



ALABAMA MEDICAID AGENCY REQUEST FOR PROPOSALS

RFP Number: 2017-MCP-01	RFP Title: Alabama Medicaid Agency Maternity Care Program District 10 and District 12
RFP Due Date and Time: October 27, 2017 by 5:00 pm Central Time	Number of Pages: 166
PROCUREMENT INFORMATION	
Project Director: Sylisa Lee-Jackson	Issue Date: September 27, 2017
E-mail Address: MCPRFP@medicaid.alabama.gov Website: http://www.medicaid.alabama.gov	Issuing Division: Managed Care
INSTRUCTIONS TO CONTRACTORS	
Return Proposal to: Alabama Medicaid Agency Lurleen B. Wallace Building 501 Dexter Avenue PO Box 5624 Montgomery, AL 36103-5624	Mark Face of Envelope/Package: Alabama Medicaid Agency Maternity Care Program District 10 and District 12 RFP Number: 2017-MCP-01 RFP Due Date: October 27, 2017 by 5:00 pm Central Time Firm and Fixed Price:
CONTRACTOR INFORMATION <i>(Contractor must complete the following and return with RFP response)</i>	
Contractor Name/Address:	Authorized Contractor Signatory: (Please print name and sign in ink)
Contractor Phone Number:	Contractor FAX Number:
Contractor Federal I.D. Number:	Contractor 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 Contractor'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. Contractors 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 Contractor'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 Contractor's Response.

Section B. Schedule of Events

The following RFP Schedule of Events represents Medicaid's best estimate of the schedule that shall be followed. Except for the deadlines associated with the Contractor 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. Medicaid reserves the right, at its sole discretion, to adjust this schedule as it deems necessary. Notification of any adjustment to the Schedule of Events shall be posted on the RFP website at www.medicaid.alabama.gov.

EVENT	DATE
RFP Issued	9/27/2017
Questions Due	10/16/2017
Posting of Questions and Answers	10/20/2017
Proposals Due by 5 pm CT	10/27/2017
Evaluation Period	11/1/2017 thru 11/7/2017
Contract Award Notification	11/13/2017
**Contract Review Committee	12/7/2017
Official Contract Award/Begin Work	1/1/2018 **

* *By State law, this contract 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) days. The "Contractor Begins Work" 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.

Table of Contents

Section A. RFP Checklist	2
Section B. Schedule of Events	3
I. Introduction	7
II. Scope of Work	8
III. Pricing	96
IV. General Medicaid Information	97
V. General	98
VI. Corporate Background and References	100
VII. Submission Requirements	101
A. Authority	101
B. Single Point of Contact	102
C. RFP Documentation	102
D. Questions Regarding the RFP	102
E. Acceptance of Standard Terms and Conditions	102
F. Adherence to Specifications and Requirements	103
G. Order of Precedence	103
H. Vendor's Signature	103
I. Offer in Effect for 90 Days	103
J. State Not Responsible for Preparation Costs	103
K. State's Rights Reserved	103
L. Price	104
M. Submission of Proposals	104
N. Copies Required	104
O. Late Proposals	104
P. E-Verify Memorandum of Understanding	104
Q. Proposal Format	104
R. Proposal Withdrawal	105
S. Proposal Amendment	105
T. Proposal Errors	105
U. Proposal Clarifications	105
V. Disclosure of Proposal Contents	105
VIII. Evaluation and Selection Process	106
A. Initial Classification of Proposals as Responsive or Non-responsive	106
B. Determination of Responsibility	106

C.	Opportunity for Additional Information _____	106
D.	Evaluation Committee _____	107
E.	Scoring _____	107
F.	Determination of Successful Proposal _____	107
IX.	General Terms and Conditions _____	107
A.	General _____	107
B.	Compliance with State and Federal Regulations _____	108
C.	Term of Contract _____	108
D.	Contract Amendments _____	108
E.	Confidentiality _____	108
F.	Security and Release of Information _____	109
G.	Federal Nondisclosure Requirements _____	109
H.	Contract a Public Record _____	109
I.	Termination for Bankruptcy _____	110
J.	Termination for Default _____	110
K.	Termination for Unavailability of Funds _____	110
L.	Proration of Funds _____	110
M.	Termination for Convenience _____	110
N.	Force Majeure _____	111
O.	Nondiscriminatory Compliance _____	111
P.	Conflict of Interest _____	111
Q.	Open Trade _____	111
R.	Small and Minority Business Enterprise Utilization _____	111
S.	Worker’s Compensation _____	111
T.	Employment of State Staff _____	111
U.	Immigration Compliance _____	112
V.	Share of Contract _____	112
W.	Waivers _____	112
X.	Warranties Against Broker’s Fees _____	112
Y.	Novation _____	113
Z.	Employment Basis _____	113
AA.	Disputes and Litigation _____	113
BB.	Records Retention and Storage _____	113
CC.	Inspection of Records _____	114
DD.	Use of Federal Cost Principles _____	114
EE.	Payment _____	114

FF. Notice to Parties	114
GG. Disclosure Statement	114
HH. Debarment	114
II. Not to Constitute a Debt of the State	115
JJ. Qualification to do Business in Alabama	115
KK. Choice of Law	115
LL. Alabama interChange Interface Standards	115
X. Performance Guarantee	115
XI. Damages for Cost Associated with Breach of Contract/Liquidated Damages	116
XII. Contract Ending Transition and Implementation Plan Incumbent	118
Appendix A: Proposal Compliance Checklist	119
Appendix B: Contract and Attachments	121
Appendix C: Performance Improvement Projects Guidelines	136
Appendix D: Home Visit Program	138
Attachment E: Care Coordination Program	140
Appendix F: Program Glossary of Terms	147
Attachment G: Managed Care Rule Glossary of Terms	154

I. Introduction

A. Background

The Alabama Medicaid Agency, hereinafter called Medicaid, an Agency of the State of Alabama, began the Maternity Care Program in 1988 under the authority of a 1915(b) Waiver. This authority allows the State to require pregnant women to receive their care through specified networks. The waiver was developed in an effort to address Alabama's high infant mortality rate, the high drop-in delivery rate and the lack of Delivering Healthcare Professionals (DHCP) participation. The waiver is administered statewide in each of the 67 counties, divided into 14 districts. The current 1915(b) Waiver is effective September 1, 2017 through August 31, 2019.

A five (5) year term RFP was released in 2015 for the provision of maternity services for 14 Districts. Medicaid did not receive any proposals in response to the RFP for District 10, which covers Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery and Pike Counties. This resulted in atypical contracting circumstances for District 10.

Contracts under a Request for Proposal (RFP) are termed for 12 months. The Primary Contractor for District 12, which serviced Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe and Washington Counties, did not execute a contract for calendar year 2017. This resulted in atypical contracting circumstances for District 12.

B. Purpose

This RFP is for the provision of maternity services by a Primary Contractor for Districts 10 and 12, see **Figure 1** below. The Contractor servicing District 10 and District 12 will have the responsibility of establishing a comprehensive network of subcontractors that can provide prenatal, delivery and postpartum care to maternity enrollees. Care coordination is a major component of this comprehensive plan and must be the responsibility of the Contractor. Any access to care issues must be addressed under the Contractor's infrastructure and the Contractor must provide methods and procedures to safeguard against unnecessary utilization of care and services to assure efficiency, economy and quality of care as required by law pursuant to Section 1902 (a) (30) of the Social Security Act (ACT).

Figure 1. Districts and Counties Served

District	Counties Served
District 10	Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery and Pike
District 12	Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe and Washington

C. RFP Description

The scope of work term dates for this RFP are January 1, 2018 through December 31, 2020.

The Contractor to whom the contract is awarded must be responsible for the performance of all duties contained within this RFP for the firm and fixed price quoted in the Contractor's proposal to this RFP. All proposals must state a firm and fixed price for the services described. All information contained in this RFP and any amendments reflect the best and most accurate information available to Medicaid at the time of RFP preparation. No inaccuracies in such data shall constitute a basis for change of the payments to the Contractor or a basis for legal recovery of damages, actual, consequential or punitive, except to the extent that such inaccuracies are the result of intentional misrepresentation by Medicaid.

II. Scope of Work

AS PART OF THE PROPOSAL, CONTRACTORS MUST ACKNOWLEDGE AND COMPLY WITH ALL REQUIREMENTS LISTED IN THE SCOPE OF WORK SECTIONS A-ZZ. The Contractor's proposal must provide a detailed plan (i.e., draft policies, procedures, or documents deemed necessary) detailing how it will meet and comply with the requirements listed in Sections A-ZZ. Responses to this RFP must align with the requirements format.

A. General Maternity Care Program Requirements

- A.1 The Vendor's proposal must contain a written statement stating the Vendor acknowledges and will comply with the requirements set forth in the entire RFP.
- A.2 The Vendor's proposal must acknowledge the federal definition of a PAHP, as defined in the Managed Care Rule, 42 CFR §438.
- A.3 The Vendor must meet solvency standards as specified in 42 CFR §438.116.
- A.4 The Vendor's proposal must acknowledge compliance with the applicable requirements of Alabama Medicaid Administrative Code, 560-X-37 and 560-X-45 and any revisions thereof that governs the PAHP.
- A.5 The Vendor's proposal must acknowledge compliance with the requirements of the 1915(b) Maternity Care Waiver and amendments thereof that governs the PAHP.
- A.6 The Vendor's proposal must acknowledge comply with the applicable requirements of the Alabama Medicaid Provider Manual and any revisions thereof that governs the PAHP.
- A.7 The Vendor's proposal must acknowledge comply with the requirements of the Maternity Care Program Operational Manual and any revisions thereof that governs the PAHP.
- A.8 The Vendor must successfully complete the Medicaid's Readiness Review prior to the start of operations as defined by federal regulations.
- A.9 The Vendor's proposal must acknowledge compliance with all current state and federal statutes, regulations, and administrative procedures that are or become

effective during the term of this Contract. regulations governing contracts with PAHPs are specified in 42 CFR Part §438 and will govern this Contract. Medicaid is not precluded from implementing any changes in state or federal statutes, rules or administrative procedures that become effective during the term of this Contract and will implement such changes.

B. General Program Requirements

- B.1 In accordance with 42 CFR 438.210(a)(1); 42 CFR 438.210(a)(2), the Vendor's proposal must identify, define and specify the amount, duration, and scope of each service it will offer to enrollees on the Maternity Care Program. The services provided to adults must be furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided under Fee-for-Service (FFS) Medicaid. The Vendor will provide services for enrollees under the age of 21 to the same extent that services are furnished to individuals under the age of 21 under FFS Medicaid.
- B.2 The Vendor may place appropriate limits on a service for utilization control:
- B.2.1 Provided the services furnished can reasonably achieve their purpose.
 - B.2.2 Provided the services supporting individuals with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects the enrollee's ongoing need for such services and supports.
 - B.2.3 Provided family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used.
- B.3 The Vendor must procure a network of subcontractors within 50 miles of all areas in their district. A GPS mapping attachment is required to support this requirement. This is determined through the RFP evaluation process using Letter of Intent to Contract from all subcontractors which must list sites where they are located and shall be submitted with the GPS mapping as part of the Vendor's proposal.
- B.4 Neither the Vendor nor any person, firm or corporation employed by the Vendor in the performance of this contract shall offer or give, directly or indirectly, to any employee or agent of the State, any gift, money or anything of value, or any promise, obligation or contract for future reward or compensation at any time during the term of this contract.
- B.5 The Vendor must comply with 42 CFR 438.230(b)(1); 42 CFR 438.3(k) and will maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the state, notwithstanding any relationship(s) that the Vendor may have with any subcontractor.

- B.6 The Vendor must comply with 42 CFR 438.230(c)(1)(i) - (iii); 42 CFR 438.3(k). If any of the Vendor's activities or obligations under the contract with the state are delegated to a subcontractor, the activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the Vendor and the subcontractor. The contract or written arrangement between the Vendor and the subcontractor must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the state or the Vendor determines that the subcontractor has not performed satisfactorily.
- B.7 The Vendor must comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions in accordance with 42 CFR 438.230(c)(2); 42 CFR 438.3(k).
- B.8 The vendor must accept new enrollment from individuals in the order in which they apply without restrictions as specified in 42 CFR 42 CFR 438.6(d)(1).
- B.9 The Vendor must comply with 42 CFR 438.3(f)(1); 42 CFR 438.100(d). The Vendor shall comply with all applicable Federal and state laws and regulations including:
- B.9.1 Title VI of the Civil Rights Act (CRA) of 1964;
 - B.9.2 The Age Discrimination Act of 1975;
 - B.9.3 The Rehabilitation Act of 1973;
 - B.9.4 Title IX of the Education Amendments of 1972 (regarding education programs and activities);
 - B.9.5 The Americans with Disabilities Act; and
 - B.9.6 Section 1557 of the Patient Protection and Affordable Care Act (ACA).
- B.10 The Vendor must comply with Title VI of the Civil Rights Act of 1964 (42 USC §2000d, et seq.), Section 504 of the Rehabilitation Act of 1973 (29 USC §6101, et seq.) and the Americans with Disabilities Act of 1990 (42 USC §2101, et seq.), (42 CFR 42 CFR 438.3(d)(4)). No individual shall, on the ground of race, color, national origin, sex, sexual orientation, gender identity disability, creed, or age, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program of services.
- B.11 The Vendor may not use any policy or practice that has the effect of discriminating against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability in accordance with 42 CFR 438.3(d)(4).

- B.12 Enrollees are notified at the time of Medicaid application of the requirement to participate and enroll in the program. The Vendor must have an outreach plan in their district to inform women of program requirements.
- B.13 The Vendor must serve the following Medicaid Enrollees who are pregnant and who are required to participate in the Maternity Care Program:
- B.13.1 Those certified under the Affordable Care Act using the Modified Adjusted Gross Income (MAGI) rules for pregnant women with the exception of the Department of Youth Services enrollees identified with County Code 69.
 - B.13.2 Those certified through the Parent Other Caretaker Relative (POCR)
 - B.13.3 Refugees
 - B.13.4 Supplemental Security Income (SSI) eligible women
- B.14 The following Medicaid enrollees are not required to participate in the Maternity Care Program and should not be enrolled by the Vendor:
- B.14.1 Dual eligible (Medicare/Medicaid)
 - B.14.2 Individuals granted emergency Medicaid due to their non-citizen status
- B.15 The Vendor may not assign a contract without written consent of Medicaid.
- B.16 The Vendor may subcontract for the professional services necessary for the completion and maintenance of this contract and for the performance of its duties under this contract with advance written approval of both the subcontracted function and the subcontractor by Medicaid. Subcontractors shall demonstrate the capability to perform the function to be subcontracted at a level equal or superior to the requirements of the contract relevant to the service to be performed. All subcontracts shall be in writing, with the subcontractor functions and duties clearly identified, and shall require the subcontractor to comply with all applicable provisions of this RFP.
- B.17 The Vendor shall at all times remain responsible for the performance by subcontractors approved by Medicaid. The Vendor's subcontractor contracts must include language to comply with 42 CFR 438.3(h). The contract must require that the state, the Centers for Medicare and Medicaid Services (CMS), the Office of Inspector General (OIG), the Comptroller General, and their designees be allowed to inspect and audit any records or documents of the Vendors' subcontractors at any time.
- B.18 The Vendor's performance guarantee and responsibility for damages shall apply whether performance or non-performance was by the Vendor or one of its subcontractors.

- B.19 Medicaid shall not release the Vendor from any claims or defaults of this contract which are predicated upon any action or inaction or default by any subcontractor of Vendor, even if such subcontractor was approved by Medicaid as provided above.
- B.20 The Vendor shall give Medicaid notice in writing by registered mail of any action or suit made against said Vendor by any subcontractor or vendor, which, in the opinion of Vendor, may result in litigation related in any way to this contract with the State of Alabama.
- B.21 The Vendor must submit Letters of Intent to Contract from each subcontractor, if the use of subcontractors is necessary to meet the requirements of this RFP. The Letters of Intent to Contract must be signed by an individual authorized to legally bind the subcontractor to perform the scope of work as assigned, stating:
- B.21.1 The general scope and volume of work to be performed by the subcontractor.
 - B.21.2 The subcontractor's willingness to perform the work indicated.
 - B.21.3 The names and titles of individuals who will be responsible for the subcontractor's efforts.
 - B.21.4 The rate or methodology (if a varying rate is to be paid) of reimbursement to be received for the subcontractor's efforts.
- B.22 In accordance with 42 CFR 438.230(b)(1), the Vendor will evaluate a prospective subcontractor's ability to perform the activities prior to delegating the activities.
- B.23 In accordance with 42 CFR 438.230(b)(2)(i), the Vendor will execute a written agreement with any subcontractors that specifies the activities and report responsibilities delegated to the subcontractor.
- B.24 In accordance with 42 CFR 438.230(b)(2)(ii), the Vendor will execute a written agreement with any subcontractors that specifies the vendor's right to revoke the subcontract or impose sanctions if the subcontractor's performance is inadequate.
- B.25 In accordance with 42 CFR 438.230(b)(3), the Vendor will monitor the subcontractor's performance on an ongoing basis. This includes conducting formal reviews according to a review schedule that is set by the state and consistent with industry standards and state MCO laws.
- B.26 In accordance with 42 CFR 438.230(b)(4), the Vendor and subcontractor will take corrective action on any identified deficiencies or areas of improvement.
- B.27 The Vendor must comply with all authoritative documents guiding the administration of the Maternity Care Program:

- The Alabama Medicaid Agency Administrative Code, and any amendments thereto;
- The Maternity Care Program Operational Manual, and any amendments thereto;
- The Alabama Medicaid Provider Manual, and any amendments thereto;
- The 1915(b) Waiver, and any amendments thereto; and
- The CMS Managed Care Rules, and any amendments thereto;

C. Operation Requirements

C.1 Directorship

- C.1.1 The Vendor **must** have a full time director for the district. The full time director cannot assume any other responsibilities that are not related to this scope of work. This full time director may simultaneously assume the directorship position of more than one district if the other district is administered by the **same Vendor, under the exact same business name, under the exact same scope of work.**
- C.1.2 The director must have the following minimum qualifications:
- C.1.2.1 A BS or BA degree from an accredited college or, or a minimum of three years of management experience in managed health care.
- C.1.2.2 Experience in working with low-income populations.
- C.1.3 The Vendor's proposal must include a resume for the director. The director or an appropriately qualified designee must be available/accessible, and on call 24 hours a day, 7 days a week for any administrative and/or medical problems which may arise.
- C.1.4 The director will make day to day decisions, implement program policy, and oversee the provision of care to qualified enrollees according to the Federal and State regulations. The director must participate in all monthly status calls and attend all called meetings by the Alabama Medicaid Agency.
- C.1.5 Any changes in the Directorship position must be approved by Medicaid. The notification for change must be submitted in writing to the Associate Director of the Maternity Care Program no later than 30 days prior to the effective date of the change.

C.2 Accreditation

C.2.1 In accordance with 42 CFR 438.332(a), the Vendor must inform Medicaid as to whether it has been accredited by a private independent accrediting entity.

C.2.2 In accordance with 42 CFR 438.332(b)(1) - (3), the Vendor that has received accreditation must authorize the private independent accrediting entity to provide the state a copy of its most recent accreditation review, including:

C.2.2.1 Its accreditation status, survey type, and level (as applicable);

C.2.2.2 Recommended actions or improvements, corrective action plans, and summaries of findings; and

C.2.2.3 The expiration date of the accreditation.

C.3 Provider Preventable Conditions

C.3.1 Payments cannot be made to a provider for provider-preventable conditions that meet the following criteria:

C.3.1.1 Provider-preventable conditions as identified in the state plan.

C.3.1.2 Provider-preventable conditions that have been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

C.3.1.3 Provider-preventable conditions that have a negative consequence for the beneficiary.

C.3.1.4 Auditable provider-preventable conditions.

C.3.1.5 Provider-preventable conditions, at a minimum, that includes wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

C.3.2 The Vendor must require their subcontractors for whom they subcontract with to report to the contractor all provider-preventable conditions associated with claims for payment or enrollee treatments for which payment would otherwise be made.

C.3.3 All identified provider-preventable conditions must be reported to the Maternity Care Program quarterly in the form specified by the state.

C.4 Cost Sharing

- C.4.1 Cost sharing shall not be imposed on Medicaid enrollees that are not in accordance with Medicaid's FFS requirements at 42 CFR 447.50 through 42 CFR 447.82.
- C.4.2 Any Indian who is eligible to receive or has received an item or service furnished by an IHCP or through referral under contract health services will be exempted from premiums.
- C.4.3 Any Indian who is currently receiving or has ever received an item or service furnished by an IHCP or through referral under contract health services will be exempted from all cost sharing.

D. Beneficiary Notification

D.1 Language and Format

- D.1.1 Information provided to enrollees and potential enrollees must be provided in a manner and format that is easily understood and readily accessible by such enrollees and potential enrollees of the Maternity Care Program.
- D.1.2 The Vendor proposal shall contain details of mechanisms in place to help enrollees and potential enrollees understand the requirements and benefits of their plan.
- D.1.3 Written materials that are critical to obtaining services, including the enrollee handbooks must be available in the prevalent non-English languages for the district(s) the Vendor will be servicing.

D.2 Written materials must be:

- D.2.1 Available in alternative formats upon request of the potential enrollee or enrollee at no cost.
- D.2.2 Include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand.
- D.2.3 Include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the Vendor's member/customer service unit.

- D.3 Auxiliary aids and services must be available upon request of the potential enrollee or enrollee at no cost.

D.4 Interpretation services, including oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language (ASL), shall be made available , free of charge to each Maternity Care Program enrollee.

D.5 Each enrollee must receive notification that:

D.5.1 Oral interpretation is available for any language, and how to access those services.

D.5.2 Written translation is available in prevalent languages, and how to access those services.

D.5.3 Auxiliary aids and services are available upon request at no cost for enrollees with disabilities, and how to access those services.

D.6 All written materials for enrollees and potential enrollees shall be provided in a font size no smaller than 12 point.

D.7 Written materials shall be provided in alternative formats in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.

D.8 Written materials for potential enrollees and enrollees must be available through auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.

D.9 Vendors must include on all written materials a large print tagline and information on how to request auxiliary aids and services, including materials in alternative formats.

D.10 Enrollee and Potential Enrollee Information

In compliance with 42 CFR 438.10(d)(1), the Prevalent Non-English Languages as defined by the state are:

D.1 Spanish or Spanish Creole

D. 2 Korean

D. 3 Chinese

D. 4 Vietnamese

D. 5 Arabic

D. 6 German

D. 7 French

D. 8 Gujarati

D. 9 Tagalog

D.10 Hindi

D.11 Laotian

D.12 Russian

D.13 Portuguese

D.14 Turkish

D.15 Japanese

E. Enrollee Handbook

E.1 The Vendor must use and provide to each enrollee the state developed model enrollee handbook which serves as a summary of benefits and coverage, within a reasonable time not to exceed fifteen (15) calendar days after enrollment.

E.2 The content of the enrollee handbook must include information that enables the enrollee to understand how to effectively use the Maternity Care Program including at a minimum the information set forth in 42 CFR § 438.10(g)(2).

E.3 The Vendor must utilize the model enrollee handbook developed by the state that includes information:

E.3.1 On benefits provided by the Vendor. This includes information about the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and how to access component services if individuals under age 21 entitled to the EPSDT benefit are enrolled in the Vendor's Maternity program;

E.3.2 About how and where to access any benefits provided by the state, including EPSDT benefits delivered outside the Vendor, if any;

E.3.3 About cost sharing on any benefits carved out of the Vendor's contract and provided by the state; and

E.3.4 About how non-emergency transportation is provided for any benefits carved out of the Vendor's contract and provided by the state.

E.4 The Vendor must utilize the model enrollee handbook developed by the state that includes detail that in the case of a counseling or referral service that Vendor does not cover because of moral or religious objections, the Vendor informs enrollees:

- E.4.1 That the service is not covered by the Vendor.
- E.4.2 How they can obtain information from the state about how to access those services.
- E.5 The Vendor must utilize the model enrollee handbook developed by the state that includes:
 - E.5.1 The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
 - E.5.2 Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's PCP.
- E.6 The Vendor must utilize the model enrollee handbook developed by the state that includes the extent to which, and how, after-hours care is provided.
- E.7 The Vendor must utilize the model enrollee handbook developed by the state that includes:
 - E.7.1 How emergency care is provided.
 - E.7.2 Information regarding what constitutes an emergency medical condition.
 - E.7.3 Information regarding what constitutes an emergency service.
 - E.7.4 The fact that prior authorization is not required for emergency services.
 - E.7.5 The fact that the enrollee has a right to use any hospital or other setting for emergency care.
- E.8 The Vendor must utilize the model enrollee handbook developed by the state that includes:
 - E.8.1 Any restrictions on the enrollee's freedom of choice among network providers.
 - E.8.2 The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers.
- E.9 The Vendor must utilize the model enrollee handbook developed by the state that includes an explanation that the Vendor cannot require an enrollee to obtain a referral before choosing a family planning provider.
- E.10 The Vendor must utilize the model enrollee handbook developed by the state that

includes cost sharing for services furnished by the Vendor , if any is imposed under the state plan.

- E.11 The Vendor must utilize the model enrollee handbook developed by the state that includes enrollee rights and responsibilities, including the enrollee's right to:
 - E.11.1 Receive information on beneficiary and plan information.
 - E.11.2 Be treated with respect and with due consideration for his or her dignity and privacy.
 - E.11.3 Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
 - E.11.4 Participate in decisions regarding his or her health care, including the right to refuse treatment.
 - E.11.5 Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
 - E.11.6 Request and receive a copy of their medical records and request that they be amended or corrected.
- E.12 The Vendor must utilize the model enrollee handbook developed by the state that includes enrollee rights and responsibilities, including the enrollee's right to obtain available and accessible Medicaid covered health care services.
- E.13 The Vendor must utilize the model enrollee handbook developed by the state that includes the process of selecting and changing the enrollee's PCP.
- E.14 The Vendor must utilize the model enrollee handbook developed by the state that includes grievance, appeal, and fair hearing procedures and timeframes in a state-developed or state-approved description.
- E.15 The Vendor must utilize the model enrollee handbook developed by the state that:
 - E.15.1 Includes the enrollee's right to file grievances and appeals.
 - E.15.2 Includes the requirements and timeframes for filing a grievance or appeal.
 - E.15.3 Includes information on the availability of assistance in the filing process for grievances.
 - E.15.4 Includes information on the availability of assistance in the filing process for appeals.

- E.15.5 Includes the enrollee's right to request a state fair hearing after the Vendor has made a determination on an enrollee's appeal which is adverse to the enrollee.
- E.15.6 Specifies that, when requested by the enrollee, benefits that the Vendor seeks to reduce or terminate will continue if the enrollee files an appeal or a request for state fair hearing within the timeframes specified for filing, and that the enrollee may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.
- E.16 The Vendor must utilize the model enrollee handbook developed by the state that includes how to exercise an advance directive, if the Vendor includes any of the following providers in its network: hospitals, critical access hospitals, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious nonmedical health care institutions.
- E.17 The Vendor must utilize the model enrollee handbook developed by the state that includes:
 - E.17.1 How to access auxiliary aids and services, including additional information in alternative formats or languages.
 - E.17.2 The toll-free telephone number for member services.
 - E.17.3 The toll-free telephone number for medical management.
 - E.17.4 The toll-free telephone number for any other unit providing services directly to enrollees.
 - E.17.5 Information on how to report suspected fraud or abuse.
 - E.17.6 Any other content required by the state.
- E.18 The Vendor must provide each enrollee notice of any significant change, as defined by the state, in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change.
- E.19 The Vendor must utilize the model enrollee handbook and notices that describe the transition of care policies for enrollees and potential enrollees.
- E.20 Any changes to the enrollee handbook must be approved by the Alabama Medicaid Agency, Managed Care Program.
- E. 21 Any changes to the enrollee handbook must be submitted to the Alabama Medicaid Agency, Managed Care Program for approval no later than 90 days of the effective date of such change request.

