to cover eight (8) days with the oldest incremental back-up archiving off on the ninth day in the cycle. Back-ups must be adequate and secure for all computer software and operating programs, databases, files, systems, operations and user document (in electronic and non-electronic form). All back-ups must be sufficient to support the immediate restoration and recovery of lost or corrupted data or software. The Contractor shall maintain a back–up log to verify the back–ups were successfully run, and a back–up status report shall be provided to the Agency upon request. The Contractor shall store its back-up data in an off-site location in compliance with Federal Information Security requirements/guidelines and approved by the Agency. Upon the expiration of the Contract term or the termination date, all the Agency related data shall be returned to the Agency. After the Agency's verification of the returned data, the Contractor shall remove/delete and sanitize all Medicaid data from all Vendor storage devices and media in accordance with the National Institute of Standards and Technology (NIST) Special Publication 800-88 Guidelines for Media Sanitization Revision 1 or the most current revision and submit an attestation of those actions to the Agency. The Contractor's obligation to remove/delete and sanitize Medicaid data from all Contractor storage devices and media shall survive the expiration or termination of this Contract. The Contractor may retain data obtained from the Agency only if the Agency determines, in its sole discretion, that the data to be retained by the Contractor is necessary for the Contractor's management and administration or to perform its legal responsibilities. The duration and terms of such retention will be determined by the Agency at the time the Agency approves the Contractor's request to retain data.

Noncompliance with Disaster Recovery Requirements.

The Contractor is responsible for executing all activities needed to recover and restore operation of information systems, data and software at an existing or alternate location under emergency conditions within six (6) hours of identification or a declaration of a Disaster for the recovery time objective (RTO) and six (6) hours for recovery point objective (RPO). Noncompliance with requirements for contingency and continuity planning may result in sanctions. In addition, if the Contractor's failure to restore operations requires the Agency to transfer users to another vendor, to assign operational responsibilities to another vendor or the Agency is required to assume the operational responsibilities, the Agency will require the Contractor to pay any difference between the payments that would have been paid to the

Contractor and the payments and/or other payments being paid to the replacement vendor. In addition, the Contractor shall pay any costs the Agency incurs associated with the Contractor's failure to restore operations following a Disaster, including but not limited to costs to accomplish the transfer of users or reassignment of operational duties.

EXHIBIT S – PCCM-E PAYMENT

The Agency will pay the PCCM-E's based on Care Coordination activity. The Care Coordination activity is grouped into three categories (please see Exhibit N for additional information):

i) General Population;

ii) Maternity; and

iii) Family Planning.

The Care Coordination activity payments for the general population is separated into three levels. The Care Coordination activity payments for the maternity population are separated into five levels. The Care Coordination activity payments for the family planning population are separated into three levels.

In addition to the activity payments, a monthly PMPM payment for the general, Pregnant Women, and Plan First populations will be made to reimburse the PCCM-E for Quality Improvement Projects. This rate of payment varies slightly by Region due to the CMS classification of counties in the Region as being urban or rural.

There will be a one-time Maternity Care Coordination transfer payment, to the PCCM-E, for one hundred dollars ($100.00) to ensure continuity of care for each Pregnant Woman that transfers from an existing Medicaid maternity contractor.

Payment Rates per Region

Note: The number of EIs will vary month to month. The number of EIs shown below were as of July 2018

	Central	East	Jefferson Shelby	NE	NW	SE	SW
All EIs General + Pregnant Women (formerly SOBRA) + Plan First	113,338	117,075	128,225	112,784	110,983	112,896	137,113
QIP Per Member Per Month	$1.12	$1.09	$0.97	$1.05	$1.16	$1.16	$0.98
General Population - EIs	99,374	104,931	115,032	100,760	97,502	99,486	119,341
Intensely Managed	$202.86	$202.86	$202.86	$202.86	$202.86	$202.86	$202.86
Moderately Managed	$101.43	$101.43	$101.43	$101.43	$101.43	$101.43	$101.43
Monitoring	$35.00	$35.00	$35.00	$35.00	$35.00	$35.00	$35.00
Maternity - Deliveries	4,059	4,561	5,273	5,012	4,492	4,413	5,507
Face to Face Eligibility Assistance	$45.06	$45.06	$45.06	$45.06	$45.06	$45.06	$45.06
First Face to Face Encounter	$96.66	$96.66	$96.66	$96.66	$96.66	$96.66	$96.66
Follow-up Face to Face Encounter	$28.26	$28.26	$28.26	$28.26	$28.26	$28.26	$28.26
Inpatient Face to Face Delivery Encounter	$58.60	$58.60	$58.60	$58.60	$58.60	$58.60	$58.60
In Home Face to Face Post Partum Encounter	$83.22	$83.22	$83.22	$83.22	$83.22	$83.22	$83.22
Family Planning - Utilizers	23,825	19,889	22,028	19,127	22,780	22,572	30,019
Intensely Managed	$69.44	$69.44	$69.44	$69.44	$69.44	$69.44	$69.44
Risk Screening only	$34.44	$34.44	$34.44	$34.44	$34.44	$34.44	$34.44
Moderately Managed	$25.69	$25.69	$25.69	$25.69	$25.69	$25.69	$25.69

