

Announcement of Selected Vendor
Electronic Visit Verification and Monitoring System
Request for Proposal (RFP) Number 2015-EVVM-01
Alabama Medicaid Agency

On July 7, 2016, the Alabama Medicaid Agency issued an Intent to Award Notice to First Data Government Solutions, LP. RFP Number 2015-EVVM-01.

The final award of this contract is subject to review by Centers for Medicare and Medicaid Services, the Alabama Legislative Oversight Committee and signature by Governor Robert Bentley.



ALABAMA MEDICAID AGENCY REQUEST FOR PROPOSALS

RFP Number: 2015-EVVM-01	RFP Title: Alabama Medicaid Agency Electronic Visit Verification and Monitoring System	
RFP Due Date and Time: April 6, 2016 by 5pm Central Time		Number of Pages: 44
PROCUREMENT INFORMATION		
Project Director: LaQuita Robinson		Issue Date: February 19, 2016
E-mail Address: evvmrfp@medicaid.alabama.gov Website: http://www.medicaid.alabama.gov		Issuing Division: Long Term Care
INSTRUCTIONS TO VENDORS		
Return Proposal to: LaQuita Robinson Alabama Medicaid Agency Lurleen B. Wallace Building 501 Dexter Avenue PO Box 5624 Montgomery, AL 36103-5624		Mark Face of Envelope/Package: RFP Number: 2015-EVVM-01 RFP Due Date: April 6, 2016 by 5pm CT Total Evaluated Price:
VENDOR INFORMATION <i>(Vendor must complete the following and return with RFP response)</i>		
Vendor Name/Address:	Authorized Vendor Signatory: (Please print name and sign in ink)	
Vendor Phone Number:	Vendor FAX Number:	
Vendor Federal I.D. Number:	Vendor E-mail Address:	

Section A. RFP Checklist

1. ____ **Read the *entire* document.** Note critical items such as: mandatory requirements; supplies/services required; submittal dates; number of copies required for submittal; licensing requirements; contract requirements (i.e., contract performance security, insurance requirements, performance and/or reporting requirements, etc.).
2. ____ **Note the project director’s name, address, phone numbers and e-mail address.** This is the only person you are allowed to communicate with regarding the RFP and is an excellent source of information for any questions you may have.
3. ____ **Take advantage of the “question and answer” period.** Submit your questions to the project director by the due date(s) listed in the Schedule of Events and view the answers as posted on the WEB. All addenda issued for an RFP are posted on the Alabam Medicaid Agency’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 Alabama Medicaid Agency’s website for RFP addenda.** It is the Vendor’s responsibility to check the Agency’s website at www.medicaid.alabama.gov for any addenda issued for this RFP, no further notification will be provided. Vendors must submit a signed cover sheet for each addendum issued along with your RFP response.
6. ____ **Review and read the RFP document again** to make sure that you have addressed all requirements. Your original response and the requested copies must be identical and be complete. The copies are provided to the evaluation committee members and will be used to score your response.
7. ____ **Submit your response on time.** Note all the dates and times listed in the Schedule of Events and within the document, and be sure to submit all required items on time. Late proposal responses are *never* accepted.
8. ____ **Prepare to sign and return the Contract, Contract Review Report, Business Associate Agreement and other documents** to expedite the contract approval process. The selected vendor’s contract will have to be reviewed by Medicaid’s Contract Review Committee which has strict deadlines for document submission. Failure to submit the signed contract can delay the project start date but will not affect the deliverable date.

This checklist is provided for assistance only and should not be submitted with Vendor’s Response.

Section B. Schedule of Events

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

Task	Date
Issuance of RFP (PDF) via RFP Website	02/19/2016
Deadline for First Round of Questions Submission	02/26/2016
Post First Round Question Responses to Website	03/14/2016
Deadline for Second Round of Questions Submission	03/16/2016
Post Second Round Question Responses to Website	03/30/2016
Proposals Submitted	04/06/2016
Evaluation Period	04/07/2016 – 04/29/2016
Vendor Selection Announcement	05/17/2016
**Contract Review Committee	09/01/2016
Official Contract Award/Begin Work	10/01/2016

* *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 “Vendor 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.

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I. Background

The Alabama Medicaid Agency, hereinafter called Medicaid, an Agency of the State of Alabama, hereby solicits proposals for the procurement of an Electronic Visit Verification and Monitoring (EVVM) system. The purpose is to secure error rate reductions in billings, safeguard against fraud, and improve program oversight. This involves State operated home care services for more than 14,500 individuals with disabilities and the elderly, who would otherwise require care in institutions utilizing more than 175 individual personal assistant/homemaker agency service providers. These programs are governed by both State and Federal Medicaid regulations. Services required are outlined through this RFP. The Vendor to whom the RFP is awarded shall be responsible for the performance of all duties contained within this RFP for the firm and fixed price quoted in Vendor's proposal on the pricing form found in Attachment E to this RFP. All proposals must state a firm and fixed price for the services described. **The total firm and fixed price from Attachment E must be entered on the RFP Coversheet.**

II. Scope of Work

The Alabama Medicaid Agency is seeking a vendor solution which must provide for the following:

- Tracking, verifying, recording, and reconciling the real time, electronic entry of start and end times of Personal Assistant and Homemaker Providers,
- Timesheet creation and entry with start and end time,
- Verifying the presence of the Provider at the client's location providing service as noted in the service plan,
- Preventing Providers from electronically starting a work shift if:
 - the Provider is not an approved vendor;
 - there are no hours left in the monthly service plan
 - the Provider is not approved for that client; or
 - the Provider is not physically present at the client location,
- Storage, manipulation, and reporting of data collected with access to data by defined security roles in:
 - The Alabama Medicaid Agency and other Administering State Agencies of Home and Community Based Waiver Services
 - The Provider Agencies, and
 - All case managers/care coordinators,
- Filing of claims to the Medicaid Fiscal Agent.

The EVVM solution must adhere to architecture guidance and the seven conditions and standards for enhanced Federal funding as provided by CMS. In alignment with this guidance, the technical solution architecture must employ a modular design, based on Service Oriented Architecture design principles and the Medicaid Information Technology Architecture (MITA) framework. The timely bi-directional exchange of key data will be critical to the success of implementation and operation, as described in the "AMMIS Interface Standards Document" available in posted on the Medicaid website, www.medicaid.alabama.gov.

1. Multiple Point of Care Options

Multiple point of care options must be available for visit verification to provide adequate coverage statewide. Options must include at a minimum telephone, real-time GPS technology, and fixed visit technology when no landline or cellular service is available.

As part of the Proposal, the Vendor must:

1.1 Describe how the Vendor proposes to provide multiple point of care options to include at a minimum telephone, real-time GPS technology, and fixed visit technology when no landline or cellular service is available.

2. Role-Based Access

The system must provide role-based access controls that allow system administrators to create user roles and assign access to the user roles. The system must provide real time jurisdictional views for Medicaid, other state agencies, and Area Agencies on Aging. The system must have the ability to track and report modifications to the EVVM system data input elements after the direct service worker has called in their time or services, including the name of the provider staff making the changes and the reason for changes. The system must have the capability to limit providers' authority to modify service entries or input manual service entries based on program rules which may vary between programs. This must include limiting the number or percentage of manual service entries a provider is allowed to enter. It must provide for role-based access controls in a multi-tiered environment that allow Medicaid, support coordinators and providers to create user roles and assign access to user roles for viewing of appropriate levels of data. For instance, support coordination agencies serve recipients across multiple provider agencies and must be able to access information across provider agencies, but only for those individuals that the support coordination agency serves.

As part of the Proposal, the Vendor must:

2.1 Describe how the Vendor proposes to provide role based access controls for real time jurisdictional views for Medicaid, other state agencies, and Area Agencies on Aging.

2.2 Describe how the Vendor proposes to provide role based access controls to track and report modifications to the EVVM system data input elements after the direct service worker has called in their time or services, including the name of the provider staff making the changes and the reason for changes.

2.3 Describe how the Vendor proposes to provide role based access controls to limit providers' authority to modify service entries or input manual service entries based on program rules which may vary between programs to include limiting the number or percentage of manual service entries a provider is allowed to enter.

2.4 Describe how the Vendor proposes to provide role based access controls in a multi-tiered environment that allow Medicaid, support coordinators and providers to create user roles and assign access to user roles for viewing of appropriate levels of data.

3. Scalability and Flexibility

The system must be capable of adding new functional features and supporting more users in the future without affecting the underlying architecture. The system must provide system architecture that is configurable to support multiple programs or services which have different policies and procedures, reimbursement rates, and business rules, all of which are subject to change during the contract period in response to state and federal regulations, budget appropriations, court proceedings, and other factors. The EVVM system must be capable of supporting the following business rules/procedures:

Allow for only certain providers to enter service tasks, based on program needs and rules.

Certain programs may require service tasks to be entered in the EVVM system for only certain provider types, whereas others may require providers to document service tasks through the current paper process or other alternative process.

As part of the Proposal, the Vendor must:

3.1 Describe how the Vendor proposes to allow for multiple groups or lists of acceptable service task activities to be billed and/or recorded, based on program needs and rules.

3.2 Describe how the Vendor proposes to provide the capability for direct service/in-home workers to denote the recipient's status or need for other assistance in the EVVM system and to require such notation where necessary based on program needs and rules.

3.3 Describe how the Vendor proposes to permit the fiscal/employer agent to load various rates of pay for individual direct service workers.

3.4 Describe how the Vendor proposes to permit certain other providers to bypass entering a worker schedule, based on program-specific rules. Certain programs/services may require providers to enter workers' schedule, whereas other program/services may not require such.

3.5 Describe how the Vendor proposes to handle multiple procedure codes, modifiers, and rates.

3.6 Describe how the Vendor proposes to allow and enforce multiple service limits for different service ranges (i.e., day, week, month, and year).

3.7 Describe how the Vendor proposes to limit providers' authority to modify service information and create program rules as to how many modifications can be made by providers because they may differ based on the population or service/program.

3.8 Describe how the Vendor proposes to permit support coordinators to receive alerts for monitoring purposes.

3.9 Describe how the Vendor proposes to handle automatic loading of provider and recipient files.

3.10 Describe how the Vendor proposes to securely handle and store sensitive participant and provider information in accordance with HIPAA requirements, including the Health Information Technology for Economic and Clinical Health (HITECH) Act amendments. Vendor owned resources must be compliant with industry standard physical and procedural safeguards (NIST

SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (HITECH, 45 CFR Part 164)

3.11 Describe how the Vendor proposes to align with Medicaid Information Technology Architecture (MITA).

4. Verification of hours worked

A key component to ensuring accuracy in time reporting is to ensure that the hours reported occurred in the client's home. The system must allow for review/approval of time by the client or a client designee.

As part of the Proposal, the Vendor must:

4.1 Describe how the Vendor proposes to provide verification that the hours reported occurred in the client's home.

4.2 Describe how the Vendor proposes to allow for review/approval of time by the client or a client designee.

5. Alerts

The systems must be capable of generating real time alerts for potential gaps in care. The system must provide real-time multi-level escalating alerts of pending late and missed visits to the provider, support coordination agency, and other entities as determined by Medicaid.

As part of the Proposal, the Vendor must:

5.1 Describe how the Vendor proposes to provide real-time multi-level escalating alerts of pending late and missed visits to the provider, support coordination agency, and other entities as determined by Medicaid

6. Reporting Features

The system must provide reporting tools that enable users to have real time data and dashboards as well as retrospective reporting capabilities. The reporting engine must provide the ability to build versatile reporting mechanisms from the data collected during service delivery. The data must be available for data modeling, benchmarking and tracking of quality indicators. The EVVM system must be able to provide a standard suite of reports to Medicaid, support coordination agencies, provider agencies, and managed care organizations. In addition, the system must permit Medicaid to use data elements to query and generate ad-hoc reports. The proposer must describe the methodology for generating Ad-Hoc reports in the proposal and include a sample listing of reports as evidence of the capability of the function.

As part of the Proposal, the Vendor must:

6.1 Describe how the Vendor proposes to provide direct service worker reporting, including but not limited to service delivery, timesheets, etc.

6.2 Describe how the Vendor proposes to provide scheduling reports.

6.3 Describe how the Vendor proposes to provide reports on claims filed and unbilled encounters including activity by recipient, agency, support coordination agency, managed care organization, and direct service worker.

6.4 Describe how the Vendor proposes to provide Claims/Authorizations/Services reconciliation reports.

6.5 Describe how the Vendor proposes to provide daily system activity reports including all calls received, calls by recipient, calls by direct service workers, late or missed visits, and unscheduled visits.

6.6 Describe how the Vendor proposes to retain direct service worker and recipient service data for at least four (4) years with sufficient capacity to allow for recording and storing of all data for at least four (4) years.

6.7 Describe how the Vendor proposes to provide for future expansion of additional populations or services in the future.

6.8 Describe how the Vendor proposes to transmit all raw data elements to Medicaid in the format and frequency approved by Medicaid.

7. Authorization and Claims Submission

The system must provide for a consistent rules based billing and scheduling software platform across all service providers. Only claims where the service has been verified and the services are within Medicaid limit rules must be sent to the Fiscal Agent.

As part of the Proposal, the Vendor must:

7.1 Describe how the Vendor proposes to provide for a consistent rules based billing and scheduling software platform across all service providers.

7.2 Describe how the Vendor proposes to ensure only claims where the service has been verified and the services are within Medicaid limit rules are sent to the Fiscal Agent.

8. Customer Service

Technical support must be available during normal business hours (8 AM to 5 PM Central Time) to Medicaid, administering agencies, and providers to address questions and issues pertaining to the use of the EVVM program.

As part of the Proposal, the Vendor must:

8.1 Describe how the Vendor proposes to provide technical support during normal business hours (8 AM to 5 PM Central Time) to Medicaid, administering agencies, and providers to address questions and issues pertaining to the use of the EVVM program.

9. Training, Education, and Outreach

Vendor must prepare written communication, participate in stakeholder meetings, and provide web-based outreach and training materials for users of the system. No communications material

will be distributed without prior approval from Medicaid. The Vendor must provide initial, refresher, and ongoing system training at least annually to Medicaid, providers, support coordinators, and others as deemed necessary by Medicaid. The Vendor must provide a detailed plan for initial and ongoing training, including a training manual and Self-Paced Web Based Training Modules. In addition, the Vendor must address how questions will be received and answered once the system is up and running.

As part of the Proposal, the Vendor must:

9.1 Describe how the Vendor proposes to provide written communication, participate in stakeholder meetings, and provide web-based outreach and training materials for users of the system.

9.2 Describe how the Vendor proposes to provide initial, refresher, and ongoing system training at least annually to Medicaid, providers, support coordinators, and others as deemed necessary by Medicaid.

9.3 Describe how the Vendor proposes to provide a detailed plan for initial and ongoing training, including a training manual and Self-Paced Web Based Training Modules.

9.4 Describe how the Vendor proposes to address how questions will be received and answered once the system is up and running.

10. Disaster Recovery and Business Continuity

Vendors must develop a Disaster Recovery Plan that complies with Federal Guidelines (45 CFR 94.62(f)), identifying every resource that requires backup and to what extent backup is required. The Disaster Recovery Plan must include a robust disaster recovery plan and backups minimally on a daily basis in the event of a system failure. This must include offsite electronic and physical storage in the United States. In addition, the Vendor must identify the software and data backup requirements.

As part of the Proposal, the Vendor must:

10.1 Describe how the Vendor proposes to provide recovery procedures from all events ranging from a minor malfunction to a major disaster.

10.2 Describe how the Vendor proposes to provide recovery procedures for offsite environments, roles and responsibilities of vendor, State, and outsourcer staff.