F. Enrollee Handbook Dissemination

F.1 The enrollee handbook in any of the following formats will be considered to have been properly provided if the Vendor:

F.1.1 Mails a printed copy of the information to the enrollee's mailing address.

F.1.1 Provides the information by email after obtaining the enrollee's agreement to receive the information by email.

F.1.1 Posts the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.

or

F.1.1 Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

G. Network Provider Directory

G.1 The Vendor's network providers must be available to the enrollee in paper form, upon request, and electronic form for each of their participating providers and must include the following:

G.1.1 The Provider's names, as well as any group affiliations.

G.1.2 The Provider's street addresses.

G.1.3 The Provider's telephone numbers.

G.1.4 The Provider's website URLs, as appropriate.

G.1.5 Specialties, as appropriate.

G.1.6 Whether providers will accept new enrollees.

G.1.7 The cultural and linguistic capabilities of providers, including languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.

G.1.8 Whether providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

G.2 The paper provider directory must be updated at least monthly. The electronic provider directory must be updated no later than 30 calendar days after the Vendor receives updated provider information from the subcontractor.

G.3 The provider directories shall be made available on the Vendor's website in a machine readable file and format approved by Medicaid

H. Provider Terminations and Incentives

H.1 The Vendor must provide a written notice of termination of a subcontractor, within 15 calendar days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from the subcontractor, or was seen on a regular basis by the terminated subcontractor.

H.2 Any physician incentive plans in place by the Vendor will be made available to Medicaid, upon request of Medicaid

I. Marketing

I.1 Marketing materials shall not be distributed without first obtaining state approval.

I.1.1 When approved marketed materials are distributed, the marketing materials must be distributed to the entire service area as indicated in the contract.

I.1.2 Seeking to influence enrollment in conjunction with the sale or offering of any private insurance is prohibited under this contract.

I.1.3 Directly or indirectly engaging in door-to-door, telephone, e-mail, texting, or other cold-call marketing activities are prohibited under this contract.

I.2 The Marketing materials, including plans and materials, shall be accurate and does not mislead, confuse, or defraud the enrollees or the state.

I.3 The Marketing materials will not contain assertion or statement (whether written or oral) that the recipient must enroll in the Vendor's program to obtain Medicaid benefits or to not lose Medicaid benefits.

I.4 The Marketing materials will not contain assertion or statement (whether written or oral) that the Vendor is endorsed by CMS, the Federal or state government, or a similar entity.

J. General Information Requirements

J.1 If the required information is provided electronically to enrollees:

J.1.1 The information must be in a format that is readily accessible.

J.1.2 The information must be placed in a location on the Vendor's website that is prominent and readily accessible.

J.1.3 The information must be provided in an electronic form which can be electronically retained and printed.

J.1.4 The information must be consistent with content and language requirements.

J.1.5 The Vendor must notify enrollees that the information is available in paper form without charge upon request.

J.1.6 The Vendor must provide, upon request, information in paper form within 5 business days.

J.2 Written advance directives policies, including a description of applicable state law must be provided to adult enrollees.

J.3 Written advance directives information will reflect all changes in state law in its as soon as possible, but no later than 90 days after the effective date of the change.

K. Cultural Competence

K.1 The Vendor will participate in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

L. Health Information Systems and Enrollee Data

L.1 The Vendor must comply with 42 CFR 438.242(a) and maintain a computer based health information system that collects, integrates, analyzes and reports enrollee information.

L.2 The health information system must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility

L.3 The Vendor must comply with the requirement of 42 CFR 438.242(b)(1). The Vendor will comply with Section 6504(a) of the Affordable Care Act (ACA), which requires that state claims processing and retrieval systems be able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of section 1903(r)(1)(F) of the Act [42 CFR 438.242(b)(1); Section 6504(a) of the ACA; section 1903(r)(1)(F) of the Act.

- L.4 The Vendor will collect data on enrollee and provider characteristics as specified by the Medicaid and on all services furnished to enrollees through an encounter data system or other methods as may be specified by the Medicaid in accordance with 42 CFR 438.242(b)(2).
- L.5 The Vendor must verify the accuracy and timeliness of data reported by subcontractors the Vendor is compensating on the basis of capitation payments in accordance with 42 CFR 438.242(b)(3)(i).
- L.6 The Vendor must screen the data received from subcontractors for completeness, logic, and consistency in accordance with 42 CFR 438.242(b)(3)(i) before entering into Medicaid's data collection system.
- L.7 The Vendor must comply with requirement of 42 CFR 438.242(b)(3)(iii) by collecting data from subcontractors in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for state Medicaid quality improvement and care coordination efforts.
- L.8 The Vendor must make all collected data available to Medicaid and CMS upon request in accordance with 42 CFR 438.242(b)(4).
- L.9 The Vendor must collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees in accordance with 42 CFR 438.242(c)(1) - (4); 42 CFR 438.818.
- L.11 The Vendor must submit enrollee encounter data to the state at a frequency and level of detail to be specified by CMS and the state, based on program administration, oversight, and program integrity needs in accordance with 42 CFR 438.242(c)(1) - (4); 42 CFR 438.818.
- L.12 The Vendor must submit all enrollee encounter data that Medicaid is required to report to CMS in accordance with 42 CFR 438.242(c)(1) - (4); 42 CFR 438.818.
- L.13 The Vendor must comply with the requirements of 42 CFR 438.242(c)(1) - (4); 42 CFR 438.818 regarding specifications for submitting encounter data to the Medicaid in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate in accordance with 42 CFR 438.242(c)(1) - (4); 42 CFR 438.818.
- L.14 The Vendor must submit Encounter Data claims that are complete, accurate and reflective of care provided to enrollees. A capitated payment will not be generated until all required encounter claims have been submitted.
- L.15 The Vendor must submit all Encounter Data claims to Medicaid through the approved process within 90 days of the date of delivery. Damages for cost associated with breach of contract may be imposed for Encounter Claims data not submitted according to guidelines.

- L.16 When a Vendor bills for another districts, the billing district must enter the Encounter Data claims for the capitated payment being billed.
- L.17 The Vendor is responsible for continued reporting beyond the term of the contract due to lag time in filing source documents by subcontractors.
- L.18 If the Vendor enters into a capitated arrangement with a participating provider, the Vendor must impose the same detailed encounter data reporting requirements as for other subcontractors paid by the Vendor.
- L.19 The Vendor must comply with the required format provided by Medicaid. Encounter data includes claims paid by the Vendor for services delivered to members through the subcontractor during a specified reporting period. Medicaid collects and uses this data for many reasons such as: federal reporting, rate setting, service verification, managed care quality improvement program, utilization patterns, access to care, and research studies.
- L.20 Medicaid may change the Encounter Data Transaction requirements with thirty (30) calendar days written notice to the Vendor. The Vendor must, upon notice from Medicaid, provide notice of changes to the subcontractors

M. Program Functions

- M.1 The Vendor must provide the pregnant Medicaid eligible population obstetrical care through a comprehensive system of quality care. The care can be provided directly or through subcontracts. The successful Vendor's delivery system will not include the hospital component. The hospital will be outside of the capitated payment for maternity care.
- M.2 The Vendor must implement and maintain a Medicaid approved quality assurance improvement system by which program access, process and outcomes are measured.
- M.3 The Vendor must provide Application Assister services to Medicaid enrollees utilizing individuals with up-to-date certification as Application Assisters.
- M.4 The Vendor must utilize proper tools and service planning for women assessed to be at risk medically or psychosocially.
- M.5 The Vendor must provide enrollees choice among DHCPs.
- M.6 The Vendor must meet all requirements of the provider network, including but not limited to, maintaining written subcontracts, notifying Medicaid of any changes in the network, and maintaining a network of providers to meet program requirements.
- M.7 The Vendor must maintain a toll-free line and adequate staff to enroll enrollees and

provide program information. If the Vendor, subcontractors and enrollees are within the local calling distance area a toll-free line is not necessary.

M.8 The Vendor must develop, implement and maintain an extensive enrollee education plan. Documentation must be maintained to support compliance with this requirement

M.9 The Vendor must develop, implement and maintain a provider education plan. Documentation must be maintained to support compliance with this requirement.

M.10 The Vendor must develop, implement and maintain an effective outreach plan to make providers, enrollees and the community aware of the purpose of the Maternity Care Program and the services offered. Documentation must be maintained to support compliance with this requirement

M.11 The Vendor must develop, implement and maintain an educational program explaining how to access the Maternity Care Program including service locations. Documentation must be maintained to support compliance with this requirement

M.12. The Vendor must develop, implement and maintain a grievance procedure that is easily accessible and that is explained to enrollees upon entry into the system. Documentation must be maintained to support compliance with this requirement

M.13 The Vendor must develop, and implement a system for accommodating enrollee transfer requests that may occur as a result of a grievance or complaint so that care provided by the transferring Delivering Healthcare Professional as well as the receiving Delivering Healthcare Professional may receive payment for services rendered.

M.14 The Vendor must develop, implement and maintain a system for handling billing inquiries from enrollees and subcontractors so that inquiries are handled in a timely manner.

M.16 The Vendor must give Medicaid immediate notification, by telephone and followed in writing, of any action or suit filed and prompt notice of any claim made against the Vendor by any subcontractor which may result in litigation related in any way to this contract. In the event of the filing of a petition for bankruptcy by or against any subcontractor or the insolvency of any subcontractor, the Vendor must ensure that all tasks related to any subcontractor are performed in accordance with the Terms of the Agreement.

M.17 The Vendor must ensure the subcontractor maintain, for each enrollee, a complete record at one location of all services provided by the subcontractor.. the care coordination notes must be included as part of this complete record. Such information shall be accessible to the Vendor and shall obtain such information from all providers of services and identify by enrollee name, enrollee number, date of service, and services provided prior to making payment to that provider of service. Any record requested by the Vendor or Medicaid shall be provided free

of charge.

- M.18 The Vendor must provide copies of medical record documentation to Medicaid, as requested, for medical record reviews and other quality related activities.
- M.19 The Vendor must perform claim reviews prior to submission to Medicaid for administrative review.
- M.20 The Vendor must advise enrollees of services that may be covered by Medicaid that are not covered through the Maternity Care Program.
- M.21 The Vendor must promptly provide to Medicaid all information necessary for the reimbursement of outstanding claims in the event of insolvency.
- M.22 The Vendor must coordinate care from out-of-network providers to ensure that there is no added cost to the enrollee. If the Vendor is unable to provide the necessary care covered under this contract, the Vendor must adequately and timely cover these services out of network for the enrollee with the exception of an exemption granted by the Medicaid. The exemption would be paid fee for service.
- M.23 The Vendor must use Medicaid's Web Service Database for reporting program demographics and other elements related to the pregnancy.
- M.24 The Vendor must designate a person to enter data and manage Medicaid's Service Database entries. This designee is responsible for the transmission of valid, timely, complete and comprehensive data, along with auditing the database periodically. The designated representative(s) shall evaluate data for quantitative integrity, such as variances compared to the eligibility system and Service Report omissions. Other responsibilities include, but are not limited to, ensuring that all enrollees, excluding exemptions, are entered into the database with all required reporting elements, and correcting discrepancies to ensure an error rate of no greater than 5%. This person must attend mandatory training as designated by the Medicaid.
- M.25 The Vendor must coordinate service database data entries for enrollees transferring from one district to another district to ensure transmission of valid, timely, complete and comprehensive data entries.
- M.26 The Vendor must meet all of the requirements of 42 CFR 438. The Primary Contractors must provide information to enrollees on the names, locations, telephone numbers of, and non-English languages spoken by current subcontractors in the enrollee's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.
- M.28 The Vendor must meet all of the requirements of 42 CFR 438.3(j)(1) and (2); 42 CFR 422.128(a); 42 CFR 422.128(b); 42 CFR 489.102(a); 42 CFR 438.3(j)(1) and (2); 42 CFR 422.128(b)(1)(ii)(F); 42 CFR 489.102(a)(3); 42 CFR 438.3(j)(1)

and (2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5) regarding advance directives. The Vendor will:

M.28.1 Maintain written policies and procedures on advance directives for all adults receiving medical care by or through the vendor;

M.28.2 Not condition the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive; and

M.28.3 Educate staff concerning their policies and procedures on advance directives.

N. Grievance and Appeals System

N.1 In accordance with 42 CFR 438.402(a); 42 CFR 438.228(a), the Vendor must have a grievance and appeal system in place for enrollees. The Vendor must only have one level of appeal for enrollees.

N.2 In accordance with 42 CFR 438.406(a); 42 CFR 438.228(a), the Vendor must give enrollees any reasonable assistance in completing grievance and appeal forms and other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with Teletypewriter Telephone/Telecommunication Device for the Deaf (TTY/TDD) and interpreter capability.

N.3 In accordance with 42 CFR 438.406(b)(1); 42 CFR 438.228(a), the Vendor must acknowledge receipt of each grievance and appeal of adverse benefit determinations

N.4 In accordance with 42 CFR 438.406(b)(2)(i); 42 CFR 438.228(a), the Vendor must ensure that decision makers on grievances and appeals of adverse benefit determinations were not involved in any previous level of review or decision-making or subordinates of any individual who was involved in a previous level of review or decision-making.

N.5 In accordance with 42 CFR 438.406(b)(2)(ii)(A) - (C); 42 CFR 438.228(a), the Vendor must ensure that decision makers on grievances and appeals of adverse benefit determinations are individuals with appropriate clinical expertise, as determined by the state, in treating the enrollee's condition or disease:

N.5.1 If the decision involves an appeal of a denial based on lack of medical necessity.

N.5.2 If the decision involves a grievance regarding denial of expedited resolution of an appeal.

N.5.3 If the decision involves a grievance or appeal involving clinical issues.

N.6 In accordance with 42 CFR 438.406(b)(2)(iii); 42 CFR 438.228(a), the Vendor must ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

N.7 In accordance with 42 CFR 438.56(d)(5)(ii); 42 CFR 438.56(e)(1); 42 CFR 438.228(a), the Vendor must complete a review of the grievance in time to permit the disenrollment to be effective no later than the first day of the second month following the month in which the enrollee requests disenrollment or the Vendor refers the request to the state.

O. Notice of Adverse Benefit Determination Requirements

O.1 In accordance with 42 CFR 438.404(b)(1), if an adverse benefit determination is made, the Vendor's notice of adverse benefit determination must explain the decision the Vendor has made or intends to make .

O.2 In accordance with 42 CFR 438.404(b)(2), the Vendors 's notice of adverse benefit determination must explain the reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

O.3 In accordance with 42 CFR 438.404(b)(3); 42 CFR 438.402(b) - (c), the Vendor's notice of adverse benefit determination must explain the enrollee's right to request an appeal due to the adverse benefit determination, including information on exhausting the one level of appeal and the right to request a state fair hearing after receiving notice of the adverse benefit determination.

O.4 In accordance with 42 CFR 438.404(b)(4), the Vendor's notice of adverse benefit determination must explain the procedures for exercising the enrollee's rights to appeal.

O.5 In accordance with 42 CFR 438.404(b)(5), the Vendor's notice of adverse benefit determination must explain the circumstances under which an appeal process can be expedited and how to request it.

O.6 In accordance with 42 CFR 438.404(b)(6), the Vendor's notice of adverse benefit determination must explain the enrollee's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of continued services.

P. Notice of Adverse Benefit Determination Timing

- P.1 In accordance with 42 CFR 438.404(c)(1); 42 CFR 431.21, the Vendor must mail the notice of adverse benefit determination at least 10 days before the date of action, when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services.
- P.2 In accordance with 42 CFR 438.404(c)(1); 42 CFR 431.214, the Vendor must mail the notice of adverse benefit determination as few as 5 days prior to the date of action if the agency has facts indicating that action should be taken because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources.
- P.3 In accordance with 42 CFR 438.404(c)(1); 42 CFR 431.213; 42 CFR §431.231(d); section 1919(e)(7) of the Act; 42 CFR 483.12(a)(5)(i); 42 CFR 483.12(a)(5)(ii), the Vendor must mail the notice of adverse benefit determination by the date of the action when any of the following occur:
- P.3.1 The enrollee has died.
 - P.3.2 The enrollee submits a signed written statement requesting service termination.
 - P.3.3 The enrollee submits a signed written statement including information that requires service termination or reduction and indicates that she understands that service termination or reduction will result.
 - P.3.4 The enrollee has been admitted to an institution where he or she is ineligible under the plan for further services.
 - P.3.5 The enrollee's address is determined unknown based on returned mail with no forwarding address.
 - P.3.6 The enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
 - P.3.7 A change in the level of medical care is prescribed by the enrollee's physician.
 - P.3.8 The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act.
 - P.3.9 The transfer or discharge from a facility will occur in an expedited fashion.

- P.4 In accordance with 42 CFR 438.404(c)(2), the Vendor must give notice of adverse benefit determination on the date of determination when the action is a denial of payment.
- P.5 In accordance with 42 CFR 438.210(d)(1); 42 CFR 438.404(c)(3), the Vendor must give notice of adverse benefit determination as expeditiously as the enrollee's condition requires within state-established timeframes that may not exceed 14 calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services.
- P.6 In accordance with 42 CFR 438.404(c)(4); 42 CFR 438.210(d)(1)(i), the Vendor may extend the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the enrollee or the provider requests extension.
- P.7 In accordance with 42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4), the Vendor may extend the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the Vendor justifies a need (to the state agency, upon request) for additional information and shows how the extension is in the enrollee's best interest.
- P.8 In accordance with 2 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(i), the Vendor may extend the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services, it must give the enrollee written notice of the reason for the extension and inform the enrollee of the right to file a grievance if she disagrees with the decision.
- P.9 In accordance with 42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(ii), if the Vendor extends the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services, it must issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
- P.10 In accordance with 42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6), for cases in which a provider indicates, or the Vendor determines, that following the standard authorization timeframe could seriously jeopardize the enrollee's life or health or his/her ability to attain, maintain, or regain maximum function, the Vendor must make an expedited service authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.
- P.11 In accordance with 42 CFR 438.210(d)(2)(ii); 42 CFR 438.404(c)(6), the Vendor may extend the 72 hour expedited service authorization decision time period by up to 14 calendar days if the enrollee requests an extension, or if the Vendor justifies (to the state agency, upon request) a need for additional information and how the extension is in the enrollee's interest.

P.12 In accordance with 42 CFR 438.404(c)(5), the Vendor must give notice on the date that the timeframes expire, when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations.

Q. Appeals and Grievances System

Q.1 Who May File Appeals and Grievances

- Q.1.1 In accordance with 42 CFR 438.402(c)(1); 42 CFR 438.408, the Vendor may allow enrollees to file appeals, grievances, and state fair hearing requests after receiving notice that an adverse benefit determination is upheld.
- Q.1.2 In accordance with 42 CFR 438.402(c)(1)(i)(B), the Vendor must comply with the state's external medical review that complies with 42 CFR 402(c)(1)(i)(B).
- Q.1.3 In accordance with 42 CFR 438.402(c)(1)(i) - (ii); 42 CFR 438.408. The Vendor must allow providers, or authorized representatives, acting on behalf of the enrollee and with the enrollee's written consent, to request an appeal, file a grievance, or request a state fair hearing request.

Q.2 Timeframes for Filing Appeals

- Q.2.1 In accordance with 42 CFR 438.408; 42 CFR 438.402(c)(1)(i)(A), if the Vendor fails to adhere to notice and timing requirements, the enrollee is deemed to have exhausted the Vendor's appeals process, and the enrollee may initiate a state fair hearing.
- Q.2.2 In accordance with 42 CFR 438.402(c)(2)(ii), the Vendor will allow the enrollee to file an appeal to the Vendor within 60 calendar days from the date on the adverse benefit determination notice.
- Q.2.3 In accordance with 42 CFR 438.402(c)(2)(ii), the Vendor will allow the provider or authorized representative acting on behalf of the enrollee, as state law permits, to file an appeal to the Vendor within 60 calendar days from the date on the adverse benefit determination notice.

Q. 3 Process for Filing an Appeal or Expedited Appeal Request

- Q.3.1 In accordance with CFR 438.402(c)(3)(ii), the Vendor must allow the enrollee to request an appeal either orally or in writing. Unless an expedited resolution is requested by the enrollee, the contract requires the oral filing of an appeal to be followed by a written, signed appeal.

- Q.3.2 In accordance with 42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii), the Vendor must allow the provider or authorized representative acting on behalf of the enrollee, as state law permits, to request an appeal either orally or in writing.
- Q.3.3 In accordance with 42 CFR 438.406(b)(3), the Vendor must ensure that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals, and confirmed in writing unless the enrollee or the provider requests expedited resolution.
- Q.3.4 In accordance with 42 CFR 438.406(b)(4), the Vendor must provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.
- Q.3.5 In accordance with 42 CFR 438.406(b)(5);438.408(b) - (c), the Vendor must provide the enrollee and his or her representative the enrollee's case file (including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Vendor (or at the direction of the Vendor) in connection with the appeal of the adverse benefit determination. The enrollee's case file will be provided free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. For standard resolution of an appeal and notice to the affected parties, the Vendor must comply with the state-established timeframe that is no longer than 30 calendar days from the day the Vendor receives the appeal. For expedited resolution of an appeal and notice to affected parties, the Vendor must comply with the state-established timeframe that is no longer than 72 hours after the Vendor receives the appeal.
- Q.3.6 In accordance with 42 CFR 438.406(b)(6), the Vendor must consider the enrollee, his/her representative, or the legal representative of a deceased enrollee's estate as parties to an appeal.
- Q.3.7 In accordance with 42 CFR 438.410(a), the Vendor must establish and maintain an expedited review process for appeals, when the Vendor determines (for a request from the enrollee) or when the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's In accordance with request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
- Q.3.8 In accordance with 42 CFR 438.406(b)(4); 42 CFR 438.408(b); 42 CFR 438.408(c), the Vendor must inform enrollees of the limited

time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an expedited appeal resolution. The Vendor must inform enrollees of this sufficiently in advance of the resolution timeframe for appeals.

Q.3.9 In accordance with 42 CFR 438.410(c); 42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2), if the Vendor denies a request for expedited resolution of an appeal, it must transfer the appeal to the standard timeframe of no longer than 30 calendar days from the day the Vendor receives the appeal (with a possible 14-day extension).

Q.4 Timeframes for Resolving Appeals and Expedited Appeals

Q.4.1 In accordance with 42 CFR 438.408(a); 42 CFR 438.408(b)(2), the Vendor must resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within state-established timeframes not to exceed 30 calendar days from the day the Vendor receives the appeal.

Q.4.2 In accordance with 42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2), the Vendor may extend the timeframe for processing an appeal by up to 14 calendar days if the enrollee requests the extension, or if the Vendor shows that there is need for additional information and that the delay is in the enrollee's interest (upon state request).

Q.4.3 In accordance with 42 CFR 438.408(c)(2)(i) - (iii); 42 CFR 438.408(b)(2), if the Vendor extends the timeline for an appeal not at the request of the enrollee, it must:

Q.4.3.1 Make reasonable efforts to give the enrollee prompt oral notice of the delay.

Q.4.3.2 Give the enrollee written notice, within 2 calendar days, of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

Q.4.3.3 Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

Q.4.4 In accordance with 42 CFR 438.408(a); 42 CFR 438.408(b)(3), the Vendor must resolve each expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, within state-established timeframes not to exceed 72 hours after the Vendor receives the expedited appeal request.

Q.4.5 In accordance with 42 CFR 438.408(c)(1)(i) - (ii); 42 CFR 438.408(b)(3), the Vendor may extend the timeframe for processing an expedited appeal by up to 14 calendar days:

Q.4.5.1 If the enrollee requests the extension; or

Q.4.5.2 If the Vendor shows that there is need for additional information and that the delay is in the enrollee's interest (upon state request).

Q.4.6 In accordance with 42 CFR 438.408(c)(2)(i) - (iii); 42 CFR 438.408 (b)(3), if the Vendor extends the timeline for processing an expedited appeal not at the request of the enrollee, it must:

Q.4.6.1 Make reasonable efforts to give the enrollee prompt oral notice of the delay.

Q.4.6.2 Give the enrollee written notice, within 2 calendar days, of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

Q.4.6.3 Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

Q.5 Notice of Resolution for Appeals

Q.5.1 In accordance with 42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1) - (2), the Vendor must provide written notice of the resolution of the appeals process:

Q.5.1.1 in a format and language that, at a minimum, meets applicable notification standards;

Q.5.1.2 include the results of the appeal resolution; and

Q.5.1.3 include the date of the appeal resolution.

Q.5.2 For appeal decisions not wholly in the enrollee's favor, the contract requires the Vendor to include the following in the written resolution notice:

Q.5.2.1 The right to request a state fair hearing.

Q.5.2.2 How to request a state fair hearing.

Q.5.2.3 The right to request and receive benefits pending a hearing.

Q.5.2.4 How to request the continuation of benefits.

Q.5.2.5 Notice that the enrollee may, consistent with state policy, be liable for the cost of any continued benefits if the Vendor's adverse benefit determination is upheld in the hearing.

Q.5.3 In accordance with 42 CFR 438.408(d)(2)(ii), the Vendor must provide written notice, and make reasonable efforts to provide oral notice, of the resolution of an expedited appeal.

Q.6 Continuation of Benefits

Q.6.1 In accordance with 42 CFR 438.420(a); 42 CFR 438.420(b)(1) - (5); 42 CFR 438.402(c)(2)(ii), the Vendor must continue the enrollee's benefits while an appeal is in process if all of the following occur:

Q.6.1.1 The enrollee files the request for an appeal within 60 calendar days following the date on the adverse benefit determination notice.

Q.6.1.2 The appeal involves the termination, suspension, or reduction of a previously authorized service.

Q.6.1.3 The enrollee's services were ordered by an authorized provider.

Q.6.1.4 The period covered by the original authorization has not expired.

Q.6.1.5 The request for continuation of benefits is filed on or before the later of the following:

Q.6.5.5.1 Within 10 calendar days of the Vendor sending the notice of adverse benefit determination, or

Q.6.5.5.2 The intended effective date of the Vendor's proposed adverse benefit determination.

Q.6.2 In accordance with 42 CFR 438.420(c)(1)-(3); 42 CFR 438.408(d)(2), if, at the enrollee's request, the Vendor continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of the following occurs:

Q.6.2.1 The enrollee withdraws the appeal or request for state fair hearing.

Q.6.2.2 The enrollee does not request a state fair hearing and continuation of benefits within 10 calendar days from the date the Vendor sends the notice of an adverse appeal resolution.

Q.6.2.3 A state fair hearing decision adverse to the enrollee is issued.

Q.6.3 In accordance with 42 CFR 438.420(d); 42 CFR 431.230(b), the Vendor may, consistent with the state's usual policy on recoveries and as specified in the Vendor's contract, recover the cost of continued services furnished to the enrollee while the appeal or state fair hearing was pending if the final resolution of the appeal or state fair hearing upholds the Vendor's adverse benefit determination.

Q.6.4 In accordance with 42 CFR 438.424(a), the Vendor must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires (but no later than 72 hours from the date it receives notice reversing the determination) if the services were not furnished while the appeal was pending and if the Vendor or state fair hearing officer reverses a decision to deny, limit, or delay services.

Q.6.5 In accordance with 42 CFR 438.424(b), the Vendor must pay for disputed services received by the enrollee while the appeal was pending, unless state policy and regulations provide for the state to cover the cost of such services, when the Vendor or state fair hearing officer reverses a decision to deny authorization of the services.

Q.6.6 In accordance with 42 CFR 438.210(c); 42 CFR 438.404, the Vendor must notify the requesting provider and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

Q.7 Grievances

Q.7.1 In accordance with 42 CFR 438.402(c)(2)(i), the Vendor must allow an enrollee to file a grievance with the Vendor at any time.

Q.7.2 In accordance with 42 CFR 438.402(c)(3)(i), the Vendor must allow the enrollee to file a grievance either orally or in writing.

Q.7.3 In accordance with 42 CFR 438.402(c)(3)(i), the Vendor contract specifies whether enrollees may file grievances only with the Vendor or if the enrollee can also file a grievance directly with the state.