EXHIBIT T – REGION MAP

Central

East

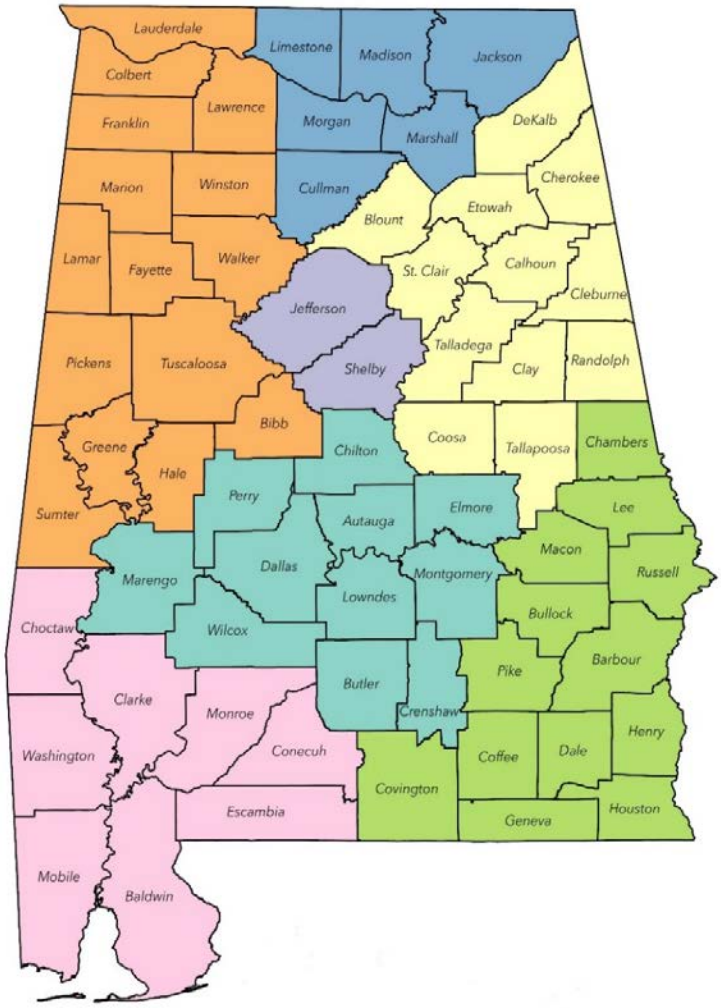
Jefferson / Shelby

Northeast

Northwest

Southeast

Southwest



APPENDIX A: PROPOSAL COMPLIANCE CHECKLIST

NOTICE TO VENDOR:

It is highly encouraged that the following checklist be used to verify completeness of Proposal content. It is not required to submit this checklist with your proposal.

Vendor Name

Project Director Review Date

*Proposals for which **ALL** applicable items are marked by the Project Director are determined to be compliant for responsive proposals.*

☒ **IF CORRECT**	BASIC PROPOSAL REQUIREMENTS
☐	1. Vendor's original proposal received on time at correct location.
☐	2. Vendor submitted the specified copies of proposal and in electronic format.
☐	3. The Proposal includes a completed and signed RFP Cover Sheet.
☐	4. The Proposal is a complete and independent document, with no references to external documents or resources.
☐	5. Vendor submitted signed acknowledgement of any and all addenda to RFP.
☐	6. The Proposal includes written confirmation that the Vendor understands and shall comply with all of the provisions of the RFP.
☐	7. The Proposal includes required client references (with all identifying information in specified format and order).
☐	8. The Proposal includes a corporate background.
☐	9. The Proposal includes a detailed description of the plan to design, implement, monitor, address special situations related to a new PCCM-E as outlined in the request for proposal regarding each element listed in the scope of work.
☐	10. Vendor must submit a statement stating that the Vendor understands and will comply with the terms and conditions as set out in this RFP. Additions or exceptions to the standard terms and conditions are not allowed. Any addition or exception to the terms and conditions are considered severed, null and void, and may result in the Vendor's proposal being deemed non-responsive.

☐	11. The response includes (if applicable) a Certificate of Authority or letter/form showing application has been made with the Secretary of State for a Certificate of Authority.
☐	12. The response must include an E-Verify Memorandum of Understanding with the Department of Homeland Security.

APPENDIX B: SCORED ITEMS AND COMPLIANCE ACKNOWLEDGEMENT

ALABAMA MEDICAID AGENCY
Request for Proposal RFP# 2019-ACHN-01

Instructions: In accordance with Section VII, Vendors must provide a hard and soft copy narrative response to the Section II – Scope of Work (**Scored Items**), listed below. The vendor's response should include:

- HOW do you intend to complete the requirement?
- WHAT problems/issues need to be resolved?
- WHAT assistance will be needed from the Agency?
- WHO will execute the requirement?
- WHAT additional information would you like to submit?

The response to each requirement, listed below, must not exceed two (2) pages. Attached documents, including graphics, flow charts, diagrams, and other descriptive information should only be used to support the information in the narrative response. Attachments not directly referenced in the narrative response, will not be reviewed. Attachments, including graphics, charts, and other supplemental information must not exceed ten (10) pages for the entirety of this document. Pages in excess of the stated page limits (including supplemental pages), will not be reviewed.

Requirements, listed below, may be paraphrased. Refer to RFP document for complete description.

