Amendment 2 to RFP 2023-ACHN-01

01/30/2024

NOTE THE FOLLOWING AND ATTACHED ADDITIONS, DELETIONS, AND/OR CHANGES TO THE REQUIREMENTS FOR THE REQUEST FOR PROPOSAL NUMBER 2023-ACHN-01. THIS AMENDMENT MUST BE INCLUDED IN THE VENDOR'S RESPONSE AND MEET THE REQUIREMENTS AS DEFINED IN THE RFP.

THE VENDOR MUST SIGN AND RETURN THIS AMENDMENT WITH THEIR PROPOSAL.

1. **Amendment 1, Item 1, Changed as follows:**

Currently Reads as:

EVENT	DATE
RFP Issued	12/27/2023
Round 1 Questions Due by 5pm CT	01/08/2024
Posting of Round 1 Questions and Answers	01/26/2024
Round 2 Questions Due by 5pm CT	02/06/2024
Posting of Round 2 Questions and Answers	02/22/2024
Proposals Due by 5 pm CT	03/04/2024
Evaluation Period	03/05/2024-04/09/2024
Intent to Award Notification	04/19/2024
Selected Contractor Readiness Review	06/06/2024-09/20/2024
**Contract Review Committee	09/07/2024
Official Contract Award/Begin Work	10/01/2024

Revised as:

EVENT	DATE
RFP Issued	12/29/2023
Round 1 Questions Due by 5pm CT	01/10/2024
Posting of Round 1 Questions and Answers	01/30/2024
Round 2 Questions Due by 5pm CT	02/07/2024
Posting of Round 2 Questions and Answers	02/22/2024
Proposals Due by 5 pm CT	03/04/2024
Evaluation Period	03/05/2024-04/09/2024

Intent to Award Notification	04/19/2024
Selected Contractor Readiness Review	06/06/2024-09/20/2024
**Contract Review Committee	09/05/2024
Official Contract Award/Begin Work	10/01/2024

2. **Appendix K, Key Staff and other Position Requirements, Pages 120-124, Changed as follows:**

Currently Reads as:

Appendix K: Key Staff and other Positions Requirements

Executive Director

Requirements

- Full-time;
- Possess excellent organizational and administrative skills; and
- Must maintain a full-time office in the PCCM-e Region.

Education/Experience

- Possess a B.S. degree in Business Administration, Finance, Accounting or related field from an accredited college or university (preferred);
- Have a minimum of three years management experience in managed healthcare (to include population health management) and experience working with low-income populations; or
- In lieu of a bachelor's degree, the individual may have 10 years management experience in managed healthcare.

Primary responsibilities include, but are not limited to:

- Authority to make all day-to-day program decisions including hiring, firing, and financial decisions 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.
- Leads and maintains a team of qualified staff to ensure quality of services are provided in accordance with state and federal requirements and regulations; Agency and program goals and objectives are met; and desired health outcomes are achieved; and
- Serves as primary administrative liaison between the PCCM-e and the Agency.

Medical Director

Requirements

- Be a practicing 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.
- Part-time.

Education/Experience

- Be a licensed physician in the State of Alabama (required); and
- Have three (3) years of experience with low-income populations.

Primary responsibilities include, but are not limited to:

- Maintain contact with local providers.
- Represent the PCCM-e in person at select meetings as required by the Agency and/or the PCCM-e.
- Address local issues at the community level.
- Lead quarterly Medical Management Meetings in the Region; and
- Approve the Quality Initiatives and Quality Improvement Plan of PCCM-e.

Pharmacy Director

Requirements

- Possess excellent organizational and administrative skills;
- Full time;
- Current Alabama pharmacy license in good standing; and
- Work within the Region; live within the Region (preferred).

Education/Experience

- Holds at a minimum a B.S. degree in Pharmacy; and
- Must have a minimum of five years of pharmacist experience within the past six years; supervisory experience (preferred).

Primary responsibilities include

- 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.
- May serve simultaneously as either the Transitional Pharmacist or Community Pharmacist but must meet the educational/professional criteria for both positions held.
- Serve as the primary point of contact with the Agency for all meetings and coordination in all pharmacy related matters.
- Develop, coordinate, implement, and manage education of community, inpatient, transitional, and all pharmacists and PCPs within the PCCM-e and Agency pharmacy initiatives.
- Develop, coordinate, engage within, and manage staff to implement programs that advance the Medical Home.
- Work with the PCCM-e's management team to determine ways to support pharmacists and prescribers with management of drug costs and policies.
- Create and manage programs that address new policies as the Agency implements them.
- Attend and present at various local PCCM-e and Agency meetings as requested, such as Steering Committee meetings, Medical Management meetings, Alabama Medicaid

Pharmacy and Therapeutics (P&T) and Drug Utilization Review (DUR) meetings, and PCCM-e Director's Meetings.
- Serve as a resource to PCPs and care managers on general drug information and Agency pharmacy policy issues.
- 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.
- Educate, train or coordinate the education and training of staff on processes to be developed, such as Medication Reconciliation.
- Coordinate efforts with the Alabama Medicaid Academic Detailing Program regarding obtaining administrative detailing sessions for the PCCM-e's network PCPs.
- Participate in regular status calls with Agency Pharmacy Program staff.
- Complete, oversee, be responsible for, and submit all reports for the PCCM-e Pharmacy Program.

Population Health Data Analyst

Requirements
- Ensures analytics supports the quality improvement plan, projects, activities and clinical management initiatives identified as priorities by the Agency and the PCCM-e.
- Lead the design, implementation, dissemination, and interpretation of population health analysis and reporting.
- Utilizes claims and administrative data to identify and measure key metrics for improving the quality of care and health outcomes of Medicaid recipients.
- Develops strong, collaborative relationships and communications with internal and external partners in clinical, administrative, financial, and technical matters.
- Self-starter, independent worker, collaborative, and the ability to work under tight deadlines.

Education/Experience
- Minimum – B.S degree in a science, public health, or statistical-related field with seven (7) years of relevant experience in public health data analysis, epidemiology, or statistical analysis
- Preferred – Doctorate or Master's degree in a science, public health, or statistical-related field with a minimum of 3-5 years of relevant experience in public health data analysis, epidemiology, or statistical analysis
- Qualifications and Skills
    - Must have 5 years of experience writing SQL queries or similar languages with knowledge of database design, data entry, and data management.
    - Must have 5 years of experience managing large, complex, and longitudinal datasets; moving and merging data files from different platforms cleaning and aggregating data and performing quality control.
    - Must demonstrate the ability to use statistical software such as SAS, SPSS, or R for statistical analysis.

- Ability to use Tableau, Microsoft EXCEL, and Power BI to manipulate, analyze, and visualize data for dashboards and presentations.
- Knowledge and/or experience with external data sources such as Department of Public Health and Centers for Disease Control (CDC).

- Primary responsibilities include
  - Assists the Quality Care Director in effectively managing quality improvement projects, by providing consultative, technical, and subject matter expertise, and actively designing and executing analyses.
  - Conducts analyses, interpret results, and summarize and present findings to relevant stakeholders.
  - Communicates analytic advice and statistical methodology effectively with clients, management, and staff.
  - Analyzes and understands stakeholder's needs and translate them into formal requirements.
  - Maintains public health management expertise; stays abreast of industry changes and trends.