Q.7.4 In accordance with 42 CFR 438.408(a); 42 CFR 438.408(b)(1), the Vendor must resolve each grievance and provide notice, as expeditiously as the enrollee's health condition requires, within state-established timeframes not to exceed 90 calendar days from the day the Vendor receives the grievance.

Q.7.5 In accordance with 42 CFR 438.408(c)(1)(i) - (ii); 438.408(b)(1), the Vendor may extend the timeframe for processing a grievance by up to 14 calendar days:

Q.7.5.1 If the enrollee requests the extension; or

Q.7.5.2 If the Vendor shows that there is need for additional information and that the delay is in the enrollee's interest (upon state request).

Q.7.6 In accordance with 42 CFR 438.408(c)(2)(i) - (ii); 42 CFR 438.408(b)(1), if the Vendor extends the timeline for a grievance not at the request of the enrollee, it must:

Q.7.6.1 Make reasonable efforts to give the enrollee prompt oral notice of the delay. Give the enrollee written notice, within 2 calendar days, of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

Q.7.7 In accordance with 42 CFR 438.408(d)(1); 42 CFR 438.10, the Vendor must adhere to the state's established method used to notify an enrollee of the resolution of a grievance in a format and language that, at a minimum, meets applicable notification standards.

Q.8 Grievance and Appeal Recordkeeping Requirements

Q.8.1 In accordance with 42 CFR 438.416(a), the Vendor must maintain records of grievances and appeals.

Q.8.2 In accordance with 42 CFR 438.416(b)(1) - (6), the Vendor's record of each grievance or appeal must include:

Q.8.2.1 A general description of the reason for the appeal or grievance.

Q.8.2.2 The date received.

Q.8.2.3 The date of each review or, if applicable, review meeting.

Q.8.2.4 Resolution information for each level of the appeal or grievance, if applicable.

Q.8.2.5 The date of resolution at each level, if applicable.

Q.8.2.6 The name of the covered person for whom the appeal or grievance was filed.

Q.8.3 In accordance with 42 CFR 438.416(c), the Vendor's record of each grievance or appeal be accurately maintained in a manner accessible to the state and available upon request to CMS.

R. Program Integrity

R.1 Exclusions

R.1.1 In accordance with 42 CFR 438.214(d)(1), the Vendor must not employ or contract with providers excluded from participation in Federal health care programs.

R.1.2 The Vendor cannot be controlled by a sanctioned individual under section 1128(b)(8) of the Act in accordance with 42 CFR 438.808(a); 42 CFR 438.808(b)(1); 42 CFR 431.55(h); section 1903(i)(2) of the Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09.

R.1.3 The Vendor must not have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with an individual convicted of crimes described in section 1128(b)(8)(B) of the Act in accordance with 42 CFR 438.808(a); 42 CFR 438.808(b)(2); 42 CFR 431.55(h); section 1903(i)(2) of the Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09 .

R.1.4 In accordance with 42 CFR 438.808(a); 42 CFR 438.808(b)(2); 42 CFR 438.610(a); 42 CFR 431.55(h); section 1903(i)(2) of the Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549, the Vendor must not have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

- R.1.5 In accordance with 42 CFR 438.808(a); 42 CFR 438.808(b)(2); 42 CFR 438.610(b); 42 CFR 431.55(h); section 1903(i)(2) of the Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09, the Vendor will not contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.
- R.1.6 In accordance with , 42 CFR 438.808(a); 42 CFR 438.808(b)(3)(i); 42 CFR 438.610(a); 1903(i)(2); 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549. The Vendor will not employ or contract, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- R.1.7 In accordance with 42 CFR 438.808(a); 42 CFR 438.808(b)(3)(i); 42 CFR 438.610(b); section 1903(i)(2) of the Act; 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09, the Vendor will not employ or contract, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.
- R.1.8 In accordance with 42 CFR 438.808(a); 42 CFR 438.808(b)(3)(ii); 42 CFR 438.610(a); section 1903(i)(2) of the Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549, the Vendor will not employ or contract, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that would (or is affiliated with a person/entity that would) provide those services through an individual or entity debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- R.1.9 In accordance with 42 CFR 438.808(a); 42 CFR 438.808(b)(3)(ii); 42 CFR 438.610(b); section 1903(i)(2) of the Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09, the Vendor

will not employ or contract, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that would provide those services through an individual or entity excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

R.1.10 In accordance with 42 CFR 455.436, the Vendor must comply with state and federal requirements of checking the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

R.1.11 The Vendor must search the LEIE, EPLS, SSA-DMF, and NPPES, upon contract execution, by the name of any person with an ownership or control interest or who is an agent or managing employee to ensure that the subcontractors are not currently debarred or suspended from participation from Medicare/Medicaid programs.

R.1.12 The Vendor must check the System for Award Management formerly Excluded Party List System (EPLS) monthly thereafter by the name of any person with an ownership or control interest, or who is an agent or managing employee.

R.1.13 The Vendor must check the Medicaid's Exclusion List and the List of Excluded Individuals and Entities (LEIE) monthly thereafter by the name of any person with an ownership or control interest, or who is an agent or managing employee.

R.1.14 The Vendor must sure subcontractors are complying with State and Federal laws regarding checking Medicaid's Exclusion List and the List of Excluded Individuals and Entities (LEIE) monthly to determine if any of their existing employees or affiliated entities have not been excluded from participation in the Medicaid program.

R.1.15 In accordance with Section 1932(d)(1) of the Act; 42 CFR 438.610(a)(1) - (2); 42 CFR 438.610(c)(1); 42 CFR 438.610(c)(3) - (4); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549. The Vendor will not knowingly have:

- R.1.15.1 A director, officer, or partner who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- R.1.15.2 A person with ownership of 5% or more of the Vendor's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- R.1.15.3 A network provider who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- R.1.15.4 An employment, consulting, or other agreement for the provision of Vendor contract items or services with a person who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- R.1.16 In accordance with 42 CFR 438.610(d)(2); 42 CFR 438.610(a); Exec. Order No. 12549, if the state learns that a Vendor has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the Vendor has relationship with an individual who is an affiliate of

such an individual, the state may continue an existing agreement with the Vendor unless the Secretary directs otherwise.

- R.1.17 In accordance with 42 CFR 438.610(d)(2); 42 CFR 438.610(b), if the state learns that an Vendor has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act, the state may continue an existing agreement with the Vendor unless the Secretary directs otherwise.
- R.1.18 In accordance with 42 CFR 438.610(d)(3); 42 CFR 438.610(a); Exec. Order No. 12549, if the state learns that an Vendor has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the Vendor has relationship with an individual who is an affiliate of such an individual, the state may not renew or extend the existing agreement with the Vendor unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.
- R.1.19 In accordance with 42 CFR 438.610(d)(3); 42 CFR 438.610(b), if the state learns that an Vendor has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act, the state may not renew or extend the existing agreement with the Vendor unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.
- R.1.20 In accordance Section 1932(d)(1) of the Act; 42 CFR 438.610(a)(1) - (2); 42 CFR 438.610(c)(2); Exec. Order No. 12549, the Vendor will not knowingly having a subcontractor of the Vendor who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non- procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- R.1.21 In accordance Section 1932(d)(1) of the Act; 42 CFR 438.608(c)(1); 42 CFR 438.610(a)(1) - (2); 42 CFR 438.610(b); 42 CFR 438.610(c)(1) - (4); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549 I.I.2.27 - I.I.2.37.

R.1.22 The Vendor must provide written disclosure of any:

R.1.22.1 Director, officer, or partner who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

R.1.22.2 Subcontractor of the Vendor who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

R.1.23 Person with ownership of 5% or more of the Vendor's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

R.1.23 Network provider who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

R.1.24 Employment, consulting, or other agreement for the provision of Vendor contract items or services with a person who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

R.1.25 An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

R.1.26 In accordance with 42 CFR 438.604(a)(6); 42 CFR 438.606; 42 CFR 455.104(b)(1)(i) - (iii); 42 CFR 455.104(b)(2) - (4); 42 CFR 438.230; 42 CFR 438.608(c)(2), the Vendor must submit:

R.1.26.1 The name and address of any person (individual or corporation) with an ownership or control interest in the managed care entity and its subcontractors. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

R.1.26.2 The date of birth and Social Security Number (SSN) of any individual with an ownership or control interest in the Vendor and its subcontractors.

R.1.26.3 Other tax identification number of any corporation with an ownership or control interest in the Vendor and any subcontractor in which the Vendor has a 5 percent or more interest.

R.1.26.4 Information on whether an individual or corporation with an ownership or control interest in the Vendor is related to another person with ownership or control interest in the Vendor as a spouse, parent, child, or sibling.

R.1.26.5 Information on whether a person or corporation with an ownership or control interest in any subcontractor in which the Vendor has a 5 percent or more interest is related to another person with ownership or control interest in the Vendor as a spouse, parent, child, or sibling.

R.1.26.6 The name of any other disclosing entity in which an owner of the Vendor has an ownership or control interest.

R.1.26.7 The name, address, date of birth, and SSN of any managing employee of the Vendor.

R.1.27 The Vendor must maintain document of compliance with all database checks.

R.1.28 In accordance 42 CFR 438.608(b); 42 CFR 455.100-106; 42 CFR 455.400 – 470, the Vendor must ensure that all network

providers are enrolled with the state as Medicaid providers consistent with provider disclosure, screening, and enrollment requirements. [] [Effective: No later than the rating period for contracts starting on or after 7/1/2018]

- R.1.29 In accordance with 42 CFR 438.602(b)(1), the state will screen and enroll, and periodically revalidate all Vendor network providers as Medicaid providers.
- R.1.30 In accordance 42 CFR 438.602(b)(2), the Vendor may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider, and notify affected enrollees.
- R.1.31 In accordance 42 CFR 438.602(c); 42 CFR 438.608(c), the state will review the ownership and control disclosures submitted by the Vendor and any of the Vendor's subcontractors.
- R.1.32 In accordance 42 CFR 438.602(i), the Vendor shall not be located outside of the United States

R.2 Inspection of Records

- R.2.1 The Vendor must comply with the requirement of 42 CFR 438.230(c)(3)(iv); 42 CFR 438.3(k), if the state, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, the state, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.
- R.2.2 The Vendor must comply with the requirement of 42 CFR 438.230(c)(3)(iv); 42 CFR 438.3(k), if the state, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, the state, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.
- R.2.3 The Vendor must comply with 42 CFR 438.3(h), the state, CMS, the OIG, the Comptroller General and their designees have the right to audit records or documents of the MCP or the MCP's subcontractors for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

- R.2.4 The Vendor must comply with Section 1903(m)(2)(A)(iv) of the Act, the risk contract requires that the Secretary, DHHS, and the state (or any person or organization designated by either) have the right to audit and inspect any books or records of the MCP or its subcontractors pertaining to:
- R.2.4.1 The ability of the Vendor to bear the risk of financial losses.
 - R.2.4.2 Services performed or payable amounts under the contract.
- R.2.5 The Vendor must comply with of 42 CFR 438.3(u), the Vendor and Vendor's subcontractors will retain, as applicable, enrollee grievance and appeal records in 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years. [42 CFR 438.3(u)]
- R.2.6 The Vendor must comply with 42 CFR 438.230(c)(3)(i); 42 CFR 438.3(k), the state, 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 Vendor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCP's contract with the state.
- R.2.7 The Vendor must comply with 42 CFR 438.230(c)(3)(ii); 42 CFR 438.3(k), the Vendor must make available, for the purposes of an audit, evaluation, or inspection by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid enrollees.
- R.2.8 The Vendor must comply with 42 CFR 438.230(c)(3)(iii); 42 CFR 438.3(k), the Vendor must require the subcontractor to agree that the right to audit by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- R.2.9 The Vendor must comply with 42 CFR 438.3(h), the Vendor's subcontract with the subcontractor must include language to comply with the requirement that the state, CMS, the OIG, the Comptroller General, and their designees be allowed to inspect

and audit any records or documents of the vendor's subcontractors at any time

R.2.10 Inspection of Premises

The Vendor must comply with 42 CFR 438.3(h). The Vendor must allow the state, CMS, the OIG, the Comptroller General, and their designees to inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted at any time.

S. Requirements, Procedures, and Reporting

- S.1 The Vendor must submit encounter data in accordance with 42 CFR 438.604(a)(1); 42 CFR 438.606; 42 CFR 438.818. The encounter data and base data will be used by the state to develop and certify the actuarial soundness of capitation rates to an Vendor in accordance with 42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c).
- S.2 In accordance with 42 CFR 438.604(a)(3); 42 CFR 438.606; 42 CFR 438.8, the Vendor must submit data on the basis of which the state determines the compliance of the Vendor with the MLR requirement.
- S.3 In accordance with 42 CFR 438.604(a)(4); 42 CFR 438.606; 42 CFR 438.116, the Vendor will submit data on the basis of which the state determines that the Vendor has made adequate provision against the risk of insolvency.
- S.4 In accordance with 42 CFR 438.604(a)(5); 42 CFR 438.606; 42 CFR 438.207(b); 42 CFR 438.206 the Vendor must submit documentation on which the state bases its certification that the Vendor complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network.
- S.5 In accordance with 42 CFR 438.604(b); 42 CFR 438.606, the Vendor must submit any other data, documentation, or information relating to the performance of the entity's obligations as required by the state or Secretary.
- S.6 In accordance with 42 CFR 438.604; 42 CFR 438.606(b), the Vendor must provide the state a certification, which attests, based on best information, knowledge and belief that the data, documentation and information are accurate, complete and truthful.
- S.7 In accordance with 42 CFR 438.604; 42 CFR 438.606(a), the Vendor's data, documentation, or information submitted to the state by the Vendor must be certified by one of the following:

S.7.1 The Vendor's Chief Executive Officer (CEO).

S.7.1 The Vendor's Chief Financial Officer (CFO).

S.7.1 An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

S.8 In accordance with 42 CFR 438.606(c); 42 CFR 438.604(a) - (b), the Vendor must submit certification concurrently with the submission of data, documentation, or information.

S.9 In accordance with 42 CFR 438.608(c)(3), the Vendor and any subcontractor must report to the state within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

S.10 In accordance with 42 CFR 438.3(m), the Vendor must submit audited financial reports specific to the Medicaid contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

T. Disclosure

T.1 In accordance with Section 1124(a)(2)(A) of the Act; section 1903(m)(2)(A)(viii) of the Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 – 104, the Vendor and subcontractors will disclose to the state any persons or corporations with an ownership or control interest in the Vendor that:

T.1.1 Has direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Vendor's equity;

T.1.2 Owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Vendor if that interest equals at least 5% of the value of the Vendor's assets;

T.1.3 Is an officer or director of an Vendor organized as a corporation; or

T.1.4 Is a partner in an Vendor organized as a partnership.

T.2 In accordance with Section 1124(a)(2)(A) of the Act; section 1903(m)(2)(A)(viii) of the Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 103; 42 CFR 455.104(c)(3) the Vendor and subcontractors will disclose information on individuals or corporations with an ownership or control interest in the Vendor to the state at the following times:

T.2.1 When the Vendor submits a proposal in accordance with the state's procurement process.

T.2.2 When the Vendor executes a contract with the state.

T.2.3 When the state renews or extends the Vendor contract.

T.2.4 Within 35 days after any change in ownership of the Vendor.

U. Compliance Program

U.1 In accordance with 42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i) - (vii), the Vendor must implement and maintain a compliance program that must include:

U.1.1 Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.

U.1.2 A Compliance Officer (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the CEO and the Board of Directors (BoD).

U.1.3 A Regulatory Compliance Committee (RCC) on the BoD and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.

U.1.4 A system for training and education for the CO, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract.

U.1.5 Effective lines of communication between the CO and the organization's employees.

U.1.6 Enforcement of standards through well-publicized disciplinary guidelines.

U.1.7 The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

U.2 In accordance with 42 CFR 438.608(a)(2), the e Vendor must implement and maintain arrangements or procedures for prompt reporting of all overpayments identified to the Vendor or subcontractor or recovered from Vendor or subcontractor, specifying the overpayments due to potential fraud, to the state.

- U.3 In accordance with 42 CFR 438.608(a)(3), the Vendor must implement and maintain arrangements or procedures for prompt notification to the state when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including changes in the enrollee's residence or the death of the enrollee.
- U.4 In accordance with 42 CFR 438.608(a)(4), the Vendor must implement and maintain arrangements or procedures for notification to the state when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Vendor.
- U.5 In accordance with 42 CFR 438.608(a)(5), the Vendor must implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.
- U.6 In accordance with Section 1902(a)(68) of the Act; 42 CFR 438.608(a)(6), for a Vendor that make or receive annual payments under this RFP of at least \$5,000,000, the Vendor must implement and maintain written policies for all employees of the entity, and of any subcontractor or agent, that provide detailed information about the False Claims Act (FCA) and other Federal and state laws, including information about rights of employees to be protected as whistleblowers.
- U.7 The Vendor must implement and maintain arrangements or procedures that include provision for the prompt referral of any potential fraud, waste, or abuse that the Vendor identifies to the state Medicaid program integrity unit or any potential fraud directly to the state Medicaid Fraud Control Unit. The report must include the number of complaints of fraud and abuse made to the Vendor that warrant an investigation. If an investigation is warranted, the Vendor must supply the name, identification number, source of the complaint, type of provider, nature of complaint, approximate dollars involved and legal and administrative disposition of the case. The report should be submitted to Medicaid quarterly according to the format specified by Medicaid.
- U.8 In accordance with 42 CFR 438.608(a)(8); 42 CFR 455.23, the Vendor must implement and maintain arrangements or procedures that include provision for the Vendor's suspension of payments to a network provider for which the state determines there is a credible allegation of fraud. Any suspension of payment must be reported to Medicaid within 3 business days of the suspension.

V. Treatment of Recoveries

- V.1 In accordance with 42 CFR 438.608(d)(1)(i), the Vendor will specify the retention policies for the treatment of recoveries of all overpayments from the Vendor to a

provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.

- V.2 In accordance with 42 CFR 438.608(d)(1)(ii), the Vendor will specify the process, timeframes, and documentation required for reporting the recovery of all overpayments.
- V.3 In accordance with 42 CFR 438.608(d)(1)(iii), the Vendor will specify the process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the Vendor is not permitted to retain some or all of the recoveries of overpayments.
- V.4 In accordance with 42 CFR 438.608(d)(2), the Vendor will have, and require the use of, a mechanism for a subcontractor to report to the Vendor when it has received an overpayment, to return the overpayment to the Vendor within 60 calendar days after the date on which the overpayment was identified, and to notify the Vendor in writing of the reason for the overpayment.
- V.5 In accordance with 42 CFR 438.604(a)(7); 42 CFR 438.606; 42 CFR 438.608(d)(3), the Vendor will submit the annual report of overpayment recoveries.

The Contractor's proposal must present a plan (i.e., draft policies and procedures, or documents deemed necessary) to describe how it will meet each of the following requirements.

W. Healthcare Professionals

W.1 Provider Network

- W.1.1 In accordance with 42 CFR 438.207(a); 42 CFR 438.68; 42 CFR 438.206(c)(1), the Vendor must give assurances and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state's standards for access and timeliness of care. The Vendor must have a delivery system that meets Medicaid standards and that promotes continuity of care and quality care. The Vendor must ensure that all medically necessary services, included as covered services pursuant to this proposal, are provided. The proposal must contain documentation that the Vendor has a provider network in place.
- W.1.2 The Vendor will require subcontractors providing direct care to be on call or make provisions for medical problems 24-hours per day, seven days per week.
- W.1.3 The Vendor must offer participation opportunities for 30 days prior to the contract start date and for the first month of each succeeding contract year to all interested potential subcontractors

within district boundaries. Subcontractors must be willing to abide by all program requirements and accept offered reimbursement for services provided. For purposes of offering and awarding subcontracts, Contractor must offer the reimbursement level consistent with other like subcontractors.

- W.1.4 In accordance with 42 CFR 438.12(a)(1), the Vendor will give written notice of the reason for its decision when it declines to include individual or groups of providers in its provider network.
- W.1.5 The Vendor must not offer participation to potential subcontractors who do not agree to abide by program requirements or to those who have been disqualified from participation in any federal program or any person convicted of an offense involving Medicaid. However, providers who are willing to abide by program requirements must be given equal and fair participation opportunities. Complaints of discrimination will be investigated by Medicaid.
- W.1.6 In accordance with 42 CFR 438.206(b)(1); 42 CFR 438.207(b)(2), the Vendor must maintain and monitor a network of appropriate providers that is supported by written agreements.
- W.1.7 The Vendor must submit documentation to the state, in a format specified by the state, to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.
- W.1.8 The Vendor must contract with subcontractors who are geographically appropriate (50 miles) to enrollees within the district.
- W.1.9 The Vendor must maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities. Network adequacy is subject to review by Medicaid or its designee.
- W.1.10 The Vendor must continually maintain and monitor the provider network to ensure that the capacity is sufficient to meet the needs of all Medicaid enrollees and availability and accessibility are not hindered. The Contractor must submit documentation to Medicaid when there are changes in services, benefits, geographic service area or payments in order to assure adequate capacity and services.

W.1.11 The Vendor must monitor and evaluate provider performance to ensure that Medicaid and Contractor standards are met. Such monitoring and evaluation system must include a corrective action system. Contractor must include full documentation of the proposed monitoring system in the proposal.

W.1.12 The Vendor must notify Medicaid within one working day of any unexpected changes which would impair its provider network. This notification must include:

W.1.12.1 Information about how the change will affect the delivery of covered services; and

W.1.12.2 The Contractor's plans for maintaining the quality of member care if the provider network change is likely to result in deficient delivery of covered services.

W.1.13 The Contractor is held accountable for any functions and responsibilities that it delegates to any subcontractor and must evaluate the subcontractor's ability to perform the activities delegated. The Contractor's subcontract(s) must:

W.1.13.1 Require subcontractors to fulfill the requirements of 42 C.F.R. 438.

W.1.13.2 Be in writing and specify the responsibilities delegated and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

W.1.13.3 Require the Contractor to monitor subcontractor's performance and conduct a formal review.

W.1.13.4 Require subcontractor to comply with accepted Medicaid standards of care.

W.1.13.5 Require subcontractor to comply with all applicable other terms and conditions contained in this RFP.

W.1.13.6 Contain subcontractor's reimbursement provisions.

W.1.13.7 Contain a provision specifying that subcontractor must agree that under no circumstances (including, but not limited to, situations involving non-payment by the Contractor, insolvency of the Contractor, or breach of agreement) must the

subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against Medicaid enrollees, or persons acting on their behalf, for covered services, rendered during the term of subcontractor's agreement or sub-contract with the Contractor. A provider may charge for non-covered services delivered on a fee-for-service basis to Medicaid enrollees.

W.1.13.8 Contain a provision that states "payment for maternity-related services, not covered by the Maternity Care Program, does not make the enrollee responsible for all of her maternity care".

W.1.13.9 Require that the contract term covers the same time period as the Contractor's contract with Medicaid.

W.1.13.10 Only be terminated for cause.

W.1.13.11 Require the Contractor to identify deficiencies and require the subcontractor to take corrective action.

W.1.14 In accordance with 42 CFR 438.206(b)(7), the Vendor's network must include sufficient family planning providers to ensure timely access to covered services.

W.1.15 In accordance with 42 CFR 438.207(b) - (c), the Vendor must submit documentation as specified by the state, but no less frequently than the following:

W.1.15.1 at the time it enters into a contract with the state;

W.1.15.2 on an annual basis; and

W.1.15.3 at any time there has been a significant change in the Vendor's operations that would affect the adequacy of capacity and services, including changes in Vendor services, benefits, geographic service area, composition of or payments to its provider network, or at the enrollment of a new population in the Vendor.

W.1.16 In accordance with, 42 CFR 438.116(a), the Vendor must provide assurances satisfactory to the state that its provision against the risk of insolvency is adequate to ensure that Medicaid enrollees will not be liable for the Vendor's debt if the Vendor becomes insolvent.

- W.1.17 In all contracts with subcontractors, the Vendor must comply with any additional provider selection requirements established by the state in accordance with 42 CFR 438.12(a)(2); 42 CFR 438.214(e).
- W.1.18 In accordance with 42 CFR 438.12(b)(1), the Vendor must not contract with more providers than necessary to meet the needs of its enrollees.
- W.1.19 In accordance with 42 CFR 438.12(b)(2), the Vendor is not precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.
- W.1.20 In accordance with 42 CFR 438.12(b)(3), the Vendor is not precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.
- W.1.21 In accordance with 42 CFR 438.214. [42 CFR 438.206(b)(6), the Vendor is required to demonstrate that its network providers are credentialed as required under 42 CFR 438.214.

X. No Discrimination

- X.1 In accordance with 42 CFR 438.12(a)(1), the Vendor will not discriminate against any provider (limiting their participation, reimbursement or indemnification) who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.
- X.2 In accordance with 42 CFR 438.12(a)(2); 42 CFR 438.214(c), in all Vendor contracts with subcontractors, the Vendor's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- X.3 The Vendor will not discriminate against enrollees based on health status or need for health services.

Y. Credentialing and Retention

- Y.1 In accordance with 42 CFR 438.12(a)(2); 42 CFR 438.214(a); 42 CFR 438.12(a)(2); 42 CFR 438.214(b)(1); 42 CFR 438.214(b)(2), in all contracts with network providers, the Vendor must follow a documented process and follow the state's uniform credentialing and recredentialing policy that addresses delivering healthcare providers, as appropriate.
- Y.2 The Vendor, all persons, including employees, agents, and subcontractors acting for or on behalf of the Vendor, be properly licensed under

applicable State laws and/or regulations.

Y.3 The Vendor must comply with certification and licensing laws and regulations applicable to the Vendor's practice, profession or business. The Vendor agrees to perform services consistent with the customary standards of practice and ethics in the medical profession.

Z. Anti-gag

Z.1 In accordance with Section 1932(b)(3)(A) of the Act; 42 CFR 438.102(a)(1)(i) - (iv), the Vendor must not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient regarding:

Z.1.1 The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

Z.1.2 Any information the enrollee needs to decide among all relevant treatment options.

Z.1.3 The risks, benefits, and consequences of treatment or non-treatment.

Z.1.4 The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Z.2 In accordance with 42 CFR 438.410(b), the Vendor must not take no punitive action against a provider who either requests an expedited resolution or supports an enrollee's appeal.

AA. Network Adequacy Standards

AA.1 In accordance with 42 CFR 438.206(c)(1)(i) - (vi), the Vendor shall have a delivery system that meets Medicaid requirements as defined in this proposal and any attachment and references hereto, as amended. The contract requires that:

AA.1.1 The Vendor and its network providers meet the state standards for timely access to care and services, taking into account the urgency of need for services.

AA.1.2 The Vendor's network providers must offer hours of operation that are no less than the hours offered to commercial enrollees or are comparable to Medicaid FFS, if the provider serves only Medicaid enrollees.

AA.1.3 All services defined in this proposal must be available, accessible 24 hours a day, seven days a week, when medically necessary.

- AA.2 The Vendor must have an accessible and adequate number of facilities, locations and personnel for the provision of covered services.
- AA.3 The Vendor must have establish mechanisms to ensure that its network providers comply with the timely access requirements.
- AA.4 The Vendor must monitor network providers regularly to determine compliance with the timely access requirements.
- AA.5 The Vendor will take corrective action if it, or its network providers, fail to comply with the timely access requirements.
- AA.6 In accordance with 2. 42 CFR 438.206(c)(3), the Vendor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.
- AA.7 In accordance with 42 CFR 438.68(b)(1)(i) - (viii), the Vendor must adhere to the time and distance standards developed by the state for all provider types covered under this contract:
- AA.7.1 Obstetrics and Gynecology (OB/GYN) providers.
 - AA.7.2 Nurse Midwives
 - AA.7.3 Any additional provider types when it promotes the objectives of the Medicaid program for the provider type to be subject to time and distance access standards, as determined by CMS.
- AA.8 In accordance with 42 CFR 438.68(b)(3); 42 CFR 438.68(b)(1)(i) - (viii),the Vendor will meet relevant state network adequacy standards in all geographic areas in which the Vendor operates for the following provider types covered under the contract:
- AA.8.1 OB/GYN providers.
 - AA.8.2 Nurse Midwives
 - AA.8.3 Any additional provider types when it promotes the objectives of the Medicaid program as determined by CMS. States are permitted to have varying standards for the same provider type based on geographic areas. The Vendor is permitted to have varying standards for the same provider type based on geographic areas.
- AA.9 In accordance with 42 CFR 438.68(d)(1), any exceptions to the Vendor's provider network adequacy standards will have to be evaluated and approved by the state. Any such approval will be shared with other Vendors.