SCOPE OF WORK		
Section Title	Sec #	Requirement (Provide Description for :)
Coordination of Services/ Care	II Scope of Work	Describe how the Vendor will provide seamless coordination between General Care Coordination, Family Planning Care Coordination, and Maternity Care Coordination to better achieve quality outcomes. Include organizational structure, flow charts, policy on staff cross-training staff (if applicable), and oversight procedures to ensure quality outcomes and seamless coordination.
Solutions to Regional Barriers	II Scope of Work	Describe how the Vendor will overcome regional barriers to healthcare, such as transportation and other access to care issues. In addition to the minimum requirements of this RFP what types of programs, how many programs, how many

		individuals will be affected, and what is the expected financial impact of those programs to address these issues will be an important component of your response.”
PCCM-E Organizational Requirements	II.C.1.-4.	Describe the Vendor organizational background and experience. (Date established, ownership, Governing Board composition, CAC composition.)
Key Staff	II.H.	Submit an organizational chart, staffing plan with staffing experience requirements for key staff, and resumes for existing key staff.
Care Coordination Staff	II.I.1.d. – g.	Submit an organization chart and staffing plan for Care Coordination staff.
Relationship with Community Agencies	II.I.1.h.	Describe the Vendor’s plan to develop and maintain relationships with community agencies.
Process for selecting a PCP.	II.I.1.i.	Describe the Vendor’s plan to assist EI’s select a PCP.
NET Care Coordination	II.I.2.	Describe the process for assisting EIs with NET.
General Care Coordination – Stratification of EIs	II.I.3.c.-e.	Describe the screening and stratification of EIs for General Care Coordination.
Assessment and Care Planning	II.I.3.g.-j.	Describe the assessment, reassessment and Care Planning process for EIs for General Care Coordination.
Children with Medical Complexity (CMC)	II.I.3.k.	Describe the process to coordinate care for children with medical complexities.
Multidisciplinary Care Team (MCT)	II.I.3.l.	Describe the role and process of the MCT for EIs receiving Care Coordination services.
Behavioral Health Program	II.I.3.m.	Describe the Vendor’s plan to develop, implement, and maintain a Behavioral Health Program
Transitional Care Team	II.I.3.n.iii.	Describe the development of the Transitional Care Team and how it will be utilized in the Transitional Care Program.
Transitional Care Process	II.I.3.n.iv.	Describe the Vendor’s Transitional Care process to assist EIs from their transition from a facility to a community setting.

Monitoring – Medical Review	II.I.3.o.	Describe the Vendor's process for completing Medical Reviews.
Collaboration with DHCPs	II.I.4.a.–e.	Describe the Vendor's plan to collaborate with DHCPs to provide Care Coordination services to pregnant women.
Maternity Care Coordination Processes	II.I.4.f.	Describe the Vendor's process for providing Maternity Care Coordination services to pregnant women as described in II.I.4.f.
Maternity Risk Stratification and Assessment	II.I.4.g.-k. Exhibit H Exhibit I	Describe the stratification, psychosocial assessment process and Care Planning for pregnant EIs.
Application assisters	II.I.4.l.-p.	Describe how the Vendor will assist Pregnant Women complete Medicaid applications through application assisters.
Care Coordination for newborns delivered with no prenatal care	II.I.4.q.	Describe the plan to provide Care Coordination for newborns delivered without prenatal care.
Selection of DHCP	II.I.4.r.-v.	Describe the process for selection or changes in DHCP.
Maternity Care Provider Referral Process	II.I.5.	Describe the Vendor's process for Maternity Care Provider referrals.
Family Planning Screening, Assessment, and Stratification	II.I.6. Exhibit J Exhibit K	Describe the process to screen, assess, stratify, and provide services to EIs eligible for family planning Care Coordination services.
Pharmacy Program - Medication List	II.I.7.d.-g.	Describe the Vendor's plan to complete Medication lists for EIs receiving Care Coordination services.
Medication Reconciliation	II.I.7.h.	Describe the process for medication reconciliations for EIs receiving Care Coordination services.
Transitional Plan – General Care Coordination	II.I.8.a.	Provide the Vendor's plan to ensure continuity of care for EIs in the General Care Coordination population transitioning to their care during the implementation of the program.
Transitional Plan – Maternity Care Coordination	II.I.8.b.	Provide the Vendor's plan to transition pregnant EIs into the program during implementation to ensure continuity of care.

Transition of EIs between PCCM-Es	II.I.9.	Describe the process for EIs moving into the PCCM-E Region needing services and transitioning to another PCCM-Es Region.
Quality Improvement Program	II.I.12.a.i.-iv.	Provide the plan to implement and monitor a Quality Improvement Program and Population Health Management practices as specified in i.-v.
Quality Improvement Plan	II.I.12.g.	Describe the development, implementation, monitoring, and reporting of the Vendor's Quality Improvement Plan.
Quality Improvement Projects	II.I.12.j.	Describe the process of development and implementation of Quality Improvement Projects.
Region Medical Management Committee	II.I.12.l.	Describe the Vendor's development and implementation of the Region Medical Management Committee including a description of the quarterly meetings.
Health Information Management System (HIMS)	II.U.	Describe the Vendor's HIMS including the functional and technical requirements.
Services Telephone Line	II.V.	Describe the plan to implement, maintain and monitor performance standards of a telephone line for PCPs and EIs.
Information Requirements	II.W.	Describe the Vendor's plan to develop and provide access information regarding the program to EIs and PCPs.
Outreach and Education	II.Y.	Describe the Education and Outreach Plan for EIs, PCPs, and DHCPs.
PCCM-E Website	II.AA.	Describe the Vendor's plan to develop and maintain an EI Portal to meet the contractual requirements.
ACHN Staff	Exhibit F	In addition to the required staff as stated in Exhibit F, will the Vendor contract with or hire other staff to enhance Care Coordination to recipients? If so, describe positions, including number of staff, qualifications, and functions.
Family Planning Care Coordination Services	Exhibit K	Describe the Vendor's contact schedule for providing family planning Care Coordination services.