Quality Care Director

Requirements

- Works and lives in the region.

Education/Experience

- Certified Professional in Healthcare Quality (CPHQ) or equivalent experience related to healthcare quality.
- Bachelor's degree in public health, public administration or healthcare quality and safety, master's degree preferred. Relevant work experience can be substituted for master's degree.
- Clinical background preferred.
- Prior experience, at least one year, working with the Medicaid population.
- Familiarity with Healthcare Effectiveness Data and Information Set (HEDIS®), CAHPS, and other standardized quality measures/assessments
- Proficiency in quantitative data analysis
- At least 3 years' experience related to population health management, including interpretation and presentation of data; identifying opportunities for improvement; and developing strategic plans to address quality deficits.
- Population Health Management strategies – Oversees the PCCM-e quality Improvement Plan by:
  - Systematic data analysis to target Medicaid recipients and providers for outreach, education, and intervention to improve health outcomes.
  - Monitoring system access to care, services, and treatment including linkage to a Medical Home.
  - Monitoring quality and effectiveness of interventions to the population.
  - Facilitating quality improvement activities that educate, support, and monitor Providers regarding evidence-based care for best practice.

- Implementing clinical management initiatives identified as priorities by the Agency and the PCCM-e.

Primary responsibilities include but are not limited to:

- Oversee the development of the Quality Improvement Plan.
- Work with practices and community providers in the implementation of the Quality Improvement Program.
- Ensure the PCCM-e completes the required QIP and meets required benchmarks.
- Review and report data to the Medical Director, and conveys information related to Quality Measures, QIPs, and any Agency directed quality initiatives adopted by the Agency to the PCCM-e.
- 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; and
- Ensure quality of services are provided in accordance with state and federal regulations.

Care Management Director

Requirements

- Is full time, and
- works and lives within the Region.

Education/Experience

- Master of Social Work (MSW) degree from an accredited school of Social Work, and minimum Licensed Graduate Social Worker (LGSW); or
- Minimum of Bachelor of Science in Nursing (BSN) degree with appropriate license; Master of Science in Nursing (MSN) degree with appropriate license (preferred), or
- Master of Counseling degree from an accredited school and a minimum licensed professional counselor (LPC) designation.
- Minimum of three (3) years' experience in care coordination/case management working with low-income and diverse populations; must include experience working with individuals in the specific Medicaid population(s) receiving care coordination/case management services.

Primary responsibilities include:

- Develops, implements, and provides oversight of the PCCM-e's Care Management Program including utilization review, intake or discharge planning, and managed care in accordance with the Medicaid program rules and state and federal regulations.
- Supervise, recruit and train qualified care management staff that include Care Coordinators, Case Managers, Community Health Workers, and Behavioral Health and Transitional Care staff.
- Evaluates patient data to ensure the provision of quality care coordination services in accordance with clinical guidelines while improving cost effectiveness.

Other Positions

Community Pharmacist

Requirements:

- Current Alabama Pharmacy license in good standing.
- Must hold a current Alabama Preceptor certification (at the time of or within six months of start of contract or employment).

- Works within the PCCM-e Region; live within the Region preferred.
- Possesses excellent organizational and administrative skills.

Education/Experience

- Holds at a minimum a B.S. in Pharmacy; Pharm.D. preferred.
- Must have three years of community pharmacy experience within the past four years; supervisory experience preferred.

Primary responsibilities:

- Coordinate and support outpatient pharmacy initiatives, such as dispensing of 90-day supply for maintenance medications, pharmacist vaccine administration, opioid use and disorder

Revised as:

Appendix K: Key Staff and other Positions Requirements

Key Staff

Executive Director

Requirements:

- Full-time;
- Possess excellent organizational and administrative skills; and
- Must maintain a full-time office in the PCCM-e Region.

Education/Experience

- Possess a Bachelor's Degree in Business Administration, Finance, Accounting or related field from an accredited college or university (preferred).
- Have a minimum of three years management experience in managed health care (to include population health management) and experience working with low-income populations; or
- In lieu of a bachelor's degree, the individual may have 10 years management experience in managed healthcare.

Primary responsibilities include, but are not limited to:

- Authority to make all day-to-day program decisions including hiring, firing, and financial decisions 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.
- Leads and maintains a team of qualified staff to ensure quality of services are provided in accordance with state and federal requirements and regulations; Agency and program goals and objectives are met; and desired health outcomes are achieved; and
- Serves as primary administrative liaison between the PCCM-e and the Agency.

Medical Director

Requirements:

- Be a practicing 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.
- Part-time.

Education/Experience

- Be a licensed physician in the State of Alabama (required).
- Have three (3) years' experience with low-income populations; and

Primary responsibilities include, but are not limited to:

- Maintain contact with local providers.
- Represent the PCCM-e in person at select meetings as required by the Agency and/or the PCCM-e.
- Address local issues at the community level.
- Lead quarterly Medical Management Meetings in the Region; and
- Approve the Quality Initiatives and Quality Improvement Plan of PCCM-e.

Pharmacy Director

Requirements:

- Possess excellent organizational and administrative skills; and
- Is full-time.
- Current Alabama pharmacy license in good standing.
- Work within the Region; live within the Region (preferred).

Education/Experience

- Holds at a minimum a B.S. degree in Pharmacy.
- Must have a minimum of five years of pharmacist experience within the past six years; supervisory experience (preferred).

Primary responsibilities include:

- 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.
- May serve simultaneously as either the Transitional Pharmacist or Community Pharmacist but must meet the educational/professional criteria for both positions held.
- Serve as the primary point of contact with the Agency for all meetings and coordination in all pharmacy related matters.

- Develop, coordinate, implement, and manage education of community, inpatient, transitional, and all pharmacists and PCPs within the PCCM-e and Agency pharmacy initiatives.
- Develop, coordinate, engage within, and manage staff to implement programs that advance the Medical Home.
- Work with the PCCM-e's management team to determine ways to support pharmacists and prescribers with management of drug costs and policies.
- Create and manage programs that address new policies as the Agency implements them.
- Attend and present at various local PCCM-e and Agency meetings as requested, such as Steering Committee meetings, Medical Management meetings, Alabama Medicaid Pharmacy and Therapeutics (P&T) and Drug Utilization Review (DUR) meetings, and PCCM-e Director's Meetings.
- Serve as a resource to PCPs and care managers on general drug information and Agency pharmacy policy issues.
- 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.
- Educate, train or coordinate the education and training of staff on processes to be developed, such as Medication Reconciliation.
- Coordinate efforts with the Alabama Medicaid Academic Detailing Program regarding obtaining administrative detailing sessions for the PCCM-e's network PCPs.
- Participate in regular status calls with Agency Pharmacy Program staff.
- Complete, oversee, be responsible for, and submit all reports for the PCCM-e Pharmacy Program.