10.3 Describe how the Vendor proposes to provide recovery procedures for checkpoint/restart capabilities.

10.4 Describe how you propose to provide recovery procedure for retention and storage of backup files and software.

10.5 Describe how you propose to provide recovery procedure for hardware backup for the main processor.

10.6 Describe how you propose to provide recovery procedure for Application and operating system software libraries, including related documentation.

10.7 Describe how you propose to provide recovery procedure for identification of the core business processes involved in the Electronic Visit Verification System.

10.8 Describe how you propose to provide a recovery procedure to include documentation of contingency plans.

10.9 Describe how you propose to provide a recovery procedure plan to include a definition of triggers for activating contingency plans.

10.10 Describe how you propose to provide recovery procedure plan for replacement of hardware and software.

11. Contract Turnover Requirements

Six months prior to the end of the base contract period or any extension thereof, a selected vendor must submit, and implement an Agency-approved Turnover Plan covering the possible turnover of contract requirements to Medicaid, its designee, or a successor vendor. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks outlined in this section below. Medicaid reserves the right to have the EVVM vendor submit an additional updated Turnover Plan one month prior to the end of the base contract or any extension thereof. The plan will describe the EVVM vendor's approach and schedule for transfer of activities and operational support information. The information must be supplied on media specified by and according to the schedule approved by Medicaid. The time frames and turnover task requirements are provided herein. The timing and data requirements are illustrative only and do not limit or restrict Medicaid's ability to require additional information from the selected vendor or modify the turnover schedule as necessary. All EVVM data gathered from this contract and EVVM contracts with Medicaid-contracted entities is considered property of Medicaid. Proprietary software programs will not be required to be delivered to Medicaid pursuant to these Turnover Requirements.

As part of the Turnover Plan to be delivered no later than three working days following the expiration of the contract, the EVVM vendor must provide Medicaid with copies of all relevant non-proprietary data, all documentation, including but not limited to the following:

- Copies of working papers, including procedures, programs, and schedules;
- Status of current projects;
- Copies of correspondence (internal and external);
- Listings of third-party software used by the vendor(s), including availability of the software for transfer or purchase by Medicaid or successor vendor(s);
- Description of functional business process flows;
- Operational and system information concerning subcontractors;
- Documentation of ongoing outstanding issues;
- Other documentation necessary to support contract operations; and
- Other pertinent information necessary to take over and operate the project or to

assume the operational activities successfully.

As part of the Proposal, the Vendor must:

11.1 Describe how the Vendor proposes to provide a **draft** Turnover Plan in adherence with the requirements referenced above.

Three months prior to the end of the contract or any extension thereof, the EVVM vendor must begin training Medicaid staff or its designated agent in the operation of non-proprietary systems and business processes. Such training must be completed at least two months prior to the end of the contract or any extension thereof. Medicaid may, at its discretion, modify this timing.

11.2 Describe how the Vendor proposes to train Medicaid staff or its designated agent in the operation of non-proprietary systems and business processes.

Two months prior to the end of the contract or any extension thereof, the EVVM vendor must appoint, with Medicaid approval, a manager to coordinate and supervise all turnover activities.

11.3 Describe how the Vendor proposes to appoint, with Medicaid approval, a manager to coordinate and supervise all turnover activities.

The EVVM vendor must not reduce operational staffing levels during the turnover period without prior Medicaid approval.

11.4 Describe how the Vendor proposes to ensure there is no reduction in operational staffing levels during the turnover period without prior Medicaid approval.

11.5 Provide a **draft** Turnover Plan in adherence with the requirements referenced above.

12. Post-Turnover Services

One month after the scheduled end of the contract, the EVVM vendor must provide Medicaid with a Turnover Results Report documenting the completion and results of each part of the Turnover Plan. The outline and format of the Turnover Results Report must be approved in advance by Medicaid. Turnover will not be considered complete until this document is approved by Medicaid.

As part of the Proposal, the Vendor must:

12.1 Describe how your propose to provide a Turnover Results Report documenting the completion and results of each part of the Turnover Plan.

The EVVM vendor must be prepared to provide the services (“Turnover Assistance”) of a knowledgeable employee who has worked on the contract for at least one year and who has access to other technical experts within the EVVM vendor’s operations. If so requested by Medicaid, this individual must be required to be available for up to 90 calendar days following contract termination. The individual proposed by the EVVM vendor must be approved by Medicaid. Medicaid may provide working space and assign work to be done on a partial or full-time basis to support post-turnover activity.

12.2 Describe how the Vendor proposes to provide “Turnover Assistance” services of a knowledgeable employee who has worked on the contract for at least one year and who has access to other technical experts within the EVVM vendor’s operations.

13. Staffing

Vendor must maintain sufficient staffing levels to ensure successful implementation within the specified timeframes and for the ongoing operation of the EVVM system throughout the duration of the contract.

As part of the Proposal, the Vendor must:

13.1 Describe how the Vendor proposes to maintain sufficient staffing levels to ensure successful implementation within the specified timeframes and for the ongoing operation of the EVVM system throughout the duration of the contract.

III. Pricing

Vendor's response must specify a firm and fixed fee for completion of the EVVM development, implementation, and updating/operation process. The Firm and Fixed Price of the first year of the proposed contract (implementation phase) and subsequent years (updating/ operation phase) must be separately stated in the RFP Cover Sheet on the first page of this document as well as the pricing form (Appendix C).

IV. General Medicaid Information

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

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 recipient eligibility services. For certain recipient 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 November 2014, more than 1,050,254 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 Contractor. It is imperative that potential Contractors 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 Contractor has been or is currently participating in a Medicaid Program. Proposals will be evaluated based on the written information that is presented in the response. This requirement underscores the importance and the necessity of providing in-depth information in the proposal with all supporting documentation necessary.

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

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

VI. Corporate Background and References

Entities submitting proposals must:

- a. Provide evidence that the Vendor possesses the qualifications required in this RFP.
- b. Provide a description of the Vendor's organization, including
 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 key positions in regards to this contract.
 5. A list of all similar projects the Vendor has completed within the last three years.
 6. A list of all Medicaid agencies or other entities for which the Vendor currently performs similar work.
 7. 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.

8. Vendor's acknowledgment that the Agency will not reimburse the Vendor until: (a) the Project Director has approved the invoice; and (b) the Agency has received and approved all deliverables covered by the invoice.
 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. The Agency reserves the right to reject a proposal solely on the basis of this information.
- c. Have all necessary business licenses, registrations and professional certifications at the time of the contracting to be able to do business in Alabama. Alabama law provides that a foreign corporation (a business corporation incorporated under a law other than the law of this state) may not transact business in the state of Alabama until it obtains a Certificate of Authority from the Secretary of State. To obtain forms for a Certificate of Authority, contact the Secretary of State, (334) 242-5324, www.sos.state.al.us. The Certificate of Authority or a letter/form showing application has been made for a Certificate of Authority must be submitted with the bid.
 - d. Describe proven experience in implementing and maintaining EVVM programs and have been in business a minimum of three 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.**
 - f. Document the resources and capability for completing the work necessary to implement the new EVVM system. The Vendor proposal must include a chart outlining the proposed tasks needed to complete the implementation within 30 days of Contract Award as well as outline follow-up and routine reporting deliverables and staff needed to complete the proposed tasks. A **sample schedule** is outlined as follows:

TASK (Sample)	Date/Timeframe
1. Review data elements necessary for EVVM implementation and present EVVM detailed procedure to State for approval	3/8/10 – May 2010
2. Implement EVVM procedure	6/1/10
3. Detailed Reports to Agency	6/11/10, 6/18/10, 6/25/10, and monthly thereafter
4. Update web-based EVVM table	6/1/10 and on a regularly scheduled basis thereafter
5. Respond to questions from provider community and update provider inquiry tracking log	Daily

Medicaid 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>	La'Quita Robinson
<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>	evvmrfp@medicaid.alabama.gov

C. RFP Documentation

All documents and updates to the RFP including, but not limited to, the actual RFP, questions and answers, addenda, etc, will be posted to the Agency'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 website.

E. Acceptance of Standard Terms and Conditions

Vendor 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.

F. Adherence to Specifications and Requirements

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. Requirement Response Structure

The Vendor must structure its response in the same sequence, using the same labeling and numbering that appears in the RFP Section in question. For example, the Proposal would have a major Section entitled "Corporate Background and References". Within this Section, the Vendor would include their response, addressing each of the numbered Sections in sequence, as they

appear in the RFP; i.e. VI.b.1, VI.b.2, VI.b.3, and so on. The response to each Section must be preceded by the Section text of the RFP followed by the Vendor's response.

N. Submission of Proposals

Proposals must be sealed and labeled on the outside of the package to clearly indicate that they are in response to Alabama Medicaid Agency's EVVM System-2015-EVVM-01. Proposals must be sent to the attention of the Project Director and received at the Agency as specified in the Schedule of Events. It is the responsibility of the Vendor to ensure receipt of the Proposal by the deadline specified in the Schedule of Events.

O. Copies Required

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

P. Late Proposals

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

Q. 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" on the bottom of the page. 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, the Agency 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

Medicaid 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 Medicaid’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. Medicaid may change the size or composition of the committee during the review in response to exigent circumstances.

E. Scoring

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

Evaluation Factor	Highest Possible Score
Corporate Background and References	15
Scope of Work	40
Price	45
Total	100

F. Determination of Successful Proposal

The Vendor whose proposal is determined to be in the best interest of Medicaid 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, Medicaid will notify the selected Vendor. If Medicaid rejects all proposals, it will notify all Vendors. Medicaid will post the award on the Agency 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 Contractor'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. Contractor'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
 - The Medicaid Administrative Code
 - Medicaid's written response to prospective Vendor questions

B. Compliance with State and Federal Regulations

Contractor 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 contract term shall be for two years effective October 1, 2016, through September 31, 2018. Alabama Medicaid shall have three, one-year options for extending this contract if approved by the Legislative Contract Review Oversight Committee. At the end of the contract period Alabama Medicaid may at its discretion, exercise the extension option and allow the period of performance to be extended at the rate indicated on the RFP Cover Sheet. The Vendor will provide pricing for each year of the contract, including any extensions.

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

D. Contract Amendments

No alteration or variation of the terms of the contract shall be valid unless made in writing and duly signed by the parties thereto. The contract may be amended by written agreement duly executed by the

parties. Every such amendment shall specify the date its provisions shall be effective as agreed to by the parties.

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

E. Confidentiality

Contractor shall treat all information, and in particular information relating to individuals that is obtained by or through its performance under the contract, as confidential information to the extent confidential treatment is provided under State and Federal laws including 45 CFR §160.101 – 164.534. Contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and rights under this contract.

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

1. Establishing eligibility;
2. Determining the amount of medical assistance;
3. Providing services for recipients; and
4. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan.

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

F. Security and Release of Information

Contractor shall take all reasonable precautions to ensure the safety and security of all information, data, procedures, methods, and funds involved in the performance under the contract, and shall require the same from all employees so involved. Contractor shall not release any data or other information relating to the Alabama Medicaid Program without prior written consent of Medicaid. This provision covers both general summary data as well as detailed, specific data. Contractor shall not be entitled to use of Alabama Medicaid Program data in its other business dealings without prior written consent of 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 contractor to inform its officers and employees of penalties for improper disclosure implied by the Privacy Act of 1974, 5 USC 552a. Specifically, 5 USC 552a (i) (1), which is made applicable to contractors by 5 USC 552a (m) (1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position, has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established there under, and who knowing that disclosure of the specific material is prohibited, willfully discloses that material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than \$5,000.

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. Contractor agrees to allow public access to all documents, papers, letters, or other materials subject to the current Alabama law on disclosure. It is expressly understood that substantial evidence of Contractor's refusal to comply with this provision shall constitute a material breach of contract.

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 Contractor effective the date of such filing. Contractor 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 Contractor in writing that performance under the contract is terminated and proceed to seek appropriate relief from Contractor.

J. Termination for Default

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

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 Contractor to that effect, whereupon the obligations of the parties hereto shall end as of the date of the receipt of such notice and the contract shall at such time be cancelled without penalty to 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 Contractor by certified or registered mail, return receipt requested. The termination shall be effective as

of the date specified in the notice. In such event, Contractor will be entitled only to payment for all work satisfactorily completed and for reasonable, documented costs incurred in good faith for work in progress. The Contractor will not be entitled to payment for uncompleted work, or for anticipated profit, unabsorbed overhead, or any other costs.

N. Force Majeure

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

O. Nondiscriminatory Compliance

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

P. 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.

Q. Worker's Compensation

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

R. Employment of State Staff

Contractor shall not knowingly engage on a full-time, part-time, or other basis during the period of the contract any professional or technical personnel, who are or have been in the employment of 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.

S. Immigration Compliance

Contractor will not knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama. Contractor shall comply with the requirements of the Immigration Reform and Control Act of 1986 and the Beason-Hammon Alabama Taxpayer and Citizen Protection Act (Ala. Act 2012-491 and any amendments thereto) and certify its compliance by executing Attachment G. Contractor will document that the Contractor is enrolled in the E-Verify Program operated by the US Department of Homeland Security as required by Section 9 of Act 2012-491. During the performance of the contract, the contractor shall participate in the E-Verify program and shall verify every employee that is required to be verified according to the applicable federal rules and regulations. Contractor further agrees that, should it employ or contract with any subcontractor(s) in connection with the performance of the services pursuant to this contract, that the Contractor will secure from such subcontractor(s) documentation that subcontractor is enrolled in the E-Verify program prior to performing any work on the project. The subcontractor shall verify every employee that is required to be verified according to the applicable federal rules and regulations. This subsection shall only apply to subcontractors performing work on a project subject to the provisions of this section and not to collateral persons or business entities hired by the subcontractor. Contractor shall maintain the subcontractor documentation that shall be available upon request by the Alabama Medicaid Agency.

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

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

T. 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.

U. 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.

V. Warranties Against Broker's Fees

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

W. Novation

In the event of a change in the corporate or company ownership of Contractor, 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 Contractor. 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.

X. Employment Basis

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

Y. Disputes and Litigation

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

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

For any and all disputes arising under the terms of this contract, the parties hereto agree, in compliance with the recommendations of the Governor and Attorney General, when considering settlement of such

disputes, to utilize appropriate forms of non-binding alternative dispute resolution including, but not limited to, mediation by and through private mediators.

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

Z. Records Retention and Storage

Contractor shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of three years from the date of the final payment made by Medicaid to Contractor under the contract. However, if audit, litigation, or other legal action by or on behalf of the State or Federal Government has begun but is not completed at the end of the 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.

AA. Inspection of Records

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

BB. 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 Contractor's compliance with applicable federal procurement requirements, and the determination of costs shall be governed by federal cost principles.

CC. Payment

Contractor shall submit to Medicaid a detailed monthly invoice for compensation for the deliverable and/or work performed. Invoices should be submitted to the Project Director. Payments are dependent upon successful completion and acceptance of described work and delivery of required documentation.

DD. Notice to Parties

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

EE. Disclosure Statement

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

FF. Debarment

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

GG. 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 Contractor's sole remedy for the settlement of any and all disputes arising under the terms of this agreement shall be limited to the filing of a claim against Medicaid with the Board of Adjustment for the State of Alabama.

HH. 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.

II. 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.

JJ. Alabama interChange Interface Standards

Contractor hereby certifies that any exchange of MMIS data with the Agency's fiscal agent will be accomplished by following the Alabama interChange Interface Standards Document, which will be posted on the Medicaid Website, www.medicaid.alabama.gov.

Appendix A: Proposal Compliance Checklist

NOTICE TO VENDOR:

It is highly encouraged that the following checklist be used to verify completeness of Proposal content. It is not required to submit this checklist with your proposal.