Contingency and Continuity Plan	Exhibit R	Describe the Vendor's Contingency and Continuity Plan during a disaster.

APPENDIX C: MANDATORY VENDOR CONFERENCE NOTIFICATION

INTENT TO ATTEND MANDATORY VENDOR CONFERENCE NOTIFICATION

This form acknowledges that _____(company name) intends to attend the Mandatory Vendor Conference for the ACHN RFP. This conference is **mandatory** for all Vendors that will be submitting a response to the RFP. This sheet must be received by 5:00 p.m. CT on 1/17/2019.

NOTE:

Vendors who require clarification and/or interpretation of any sections of the RFP are allowed to ask verbal question that must also be submit in writing during the mandatory conference.

VENDOR NAME

REPRESENTATIVE'S NAME (List all attending. The Agency must be notified in advance of changes in representation).

COMPANY ADDRESS

Phone:

Fax:

Email:

Date:

APPENDIX D: KEY PERSONNEL RESUME SHEET

This form must be used to respond to key positions. For each named individual a separate Key Personnel Resume Sheet must be submitted.

Vendor Organization: _____

Key Position: _____

Candidate:

Full Name: [Last Name] [First Name] [MI]

Address
Street: City: State: Zip:

U.S. Citizen Non-U.S. Citizen Visa Status (please circle appropriate answer):

Status: Employee Self Employed Subcontractor (Name: _____)

Other:

Education:

Mark highest level completed.	Some HS	HS/GED	Associate	Bachelor	Master	Doctoral

List most recent first, all secondary and post-secondary education (high school, GED, colleges, and universities) attended. Do not include copies of transcripts unless requested. Add additional rows if necessary

School Name	Degree/Major	Degree Earned	Year Received

Work Experience:

Describe your work experience related specifically to the Request for Proposal to which you are responding. Please list most recent job first. To add work experience, copy the format below and add additional sheets as needed.

Work Experience #:			
Job Title:			
From	To	Reason for Leaving:	Hours per week
Describe your duties and responsibilities as they relate to the Request for Proposal:			

Professional References:

List 3 Professional References below.

Reference 1		
Name	Title	Organization
Address	Phone ( ) -	E-mail Address

Reference 2		
Name	Title	Organization
Address	Phone ( ) -	E-mail Address

Reference 3		
Name	Title	Organization
Address	Phone ( ) -	E-mail Address

Candidate and Vendor Certification

By submitting this data sheet to Alabama Medicaid Agency, the Candidate and Vendor certify that, to the best of their knowledge and belief, all of the information on and attached to this data sheet is true, correct, complete, and made in good faith. The candidate further authorizes the release of all relevant prior employment, military service, academic/school, and criminal records. False or fraudulent information on or attached to this data sheet may be grounds for disqualifying a candidate or firing a candidate once work has begun. Any information provided to Alabama Medicaid Agency may be investigated.

By submitting this data sheet to Alabama Medicaid Agency, the Candidate and Vendor certify that both parties understand the entire scope of requirements for this position as defined in the RFP and the Candidate agrees to be submitted for consideration exclusively by this Vendor. Any candidate that is submitted by more than one Vendor for a line item will be considered disqualified.

Candidate Data Sheets must be signed below by the Vendor.

_____ _____

Authorized Vendor Signature Date

Sample Key Personnel Resume Sheet

Vendor Organization: Auburn University Montgomery

Key Position: Key Staff – Executive Director

Candidate:

Full Name: Jackson, Hewlett M

Address Street: 6760 Happy Lane Circle City: Oklahoma State: OK Zip: 54671

U.S. Citizen Non-U.S. Citizen Visa Status:

Status: Employee Self Employed Subcontractor (Name: __) Other:

Education:

Mark highest level completed.	Some HS	HS/GED	Associate	Bachelor	Master	Doctoral

List most recent first, all secondary and post-secondary education (high school, GED, colleges, and universities) attended. Do not include copies of transcripts unless requested. Add additional rows if necessary

School Name	Degree/Major	Degree Earned	Year Received
Harvard University	Master Business Administration		2001
Yale University	Bachelor of Science in Information Technology		2000
Princeton University	Associate in Data Processing Technology		1997

Work Experience:

Describe your work experience related specifically to the Request for Proposal to which you are responding. Please list most recent job first. To add work experience, copy the format below and add additional sheets as needed.

Work Experience #:			
Job Title: Sr. SQL Administrator			
From 02/2001	To Present	Reason for Leaving:	Hours per week 40
Describe your duties and responsibilities as they relate to the Request for Proposal. Maintain and develop employee database, supply database, clientele databases, and administer programming for these databases, Keep all records up to date in hard copies and soft on a network. Keep general knowledge of network in order to coordinate employee computers. Keep clientele in a secure intranet database.			

Work Experience #:			
Job Title: Software Application Engineer			
From 03/1995	To 01/2001	Reason for Leaving: New Job Opportunity	Hours per week 40
Describe your duties and responsibilities as they relate to the Request for Proposal. Designs, develops, debugs, modifies, and tests software programs by using current programming languages, methodologies and technologies. Documents software development and/or test development by writing documents, reports, memos, change requests. Methods used are determined by approved procedures and standards Tracks software development effort by creating and maintaining records in the approved tracking management tool. Analyzes, evaluates, and verifies requirements, software and systems by using software engineering practices.			

Professional References:

List 3 Professional References below.