AA.10 Network adequacy will be evaluated by Medicaid or Medicaid's designee.

BB. Provider Notification of Grievance and Appeals Rights

BB.1 In accordance with 42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(A) - (C), the Vendor must inform providers and subcontractors, at the time they enter into a contract, about:

BB.1.1 Enrollee grievance, appeal, and fair hearing procedures and timeframes as specified in 42 CFR 438.400 through 42 CFR 438.424 and described in the Grievance and Appeals section of this State Guide.

BB.1.2 The enrollee's right to file grievances and appeals and the requirements and timeframes for filing.

BB.1.3 The availability of assistance to the enrollee with filing grievances and appeals.

BB.2 In accordance with 42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(D), the Vendor must inform providers and subcontractors, at the time they enter into a contract, about the enrollee's right to request a state fair hearing after the Vendor has made a determination on an enrollee's appeal which is adverse to the enrollee.

BB.3 In accordance with 42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(E), the Vendor must inform providers and subcontractors, at the time they enter into a contract, about the enrollee's right to request continuation of benefits that the Vendor seeks to reduce or terminate during an appeal or state fair hearing filing, if filed within the allowable timeframes, although the enrollee may be liable for the cost of any continued benefits while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.

CC. Balance Billing

CC.1 In accordance with Section 1932(b)(6) of the Act; 42 CFR 438.3(k); 42 CFR 438.230(c)(1) - (2), the Vendor must ensure that subcontractors and referral providers not bill enrollees, for covered services, any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers).

DD. Physician Incentive Plan

DD.1 In accordance with Section 1903(m)(2)(A)(x) of the Act; 42 CFR 422.208(c)(1); 42 CFR 438.3(i), the Vendor may only operate a physician incentive plan if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an incentive to reduce or limit medically necessary services to an enrollee.

DD.2 In accordance with Section 1903(m)(2)(A)(x) of the Act; 42 CFR 422.208(c)(2); 42 CFR 438.3(i), if the Vendor puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the Vendor must ensure that the physician/physician group has adequate stop-loss protection.

EE. Network Requirements Involving Indians, Indian Health Care Providers (IHCPs), and Indian Managed Care Entities (IMCEs)

EE.1 In accordance with 42 CFR 438.14(b)(6), the Vendor will demonstrate that there are sufficient IHCPs participating in the provider network to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services.

EE.2 In accordance with 42 CFR 438.14(b)(2)(i) - (ii), IHCPs, whether participating or not, must be paid for covered services provided to Indian enrollees, who are eligible to receive services at a negotiated rate between the Vendor and IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the managed care entity would make for the services to a participating provider that is not an IHCP.

EE.3 In accordance with 42 CFR 438.14(b)(4), Indian enrollees are permitted to obtain covered services from out- of-network IHCPs from whom the enrollee is otherwise eligible to receive such services.

EE.4 In accordance with 42 CFR 438.14(b)(6), the Vendor must permit an out-of-network IHCP to refer an Indian enrollee to a network provider.

FF. Practice guidelines

FF.1 In accordance with 42 CFR 438.236(c), the Vendor will disseminate practice guidelines to all affected providers.

GG. Training

GG.1 In accordance with 42 CFR 438.236(b)(1); CFR 438.236(b)(2); 42 CFR 438.236(b)(3), the Vendor must:

GG.1.1 adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in maternity care.

GG.1.2 adopt practice guidelines that consider the needs of the enrollees.

GG.1.3 adopt practice guidelines in consultation with contracting health care professionals.

GG.1.4 review and update practice guidelines periodically as appropriate.

GG.2 In accordance with 42 CFR 438.236(d), the Vendor's decisions regarding utilization management, enrollee education, coverage of services, and other areas to which practice guidelines apply should be consistent with such practice guidelines.

GG.3 In accordance with 42 CFR 438.210(b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

GG.4 In accordance with 42 CFR 438.210(e), the Vendor must ensure that compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for denying, limiting, or discontinuing medically necessary services to any enrollee.

HH. Requirements for Vendor's Subcontractors

HH.1 The Vendor may enter into subcontracts only where the subcontractor:

HH.1.1 have current Alabama Medical License or certification and licensure as a Certified Nurse Midwife or other appropriate licensure requirements;

HH.1.2 are enrolled as a Medicaid provider;

HH.1.3 have current privileges at a hospital which participates in Medicaid, and be in good standing at that hospital; and

HH.1.4 are not currently debarred or sanctioned from participation by any Federal department or agency.

HH.2 The Vendor is required to notify Medicaid within two business days of time that a debarred provider is identified. The quarterly sanctions report that is distributed by Medicaid as well as the Debarred Provider List that is maintained at the federal level should be monitored on an ongoing basis to identify these individuals.

II. Enrollee Rights

II.1 The Vendor must have written policies guaranteeing each enrollee's right to receive information on the Maternity Care Program and plan into which he/she is enrolled.

II.2 The Vendor must have written policies guaranteeing each enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy.

- II.3 The Vendor must have written policies guaranteeing each enrollee's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
- II.4. The Vendor must have written policies guaranteeing each enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- II.5. The Vendor must have written policies guaranteeing each enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- II.6 The Vendor must have written policies guaranteeing each enrollee's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected.
- II.7 The Vendor must ensure that each enrollee is free to exercise his or her rights without the Vendor or its network providers treating the enrollee adversely.
- II.8 The Vendor must comply with any applicable Federal and state laws that pertain to rights and ensure that its employees and contracted providers observe and protect those rights.

JJ. Enrollee Choice

- JJ.1 Enrollees must be allowed to choose a DHCP at the time of entry into the Maternity Care Program. If the enrollee is enrolled in the Patient 1st Program, care continues through that program for non-maternity related services. A DHCP List must be available for use in the selection process. The Vendor must specify the approach in complying with choice requirements.

KK. Changes in the Selection Process

KK.1 Choice of Doctors

- KK.1.1 Enrollees must be allowed to change healthcare professionals once without cause within the first 90 days of enrolling in the maternity program and at any time for just cause, which is defined as a valid complaint submitted to the Vendor in writing. Valid causes for disenrollment by the enrollee are set forth in 42 C.F.R. 438.56 (d) (2).
- KK.1.2 The Vendor must notify all enrollees, at the time of enrollment, of the enrollee's rights to change providers or disenroll enrollment for cause.
- KK.1.3 The enrollee may request disenrollment without cause during the 90 days following the date of the enrollee's initial enrollment

with the Vendor or the date the Vendor sends the enrollee notice of the enrollment, whichever is later.

KK.1.4 The Vendor must notify the enrollee of their right to request and obtain the information regarding disenrollment or changes in providers at least once per year.

KK.1.5 The Vendor must provide enrollees of their disenrollment rights at a minimum annually. If there are any changes in the information, the Vendor must notify the enrollee of the changes at least 30 days before the effective date of the change.

LL. Disenrollment

LL.1 In accordance with 42 CFR 438.3(q)(5); 42 CFR 438.56(c)(1); 42 CFR 438.56(c)(2)(i) - (iii); ; 42 CFR 438.56(d)(2)(v), the Vendor must allow enrollees to disenroll:

LL.1.1 For cause, at any time.

LL.1.2 Without cause 90 days after initial enrollment or during the 90 days following notification of enrollment, whichever is later.

LL.1.3 Without cause at least once every 12 months.

LL.1.4 Without cause upon reenrollment if a temporary loss of enrollment has caused the enrollee to miss the annual disenrollment period.

LL.1.5 For other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs

LL.2 In accordance with 42 CFR 438.3(l); 42 CFR 438.56(d)(2)(i) - (ii)., the Vendor will allow each enrollee to choose his or her network provider to the extent possible and appropriate. The Vendor must allow enrollee to request disenrollment if:

LL.2.1 The enrollee moves out of the service area.

LL.2.2 The plan does not cover the service the enrollee seeks, because of moral or religious objections.

LL.3 In accordance with 42 CFR 438.56(d)(2)(iii), the Vendor must allow enrollees to request disenrollment if the enrollee needs related services to be performed at the same time and not all related services are available within the provider network. The enrollee's Primary Care Provider or another provider must determine that receiving the services separately would subject the enrollee to unnecessary risk.

- LL.4 In accordance with 42 CFR 438.3(q)(5); 42 CFR 438.56(c)(2)(iv), the Vendor must allow enrollees to disenroll without cause when the state imposes intermediate sanctions on the Vendor.
- LL.5 In accordance with 42 CFR 438.56(b)(1); Section 1903(m)(2)(A)(v) of the Act; 42 CFR 438.56(b)(2); 42 CFR 438.56(b)(3), the Vendor must specify the reasons the Vendor is requesting disenrollment of an enrollee. The Vendor may not request disenrollment because of:
- LL.5.1 An adverse change in the enrollee's health status.
 - LL.5.2 The enrollee's utilization of medical services.
 - LL.5.3 The enrollee's diminished mental capacity.
 - LL.5.4 The enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Vendor's ability to furnish services to the enrollee or other enrollees).
 - LL.5.5 The Vendor assures the state that it will not request disenrollment for reasons other than those permitted under the contract.
- LL.6 In accordance with 42 CFR 438.56(d)(3)(i), the Vendor may approve a request for disenrollment by or on behalf of the enrollee according to guidelines provided by the state.
- LL.7 In accordance with 42 CFR 438.56(e)(1) - (2); 42 CFR 438.56(d)(3)(ii); 42 CFR 438.3(q); 42 CFR 438.56(c), the Vendor must allow the effective date of an approved disenrollment to be no later than the first day of the second month following the month in which the enrollee requests disenrollment.
- LL.8 In accordance with 42 CFR 438.56(e)(1) - (2); 42 CFR 438.56(d)(3)(ii); 42 CFR 438.3(q); 42 CFR 438.56(c), if the Vendor 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 enrollee requests disenrollment) the disenrollment is considered approved for the effective date that would have been established had Vendor made a determination in the specified timeframe.
- LL.9 In accordance with 42 CFR 438.3(l), the Vendor must acknowledge that enrollee enrollment is not voluntary, and CMS has approved federal authority allowing the state to mandate enrollment.

M.M. For Indian Managed Care Entities

MM.1 In accordance with American Reinvestment and Recovery Act (ARRA) 5006(d); SMDL 10-001; 42 CFR 438.14(b)(3), any Indian enrolled with a Vendor, that is not a Indian Managed Care Entity (IMCE), and eligible to receive services from an Indian health care provider (IHCP) Primary Care Provider (PCP) participating as a network provider, is permitted to choose that IHCP as their Delivering Healthcare Provider, as long as that provider has capacity to provide the services.

NN. Data Collection

NN.1 In accordance with 42 CFR 438.66(c)(1) - (2), the Vendor will report the following information to the state according to the timeline specified by the state.

NN.1.1 Enrollment and disenrollment data

NN.1.2 Member grievance and appeal logs

NN.2 In accordance with 42 CFR 438.66(c)(3), the Vendor will report complaint and appeal logs to the state according to the timeline specified by the state.

NN.3 In accordance with 42 CFR 438.66(c)(5), the Vendor will collect and report:

NN.3.1 The results of any enrollee satisfaction survey conducted by the Vendor.

NN.3.2 The results of any provider satisfaction survey conducted by the Vendor.

NN.4 In accordance with 42 CFR 438.66(c)(6) - (8), the Vendor will report the following information to state according to timeline specified by the state:

NN.4.1 Performance on required quality measures

NN.4.2 Medical management committee reports and minutes

NN.4.3 The Vendor's annual quality improvement plan

NN.5 In accordance with 42 CFR 438.66(c)(9) - (11); 42 CFR 438.8, the Vendor will report the following information to state according to timeline specified by the state:

NN.5.1 Audited financial and encounter data

NN.5.2 The Medical Loss Ratio (MLR) summary reports

NN.5.3 Customer service performance data

OO. Coverage

OO.1 Covered Services

OO.1.1 The Vendor must have or arrange for a comprehensive system of maternity care that provides for pregnancy- related care, including high risk care, to all pregnant enrollees that reside in the district, with the exception of those enrollees that are exempted from the program. Below is a listing of the services that must be covered at a minimum:

OO.1.1.1 Antenatal Services, excluding inpatient care

OO.1.1.2 Delivery Services, excluding inpatient care

OO.1.1.3 Postpartum care services, excluding hospital inpatient care but including home visits when indicated

OO.1.1.4 Care Coordination Services

OO.1.2 The Vendor must describe protocols for service delivery, including the process for managing high-risk pregnancies. Covered services must be medically necessary. “Medically necessary services” encompass maternity related services as well as those that might otherwise complicate or exacerbate the pregnancy. “Medically necessary services” must be provided in a manner that is no more restrictive than the state Medicaid program, including Quantitative and Non- Quantitative Treatment Limits (QTL) (NQTL), as indicated in state statutes and regulations, the Medicaid State Plan (MSP), and other state policies and procedures in accordance with 42 CFR 438.210(a)(5)(i).

OO1.3 In accordance with 42 CFR 438.210(a)(5)(ii)(A). the Vendor must provide “medically necessary services” related to the enrollee’s pregnancy in a manner that addresses the extent to which covered services address the prevention, diagnosis, and treatment in pregnancy and pregnancy related services.

OO1.4 The Vendor must describe how it will be responsible for pregnancy-related services as defined in this RFP from the time the pregnancy is diagnosed until the end of the month in which the 60th postpartum day falls. Maternity Care services are those that are pregnancy-related, medically necessary, and encompass maternity-related services as well as services to treat conditions that might otherwise complicate or exacerbate the pregnancy.

OO1.5 The Vendor is responsible for Specific CPT (current procedural terminology) codes which are included in the capitation rate. The codes are specified in the Maternity Care Program Operational Manual, Attachment Three, Global Associated Codes List. Specific CPT codes not included in the capitation rate are specified in the Maternity Care Program Operational Manual, Section V., Services.

OO.2 Excluded Services

OO.2.1 The following services are excluded from the Maternity Care Program capitation payment methodology and are reimbursed fee-for-service:

OO.2.1.1 Inpatient Care

OO.2.1.2 Prescription Drugs

OO.2.1.3 Injections

OO.2.1.4 Family Planning visits

OO.2.1.5 Lab services other than Hemoglobin, Hematocrit and Urinalysis

OO.2.1.6 Radiology services with the exception of maternity ultrasounds. Maternity ultrasounds are unlimited in number and are a component of the capitation fee payment. A Vendor may develop an evidence-based prior authorization process to manage the number of ultrasounds performed.

OO.2.1.7 Dental services

OO.2.1.8 Circumcision

OO.2.1.9 Physician charges for routine newborn care, standby and infant resuscitation

OO.2.1.10 Non-pregnancy related care

OO.2.1.11 Emergency Room Care (facility and physician)

OO.2.1.12 Medicaid emergency and non-emergency transportation

OO.2.1.13 Drop out fees

OO.2.1.14 Face-to-Face Tobacco Cessation Counseling

OO.2.1.15 Specialist referrals

OO.2.1.16 Miscarriages <21 weeks

OO.2.1.17 Program Exemptions

OO.3 Family Planning

OO.3.1 In accordance with Section 1902(a)(23) of the Act; 42 CFR 431.51(b)(2), the Vendor will not restrict the enrollee's free choice of family planning

OO.4 Abortions

OO.4.1 In accordance with 42 CFR 441.202; Consolidated Appropriations Act of 2008, the Vendor will stipulate that abortions in the following situations are covered Medicaid benefits:

OO.4.1.1 If the pregnancy is the result of an act of rape or incest.

OO.4.1.2 In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

OO.5 Delivery Network

OO.5.1 In accordance with 42 CFR 438.206(b)(2), if a female enrollee's designated primary care physician is not a women's health specialist, the contract requires the Vendor to provide the enrollee with direct access to a women's health specialist within the provider network for covered routine and preventive women's health care services.

OO.5.2 In accordance with 42 CFR 438.206(b)(3)I.F.4.02, the Vendor must provide for a second opinion from a network provider, or arrange for the enrollee to obtain a second opinion outside the network, at no cost to the enrollee.

OO.5.3 In accordance with 42 CFR 438.206(b)(4), if the Vendor's provider network is unable to provide necessary medical services covered under the contract to a particular enrollee, the Vendor must adequately and timely cover the services out of network, for as long as the Vendor's provider network is unable to provide them.

OO.5.4 In accordance with 42 CFR 438.206(b)(5), the Vendor must coordinate payment with out-of-network providers and ensure the cost to the enrollee is no greater than it would be if the services were furnished within the network.

OO.5.5 In accordance with 42 CFR 493.1; 42 CFR 493.3, the Vendor contracting with laboratory testing sites must ensure the laboratory testing sites have a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

OO.6 Services Not Covered Based on Moral Objections

The Vendor is not required to provide, reimburse payment, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds in accordance with 42 CFR 438.102(a) (2); . If the Vendor elects not to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover to the state according to 42 CFR 438.10(e)(2)(v)(C); Section 1932(b)(3)(B)(i) of the Act; 42 CFR 438.102(b)(1)(i)(A)(1); Section 1932(b)(3)(B)(i) of the Act; 42 CFR 438.102(b)(1)(i)(A)(2).The information must be provided:

OO.6.1 with its application for a Medicaid contract;

OO.6.2 whenever it adopts such policy during the term of the contract;

OO.6.3 to potential enrollees before and during enrollment; and

OO.6.4 within 30 days after adopting the policy with respect to any particular service.

PP. Service Delivery

The Vendor must have a delivery system that meets Medicaid requirements as defined in this proposal and any attachment and references hereto, as amended. Medicaid enrollees must be offered the same access to provider office appointments and services that are available to all other maternity enrollees of the Delivering Health Care Professional.

QQ. High Risk Protocol

QQ.1 A high risk pregnancy is one in which some condition puts the mother, the developing fetus, or both at higher-than-normal risk for complications during or after the pregnancy and birth.

The Vendor must clearly describe in the proposal the way it will manage high-risk pregnancies, including a process for identifying high-risk cases, a method to denote high-risk status and the reason for high risk-status, a network for care, policy and procedures for monitoring referrals and services to be provided to high risk maternity enrollees.

QQ.1 Referrals for high-risk care are the responsibility of the Contractor. High risk care is not carved out of the Maternity District Plan. The Vendor must assess each enrollee entering into the care system for high-risk pregnancy status and refer to a DHCP qualified to provide high-risk care if the assessment reflects a condition that cannot be appropriately handled in routine prenatal care sites.

QQ.2 The following guidelines apply to teaching physicians and any Board-Certified or Board-Eligible Perinatologist approved to provide maternity services under a fee-for-service payment methodology outside of the Maternity District plan.

QQ.2.1 Care Provided by a Teaching Physician

The reimbursement for the provision of services provided by a teaching physician as defined in State Plan AL-11-022, 4.19-B which states “Teaching physicians are defined as doctors of medicine or osteopathy employed by or under contract with (a) a medical school that is part of the public university system (The University of Alabama at Birmingham and The University of South Alabama) or (b) a children’s hospital healthcare system which meets the criteria and receives funding under Section 340E (a) of the U.S. Public Health Service Act (42 USC 256e), and which operates and maintains a state license for specialty pediatric beds,” is excluded from the capitation payment “and may be reimbursed fee-for-service.

QQ.2.2 Care provided by a Board-Certified or Board-Eligible Perinatologist

The reimbursement for the provision of high-risk care provided by a Board Certified Perinatologist or Board-Eligible Perinatologist is excluded from the capitation payment and may be reimbursed fee-for-service. All routine maternity services are subject to the Maternity District’s Plan. The Perinatologist must subcontract with a Contractor for routine maternity services. Reimbursement for the provision of routine maternity services will be through the capitation payment methodology according to Contractor-subcontractor agreement.

QQ.2.3 Routine maternity services provided to enrollees before or after transferring to a Medicaid enrolled Teaching Physician or Medicaid enrolled Board-Certified or Board-Eligible Perinatologist

QQ.2.4 Routine maternity services provided by a Contractor to an enrolled recipient before or after transferring to a Medicaid enrolled teaching physician for high risk care or routine care or a Medicaid enrolled Board Certified Perinatologist or a Board-Eligible Perinatologist for high risk care will be reimbursed fee-for-service and will not be reimbursed through the capitation payment methodology. Reference the Maternity Care Program Operational Manual, Section VIII., Payment of Services, for additional information.

RR. Care Coordination Program

For Section RR, utilize Appendix E for preparing the Contractor's detailed description. Any or all guidelines in Appendix E All guidelines are subject to be amended by the Alabama Medicaid Agency as deemed necessary by state and federal authorities.

An integral part of the medical care delivered through the Maternity Care Program is care coordination. Care coordination is a professional skill and should be supported from within the Contractor's system. Care coordination is the mechanism for linking and coordinating segments of a service delivery system to ensure that the most comprehensive program meets the enrollee's needs for care. Care coordination is to be utilized as a resource by which the system can be brought together for the betterment of the enrollee. Reference Appendix E for a complete description of the Care Coordination Program. All guidelines are subject to be amended by the Alabama Medicaid Agency as deemed necessary by state and federal authorities.

RR.1 The Vendor must clearly operate a Care Coordination Program, to include, but not limited to, how the administrative component, medical component and other elements of the program are supported by the efforts of the care coordinators.

RR.2 The care coordinator duties are as varied as the enrollees served. Care coordinators serve a vital role in ensuring that the medical care women receive is augmented with the appropriate psychosocial support. Care coordinator responsibilities include, but are not limited to, the following:

RR.2.1 Performing the initial encounter requirements;

RR.2.2 Performing encounter requirements;

RR.2.3 Performing the psychosocial risk assessment;

RR.2.4 Assessing the medical and social needs;

RR.2.4 Developing service plans;

RR.2.6 Providing information and education on how to contact their designated person or entity in compliance with 42 CFR 438.208(b)(1).

RR.2.7 Tracking enrollees throughout their pregnancy and postpartum period.

RR.3 The Vendor must develop, implement and maintain policies, procedures and protocols related the daily operations of the Care Coordination Program.

RR.4 The Vendor must ensure that the staff who are completing care coordination functions are operating within their professional scope of practice, are appropriate for responding to enrollees' needs and follow the States licensure/credentialing requirement as defined in the Maternity Care Operational Manual, Section VI., Care Coordination.

RR.5 The Vendor must include a stratification of care coordination and must include visit flexibility to meet the needs of the enrollee.

RR.5.1 Minimums are established, but, beyond the minimum, the total number of visits should be dictated by the needs of the enrollees. The care coordinator will be required to assess the enrollee face to face at a minimum of two (2) visits. The care coordinator will have flexibility to determine how to best improve outcomes.

RR.5.2 If the medical or psychosocial status of the enrollee changes, the care coordinator is responsible for adjusting the service plan and proceeding accordingly.

RR.5.3 It is up to the DHCP and care coordinator to decide and develop a service plan that meets the enrollee's needs.

RR.5.4 In accordance with 42 CFR 438.208(b)(1); 42 CFR 438.208(b)(2)(i); 42 CFR 438.208(b)(2)(ii); 42 CFR 438.208(b)(2)(iii); 42 CFR 438.208(b)(2)(iv); 42 CFR 438.208(b)(3), the Vendor will:

RR.5.4.1 Implement procedures to ensure that each enrollee has an ongoing source of care appropriate to their needs.

RR.5.4.2 Be the primary entity responsible for coordinating services accessed by the enrollee.

RR.5.4.3 Implement procedures to coordinate the services the Vendor furnishes to the enrollee between settings of care, including appropriate discharge planning for

short-term and long-term hospital and institutional stays.

RR.5.4.4 Furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP, or PAHP.

RR.5.4.5 Implement procedures to coordinate the services the Vendor furnishes to the enrollee with the services the enrollee receives in FFS Medicaid.

RR.5.4.6 Implement procedures to coordinate the services the Vendor furnishes to the enrollee with the services the enrollee receives from community and social support providers.

RR.5.4.7 Make a best effort to conduct an initial screening of each enrollee's needs and a face to face encounter according to the entry into care timeframe:

RR.5.4.7.1 Enrolled 0-6 weeks gestation - this encounter should be no later than 21 days after enrollment date.

RR.5.4.7.2 Enrolled 7-14 weeks gestation - this encounter should be no later than 14 days after enrollment date.

RR.5.4.7.3 Enrolled 15 weeks gestation or more - this encounter should be no later than 7 days after enrollment date.

RR.5.5 Make subsequent attempts to conduct an initial screening of each enrollee's needs if the initial attempt to contact the enrollee is unsuccessful.

RR.6 In accordance with 42 CFR 438.208(b)(4); 42 CFR 438.208(b)(5); 42 CFR 438.208(b)(6); 42 CFR 438.224; 45 CFR 160; 45 CFR 164; 42 CFR 438.62(b)(1) - (2); 42 CFR 438.208(b)(3), the Vendor will

RR.6.1 Share with the state or other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities.

RR.6.2 Ensure that each provider furnishing services to enrollees maintains and shares an enrollee health record in accordance with professional standards.

RR.6.3 Disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular enrollee, in accordance with the confidentiality requirements in 45 CFR parts 160 and 164.

RR.6.4 Implement a transition of care policy that is consistent with federal requirements and at least meets the state defined transition of care policy.

R.7 Requirements for Care Coordinators

R.7.1 Care Coordinators must have the following credentials:

R.7.1.1 Social workers licensed and/or license-eligible for Alabama practice with a BSW or an MSW from a school accredited by the Council on Social Work Education. License-eligible social worker(s) must obtain license within 12 months of date of employment to function as a care coordinator.

R.7.1.2 Registered Nurses, licensed by the Alabama Board of Nursing, with a minimum of one year experience in care coordination, accessing resources, and coordinating care with low-income populations; or, if no care coordination experience, completion of a care coordinator training course provided by the Vendor and supervision by an experienced care coordinator for at least six months. Documentation must support the care coordinator's training has been completed and supervision for the specified period was provided. Compliance with this requirement will be reviewed during the Administrative Audit.

R.7.1.3 Licensed Practical Nurse(s), licensed by the Alabama Board of Nurses, with at least two (2) years of clinical experience and one year experience in care coordination, accessing resources and coordinating care with low-income populations.

R.8 The Vendor has flexibility in determining how to perform the Application Assister function. Care coordinators are not required to be Application Assisters; however, the Application Assister function is required to be performed by the Vendor. The Vendor may choose to use a care coordinator for this function, while others may choose to have other staff provide this function. Application Assister training is

provided free of charge by the Alabama Medicaid Agency staff (Attachment Six of the Operational Manual). The Vendor must have an individual (s) designated as a trainer for the Train-the Trainer Program. The designee must attend the Train-the-Trainer class and provide certification training to Application Assisters as deemed necessary in order to maintain compliance with certification and re-certification requirements. The certification period for Application Assisters and Train-the-Trainer designee is every two (2) years.

R.9 Care coordination is a professional skill and must be supported from within the Vendor system. Skills and functions employed by the care coordinator include, but are not limited to:

R.9.1 Performing the initial encounter requirements, performing the psychosocial risk assessment, assessing the medical and social needs, developing service plans, providing information and education, making all appropriate referrals (including Plan First and CoIIN referrals), and tracking enrollees throughout their pregnancy and postpartum period.

R.9.2 Community orientations, including the ability to locate, augment, and develop resources including information on services offered by other agencies.

R.10 The Vendor must advise all subcontractors of care coordination services and must require that the subcontractors refer all Medicaid enrollees to enroll in the program with the Vendor within ten days of the first visit.

R.11 The care coordinator must provide the enrollee with a business card that provides location and telephone number of the care coordinator should any questions arise.