Vendor Name

Project Director

Review Date

Proposals for which ALL applicable items are marked by the Project Director are determined to be compliant for responsive proposals.

<input checked="" type="checkbox"/> IF CORRECT	BASIC PROPOSAL REQUIREMENTS
<input type="checkbox"/>	1. Vendor's original proposal received on time at correct location.
<input type="checkbox"/>	2. Vendor 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. Vendor submitted signed acknowledgement of any and all addenda to RFP.
<input type="checkbox"/>	6. The Proposal includes written confirmation that the Vendor 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 section.
<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 EVVM system as outlined in the request for proposal regarding each element listed in the scope of work.
<input type="checkbox"/>	10. Vendor 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.
<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.

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. The current copy of these documents can be found on the Q drive in the LEGAL/Contract Forms folder.

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 recipient records involved in the breach.
 - 3.12.1(b) A description of what happened, including the date of the breach and the date of the discovery of the breach if known.
 - 3.12.1(c) A description of the types of unsecure protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other type information were involved).
 - 3.12.1(d) Any steps the individuals should take to protect themselves from potential harm resulting from the breach.
 - 3.12.1(e) A description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches.
 - 3.12.1(f) Contact procedures for individuals to ask questions or learn additional information, which shall include the Business Associate's toll-free number, email address, Web site, or postal address.
 - 3.12.1(g) A proposed media release developed by the Business Associate.
- 3.12.2** Work with Covered Entity to ensure the necessary notices are provided to the recipient, prominent media outlet, or to report the breach to the Secretary of Health and Human Services (HHS) as required by 45 C.F.R. Part 164, Subpart D.;
- 3.12.3** Pay the costs of the notification for breaches that occur as a result of any act or failure to act on the part of any employee, officer, or agent of the Business Associate;
- 3.12.4** Pay all fines or penalties imposed by HHS under 45 C.F.R. Part 160, "HIPAA Administrative Simplification: Enforcement Rule" for breaches that occur as a result of any act or failure to act on the part of any employee, officer, or agent of the Business Associate.
- 3.12.5** Co-ordinate with the Covered Entity in determining additional specific actions that will be required of the Business Associate for mitigation of the breach.

4. PERMITTED USES AND DISCLOSURES

Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may

- 4.1.** Use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure would not violate the Subpart E of 45 C.F.R. Part 164 if done by Covered Entity;
- 4.2.** Use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- 4.3.** Disclose PHI for the proper management and administration of the Business Associate, provided that:
 - 4.3.1** Disclosures are Required By Law; or
 - 4.3.2** Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- 4.4** Use PHI to provide data aggregation services to Covered Entity as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

5. REPORTING IMPROPER USE OR DISCLOSURE

The Business Associate shall report to the Covered Entity within five (5) business days from the date the Business Associate becomes aware of:

- 5.1** Any use or disclosure of PHI not provided for by this agreement
- 5.2** Any Security Incident and/or breach of unsecured PHI

6. OBLIGATIONS OF COVERED ENTITY

The Covered Entity agrees to the following:

- 6.1** Notify the Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect Alabama Medicaid's use or disclosure of PHI.
- 6.2** Notify the Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect the Business Associate's use or disclosure of PHI.
- 6.3** Notify the Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.
- 6.4** Not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.
- 6.5** Provide Business Associate with only that PHI which is minimally necessary for Business Associate to provide the services to which this agreement pertains.

7. TERM AND TERMINATION

7.1 Term. The Term of this Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.

7.2 Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:

7.2.1 Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

7.2.2 Immediately terminate this Agreement; or

7.2.3 If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

7.3 Effect of Termination.

7.3.1 Except as provided in paragraph (2) of this section or in the Contract, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

7.3.2 In the event that Business Associate determines that the PHI is needed for its own management and administration or to carry out legal responsibilities, and returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall:

7.3.2(a) Retain only that PHI which is necessary for business associate to continue its proper management and administration or to carry out its legal responsibilities;

7.3.2(b) Return to covered entity or, if agreed to by covered entity, destroy the remaining PHI that the business associate still maintains in any form;

7.3.2(c) Continue to use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as business associate retains the PHI;

7.3.2(d) Not use or disclose the PHI retained by business associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Section 4, "Permitted Uses and Disclosures" which applied prior to termination; and

7.3.2(e) Return to covered entity or, if agreed to by covered entity, destroy the PHI retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

7.4 Survival

The obligations of business associate under this Section shall survive the termination of this Agreement.

8. GENERAL TERMS AND CONDITIONS

- 8.1** This Agreement amends and is part of the Contract.
- 8.2** Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.
- 8.3** In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the HIPAA Rules shall prevail. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the HIPAA Rules.
- 8.4** A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.
- 8.5** The Parties agree to take such action as is necessary to amend this Agreement from time to time for Covered Entity to comply with the requirements of the HIPAA Rules.

IN WITNESS WHEREOF, Covered Entity and Business Associate have executed this Agreement effective on the date as stated above.

ALABAMA MEDICAID AGENCY

Signature: _____

Printed Name: Clay Gaddis

Title: Privacy Officer

Date: _____

BUSINESS ASSOCIATE

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Contract Review Permanent Legislative Oversight Committee
Alabama State House
Montgomery, Alabama 36130

CONTRACT REVIEW REPORT

(Separate review report required for each contract)

Name of State Agency: Alabama Medicaid Agency

Name of Contractor:

Contractor's Physical Street Address (No. P.O. Box) City State

* Is Contractor organized as an Alabama Entity in Alabama? YES NO

* If not, has it qualified with the Alabama Secretary of State to do business in Alabama? YES NO

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:

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 total \$

(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: 2/20/2013

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 Act 2001-955)

ENTITY COMPLETING FORM

ADDRESS

CITY, STATE, ZIP NUMBER TELEPHONE

STATE AGENCY/DEPARTMENT THAT WILL RECEIVE GOODS, SERVICES, OR IS RESPONSIBLE FOR GRANT AWARD

Alabama Medicaid Agency
 ADDRESS
 501 Dexter Avenue, Post Office Box 5624
 CITY, STATE, ZIP TELEPHONE NUMBER
 Montgomery, Alabama 36103-5624 (334) 242-5833

This form is provided with:

Contract Proposal Request for Proposal Invitation to Bid Grant Proposal

Have you or any of your partners, divisions, or any related business units previously performed work or provided goods to any State Agency/Department in the current or last fiscal year?

Yes No

If yes, identify below the State Agency/Department that received the goods or services, the type(s) of goods or services previously provided, and the amount received for the provision of such goods or services.

STATE AGENCY/DEPARTMENT RECEIVED	TYPE OF GOODS/SERVICES	AMOUNT

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 DEPARTMENT/AGENCY	ADDRESS	STATE

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
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Notary's Signature	Date	Date Notary Expires
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Act 2001-955 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.



ROBERT BENTLEY
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
Acting 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: Pricing Form

Pricing Schedule A Implementation Fees and Deliverables

Implementation Component	Price
License Fees	\$
Training	\$
Technical Deliverables by Phase (Enter Vendor Proposed Deliverables in space below)	\$
Total	\$

Pricing Schedule B Fixed Operational Cost

Year	Monthly Fee	Months	Price
YR1 (assumes 6 mos. of operation)	\$	6	\$
YR2	\$	12	\$
YR3	\$	12	\$
YR4	\$	12	\$
YR5	\$	12	\$
Total			\$

Pricing Schedule C Variable Transaction Fees

Year	Transaction Fee	Transactions	Price
YR1		1,400,000	\$
YR2		5,700,000	\$
YR3		5,700,000	\$
YR4		5,700,000	\$
YR5		5,700,000	\$
Total			\$

Pricing Schedule D Evaluated Price

Contract Item	Price
Implementation Fees and Deliverables (Schedule A)	\$
Fixed Operational Cost (Schedule B)	\$
Variable Transaction Fees (Schedule C)	\$
Total Evaluated Price (Enter on RFP Form)	\$

Signature _____

Date _____

SHIPPING AND BILLING

Shipping

Medicaid Headquarters Shipping
501 Dexter Avenue
Montgomery, AL 36104

Delivery Date:

Billing

,

Delivery Type:

COMMODITY INFORMATION

Group: 1 Default

Line: 3

Line Type: Service

Commodity Code: PRF09

Quantity:

Commodity Description: DATA PROCESSING, COMPUTER,

Unit:

Extended Description:

DATA PROCESSING, COMPUTER, PROGRAMMING, AND SOFTWARE SERVICE

SHIPPING AND BILLING

Shipping

Medicaid Headquarters Shipping
501 Dexter Avenue
Montgomery, AL 36104

Delivery Date:

Billing

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Delivery Type:

1600000008	Document Phase Final	Document Description Electronic Visit Verification and Monitoring System (EVVM)	Page 3 of 5
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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

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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.

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ATTENTION: Download the Alabama Medicaid Agency Electronic Visit Verification and Monitoring (EVVM) System RFP specifications document located on 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: EVVMRFP@medicaid.alabama.gov.

Amendment I to RFP 2015-EVVM-01

03/15/2016

NOTE THE FOLLOWING AND ATTACHED ADDITIONS, DELETIONS AND/OR CHANGES TO THE REQUIREMENTS FOR THE REQUEST FOR PROPOSAL NUMBER: 2015-EVVM-01. THIS AMENDMENT MUST BE INCLUDED IN THE PROPOSER'S RESPONSE AND MEET THE REQUIREMENTS AS DEFINED IN THE RFP.

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

I. RFP Coversheet, page 1, change as follows:

Currently Reads as:

RFP Number: 2015-EVVM-01	RFP Title: Alabama Medicaid Agency Electronic Visit Verification and Monitoring System	
RFP Due Date and Time: April 6, 2016 by 5pm Central Time		Number of Pages: 44
PROCUREMENT INFORMATION		
Project Director: LaQuita Robinson		Issue Date: February 19, 2016
E-mail Address: evvmrfp@medicaid.alabama.gov Website: http://www.medicaid.alabama.gov		Issuing Division: Long Term Care
INSTRUCTIONS TO VENDORS		
Return Proposal to: LaQuita Robinson Alabama Medicaid Agency Lurleen B. Wallace Building 501 Dexter Avenue PO Box 5624 Montgomery, AL 36103-5624		Mark Face of Envelope/Package: RFP Number: 2015-EVVM-01 RFP Due Date: April 6, 2016 by 5pm CT
		Total Evaluated Price:
VENDOR INFORMATION <i>(Vendor must complete the following and return with RFP response)</i>		
Vendor Name/Address:		Authorized Vendor Signatory: (Please print name and sign in ink)
Vendor Phone Number:		Vendor FAX Number:
Vendor Federal I.D. Number:		Vendor E-mail Address:

Revised as:

RFP Number: 2015-EVVM-01	RFP Title: Alabama Medicaid Agency Electronic Visit Verification and Monitoring System	
RFP Due Date and Time: April 13, 2016 by 5pm Central Time		Number of Pages: 44
PROCUREMENT INFORMATION		
Project Director: LaQuita Robinson		Issue Date: February 19, 2016
E-mail Address: evvmrpf@medicaid.alabama.gov Website: http://www.medicaid.alabama.gov		Issuing Division: Long Term Care
INSTRUCTIONS TO VENDORS		
Return Proposal to: LaQuita Robinson Alabama Medicaid Agency Lurleen B. Wallace Building 501 Dexter Avenue PO Box 5624 Montgomery, AL 36103-5624		Mark Face of Envelope/Package: RFP Number: 2015-EVVM-01 RFP Due Date: April 13, 2016 by 5pm CT
		Total Evaluated Price:
VENDOR INFORMATION <i>(Vendor must complete the following and return with RFP response)</i>		
Vendor Name/Address:	Authorized Vendor Signatory: (Please print name and sign in ink)	
Vendor Phone Number:	Vendor FAX Number:	
Vendor Federal I.D. Number:	Vendor E-mail Address:	

II. Section B. Schedule of Events, page 6 change as follows:

Currently reads as:

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

Task	Date
Issuance of RFP (PDF) via RFP Website	02/19/2016
Deadline for First Round of Questions Submission	02/26/2016
Post First Round Question Responses to Website	03/14/2016
Deadline for Second Round of Questions Submission	03/16/2016
Post Second Round Question Responses to Website	03/30/2016
Proposals Submitted	04/06/2016
Evaluation Period	04/07/2016 – 04/29/2016
Vendor Selection Announcement	05/17/2016
**Contract Review Committee	09/01/2016
Official Contract Award/Begin Work	10/01/2016

* *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 “Vendor 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.

Revised as:

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

Task	Date
Issuance of RFP (PDF) via RFP Website	02/19/2016
Deadline for First Round of Questions Submission	02/26/2016
Post First Round Question Responses to Website	03/15/2016
Deadline for Second Round of Questions Submission	03/22/2016
Post Second Round Question Responses to Website	04/05/2016
Proposals Submitted	04/13/2016
Evaluation Period	04/20/2016 – 05/06/2016
Vendor Selection Announcement	05/26/2016
**Contract Review Committee	TBD
Official Contract Award/Begin Work	TBD

* *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 "Vendor 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.

III. Section I. Background, page 6, change as follows:

Currently reads as:

I. Background

The Alabama Medicaid Agency, hereinafter called Medicaid, an Agency of the State of Alabama, hereby solicits proposals for the procurement of an Electronic Visit Verification and Monitoring (EVVM) system. The purpose is to secure error rate reductions in billings, safeguard against fraud, and improve program oversight. This involves State operated home care services for more than 14,500 individuals with disabilities and the elderly, who would otherwise require care in institutions utilizing more than 175 individual personal assistant/homemaker agency service providers. These programs are governed by both State and Federal Medicaid regulations. Services required are outlined through this RFP. The Vendor to whom the RFP is awarded shall be responsible for the performance of all duties contained within this RFP for the firm and fixed price quoted in Vendor's proposal on the pricing form found in Attachment E to this RFP. All proposals must state a firm and fixed price for the services described. **The total firm and fixed price from Attachment E must be entered on the RFP Coversheet.**

Revised as:

I. Background

The Alabama Medicaid Agency, hereinafter called Medicaid, an Agency of the State of Alabama, hereby solicits proposals for the procurement of an Electronic Visit Verification and Monitoring (EVVM) system. The purpose is to secure error rate reductions in billings, safeguard against fraud, and improve program oversight. This involves State operated home care services for more than 14,500 individuals with disabilities and the elderly, who would otherwise require care in institutions utilizing more than 175 individual personal assistant/homemaker agency service providers. These programs are governed by both State and Federal Medicaid regulations. Services required are outlined through this RFP. The Vendor to whom the RFP is awarded shall be responsible for the performance of all duties contained within this RFP for the firm and fixed price quoted in Vendor's proposal on the pricing form found in Attachment E to this RFP. All proposals must state a firm and fixed price for the services described. **The Total Evaluated Price from Appendix C must be entered on the RFP Coversheet.**

- IV. Section II, Scope of Work, page 6, change as follows:

Currently reads as:

II. Scope of Work

The Alabama Medicaid Agency is seeking a vendor solution which must provide for the following:

Revised as:

II. Scope of Work

The Alabama Medicaid Agency is seeking a hosted vendor solution which must provide for the following:

- V. Section II, Scope of Work, Item 2, Role-Base Access, page 7, add the following:

2.5 Describe how the Vendor proposes to provide role based access controls that allow based on the user's authority, an override process to reject, cancel or suspend automatic functions within the system.

- VI. Section II, Scope of Work, page 13, remove the following:

11.1 Describe how the Vendor proposes to provide a **draft** Turnover Plan in adherence with the requirements referenced above.