Reference 1		
Name Bob Thorton	Title CEO	Organization Bob Thornton Enterprise
Address 3245 Grey Hat Drive	Phone (123) 456 - 7589	E-mail Address bob@greyhat.com

Reference 2		
Name Henry Ford	Title CEO	Organization Humpfrey Corp.
Address 234 Humpfrey St.	Phone (123) 456 - 7589	E-mail Address hford@humpfrey.com

Reference 3		
Name Jeffrey Daniels	Title Software Director	Organization Red Brick Software Services
Address 987 Daniels Dr.	Phone (123) 456 - 7589	E-mail Address j@daniels.com

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Candidate and Vendor Certification

By submitting this data sheet to Alabama Medicaid Agency, the Candidate and Vendor certify that, to the best of their knowledge and belief, all of the information on and attached to this data sheet is true, correct, complete, and made in good faith. The candidate further authorizes the release of all relevant prior employment, military service, academic/school, and criminal records. False or fraudulent information on or attached to this data sheet may be grounds for disqualifying a candidate or firing a candidate once work has begun. Any information provided to Alabama Medicaid Agency may be investigated.

By submitting this data sheet to Alabama Medicaid Agency, the Candidate and Vendor certify that both parties understand the entire scope of requirements for this position as defined in the RFP and the Candidate agrees to be submitted for consideration exclusively by this Vendor.

Any candidate that is submitted by more than one Vendor for a line item will be considered disqualified.

Candidate Data Sheets must be signed below by the Vendor.

*[SIGNATURE]*_____ _____

Authorized Vendor Signature Date

CONTRACT

APPENDIX E: CONTRACT AND ATTACHMENTS

The following are the documents that must be signed AFTER Contract award and prior to the meeting of the Legislative Contract Oversight Committee Meeting.

Sample Contract

Attachment A:	Business Associate Addendum
Attachment B:	Contract Review Report for Submission to Oversight Committee
Attachment C:	Immigration Status
Attachment D:	Disclosure Statement
Attachment E:	Letter Regarding Reporting to Ethics Commission
Attachment F:	Instructions for Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion
Attachment G:	Beason-Hammon Certificate of Compliance

SAMPLE CONTRACT

BETWEEN
THE ALABAMA MEDICAID AGENCY
AND

KNOW ALL MEN BY THESE PRESENTS, that the Alabama Medicaid Agency, an Agency of the State of Alabama, and _____, Contractor, agree as follows:

Contractor shall furnish all labor, equipment, and materials and perform all of the work required under the Request for Proposal (RFP Number _____, dated _____, strictly in accordance with the requirements thereof and Contractor's response thereto.

Contractor shall be compensated for performance under this contract in accordance with the provisions of the RFP and the price provided on the RFP Cover Sheet response, in an amount not to exceed _____.

Contractor and the Alabama Medicaid Agency agree that the initial term of the contract is ____to _____.

This contract specifically incorporates by reference the RFP, any attachments and amendments thereto, and Contractor's response.

CONTRACTOR

_____
Contractor's name here

_____
Date signed

_____
Printed Name

Tax ID:_____

APPROVED:

_____
Governor, State of Alabama

ALABAMA MEDICAID AGENCY
This contract has been reviewed for and is approved as to content.

_____
Stephanie McGee Azar
Commissioner

_____
Date signed

This contract has been reviewed for legal form and complies with all applicable laws, rules, and regulations of the State of Alabama governing these matters.

_____
General Counsel

ALABAMA MEDICAID AGENCY
BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum (this "Agreement") is made effective the _____ day of _____, 20____, by and between the Alabama Medicaid Agency ("Covered Entity"), an agency of the State of Alabama, and _____ ("Business Associate") (collectively the "Parties").

1. BACKGROUND

1.1. Covered Entity and Business Associate are parties to a contract entitled _____

_____

(the "Contract"), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

1.2. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Rules (as defined below).

1.3. The Parties enter into this Business Associate Addendum with the intention of complying with the HIPAA Rules allowing a covered entity to disclose protected health information to a business associate, and allowing a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. DEFINITIONS

2.1 General Definitions

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Electronic Protected Health Information, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

2.2 Specific Definitions

2.2.1 Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 C.F.R. § 160.103

2.2.2 Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 C.F.R. § 160.103.

2.2.3 HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Part 160 and Part 164.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

Business Associate agrees to the following:

3.1 Use or disclose PHI only as permitted or required by this Agreement or as Required by Law.

3.2 Use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement. Further, Business Associate will implement administrative, physical and technical safeguards (including written policies and procedures) that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity as required by Subpart C of 45 C.F.R. Part 164.

3.3 Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

3.4 Report to Covered Entity within five (5) business days any use or disclosure of PHI not provided for by this Agreement of which it becomes aware.

3.5 Ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information in accordance with 45 C.F.R. § 164.502(e)(1)(ii) and § 164.308(b)(2), if applicable.

3.6 Provide Covered Entity with access to PHI within thirty (30) business days of a written request from Covered Entity, in order to allow Covered Entity to meet its requirements under 45 C.F.R. § 164.524, access to PHI maintained by Business Associate in a Designated Record Set.

3.7 Make amendment(s) to PHI maintained by Business Associate in a Designated Record Set that Covered Entity directs or agrees to, pursuant to 45 C.F.R. § 164.526 at the written request of Covered Entity, within thirty (30) calendar days after receiving the request.