R.12 Care coordinators must be located in an area which provides adequate enrollee access and maintains enrollee confidentiality. Private offices are preferred.

R.13 Telephones must be available for use in enrollee contacts.

R.14 The Vendor must have a training plan for initial and on-going care coordination. These plans must at a minimum support the requirements of this document and include training specific to the Maternity Care Program and/or related topics on an on-going basis. Educational materials must include obtaining TPL information, the importance of keeping appointments with both the care coordinator and the DHCP, exemption candidates, current proper sleeping positions for the infant, domestic abuse, breast feeding, smoking & alcohol or other substance cessation, nutrition, and bonding for mother and infant. The effectiveness of the training plans will be monitored per quality outcome measures.

R.15 The care coordinators or other Vendor's staff will enroll the enrollee in the Maternity Care Program and start the Medicaid application process.

R.16 The Vendor must have a system for verification of current license for each care coordinator. Verification of current licensure will be checked during the Administrative Audit.

SS. HOME VISITS

SS.1 The Vendor may provide home visits as an optional service. Reference Appendix D for the Home Visits requirements. Home Visit requirements are subject to amendments as deemed necessary by the Alabama Medicaid Agency. The Vendor's proposal must address this optional service.

TT. Payment for Services Rendered.

TT.1 In accordance with 42 CFR 438.60, the state will not make any payment to a network provider other than by the Vendor for services covered under the contract between the state and the Vendor, except when these payments are specifically required to be made by the state in Title XIX of the Act, in 42 CFR, or when the state agency makes direct payments to network providers for graduate medical education costs approved under the state plan.

TT.2 In accordance with 42 CFR 438.14(c)(3), when the amount the IHCP receives from an Vendor is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, the state must make a supplemental payment to the IHCP to make up the difference between the amount the Vendor pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

TT.3 Global/delivery only reimbursement methodology.

The Vendor must acknowledge 42 CFR 438.60. The state will ensure that no payment is made to a network provider other than by the Vendor for services covered under the contract between the state and the Vendor, except when these payments are specifically required to be made by the state in Title XIX of the Act, in 42 CFR, or when the state agency makes direct payments to network providers for graduate medical education costs approved under the state plan.

TT.3.1 In accordance with 42 CFR 438.106(b)(1) - (2); 42 CFR 438.3(k); 42 CFR 438.230; section 1932(b)(6) of the Act, the Vendor must not hold liable any Medicaid enrollee for covered services provided to the enrollee, for which the state does not pay the Vendor, or for which the state or Vendor does not pay the provider that furnished the service under a contractual, referral, or other arrangement.

TT.3.2 In accordance with 42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230; section 1932(b)(6) of the Act, the Vendor must not hold liable any Medicaid enrollee for covered services furnished under a contract, referral, or other arrangement to the

extent that those payments are in excess of the amount the enrollee would owe if the Vendor covered the services directly.

TT3.3 The Vendor must receive a payment fee upon completion of the services provided. Global/delivery-only fees paid by Medicaid to the Vendor represent payment in full. These fees encompass all components of care as defined in the Section II. Scope of Work.

TT.3.4 For Enrollees who receive total care through the Vendor's network, a capitation fee should be billed.

TT.3.4 For Enrollees who receive no prenatal care through the Vendor's network, a delivery-only fee must be billed. The components of the delivery-only fee include those services provided from the time of delivery through the postpartum period including all the required encounters by the Care Coordinator. The reimbursement amount for a delivery only is 80% of the capitation fee.

TT.4 Subcontractor Reimbursement System

TT.4.1 The Vendor must implement an automated reimbursement system for payments to subcontractors, out-of-plan providers and districts.

TT.4.2 The Vendor must ensure payments to subcontractors within 20 calendar days of the date of Medicaid payment (date funds deposited).

TT.4.3 The Vendor must ensure that in all cases, except where third party insurance billing is required by the DHCP, payments to subcontractors must be within 60 calendar days of the date of delivery.

TT.4.4 The Vendor must specify the payment methodology, i.e. capitation, fee for service, or partial capitation in provider subcontracts. The reimbursement system must comply with Health Insurance Portability and Accountability Act.

TT.4.5 The Vendor must ensure out-of-plan providers be paid within 90 calendar days of submission of a clean claim to the, unless the payment is under appeal.

TT.5 DHCP Payment

TT.5.1 DHCP, except for those associated with a teaching facility as defined in State Plan AL-11-022, 4.19-B, must be paid at a rate no less than the Medicaid fee-for-service urban rate for delivery only. The urban

fee-for-service rate is \$1,000 for delivery only. Nurse midwives are paid at 80% of that rate.

UU. Incentive Arrangements

UU.1 In accordance with 42 CFR 438.6(b)(2)(i), all incentive arrangements are for a fixed period of time if offered in the Maternity Care Program. The performance for all incentive arrangements is measured during the rating period under the contract in which the incentive arrangement is applied

UU.2 In accordance with 42 CFR 438.6(b)(2)(ii) - (iv), incentive arrangements:

UU.2.1 Are not renewed automatically.

UU.2.2 Are made available to both public and private contractors under the same terms of performance.

UU.2.3 Do not condition Vendor participation in the incentive arrangement on the Vendor entering into or adhering to intergovernmental transfer agreements.

UU.3 In accordance 42 CFR 438.6(b)(2)(v); 42 CFR 438.340, all incentive arrangements are necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the state's quality strategy.

UU.4 Third Party Liability (TPL) Activities

UU.4.1 The Vendor is responsible for collecting all third party insurance information prior to submitting a request for payment to Medicaid. Enrollees with third party coverage are required to follow program guidelines.

UU.5 The Vendor is responsible for collecting all third party insurance information prior to submitting a request for payment to Medicaid. Enrollees with third party coverage are required to follow program guidelines. Global claims must reflect the payments made by the third party carrier to all Vendor subcontractors. The Vendor cannot ask maternity enrollees to pay any part of another payer's co-pay/deductible.

UU.6 In accordance with 42 CFR 433 Sub D; 42 CFR 447.20, the Vendor will acknowledge and comply with the state's activities as it relates to Third Party Liability (TPL), including:

UU.6.1 The activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the Vendor and the subcontractor.

- UU.6.2 How the Vendor will reduce payments based on payments by a third party for any part of a service.
- UU.6.3 Whether the state or the Vendor retains the TPL collections.
- UU.6.4 How the state monitors to confirm that the Vendor is upholding contractual requirements for TPL activities.
- UU.7 TPL requirements are: The person enrolling the recipient into the program must ascertain if the woman has third party liability. If TPL is available, obtain the name of the insurance company, the name on the policy (name of insured), enrollee relationship to the insured, address, phone number and policy number. If possible, ascertain from the enrollee what type of coverage the policy provides. The Vendor must verify the information with the insurance company or Medicaid and record all information in the file.
- UU.8 The Vendor shall inform the enrollee of coverage limits of pregnancy related illness and allowed the enrollee to make an informed choice regarding continued coverage of any previous insurance coverage. It is vital that this type of information be collected at the beginning of prenatal care.
- UU.9 The Vendor is responsible for collecting all third party payments prior to submitting a claim to Medicaid for payment. Enrollees with third party coverage are required to follow all program guidelines. Global claims must reflect the payments made by the third party carrier to all subcontractors. Vendors cannot ask maternity enrollees to pay any part of another payer's co-pay/deductible.
- UU.10 The Vendor subcontractors must file with the other insurer and report amount collected to the Vendor. The Vendor must collect the other payer amounts that were obtained from each of their subcontractors. The Vendor shall sum up the lesser of: a) the amount paid by the other payer, or b) the contracted rate between the Vendor and the subcontractor. The total sum of all subcontractors will be reported as "TPL Paid Amount" on the Medicaid claim.
- UU.11 The Vendor's claim must reflect the total payments as outlined in a documented denial from the TPL insurer. Denials must be submitted only when the entire claim is denied. If there is a TPL payment on any part of the claim, that amount shall be listed on the claim. When a Vendor sends a claim to AMA for drop-out, miscarriages, or other reasons that have TPL payment, the subcontractor must attach form ALTPL-01 10/12 (Attachment Twenty-four). Providers are to submit TPL forms when third party payment is made. These forms are scanned and matched electronically with the related claims before processing, and no denial information is submitted.
- UU.12 The Vendor is responsible for notifying Medicaid's TPL Division by telephone or by mail if the enrollee has TPL insurance, and it is not listed on the Medicaid file. The Vendor must review eligibility for current TPL information prior to

submitting claims. To ensure payment, subcontractors should check Medicaid and third party eligibility prior to rendering services.

UU.13 Medicaid must grant a program exemption for TPL carrier only if enrollee is enrolled in an HMO or a managed care plan that requires assignment to a particular provider. An HMO is defined as a TPL carrier which requires the individual to utilize a limited network of providers. In many cases these providers do not accept Medicaid.

UU.14 For enrollees with TPL Coverage, excluding Maternity, the Vendor must notify Medicaid's TPL Division if the enrollee has TPL but the contract does not provide maternity coverage or maternity coverage is not provided for dependents. The provider must obtain a denial and submit it with the claim. This information may be provided by phone directly to Medicaid's TPL Division or may be mailed to Medicaid's TPL Division.

UU.15 For enrollees with TPL coverage that has lapsed, the Vendor must notify Medicaid's TPL Division of the actual month, date, and year the policy lapsed.

UU.16 The Vendor must comply with Medicaid's Administrative Review Process for TPLs. Claims that are received by the Agency from subcontractors will be returned to the Vendor for follow up. When claims are sent through the Administrative Review Process, the Vendor should review the claims and follow all TPL guidelines to ensure that the claim meets requirements.

VV. High Risk Transfers / Reimbursement Methodology

VV.1 Routine maternity services provided to a enrollee by a DHCP and/or Vendor before and after the transfer of a enrollee to a teaching physician as define in State Plan AL-11-022,4.19-B or to a Medicaid enrolled Board-Certified to Board-Eligible Perinatologist will be reimbursed fee-for-service.

VV.2 Services Provided by a Vendor Before a High Risk Transfer:

VV.2.1 The Vendor may receive an Administrative Collaborative Fee for enrolled enrollees who are transferred to high risk care as described above. The Vendor may also receive an Administrative Collaborative Fee for enrolled enrollees who receive routine maternity services from a teaching physician. The CPT code for the Administrative Collaborative Fee is 99199 with a UA modifier and a Diagnosis Code of V239 indicating high risk transfer or routine maternity care by a teaching physician. The Administrative Collaborative fee is \$365.00. The CPT code and the Administrative Collaborative fee are subject to amendments by the Alabama Medicaid Agency. The Administrative Collaborative Fee is paid for services provided by the Vendor which include, but is not limited to:

VV.2.1.1 administration services;

VV.2.1.2 processing administrative review claims for subcontractors;

VV.2.1.3 RMEDE data collection, data entry, and data reporting from the time of enrollment by the Vendor to the end of the postpartum period for high risk enrollees and enrollees under routine care by a teaching physician as defined in State Plan AL-11-022, 4.19-B; and

VV.2.1.4 care coordination encounters.

VV.3 The Vendor and/or DHCP/Subcontractors cannot bill a delivery code or a full global code for high risk transfers or routine care provided by a teaching physician.

VV.4 Exception: When maternity services are subcontracted under the umbrella of a Federally Qualified Health Center (FQHC) and a teaching physician (as defined in State Plan AL-11-022 4.19-B), the Vendor may bill an applicable global CPT code. The reimbursement of the FQHC for provision of maternity services will be the responsibility of the Vendor. The teaching physician will be reimbursed for provision of maternity services under the fee-for-service payment methodology. In this instance, the Administrative Collaborative fee cannot be billed by the Vendor.

VV.5 Services Provided by a DHCP/Subcontractor for a High Risk Transfer:

VV.5.1 Claims for the provision of services by a DHCP/Subcontractor for a high risk transfer will be submitted to the Medicaid by the Vendor. These claims will be considered for payment through the Administrative Review Process. Types of Claims that may be submitted for consideration of payment include, but are not limited to:

VV.5.1.1 Antepartum Care Claims

VV.5.1.2 Postpartum Care Claims

VV.5.1.3 Associated Services Claims

VV.5.1.4 Ultrasounds Claims

VV.5.1.5 Claims for Referrals to specialty doctors

VV.5.1.6 Lab Claims

WW. Quality

- WW.1 Through QAPI, the adequacy and effectiveness, both in clinical and nonclinical areas of the program can be addressed. This section outlines the requirements of the program and the responsibilities of the Vendor and Medicaid. Within Medicaid, the Maternity Care Program Associate Director has primary responsibility for QAPI activities. Details on the requirements of the QAPI process are included in the Maternity Care Program Operational Manual, Sections IX., Quality Assurance and Performance Improvement and X., Records and Reports.
- WW.2. In accordance with 42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3), the Vendor must establish and implement an ongoing Comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes to its enrollees on the Maternity Care Program.
- WW.3 In accordance 42 CFR 438.330(b)(1); 42 CFR 438.330(d)(1); 42 CFR 438.330(a)(2), the Vendor's comprehensive QAPI program must include Performance Improvement Project (PIP), including any required by the state or CMS, that focus on clinical and non-clinical areas. The Vendor must comply with all requirement for PIP as listed in Appendix C.
- WW.4. In accordance 42 CFR 438.330(b)(2); 42 CFR 438.330(c); 42 CFR 438.330(a)(2), the Vendor's QAPI program must include collection and submission of performance measurement data as required by the state, quarterly, in the format specified by the state, including any required by CMS.
- WW.5 In accordance 42 CFR 438.330(b)(3), the Vendor's comprehensive QAPI program must include mechanisms to detect both underutilization and overutilization of services.
- WW.6 In accordance 42 CFR 438.330(b)(4); 42 CFR 438.340, the Vendor's comprehensive QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the state in the quality strategy.
- WW.7 In accordance 42 CFR 438.330(c)(1) and (2), the Vendor must quarterly report to Medicaid on its QAPI performance, using the standard measures required by Medicaid; submit to Medicaid data, specified by Medicaid, which enables Medicaid to calculate the Vendor's performance using the standard measures identified by Medicaid.
- WW.8 In accordance 42 CFR 438.330(d)(2). The Vendor's PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction.

- WW.9 In accordance 42 CFR 438.330(d)(2)(i). The Vendor's PIP must include measurement of performance using objective quality indicators.
- WW.10 In accordance 42 CFR 438.330(d)(2)(ii). The Vendor's PIP must include implementation of interventions to achieve improvement in the access to and quality of care.
- WW.11 In accordance 42 CFR 438.330(d)(2)(iii). The Vendor's PIP must include an evaluation of the effectiveness of the interventions based on the performance measures collected as part of the PIP.
- WW.12 In accordance 42 CFR 438.330(d)(2)(iv). The Vendor's PIP must include planning and initiation of activities for increasing or sustaining improvement.
- WW.13 In accordance 42 CFR 438.330(d)(1) and (3). The Vendor's must provide a status report 6 months into the PIP.
- WW.14 In accordance 42 CFR 438.330(e)(2); 42 CFR §438.310(c)(2)]I.G.5.17, the Vendor must develop a process to evaluate the impact and effectiveness of its own QAPI, including all PIP.
- WW.15 The Vendor must comply with all requirements of the QAPI which includes the following:
- WW.15.1 DHCP Report Cards
 - WW.15.2 Grievance Procedures
 - WW.15.3 Medicaid Agency Web Based Service Database
 - WW.15.4 Performance Improvement Projects
 - WW.15.5 Recipient Surveys

XX. Medicaid Oversight

The Vendor's performance is monitored through a combination of performance measures, DHCP report cards, medical record reviews, Service Database reviews and administrative reviews. The purpose of oversight activities is to ensure that contract requirements are being met, standards of care are being implemented and enforced and that the Vendor is meeting the expectations of the DHCP. Details of the requirements of Oversight process are included in the Maternity Care program Operational Manual Section IX., Quality Assurance and Performance Improvements.

XX.1 Administrative Reviews

- XX.1.1 Purpose - To measure performance, the Vendor will be visited at least annually on-site to ensure compliance with program requirements.

XX.1.2 Elements - Detailed in Figure 2

Figure 2. Administrative Reviews Elements

Subcontractors not enrolled as Medicaid providers
Valid subcontracts (credentialing and licensure)
DHCP have hospital privileges
Claim payment within timeframes
Staff knowledge of billing/reimbursement policies
Training (Subcontractor and Care Coordinator) as required
Application Assister requirements
DHCP choice requirements

XX.1.3 Standards - If after the administrative review, the Vendor is found to not be meeting the requirements, the following damages for cost associated with breach of contract as indicated in Figure 3 will be imposed. As indicated, corrective action will be allowed for some program elements with imposition of damages for cost associated with breach of contract as a final act.

Figure 3. Administrative Measures and Damages for Cost Associated with Breach of Contract.

Measure	Damages for Cost Associated with Breach of Contract
Subcontractor not enrolled with Medicaid	1st occurrence: Corrective Action 2nd occurrence: \$500 per provider not enrolled
Valid subcontracts	1st occurrence: Corrective Action 2nd occurrence: \$500 per subcontract not meeting requirements
DHCP have hospital privileges	1 st occurrence: Corrective Action 2 nd occurrence: \$500 per DHCP not having hospital privileges
Claim payment within timeframes	95% of audit sample of claims paid within timeframes, \$100 per incident for payments not meeting timeframes
Staff knowledge of billing/reimbursement policies	1st occurrence: Corrective Action 2nd occurrence: Staff re-training, of \$100 per incident thereafter.
Training (Subcontractor and Care Coordinator) as required	\$500 per training session not completed
Application Assister services	\$500 per week that there is no certified Application Assister in all counties
DHCP choice requirements	1st occurrence: Corrective Action 2nd occurrence: \$500 per choice requirements not met

XX.1.4 Corrective Action - If program requirements are not met, corrective action will be requested. The Vendor will implement a Corrective Action Plan and submit a signed report to the Medicaid Maternity Care Program via fax, email or United States Postal Service within 15 working days of the request from Medicaid. The Vendor must follow-up on identified issues to ensure that actions for improvement have been effective with a written and signed report of findings submitted to the Medicaid Maternity Care program six months after the Corrective Action Plan has been implemented. If improvement is not noted in subsequent reviews, further actions may be taken including damages for cost associated with breach of contract described above in Figure 3.

XX.2 Medical Record Reviews

XX.2.1 Purpose - To ensure that each Vendor is providing quality maternity care to its enrollees, determine the effectiveness of the Maternity Care Program and to ensure services are provided according to federal and state guidelines, medical record reviews in addition to the elements that are measured from the Web Database as described in the Maternity Care Program Operational Manual, Section XI., Medicaid Oversight will be conducted. Periodic reviews will be conducted to evaluate the effectiveness and adequacy of care coordination, and quality of care delivered by a Vendor and subcontractors.

Service Database Reviews will be completed simultaneously with medical record reviews to ensure that data collected is valid, timely, complete and comprehensive. Verifications will include, but will not be limited to verifying data quality, variances, validity, timeliness, completeness and accuracy with an expected error rate of no greater than 10%.

XX.2.2 Sample Size/Process - Reviews will be conducted on a semi-annual basis. The sample number of records will be chosen randomly from a DSS Query generated for a specific period of time prior to the review but in no case reflective of less than three months prior to the review month. A request for enrollee records will be sent to the Vendor requesting that enrollee's records be sent back to the Medicaid Managed Care Division for review. The Vendor will be responsible for obtaining all record information for review which includes documentation from the DHCP, Hospital, etc. The subcontractor or the Vendor cannot charge for these records.

XX.2.3 Findings - After the review is completed and all data compiled, the Vendor will be provided a summary of the findings.

Statewide statistical reports will be generated after all district reviews are completed, excluding Service Database reviews. Further review and/or a request for a corrective action plan may be necessary dependent on Medical Record and Service Database Review findings. Statewide statistical averages are computed by using weighted district averages to present a more accurate measurement due to the variation in the volume of deliveries per district.

XX.2.4 Elements and Expectations-Detailed in Figure 4.

Figure 4. Medical Record Reviews Elements and Expectations

Measure	What it is	Expectation
Care coordination encounters	The percentage of enrollees for which a care coordination encounter was completed. If no encounter was completed in the hospital prior to discharge, were two (2) attempts made to contact the enrollee within 20 days of delivery so that the encounter could be accomplished?	90% of enrollees receive an encounter.
Documentation of care coordination activities	All encounters are documented	100% of encounters are documented
Content of care coordination	Required encounters meet the guidelines specified in Section VI., Care Coordination , of the Maternity Care Program Operational Manual.	90% of encounters meet the required guidelines.
Service Database Verification-Content of data elements in the Service Database	The percentage of enrollees for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) entered into RMEDE is reflective of medical records and claims documentation	90% of the total selected audit sample Service Database elements should mirror medical record and claims documentation

Figure 5. Medical Record Reviews Standards and Damages for Cost Associated with Breach of Contract.

Measure	Damages for Cost Associated with Breach of Contract
---------	---

Care coordination encounters	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark with no improvement noted, \$500 per enrollee
No documentation of care coordination activity	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark with no improvement noted, \$700 per enrollee
Content of care coordination	1 st Occurrence: Corrective Action 2 nd occurrence: if below established benchmark with no improvement noted, \$500 per enrollee
Content of Service Database - RMEDE Verifications Source-Medical Record Reviews and Claims Data	1 st Occurrence: Letter of Concern 2 nd occurrence: Corrective Action Subsequent Occurrences if below established benchmark, \$500 per occurrence

XX.2.5 Corrective Action - If program requirements are not met, corrective action will be requested. The Vendor will implement a Corrective Action Plan and submit a signed report to the Medicaid Maternity Care Program via fax, email or United States Postal Service within 15 working days of the request from Medicaid. The Vendor must follow-up on identified issues to ensure that actions for improvement have been effective with a written and signed report of findings submitted to the Medicaid Maternity Care Program six months after the Corrective Action Plan has been implemented. If improvement is not noted in subsequent reviews, further actions may be taken including damages for cost associated with breach of contract described above in Figure 5.

XX.3 Missing in Service Database (RMEDE) Reviews

XX.3.1 Purpose-The purpose of the Missing in Service Database (RMEDE Review) is to ensure the Vendor has entered valid data into RMEDE in a timely fashion for enrollees for whom a capitation fee was paid.

XX.3.2 Sample Size/Process- Reviews will be conducted quarterly, as outlined in Maternity Care Program Operational Manual, Section XI.,C. All deliveries for an identified quarter will be chosen randomly from a DSS Query using claims data generated for a specific period of time.

XX.3.3 Findings-After the review is completed and all data compiled, the district will be provided a summary of the findings. Further

review and/or a request for a corrective action plan may be necessary dependent on the review findings.

XX.3.4 Elements and Expectations- Detailed in Figure 6.

Figure 6. Service Database (RMEDE) Reviews Elements and Expectations

Measure	What it is	Expectation
Timeliness and valid Service Database Entries for Missing in RMEDE Reviews	The percentage of enrollees for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) are entered into the Service Database within 90 days of the delivery date and marked as complete.	100 % of enrollees for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) are entered into the Service Database within 90 days of the delivery date and marked as complete.
Validity of Service Database Entries for Missing in RMEDE Reviews	The percentage of enrollees for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) are entered into the Service Database within 90 days of the delivery date with valid data compared to claims data	95% of data entry for each enrollee who delivered in the district review period will be without error

XX.3.5 Corrective Action - If program requirements are not met, corrective action will be requested. The Vendor will implement a Corrective Action Plan and submit written and signed report to the Medicaid Maternity Care Program via fax, email or United States Postal Service within 15 working days of the request from Medicaid. The Vendor must follow-up on identified issues to ensure that actions for improvement have been effective with a written and signed report of findings submitted to the Medicaid Maternity Care Program six months after the Corrective Action Plan has been implemented. If improvement is not noted in subsequent reviews, further actions may be taken including damages for cost associated with breach of contract described in Figure 7.

Figure 7. Service Database (RMEDE) Reviews Standards and Damages for Cost Associated with Breach of Contract

Measures	Damages for Cost Associated with Breach of Contract
Timeliness of Service Database Data Entries for Missing in RMEDE Reviews	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark, \$500 per enrollee

Source: Claims Data	
Validity of Service Database - Missing in RMEDE Reviews	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark, \$100 per enrollee
Source: Claims Data	

XX.4 Corrective Action

XX.4.1 The Vendor must comply with the following standards when the need for corrective action is identified:

XX.4.1.1 There must be a written, defined corrective action plan.

XX.4.1.2 The corrective action plan must be signed by the director.

XX.4.1.3 The plan must be acceptable to and approved by the Alabama Medicaid Agency.

XX.4.1.4 The plan must include:

XX.4.1.4.1 specification of the types of problems requiring remedial/corrective action;

XX.4.1.4.2 specification of the person(s) or body responsible for making the final determinations regarding quality problems;

XX.4.1.4.3 specific actions to be taken;

XX.4.1.4.4 provision of feedback to appropriate health professional, providers and staff;

XX.4.1.4.5 the schedule and accountability for implementing corrective actions;

XX.4.1.4.6 the approach to modifying the corrective action if improvements do not occur; and

XX.4.1.4.7 procedures for terminating the affiliation with the physician or other health professional or provider.

XX.4.2 There must be an assessment of effectiveness of corrective actions.

XX.4.2.1 As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.

XX.4.2.2 The Vendor assures follow-up on identified issues to ensure that actions for improvement have been effective.

XX.4.3 Imposition of these damages for cost associated with breach of contract may be in addition to other contract remedies and does not waive Medicaid's right to terminate the contract.

YY. Reports

The Vendor must comply with the requirements for timeliness, accuracy, and completeness of reports as defined below:

YY.1 Reporting Standards

YY.1.1 Timeliness – Reports and other required Service Database data must be received on or before scheduled due dates. Reporting requirements are based on calendar dates.

YY.1.2 Accuracy – Reports and other required Service Database data must be prepared in conformity with appropriate authoritative sources and/or Medicaid defined standards.

YY.1.3 Completeness – All required information must be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.

YY.2 Reporting Requirements

YY.2.1 The Vendor must submit Report as specified in the description of reports and as listed in Figure 8.

YY.2.2 The Vendor is responsible for continued reporting beyond the term of the contract. For example, processing claims and reporting encounter data must likely continue beyond the term of the contract because of lag time in filing source documents by subcontractors.

YY.2.3 Medicaid requirements regarding reports, report content and frequency of submission of reports are subject to change at any time during the terms of the contract. The Vendor must comply with all changes specified by Medicaid. The "to" contained in the subsequent chart indicates to where the report should be submitted. Maternity Care Program refers to the Associate Director, Maternity Care Program or a designee as directed by the Associate Director. Specific email addresses will be provided prior to contract implementation.