Population Health Data Analyst

Requirements:

- Ensures analytics supports the quality improvement plan, projects, activities and clinical management initiatives identified as priorities by the Agency and the PCCM-e.
- Lead the design, implementation, dissemination, and interpretation of population health analysis and reporting.
- Utilizes claims and administrative data to identify and measure key metrics for improving the quality of care and health outcomes of Medicaid recipients.
- Develops strong, collaborative relationships and communications with internal and external partners in clinical, administrative, financial, and technical matters.
- Self-starter, independent worker, collaborative, and the ability to work under

tight deadlines.

- Full-time

Education/Experience

- Minimum – B.S degree in a science, public health, or statistical-related field with seven (7) years of relevant experience in public health data analysis, epidemiology, or statistical analysis
- Preferred – Doctorate or Master's degree in a science, public health, or statistical-related field with a minimum of 3-5 years of relevant experience in public health data analysis, epidemiology, or statistical analysis
- Qualifications and Skills
    - Must have 5 years of experience writing SQL queries or similar languages with knowledge of database design, data entry, and data management.
    - Must have 5 years of experience managing large, complex, and longitudinal datasets; moving and merging data files from different platforms cleaning and aggregating data and performing quality control.
    - Must demonstrate the ability to use statistical software such as SAS, SPSS, or R for statistical analysis.
    - Ability to use Tableau, Microsoft EXCEL, and Power BI to manipulate, analyze, and visualize data for dashboards and presentations.
    - Knowledge and/or experience with external data sources such as Department of Public Health and Centers for Disease Control (CDC).

Primary responsibilities include:

- Assists the Quality Care Director in effectively managing quality improvement projects, by providing consultative, technical, and subject matter expertise, and actively designing and executing analyses.
- Conducts analyses, interpret results, and summarize and present findings to relevant stakeholders.
- Communicates analytic advice and statistical methodology effectively with clients, management, and staff.
- Analyzes and understands stakeholder's needs and translate them into formal requirements.
- Maintains public health management expertise; stays abreast of industry changes and trends.

Quality Care Director

Requirements:

- Is full-time, and
- Works and lives in the region.

Education/Experience

- Certified Professional in Healthcare Quality (CPHQ) or equivalent experience related to healthcare quality.
- Bachelor's degree in public health, public administration or healthcare quality and safety, master's degree preferred. Relevant work experience can be substituted for master's degree.
- Clinical background preferred.
- Prior experience, at least one year, working with the Medicaid population.
- Familiarity with Healthcare Effectiveness Data and Information Set (HEDIS®), CAHPS, and other standardized quality measures/assessments
- Proficiency in quantitative data analysis
- At least 3 years' experience related to population health management, including interpretation and presentation of data; identifying opportunities for improvement; and developing strategic plans to address quality deficits.
- Population Health Management strategies- Oversees the PCCM-e quality Improvement Plan by:
    - Systematic data analysis to target Medicaid recipients and providers for outreach, education, and intervention to improve health outcomes.
    - Monitoring system access to care, services, and treatment including linkage to a Medical Home.
    - Monitoring quality and effectiveness of interventions to the population.
    - Facilitating quality improvement activities that educate, support, and monitor Providers regarding evidence-based care for best practice.
    - Implementing clinical management initiatives identified as priorities by the Agency and the PCCM-e.

Primary responsibilities include but are not limited to:

- Oversee the development of the Quality Improvement Plan.
- Work with practices and community providers in the implementation of the Quality Improvement Program.
- Ensure the PCCM-e completes the required Quality Improvement Projects (QIPs) and meets required benchmarks.
- Review and report data to the Medical Director, and conveys information related to Quality Measures, QIPs, and any Agency directed quality initiatives adopted by the Agency to the PCCM-e.
- 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; and
- Ensure quality of services are provided in accordance with state and federal regulations.

Care Management Director

Requirements:

- Is full time, and
- works and lives within the Region.

Education/Experience

- Master of Social Work (MSW) degree from an accredited school of Social Work, and minimum Licensed Graduate Social Worker (LGSW); or
- Minimum of Bachelor of Science in Nursing (BSN) degree with appropriate license; Master of Science in Nursing (MSN) degree with appropriate license (preferred), or
- Master of Counseling degree from an accredited school and a minimum licensed professional counselor (LPC) designation.
- Minimum of three (3) years' experience in care coordination/case management working with low-income and diverse populations; must include experience working with individuals in the specific Medicaid population(s) receiving care coordination/case management services.

Primary responsibilities include:

- Develops, implements, and provides oversight of the PCCM-e's Care Management Program including utilization review, intake or discharge planning, and managed care in accordance with the Medicaid program rules and state and federal regulations.
- Supervise, recruit and train qualified care management staff that include Care Coordinators, Case Managers, Community Health Workers, and Behavioral Health and Transitional Care staff.
- Evaluates patient data to ensure the provision of quality care coordination services in accordance with clinical guidelines while improving cost effectiveness.

Other Positions

Community Pharmacist

Requirements:

- Current Alabama Pharmacy license in good standing.
- Must hold a current Alabama Preceptor certification (at the time of or within six months of start of contract or employment).
- Works within the PCCM-e Region; live within the Region preferred.
- Possesses excellent organizational and administrative skills.

Education/Experience

- Holds at a minimum a B.S. in Pharmacy; Pharm.D. preferred.
- Must have three years of community pharmacy experience within the past four years; supervisory experience preferred.

Primary responsibilities:

- Coordinate and support outpatient pharmacy initiatives, such as dispensing of 90-day supply for maintenance medications, pharmacist vaccine administration, opioid use disorder, smoking cessation, and other programs as outlined by the Agency or PCCM-e.

- Assist prescribers in creating and managing drug regimens of recipients with chronic disease (e.g., diabetes, asthma, congestive heart failure). This may include, but shall not be limited to, activities such as meeting with recipients and adjusting medication dosages in concert with PCP.

- 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.

- 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:

    - Improve medication adherence.

    - Prevent and reduce potential medication-related errors.

    - Reduce 'doctor shopping'; and

    - Cost-effectiveness.

- Perform Medication Reconciliation assessments to optimize the recipient's drug regimen.

- Educate community pharmacists within the Region on the PCCM-e program and Agency pharmacy initiatives.

- 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 Recipients in the General Population.

- Serve as a resource to PCCM-e's PCPs and Care Management staff on general drug information and Agency drug policy issues.

- Serve as the Preceptor for the Pharmacy Student Advance Practice Experience.

- 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/).

- Manage any additional pharmacy staff (pharmacists, certified pharmacy technicians, etc.) hired by the Region to work on Community Pharmacy Program tasks.

Transitional Pharmacist

Requirements:

- Current Alabama Pharmacy license in good standing.
- Must hold a current Alabama Preceptor certification (at the time of or within six months of start of contract or employment).
- Works within the PCCM-e Region; live within the Region preferred.
- Possesses excellent organizational and administrative skills.

Education/Experience

- Current Alabama Pharmacy license in good standing.
- Must hold a current Alabama Preceptor certification.
- Works within the PCCM-e Region; live within the Region preferred.
- Holds at a minimum a B.S. in Pharmacy; Pharm.D. preferred.
- Must have formal residency training or equivalent clinical inpatient experience (minimum of three calendar years within the past four years); supervisory experience preferred.