- VII. Section III, Pricing, page 14, change as follows:

Currently reads as:

Vendor's response must specify a firm and fixed fee for completion of the EVVM development, implementation, and updating/operation process. The Firm and Fixed Price of the first year of the proposed contract (implementation phase) and subsequent years (updating/ operation phase) must be separately stated in the RFP Cover Sheet on the first page of this document as well as the pricing form (Appendix C).

Revised as:

Vendor's response must specify a firm and fixed fee for completion of the EVVM development, implementation, and updating/operation process. In pricing schedule A, the implementation cost must be a one-time fee. The Total Evaluated Price must be separately stated in the RFP Cover Sheet on the first page of this document as well as the pricing form (Appendix C).

VIII. Section VI, Corporate Background and References, page 15, change as follows:

Currently reads as:

VI. Corporate Background and References

Entities submitting proposals must:

Revised as:

VI. Corporate Background and References

Entities submitting proposals and all subcontractors must:

IX. Section VI f, Corporate Background and References, page 16, change as follows:

Currently reads as:

f. Document the resources and capability for completing the work necessary to implement the new EVVM system. The Vendor proposal must include a chart outlining the proposed tasks needed to complete the implementation within 30 days of Contract Award as well as outline follow-up and routine reporting deliverables and staff needed to complete the proposed tasks. A sample schedule is outlined as follows:

Revised as:

f. Document the resources and capability for completing the work necessary to implement the new EVVM system. The Vendor proposal must include a chart outlining the proposed tasks needed to complete the implementation, as well as outline follow-up and routine reporting deliverables and staff needed to complete the proposed tasks. A sample schedule is outlined as follows:

X. Section IX C, Term of Contract, page 21, change as follows:

Currently reads as:

C. Term of Contract

The initial contract term shall be for two years effective October 1, 2016, through September 31, 2018. Alabama Medicaid shall have three, one-year options for extending this contract if approved by the Legislative Contract Review Oversight Committee. At the end of the contract period Alabama Medicaid may at its discretion, exercise the extension option and allow the period of performance to be extended at the rate indicated on the RFP Cover Sheet. The Vendor will provide pricing for each year of the contract, including any extensions.

Revised as:

C. Term of Contract

The initial contract term shall be for two years effective upon execution of the contract. Alabama Medicaid shall have three, one-year options for extending this contract if approved by the Legislative Contract Review Oversight Committee. At the end of the contract period Alabama Medicaid may at its discretion, exercise the extension option and allow the period of performance to be extended at the rate indicated on the RFP Cover Sheet. The Vendor will provide pricing for each year of the contract, including any extensions.

I hereby acknowledge the receipt of Amendment I to RFP 2015-EVVM-01.

Authorized Vendor Signature

Date

Vendor Organization

ALABAMA HOME AND COMMUNITY-BASED WAIVER SERVICES

Medicaid is a health care program for low income Alabamians. Home and Community-Based Waiver services provide additional Medicaid benefits to specific populations who meet special eligibility criteria. This chart summarizes those benefits, criteria, and informs you on how to apply for a HCBS waiver.

Applicants must meet financial, medical, and program criteria to access waiver services. The applicant also must be at risk of nursing institutionalization (nursing facility, hospital, ICF/MR). A client who receives services through a waiver program also is eligible for all basic Medicaid covered services. Each waiver program has an enrollment limit. There may be a waiting period for any particular waiver. Applicants may apply for more than one waiver, but may only receive services through one waiver at a time. Anyone who is denied Medicaid eligibility for any reason has a right to appeal. Additional information can be found on the Alabama Medicaid Agency's website: www.medicaid.alabama.gov

	Elderly & Disabled Waiver (Since 1982)	Intellectual Disabilities Waiver (Since 1981)	Living at Home Waiver (Since 2002)	State of Alabama Independent Living Waiver (Since 1992)
What is the purpose?	To provide services that would allow elderly and/or disabled individuals to live in the community who would otherwise require nursing facility level of care	To provide service to individuals that would otherwise require the level of care available in an intermediate care facility for Individuals with Intellectual Disabilities (ICF/IID)	To provide services to individuals who would otherwise require the level of care available in an ICF/IID	To provide services to disabled adults with specific medical diagnoses** who meet the nursing facility level of care criteria
What is the target population?	Individuals meeting the Nursing Facility Level of Care	Individuals with a diagnosis of Intellectual Disabilities (ID); Individuals meeting an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)	Individuals with a diagnosis of Intellectual Disabilities (ID); Individuals meeting the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Level of Care; Persons not residing in a group home setting or environment; Persons currently on the waiting list for ID services	Individuals with a specific medical diagnoses
What are the services provided?	<ul style="list-style-type: none"> ▪ Case Management ▪ Homemaker Services ▪ Personal Care ▪ Adult Day Health ▪ Respite Care (Skilled and Unskilled) ▪ Adult Companion Services ▪ Home Delivered Meals 	<ul style="list-style-type: none"> ▪ Residential Habilitation ▪ Residential Habilitation - Other Living Arrangement ▪ Day Habilitation – Level 1-4 ▪ Day Habilitation with Transportation – Level 1-4 ▪ New Day Habilitation ▪ Prevocational Services ▪ Supported Employment ▪ Individual Job Coach ▪ Individual Job Developer ▪ Occupational Therapy ▪ Speech and Language Therapy ▪ Physical Therapy ▪ Behavior Therapy– Level 1-3 ▪ In-Home Respite Care ▪ Out-of-Home Respite Care ▪ Institutional Respite Care ▪ Personal Care ▪ Personal Care on Worksite ▪ Personal Care Transportation ▪ Environmental Accessibility Adaptations ▪ Specialized Medical Equipment ▪ Specialized Medical Supplies ▪ Skilled Nursing ▪ Adult Companion Services ▪ Crisis Intervention ▪ Community Specialist 	<ul style="list-style-type: none"> ▪ Residential Habilitation In-Home ▪ Day Habilitation-Level 1-4 ▪ Day-Habilitation with Transportation – Level 1-4 ▪ New Day Habilitation ▪ Prevocational Services ▪ Supported Employment Small Group ▪ Supported Employment ▪ Individual Job Coach ▪ Individual Job Developer ▪ Occupational Therapy Services ▪ Speech and Language Therapy ▪ Physical Therapy ▪ Behavior Therapy- Level 1-3 ▪ In-Home Respite ▪ Out-of-Home Respite ▪ Personal Care ▪ Personal Care on Worksite ▪ Personal Care Transportation ▪ Environmental Accessibility Adaptations ▪ Specialized Medical Equipment ▪ Specialized Medical Supplies ▪ Skilled Nursing ▪ Community Specialist ▪ Crisis Intervention ▪ Individual Directed Goods and Services 	<ul style="list-style-type: none"> ▪ Case Management ** ▪ Personal Care ▪ Personal Assistance Service ▪ Environmental Accessibility Adaptations ** ▪ Personal Emergency Response System (Initial Setup) ▪ Personal Emergency Response System (Monthly Fee) ▪ Medical Supplies ▪ Minor Assistive Technology ▪ Assistive Technology** ▪ Evaluation for Assistive Technology ▪ Assistive Technology Repairs <p>**Includes Transitional Services</p>
Waiver criteria :	Nursing facility level of care	ICF/IID level of care	ICF/IID level of care	Nursing facility level of care
What groups can be eligible for this waiver?	<ul style="list-style-type: none"> ▪ Individuals receiving SSI ▪ Individuals receiving State Supplementation ▪ SSI related protected groups deemed to be eligible for SSI / Medicaid ▪ Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate ▪ Federal or State Adoption Subsidy Individuals 	<ul style="list-style-type: none"> ▪ Individuals receiving SSI ▪ SSI related protected groups deemed to be eligible for SSI / Medicaid ▪ Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate ▪ Low Income Families with Children ▪ Federal or State Adoption Subsidy Individuals 	<ul style="list-style-type: none"> ▪ SSI recipients ▪ Federal or State Adoption Subsidy Individuals ▪ SSI related protected groups deemed to be eligible for SSI / Medicaid ▪ Low Income Families with Children ▪ Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI 	<ul style="list-style-type: none"> ▪ Individuals receiving SSI ▪ Individuals receiving State Supplementation ▪ SSI related protected groups deemed to be eligible for SSI / Medicaid ▪ Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate
Enrollment Limit:	9,205	5,260	569	660
Is there an age requirement?	No age requirement	3 years and older	3 years and older	18 years and older
Who provides Case Management?	Alabama Department of Senior Services	Alabama Department of Mental Health	Alabama Department. of Mental Health	Alabama Department of Rehabilitation Services
Where to go to receive information on how to apply?	Alabama Department of Senior Services www.adss.alabama.gov	Alabama Department of Mental Health www.mh.alabama.gov	Alabama Department of Mental Health www.mh.alabama.gov	Alabama Department of Rehabilitation Services www.rehab.alabama.gov
Who are the contact persons?	Jean Stone 1-800-243-5463	DMH / ID Call Center 1-800-361-4491 Karen Coffey 242-3719	DMH / ID Call Center 1-800-361-4491 Karen Coffey 242-3719	Lisa Alford 1-800-441-7607
What are the reference sources?	Code of Federal Regulations: 42 CFR 440.180 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 36	Code of Federal Regulations: 42 CFR 440.180 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 35	Code of Federal Regulations: 42 CFR 440.180 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 52	Code of Federal Regulations: 42 CFR 440.180 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 57

****Specific medical diagnoses include, but are not limited to: Quadriplegia, Traumatic Brain Injury, Amyotrophic Lateral Sclerosis, Multiple Sclerosis, Spinal Muscular Atrophy, Muscular Dystrophy, Severe Cerebral Palsy, Stroke, and other substantial neurological impairments, severely debilitating diseases, or rare genetic diseases (such as Lesch-Nyhan disease).**

ALABAMA HOME AND COMMUNITY-BASED WAIVER SERVICES

	Technology Assisted Waiver for Adults (Since 2003)	HIV/AIDS Waiver A.K.A. 530 Waiver (Since 2003)	Alabama Community Transition (ACT) Waiver (Since 2011)
What is the purpose?	To provide services to adults with complex skilled medical conditions who would otherwise require nursing facility level of care	To provide services to individuals with a diagnosis of HIV, AIDS, and related illness who would meet the nursing facility level of care criteria	To provide services to individuals with disabilities or long term illnesses, who live in a nursing facility and who desire to transition to the home or community setting
What is the target population?	Individuals with complex skilled medical conditions who are ventilator dependent or who has a tracheostomy.	Individuals with a diagnosis of HIV or AIDS and related illnesses.	Individuals with disabilities or long term illnesses currently residing in a nursing facility.
What are the services provided?	<ul style="list-style-type: none"> ▪ Private Duty Nursing ▪ Personal Care/Attendant Services ▪ Medical Supplies ▪ Assistive Technology <p>**Targeted Case Management which includes transitional services. (A covered service under Medicaid's State Plan)</p>	<ul style="list-style-type: none"> ▪ Case Management ** ▪ Homemaker Services ▪ Personal Care ▪ Respite Care ▪ Skilled Nursing ▪ Companion Services <p>**Includes Transitional Services</p>	<ul style="list-style-type: none"> ▪ Case Management ▪ Transitional Assistance ▪ Personal Care ▪ Homemaker Services ▪ Adult Day Health ▪ Home Delivered Meals ▪ Respite Care (Skilled and Unskilled) ▪ Skilled Nursing ▪ Adult Companion Services ▪ Home Modifications ▪ Assistive Technology ▪ Personal Emergency Response Systems (PERS) Installation/Monthly Fee ▪ Medical Equipment Supplies and Appliances ▪ Personal Assistant Services (PAS)
Waiver criteria:	Nursing facility level of care	Nursing facility level of care	Nursing facility level of care
What groups can be eligible for this waiver?	<ul style="list-style-type: none"> ▪ Individuals receiving SSI ▪ SSI related protected groups deemed to be eligible for SSI ▪ Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate 	<ul style="list-style-type: none"> ▪ Individuals receiving SSI ▪ Medicaid for Low Income Families (MLIF) ▪ SSI related protected groups deemed to be eligible for SSI ▪ Individuals receiving State Supplementation ▪ Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate 	<ul style="list-style-type: none"> ▪ Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate ▪ Individuals receiving SSI ▪ Individuals determined to be eligible for transition into the community based upon an assessment
Enrollment Limit:	40	150	200
Is there an age requirement?	21 years and older	21 years and above	No age requirement
Who provides Case Management?	Alabama Department of Senior Services	Alabama Department of Senior Services	Alabama Department of Senior Services
Where to go to receive information on how to apply?	Alabama Medicaid Agency www.medicaid.alabama.gov	Alabama Department of Senior Services www.adss.alabama.gov	Alabama Department of Senior Services www.adss.alabama.gov
Who are the contact persons?	Jessie Burris 1-877-425-2243	Jean Stone 1-800-243-5463	Jessie Burris 1-877-425-2243
What are the reference sources?	Code of Federal Regulations: 42 CFR 440.180 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 54	Code of Federal Regulations: 42 CFR 440.180 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 58	Code of Federal Regulations: 42 CFR 440.180 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 44

Revised: 10/19/2015

Home and Community Based Waiver Service Utilization by Procedure and Modifier Code

Procedure Code	Billing Provider Specialty Code & Description	First Modifier Code	Second Modifier Code	Recipient Unduplicated Count	Billed Quantity	Average units used per month.	Billing Provider Medicaid Count
S5130	661 - ACT Waiver Homemaker Services	TF	UB	6	4,844	404	24
S5135	661 - ACT Waiver Adult Companion Service	TF	UB	3	4,304	359	15
S9123	661 - ACT Waiver Skilled Nursing RN	TF	UB	2	656	55	7
S9124	661 - ACT Waiver Skilled Nursing LPN	TF	UB	4	3,822	319	27
T1019	661 - ACT Waiver Personal Care Services	TF	UB	13	36,235	3,020	83
S5130	620 - HIV-AIDS Homemaker Services	U6		88	67,078	5,590	826
S5135	620 - HIV-AIDS Companion Service	U6		9	2,382	199	341
S5150	620 - HIV-AIDS Respite Care Services-Unskilled	U6		7	9,561	797	59
S9123	620 - HIV-AIDS Skilled Nursing	U6		1	116	10	7
T1005	620 - HIV-AIDS Respite Care Services-Skilled	U6		1	12	1	1
T1019	620 - HIV-AIDS Personal Care Services	U6		32	22,139	1,845	274
S5130	670 - ADSS (Elderly and Disabled) Homemaker Services	UA		6,266	4,616,582	384,715	57,420
S5135	670 - ADSS (Elderly and Disabled) Adult Companion Service	UA		228	85,911	7,159	6,569
S5150	670 - ADSS (Elderly and Disabled) Respite Care Services-Unskilled	UA		1,243	1,389,937	115,828	10,289
T1005	670 - ADSS (Elderly and Disabled) Respite Care Services-Skilled	UA		255	317,237	26,436	2,163
T1019	670 - ADSS (Elderly and Disabled) Personal Care Service	UA		4,519	2,824,597	235,383	39,528

Procedure Code	Billing Provider Specialty Code & Description	First Modifier Code	Second Modifier Code	Recipient Unduplicated Count	Billed Quantity	Average units used per month.	Billing Provider Medicaid Count
T1019	670 - ADSS (Elderly and Disabled) Personal Options	UA	HX	106	518	43	518
S5125	660 - ADRS Sail Waiver Personal Assistance Services	UB		2	2,576	215	9
T1019	660 - ADRS Sail Waiver Personal Care Services	UB		367	967,528	80,627	3,127
T1019	660 - ADRS Sail Waiver Personal Options	UB	HX	29	182	15	182
92507	680 - ADMH/ID Speech and Language Therapy	UC		31	4,010	334	251
97110	680 - ADMH/ID Physical Therapy	UC		73	3,721	310	354
97535	680 - ADMH/ID Occupational Therapy	UC		73	6,496	541	482
S5135	680 - ADMH/ID Companion Services	UC		30	120,333	10,028	306
S5150	680 - ADMH/ID In-Home Respite Care	UC		26	31,639	2,637	141
S9123	680 - ADMH/ID Skilled Nursing RN	UC		62	21,448	1,787	559
S9124	680 - ADMH/ID Skilled Nursing LPN	UC		43	27,217	2,268	392
T1019	680 - ADMH/ID Personal Care Services	UC		436	2,004,666	167,056	5,709
T1019	680 - ADMH/ID Self-Directed Personal Care	UC	HN	12	119,506	9,959	387
T1019	680 - ADMH/ID Personal Care on Worksite	UC	HW	1	1,520	127	12
T2017	680 - ADMH/ID Residential Services- Other Living Arrangements	UC		68	212,636	17,720	772
92507	690 - ADMH/ID Living Speech Therapy	UD		5	810	68	51
97110	690 - ADMH/ID Living Physical Therapy	UD		3	105	9	14
97535	690 - ADMH/ID Living Occupational Therapy	UD		7	658	55	65
S5150	690 - ADMH/ID Living Respite In Home	UD		4	6,299	525	24
S9123	690 - ADMH/ID Living Skilled Nursing RN	UD		1	155	13	12
S9124	690 - ADMH/ID Living Skilled Nursing LPN	UD		3	396	33	20

Procedure Code	Billing Provider Specialty Code & Description	First Modifier Code	Second Modifier Code	Recipient Unduplicated Count	Billed Quantity	Average units used per month.	Billing Provider Medicaid Count
T1019	690 - ADMH/ID Living Personal Care Services	UD		121	308,450	25,704	1,611
T2017	690 - ADMH/ID Living In Home Residential Habilitation	UD		1	1,057	88	12

This table is a representation of data analysis completed by HP (fiscal agent) of HCBS Waiver utilization over a 12 month period. Each procedure code has a corresponding HCBS Waiver service description followed by a system modifier code(s) and its utilization by number of recipients, billed quantity, average billed units per month and the number of Medicaid providers.