YY.2.4 Reporting requirements as listed in Figure 8 are the responsibility of the Vendor and are required on a routine basis. Details on specific reporting requirements may have been contained in other sections of the Maternity Care Program Operational Manual and referred to below. Failure to deliver reports in the manner and timeframe specified may result in damages for cost associated with breach of contract

Figure 8. Reporting Requirements

Report Name	To	Media	Format	Timeframe	Due
Service Database	n/a	Web-based	In the format as designated in the Web based instructions	Data must be entered within 90 days of the delivery	Within 90 days of delivery
Global Summary Report	MCP	Email	Excel as indicated in the format as specified in Attachment 19 of the Maternity Care Program Operational Manual	Quarterly	Within 45 days of the end of the quarter being reported
Organizational Structure	MCP	e-mail	Word	Annual and upon change	January 1st and/or within 5 days of occurrence
Provider Network	MCP	e-mail	Excel as indicated in the format as specified in Attachment 20 of the Maternity Care Program Operational Manual	Annual and upon change	January 1 st and/or within 5 days of occurrence (exception: due weekly for 30 days after contract award)
Application Assistors	MCP	e-mail	Word as indicated in the format specified in Attachment 6 of the Maternity Care Program Operational Manual	Annual and upon change	Within 45 days of the end of the year and within 45 days of any change
Quality Improvement Activity Summary	MCP	e-mail	Word as indicated in the format specified in Attachment 10 of the Maternity Care Program Operational Manual	Quarterly	Within 45 days of the end of the quarter being reported
Grievance and Appeal Log	MCP	e-mail	Word or excel format as indicated in the format specified in Attachment 18 of the Maternity Care Program Operational Manual	Quarterly	Within 45 days of the end of the quarter being reported

Quality Assurance Committee Meeting Minutes	MCP	e-mail	Word as indicated in the format specified in Attachment 16 of the Maternity Care Program Operational Manual	Quarterly	Within 45 days of the end of the quarter being reported
Managed Care Organization (MCO) Experience Report	MCP	email	As indicated in the format as provided by the Alabama Medicaid Agency	Annually and as requested by Medicaid	Within 45 days of the end of each calendar year
The Medical Loss Ratio (MLR) summary reports	MCP	e-mail	As indicated in the format as provided by the Alabama Medicaid Agency	Annually and as requested by Medicaid	Within 45 days of the end of each calendar year
Quality Improvement Tracking Log	MCP	e-mail	Word as indicated in the format specified in Attachment 17 of the Maternity Care Program Operational Manual	Quarterly	Within 45 days of the end of the quarter being reported
Fraud and Abuse Reports	MCP	e-mail	Excel as indicated in the format specified by Medicaid	Quarterly	Within 10 days of the end of the quarter being reported
Audited financial and encounter data	MCP	e-mail	In the format as requested by Medicaid	Every 6 months	Within 45 days of the end of the 6 month reporting period
Customer service performance data	MCP	e-mail	In the format as reported by the Vendor	quarterly	Within 45 days of the end of the quarter being reported
PIP	MCP	e-mail	Word as indicated in the format specified by Medicaid and as outlined in Appendix C	An update is due 6 months into the PIP and a final report is due annually	Within 10 days of the end of the PIP end date
Sale, Exchange, Lease of Property	MCP	Paper	Word	Occurrence	Within 5 days of occurrence
Loans and/or Extension of Credit	MCP	Paper	Word	Occurrence	Within 5 days of occurrence
Furnishing for Consideration of Goods & Services	MCP	Paper	Word	Occurrence	Within 5 days of occurrence

YY.3 Report Details

YY.3.1 Service Database

YY.3.1.1 The purpose of this report is to collect specifics on each delivery for which the Vendor receives payment. Information will be entered via a web-based database as described in Section IX.C., of the Maternity Care Program Operational Manual

YY.3.2 Global Summary Report

YY.3.2.1 The purpose of this report is to collect specifics on amounts paid to subcontractors for services reimbursed through the capitation fee. The format and instructions are included in Attachment 19 of the Maternity Care Program Operational Manual.

YY.3.3 Organizational Structure

YY.3.3.1 This report indicates for Medicaid the individuals involved in the Vendor's organization. Significant changes must be reported to the Maternity Care program Associate Director within 5 days of occurrence in a word format.

YY.3.4 Provider Network

YY.3.4.1 This report must be reflective of all subcontractors in the Vendor's network. Complete demographic information must be included, the service offered and the providers NPI number. The format and instructions are included in Attachment 20 of the Maternity Care Program Operational Manual.

YY.3.5 Application Assister services

YY.3.5.1 The Vendor must submit a list of counties and names of assigned Application Assisters and the name(s) of the Application Assisters' trainer to the Maternity Care program Associate Director or designee annually and upon change. The format is included in Attachment 6 of the Maternity Care Program Operational Manual.

YY.3.6 Quality Improvement Activity Summary

YY.3.6.1 This report must summarize the district's Quality Improvement activity for the quarter.

YY.3.7 Grievance Log

YY.3.7.1 This report allows Medicaid to track issues as they arise as well as assure that each issue is resolved.

YY.3.8 Quality Assurance Committee Meeting Minutes

YY.3.8.1 This report allows the Quality Assurance Division to focus on quality improvement and quality concerns in individual districts and how improvements initiatives are implemented and the concerns are being resolved. Details are contained in Section IX.A. The format for reporting Quality Assurance Committee Meeting minutes is located in Attachment 16 of the Maternity Care Program Operational Manual.

YY.3.9 MCO Experience Report

YY.3.9.1 This report will be used during the development of delivery rates for the Alabama Medicaid Population. Each Vendor will be required to complete the report for each of its districts annually and as requested by Medicaid.

YY.3.10 Tracking Log

YY.3.10.1 A means by which the Vendor can identify and track problems and/or issues noted within their districts. Identified problems or issues are taken to the QA Committee for discussion and recommendations.

YY.3.11 Sale, Exchange, Lease or Property

YY.3.11.1 These reports are Centers for Medicare and Medicaid Services required for Managed Care Organizations and are required in a word format.

YY.3.12 Loans or Extension of Credit

YY.3.12.1 These reports are centers for Medicare and Medicaid Services requirements for Managed Care Organizations and are required in a word format.

YY.3.13 Furnishing for Consideration of Goods and Services

YY.13.1 These reports are centers for Medicare and Medicaid Services requirements for Managed Care Organizations and are required in a word format.

ZZ. Implementation Activities

The Vendor's proposal must acknowledge and comply with each of the following requirements:

ZZ.1 Readiness Review

ZZ.1.1 Prior to the implementation date Medicaid may elect to conduct a readiness review with the Vendor to ensure that all program requirements are established. If this review is required it will be completed prior to the contract initiation. The purpose of the review will be to review administrative capability, provider subcontracts demonstrating the network, formal policies and procedures for enrollee care, a system of care coordination and optional home visits, review of education and outreach material, participation in the subcontractor training session and review of the quality assurance process. A checklist for the review will be provided prior to the review in order to allow the Vendor time to prepare.

ZZ.2 District Training Sessions

ZZ.2.1 The Vendor will be required to hold a training session for subcontractors in its district. Advance notice of the date of the session must be provided to Medicaid in writing. This session must review all components of the program including, but not limited to, a review of billing procedures, procedure for protection of enrollee choice, and quality assurance activities. Medicaid staff may attend but will not conduct these sessions.

ZZ.3 Corrective Action Measures

ZZ.3.1 In the event that a Vendor fails to meet the requirements of the Contract during the readiness review, the Vendor will be informed of its deficiencies in writing by Medicaid. The Vendor will be given a deadline by which time all identified deficiencies must be corrected to the satisfaction of Medicaid. The Vendor must respond within 48 hours of this notice of deficiencies with an acceptable corrective action plan.

In the event that a Vendor fails to correct the deficiencies noted by Medicaid within the time frame specified by Medicaid approved corrective action plan, Vendor will not be allowed to begin work. The geographic district covered by the deficient Vendor must not participate in the Maternity Care program and Medicaid eligible enrollees must receive their services under a fee-for-service system for a period of no greater than thirty calendar days. At the expiration of this thirty day period, Vendor's completion of the Medicaid corrective action plan will be evaluated.

If the Vendor has not corrected the deficiencies noted by Medicaid, the Vendor's contract with Medicaid will be terminated.

ZZ.4 Duties Upon Expiration/Termination Transfer of Documents

ZZ.4.1 At Medicaid's discretion but no later than three (3) working days following the expiration or termination of the contract, the Vendor at its own expense, must box, label, and deliver to Medicaid or, at Medicaid's direction, the successor Vendor any information, data, manuals, records, claims or other documentation which must permit Medicaid to continue contract performance or contract for further performance with another Vendor. The Vendor must organize and label this documentation by contract component.

The Vendor must at any time during the transition period and up to 90 calendar days after expiration of the contract answer all questions and provide all dialogue and training that Medicaid deems necessary to enable the successor Vendor to take over the provision of maternity care services. All such communications must be with or through the Associate Director of the Maternity Care Program.

III. Pricing

- A. The Vendor's proposal must contain a technical component and a pricing component. The technical component must present a complete and detailed description of the Vendor's qualification to perform and its approach to carry out the requirements of the RFP.
- B. The pricing component is a firm and fixed price for each year of the contract, including any extensions. If the proposal does not contain a firm and fixed price for each delivery, it will not be considered to meet RFP submission requirements. As part of the firm and fixed price submission, Vendor's must include details to support the development of the price including the amounts/percentages of the price to be spent on each component. Once the proposal price is received to the extent that the price is above or below the developed CY18 rate range, the price will be adjusted to appropriate levels within the actuarially sound rate ranges.
- C. Rates ranges will be adjusted according to guidance provided by CMS in accordance with 42 CFR 438.6(c). Rate ranges will be developed using a combination of district specific encounter data, Managed Care Organization (MCO) Experience Financial Reports for the base data and other data as deemed necessary by the Certified Actuaries. Once the base data is established, prospective changes including trends, programmatic changes and non-medical load will be applied in order to develop actuarially sound rate ranges specific to each contract period. CMS defines actuarially sound rates as meeting the following criteria:
 - C.1 Rates developed in accordance with generally accepted actuarial principles and practice;
 - C.2 Rates appropriate for the populations to be covered and the services to be furnished under the contract; and

C.3 Rates certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

- D. Actuary reviews will be completed annually and as often as necessary to keep all payments actuarially sound. Circumstances for actuary reviews include, but are not limited to, significant changes to baseline data, significant program changes by the state, or significant changes in financial condition.
- E. The successful Vendor in each district will be paid a capitation fee per delivery. The capitation fee for each delivery will be actuarially sound. The capitation fee will be payment in full for all services, duties, and administrative requirements as specified in the RFP. This will not be cost settled or modified and therefore should be considered as a firm and fixed price.
- F. Vendors are to submit a single price per district for a global delivery. In paying individual claims, those figures will be reduced by 20% for persons who only receive services at the time of delivery and during the postpartum period.
- G. Contracts for the provision of services under this RFP are risk-bearing and must be approved by CMS.
- H. Contracts shall be amended to support actuarially sound rate ranges in accordance with 42 CFR 438.6(c) to include any contract extensions.

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, Medicaid 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.

Medicaid'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 enrollee eligibility services. For certain enrollee 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 Medicaid 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. General

This document outlines the qualifications which must be met in order for an entity to serve as Vendor. It is imperative that potential 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.

The proposal must contain an “acknowledgement and comply statement” regarding Sections A through N:

- A. Medicaid is hereby seeking Vendors for the procurement of Maternity Care Services in District 10 and District 12, defined by this RFP. Services required are outlined throughout this RFP.
- B. A separate proposal must be submitted for each district. Each proposal submission must be complete and stand on its own.
- C. It is acceptable for a potential Contractor to create a common management or administrative infrastructure that would serve more than one district. Any such arrangement must be described and the functions must be satisfied for each proposal.
- D. All proposals must become the property of Medicaid.
- E. The Vendor to whom a contract is awarded must be responsible for the performance of all duties contained within this RFP. The Vendor must be responsible for implementation and coordination of a comprehensive maternity care delivery system (with the exception of the inpatient hospital component) that meets the needs of the Medicaid enrollees within its district as described within this RFP. The mission of the program is to provide for the best possible birth outcome. This is accomplished through a coordinated system, augmented with care coordination and with an emphasis on quality.
- F. The successful Vendor's delivery system must not include the inpatient hospital component. The inpatient hospital must be outside of the capitation reimbursement for maternity care.
- G. All information contained in this RFP and any amendments reflect the best and most accurate information available to Medicaid at the time of RFP preparation. No inaccuracies in such data must constitute a basis for change of the payments to the Vendor or a basis for legal recovery of damages, actual, consequential or punitive, except to the extent that such inaccuracies are the result of intentional misrepresentation by Medicaid.
- H. The submission of a proposal does not guarantee the award of a contract. Any contract resulting from the proposal is not effective until it has received all required governmental approvals and signatures. In addition, the selected Vendor must not begin performing work under this contract until notified to do so by the departmental contracting agent. The projected implementation date of the contract is January 1, 2018.
- I. The proposal must be received by Medicaid as specified in the Schedule of Activities.
- J. The proposal response must present a complete and detailed description of the Vendor's qualifications to perform such services, and its approach to carry out the requirements of this RFP. Complete program details are included in the 2016 Maternity Care Program Operational Manual. Vendors must review this Operational Manual in detail to gain a complete

understanding of program requirements. In addition, Vendors are encouraged to review the Administrative Code (www.medicaid.alabama.gov); Code of Federal Regulations (www.access.gpo.gov); and the Medicaid Provider Billing Manual (www.medicaid.alabama.gov) prior to completing their proposal to ensure that all program requirements are understood and can be met. The proposal must explain how the requirements set forth will be met including examples where appropriate.

- K. The proposal must contain documentation of the care delivery system that includes, but are not limited to:
 - K.1 A flowchart addressing both high and low risks enrollee flow through the care system from entry into care to the conclusion of postpartum care;
 - K.2 A narrative explaining the enrollee flow;
 - K.3 Protocols to be followed by providers for providing maternity care which prescribe services for prenatal visits, risk assessment, referral and follow up arrangements and postpartum services for both enrollees at low and high risk;
 - K.4 List of all the proposed DHCP subcontractors with specialty;
 - K.5 Subcontractors are located within 50 miles of the location of enrollees receiving care through the program;
 - K.6 Estimated DHCP/enrollee ratio; and a
 - K.7 Specialty (high risk) hospital arrangements which are utilized by DHCP.
- L. Submission of a response to this RFP, acceptance of the award, and signing of the contract and applicable attachments constitute evidence of Vendor's understanding of an agreement to the terms and conditions expressed in this proposal and contract.
- M. This contract can only be offered in conjunction with an approved 1915(b) waiver. If the waiver is not granted or continued, then Medicaid does not have the legal authority to operate this program as explained in this RFP.
- N. Medicaid may by written notice revise and amend the RFP prior to the due date for the proposal. If, in the opinion of Medicaid, revisions or amendments will require substantive changes in the RFP, the due date may be extended at the sole discretion of Medicaid.

VI. Corporate Background and References

Entities submitting proposals and all subcontractors must:

- a. Provide evidence that the Vendor possesses the qualifications required in this RFP.
- b. Provide a description of the Vendor's organization, including

1. Date established.
 2. Ownership (public company, partnership, subsidiary, etc.). Include an organizational chart depicting the Vendor's organization in relation to any parent, subsidiary or related organization.
 3. Number of employees and resources.
 4. Names and resumes of Senior Managers and Partners in regards to this contract.
 5. A list of all similar projects the Vendor has completed within the last three years.
 6. A detailed breakdown of proposed staffing for this project, including names and education background of all employees that will be assigned to this project.
 7. A list of all Medicaid agencies or other entities for which the Vendor currently performs similar work.
 8. Evidence that the Vendor is financially stable and that it has the necessary infrastructure to complete this contract as described in the Vendor's Proposal. The Vendor must provide audited financial statements for the last three years, or similar evidence of financial stability for the last three years.
 9. 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. Medicaid 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. Have proven eight (8) years experience in implementing and maintaining maternity care services for a Maternity Care program, with four (4) of those years of experience being with a state Medicaid maternity care program, and have been in business a minimum of five (5) years.
- e. Furnish three (3) references for projects of similar size and scope, including contact name, title, telephone number, and address. Performance references should also include contract type, size, and duration of services rendered. **You may not use any Alabama Medicaid Agency personnel as a reference.**

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 and 45 CFR 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 CFR 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 Vendor 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:

<i>Project Director:</i>	Sylisa Lee-Jackson
	Managed Care Division
<i>Address:</i>	Alabama Medicaid Agency
	Lurleen B. Wallace Bldg.
	501 Dexter Avenue
	PO Box 5624
	Montgomery, Alabama 36103-5624
<i>E-Mail Address:</i>	<u>MCPRFP@medicaid.alabama.gov</u>

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. Acceptance of Standard Terms and Conditions

Vendors must submit a statement stating that the Vendor has an understanding of 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.

F. Adherence to Specifications and Requirements

The Vendor must submit a statement stating that the Vendor has an understanding of and will comply with the specifications and requirements described in this RFP.

G. 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.

H. 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.

I. 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.

J. 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.

K. State's Rights Reserved

While the State has every intention to award a contract as a result of this RFP, issuance of the 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 Vendor whose proposal is within the competitive range with respect to technical plan and cost;

- Adopt to its use all, or any part, of a Vendor'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.

L. Price

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.

M. Submission of Proposals

Proposals must be sealed and labeled on the outside of the package to clearly indicate that they are in response to **2017-MCP-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.

N. Copies Required

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

O. Late Proposals

Regardless of cause, late proposals will not be accepted and will automatically be disqualified from further consideration. It shall be at 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.

P. E-Verify Memorandum of Understanding

The proposal response must include an E-Verify Memorandum of Understanding with the Department of Homeland Security.

Q. Proposal Format

Proposals must be prepared on standard 8 1/2" 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.

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 Vendor'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 Vendor'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

Medicaid will not accept any amendments, revisions, or alterations to proposals after the deadline for submitting proposals unless such is formally requested, in writing, by Medicaid.

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 and a Vendor has been selected. 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. Medicaid 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 State 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 State'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 State 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
Scope of Work	40%
Care Coordination Program	35%
Cooperate Background	25%
Total	100%

F. Determination of Successful Proposal

The Vendor whose proposal is determined to be in the best interest of the State will be recommended as the successful 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 State will notify the selected Vendor. If the State rejects all proposals, it will notify all Vendors. The State 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:
 - Title XIX of the Social Security Act, as amended and regulations promulgated hereunder by HHS and any other applicable federal statutes and regulations
 - The statutory and case law of the State of Alabama

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

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. Medicaid 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 term of this RFP shall be for two years effective January 1, 2018, through December 31, 2019. At the end of the contract period, Alabama Medicaid may at its discretion, exercise a one year extension option and allow the period of performance to be extended at the rate indicated on the RFP Cover Sheet if approved by the Legislative Contract Review Oversight Committee. The Vendor will provide pricing for each year of the contract, including any extensions. Contract execution for the provision of work under this RFP are termed 12 months based on calendar year, effective January 1st of each year and ends December 31st of each year.

Vendor acknowledges and understands that this contract is not effective until it has received all requisite state government approvals and Vendor shall not begin performing work under this contract until notified to do so by Medicaid. Vendors 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. Confidentiality

Vendor 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. Vendor 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.

Vendor 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 enrollees; 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 Vendor shall sign and comply with the terms of a Business Associate agreement with the Agency (Appendix B).

F. Security and Release of Information

Vendor 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. Vendor shall not release any data or other information relating to the Alabama Medicaid Program without prior written consent of Medicaid. This provision covers both general summary data as well as detailed, specific data. Vendor shall not be entitled to use of Alabama Medicaid Program data in its other business dealings without prior written consent of Medicaid. All requests for program data shall be referred to Medicaid for response by the Commissioner only.

G. 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 Vendor 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 Vendors by 5 USC 552a (m) (1), provides that any officer or employee of a Vendor, 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.

H. 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. Vendor 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 Vendor's refusal to comply with this provision shall constitute a material breach of contract.

I. 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 Medicaid, constitute default by Vendor effective the date of such filing. Vendor shall inform Medicaid in writing of any such action(s) immediately upon occurrence by the most expeditious means possible. Medicaid may, at its option, declare default and notify Vendor in writing that performance under the contract is terminated and proceed to seek appropriate relief from Vendor.

J. Termination for Default

Medicaid may, by written notice, terminate performance under the contract, in whole or in part, for failure of Vendor to perform any of the contract provisions. In the event Vendor defaults in the performance of any of Vendor's material duties and obligations, written notice shall be given to Vendor specifying default. Vendor shall have 10 calendar days, or such additional time as agreed to in writing by Medicaid, after the mailing of such notice to cure any default. In the event Vendor does not cure a default within 10 calendar days, or such additional time allowed by Medicaid, Medicaid may, at its option, notify Vendor in writing that performance under the contract is terminated and proceed to seek appropriate relief from Vendor.

K. 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 Medicaid, 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, Medicaid shall promptly notify Vendor 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 Medicaid, State or Federal Government.

L. 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.

M. Termination for Convenience

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

N. Force Majeure

Vendor shall be excused from performance hereunder for any period Vendor 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.

O. Nondiscriminatory Compliance

Vendor 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.

P. Conflict of Interest

The parties acknowledge and agree that the Vendor 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 Vendor 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.

Q. Open Trade

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

R. 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.

S. Worker's Compensation

Vendor 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.

T. Employment of State Staff

Vendor 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 Medicaid during the previous twelve (12) months, except retired employees or contractual consultants, without the written consent of Medicaid. Certain Medicaid employees may be subject to more stringent employment restrictions under the Alabama Code of Ethics, §36-25-1 et seq., Code of Alabama 1975.

U. Immigration Compliance

Vendor will not knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama. Vendor 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. Vendor will document that the Vendor 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 Vendor 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. Vendor 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 Vendor 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. Vendor 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.

V. 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.

W. 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.

X. Warranties Against Broker's Fees

Vendor 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, Medicaid shall have the right to terminate the contract without liability.

Y. Novation

In the event of a change in the corporate or company ownership of Vendor, Medicaid shall retain the right to continue the contract with the new owner or terminate the contract. The new corporate or company entity must agree to the terms of the original contract and any amendments thereto. During the interim between legal recognition of the new entity and Medicaid execution of the novation agreement, a valid contract shall continue to exist between Medicaid and the original Vendor. When, to Medicaid's satisfaction, sufficient evidence has been presented of the new owner's ability to perform under the terms of the contract, Medicaid may approve the new owner and a novation agreement shall be executed.

Z. Employment Basis

It is expressly understood and agreed that Medicaid enters into this agreement with Vendor 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.

AA. Disputes and Litigation

Except in those cases where the proposal response exceeds the requirements of the RFP, any conflict between the response of Vendor 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 Medicaid.

The Vendor'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 Vendor 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 Medicaid or Vendor 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.

BB. Records Retention and Storage

Vendor shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of three years from the date of the final

payment made by Medicaid to Vendor 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 three- 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.

CC. Inspection of Records

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

DD. 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, Chapter 1, 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 Vendor's compliance with applicable federal procurement requirements, and the determination of costs shall be governed by federal cost principles.

EE. Payment

Vendor shall submit to Medicaid claims for compensation for the deliverable and/or work performed. Claims must be submitted according to guidelines provided in the Alabama Medicaid Provider Manual. Payments are dependent upon successful completion and acceptance of described work and delivery of required documentation.

FF. Notice to Parties

Any notice to Medicaid under the contract shall be sufficient when mailed to the Project Director. Any notice to Vendor shall be sufficient when mailed to Vendor 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.

GG. Disclosure Statement

The successful Vendor shall be required to complete a financial disclosure statement with the executed contract.

HH. Debarment

Vendor 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.

II. Not to Constitute a Debt of the State

Under no circumstances shall any commitments by Medicaid 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 Vendor'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 Medicaid with the Board of Adjustment for the State of Alabama.

JJ. 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.

KK. 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.

LL. Alabama interChange Interface Standards

Vendor 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 Medicaid website.

X. Performance Guarantee

The Vendor's proposal must acknowledge and comply with each of the following requirements:

In order to assure full performance of all obligations imposed on a Vendor contracting with the State of Alabama, the Vendor will be required to provide a performance guarantee in an amount equal to one percent of the expected annual Medicaid payment. The actual figure will be based on the firm and fixed price multiplied by the expected number of annual deliveries multiplied by one percent. The performance guarantee must be submitted by Vendor at least ten calendar days prior to the contract start date. The form of performance guarantee must be one of the following:

- a. Cashier's Check (personal or company checks are not acceptable)
- b. Other type of bank certified check
- c. Money order
- d. An irrevocable letter of credit
- e. Surety bond issued by a company authorized to do business within the State of Alabama

The Alabama Medicaid Agency's Director of Financial Administration shall be the custodian of the performance guarantee. The performance guarantee shall reference this RFP and it shall be made payable to the State of Alabama.

If Vendor fails to deliver the required performance guarantee, the proposal shall be rejected and the contract may be awarded to the provider of the next ranked proposal.

In the event of a breach of contract, Medicaid will notify Vendor in writing of the default and may assess reasonable charges against the Vendor's Performance guarantee.

Failure of the Vendor to perform satisfactorily, breach of contract, or termination of contract shall cause the performance guarantee to become due and payable to the state of Alabama to the extent necessary to cover the costs incurred by Medicaid as a result of the Vendor's failure to perform its contractual obligations.

These cost include, but not limited to cost to correct any Medicaid errors caused by the Vendor's default and cost incurred by Medicaid for completion of contracted work including any cost associated with preparation, solicitation and award of a competitive proposals for these contract services and any federal, state or other penalties, sanctions, disallowance, or any other cost incurred by Medicaid as a result of the Vendor's default and any sanctions and/or liquidated damages necessary as a result of the Vendor's default.

In order to achieve the greatest economy for the State, Medicaid may choose the next responsive Vendor, re-release the RFP, or complete any other action consistent with state purchasing laws.

Performance Guarantees must remain current and enforced for the duration of the contract as well as extension options. The performance guarantee will be released within 60 days of the end of the contract term.

XI. Damages for Cost Associated with Breach of Contract/Liquidated Damages

The Vendor's proposal must acknowledge and comply with the following requirements:

In the event that Vendor fails to meet the requirements of this RFP and contract requirements, Medicaid will recover damages for cost associated with breach of contract. Vendor agrees to pay Medicaid the sums set forth below unless waived by Medicaid.

- A. Failure to deliver requisite reports/enrollee records/services/deliverables as defined by the RFP by the date specified by Medicaid - \$100 per day per report or review.
- B. Failure to provide documentation as required by the RFP - \$1,000 per instance.
- C. Failure to comply with any other requirement of the RFP - \$1,000 per instance.
- D. Failure to perform tasks as specified in the RFP within the time specified by Medicaid, including but not limited to data entered into the Service Database - \$100 per day.
- E. Failure to submit an acceptable required corrective action plan - \$1,000 per instance.
- F. Failure to maintain adequate staffing levels necessary to perform the requirements of the RFP - \$1,000 per instance.
- G. Failure to meet technical requirements - \$1,000 per instance.
- H. Insufficient or absence of Care Coordination documentation to meet required benchmark - \$500.00 per medical record.
- I. Misrepresentation or falsification of information furnished to Centers for Medicare and Medicaid Services. Medicare/Medicaid Services, to the State, to an enrollee, potential enrollee or health care provider- \$5,000 per instance.
- J. Vendor must be liable for any penalties or disallowance of Federal Financial Participation incurred by Medicaid due to Vendor's failure to comply with the terms of the contract. Total dollars may include State funds as well as federal funds.
- K. Imposition of damages for cost associated with breach of contract and liquidated damages may be in addition to other contract remedies and does not waive Medicaid's right to terminate the contract.
- L. Unauthorized use of information must be subject to the imposition of damages for cost associated with breach of contract in the amount of ten thousand dollars (\$10,000) per instance.
- M. Failure to safeguard confidential information of providers, enrollees or the Medicaid program shall be subject to the imposition of \$10,000 per instance for damages for cost associated with breach of contract and any penalties incurred by Medicaid for said infractions.
- N. Other damages for cost associated with breach of contract are noted in Section II.Q. Medicaid Oversight.

Vendor shall receive written notice from Medicaid upon a finding of failure to comply with contract requirements, which contains a description of the events that resulted in such a finding. Vendor shall be allowed to submit rebuttal information or testimony in opposition to such

findings. Medicaid shall make a final decision regarding implementation of damages for cost associated with breach of contract.

XII. Contract Ending Transition and Implementation Plan Incumbent

The Vendor's proposal must acknowledge and comply with the following requirements:

At the end of the contract period to be covered by this RFP (January 1, 2018 – December 31, 2020, unless extended), the following payments will be made for transitioning enrollees. Transitioning enrollees are women who entered care with a Vendor and have not delivered the infant when the new contract begins.