Primary responsibilities:

- Develop, establish, and oversee an organizational process and policy on recipient transition of care from inpatient to the community. Aspects of the transitional care should include but are not limited to: Medication reconciliation on patients from pre-hospitalization, during inpatient stay, and post-discharge within three days of receiving the patient medication list.

- Transitional medication management to include face-to-face visits, calls, and any other means necessary.

- Obtain and review discharge information (e.g., discharge summary or continuity of care documents).

- Prior authorization assistance.

- Reduction of readmission rates related to medication issues/errors.

- Coordination with the Care Manager to ensure post-discharge appointments are made; needed prescriptions are obtained.

- Review the need for or follow-up on pending diagnostic tests related to the medications and treatments.

- Interact with other health care professionals who will assume or reassume care of the recipient specific problems.

- Provide education to the recipient, family, guardian, and/or caregiver.

- Refer recipient to the Community Pharmacy Program if continued services are needed.

- 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.

- Coordinate and support recipients as they transition to the community or outpatient on Agency pharmacy initiatives, such as dispensing of 90-calendar day supply for maintenance medications, pharmacist vaccine administration, smoking cessation, and other programs as outlined by the Agency or PCCM-e.

- Assist prescribers in creating and managing drug regimens of recipient 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 recipients, adjusting medication dosages in concert with prescribing physician.

- 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.

- Medication Reconciliations for inpatient/discharge patients must be performed by a pharmacist for all discharge patients.

- Perform Medication Reconciliation assessments as requested by PCPs and/ or Care Managers to optimize the recipient's drug regimen.

- Educate inpatient prescribers and pharmacists within the Region on the PCCM-e Program and Agency pharmacy initiatives. Serve as the Preceptor for the Pharmacy Student Advance Practice Experience.

- 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/).

- Manage any additional pharmacy staff (pharmacists, certified pharmacy technicians, etc.) hired by the Region to work on Inpatient/Transitional Pharmacy program tasks.

Application Assister

Requirements:

- Agency approved Application Assister Certification

Primary responsibilities include:

- Documentation of eligibility status at screening intake.

- Assistance with completing the application electronically or paper format.

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

- Assistance with any other barriers to the application process.

- Completion of the initial screening

- Documentation of activities associated with the encounter in the Health Information Management Systems (HIMS), when applicable.

Case Manager

Requirements:

- Must be licensed.
- Have strong verbal and written communication skills to include ability to encourage and engage recipients in plan of care.
- Ability to sufficiently document electronic case records including writing effective care plans and SMART goals.
- Ability to manage a heavy caseload; and
- Works and lives within the Region

Education/Experience
Must have at a minimum:

- Bachelor's degree in a health science, social or behavioral health area of study. Examples include:
- Bachelor of Science in Nursing (BSN) degree with appropriate license; or
- Bachelor of Social Work (BSW) from an accredited school of Social Work and appropriate license; or
- Bachelor of Counseling from an accredited school of Counseling and appropriate license; or
- Bachelor of Social Work (BSW) or MSW from an accredited school of Social Work and appropriate license

OR

- Licensed Registered Nurse (RN) with an Associate Degree in Nursing (ADN) and two (2) years of recent experience working in a clinic setting or combined hospital experience.
- Minimum of one (1) year experience in care coordination/case management working with low-income and diverse populations; must include experience working with individuals in the specific Medicaid population(s) receiving care coordination/case management services.

Primary responsibilities include:

- Provide and coordinate the care management services of Medicaid recipients, especially those stratified as high risk, to increase quality of care, reduce the use of inpatient and emergency department utilization and improve health outcomes.
- Conduct home visits and non-home encounters with recipients, recipients' family/caregiver, and/or support network to identify needs, provide education, address health literacy, develop, update, and evaluate person-centered care plans and perform other case management activities as deemed necessary (i.e., completing health risk assessments, social determinants of health screenings, attending medical appointments with the recipient, updating medication list, assisting with provider referrals and directives, linkage to a medical home).
- Collaborate with providers and healthcare professionals to advocate for recipient and to ensure delivery of appropriate care and timely follow up care, creating sustainable clinical-community linkages to improve recipients' access to care and fill any identified gaps in services.
- Provide consistent communication to the Care Coordinator to evaluate recipient/family status, provide necessary follow-up and document progress in case record.

Care Coordinator

Requirements:

- Strong verbal and written communication skills to include ability to encourage and engage recipients in plan of care; ability to sufficiently document electronic case records including writing effective care plans and SMART goals,
- Ability to manage a heavy caseload; and
- Works and lives within the Region.

Education/Experience

- Can meet Case Manager educational and/or experience requirements listed in the Case Manager section;
  or the following:
- Master's degree from an accredited college or university in a health science, social and/or behavioral science and one years of professional care management experience;
  OR
- Bachelor's degree from an accredited four-year college or university in a health science, social and/or behavioral science and two years of professional care management experience
  OR
- Bachelor's degree from an accredited four-year college or university in any major with at least 30 semester or 45 quarter hours in social and/or behavioral science courses and three years of professional care management experience
  OR
- Minimum of Bachelor of Science in Nursing (BSN) degree with appropriate license; or
- Minimum of Bachelor of Social Work (BSW) or MSW from an accredited school of Social Work and appropriate license
  OR
- Licensed Registered Nurse (RN) with an Associate Degree in Nursing (ADN) and two years of recent experience working in a clinic setting or combined hospital experience; and
- Minimum of one year experience in care coordination/case management working with low-income and diverse populations; must include experience working with individuals in the specific Medicaid population(s) receiving care coordination/case management services.

Primary responsibilities:

- Provide care coordination services to Medicaid recipients in the general, maternity (including postpartum), and medically complex populations in a specified region to ensure and advance the plan of care to support positive health outcomes and successful transitions.

- Conduct home visits and non-home encounters with recipients, recipients' family/caregiver, and/or support network to identify needs, provide education, address health literacy, assist in developing, updating, and evaluating person-centered care plans and perform other case management activities as deemed necessary.
- Collaborate with providers and healthcare professionals to advocate for recipient and to ensure delivery of appropriate care and timely follow up care, creating sustainable clinical-community linkages to improve recipients' access to care and fill any identified gaps in services.
- Provide consistent communication to the Case Manager to evaluate recipient/family status, provide necessary follow-up and document progress in case record.

Community Health Worker (CHW)

Requirements:

- Have a valid driver's license and ability to travel.
- Lives and works within the Region.

Education/Experience

- Licensed Practical Nurse (LPN) or
- Minimum of a high school diploma or GED and completion of any required training.
- Have two years of human or social services, public health, healthcare or community health experience; and
- Knowledge of local community and public resources serving the Medicaid population
- CHW certifications or licenses and Medicaid population experience preferred.

Primary responsibilities include:

- Provide outreach & education to recipient and community.
- Act as liaison linking recipients and families to community resources making appropriate referrals.
- Assist applicants in completing necessary documents to obtain Medicaid program eligibility.