3.8 Make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, Covered Entity, available to Covered Entity or to the Secretary within five (5) business days after receipt of written notice or as designated by the Secretary for purposes of determining compliance with the HIPAA Rules.

3.9 Maintain and make available the information required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI as necessary to satisfy the Covered Entity's obligations under 45 C.F.R. § 164.528.

3.10 Provide to the Covered Entity, within thirty (30) days of receipt of a written request from Covered Entity, the information required for Covered Entity to respond to a request by an Individual or an authorized representative for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

3.11 Maintain a comprehensive security program appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities as defined in the Security Rule.

3.12 Notify the Covered Entity within five (5) business days following the discovery of a breach of unsecured PHI on the part of the Contractor or any of its sub-contractors, and

3.12.1 Provide the Covered Entity the following information:

3.12.1(a) The number of recipient records involved in the breach.
3.12.1(b) A description of what happened, including the date of the breach and the date of the discovery of the breach if known.
3.12.1(c) A description of the types of unsecure protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other type information were involved).
3.12.1(d) Any steps the individuals should take to protect themselves from potential harm resulting from the breach.
3.12.1(e) A description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches.
3.12.1(f) Contact procedures for individuals to ask questions or learn additional information, which shall include the Business Associate's toll-free number, email address, Web site, or postal address.
3.12.1(g) A proposed media release developed by the Business Associate.

3.12.2 Work with Covered Entity to ensure the necessary notices are provided to the recipient, prominent media outlet, or to report the breach to the Secretary of Health and Human Services (HHS) as required by 45 C.F.R. Part 164, Subpart D.;

3.12.3 Pay the costs of the notification for breaches that occur as a result of any act or failure to act on the part of any employee, officer, or agent of the Business Associate;

3.12.4 Pay all fines or penalties imposed by HHS under 45 C.F.R. Part 160, "HIPAA Administrative Simplification: Enforcement Rule" for breaches that occur as a result of any act or failure to act on the part of any employee, officer, or agent of the Business Associate.

3.12.5 Co-ordinate with the Covered Entity in determining additional specific actions that will be required of the Business Associate for mitigation of the breach.

4. PERMITTED USES AND DISCLOSURES

Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may

4.1. Use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure would not violate the Subpart E of 45 C.F.R. Part 164 if done by Covered Entity;

4.2. Use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

4.3. Disclose PHI for the proper management and administration of the Business Associate, provided that:

4.3.1 Disclosures are Required By Law; or

4.3.2 Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

4.4 Use PHI to provide data aggregation services to Covered Entity as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

5. REPORTING IMPROPER USE OR DISCLOSURE

The Business Associate shall report to the Covered Entity within five (5) business days from the date the Business Associate becomes aware of:

5.1 Any use or disclosure of PHI not provided for by this agreement

5.2 Any Security Incident and/or breach of unsecured PHI

6. OBLIGATIONS OF COVERED ENTITY

The Covered Entity agrees to the following:

6.1 Notify the Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect Alabama Medicaid's use or disclosure of PHI.

6.2 Notify the Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect the Business Associate's use or disclosure of PHI.

6.3 Notify the Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

6.4 Not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

6.5 Provide Business Associate with only that PHI which is minimally necessary for Business Associate to provide the services to which this agreement pertains.

7. TERM AND TERMINATION

7.1 Term. The Term of this Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.

7.2 Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:

7.2.1 Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

7.2.2 Immediately terminate this Agreement; or

7.2.3 If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

7.3 Effect of Termination.

7.3.1 Except as provided in paragraph (2) of this section or in the Contract, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

7.3.2 In the event that Business Associate determines that the PHI is needed for its own management and administration or to carry out legal responsibilities, and returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall:

7.3.2(a) Retain only that PHI which is necessary for business associate to continue its proper management and administration or to carry out its legal responsibilities;

7.3.2(b) Return to covered entity or, if agreed to by covered entity, destroy the remaining PHI that the business associate still maintains in any form;

7.3.2(c) Continue to use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as business associate retains the PHI;

7.3.2(d) Not use or disclose the PHI retained by business associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Section 4, "Permitted Uses and Disclosures" which applied prior to termination; and

7.3.2(e) Return to covered entity or, if agreed to by covered entity, destroy the PHI retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

7.4 Survival

The obligations of business associate under this Section shall survive the termination of this Agreement.

8. GENERAL TERMS AND CONDITIONS

8.1 This Agreement amends and is part of the Contract.

8.2 Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.

8.3 In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the HIPAA Rules shall prevail. Any ambiguity

in this Agreement shall be resolved to permit Covered Entity to comply with the HIPAA Rules.

8.4 A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

8.5 The Parties agree to take such action as is necessary to amend this Agreement from time to time for Covered Entity to comply with the requirements of the HIPAA Rules.

IN WITNESS WHEREOF, Covered Entity and Business Associate have executed this Agreement effective on the date as stated above.