Alabama Medicaid Agency

Medicaid



Alabama Medicaid ANSI ASC X12N HIPAA Companion Guide for 5010

Standard Companion Guide Communications/Connectivity Information

Instructions related to Transactions based on ASC X12 Implementation Guides, CORE version 005010

Companion Guide Version Number: 3.1

Last Updated: December 21, 2015

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http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.3_Companion_Guides.aspx

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Alabama Medicaid will track revision changes using a Change Summary Table.

PREFACE

This Companion Guide to the v5010 ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Acme Health Plan. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

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1 INTRODUCTION

1.1 PURPOSE

The intended purpose of this document is to provide information such as registration, testing, support and specific transaction requirements to electronic data interchange (EDI) trading partners that exchange X12 information with the Alabama Medicaid Agency.

An EDI trading partner is defined by Alabama Medicaid as anybody such as a provider, software vendor and clearinghouse that exchanges transactions adopted under the Healthcare Portability and Accountability Act of 1996 (HIPAA).

1.2 OVERVIEW

This document contains information to initiate and maintain data exchange with Alabama Medicaid. The information within the document is organized in the following sections:

Getting Started

This section includes information related to contact information and hours, trading partner registration and testing requirements.

Testing and Certification Requirements

This section includes detailed transaction testing information as well as certification requirements needed to complete transaction testing with Medicaid.

Connectivity/Communications

This section includes information on Medicaid's transmission procedures as well as communication and security protocols.

Contact Information

This section includes EDI customer service and technical assistance, provider services and applicable Websites.

Control Segments/Envelopes

This section contains information needed to create the ISA/IEA, GS/GE and ST/SE control segments for transactions in conjunction with the requirements outlined in the implementation guide.

Acknowledgments and Reports

This section contains information on all transaction acknowledgments sent by Medicaid and any applicable report inventory.

Included ASC X12N Implementation guides

This section list the applicable implementation guide referenced throughout the document.

Instruction Tables

This section list trading partner specific information directly related to loops, segments and data elements to be used in conjunction with the implementation guide.

Section 1104 of the Patient Protection Affordable Care Act (ACA)

Throughout the companion guide updates have been added to address the CAQH CORE Operating Rules Connectivity/Security Rule, a safe harbor that requires the use of the HTTP/S transport protocol over the public internet for both interactive and batch submissions.

Additional Information

This section will list payer specific business scenarios and scenario examples if applicable for this transaction.

Change Summary

This section describes the differences between the current Companion Guide and the previous Companion Guide.

1.3 REFERENCES

Implementation Guides for all X12 transaction sets can be purchased from the publisher, Washington Publishing Company, at their website www.wpc-edi.com.

Information concerning CAQH CORE Operating Rules is available on the CAQH website.
<http://caqh.org/benefits.php>

1.4 INTENDED USE

The following information is intended to serve only as a companion document to the HIPAA ASC X12N implementation guides. The instruction tables contain trading partner specific requirements for processing EDI data in the Alabama Medicaid Information System (AMMIS). The use of this document is solely for the purpose of clarification. This document supplements, but does not contradict any requirements in the ASC X12N implementation guides.

2 GETTING STARTED

2.1 WORKING TOGETHER

Alabama Medicaid in an effort to assist the community with their electronic data exchange needs have the following options available for either contacting a help desk or referencing a website for further assistance.

Alabama Medicaid Website: <http://www.medicaid.alabama.gov/>

Contacts: http://medicaid.alabama.gov/CONTENT/8.0_Contact/

2.2 TRADING PARTNER REGISTRATION

An EDI Trading Partner is any entity (provider, billing service, clearinghouse, software vendor, etc.) that transmits electronic data to and receives electronic data from another entity. Alabama Medicaid requires all trading partners to complete EDI registration regardless of the trading partner type as defined below.

Contact the EMC Helpdesk to register.

- **Trading Partner** is an entity engaged in the exchange or transmission of electronic transactions.
- **Vendor** is an entity that provides hardware, software and/or ongoing technical support for covered entities. In EDI, a vendor can be classified as a software vendor, billing or network service vendor or clearinghouse.
- **Software Vendor** is an entity that creates software used by billing services, clearinghouses and providers/suppliers to conduct the exchange of electronic transactions.
- **Billing Service** is a third party that prepares and/or submits claims for a provider.
- **Clearinghouse** is a third party that submits and/or exchanges electronic transactions on behalf of a provider.

All EDI Trading Partners must fill out a data switch agreement. The Trading Partner Data Switch agreement form is located at:

http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.3_Companion_Guides.aspx

2.3 TRADING PARTNER TESTING AND CERTIFICATION

Alabama Medicaid requires that all newly registered Trading Partners complete basic transaction submission testing. Successful transaction submission and receipt of both valid responses and error responses is an indication that all systems involved can properly submit and receive transactions.

2.3.1 TRADING PARTNER ID

Once registration is completed the following ids will be created:

- Test Trading Partner ID
- Production Trading Partner ID

These IDs are mutually exclusive to the environment a transaction is submitted to and the transaction will not be accepted if submitted incorrectly.

2.3.2 WEB USER ID

Each entity that successfully completes enrollment as a trading partner will be assigned a Personal Identification Number (PIN) that allows access to the secure Web Portal. Prior to submission of EDI transactions users must access the secure web site and setup an account which once successfully completed will allow for the uploading and downloading of electronic transactions through the Web Portal and/or Safe Harbor. PINs are issued for test and production separately and are only valid to be used in the appropriate environment.

- Web User Account Setup

The following steps outline the process for logging onto the secure testing and production web portal.

Action	Response
Log on to the secure web site by selecting the Secure Site link. Testing: https://www.alabama-uat.com/ALPortal/ Production: https://www.medicaid.alabamaservices.org/ALPortal/	Login page displays.
Select setup account button.	Account setup panel displays.
Enter the Login ID (Trading Partner ID) and Personal Identification Number (PIN) that has been issued. Select setup account button.	Web User Profile panel displays.
Enter data in all required fields and select submit .	Account Setup information is saved and the Medicaid Home Page displays. <i>NOTE:</i> A Web Password must, at a minimum, include the following format: <ul style="list-style-type: none"> • 1 Lower and 1 Upper Case value • 1 numeric value • minimum of 8 bytes in length

2.3.3 USAGE INDICATOR

ISA15 of the HIPAA X12 transaction allows for the submission of either a T, to indicate testing or a P, to indicate production. The following process is defined for these usage indicators:

T – May be submitted into the test and production environments. However, only a compliance check will be performed. The electronic files submitted with a T will not be translated for further processing.

P – May be submitted into the test and production environments. A compliance check will be performed and the files will be translated for further processing (edit, audit, adjudication and response).

2.3.4 SECURE WEB UPLOAD - TRACKING NUMBER

A tracking number will be assigned and returned on-line for each successful upload of an electronic file. This tracking number should be maintained if any questions should arise concerning the processing of the file. The following message will be returned:

“File was uploaded successfully. File tracking number is 0123456. Please make note of this number for future reference.”

2.3.5 SECURE WEB UPLOAD - ERROR MESSAGES

If an electronic file fails to upload through the web portal, an error message will be returned on-line.

The following messages will be returned:

- *Error occurred. Error Uploading File:*
- *Error occurred. Error Gathering information for Upload:*
- *The session has been timed out. Please try login again.*

2.3.6 SECURE WEB DOWNLOAD – FILE RETENTION

All electronic files that have been made available for download will remain available on-line for download as follows:

7 Days	999, TA1, 271, 277, 278, BRF
30 Days	277U
90 Days	835, RA

After the allotted time frame has passed the files will be removed from the list and will no longer be available for download. This applies to both testing and production.

2.3.7 SAFE HARBOR PAYLOAD ID

Payload ID must be unique for each batch or real time transaction submitted. See the CAQH CORE Rule 270 Connectivity Rule for instructions on generating a Payload ID.

<http://caqh.org/pdf/CLEAN5010/270-v5010.pdf>

3 TESTING

The following ASC X12 transaction types are available for testing through the web portal:

- 270 Eligibility Request / 271 Eligibility Response
- 276 Claim Status Request / 277 Claim Status Response
- 278 Prior Authorization Request / 278 Prior Authorization Response
- 837D Dental Claim
- 837P Professional (HCFA) Claim
- 837I Institutional (UB) Claim
- 835 Electronic Remittance Advice
- 277U Unsolicited Claim Status
- NCPDP Pharmacy Transactions (B1, B2, E1)
- TA1/999

The following ASC X12 transaction types currently available for testing through Safe Harbor in both batch and realtime:

- 270 Eligibility Request / 271 Eligibility Response
- 276 Claim Status Request / 277 Claim Status Response
- TA1/999

Testing data such as provider ids and recipient ids will not be provided. Users should submit Recipient information and Provider information as done so for production as the test environment is continually updated with production information.

There is not a limit to the number of files that may be submitted. Users will be allowed to move to production once a successfully compliant transaction is received and the appropriate responses returned.

3.1 835 TESTING

If an 835 response is desired for claims submitted the trading partner submitting the test files needs to contact the EMC (EDI) Help Desk and provide a list of the provider ids to be tested as a link between the trading partner id and provider ids must be established for the return of this transaction.

3.2 PAYER SPECIFIC DOCUMENTATION

For additional information in regards to business processes related to eligibility, prior authorization and claims processing please review the Provider Manual located on the Alabama Medicaid Website.

http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx

For further information on specific Payer Prior Authorization Information please see the Alabama Medicaid website.

http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.9_Prior_Authorization.aspx

3.3 TESTING CONTACT INFORMATION

All correspondence for assistance with testing should be submitted to the following email address:

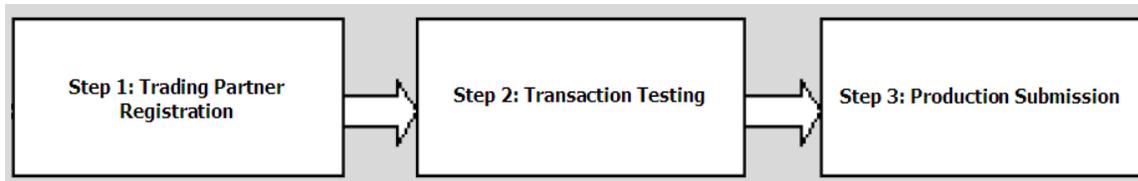
alabamaictesting@hp.com

The following information should be included in the email:

Trading Partner ID, Contact Name, Contact Phone/Email, File Tracking numbers or Payload IDs

4 CONNECTIVITY/COMMUNICATIONS

4.1 PROCESS FLOWS



4.2 TRANSMISSION PROCEDURES

System Availability

http://www.medicaid.alabama.gov/documents/8.0_Contact/8.2_HP_Contact_Information/8.2.8_System_Availability/8.2.8_2014_Medicaid_System_Availability_7-25-14.pdf

4.2.1 RE-TRANSMISSION PROCEDURES

Trading Partners may call Alabama Medicaid for assistance in researching problems with submitted transactions. Alabama Medicaid will not edit Trading Partner data and/or resubmit transactions for processing on behalf of a Trading Partner. The Trading Partner must correct any errors found and resubmit.

4.3 COMMUNICATION AND SECURITY PROTOCOLS

Vendors may find information regarding communication protocols in the Vendor Specifications Document. http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.3_Companion_Guides.aspx

4.4 SECURE WEB PORTAL

The accepted HIPAA X12 transactions may be processed by submission to Alabama Medicaid using a secure web portal.

- User Acceptance Test

<https://www.alabama-uat.com/ALPortal/>

- Production

<https://www.medicaid.alabamaservices.org/ALPortal/>

4.5 SAFE HARBOR

CAQH CORE described a specific set of web services which can be used over the Safe Harbor connection. It is assumed that the trading partner has reviewed the CAQH CORE operating rules in regards to use of Safe Harbor.