Medically Complex Population Staff

Requirements:

- 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.
- 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.

- Pharmacist: A Pharm D is required with pediatric experience preferred.

The PCCM-e must have at a minimum, a nurse and a social worker with pediatric experience to provide training to applicable general care management staff. The applicable staff includes those staff members who render care management services to those recipients who meet the medically complex criteria. This training should include topics related to the care and linking of services for children with medical complexity. A designated pharmacist will also receive this training.

Staff Training:

- Each PCCM-e will be required to identify a pediatric nurse, social worker, and pharmacist to attend an in-person training at an Agency designated location.
- 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.

3. **Section II. Scope of Work, Sub-Section 1. Comprehensive Care Management. F. Care Management Goals, 5. Population Goals, c, Maternity Population, Page 22, Changed as follows:**

Currently Reads as:

Care Management Goals *Care management activities must be completed in timeframes indicated in the Care Management Activity Schedule.*	
Care Management Activity	**Annual Care Management Goals**
Assigned population management	40% of the assigned pregnant population must receive a psychosocial assessment
High-risk population management	100% of those who received a psychosocial assessment must be managed as high-risk stratification for the first three months
Delivery Encounter	95% of those who participated in a Care Plan Review received a Delivery Encounter
Care Management Activity	**Monthly Care Management Goals**
Initial Assessment	60% of the enrolled population received an initial psychosocial assessment
Care Plan Review	70% of those who received an initial psychosocial assessment participated in a Care Plan Review
MCT (high)	25% of those who received a Care Plan Review received an initial MCT
1st follow-up (high and low)	90% those who received a Care Plan Review received a 1st follow-up encounter
In-home Postpartum Encounter (twenty (20) calendar days post-delivery)	80% of those with a Delivery Encounter received an In-home Postpartum Encounter
3rd Postpartum Encounter	80% of those with an In-home Postpartum Encounter
Family planning encounter with 6 months of delivery date	80% of those with a Delivery Encounter had a family planning related encounter within six months of the delivery date

Family planning referral with 6 months of pregnancy loss	80% of those enrolled within a pregnancy loss (no Delivery Encounter) had a family planning referral within six months of pregnancy loss

Revised as:

Care Management Goals *Care management activities must be completed in timeframes indicated in the Care Management Activity Schedule.*	
Care Management Activity	**Annual Care Management Goals**
Assigned population management	40% of the assigned pregnant population must receive a psychosocial assessment
High-risk population management	100% of those who received a psychosocial assessment must be managed as high-risk stratification for the first three months
Delivery Encounter	95% of those who participated in a Care Plan Review received a Delivery Encounter
Care Management Activity	**Monthly Care Management Goals**
Initial Assessment	60% of the enrolled population received an initial psychosocial assessment
Care Plan Review	70% of those who received an initial psychosocial assessment participated in a Care Plan Review
MCT (high)	25% of those who received a Care Plan Review received an initial MCT
1st follow-up (high and low)	90% those who received a Care Plan Review received a 1st follow-up encounter
In-home Postpartum Encounter	80% of those with a Delivery Encounter received an In-home Postpartum Encounter
3rd Postpartum Encounter	80% of those with an In-home Postpartum Encounter
Family planning encounter within 6 months of delivery date	80% of those with a Delivery Encounter had a family planning related encounter within six months of the delivery date
Family planning referral within 6 months of pregnancy loss	80% of those enrolled within a pregnancy loss (no Delivery Encounter) had a family planning referral within six months of pregnancy loss

.

4. Appendix I: Care Management Activity Schedule- Maternity/Postpartum Population, Page 117, Replaced as follows:

Replaced Chart:

Maternity/Postpartum Population
Care Management (CM) Activity Schedule

ACTIVITY CODE	Description (title subject to change)	Case Management Stratification		ACTIVITY TYPE		Schedule		Activity Requirement
		HIGH	LOW	Face to Face (F2F)	Telephonic	Frequency	Month	All documentation to support completion of the activity must be present in the HIMS before submission for payment
TBD	Initial Encounter (Screening)	X	N/A	N/A	X	1/ Pregnancy	0-1	Screening for care management services. Typically completed in 1 hour
TBD	Initial Assessment Psychosocial	X	N/A	X	N/A	1/ Pregnancy	0-1	Completion of a Health Risk and Psychosocial Assessment within 21 days of screening. Stratification determination. Medication list completion. PHQ assessment (required for the General population for ages 12 and older), Substance Abuse Screening (required for the General population for ages 12 and older). Initial determination of medical, social, and behavioral health needs along with the barriers to achieving optimal health. Requires completion of all forms and a progress note before requesting payment. Typically completed in 2 hours
TBD	Medication Reconciliation & Education Follow-Up (completed during care plan review)	X	N/A	N/A	X	1/ Pregnancy	0-1	Complete within 5 days of Psychosocial Assessment. Pharmacist reviews and reconciles the medication list and provides recommendations to the care manager for discussion and education of the recipient.
TBD	Care Plan completion	X	N/A	X	N/A	1/ Pregnancy	0-1	Complete within 15 days of the Initial Psychosocial Assessment. Development a recipient centered plan of care. The goals and interventions must be focused on increasing the recipient's knowledge, compliance, and confidence to navigate the healthcare system while decreasing physical, mental, social and economic barriers and disparities. Development of interventions geared to aiding the recipient to achieve their goals. Documentation must include but is not limited to the care plan, phone calls with recipient, the primary care provider, and community resource agencies to gather information to complete the care plan. All documentation must be complete before requesting payment for services. **(Payment of this code is included in the payment of care plan Review.)**
TBD	Care Plan Review (with/rec; signature required) incl Med Rec education and additional follow-ups with rec	X	N/A	X	N/A	1/ Pregnancy	2	Complete within 15 days of care plan (CP) completion activity. Discussion with recipient regarding pharmacist recommendations. Review and amend (if necessary, the CP with the recipient which includes agreement and signing of CP.) Completion of a Progress note. All documentation must be complete before requesting payment for services. **Payment Includes the Care plan completion activity and a 30 day follow- up call to be completed after CP review to evaluate progress. Recipient signature required.**
TBD	Care Plan Review Follow up	X	N/A	N/A	X	1/ Pregnancy	3	Phone call with recipient 30 days after care plan review to evaluate progress, reassess stratification level and address any new needs or concerns. Requires progress note.
TBD	Multi-disciplinary Care Team (MCT)	X	N/A	X	N/A	1/ Pregnancy	4	F2F or virtual meeting to include the CC, recipient, health professionals and other community agencies to discuss the recipient's health and psychosocial needs, barriers, and develop a solution plan. 30 days after care plan review follow up for High and medium risk recipients. Requires a progress note.