- a. If the same Vendor is awarded the contract for the district payment for all services will be at the new capitation rate beginning with the new contract period. There will be no settlement for women who transition from one contract period to the next.
- b. If a new Vendor is awarded the contract for a district:
 1. The incumbent Vendor will be paid \$100 for each enrollee that did not deliver prior to the end of the contract period. It will be a lump sum payment to cover costs incurred. The incumbent Vendor will be responsible for payment to subcontractors for services rendered to the end of the contract period.
 2. New Vendor will receive payment for deliveries from Medicaid as follows for women that have not delivered and were enrolled with the prior Vendor:
 - i. 1st month --97% of capitation delivery fee paid for enrollees delivering in the first month of the new contract
 - ii. 2nd month--98% of capitation delivery fee paid for enrollees delivering in the second month of the new contract period.
 - iii. 3rd month--99% of capitation delivery fee paid for enrollees delivering in the third month of the new contract period.
 - iv. After the third month--100% of the capitation fee will be paid.
- c. For enrollees in their third trimester, a startup exemption may be granted if their physician is not participating with the new Vendor. Such exemptions must be received by the end of the contract period to a new Vendor.
- d. Incumbent entities must submit a list of enrollees transitioning out no later than thirty days prior to a new contract start date to Medicaid's Maternity Care program Associate Director.

Appendix A: Proposal Compliance Checklist

NOTICE TO CONTRACTOR:

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.

Contractor 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.

<input checked="" type="checkbox"/> IF CORRECT	BASIC PROPOSAL REQUIREMENTS
<input type="checkbox"/>	1. Contractor's original proposal received on time at correct location.
<input type="checkbox"/>	2. Contractor submitted the specified copies of proposal and in electronic format.
<input type="checkbox"/>	3. The Proposal includes a completed and signed RFP Cover Sheet.
<input type="checkbox"/>	4. The Proposal is a complete and independent document, with no references to external documents or resources.
<input type="checkbox"/>	5. Contractor submitted signed acknowledgement of any and all addenda to RFP.
<input type="checkbox"/>	6. The Proposal includes written confirmation that the Contractor understands and shall comply with all of the provisions of the RFP.
<input type="checkbox"/>	7. The Proposal includes required client references (with all identifying information in specified format and order).
<input type="checkbox"/>	8. The Proposal includes a corporate background.
<input type="checkbox"/>	9. The Proposal includes a detailed description of the plan to design, implement, monitor, and address special situations related to a new 2017-MCP-01 program as outlined in the request for proposal regarding each element listed in the scope of work.
<input type="checkbox"/>	10. Contractor must submit a statement stating that the Contractor has an understanding of 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 Contractor's proposal being deemed non-responsive.

<input type="checkbox"/>	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.
<input type="checkbox"/>	12. The response must include an E-Verify Memorandum of Understanding with the Department of Homeland Security.
RFP References for Acknowledge and Comply Statements	
<input type="checkbox"/>	II.D Maternity Care Program Guidelines
<input type="checkbox"/>	II.H Changes in the Selection Process
<input type="checkbox"/>	II.I.2 Medical Care System
<input type="checkbox"/>	II.O Payment for Services Rendered
<input type="checkbox"/>	II.Q. Medicaid Oversight
<input type="checkbox"/>	II.T Implementation Activities
<input type="checkbox"/>	III. Pricing
<input type="checkbox"/>	V. General
<input type="checkbox"/>	VIII. Evaluation and Selection Process
<input type="checkbox"/>	X. Performance Guarantee
<input type="checkbox"/>	XI. Damages for Cost Associated with Breach of Contract/Liquidated Damages
<input type="checkbox"/>	XII. Contract Ending Transition and Implementation Plan Incumbent
<input type="checkbox"/>	XIII. Contract Ending Transition and Implementation Plan from Contractor to RCO

Appendix B: 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

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

ALABAMA MEDICAID AGENCY

This contract has been reviewed for and is approved as to content.

Contractor's name here

Stephanie McGee Azar
Commissioner

Date signed

Date signed

Printed Name

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.

Tax ID: _____

APPROVED:

General Counsel

Governor, State of Alabama

**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 enrollee 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 enrollee, 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? (IF YES, ATTACH LETTER)
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 the 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

Contract/Amendment Total: \$ (estimate if necessary)

% of State Funds: % of 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, please give a brief explanation:

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

Printed Name

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

Montgomery, Alabama 36103-5624

TELEPHONE NUMBER

(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	DATE GRANT AWARDED	AMOUNT OF GRANT
-------------------------	--------------------	-----------------

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.



KAY IVEY
Governor

Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624
www.medicaid.alabama.gov
e-mail:
almedicaid@medicaid.alabama.gov

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

Appendix C: Performance Improvement Projects Guidelines

Performance Improvement Projects

AA.1.1. Performance Improvement Project (PIP) assess and improve the processes and outcomes of Maternity Care Services covered or provided by the Contractor. Annually, the Contractor must submit for Medicaid's approval, a description of one (1) PIP. Medicaid reserves the right to require additional PIPs if it identifies deficiencies in performances based on audits, analysis of quality measure outcomes or statistical data, or if required by CMS in accordance with 42 CFR § 438.330(a)(2).

AA.1.2. The Contractor must report the status and results of each PIP to Medicaid as requested, but not less than once per year.

AA.1.3 Study topic(s): The PIP should target improvement in either clinical or non-clinical services delivered in the state. Topics selected for study must reflect the Medicaid enrollment in terms of demographic characteristics, prevalence of disease or condition as it relates to maternal health, and the potential consequences of the disease or condition as it relates to maternal health. In addition, CMS, in consultation with Medicaid and other stakeholders, may specify performance measures and topics for PIPs.

AA.1.3.1 Study question(s): The study question(s) must be clear, concise, and answerable. The study question(s) identifies the focus of the PIP and sets the framework for data collection, analysis, and interpretation. Potential sources of information to help form the study question include:

AA.1.3.1.1. State data relevant to the topic being studied

AA.1.3.1.2. Contractor data relevant to the topic being studied

AA.1.3.1.3. Relevant clinical literature

AA.1.3.1.4 Study variable(s): A study variable is a measurable characteristic, quality, trait or attribute of a particular individual, object or situation being studied.

AA.1.3.1.5 Representative and generalizable sample: Measurement and improvement efforts must be specific to the population served in the district. The PIP must clearly identify the "system" or study population, also referred to as the universe. Once the population is identified, the Vendor must determine whether to study data for the entire population in the district or a sample of that population. A representative sample of the identified population is acceptable.

AA.1.4 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.

AA.1.5 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:

AA.1.3.6.1. Administrative data (e.g., membership, enrollment, claims, encounters)

AA.1.3.6.2. Medical records

AA.1.3.6.3. Tracking logs

AA.1.3.6.4. Results of any provider interviews

AA.1.3.6.5. Results of any Medicaid Enrollee interviews and surveys

AA.1.6 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.

AA.1.7 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.

AA.1.8 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 Vendor must demonstrate whether the cause for improvement was due to the interventions and improvement strategies implemented.

AA.1.9 Planning and initiation of activities for increasing or sustaining improvement: Real change is the result of changes in the fundamental processes of oral 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 Vendor must demonstrate whether the interventions and improvement strategies implemented are likely to achieve sustained improvement.

Appendix D: Home Visit Program

A. Purpose

Home visits are optional, unless the required visit in the hospital is missed. If the hospital face to face encounter visit is missed, a home visit must be made within twenty days of the delivery date. It is the opinion of the Alabama Medicaid Agency that home visits improve outcomes. The Primary Contractor may develop criteria within their respective district for the purpose of home visits. The Vendor's proposal must include a Home Visit Program. Below are the Home Visit Program guidelines, which may be amended at any time during this RFP term.

The following are recommendations for consideration of home visit criteria development.

1. Under 16 Years of Age

- At time of conception
- Late entry into care (20 weeks gestation and over)
- Not residing in home with parents or significant other
- Grossly overweight or underweight
- Not in school
- Use of tobacco and/or alcohol and/or drugs
- Transportation issues
- Lack of support from family or father of baby
- Any triggers that indicate a need for follow-up after delivery

2. Drug and Alcohol Abuse

- Self reported
- Psychosocial assessment
- Odor of alcohol
- Observations of track marks and/or bruises from needle use
- Unexplained late entry into care 20 weeks gestation and over
- At risk lifestyle (i.e., multiple sex partners)
- Suspicious behavior such as incessant talking, drug seeking behavior (i.e., narcotics for various pains) glazed eyes, lying, sedated, short attention span, etc.

3. Mental illness

- Postpartum depression (it is expected that these women may require a series of visits)
- Long term history of mental illness
- Taking psychotropic drugs for mental illness (ex. Mellaril, Haldol, Lithium, etc.)
- Taking anti-depressants and exhibiting outward signs of depression (i.e., flat affect depressed mood and thought process, lack of interest in personal appearance, lack of interest in planning for baby's arrival, etc.)

4. Birth weight 2500 grams or less

- Lack of prenatal care
- Previous birth outcomes including low birth weight births

- Mom or others in the household are smokers
- Whether the infant is enrolled in a hospital follow-up program

5. Partner Abuse (Attachment Nine)

- Reported by the recipient
- Unexplained visible injuries
- Fear of partner & his uncontrollable temper
- Reports of partner's threats to harm or kill recipient
- Reports of extreme partner jealousy and/or being possessive
- Reports of verbal abuse; yelling, cursing, name-calling, isolation
- Other—Care Coordinator or Delivering Health Care Professional judgment

B. Documentation

Medical records must be maintained that support the need or lack of need and the outcome of home visits. Refer to Attachment Seven.

C. Tracking Of Home Visits

The following codes have been established to assist the Primary Contractor in tracking home visits. These are not separately billable codes but codes to be used for internal tracking systems and may be expanded dependent upon your district specific criteria.

- H001 – under 16 years of age
- H002 – Drug & Alcohol Abuse
- H003 – Mental Illness
- H004 – Low Birth-weight
- H005 – Partner Abuse
- H006 – Missed Inpatient Encounter
- H007 – Other

Attachment E: Care Coordination Program

Overview

An integral part of the medical care delivered through the Maternity Care Program is Care Coordination. Care Coordination is the mechanism for linking and coordinating segments of a service delivery system to ensure the most comprehensive program meeting the clients' needs for care. It may involve one person or a team that has responsibility for managing, assessing, planning, procuring or delivering, monitoring and evaluating services to meet the identified needs of the client. The approach to Care Coordination shall vary from case to case. The needs of the patient should dictate when services are provided and the number of visits that are needed. The Vendor's proposal must include a Care Coordination Program. Listed below are the Care Coordination Program guidelines, which may be amended at any time during this RFP term.

1. Care Coordination can be generally defined in one of three ways:
 - a. A system of activities to link the service system to a recipient;
 - b. A balanced system of services; or
 - c. A process of ensuring that the recipient moves sequentially through a continuum of services.
2. Stratification of Case Management
 - a. Visit flexibility to meet the needs of the recipient is allowed. Minimums are established, but, beyond the minimum, the total number of visits should be dictated by the needs of the patient. The Care Coordinator will be required to assess the patient face to face at a minimum of two visits. The Care Coordinator will have flexibility to determine how to best improve outcomes.
 - b. If the medical or psychosocial status of the recipient changes, the Care Coordinator is responsible for adjusting the service plan and proceeding accordingly.
 - c. It is up to the Delivering Healthcare Professional and Care Coordinator to decide and develop a service plan that meets the patient's needs.

B. Requirements for Maternity Care Coordinators

1. Social workers licensed and/or license-eligible for Alabama practice with a BSW or an MSW from a school accredited by the Council on Social Work Education. License-eligible social worker(s) must obtain license within 12 months of date of employment to function as a Care Coordinator.
2. Registered Nurses, licensed by the Alabama Board of Nursing, with a minimum of one year experience in care coordination, accessing resources, and coordinating care with low-income populations; or, if no care coordination experience, completion of a Care Coordinator training course provided by the Primary Contractor and supervision by an experienced Care Coordinator for at least six months. Documentation must support the Care Coordinator's training has been completed and supervision for the specified period was provided. Compliance with this requirement will be reviewed during the Administrative Audit.

3. Licensed Practical Nurse(s), licensed by the Alabama Board of Nurses, with at least two years of clinical experience and one year experience in care coordination, accessing resources and coordinating care with low-income populations.
4. The Primary Contractor has flexibility in determining how to perform the Application Assister function. Care coordinators are not required to be Application Assisters; however, the Application Assister function is required to be performed by the Primary Contractor. The Primary Contractor may choose to use a Care Coordinator for this function, while others may choose to have other staff provide this function. Application Assister training is provided free of charge by the Alabama Medicaid Agency staff (Attachment Six). The Contractor shall have an individual (s) designated as a trainer for the Train-the-Trainer program. The designee must attend the Train-the-Trainer class and provide certification training to Application Assisters as deemed necessary in order to maintain compliance with certification and re-certification requirements. The certification period for Application Assisters and Train-the-Trainer designee is every two years.
5. Care Coordination is a professional skill and must be supported from within the Primary Contractor system. Skills and functions employed by the Care Coordinator include, but are not limited to:
 - a. Performing the initial encounter requirements, performing the psychosocial risk assessment, assessing the medical and social needs, developing service plans, providing information and education, making all appropriate referrals (including Plan First and CoIIN referrals), and tracking recipients throughout their pregnancy and postpartum period.
 - b. Community orientations, including the ability to locate, augment, and develop resources including information on services offered by other agencies.
 - c. The Primary Contractor must advise all subcontractors of Care Coordinators services and must require that the subcontractors refer all Medicaid recipients to enroll in the program with the Primary Contractor within ten days of the first visit.
 - d. The Care Coordinator shall provide the recipient with a business card that provides location and telephone number of the Care Coordinator should any questions arise.
 - e. Care Coordinators must be located in an area which provides adequate recipient access and maintains recipient confidentiality. Private offices are preferred.
 - f. Telephones must be available for use in recipient contacts.
 - g. Primary Contractor must have a training plan for initial and on-going care coordination. These plans must at a minimum support the requirements of this document and include training specific to the Maternity Care Program and/or related topics on an on-going basis. Educational materials must include obtaining TPL information, the importance of keeping appointments with both the Care Coordinator and the DHCP, exemption candidates, current proper sleeping positions for the infant, domestic abuse, breast feeding, smoking & alcohol or other substance cessation, nutrition, and bonding for mother and infant. The effectiveness of the training plans will be monitored per quality outcome measures.
 - h. Care Coordinators or other Primary Contractor staff will enroll the recipient in the Maternity Care Program and start the Medicaid application process.
 - i. Primary Contractor must have a system for verification of current license for each Care Coordinator. Verification of current licensure will be checked during the Administrative Audit.

C. Initial Encounter

Time frame: entry into care

- ✓ Enrolled 0-6 weeks gestation - this encounter should be no later than 21 days after enrollment date
- ✓ Enrolled 7-14 weeks gestation - this encounter should be no later than 14 days after enrollment date.
- ✓ Enrolled 15 weeks gestation or more - this encounter should be no later than 7 days after enrollment date.

1. Intake form- The Care Coordinator will prepare the intake form for enrollment into the Maternity Care Program. Minimum elements to be included on the intake form of your choice are: Recipient Name; Date of Birth; Address; County of Residence; Social Security Number; Medicaid Number if they have one; if the recipient has no Medicaid number make a note to assist with application as appropriate; Delivering Healthcare Professional choice; Date Delivering Healthcare Professional notified; and psychosocial risk status. A sample form is included as Attachment Twenty-six. This form will be faxed to the office of the Delivering Healthcare Professional of choice within five calendar days of the recipient's first Delivering Healthcare Professional's health visit. If the recipient does not have Medicaid financial eligibility, the Primary Contractor is responsible for immediately providing Application Assister services to aid the patient in completing the application process.
2. The following forms must be completed at the initial encounter:
 - a. Psychosocial/medical risk assessment
 - b. Agreement to Receive Care/Release of Information
 - c. Recipient Rights and Duties as described in Attachment Eight and required by 42 CFR 438.100
 - d. Maternity Care Program Fact Sheet
 - e. Maternity Care Program Smoking Cessation Form
3. Information about facility location, hours of operation, services available, etc. should be shared. Explain your role as Care Coordinator and how you will be assisting the recipient during her pregnancy and postpartum period. Encourage the recipient to contact you as needed for assistance.
4. Explain the benefits and services provided through the Maternity Care Program. Explain that all pregnancy related care including prenatal, delivery and postpartum is available through the Primary Contractor network. Stress the importance of pre-natal and postpartum visits. Stress that birth control is frequently arranged at the postpartum visit. Explain that Medicaid also offers assistance with transportation to medical appointments, emergency ambulance coverage, family planning and pediatric services.

5. Provide written and oral education about the grievance process and explain how it is designed for her. Ensure that the recipient understands the process and the procedures for filing a grievance, an appeal and/or fair hearing.
6. Explain the importance of early and continuous prenatal care. Help her understand that she can play a key role in shaping the birth outcome. Explain that if she encounters barriers such as transportation, medication, childcare, etc., she should contact the Care Coordinator for assistance.
7. Develop and document a service plan for coordinating total obstetrical care based on medical and psychosocial risk status that will best suit the needs of the recipient.
8. Screen the patient for partner abuse utilizing the Medicaid provided screening tool. Be cognizant of verbal and non-verbal clues when assessing the patient.
9. Encourage breast feeding. Explain the benefits such as better infant tolerance, better immunity from childhood viruses and illnesses. Explain that pumping can be done and the milk stored for times when the mother will be away, and that nursing the infant, avoiding any artificial nipples, will produce more mother's milk. The Care Coordinator should utilize the most effective teaching methods for increasing the rate of breast feeding.
10. Explain that the recipient may be receiving a home visit. Inform her of the positive aspects of the visit and what can be accomplished.
11. Ask if the recipient is a smoker. Encourage smoking cessation. Discuss the effects of smoking on the infant to include: increased risk of prematurity, low birth weight, infant mortality, and a sicker infant. Use the most effective evidence-based method suitable to your area to assist moms to stop smoking. Encourage the use of the Alabama Department of Public Health Quitline for counseling and assist with the referral process, educate the recipient of available face to face counseling sessions, and ask her to discuss with her doctor the possibility of obtaining a prescription to help her stop smoking.

D. Subsequent Encounters

Care Coordinators will be required to assess the recipient face to face at a minimum of two encounters. One of the required encounters is the Initial Encounter defined above. The other encounter must occur while the mother is still in the hospital after delivery. Other encounters will be at the discretion of the Care Coordinator based on the level of complexity of the recipient needs, either medical or psychosocial. The encounters should be scheduled in order to help obtain the best outcomes.

1. Update the psychosocial assessment and service plan based on client interview and any other available information.
2. Encourage continuous compliance with prenatal care, reviewing the recipient's medical high-risk factors and explaining the importance of continued prenatal care.
3. Assess for understanding of medical conditions as well as the plan for managing them as outlined by medical staff. Assist in arranging further counseling by medical staff as needed.

4. Provide the recipient with the information about the various family planning services available. Counsel on the effects of each method and assist the recipient with consent forms as appropriate.
5. Ask about status of Medicaid eligibility. Assist with resolving the delay of approval, if possible.
6. Screen the patient for partner abuse utilizing the screening tool in Attachment Nine. Be cognizant of verbal and non-verbal clues when assessing the patient.
7. Determine the need for any third party exemptions.
8. Ensure that the recipient knows which hospital will be used for delivery. If Medicaid coverage is established, complete hospital preadmission for the hospital of choice.
9. Discuss the labor and delivery process. Begin talking with the recipient about what to expect and what to do at the onset of labor, etc.
10. Re-emphasize and encourage breast feeding.
11. Explain that the patient may meet the criteria for a home visit. Re-emphasize the purpose and the positive aspects.
12. Review smoking cessation with women who smoke. Utilize the most appropriate evidence based methods. Encourage to cut down and quit. Explain harmful effects to the fetus. If she states that she has quit or cut down on the number of cigarettes that she smokes, praise her efforts. Reference the Definition Section for the meaning of “Smoker”.
13. Ask the recipient if she has considered who will provide pediatric care. If needed provide a list of Medicaid pediatric care providers. If she has not thought about a pediatric care provider, encourage her to do so. Provide information and services available for the newborn through the first year of life including Medicaid Patient 1st and EPSDT (Early Periodic Screening and Developmental Testing). Assist the patient in completing the Patient 1st Newborn Assignment Choice Form. A copy of the hospital information and the Medicaid Patient 1st Newborn Choice Form should be faxed to the selected health care professional at the time of the hospital visit.
14. Ensure that the patient is prepared for childbirth. If preadmission has not been completed, assist recipient in choosing hospital for delivery and completing preadmission. Assess transportation needs to the scheduled hospital.
15. Ensure home preparation, assistance with newborn and mother in immediate postpartum period, availability of an infant car seat, etc.
16. Verify that the recipient and father of the baby (if he is involved) have made preparations for the infant’s arrival and that they have a bed and a space designated for the new infant.
17. Educate the recipient regarding SIDS and current methods of placement of the infant for sleep.

18. Explain to the recipient the need to contact the eligibility outstation worker/DHR worker/Social Security worker with information about the baby's birth to ensure a Medicaid number for the baby.
19. Explain to the recipient that in cases of early hospital discharge where the Care Coordinator or designee does not get to visit with her in the hospital, a home visit will be made. Explain the need for the visit and what services will be offered. Encourage the recipient to use this time for education.
20. Emphasize the importance of keeping the post-partum Delivering Healthcare Professional check-up appointment. If it has not been scheduled then screen for any barriers, e.g. transportation, childcare, etc. Assist the recipient as necessary in scheduling the postpartum exam.
21. Explain to the recipient that you or someone from the Primary Contractor's staff will make a visit to the recipient during the hospitalization after delivery.
22. Re-emphasize the positive aspects of the home visit if it is determined by the Care Coordinator that a home visit is necessary. Obtain phone numbers where the recipient may be contacted. Ask where she will be staying when she takes the infant home from the hospital. Assure her that this visit is to help her in caring for herself and the infant.
23. Stress the importance of preventive dental care for the infant. Utilize Medicaid's Smile Alabama educational material available via Medicaid's website.
24. Review the importance of effective family planning methods and availability of family planning services. Verify that the recipient has chosen birth control pills or any other method (condoms, injection contraception, etc.) of family planning and explain that this must be discussed with the Delivering Healthcare Professional during the hospitalization. A prescription may be necessary in order to obtain the chosen method. Explain the option of having a Long Acting Reversible Contraceptive implanted in the hospital immediately after delivery or in an outpatient setting immediately after discharge from an inpatient setting.
25. Make referrals, including, but not limited to, Plan First and Patient 1st Programs, and CoIIN if applicable.
26. Emphasize that the recipient can become pregnant while breast feeding if she is not using any contraception.

E. Missed Encounters/Attempts

If the inpatient hospital encounter is missed, a home visit must be completed. At least two attempts must be made to complete the missed encounter. All home visits or attempts must be completed within 20 days of the delivery date. Missed attempts must be documented in the recipient's medical record.

F. Tracking of Care Coordinator Visits

In an effort to ensure standard tracking of Care Coordination services provided, the following codes have been established for use by the Contractor for internal tracking. These codes cannot be billed separately to Medicaid.

T1016 - U1	1 ST encounter
T1016 – U2	2 ND encounter
T1016 – U3	3 RD encounter
T1016 – U4	4 TH encounter
T1016 – U5	5 TH encounter

G. Oversight of Care Coordinator Activities

Contractor has the responsibility of maintaining oversight activities regarding the provision of Care Coordination services.

Appendix F: Program Glossary of Terms

Actuarially Sound Rates

CMS defines actuarially sound rates as rates that have been developed in accordance with generally accepted actuarial principles and practices appropriate for the populations to be covered and the services to be furnished under the contract and certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

Anesthesia

Any sensory and/or motor paralysis for the relief of pain including but not limited to epidural, saddle-block, pudendal block, inhalation central anesthesia, endotracheal anesthesia, or other, which is not medically contraindicated.

Antenatal Care

All usual prenatal services including, but not limited to, the initial visit at the time pregnancy is diagnosed, initial and subsequent histories, Care Coordination, risk assessments, physical exams, recordings of weight and blood pressure, fetal heart tones and rates, lab work appropriate to the level of care including hematocrit and chemical urinalysis, and any additional services required for high-risk women.

Application Assistors

Individuals trained by the Medicaid Agency to assist recipients in completing Medicaid applications.

Benchmark

A benchmark is a standard by which requirements can be measured or judged.

Recipients

Pregnant women who reside in Alabama, are certified for Medicaid and receive pregnancy related services under the Maternity Care Program.

Care Coordination

Management of obstetrical care including recruitment, outreach, psychosocial assessment, service planning, assisting the recipient in arranging for appropriate services including, but not limited to, applying for Medicaid resolving transportation issues, education, counseling, and follow-up and monitoring to ensure services are delivered and continuity of care is maintained.

Clean Claim

A clean claim is one that can be processed without Medicaid obtaining additional information from the provider of service or a third party insurance carrier.

CMS

Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

Continuity of Care

Uninterrupted continual care of the Medicaid recipient that is coordinated to address the health care needs among practitioners and across organizations and time.

Contract Services

See "covered services".

Convicted

A judgment of conviction that has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

Covered Services

Health care services, as designated in Section 5, to be delivered by a Primary Contractor or through subcontracts.

Days

Calendar days unless otherwise specified.

Debarment

Debarment is exclusion from participation as a Medicare/Medicaid provider.

Delivery

Delivery is the birth of an infant via vaginal birth canal (with or without episiotomy and with or without forceps), or cesarean section delivery.

Delivering Healthcare Professional (DHCP)

A licensed physician or nurse midwife who is qualified to perform deliveries, prenatal and postpartum care.

Disclosing Entity

The entity is a Medicaid provider or a fiscal agent.

Districts

Districts are geographic divisions of the State of Alabama as defined by the Alabama Medicaid Agency which comprise the entire state divided into fourteen districts.

Dropouts

A recipient who begins care in the district of her residence but does not deliver her infant within that district's network is considered a dropout. An example of dropout may include someone who moves to another district prior to delivery or one who miscarries prior to 21 weeks.

Eligible

A person certified as eligible to receive Medicaid benefits and who has been issued a Medicaid identification number.

Eligibility

A process of determination of eligibility for medical assistance performed by Medicaid.

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, 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 (with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy or serious impairment of bodily functions; or serious dysfunction of any bodily organ or part.

Enrollee

An enrollee is a Medicaid recipient who is currently enrolled in the Maternity Care Program via her district of residence.

Encounter Data

Encounter data are the records of services delivered to Medicaid beneficiaries enrolled in Maternity Care Program for which a capitated payment is made. These records allow the Medicaid agency to track the services received by Maternity recipients enrolled in Maternity Program and set capitation rates. Encounter data typically comes from billed claims that Primary Contractors and providers submit to the Alabama Medicaid Agency for their services.

Fee for Service

A method of Medicaid reimbursement based upon payment to providers for services rendered to Medicaid recipients subsequent to, and specifically for, the rendering of those services. Those services that are payable outside the global fees.

Fiscal Agent

The company designated by Medicaid, through contract, to maintain the Medicaid claims processing system.

Fiscal Year

Defined as October 1 through September 30.

Global Fee

The reimbursement fee paid following delivery to the Primary Contractor for recipients who meet the requirements of the Medicaid Maternity Care Program. This fee is a global amount (based on actuarial soundness) paid to the Primary Contractor who, in turn, pays subcontractors who provided services to enrolled recipients. The amount paid to each subcontractor is a negotiated amount between the Primary Contractor and the subcontractor, with Medicaid minimums established for Delivering Healthcare Professionals.

Grievance

A grievance is a written expression of dissatisfaction about any matter.

Indicator

An indicator is a measurable dimension of care (e.g., a medical event, diagnosis, or outcome) to reflect aspects of care, the importance of which is gauged by frequency, severity, or cost.

Material Omission

A fact, data or other information excluded from a report, contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.

Maternity Care Primary Contractor

A person or organization agreeing through a direct contract with the Alabama Medicaid Agency to provide those goods and services specified by contract in conformance with the requirements of the bid and state and federal laws and regulations.

Medicaid

A Federal/State program authorized by Title XIX of the Social Security Act, as amended, which provides Federal matching funds for a medical assistance program for recipients of federally aided public assistance and SSI benefits and other specified groups. Certain minimal populations and services shall be included.

Medically Necessary

Appropriate and necessary services as determined by health care practitioners according to national or community standards.

Medical Record

The document that records all of the medical treatment and services provided to the Medicaid recipient.