<http://caqh.org/benefits.php/>

4.6 SAFE HARBOR BATCH SUBMISSION

4.6.1 SOAP+WSDL

The following are the URLs for batch Safe Harbor connection using SOAP+WSDL:

- **Production SOAP Batch**

<https://ediservices.medicaid.alabamaservices.org/PROD/CoreSoapServices/CoreBatch.svc>

- **User Acceptance Test SOAP Batch**

<https://ediservices.medicaid.alabamaservices.org/UAT/CoreSoapServices/CoreBatch.svc>

4.6.2 HTTP MIME MULTIPART

The following are the URLs for batch Safe Harbor connection using HTTP MIME Multipart:

- **Production MIME Batch**

<https://ediservices.medicaid.alabamaservices.org/PROD/CoreMIMEServices/CoreTransactions.aspx>

- **User Acceptance Test MIME Batch**

<https://ediservices.medicaid.alabamaservices.org/UAT/CoreMIMEServices/CoreTransactions.aspx>

4.6.3 SAFE HARBOR ALLOWED INCOMING/OUTGOING BATCH PAYLOAD TYPES

Type	Trading Partner	Safe Harbor	Alabama Medicaid
Batch Submit	X12_270_Request_005010X279A1 X12_276_Request_005010X212	>>>>	
		<<<<	X12_BatchReceiptConfirmation CoreEnvelopeError
Batch Submit – Acknowledge Retrieval	X12_999_RetrievalRequest_005010X231A1 X12_TA1_RetrievalRequest_005010X231A1	>>>>	
		<<<<	X12_999_Response_005010231A1 X12_TA1_Response_005010231A1 X12_005010_Response_NoBatchAckFile CoreEnvelopeError
Batch Submit – Results Retrieval	X12_005010_Request_Batch_Results_271 X12_005010_Request_Batch_Results_277	>>>>	
		<<<<	X12_271_Response_005010X279A1 X12_277_Response_005010X212 X12_005010_Response_NoBatchResultFile CoreEnvelopeError
Batch Results – Acknowledge Submit	X12_999_SubmissionRequest_005010X231A1 X12_TA1_SubmissionRequest_005010X231A1	>>>>	
		<<<<	X12_Response_ConfirmReceiptReceived CoreEnvelopeError

4.7 SAFE HARBOR REAL TIME

4.7.1 SOAP+WSDL

- **Production SOAP Real Time**

<https://ediservices.medicaid.alabamaservices.org/PROD/CoreSoapServices/CoreRealTime.svc>

- **User Acceptance Test SOAP REAL TIME**

<https://ediservices.medicaid.alabamaservices.org/UAT/CoreSoapServices/CoreRealTime.svc>

4.7.2 HTTP MIME MULTIPART

- **Production MIME Real Time**

<https://ediservices.medicaid.alabamaservices.org/PROD/CoreMIMEServices/CoreTransactions.aspx>

- **User Acceptance Test MIME Real Time**

<https://ediservices.medicaid.alabamaservices.org/UAT/CoreMIMEServices/CoreTransactions.aspx>

4.7.3 SAFE HARBOR ALLOWED INCOMING/OUTGOING REAL TIME PAYLOAD TYPES

Type	Trading Partner	Safe Harbor	Alabama Medicaid
Real Time	X12_270_Request_005010X279A1 X12_276_Request_005010X212	>>>>	
		<<<<	X12_999_Response_005010231A1 X12_271_Response_005010X279A1 X12_277_Response_005010X212 CoreEnvelopeError

5 CONTACT INFORMATION

5.1 EDI CUSTOMER SERVICE/TECHNICAL ASSISTANCE

Electronic Media Claims Helpdesk

The Electronic Media Claims Helpdesk assists with Provider Electronic Solutions (PES) software, vendor-related issues, electronic transmission problems and pharmacy-related billing issues. The EMC Helpdesk also issues user IDs and passwords for the Agency's secure website portal.

For contact names, numbers and call center availability please see the EMC Help Desk website:

http://medicaid.alabama.gov/CONTENT/8.0>Contact/8.2.2_Electronic_Media_Claims_Helpdesk.aspx

5.2 PROVIDER SERVICES

Provider Relations Department

The Provider Relations Department is composed of field representatives who are committed to assisting Alabama Medicaid providers in the submission of claims and the resolution of claims processing concerns.

For contact names, numbers and call center availability please see the Provider Relations website:

http://medicaid.alabama.gov/CONTENT/8.0>Contact/8.2.7_Provider_Relations_Team.aspx

Provider Assistance Center

The Provider Assistance Center communication specialists are available to respond to written and telephone inquiries from providers on billing questions and procedures, claim status, form orders, adjustments, use of the Automated Voice Response System (AVRS), electronic claims submission and remittance advice (EOPs).

For contact names, numbers and call center availability please see the Provider Assistance Center website:

http://medicaid.alabama.gov/CONTENT/8.0>Contact/8.2.4_Provider_Assistance_Center.aspx

6 CONTROL SEGMENTS/ENVELOPES

6.1 ISA/IEA

Segment	Name	Codes	Notes/Comments
ISA	Interchange Control Header		
ISA01	Authorization Information Qualifier	00	'00' – No Authorization Information Present
ISA02	Authorization Information		[space fill]
ISA03	Security Information Qualifier	00	'00' – No Security Information Present
ISA04	Security Information		[space fill]
ISA05	Interchange ID Qualifier	ZZ	'ZZ' – Mutually Defined
ISA06	Interchange Sender ID		Use the Trading Partner ID assigned by Alabama Medicaid followed by the appropriate number of spaces to meet the minimum/maximum data element requirement of 15 bytes.
ISA07	Interchange ID Qualifier	ZZ	"ZZ" for Mutually Defined
ISA08	Interchange Receiver ID	752548221	Populate with Alabama Medicaid's Trading Partner ID followed by the appropriate number of spaces to meet the minimum/maximum data element requirement of 15 bytes.
ISA11	Repetition Separator	^	^ (carat)
ISA12	Interchange Control Version Number	00501	'00501' – Control Version Number
ISA14	Acknowledgement Requested	0	'0' – No Acknowledgment Requested
ISA15	Usage Indicator	T, P	'T' – Test Data 'P' – Production Data
ISA16	Component Element Separator	:	':'
IEA	Interchange Control Trailer		
IEA01	Number of Included Functional Groups		Number of Functional Groups (GS/GE)
IEA02	Interchange Control Number		Must be identical to ISA13

6.2 GS/GE

Segment	Name	Codes	Notes/Comments
GS	Functional Group Header		
GS02	Application Sender's Code		Trading Partner ID assigned by Alabama Medicaid. Same value as ISA06.
GS03	Application Receiver's Code	752548221	Alabama's Trading Partner ID. Same as in ISA08.
GS08	Version / Release / Industry Identifier Code		Version/Release/Industry Identifier Code including the applicable Addenda.
GE	Functional Group Trailer		
GE01	Number of Transaction Sets Included		Number of Transaction Sets (ST/SE)
GE02	Group Control Number		Must be identical to GS06

6.3 ST/SE

Segment	Name	Codes	Notes/Comments
ST	Transaction Set Header		
ST02	Transaction Set Control Number		Increment by 1 when multiple transaction sets are included. Must be identical to SE02.
ST03	Implementation Convention Reference		This element contains the same value as GS08.
SE	Transaction Set Trailer		
SE01	Number of Included Segments		Number of Segments included within the ST/SE segments.
SE02	Transaction Set Control Number		Must be identical to ST02

6.4 SAFE HARBOR CAQH CORE ENVELOPE

CAQH CORE Operating Rule 270 specifies the data elements which should be present in the CORE envelope. The following are payer-specific requirements for the envelope metadata elements.

ELEMENT	VALUE
Interchange Sender ID	Use the Trading Partner ID assigned by Alabama Medicaid
Interchange Receiver ID	Alabama Medicaid Interchange Receiver ID 752548221
Web Portal User Name	Web Portal Username
Web Portal Password	Web Portal Password
Payload ID	Payload ID must be unique for each batch or real time transaction submitted. See the CAQH CORE Rule 270 Connectivity Rule for instructions on generating a Payload ID. http://caqh.org/pdf/CLEAN5010/270-v5010.pdf

6.5 SAFE HARBOR CORE ENVELOPE ERRORS

Scenario	Error Response
Invalid username/password	The username/password or Client certificate could not be verified.
No Payload ID submitted	Set Payload ID and Resubmit.
Invalid Payload ID	The Incoming Payload ID is not defined as a properly formatted GUID. Please resubmit with a new and valid GUID.
Duplicate Payload ID	Payload ID [<i>PAYLOAD ID</i>] has been submitted on a prior transaction. Payload ID must be unique. Resubmit transaction with a unique GUID or UUID.

7 BUSINESS RULES AND LIMITATIONS

7.1 SAFE HARBOR RULES OF BEHAVIOR

Safe Harbor users should not send executable (.exe), portable document format (.pdf), or any other file type which is not a text document. Users must not deliberately submit batch files that contain viruses.

7.2 SAFE HARBOR CONNECTION LIMITATIONS

TBD

8 ACKNOWLEDGEMENTS AND REPORTS

8.1 WEB PORTAL ACKNOWLEDGEMENTS AND REPORTS

Proprietary Batch Response File (BRF)

A BRF file is returned for each batch of claims submitted which communicates the results of pre-adjudication editing.

Functional Acknowledgement (999)

The 999 will be returned for all files that have been successfully uploaded. This response is intended to convey HIPAA compliance errors.

Interchange Acknowledgement (TA1)

The TA1 will be returned for all files that have been successfully uploaded. This response is intended to report the status of processing on a received interchange header and trailer.

Health Care Claim Payment/Advice (835)

The Electronic Remittance Advice will be returned once a claims payment cycle has completed and will report all of the claims adjudicated to a paid or denied status. The claims payment cycle schedule can be found on the Alabama Medicaid website:

http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.2_Checkwrite_Schedules.aspx

Remittance Advice

The Paper Remittance Advice will be returned once a claims payment cycle has completed and will report all of the claims adjudicated to a paid, denied or suspended status. These paper remittance reports are available for download on the provider web portal..

Health Care Payer Unsolicited Claim Status (277U)

The Unsolicited Claim Status transaction is returned once a claims payment cycle has completed and will report all of the claims adjudicated to a suspended status. The claims payment cycle schedule can be found on the Alabama Medicaid website:

http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.2_Checkwrite_Schedules.aspx

8.2 SAFE HARBOR ACKNOWLEDGEMENTS AND REPORTS

Functional Acknowledgement (999)

The 999 will be returned for all files that have been successfully submitted through either batch mode or interactively. This response is intended to convey HIPAA compliance errors.

Interchange Acknowledgement (TA1)

The TA1 will be returned for all files that have been successfully submitted through batch mode. Interactively submitted transactions will return a 'System Processing Error' message if the interchange header and trailer are in error. This response is intended to report the status of processing on a received interchange header and trailer.

9 TRADING PARTNER AGREEMENTS

9.1 INCLUDED ASC X12 IMPLEMENTATION GUIDES

It is assumed that the trading partner has purchased and is familiar with the HIPAA Implementation Guides. These may be purchased through Washington Publishing Company.

<http://www.wpc-edi.com/>

The following HIPAA X12 transactions are accepted and processed by Alabama Medicaid:

005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)

005010X212 Health Care Claim Status Request and Response (276/277)

005010X217 Health Care Services for Review and Response (278)

005010X218 Payroll Deducted and Other Group Premium Payment (820)

005010X220A1 Benefit and Enrollment Maintenance (834)

005010X224A2 Health Care Claim - Dental (837 D)

005010X222A1 Health Care Claim - Professional (837 P)

005010X223A2 Health Care Claim - Institutional (837 I)

10 TRANSACTION SPECIFIC INFORMATION

10.1 005010X279A1 HEALTH CARE ELIGIBILITY BENEFIT INQUIRY AND RESPONSE (270/271)

This table contains one or more rows for each segment for which supplemental instruction is needed.

005010X279A1 ELIGIBILITY, COVERAGE OR BENEFIT INQUIRY (270)

Loop	Segment	Name	Codes	Comments
	BHT	Beginning of Hierarchical Transaction		
	BHT01	Hierarchical Structure Code	0022	'0022' – Information Source, Information Receiver, Subscriber, Dependent
	BHT02	Transaction Set Purpose Code	13	'13' – Request
2100B	NM1	Information Receiver Name		
	NM108	Identification Code Qualifier	XX	'XX' – Centers for Medicare and Medicaid Services National Provider Identifier
	NM109	Identification Code (Information Receiver Identification Number)		The National Provider ID must be submitted.
2100B	REF	Information Receiver Additional Identification		
	REF01	Reference Identification Qualifier	1D	When a provider's NPI is enrolled with more than one location, send the Medicaid Provider Number '1D' - Medicaid Provider Number.
	REF02	Reference Identification		Send the Medicaid Provider ID number. Alabama Medicaid Provider IDs may be six or nine characters in length. Send only the number of characters assigned by Alabama Medicaid (i.e. Do not add preceding or trailing zeros to a six-digit provider ID.)
2100B	N4	Information Receiver City, State, Zip Code		
	N403	Postal Code		For a provider with multiple locations submit the Zip + 4.
2100B	PRV	Information Receiver Provider Information		
	PRV02	Reference Identification Qualifier	PXC	For a provider with multiple locations, submit taxonomy information, 'PXC' - Health Care Provider Taxonomy Code
	PRV03	Reference Identification (Receiver Provider Taxonomy Code)		Provider's taxonomy code.
2100C	NM1	Subscriber Name		
	NM103	Subscriber Last Name		Alabama Medicaid will normalize the last name, please see section 8.1.1.4 for details on this process.
	NM108	Identification Code Qualifier	MI	'MI' - Member Identification Number
	NM109	Identification Code (Subscriber Primary Identifier)		If used, the Medicaid Recipient ID should be entered into the Identification Code.
2100C	REF	Subscriber Additional Identification		
	REF01	Reference Identification Qualifier	SY	'SY' - Social Security Number (SSN)

Loop	Segment	Name	Codes	Comments
	REF02	Reference Identification (Subscriber Supplemental Identifier)		If used, the Medicaid Recipient's SSN should be entered into the Reference Identification.
2100C	DMG	Subscriber Demographic Information		
	DMG01	Date Time Period Format Qualifier	D8	
	DMG02	Date Time Period	CCYYMMDD	Medicaid Recipient's Date of Birth
2110C	EQ	Subscriber Eligibility or Benefit Inquiry		When the subscriber is the patient whose eligibility is being requested, the EQ segment must be present.
	EQ01	Service Type Code		Alabama Medicaid will process Service Type Codes found on the Generic Code List or the Explicit Code List. See section 8.1.1.3 for a complete listing.
2110C	DTP	Subscriber Eligibility/Benefit Date		
	DTP01	Date/Time Qualifier	291	'291' - Plan
	DTP03	Subscriber Eligibility/Benefit Date	CCYYMMDD Or CCYYMMDD- CCYYMMDD	If the Date Time Period Format Qualifier (DTP02) is equal to 'D8', the Date Time Period (DTP03) must be in the format <i>CCYYMMDD</i> . If the Date Time Period Format Qualifier (DTP02) is equal to 'RD8', a date range in the format <i>CCYYMMDD-CCYYMMDD</i> must be input into the Date Time Period (DTP03). To receive current and previous year's data a user must enter request dates that occur in the current year and previous year to get both current and previous years data on a 271 response. Alabama Medicaid does not permit request for future eligibility. Examples: 270 Request dates: 01/01/2011 - 01/31/2011 - 271 response will only return the information for year 2011. 270 Request dates: 12/01/2010 - 12/27/2010 - 271 response will only return the information for year 2010. 270 Request dates: 12/27/2010 - 01/01/2011 - 271 response will return both 2010 and 2011 benefit information.
2000D		Dependent Level		Dependent Level information will not be supported by Alabama Medicaid when processing Eligibility, Coverage or Benefit Inquiries.

005010X279A1 ELIGIBILITY, COVERAGE OR BENEFIT INFORMATION (271)

Loop	Segment	Name	Codes	Comments
	BHT	Beginning of Hierarchical Transaction		
	BHT01	Hierarchical Structure Code	0022	'0022' - Information Source, Information Receiver, Subscriber, Dependent
	BHT02	Transaction Set Purpose Code	11	'11' - Response

Loop	Segment	Name	Codes	Comments
2100B	NM1	Information Receiver Name		
	NM108	Identification Code Qualifier		If a National Provider ID has been assigned, NM108 will equal 'XX'.
	NM109	Identification Code		NM109 will equal the Provider's National Provider ID.
2110C	EB	Subscriber Eligibility or Benefit Information		Alabama Medicaid will support the response to Generic and Explicit Service Type codes. Please see section 8.1.1.3 for examples of what to expect in the response for this segment.
2110C	MSG	Message Text		Alabama Medicaid will be returning additional message(s) when applicable and is based on the service type requested and the benefit plan the subscriber is actively enrolled with for the date of request. Please see section 8.1.1.5 for information on messages returned.
2000D		Dependent Level		Dependent Level information is not supported by Alabama Medicaid and will not be returned within an Eligibility, Coverage or Benefit Information transaction.

10.1.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

The information when applicable under this section is intended to help the trading partner understand the business context of the EDI transaction.

10.1.2 NATIONAL PROVIDER ID (NPI) VERIFICATION

Provider's should ensure the NPI submitted is valid based on the value issued by the National Plan & Provider Enumeration System (NPPES). All invalid NPI's submitted will fail a compliance check and will be returned as an error on the 999 transaction.