TBD	1st Periodic Reassessment Follow-up	X	X	N/A	X	1/ Pregnancy	5-6	Telephonic Encounter with recipient to assess progress to goals. Assess for needs and barriers to success. Evaluate the Care plan and assess need to implement new interventions and strategies to achieve goals. Provide education and informal counseling. Assist with referrals and directives of the medical provider; Update the medication list and assist with the medication reconciliation process (as applicable); Assist with follow-up appointments and provide appointment/mail appointment card reminders. Assist with communication with community resource agencies. Requires a progress note.
TBD	2nd Periodic Reassessment Follow-up	X	X	X	N/A	1/ Pregnancy	7 or 8	Encounter with recipient to access progress to goals. Assess for needs and barriers to success. Evaluate the care plan (goal progress, intervention (un)successful). Update care plan with implementation of new goals, interventions, and strategies as dictated by the recipient's needs (***Recipient signature required).*** Provide education and informal counseling. Assist with referrals and directives of the medical provider; Update the medication list and assist with the medication reconciliation process (as applicable); Assist with follow-up appointments and provide appointment/mail appointment card reminders.

Maternity/Postpartum Population
Care Management (CM) Activity Schedule

ACTIVITY CODE	Description	Case Management Stratification		ACTIVITY TYPE		Schedule		Activity Requirement
		HIGH	LOW	Face to Face (F2F)	Telephonic	Frequency	Month	All documentation to support completion of the activity must be present in the HIMS before submission for payment
TBD	3rd Periodic Reassessment Follow-up	X	N/A	N/A	X	1/ Pregnancy	9 or 10	Encounter with recipient to access progress to goals. Assess for needs and barriers to success. Evaluate the Care plan and assess need to implement new interventions and strategies to achieve goals. Provide education and informal counseling. Assist with referrals and directives of the medical provider; Update the medication list and assist with the medication reconciliation process (as applicable); Assist with follow-up appointments and provide appointment/mail appointment card reminders.
TBD	Delivery Encounter	X	X	X	N/A	1/ Pregnancy	20 days post delivery	Face to face encounter with the recipient within 20 days of delivery or end of pregnancy to assess needs and pregnancy outcome. Provide education on birth spacing, contraceptive care, safe sleep, breastfeeding and any other individual needs of mother and infant. Review discharge summary with patient to ensure patient understands prescribed plan of care. Assess infant for General care management. Visit may take place either prior to discharge from the hospital or in the recipient's home.
TBD	1st Postpartum Encounter (In home)	X	X	X	N/A	1/ Pregnancy	30-45 days post Delivery Encounter	Face to face visit with the recipient 30-45 days after completion of the delivery encounter to assess needs, risks, health, and physical and emotional well-being of mother and infant, offer support and encourage follow-up with MCP as needed. Update CP to reflect PP needs. Assess and stratify for Maternal health visits
TBD	2nd Postpartum follow-up Encounter	X	X	X	N/A	1/ Pregnancy	60-75 days Post MHP02	Visit with the recipient 60-75 days after completion of the first in- home postpartum encounter to access needs, risks, health and physical and emotional well-being of mother and infant, offer support and encourage follow-up with provider as needed. ***Assess and stratify for General Care management.***
TBD	3rd Postpartum follow-up Encounter	X	N/A	N/A	X	1/ Pregnancy	60-75 days Post MHP03	Visit with the recipient 60-75 days after completion of the second in- home postpartum encounter to access needs, risks, health and physical and emotional well-being of mother and infant, offer support and encourage follow-up with MCP as needed. ***Assess and stratify for General Care management.***

TBD	Community Care Support Coordination	X	X	N/A	X	4/mo		A successful Community Care Support Coordination encounter which shall include but is not limited to providing and linking the recipient with community resources assistance which should include phone calls or visits to community agencies and other outreach activities by the CC. Professional phone communication on behalf of the recipient to any medical provider such as a specialist, counselor, or educator, excluding the MCP. Calls made by the CC to assist the recipient with transportation requests. Requires a progress note. ***Cannot be billed without a successful completion of a periodic or inter-periodic encounter within 30 days.***
TBD	Inter-periodic Follow up Encounter	X	X	N/A	X	3/Pregnancy		Encounter with recipient to access progress to goals. Assess for needs and barriers to success. Evaluate the Care plan and assess need to implement new interventions and strategies to achieve goals. Provide education and informal counseling. Assist with referrals and directives of the medical provider; Assist with follow-up appointments and provide appointment/mail appointment card reminders. Requires a progress note. ***Activity cannot be billed in the same month as a periodic encounter.***

5. **Section VII. Submission Requirements, Sub-Section L. Price, Page 69, remove in its entirety:**

~~Vendors must respond to this RFP by utilizing the RFP Cover Sheet to indicate the firm and fixed price for the implementation and updating/operation phase to complete the scope of work.~~

6. **Add the following paragraphs after Section III, , Subsection 13:**

14. Transition Period

A. Transition from the Incumbent Vendor to a New Contractor

If the contract award results in a transition from the Incumbent Vendor to a new Contractor, a transition period prior to contract start shall be necessary to ensure all processes are implemented with a seamless transition and minimal interruption to the Medicaid recipients and providers. This transition period is in addition to the activities and responsibilities described in Subsection 10, Readiness Assessment, above. The incoming Contractor will not be compensated during the transition period. The incoming Contractor will appoint an individual to work with the Incumbent Vendor and Medicaid to ensure the integrity of the proposed solution is maintained and is viable through the Vendor switchover period.

The Contractor's transition period will include, but is not limited to:

- Receipt of knowledge transfer of all recipient care coordination activities conducted by the Incumbent Vendor.
- New Contractor to receive access to necessary Medicaid screens, MMIS systems, etc.
- Technical coordination, testing, and interface with the fiscal agent.
- Training of the staff at least one month prior to implementation.
- Any other training or system testing/interface needed for a seamless transition with little/no interruption to the Medicaid recipients and providers.

Medicaid shall appoint an individual to be available to assist in communication and coordination involving the Incumbent Vendor and the incoming Contractor. The incoming Contractor must have adequate staff, as determined by Medicaid, available during the uncompensated transition period in order to support Medicaid under the required timeline. The Contractor must make the following key positions, at a minimum, available to Medicaid during the transition period:

- Executive Director
- Medical Director
- Pharmacy Director
- Population Health Data Analyst
- Quality Care Director
- Care Management Director

The incoming Contractor, beginning July 1, 2024, will provide monthly reports reflecting progress being made to initiate delivery of all services. The incoming Contractor will not be compensated for any preparation activity conducted in advance of the Vendor switchover for the new contract which is effective October 1, 2024.