Modified Adjusted Gross Income (MAGI)

A Federal mandate, effective January 1, 2014, authorizing States with eligibility coverage groups such as Pregnant Women, Children under age 19, Family Planning, Parents and Other Caretaker Relatives (POCR), and Former Foster Care Children who were affected by the Affordable Care Act of 2010 (aka Patient Protection and Affordable Care Act of 2010) to use Modified Adjusted Gross Income (MAGI) methodology for eligibility determinations for specific groups of Medicaid applicants and beneficiaries such as pregnant women, children under age 19, family planning, and parents and other caretaker relatives.

Party of Interest

A person or organization with an ownership interest with the Primary Contractor of five percent or more or in which the Primary Contractor has ownership interest of five percent or more.

Performance Measure

A consistent measurement of service, practice, and governance of a health care organization. Measurements shall produce solid, statistically-based measurement of critical processes that, in turn, shall permit the organization to make solid decisions about improvements.

Postpartum Care

Postpartum care includes inpatient hospital visits, office 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 60-day postpartum period (e.g. whether the 60th day is on September 2nd or September 16th, the eligibility continues through the end of the month.)

Potential Enrollee

A Medicaid recipient who is subject to mandatory or voluntary enrollment, but is not yet enrolled.

Pregnant Women

Pregnant Women is an eligibility category for pregnant women within the Medicaid system. Pregnant Women is further defined as maternity services for a woman who is eligible for pregnancy only related care, postpartum and family planning services. These women are maternity eligible until the end of the month in which the 60th postpartum day falls. After Pregnant Women eligibility ends the women are covered by family planning services. These women are also identified as poverty level women.

Pre-Term Delivery

Deliveries occurring prior to 37 weeks gestation.

Program Exemption

A recipient who has an exemption is not required to receive care from the Primary Contractor's network. This is generally as a result of travel hardship or for individuals enrolled in a private Health Maintenance Organization (HMO). The claims for exempted recipients are paid fee for service if provided by an authorized Alabama Medicaid provider.

Quality Assurance

An objective and systematic process that evaluates the quality and appropriateness of services provided.

Remittance Advice

An explanation of Alabama Medicaid Agency's check writes payment. It lists the paid, denied, adjusted and recouped claims. Remittance Advice was previously called the Explanation of Payment.

Risk Assessment

Medical and psycho-social assessment performed to determine the perinatal risk status of pregnant women. The purpose of the assessment is to determine the presence of any medical and/or social risk factors.

RMEDE

Realtime Medical Electronic Data Exchange, or RMEDE, is the service database for the collection of recipient data so that an accurate reflection of program impact can be obtained.

RMEDE Exemption

A recipient who has an exemption is not required to be entered into the Service database by the Primary Contractor's network. This is generally as a result of deliveries at or less than 21 weeks gestation or other reasons as approved by the Alabama Medicaid Agency.

Risk contract

A contract under which the contractor assumes risk for the cost of the services covered under the contract; and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Smoker

A person who is actively smoking or using any form of tobacco or who has ceased the use of tobacco products within the last 3 months prior to enrollment in the Maternity Care Program.

Subcontract

A subcontract is any written agreement between the Primary Contractor and another party for any services necessary to fulfill the requirements of the Medicaid Maternity Care Program contract

Third Party Liability (TPL)

Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for covered services furnished to enrollees. The recipient is still restricted to receiving care through the Primary Contractor unless the TPL is a HMO/Managed Care Plan with a restricted provider network, and then a program exemption shall be requested. Primary Contractor is responsible for collecting all third party payments prior to submitting a claim to Medicaid for payment.

The “Act”

Affordable Care Act (ACA)

Utilization Review

Prospective, concurrent and retrospective review and analysis of data related to utilization of health care resources in terms of cost effectiveness, efficiency, control, quality, and medical necessity.

Attachment G: Managed Care Rule Glossary of Terms

Abuse:

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. [42 CFR 438.2; 42 CFR 455.2]

Access:

As used in part 438 subpart E and pertaining to external quality review, the timely use of services to achieve optimal outcomes, as evidenced by MCPs successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR §438.68 (Network adequacy standards) and §438.206 (Availability of services). [42 CFR 438.320]

Actuary:

An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In Part 438, Actuary refers to an individual who is acting on behalf of the state when used in reference to the development and certification of capitation rates. [42 CFR 438.2]

Adverse benefit determination:

In the case of an MCO, PIHP, or PAHP, any of the following:

- (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- (2) The reduction, suspension, or termination of a previously authorized service.
- (3) The denial, in whole or in part, of payment for a service.
- (4) The failure to provide services in a timely manner, as defined by the state.
- (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.
- (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities. [42 CFR 438.400(b)]

Aggregate lifetime dollar limit:

A dollar limitation on the total amount of specified benefits that may be paid under a MCO, PIHP, or PAHP. [42 CFR 438.900]

Annual dollar limit:

A dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a MCO, PIHP, or PAHP. [42 CFR 438.900]

Appeal:

A review by an MCO, PIHP, or PAHP of an adverse benefit determination. [42 CFR

438.400(b)]

Capitation payment:

A payment the state makes periodically to a contractor on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the state plan. The state makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment. [42 CFR 438.2]

Choice counseling:

The provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among MCPs and PCPs. Choice counseling does not include making recommendations for or against enrollment into a specific MCO, PIHP, or PAHP. [42 CFR 438.2]

Cold-call marketing:

Any unsolicited personal contact by the MCO, PIHP, PAHP, PCCM or PCCM entity with a potential enrollee for the purpose of marketing. [42 CFR 438.104(a)]

Comprehensive risk contract:

A risk contract between the state and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

- (1) Outpatient hospital services
- (2) RHC services
- (3) FQHC services
- (4) Other laboratory and X-ray services
- (5) Nursing facility (NF) services
- (6) EPSDT services
- (7) Family planning services
- (8) Physician services
- (9) Home health services. [42 CFR 438.2]

Credibility adjustment:

An adjustment to the MLR for a partially credible MCO, PIHP, or PAHP to account for a difference between the actual and target MLRs that may be due to random statistical variation. [42 CFR 438.8(b)]

Cumulative financial requirements:

Financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.) [42 CFR 438.900]

Default enrollment:

In its discussion of the final Medicaid managed care rule at 81 FR 27614, CMS described default enrollment (also commonly known as auto-assignment) as a process used by states with mandatory managed care programs to assign beneficiaries into plans when they do not actively select a managed care plan in the timeframe permitted by the state. [81 FR 27614]

Disability status:

For the purposes of the managed care state quality strategy element, whether the individual qualified for Medicaid on the basis of a disability. [42 CFR 438.340(b)(6)]

Discrimination:

Termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates a probably need for substantial future medical services. [42 CFR 438.700(b)(3)]

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits:

Benefits defined in section 1905(r) of the Act including: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan. [Section 1905(r) of the Act]

Emergency medical condition:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:

- (1) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- (2) Serious impairment to bodily functions.
- (3) Serious dysfunction of any bodily organ or part. [42 CFR 438.114(a)]

Emergency services:

Covered inpatient and outpatient services that are as follows:

- (1) Furnished by a provider that is qualified to furnish these services under this Title.
- (2) Needed to evaluate or stabilize an emergency medical condition. [42 CFR 438.114(a)]

Enrollee:

A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program. [42 CFR 438.2]

Enrollee encounter data:

The information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a state and a MCO, PIHP, or PAHP that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818. [42 CFR 438.2]

Enrollment activities:

Activities such as distributing, collecting, and processing enrollment materials and taking enrollments by phone, in person, or through electronic methods of communication. [42 CFR 438.810(a)]

External quality review:

As used in part 438 subpart E, the analysis and evaluation by an external quality review organization (EQRO), of aggregated information on quality, timeliness, and access to the health care services that an MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2)), or their contractors furnish to Medicaid beneficiaries. [42 CFR 438.320]

External quality review organization (EQRO):

As used in part 438 subpart E, an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other external quality review-related activities as set forth in 42 CFR 438.358, or both. [42 CFR 438.320]

Financial relationship:

As used in part 438 subpart E:

- A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or
- A compensation arrangement with an entity. [42 CFR 438.320]

Financial requirements:

Deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits. [42 CFR 438.900]

Fraud:

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or state law. [42 CFR 438.2; 42 CFR 455.2]

Full credibility:

A standard for which the experience of an MCO, PIHP, or PAHP is determined to be sufficient for the calculation of a MLR with a minimal chance that the difference between the actual and target MLR is not statistically significant. An MCO, PIHP, or PAHP that is assigned full credibility (or is fully credible) will not receive a credibility adjustment to its MLR. [42 CFR 438.8(b)]

Grievance:

An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision. [42 CFR 438.400(b)]

Grievance and appeal system:

The processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them. [42 CFR 438.400(b)]

Health care services:

As used in part 438 subpart E, all Medicaid services provided by an MCO, PIHP, or PAHP under contract with the state Medicaid agency in any setting, including but not limited to medical care, behavioral health care, and LTSS. [42 CFR 438.320]

Health insuring

A county operated entity, that in exchange for capitation payments, covers services for beneficiaries

organization (HIO):

- (1) Through payments to, or arrangements with, providers;
- (2) Under a comprehensive risk contract with the state; and
- (3) Meets the following criteria—
 - i. First became operational prior to January 1, 1986; or
 - ii. Is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act (OBRA) of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990 and section 205 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008). [42 CFR 438.2]

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 CFR 136.12. This means the individual:

- (1) Is a member of a Federally recognized Indian tribe;
- (2) Resides in an urban center and meets one or more of the four criteria:
 - i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;
 - ii. Is an Eskimo or Aleut or other Alaska Native;
 - iii. Is considered by the Secretary of the Interior to be an Indian for any purpose; or
 - iv. Is determined to be an Indian under regulations issued by the Secretary;
- (3) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- (4) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native. [42 CFR 438.14(a)]

Incentive arrangement:

Any payment mechanism under which a MCO, PIHP, or PAHP may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract. [42 CFR 438.6]

Indian health care provider (IHCP):

A health care program operated by the IHS or by an I/T/U as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). [42 CFR 438.14(a)]

Indian managed care entity (IMCE):

A MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the IHS, an I/T/U, or a consortium, which may be composed of one or more I/T/Us, and which also may include the Service. [42 CFR 438.14(a)]

Large print:

Printed in a font size no smaller than 18 point. [42 CFR 438.10(d)(2)]

Limited English proficient (LEP):

Potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be Limited English Proficient (LEP)

and may be eligible to receive language assistance for a particular type of service, benefit, or encounter. [42 CFR 438.10(a)]

Long-term services and supports (LTSS):

Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting. [42 CFR 438.2]

Managed care organization (MCO):

An entity that has, or is seeking to qualify for, a comprehensive risk contract under Part 438, and that is— (1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or (2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions: (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; (ii) Meets the solvency standards of 42 CFR 438.116. [42 CFR 438.2]

Managed care program (MCP):

A managed care delivery system operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act. [42 CFR 438.2]

Mandatory enrollment:

Enrollment where one or more groups of beneficiaries as enumerated in section 1905(a) of the Act must enroll in an MCO, PIHP, PAHP, PCCM or PCCM entity to receive covered Medicaid benefits. [42 CFR 438.54(b)(2)]

Marketing:

Any communication, from an MCO, PIHP, PAHP, PCCM or PCCM entity to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product, or either to not enroll in or to disenroll from another MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan. [42 CFR 438.104(a)]

Marketing materials:

Materials that—

- (1) Are produced in any medium, by or on behalf of an MCO, PIHP, PAHP, PCCM, or PCCM entity; and
- (2) Can reasonably be interpreted as intended to market the MCO, PIHP, PAHP, PCCM, or PCCM entity to potential enrollees. [42 CFR 438.104(a)]

MCO, PIHP, PAHP, PCCM, or PCCM entity:

Any of the entity's employees, network providers, agents, or contractors. [42 CFR 438.104(a)]

Medical/surgical benefits:

Benefits for items or services for medical conditions or surgical procedures, as defined by the state and in accordance with applicable Federal and state law, but do not include mental health or substance use disorder benefits. Any condition defined by the state as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or state guidelines). Medical/surgical benefits include long term care services. [42 CFR 438.900]

Member months:

The number of months an enrollee or a group of enrollees is covered by an MCO, PIHP, or PAHP over a specified time period, such as a year. [42 CFR 438.8(b)]

Mental health benefits:

Benefits for items or services for mental health conditions, as defined by the state and in accordance with applicable Federal and state law. Any condition defined by the state as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or state guidelines). Mental health benefits include long term care services. [42 CFR 438.900]

Medical Loss Ratio (MLR) reporting year:

A period of 12 months consistent with the rating period selected by the state. [42 CFR 438.8(b)]

Network provider:

Any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, or PAHP, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement. [42 CFR 438.2]

No credibility:

A standard for which the experience of an MCO, PIHP, or PAHP is determined to be insufficient for the calculation of a MLR. An MCO, PIHP, or PAHP that is assigned no credibility (or is non-credible) will not be measured against any MLR requirements. [42 CFR 438.8(b)]

Non-claims costs:

Those expenses for administrative services that are not:

- (1) Incurred claims;
- (2) Expenditures on activities that improve health care quality; or
- (3) Licensing and regulatory fees, or
- (4) Federal and state taxes. [42 CFR 438.8(b)]

Non-Emergency Medical Transportation PAHP (NEMT PAHP):

An entity that provides only NEMT services to enrollees under contract with the state, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates. [42 CFR 438.9(a)]

Nonrisk contract:

A contract between the state and a PIHP or PAHP under which the contractor—

- (1) Is not at financial risk for changes in utilization or for costs incurred under the

Section IV: Glossary of Terms 133

contract that do not exceed the upper payment limits specified in 42 CFR 447.362; and
(2) May be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. [42 CFR 438.2]

Outcomes:

As used in part 438 subpart E, changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services. [42 CFR 438.320]

Overpayment:

Any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a state to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act. [42 CFR 438.2]

Partial credibility:

A standard for which the experience of an MCO, PIHP, or PAHP is determined to be sufficient for the calculation of a MLR but with a non-negligible chance that the difference between the actual and target MLRs is statistically significant. An MCO, PIHP, or PAHP that is assigned partial credibility (or is partially credible) will receive a credibility adjustment to its MLR. [42 CFR 438.8(b)]

Person-centered planning process:

A process led by the individual, where possible, and includes the individual's representative in a participatory role, as needed and as defined by the individual, unless state law confers decision-making authority to the legal representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:

- (1) Includes people chosen by the individual;
- (2) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- (3) Is timely and occurs at times and locations of convenience to the individual;
- (4) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- (5) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- (6) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the state demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the state must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process;
- (7) Offers informed choices to the individual regarding the services and supports they receive and from whom;
- (8) Includes a method for the individual to request updates to the plan as needed;

- (9) Records the alternative home and community-based settings that were considered by the individual. [42 CFR 441.301(c)(1)]

Person-centered service plan:

A person-centered plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the state's 1915(c) HCBS waiver, the written plan must:

- (1) Reflect that the setting in which the individual resides is chosen by the individual. The state must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;
- (2) Reflect the individual's strengths and preferences;
- (3) Reflect clinical and support needs as identified through an assessment of functional need;
- (4) Include individually identified goals and desired outcomes;
- (5) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports;

Section IV: Glossary of Terms 135

- (6) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- (7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b) of this chapter;
- (8) Identify the individual and/or entity responsible for monitoring the plan;
- (9) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation;
- (10) Be distributed to the individual and other people involved in the plan;
- (11) Include those services, the purpose or control of which the individual elects to self-direct;
- (12) Prevent the provision of unnecessary or inappropriate services and supports;
- (13) Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of 42 CFR 431.301, must be supported by a specific assessed need and justified in the person-centered service plan. [42 CFR 431.301(c)(2)]

Prepaid ambulatory health plan (PAHP):

An entity that—

- (1) Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates.
- (2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
- (3) Does not have a comprehensive risk contract. [42 CFR 438.2]

Prevalent:

A non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient. [42 CFR 438.10(a)]

Primary care:

All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, OB/GYN, pediatrician, or other licensed practitioner as authorized by the state Medicaid program, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them. [42 CFR 438.2]

Private insurance:

Does not include a qualified health plan, as defined in 45 CFR 155.20. [42 CFR 438.104(a)]

Provider:

Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services. [42 CFR 438.2]

Other disclosing entity:

Any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

- (1) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, RHC, or HMO that participates in Medicare (title XVIII);
- (2) Any Medicare intermediary or carrier; and
- (3) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act. [42 CFR 455.101]

Quality:

As used in part 438 subpart E and pertaining to external quality review, the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2)) increases the likelihood of desired outcomes of its enrollees through:

- (1) Its structural and operational characteristics.
- (2) The provision of services that are consistent with current professional, evidenced-based-knowledge.
- (3) Interventions for performance improvement. [42 CFR 438.320]

Rating period:

A period of 12 months selected by the state for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR 438.7(a). [42 CFR 438.2]

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. [42 CFR 438.10(a)]

Risk contract:

A contract between the state an MCO, PIHP or PAHP under which the contractor—

- (1) Assumes risk for the cost of the services covered under the contract; and
 - (2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.
- [42 CFR 438.2]

Risk corridor:

A risk sharing mechanism in which states and MCOs, PIHPs, or PAHPs may share in profits and losses under the contract outside of a predetermined threshold amount. [42 CFR 438.6]

Rural Area:

Any county designated as “micro,” “rural,” or “County with Extreme Access Considerations (CEAC)” in the Medicare Advantage Health Services Delivery (HSD) Reference file for the applicable calendar year. [42 CFR 438.52(b)(3)]

Sanctioned individual:

In accordance with section 1128(b)(8) of the Act, a sanctioned individual is a person who:

5. Has a direct or indirect ownership or control interest of 5 percent or more in the entity, and:
 - a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or
 - b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or
 - c. Has been excluded from participation under a program under title XVIII or under a state health care program
6. Has an ownership or control interest (as defined in section 1124(a)(3) of the Act) in the entity, and:
 - a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or
 - b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or
 - c. Has been excluded from participation under a program under title XVIII or under a state health care program
7. Is an officer, director, agent, or managing employee of the MCP, and:
 - a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or
 - b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or

- c. Has been excluded from participation under a program under title XVIII or under a state health care program
- 8. No longer has direct or indirect ownership or control interest of 5 percent or more in the MCP or no longer has an ownership or control interest defined under section 1124(a)(3) of the Act, because of a transfer of ownership or control interest, in anticipation of or following a conviction, assessment, or exclusion against the person, to an immediate family member or a member of the household of the person who continues to maintain an ownership or control interest who:
 - a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or
 - b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or
 - c. Has been excluded from participation under a program under title XVIII or under a state health care program. [Section 1128(b)(8) of the Act]

Service Authorization:

A managed care enrollee's request for the provision of a service. [42 CFR 431.201]

State:

A Medicaid agency is the Single state agency as specified in §431.10 of this chapter. [42 CFR 438.2; 42 CFR 431.10]

State fair hearing:

The process set forth in subpart E of part 431 chapter IV, title 42. [42 CFR 438.400(b)]

Subcontractor:

An individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the state. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP. [42 CFR 438.2]

Substance use disorder benefits:

Benefits for items or services for substance use disorders, as defined by the state and in accordance with applicable Federal and state law. Any disorder defined by the state as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines). Substance use disorder benefits include long term care services. [42 CFR 438.900]

Timely files:

Files for continuation of benefits on or before the later of the following: (i) Within 10 calendar days of the MCO, PIHP, or PAHP sending the notice of adverse benefit determination. (ii) The intended effective date of the MCO's, PIHP's, or PAHP's proposed adverse benefit determination. [42 CFR 438.420(a)]

Validation:

As used in part 438 subpart E, the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis. [42 CFR 438.320]

Withhold arrangement:

Any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement. [42 CFR 438.6]

Voluntary enrollment:

Enrollment where one or more groups of beneficiaries as enumerated in section of section 1905(a) of the Act have the option to either enroll in a MCO, PIHP, PAHP, PCCM or PCCM entity, or remain enrolled in FFS to receive Medicaid covered benefits. [42 CFR 438.54(b)(1)]



State of Alabama Solicitation

Solicitation RFP 062 17000000192	Document Phase Final	Document Description Maternity Care Program
Procurement Folder 433302	Creation Date 09/25/17	Print Date 09/25/17

Request for Proposals

CONTACTS

Contact	Name	E-mail	Phone
Requestor:	Info RFP	RFP@medicaid.alabama.gov	334-353-3785
Issuer:	Info RFP	RFP@medicaid.alabama.gov	334-353-3785
Buyer:	Info RFP	RFP@medicaid.alabama.gov	334-353-3785

Bids will be accepted from: 09/27/17
to: 10/27/17

All Inquiries for Information Regarding Bid Submission Requirements or Procurement Procedures
Should be Directed To The Buyer Contact Listed Above.

COMMODITY INFORMATION

Group: 1 Line: 1 Line Type: Service
Commodity Code: PRF08000035 Quantity:
Commodity Description: CONSULTING SERVICES, MEDICAL Unit:
Extended Description:
CONSULTING SERVICES, MEDICAL

SHIPPING AND BILLING

Shipping Medicaid Headquarters Shipping 501 Dexter Avenue Montgomery, AL 36104 Delivery Date:	Billing , Delivery Type:
---	--

COMMODITY INFORMATION

Group: 1 Line: 2 Line Type: Service
Commodity Code: PRF08000036 Quantity:
Commodity Description: CONSULTING SERVICES, MEDICAL Unit:
Extended Description:

Group: 1

Line: 5

Line Type: Service

Commodity Code: PRF34

Quantity:

Commodity Description: OTHER

Unit:

Extended Description:

OTHER

SHIPPING AND BILLING

Shipping

Medicaid Headquarters Shipping
501 Dexter Avenue
Montgomery, AL 36104

Delivery Date:

Billing

,

Delivery Type:

1700000192	Document Phase Final	Document Description Maternity Care Program	Page 4 of 6
------------	-------------------------	--	----------------

GENERAL TERMS AND CONDITIONS FOR RFP FOR SERVICES v 7-9-15 rhc edit 7-28-15

GENERAL TERMS AND CONDITIONS FOR THIS REQUEST FOR PROPOSALS - All proposals are subject to these Terms and Conditions.

1. PROHIBITED CONTACTS; INQUIRIES REGARDING THIS RFP – *From the Release Date of this RFP until a contract is awarded, parties that intend to submit, or have submitted, a Proposal are prohibited from communicating with any members of the Soliciting Party’s Team for this transaction who may be identified herein or subsequent to the Release Date, or other employees or representatives of the Soliciting Party regarding this RFP or the underlying transaction except the designated contact(s) identified in {insert location in RFP where contacts are identified, such as Section S or Item 2.}*

Questions relating only to the RFP process may be submitted by telephone or by mail or hand delivery to: the designated contact. Questions on other subjects, seeking additional information and clarification, must be made in writing and submitted via email to the designated contact, sufficiently in advance of the deadline for delivery of Proposals to provide time to develop and publish an answer. A question received less than two full business days prior to the deadline may not be acknowledged. Questions and answers will be published to those parties submitting responsive proposals.

2. NONRESPONSIVE PROPOSALS - Any Proposal that does not satisfy requirements of the RFP may be deemed non-responsive and may be disregarded without evaluation. Clarification or supplemental information may be required from any Proposer.

3. CHANGES TO THE RFP; CHANGES TO THE SCHEDULE - The Soliciting Party reserves the right to change or interpret the RFP prior to the Proposal Due Date. Changes will be communicated to those parties receiving the RFP who have not informed the Soliciting Party’s designated contact that a Proposal will not be submitted. Changes to the deadline or other scheduled events may be made by the Soliciting Party as it deems to be in its best interest.

4. EXPENSES - Unless otherwise specified, the reimbursable expenses incurred by the service provider in the providing the solicited services, shall be charged at actual cost without mark-up, profit or administrative fee or charge. Only customary, necessary expenses in reasonable amounts will be reimbursable, to include copying (not to exceed 15 cents per page), printing, postage in excess of first class for the first one and one-half ounces, travel and preapproved consulting services. Cost of electronic legal research, cellular phone service, fax machines, long-distance telephone tolls, courier, food or beverages are not reimbursable expenses without prior authorization, which will not be granted in the absence of compelling facts that demonstrate a negative effect on the issuance of the bonds, if not authorized.

If pre-approved, in-state travel shall be reimbursed at the rate being paid to state employees on the date incurred. Necessary lodging expenses will be paid on the same per-diem basis as state employees are paid. Any other pre-approved travel expenses will be reimbursed on conditions and in amounts that will be declared by the Issuer when granting approval to travel. Issuer may require such documentation of expenses as it deems necessary.

5. REJECTION OF PROPOSALS - The Soliciting Party reserves the right to reject any and all proposals and cancel this Request if, in the exercise its sole discretion, it deems such action to be in its best interest.

6. EXPENSES OF PROPOSAL – The Soliciting Party will not compensate a Proposer for any expenses incurred in the preparation of a Proposal.

7. DISCLOSURE STATEMENT - A Proposal must include one original Disclosure Statement as required by Code Section 41-16-82, et seq., Code of Alabama 1975. Copies of

1700000192	Document Phase Final	Document Description Maternity Care Program	Page 5 of 6
------------	-------------------------	--	----------------

the Disclosure Statement, and information, may be downloaded from the State of Alabama Attorney General's web site at <http://ago.alabama.gov/Page-Vendor-Disclosure-Statement-Information-and-Instructions>.

8. LEGISLATIVE CONTRACT REVIEW - Personal and professional services contracts with the State may be subject to review by the Contract Review Permanent Legislative Oversight Committee in accordance with Section 29-2-40, et seq., *Code of Alabama 1975*. The vendor is required to be knowledgeable of the provisions of that statute and the rules of the committee. These rules can be found at <http://www.legislature.state.al.us/aliswww/AlaLegJointIntCommContracReview.aspx>. If a

contract resulting from this RFP is to be submitted for review the service provider must provide the forms and documentation required for that process.

9. THE FINAL TERMS OF THE ENGAGEMENT - Issuance of this Request For Proposals in no way constitutes a commitment by the Soliciting Party to award a contract. The final terms of engagement for the service provider will be set out in a contract which will be effective upon its acceptance by the Soliciting Party as evidenced by the signature thereon of its authorized representative. Provisions of this Request For Proposals and the accepted Proposal may be incorporated into the terms of the engagement should the Issuer so dictate. Notice is hereby given that there are certain terms standard to commercial contracts in private sector use which the State is prevented by law or policy from accepting, including indemnification and holding harmless a party to a contract or third parties, consent to choice of law and venue other than the State of Alabama, methods of dispute resolution other than negotiation and mediation, waivers of subrogation and other rights against third parties, agreement to pay attorney's fees and expenses of litigation, and some provisions limiting damages payable by a vendor, including those limiting damages to the cost of goods or services.

10. BEASON-HAMMON ACT COMPLIANCE. A contract resulting from this RFP will include provisions for compliance with certain requirements of the *Beason-Hammon Alabama taxpayer and Citizen Protection Act* (Act 2011-535, as amended by Act 2012-491 and codified as Sections 31-13-1 through 35, Code of Alabama, 1975, as amended), as follows:

E- VERIFY ENROLLMENT DOCUMENTATION AND PARTICIPATION. As required by Section 31-13-9(b), Code of Alabama, 1975, as amended, Contractor that is a "business entity" or "employer" as defined in Code Section 31-13-3, will enroll in the E-Verify Program administered by the United States Department of Homeland Security, will provide a copy of its Memorandum of Agreement with the United States Department of Homeland Security that program and will use that program for the duration of this contract.

CONTRACT PROVISION MANDATED BY SECTION 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.

17000000192	Document Phase Final	Document Description Maternity Care Program	Page 6 of 6
-------------	--------------------------------	---	-----------------------

ATTENTION: Alabama Medicaid intends to post the Alabama Medicaid Agency Maternity Care Program RFP specifications document by the close of business on 09/27/2017, to the Alabama Medicaid website at:

http://www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.4_Procurement.aspx.

All questions concerning this RFP must be directed to:

MCPRFP@medicaid.alabama.gov