For more information please refer to the NPPES website:

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

10.1.3 MINIMUM REQUIREMENTS FOR ELIGIBILITY SEARCH

Providers will be required to submit a minimum amount of identification in order to verify eligibility on Recipients. The valid combinations are:

- Medicaid ID
- Name (Last Name, First Name, Middle Initial) and Date of Birth (DOB)
- SSN and DOB

Middle Initial may be entered, however Middle Initial is not required to verify eligibility and no searches will be performed based on the Middle Initial entered.

10.1.4 SERVICE TYPE CODE LIST

Service type code '30' submitted on the 270 eligibility request will be returned in the 271 eligibility response in addition to all of the other Generic Service Type codes. All other service type codes requested will be returned as requested in the 271 response.

Examples:

270 Request – Service Type Codes Requested	271 Response – Service Type Codes Returned
30	1, 30, 33, 35, 47, 48, 50, 86, 88, 98, AL, MH, UC
1	1
47, 48, 50	47, 48, 50

1, 12, 18	1, 12, 18
-----------	-----------

Generic Service Type Code table:

Generic Service Type Code	Description	Generic Service Type Code	Description
1	Medical Care	98	Professional (Physician) Visit -office
30	Health Benefit Plan Coverage	AL	Vision (Optometry)
33	Chiropractic	MH	Mental Health
35	Dental Care	UC	Urgent Care
47	Hospital		
48	Hospital - Inpatient		
50	Hospital - Outpatient		
86	Emergency Services		
88	Pharmacy		

Explicit Service Type Code table:

Explicit Service Type Code	Description	Explicit Service Type Code	Description
1	Medical Care	A0	Professional (Physician) Visit - Outpatient
2	Surgical	A3	Professional (Physician) Visit - Home
4	Diagnostic X-Ray	A6	Psychotherapy
5	Diagnostic Lab	A7	Psychiatric Inpatient
6	Radiation Therapy	A8	Psychiatric Outpatient
7	Anesthesia	AD	Occupational Therapy
8	Surgical Assistance	AE	Physical Medicine
12	Durable Medical Equipment Purchase	AF	Speech Therapy
13	Facility	AG	Skilled Nursing Care
18	Durable Medical Equipment Rental	AI	Substance Abuse
20	Second Surgical Opinion	AL	Vision (Optometry)
33	Chiropractic	BG	Cardiac Rehabilitation
35	Dental Care	BH	Pediatric
40	Oral Surgery	MH	Mental Health
42	Home Health Care	UC	Urgent Care
45	Hospice	80	Immunizations
47	Hospital	81	Routine Physical
48	Hospital - Inpatient	82	Family Planning
50	Hospital - Outpatient	86	Emergency Services
51	Hospital - Emergency Accident		
52	Hospital - Emergency Medical		
53	Hospital - Ambulatory Surgical		
62	MRI/CAT Scan		

Explicit Service Type Code	Description	Explicit Service Type Code	Description
65	Newborn Care		
68	Well Baby Care		
73	Diagnostic Medical		
76	Dialysis		
80	Immunizations		
81	Routine Physical		
82	Family Planning		
86	Emergency Services		
88	Pharmacy		
93	Podiatry		
98	Professional (Physician) Visit - Office		
99	Professional (Physician) Visit - Inpatient		

10.1.5 NAME NORMALIZATION

The following steps will be used to normalize the recipient last name:

1. Make all characters upper case
2. Remove ASC X12 special characters: ! ? & ' () * + , - . / : ; ? =
3. Remove all the prefixes and suffixes when preceded by a comma, space or forward slash and followed by a space or the end of the data field: JR, SR, I, II, III, IV, V, RN, MD, MR, MS, DR, MRS, PHD, REV, ESQ

Name Normalization Examples:

Submitted Last Name	Step 1: Convert to Upper Case	Step 2: Remove Prefix and Suffix Strings	Step 3: Remove ASC X12 Characters (Final Result)
Doe	DOE	DOE	DOE
Johnson III	JOHNSON III	JOHNSON	JOHNSON
Wilson Jr.	WILSON JR.	WILSON JR.	WILSON JR
El Amin	EL AMIN	EL AMIN	ELAMIN
apl.de.ap	APL.DE.AP	APL.DE.AP	APLDEAP
N9ne	N9NE	N9NE	N9NE
von Trier, MD	VON TRIER, MD	VON TRIER,	VON TRIER
Mr. St. John	MR. ST. JOHN	MR. ST. JOHN	MR ST JOHN

10.1.6 MESSAGES

Additional messages may be returned depending on the benefit plan the recipient is currently enrolled with and for specific service types requested. The following is a list of messages that may be returned with the eligibility response.

Messages

Coverage is dependent on being allowed/covered by Medicare for service type(s):
Dental Screening data may be returned, if applicable, for service type(s):
EPSDT referral required and Hearing Screening data may be returned, if applicable for service type(s):
EPSDT referral required for service type(s):

Hearing Screening data may be returned, if applicable for service type(s):
Hearing Screening data may be returned, if applicable. Coverage is dependent on being allowed/covered by Medicare for service type(s):
Lockin data may be returned, if applicable, for service type(s):
LTC waiver data may be returned, if applicable, for service type(s):
Medical Screening data may be returned, if applicable, for service type(s):
Medical Screening data may be returned, if applicable. Coverage is dependent on being allowed/covered by Medicare for service type(s):
Only covered for family planning related services for service type(s):
Only covered for pregnancy and family planning related services for service type(s):
Service type code(s): not recognized by Alabama Medicaid
Vision Screening data may be returned, if applicable, for service type(s):

10.1.7 INTERACTIVE SUBMISSIONS

For interactive processing, submit one transaction at a time.

10.1.8 NUMBER OF REQUEST

Expected maximum allowed per day per submitter between the hours of 5:00 a.m. CT and 2:00 a.m. CT is 10,000 eligibility request per batch file up to 250,000 maximum eligibility request per day.

- If a 270 batch file submitted exceeds the maximum allowed per batch file the submitter should split the request into multiple batch files and resubmit.
- If the total maximum 270 request has been reached for the day, a submitter may resume submissions on the following day.
- A TA1 will be returned to any submitter that exceeds the maximum allowed per batch and maximum allowed per day (TA104=E and TA105=000).

10.2 005010X212 Health Care Claim Status Request and Response (276/277)

This table contains one or more rows for each segment for which supplemental instruction is needed.

005010X212 HEALTH CARE CLAIM STATUS REQUEST (276)

Loop	Segment	Name	Codes	Comments
BHT	BHT	Beginning of Hierarchical Transaction		Number assigned by the originator to identify the transaction within the originator's business application system.
	BHT01	Hierarchical Structure Code	0010	'0010' - Information Source, Information Receiver, Provider of Service, Subscriber, Dependent
	BHT02	Transaction Set Purpose Code	13	'13' - Request
	BHT03	Reference Identification		Number assigned by the originator to identify the transaction within the originator's business application system.
2100A	NM1	Payer Name		
	NM101	Entity Identifier Code	PR	'PR' - Payer
	NM102	Entity Type Qualifier	2	'2' - Non-Person Entity
2100C	NM1	Service Provider Name		
				Original Billing Provider of the claim for which a status is requested.
	NM108		XX	
	NM109			National Provider ID (NPI)
2000D	DMG	Subscriber Demographic Information		Required when the patient is the subscriber.
	DMG01	Date Time Period Format Qualifier	D8	
	DMG02	Date Time Period	CCYYMMDD	Alabama Medicaid Recipient Date of Birth
2100D	NM1	Subscriber Name		
	NM108	Identification Code Qualifier	MI	
	NM109	Identification Code (Subscriber Identifier)		The full 13 digit Alabama Medicaid Recipient ID
2200D	REF	Payer Claim Control Number		
	REF02	Reference Identification (Payer Claim Control Number)		If used, the Internal Control Number (ICN) will be populated in the Reference Identification.
2200D	AMT	Claim Submitted Charges		
	AMT01	Amount Qualifier Code	T3	
	AMT02	Total Claim Charge Amount		Submit the original billed amount
2200D	DTP	Claim Service Date		
	DTP03	Claim Service Period	CCYYMMDD Or CCYYMMDD- CCYYMMDD	Claim dates of service
2210D	SVC	Service Line Information		The 2210D loop should only be used for Pharmacy claims. Only one occurrence of the 2210D loop should be used.
	SVC01-1	Product/Service ID Qualifier	ND	For Pharmacy Claims, the Product/Service ID Qualifier must be 'ND'.
	SVC01-2	Product/Service ID (Procedure Code)		For Pharmacy Claims, the Product/Service ID must be populated with the 11 digit NDC Number.
2000E		Dependent Level		Dependent Level information will not be supported by Alabama Medicaid when processing Health Care Claim Status Notification requests.

005010X212 HEALTH CARE CLAIM STATUS RESPONSE (277)

Loop	Segment	Name	Codes	Comments
2100C	NM1	Service Provider		
	NM108	Identification Code Qualifier	XX	
	NM109	Provider Identifier		The Billing Provider NPI will be returned
2200D	STC	Claim Level Status Information		
	STC02	Statue Information Effective Date	CCYYMMDD	The effective date of the status returned for the claim
	STC03	Total Claim Charge Amount		Original billed amount
	STC04	Claim Payment Amount		Claim payment amount
2200D	REF	Payer Claim Control Number		
	REF01	Reference Identification Qualifier	1K	
	REF02	Payer Claim Control Number		Internal Control Number (ICN)
2220D	STC	Service Line Status Information		
	STC02	Statue Information Effective Date	CCYYMMDD	The effective date of the status returned for the claim
2220D	DTP	Service Line Date		
	DTP01	Date/Time Qualifier	472	
	DTP02	Date Time Period Format Qualifier	RD8	
	DTP03	Service Line Date	CCYYMMDD-CCYYMMDD	
2000E		Dependent Level		Dependent Level information is not supported by Alabama Medicaid and will not be returned within a Health Care Claim Response transaction.

10.2.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

The information when applicable under this section is intended to help the trading partner understand the business context of the EDI transaction.

10.2.2 NATIONAL PROVIDER ID (NPI) VERIFICATION

Provider's should ensure the NPI submitted is valid based on the value issued by the National Plan & Provider Enumeration System (NPPES). All invalid NPI's submitted will fail a compliance check and will be returned as an error on the 999 transaction.

For more information please refer to the NPPES website:

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

10.2.3 MINIMUM DATA REQUIRED

Providers will be required to submit a minimum amount of information on the Health Care Claim Status Notification request.

The minimum data fields for a batch submission are:

- Medicaid ID (Recipient ID (RID))
- Claim Dates of Service
- Header Claim Submitted Charges

The minimum data fields for an interactive submission are:

- Medicaid ID (Recipient ID (RID))
- Claim Dates of Service
- Header Claim Submitted Charges

- Internal Control Number (ICN)

10.2.4 INTERACTIVE SUBMISSIONS

- For interactive processing, submit one transaction at a time.
- The Internal Control Number must be submitted on an interactive transaction to receive a response.
- Alabama Medicaid will only give status replies for claims that have been accepted in the claims system within the past 90 days or less.

10.2.5 NUMBER OF REQUEST

Expected maximum allowed is 25 batches per day, of any size up to 999 requests.

10.3 005010X217 Health Care Services for Review and Response (278)

This table contains one or more rows for each segment for which supplemental instruction is needed.

005010X217 HEALTH CARE SERVICES REVIEW INFORMATION - REVIEW (278)

Loop	Segment	Name	Codes	Comments
	BHT	Beginning of Hierarchical Transaction		
	BHT02		13	'13' - Request
	BHT06	Transaction Type Code	RU	'RU' – Medical Services Reservation It is suggested to use RU when requesting Medical Services Reservation.
2010B	NM1	Requester Name		
	NM101	Entity Identifier Code	1P FA	'1P' – Provider 'FA' – Facility
	NM108	Identification Code Qualifier	XX	Use 'XX' - Centers for Medicare and Medicaid Services National Provider Identifier.
	NM109	Identification Code		The Provider's National Provider ID
2010B	N4	Requester City, State, Zip Code		
	N403	Postal Code		For a provider with multiple locations, submit the Zip + 4.
2010B	PER	Requester Contact Information		
	PER01	Contact Function Code	IC	'IC' – Information Contact
	PER02	Name (Requester Contact Name)		Used when the supplied name is different than the name supplied in the NM1 segment of this loop.
	PER03	Communication Number Qualifier		Used when PER02 is not valued to transmit a contact communication number. This field consists of one email address (UR), one phone number and one fax number in the other PER fields.
2010B	PRV	Requester Provider Information		
	PRV02	Reference Identification Qualifier	PXC	For a provider with multiple locations, submit taxonomy information. 'PXC' – Health Care Provider Taxonomy Code
	PRV03	Reference Identification (Provider Taxonomy Code)		Provider's taxonomy code
2010C	NM1	Subscriber Name		
	NM108	Identification Code Qualifier	MI	'MI' – Member Identification
	NM109	Identification Code (Subscriber Member Number)		Alabama Medicaid Recipient Identifier
2010C	REF	Subscriber Supplemental Information		
	REF01	Reference Identification Qualifier	EJ	'EJ' – Patient Account Number
	REF02	Reference Identification (Subscriber Supplemental Identifier)		Patient Account Number
2000D	HL	Dependent Level		
				Dependent Level information will not be supported by Alabama Medicaid when processing Health Care Services Review transactions.
2000E	UM	Health Care Services Review Information (Patient Event Level)		

Loop	Segment	Name	Codes	Comments
	UM01	Request Category Code	HS	'HS' – Health Care Services Review Alabama Medicaid expects 'HS' for all PA request types.
	UM02	Certification Type Code	I	'I' - Initial
2000E	DTP	Accident Date		If an accident is involved with this patient event, report the accident date.
2000E	DTP	Event Date		If UM01 = HS, use this field for service start and stop dates. Dates entered in this loop will be applied to all of the service lines if a 2000F DTP segment is not present.
	DTP01	Date/Qualifier Code	AAH	'AAH' - Event
	DTP02	Date Time Period Format Qualifier	D8 RD8	'D8' – CCYYMMDD 'RD8' – CCYYMMDD-CCYYMMDD
	DTP03	Proposed or Actual Event Date		If D8 is submitted then the date will be applied as both the start and stop date.
2000E	DTP	Admission Date		Per the X12 guide If UM01 = AR use Admit Date. Alabama Medicaid expects UM01 = HS and dates of service for the authorization request be submitted in the 2000E DTP event date segment.
2000E	HI	Patient Diagnosis (Health Care Information Codes)		Only one diagnosis code is retained for a PA. Send BK for transactions with ICD-9 diagnosis codes for service dates prior to the CMS ICD-10 Mandate date and ABK for transactions with ICD-10 diagnosis codes for service dates equal to or greater than the CMS ICD-10 Mandate date as the primary diagnosis qualifier. Only use one or the other not both.
				Although ICD-10 values may be submitted only ICD-9 values will be accepted until ICD10 CMS Mandate date is implemented.
2000E	CR6	Home Health Care Information		
	CR603	Date Time Period Format Qualifier	RD8	'RD8' – CCYYMMDD-CCYYMMDD
	CR604	Home Health Certification Period		Expected dates of certification for home health to be populated with the actual service dates carried in the 2000F DTP service date segment.
2000E	MSG	MSG Text		
				Required when needed to transmit a text message about the patient event.
2010EC		Patient Event Provider Name		Only one servicing provider is applicable per PA therefore the 1 st occurrence of the 2010EC loop will be applied to the PA. If 2010F is present, this information overrides the 2010EC submitted values and only the 1 st occurrence of this loop will be applied to the PA. All subsequent occurrences of the 2010EC and 2010F loops will be ignored.
	NM108	Identification Code Qualifier	XX	'XX' - Centers for Medicare and Medicaid Services National Provider Identifier.
	NM109	Patient Event Provider		NPI

Loop	Segment	Name	Codes	Comments
		Identifier		
2010EA	REF	Patient Event Provider Supplemental Information		
	REF01	Reference Identification Qualifier	ZH	'ZH' – Carrier Assigned Reference Number
	REF02	Patient Event Provider Supplemental Identification		Alabama Medicaid ID to assist with identifying the specific service location.
	REF01	Reference Identification Qualifier	ZZ	'ZZ' – Mutually Defined
2000F	UM	Health Care Services Review Information		This information is expected to be sent at the 2000E Patient Event Level.
2010F		Service Provider Name		Only one servicing provider is applicable per PA therefore the 1 st occurrence of the 2010EA loop will be applied to the PA. If 2010F is present, this information overrides the 2010EA submitted values and only the 1 st occurrence of this loop will be applied to the PA. All subsequent occurrences of the 2010EA and 2010F loops will be ignored.