ALABAMA MEDICAID AGENCY

Signature: _____

Printed Name: Clay Gaddis

Title: Privacy Officer

Date: _____

BUSINESS ASSOCIATE

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Contract Review Permanent Legislative Oversight Committee
Alabama State House -- Montgomery, Alabama 36130

CONTRACT REVIEW REPORT

(Separate review report required for each contract)

Name of State Agency: Alabama Medicaid Agency

Name of Contractor: _____

_____
Contractor's Physical Street Address (No. P.O. Box) City State

Is Contractor a Sole Source? YES_____NO_____
Is Contractor organized as an Alabama Entity in Alabama? YES_____NO_____
Is Contractor a minority and/or woman-owned business? YES_____NO_____
If so, is Contractor certified as such by the State of Alabama? YES_____NO_____
Check all that apply: ALDOT _____ ADECA_____ OTHER (Name)_____
Is Contractor Registered with Alabama Secretary of State to do Business as a Corporation in Alabama? YES_____ NO_____
IF LLC, GIVE NAMES OF MEMBERS:
_____
Is Act 2001-955 Disclosure Form Included with this Contract? YES __X__ NO _____
Does Contractor have current member of Legislature or family member of Legislator employed? YES_____NO_____
Was a Lobbyist/Consultant used to secure this contract OR affiliated with this Contractor? YES_____ NO_____
IF YES, GIVE NAME: _____

Contract Number: C _____ (See Fiscal Policies & Procedures Manual, Page 5-8)

Contract/Amendment Amount: $ _____ **(PUT AMOUNT YOU ARE ASKING FOR TODAY ONLY)**

% State Funds: _____ % Federal Funds: _____ % Other Funds: _____ **

**Please Specify Source of Other Funds (Fees, Grants, etc.) _____

Date Contract Effective: _____ Date Contract Ends: _____

Type of Contract: NEW: _____ RENEWAL: _____ AMENDMENT: _____

If Renewal, was it originally Bid? YES _____ NO _____

If AMENDMENT, Complete A through C:

(A) **ORIGINAL contract amount** $ _____

(B) Amended total prior to this amendment $ _____

(C) Amended total after this amendment $ _____

Was Contract secured through Bid Process? YES ____ NO ____ Was lowest Bid accepted? YES ___ NO____
Was Contract secured through RFP Process? YES ____ NO ___ Date RFP was awarded: _____
Posted to Statewide RFP Database at http://rfp.alabama.gov/Login.aspx? YES _____ NO_____
If NO, give a brief explanation as to why not:_____

Summary of Contract Services to be Provided: _____

_____

_____

Why Contract Necessary AND why this service cannot be performed by merit employee: _____

_____

_____

I certify that the above information is correct.

_____ _____
Signature of Agency Head Signature of Contractor

_____ _____
Printed Name of Agency Head Printed Name of Contractor

Agency Contact: Stephanie Lindsay Phone: (334) 242-5833
Revised: 8/2/17

IMMIGRATION STATUS

I hereby attest that all workers on this project are either citizens of the United States or are in a proper and legal immigration status that authorizes them to be employed for pay within the United States.

_____
Signature of Contractor

_____
Witness

State of Alabama
Disclosure Statement

Required by Article 3B of Title 41, Code of Alabama 1975

ENTITY COMPLETING FORM

ADDRESS

CITY, STATE, ZIP TELEPHONE NUMBER ( )

STATE AGENCY/DEPARTMENT THAT WILL RECEIVE GOODS, SERVICES, OR IS RESPONSIBLE FOR GRANT AWARD

Alabama Medicaid Agency

ADDRESS

501 Dexter Avenue, Post Office Box 5624

CITY, STATE, ZIP TELEPHONE NUMBER

Montgomery, Alabama 36103-5624 (334) 242-5833

This form is provided with:

☐ Contract ☐ Proposal ☐ Request for Proposal ☐ Invitation to Bid ☐ Grant Proposal

Have you or any of your partners, divisions, or any related business units previously performed work or provided goods to any State Agency/Department in the current or last fiscal year?

☐ Yes ☐ No

If yes, identify below the State Agency/Department that received the goods or services, the type(s) of goods or services previously provided, and the amount received for the provision of such goods or services.

STATE AGENCY/DEPARTMENT	TYPE OF GOODS/SERVICES	AMOUNT RECEIVED

Have you or any of your partners, divisions, or any related business units previously applied and received any grants from any State Agency/Department in the current or last fiscal year?

☐ Yes ☐ No

If yes, identify the State Agency/Department that awarded the grant, the date such grant was awarded, and the amount of the grant.

STATE AGENCY/DEPARTMENT OF GRANT	DATE GRANT AWARDED	AMOUNT

1. List below the name(s) and address(es) of all public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF PUBLIC OFFICIAL/EMPLOYEE	ADDRESS	STATE DEPARTMENT/AGENCY

_____

_____

_____

2. List below the name(s) and address(es) of all family members of public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the public officials/public employees and State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF FAMILY MEMBER	ADDRESS	NAME OF PUBLIC OFFICIAL/ PUBLIC EMPLOYEE	STATE DEPARTMENT/ AGENCY WHERE EMPLOYED

If you identified individuals in items one and/or two above, describe in detail below the direct financial benefit to be gained by the public officials, public employees, and/or their family members as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

_____

_____

_____

Describe in detail below any indirect financial benefits to be gained by any public official, public employee, and/or family members of the public official or public employee as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

_____

_____

List below the name(s) and address(es) of all paid consultants and/or lobbyists utilized to obtain the contract, proposal, request for proposal, invitation to bid, or grant proposal:

NAME OF PAID CONSULTANT/LOBBYIST	ADDRESS

By signing below, I certify under oath and penalty of perjury that all statements on or attached to this form are true and correct to the best of my knowledge. I further understand that a civil penalty of ten percent (10%) of the amount of the transaction, not to exceed $10,000.00, is applied for knowingly providing incorrect or misleading information.

_____

Signature Date

_____

Notary's Signature Date Date Notary Expires

Article 3B of Title 41, Code of Alabama 1975 requires the disclosure statement to be completed and filed with all proposals, bids, contracts, or grant proposals to the State of Alabama in excess of $5,000.

Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624
www.medicaid.alabama.gov
e-mail: almedicaid@medicaid.alabama.gov

KAY IVEY
Governor

Telecommunication for the Deaf: 1-800-253-0799
334-242-5000 1-800-362-1504

STEPHANIE MCGEE AZAR
Commissioner

MEMORANDUM

SUBJECT: Reporting to Ethics Commission by Persons Related to Agency Employees

Section 36-25-16(b) Code of Alabama (1975) provides that anyone who enters into a contract with a state agency for the sale of goods or services exceeding $7500 shall report to the State Ethics Commission the names of any adult child, parent, spouse, brother or sister employed by the agency.

Please review your situation for applicability of this statute. The address of the Alabama Ethics Commission is:

100 North Union Street
RSA Union Bldg.
Montgomery, Alabama 36104

A copy of the statute is reproduced below for your information. If you have any questions, please feel free to contact the Agency Office of General Counsel, at 242-5741.

Section 36-25-16. Reports by persons who are related to public officials or public employees and who represent persons before regulatory body or contract with state.

(a) When any citizen of the state or business with which he or she is associated represents for a fee any person before a regulatory body of the executive branch, he or she shall report to the commission the name of any adult child, parent, spouse, brother, or sister who is a public official or a public employee of that regulatory body of the executive branch.
(b) When any citizen of the State or business with which the person is associated enters into a contract for the sale of goods or services to the State of Alabama or any of its agencies or any county or municipality and any of their respective agencies in amounts exceeding seven thousand five hundred dollars ($7500) he or she shall report to the commission the names of any adult child, parent, spouse, brother, or sister who is a public official or public employee of the agency or department with whom the contract is made.
(c) This section shall not apply to any contract for the sale of goods or services awarded through a process of public notice and competitive bidding.
(d) Each regulatory body of the executive branch, or any agency of the State of Alabama shall be responsible for notifying citizens affected by this chapter of the requirements of this section. (Acts 1973, No. 1056, p. 1699, §15; Acts 1975, No. 130, §1; Acts 1995, No. 95-194, p. 269, §1.)

Instructions for Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion

(Derived from Appendix B to 45 CFR Part 76--Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transactions)

1. By signing and submitting this contract, the prospective lower tier participant is providing the certification set out therein.

2. The certification in this clause is a material representation of fact upon which reliance was placed when this contract was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the Alabama Medicaid Agency (the Agency) may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant shall provide immediate written notice to the Agency if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, and voluntarily excluded, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this contract is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this contract that, should the contract be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this contract that it will include this certification clause without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the Agency may pursue available remedies, including suspension and/or debarment.

State of _____)

County of _____)

CERTIFICATE OF COMPLIANCE WITH THE BEASON-HAMMON ALABAMA TAXPAYER AND CITIZEN PROTECTION ACT (ACT 2011-535, as amended by Act 2012-491)

DATE:_____

RE Contract/Grant/Incentive (*describe by number or subject):* _____ by and between _____ (Contractor/Grantee) and Alabama Medicaid Agency (State Agency or Department or other Public Entity)

The undersigned hereby certifies to the State of Alabama as follows:

1. The undersigned holds the position of _____with the Contractor/Grantee named above, and is authorized to provide representations set out in this Certificate as the official and binding act of that entity, and has knowledge of the provisions of THE BEASON-HAMMON ALABAMA TAXPAYER AND CITIZEN PROTECTION ACT (ACT 2011-535 of the Alabama Legislature, as amended by Act 2012-491) which is described herein as "the Act".

2. Using the following definitions from Section 3 of the Act, select and initial either (a) or (b), below, to describe the Contractor/Grantee's business structure.
   BUSINESS ENTITY. Any person or group of persons employing one or more persons performing or engaging in any activity, enterprise, profession, or occupation for gain, benefit, advantage, or livelihood, whether for profit or not for profit. "Business entity" shall include, but not be limited to the following:
   a. Self-employed individuals, business entities filing articles of incorporation, partnerships, limited partnerships, limited liability companies, foreign corporations, foreign limited partnerships, foreign limited liability companies authorized to transact business in this state, business trusts, and any business entity that registers with the Secretary of State.
   b. Any business entity that possesses a business license, permit, certificate, approval, registration, charter, or similar form of authorization issued by the state, any business entity that is exempt by law from obtaining such a business license, and any business entity that is operating unlawfully without a business license.

   EMPLOYER. Any person, firm, corporation, partnership, joint stock association, agent, manager, representative, foreman, or other person having control or custody of any employment, place of employment, or of any employee, including any person or entity employing any person for hire within the State of Alabama, including a public employer. This term shall not include the occupant of a household contracting with another person to perform casual domestic labor within the household.

   _____*(a)*The Contractor/Grantee is a business entity or employer as those terms are defined in Section 3 of the Act.

   _____*(b)*The Contractor/Grantee is not a business entity or employer as those terms are defined in Section 3 of the Act.

3. As of the date of this Certificate, Contractor/Grantee does not knowingly employ an unauthorized alien within the State of Alabama and hereafter it will not knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama;

4. Contractor/Grantee is enrolled in E-Verify unless it is not eligible to enroll because of the rules of that program or other factors beyond its control.

Certified this _____ day of _____ 20____. _____

Name of Contractor/Grantee/Recipient

By: _____

Its _____

The above Certification was signed in my presence by the person whose name appears above, on this _____ day of _____ 20_____.

WITNESS: _____

_____

Print Name of Witness