B. Transition for Incumbent Vendor to New Contract

If an Incumbent Vendor is awarded a contract in response to this RFP, the Agency expects the Incumbent Vendor to submit a Recipient Care Management Adjustment Plan. This plan should outline the process by which the PCCM-e will shift the current recipients to the new Care Management Activity Schedule(s). The Agency expects the PCCM-e to facilitate and accomplish a seamless transition for the recipient from the current ACHN model to the new one. The following timeline applies to this process:

1. Initial Recipient Care Management Adjustment Plan
   The PCCM-e will be required to submit an initial Recipient Care Management Adjustment Plan five (5) months prior to the contract start date. The initial Plan should include, but is not limited to, the following:
   - Detailed recipient adjustment approach: A clear description of how the currently enrolled recipients will be assessed and stratified into the new ACHN Care Management Activity Schedules.
     - Timeline of events
     - Expected completion of events
     - Total number of currently enrolled recipients per population
       - Anticipated number of recipients shifting to the new ACHN Care Management model
       - Anticipated number of recipients not shifting to the new ACHN Care Management model
   - Adjustment Plan Communication Approach
   - Adjustment Plan Team
     - Key roles and resources associated with Adjustment planning and activities
       - Defined responsibilities of each role specific to recipient adjustments
   - Recipient adjustment assumptions, constraints and risks and recommendations

2. Updated Recipient Care Management Adjustment Plan
   The PCCM-e is expected to submit an updated Recipient Care Management Adjustment Plan to the Agency for review and approval at least ninety (90) calendar days prior to the start of the contract. The updated adjustment Plan shall facilitate and accomplish a seamless transition from the current contract to the new contract. The updated adjustment Plan should include, but is not limited to, the following:
   - Detailed adjustment Approach, if updated from the initial **and** the following:
     - Total number of currently enrolled recipients per population
       - Anticipated number of recipients shifting to the new ACHN Care Management model (excludes maternity and postpartum)

        - Anticipated number of recipients not shifting to the new ACHN Care Management model (excludes maternity and postpartum)
        - Number of maternity recipients shifting to the new model
        - Number of postpartum recipients shifting to the new model
        - Number of postpartum recipients not shifting to the new model
    - Adjustment Communication Approach, if updated from the initial
    - Adjustment Team, if updated from the initial
    - Adjustment Assumptions, Constraints and Risks and Recommendations, if updated from the initial
    - Transition Readiness Assessment
    - Contract Continuity Approach
        - Adjustment Staffing Plan
        - Key Personnel transition approach
        - Overall staffing approach for continued support and ramp down
        - Procurement/Partnership Management – Details of procurements/partnerships in place, including, but not limited to, subcontractors, partnerships with community resources, Medicaid providers, etc.

3. Status Reporting
   The PCCM-e shall provide a Recipient Adjustment Status Report monthly during the first three months and the subsequent two months of the new contract period.

7. <u>Section IX. General Terms and Conditions, Sub-Section Q. Conflict of Interest, Page 77, Changed as follows:</u>

<u>Currently Reads as:</u>
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 and this amendment. The Contractor and Medicaid agree that each has no conflict of interest preventing the execution of this Contract amendment or the requirements of the original contract, and said parties will abide by applicable state and federal regulations, specifically those requirements found in the Office of Federal Procurement Policy Act. 41 U.S.C.A. 2101 through 2107.

<u>Revised as:</u>
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 RFP. The Contractor and Medicaid agree that each has no conflict of interest preventing the execution of this RFP or the requirements of the contract and said parties will abide by applicable state and federal regulations, specifically those requirements found in the Office of Federal Procurement Policy Act. 41 U.S.C.A. 2101 through 2107.

8. <u>Appendix E, RFP Documentation, Page 106, changed as follows:</u>

Currently Reads as:

Appendix E: RFP Documentation

Procurement Library Contents at the time of RFP release are listed below. Please refer to the Alabama Medicaid Procurement website for any updates to the Procurement Library.

(https://medicaid.alabama.gov/content/2.0_Newsroom/2.4_Procurement.aspx)

1. PL01_Consumer Advisory Committee Policy
2. PL02_Care Management Care Plan Requirements Policy
3. PL03_Recipient Materials Requirements
4. PL04_ Recipient Materials Requirements-Provider Directory
5. PL05_Recipient Notice Model
6. PL06_Regions Map
7. PL07_Multidisciplinary Care Team
8. PL08_Care Management Guidelines
9. PL09_General Risk Stratification Chart
10. PL10_Medically Complex Stratification Chart
11. PL11_ Maternity Risk Stratification Chart
12. PL12_Medical Monitoring Risk Stratification chart
13. PL13_Enrollments, Disenrollments and Reenrollments
14. PL14_Recipient Assignment Process
15. PL15_Training Requirements for Staff who Provide Care Management Services for the Medically Complex Population
16. PL16_Enrollee Manual Model
17. PL17_ Quarterly Grievance Reporting Template
18. PL18_Alabama Medicaid Vendor Interface Specifications
19. PL 19_Alabama Medicaid Case Management Activity Guide V4.0
20. PL 20_Medical Management Meetings

Revised as:

Procurement Library Contents at the time of RFP release are listed below. Please refer to the Alabama Medicaid Procurement website for any updates to the Procurement Library.

(https://medicaid.alabama.gov/content/2.0_Newsroom/2.4_Procurement.aspx)

1. PL01_Consumer Advisory Committee Policy
2. PL02_Care Management Care Plan Requirements Policy
3. PL03_Recipient Materials Requirements

4. PL04_ Recipient Materials Requirements-Provider Directory
5. PL05_Recipient Notice Model
6. PL06_Regions Map
7. PL07_Multidisciplinary Care Team
8. PL08_Care Management Guidelines
9. PL09_General Risk Stratification Chart-updated
10. PL10_Medically Complex Stratification Chart-updated
11. PL11_ Maternity Risk Stratification Chart-updated
12. PL12_Medical Monitoring Risk Stratification chart-updated
13. PL13_Enrollments, Disenrollments and Reenrollments
14. PL14_Recipient Assignment Process
15. PL15_Training Requirements for Staff who Provide Care Management Services for the Medically Complex Population
16. PL16_Enrollee Manual Model
17. PL17_ Quarterly Grievance Reporting Template
18. PL18_Alabama Medicaid Vendor Interface Specifications
19. PL 19_Alabama Medicaid Case Management Activity Guide V4.0
20. PL 20_Medical Management Meetings
21. PL 21_Medicaid Enterprise Security Policy - Full Set - Moderate v1.4-added
22. PL 22_Key Personnel Resume Sheet -added
23. PL 23_AL ACHN PCCM-e Payment Support

9. VI. d, Corporate Background and References, Page 66, changed as follows:

Currently Reads as:

Furnish three (3) professional references for the Executive Director position, including contact name, title, organization, address, phone number, and E-mail address. Professional references must be submitted in accordance with Appendix D: Key Personnel Resume Sheet. 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 RFP. **You may not use any Alabama Medicaid Agency personnel as a reference.**

Revised as:

Furnish three (3) professional references for the Executive Director position, including contact name, title, organization, address, phone number, and E-mail address. Professional references must be submitted in accordance with the Key Personnel Resume Sheet located in the Procurement Library. 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 RFP. **You may not use any Alabama Medicaid Agency personnel as a reference**.

10. **II. Scope of Work, Sub-Section 1. Comprehensive Care Management Program, C. Care Management Populations, 2. Maternity (includes postpartum), a, Page 13, changed as follows:**

Currently Reads as:

The population includes all pregnant and postpartum women from the following benefit types: full Medicaid (TXIX), full Medicaid and Medicare (XIXQ) and full Medicaid/Pregnancy through Postpartum (SBRW).

Revised as:

The population includes all pregnant and postpartum women from the following benefit types: full Medicaid (TXIX) and full Medicaid/Pregnancy through Postpartum (SBRW).

11. **III. General Requirements, Sub-Section 2. Financials, 7-8, Page 39, changed as follows:**

Currently Reads as:
The PCCM-e shall submit quarterly financial reports using a template provided by the Agency. The reports shall be due no later than the fifteenth (15th) business day following the last day of the quarter.

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. At the discretion of the Agency, if the PCCM-e incurs two (2) consecutive months with expenses greater than revenues, the PCCM-e will submit to the Agency a 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.

Revised as:
The PCCM-e shall submit quarterly financial reports using a template provided by the Agency. The reports shall be due as referenced in Section III.10.B.c.

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 as referenced in Section III.10.B.b. At the discretion of the Agency, if the PCCM-e incurs two (2) consecutive months with expenses greater than revenues, the PCCM-e will submit to the Agency a 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.

12. **III. General Requirements, Sub-Section 10. Administrative Requirements, B. Reporting Requirements, Page 55, changed as follows:**

Currently Reads as:

Monthly Reports	Due Dates
Copies of inbound files for PCP enrollment in lieu of signed copies of PCP Agreements to the Agency	No later than the fifteenth (15th) calendar day of the month
Copies of inbound files for MCPs enrollment in lieu of signed copies of MCPs Agreements to the Agency	No later than the fifteenth (15th) calendar day of the month
ADT Report	No later than the fifteenth (15th) calendar day of the month
Flash Report	No later than ten (10) business days following the last day of the preceding month
Terminated Providers Report	Monthly and as submitted to the Agency for processing

Revised as:

Monthly Reports	Due Dates
Copies of inbound files for PCP enrollment in lieu of signed copies of PCP Agreements to the Agency	No later than the fifteenth (15th) calendar day of the month
Copies of inbound files for MCPs enrollment in lieu of signed copies of MCPs Agreements to the Agency	No later than the fifteenth (15th) calendar day of the month
ADT Report	No later than the fifteenth (15th) calendar day of the month
Flash Report	No later than fifteen (15) business days following the last day of the preceding month
Terminated Providers Report	Monthly and as submitted to the Agency for processing

13. IV. Pricing, Sub-Section B. Payment 1., Page 63, changed as follows:

Currently Reads as:
The PCCM-e shall receive monthly, an assignment list of recipients 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 management 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 care management services are limited to the months when services are provided. (See Care Management Activity Schedules, Appendixes G-J, and the Alabama Medicaid Case management Activity Guide V4.0 located in the procurement library for additional details)

Revised as:

The PCCM-e shall receive monthly, an assignment list of recipients 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 management 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 care management services are limited to the months when services are provided. (See Care Management Activity Schedules, Appendixes G-J, and the Alabama Medicaid Case Management Activity Guide V4.0 located in the procurement library for additional details)

14. **IV. Pricing, Sub-Section B. Payment, 5., Page 64, changed as follows:**

Currently Reads as:

PMPM payment: There will also be a monthly payment for all recipients in the General, Maternity, and Medically Complex populations to fund quality improvement projects and administrative costs. Medicaid will determine the percentage of recipients to be care managed in theses populations. 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). There will also be a performance withhold that will be retained by the Agency until the period for determination of the return of the withhold to the PCCM-e. The PMPM payments are further detailed in the Quality Improvement Project Policy in Appendix L.

Revised as:

PMPM payment: There will also be a monthly payment for all recipients in the General, Maternity, and Medically Complex populations to fund quality improvement projects and administrative costs. Medicaid will determine the percentage of recipients to be care managed in theses populations. 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). There will also be a performance withhold that will be retained by the Agency until the period for determination of the return of the withhold to the PCCM-e. The PMPM payments are further detailed in the Quality Improvement Project Policy in Appendix L.

15. **III. General Requirements, Sub-Section 10. Administrative Requirements, B. Reporting Requirements d., Page 57, Changed as follows:**

Currently Reads as:

Quarterly Reports	Due Dates
Annual Operating Budget	At least thirty (30) calendar days prior to the start of each state fiscal year
Audit Report (performed by an independent certified public accountant)	Within ninety (90) calendar days of the end of the state fiscal year – December 31st
Quality Improvement Plan and Evaluation	Within thirty (30) calendar days from execution of the contract and annually by October 1st of each year
Quality Improvement Projects	At least thirty (30) calendar days prior to the start of the contract year
Quality Improvement Project Budget	At least thirty (30) calendar days before the implementation of the QIP
Annual Training Plan and Training Evaluation Summaries	No later than October 1st of each contract year
Application Assisters Report	At program implementation; thereafter, within forty-five (45) calendar days of the contract year; and within thirty (30) calendar days of any change
MCP Network Adequacy Report	At program implementation; thereafter, within forty-five (45) calendar days of the contract year; and within thirty (30) calendar days of any change

Annual Active Participation for PCPs Report	No later than the fifteenth (15th) business day of the month following the end of the last quarter of the contract year
Annual Active Participation for MCPs Report	No later than the fifteenth (15th) business day of the month following the end of the last quarter of the contract year.
Annual Governing Board Member Report	At program implementation; thereafter, within fifteen (15) calendar days of the month following the end of the last quarter of the contract year; and within thirty (30) calendar days of any change
Annual CAC Member Report	At program implementation; thereafter, within fifteen (15) calendar days of the month following the end of the last quarter of the contract year; and within thirty (30) calendar days of any change

Revised as:

Yearly Reports	**Due Dates**
Annual Operating Budget	At least thirty (30) calendar days prior to the start of each state fiscal year
Audit Report (performed by an independent certified public accountant)	Within ninety (90) calendar days of the end of the state fiscal year – December 31st
Quality Improvement Plan and Evaluation	Within thirty (30) calendar days from execution of the contract and annually by October 1st of each year
Quality Improvement Projects	At least thirty (30) calendar days prior to the start of the contract year
Quality Improvement Project Budget	At least thirty (30) calendar days before the implementation of the QIP
Annual Training Plan and Training Evaluation Summaries	No later than October 1st of each contract year
Application Assisters Report	At program implementation; thereafter, within forty-five (45) calendar days of the contract year; and within thirty (30) calendar days of any change
MCP Network Adequacy Report	At program implementation; thereafter, within forty-five (45) calendar days of the contract year; and within thirty (30) calendar days of any change
Annual Active Participation for PCPs Report	No later than the fifteenth (15th) business day of the month following the end of the last quarter of the contract year
Annual Active Participation for MCPs Report	No later than the fifteenth (15th) business day of the month following the end of the last quarter of the contract year.
Annual Governing Board Member Report	At program implementation; thereafter, within fifteen (15) calendar days of the month following the end of the last quarter of the contract year; and within thirty (30) calendar days of any change
Annual CAC Member Report	At program implementation; thereafter, within fifteen (15) calendar days of the month following the end of the last quarter of the contract year; and within thirty (30) calendar days of any change

I hereby acknowledge the receipt of Amendment 2 to RFP 2023-ACHN-01.

_____ _____

Authorized Vendor Signature Date

_____

Vendor Organization