005010X217 HEALTH CARE SERVICES REVIEW INFORMATION - RESPONSE (278)

Loop	Segment	Name	Codes	Comments
	BHT	Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose Code	11	'11' - Response
2010B	NM1	Requester Name		
	NM108	Identification Code Qualifier	XX	'XX' - Centers for Medicare and Medicaid Services National Provider Identifier.
	NM109	Identification Code (Requester Identifier)		NPI
2000E	MSG	Message Text		
	MSG01			ACCEPTED - PENDING FURTHER REVIEW
2000D	HL	Dependent Level		Dependent Level information will not be supported by Alabama Medicaid when processing Health Care Services Review transactions.
2000F	HCR			
	HCR01	Certification Action Code	A4	'A4' – Pended All accepted PA records will be initially assigned a Pending status
	HCR02	Review Identification Number		Alabama Medicaid assigned Prior Authorization Number.
	HCR03	Review Decision Reason Code	0V	Requires Medical Review

10.3.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

The information when applicable under this section is intended to help the trading partner understand the business context of the EDI transaction.

10.3.2 NATIONAL PROVIDER ID (NPI) VERIFICATION

Provider's should ensure the NPI submitted is valid based on the value issued by the National Plan & Provider Enumeration System (NPPES). All invalid NPI's submitted will fail a compliance check and will be returned as an error on the 999 transaction.

For more information please refer to the NPPES website:

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

10.3.3 PRIOR AUTHORIZATION SPECIFICATIONS

- Alabama Medicaid is expecting a single servicing provider per PA and would prefer that this be submitted in the 2010EA Loop.
- Alabama Medicaid is expecting a single diagnosis code per PA, so only HI01-2 is necessary.
- Alabama Medicaid is not expecting different service types to be combined on a single PA.
- Pharmacy Prior Authorizations are created outside of the 278 process and therefore a service type code of '88' is not expected and will be denied.
- Alabama Medicaid expects only a Procedure Code to be submitted within an SV1 segment and only a Revenue Code within an SV2 segment.
- When applicable the MSG segment will return specific descriptive error messages when a PA fails to process for any reason.

Expected submission examples:

2000E	Health Care Service Review Information
	HI01-2
2010EA	Service Provider
2000F	SV1
	SV1

2000E	Health Care Service Review Information
	HI01-2
2010EA	Service Provider
2000F	SV3
	TOO
	SV3
	TOO
	TOO

Unexpected submission example:

2000E	Health Care Service Review Information
	HI01-2, HI02-2, HI03-2
2010EA	Service Provider A
2000F	SV1
2010F	Service Provider B
	SV2
2010F	Service Provider C
	SV3
2010F	Service Provider D

10.4 005010X218 Payroll Deducted and Other Group Premium Payment (820)

This table contains one or more rows for each segment for which supplemental instruction is needed.

005010X218 PAYROLL DEDUCTED AND OTHER GROUP PREMIUM PAYMENT (820)

Loop	Segment	Name	Codes	Comments
	BPR	Financial Information		
	BPR01	Transaction Handling Code	I	'I' – Remittance Information Only
	BRP03	Credit/Debit Flag	C	'C' - Credit
	BRP04	Payment Method Code	NON	'NON' – Non-Payment Data
	BRP10	Originating Company Identifier	752548221	'752548221' - Trading Partner ID for Alabama Trading Partner.
	TRN	Reassociation Trace Number		
	TRN01	Trace Type Code	3	'3' – Financial Reassociation Trace Number
	REF	Premium Receiver's Identification Key		
	REF01	Reference Identification Qualifier	14	'14' – Master Account Number
	REF02	Reference Identification		Value assigned as the master account number.
	DTM	Coverage Period		
	DTM01	Date Time Qualifier	582	'582' – Report Period
1000A	N1	Premium Receiver's Name		
	N103	Identification Code Qualifier	FI	'FI' – Federal Taxpayer's Identification Number
	N104	Identification Code		Alabama Medicaid Federal Taxpayer ID Number
1000B	N1	Premium Payer's Name		
	N101	Entity Identifier Code	PR	'PR' - Payer
	N102	Name		'ALABAMA MEDICAID'
	N103	Identification Code Qualifier	FI	'FI' – Federal Taxpayer's Identification Number
	N104	Identification Code		'752548221'
2000B	ENT	Individual Remittance		
	ENT01	Assigned Number		Unique value. Will start at "1" and increment by 1 for each occurrence of the ENT within the ST/SE.
	ENT02	Entity ID Code	2J	'2J' – Individual
	ENT03	Identification Code Qualifier	EI	'EI' – Employee Identification Number
	ENT04	Identification Code		Employee Identification Number
2100B	NM1	Individual Name		
	NM101	Entity Identifier Code	IL	'IL' – Insured or Subscriber
	NM103	Name Last		Recipient Last Name
	NM104	Name First		Recipient First Name
	NM108	Identification Code Qualifier	N	'N' – Insured's Unique Identification Number
	NM109	Identification Code		Recipient Identification Number
2300B	RMR	Individual Premium Remittance Detail		
	RMR01	Reference Identification Qualifier	AZ	'AZ' – Health Insurance Policy Number
	RMR02	Insurance Remittance Reference Number		Unique ID that is related to the recipient's history payment.
	RMR04	Detail Premium Payment Amount		Payment Amount for the recipient.
2300B	DTM	Individual Coverage Period		
	DMT01	Date Time Qualifier	582	'582' – Report Period
2320B	ADX	Individual Premium Adjustment for Current Payment		
	ADX01	Adjustment Amount		The amount of the adjustment.

Loop	Segment	Name	Codes	Comments
	ADX02	Adjustment Reason Code	52	'52' – Credit for Previous Overpayment
			53	'53' – Remittance for Previous Underpayment

10.4.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

The information when applicable under this section is intended to help the trading partner understand the business context of the EDI transaction.

10.5 005010X220A1 BENEFIT AND ENROLLMENT MAINTENANCE (834)

This table contains one or more rows for each segment for which supplemental instruction is needed.

005010X220A1 BENEFIT AND ENROLLMENT MAINTENANCE (834)

Loop	Segment	Name	Codes	Comments
	BGN	Beginning Segment		
	BGN01	Transaction Set Purpose Coe	00	'00' - Original
	BGN05	Time Zone Code	CT	'CT' - Central Time
	BGN08	Action Code	2 4	'2' - Change (Daily update) '4' - Verify (Full file)
	REF	Reference Identification - Transaction Set Policy Number		
	REF01	Reference Identification Qualifier	38	'38' - Master Policy Number
	REF02	Reference Identification		Alabama Medicaid
1000A	N1	Sponsor Name		
	N101	Entity Identifier Cod	P5	'P5' - Plan Sponsor
	N102	Name		Alabama Medicaid
	N103	Identification Code Qualifier	FI	'FI' - Federal Taxpayer's Identification Number
	N104	Identification Code		752548221
1000B	N1	Premium Payer's Name		
	N101	Entity Identifier Code	IN	'IN' - Insurer
	N102	Name		Alabama Medicaid
	N103	Identification Code Qualifier	FI	'FI' - Federal Taxpayer's Identification Number
	N104	Identification Code		752548221
2000	INS	Member Level Detail		
	INS01	Yes/No Condition or Response Code (Subscriber Indicator)	Y	'Y' - Yes
	INS02	Individual Relationship Code	18	'18' - Self
	INS03	Maintenance Type Code	001 030	'001' - Change (Daily update) '030' - Audit or Compare (Full audit)
	INS04	Maintenance Reason Code	AI XN	'AI' - No Reason Given 'XN' - Notification Only
	INS05	Benefit Status Code	A	'A' - Active
	INS06-1	Medicare Eligibility Reason Code	A B C	'A' - Medicare Part A 'B' - Medicare Part B 'C' - Medicare Part A and B
	INS08	Employment Status Code	AC	'AC' - Active
	INS11	Date Time Period Format Qualifier	D8	'D8' - Date expressed in format CCYYMMDD
2000	REF	Subscriber Identifier		
	REF01	Reference Identification Qualifier	0F	'0F' - Subscriber Number
	REF01	Reference Identification Qualifier	1L	'1L' - Group or Policy Number. The value for the corresponding REF02 will contain the same value as the Subscriber Number (REF01 = 0F).
	REF01	Reference Identification Qualifier	ZZ	'ZZ' - Mutually Defined Social Security Number of the Alabama recipient
2100A	NM1	Member Name		
	NM101	Entity Identifier Code	74 IL	'74' - Corrected Insured 'IL' - Insured or Subscriber
	NM102	Entity Type Qualifier	1	'1' - Person
	NM108	Identification Code Qualifier	34	'34' - Social Security Number
2100A	PER	Member Communications		

Loop	Segment	Name	Codes	Comments
		Numbers		
	PER01	Contact Function Code	IP	'IP' – Insured Party
	PER03	Communication Number	TE	'TE' – Telephone
2100A	DMG	Member Demographics		
	DMG01	Date Time Period Format Qualifier	D8	'D8' – Date expressed in formation CCYYMMDD
	DMG03	Gender Code	F M U	'F' – Female 'M' – Male 'U' – Unknown
2100A	ICM	Member Income		
	ICM01	Frequency Code	U	'U' – Unknown
2100B	NM1	Incorrect Member Name		
	NM103	Prior Incorrect Member Last Name		Corrected name will be sent on the Daily Report.
	NM104	Prior Incorrect Member First Name		Corrected name will be sent on the Daily Report.
	NM105	Prior Incorrect Member Middle Name		Corrected name will be sent on the Daily Report.
	NM108	Identification Code Qualifier	ZZ	'ZZ' – Mutually Defined Previous SSN for AL recipient.
2100G	NM1	Responsible Person		
	NM101	Entity Identifier Code	QD	'QD' – Responsible Party Loop may repeat more than once for Member's Payee Information and Member's Sponsor Information.
2300	HD	Health Coverage		
	HD01	Maintenance Type Code	001 030	'001' – Change '030' – Audit or Compare For each Member, any eligibility in previous month and current month will be reported.
2310	PLA	Provider Change Reason		If the Provider effective date (PLA03) reported is end of month, this indicates the Provider assignment has ended effective as of this date and will be followed by the appropriate stop reason (PLA05). If the Provider effective date (PLA03) reported is start of month, this indicates the Provider assignment is effective beginning as of this date and will be followed by the appropriate start reason (PLA05).

10.5.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

The information when applicable under this section is intended to help the trading partner understand the business context of the EDI transaction.

- Monthly Report

The monthly is sent initially for the first time and subsequently by request only after this.

All recipients who have had any eligibility since previous month will be reported.

For each recipient, any Managed Care PMP assignment for previous month, current month and any future assignments will be reported.

- Daily Report

If a change has been made to a recipients information, the actual change is not reported, but reported will be all the current recipient data on file.

For each recipient, any Managed Care PMP assignment for previous month, current month and any future assignments will be reported.

10.6 005010X224A2 Health Care Claim - Dental (837 D)

This table contains one or more rows for each segment for which supplemental instruction is needed.

005010X224A2 HEALTH CARE CLAIM - DENTAL (837 D)

Loop	Segment	Name	Codes	Comments
1000A	PER	Submitter EDI Contact Information		The contact information in this segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
	PER01	Contact Function Code	IC	'IC' – Information Contact
	PER02	Submitter Contact Name		
	PER03	Communication Number Qualifier	EM FX TE	'EM' – Electronic Mail 'FX' – Facsimile 'TE' - Telephone
	PER04	Communication Number		Email Address, Fax Number or Telephone Number (including the area code)
2000A	PRV	Billing Provider Specialty Information		
	PRV01	Provider Code	BI	'BI' - Billing
	PRV02	Reference Identification	PXC	'PXC' - Health Care Provider Taxonomy Code
	PRV03	Provider Taxonomy Code		When the rendering provider is the same as the billing provider, the billing provider's taxonomy code should be used.
2010AA	N3	Billing Provider Address		The Billing Provider Address must be a street address.
2010AA	N4	Billing Provider City, State, Zip Code		
	N403	Postal Code		When reporting the ZIP code for U.S. submit the Zip + 4.
2010BA	NM1	Subscriber Name		This is the identifier from the subscriber's identification card (ID card).
	NM101	Entity Identifier Code	IL	'IL' - Subscriber
	NM102	Entity Type Qualifier	1	'1' – Person Alabama Medicaid subscribers are individuals. '1' is the only expected value.
	NM108	Identification Code Qualifier	MI	Member Identification Number qualifier must be submitted.
	NM109	Subscriber Primary Identifier		Alabama Medicaid Recipient ID.
2010BA	REF	Subscriber Secondary Identification		
	REF01	Reference Identification Qualifier	SY	If used, the Reference Identification Qualifier will be equal to 'SY' Social Security Number.
	REF02	Subscriber Supplemental Identifier		If used, the SSN should be entered.
2010BB	REF	Billing Provider Secondary Identification		'1D' - Medicaid Provider Number is being replaced by 'G2' - Provider Commercial Number.
	REF01	Reference Identification Qualifier	G2	'G2' - Provider Commercial Number
	REF02	Billing Provider Secondary Identifier		Alabama Medicaid Provider ID.
2000C		Patient Hierarchical Level		Dependent Level information will not be supported by Alabama Medicaid when processing Dental Health Care Claims.

Loop	Segment	Name	Codes	Comments
2300	DTP	Service Date		
				Alabama Medicaid expects the service dates to be entered for each service line submitted in the 2400 Loop.
2300	DN1	Orthodontic Total Months of Treatment		Required when the claim contains services related to treatment for orthodontic purposes.
	DN101	Quantity		The estimated number of treatment months.
	DN102	Quantity		The number of treatment months remaining.
2300	DN2	Tooth Status		Required when the submitter is reporting a missing tooth or a tooth to be extracted in the future.
	DN201	Tooth Number		The Universal National Tooth Designation System must be used to identify tooth numbers for this element.
	DN202	Tooth Status Code	E M	'E' - To Be Extracted 'M' - Missing
	DN206	Code List Qualifier Code		Code Source 135: American Dental Association
2300	REF	Payer Claim Control Number (ICN/ DCN)		
	REF01	Reference Identification Qualifier	F8	'F8' - Original Reference Number
	REF02	Payer Claim Control Number		Use this segment if an adjustment needs to be made to a previously paid claim. This will equal the original Internal Control Number (ICN) that was assigned to the paid claim.
2310A	PRV	Referring Provider Specialty Information		
	PRV01	Provider Code	RF	'RF' - Referring
	PRV02	Reference Identification	PXC	'PXC' - Health Care Provider Taxonomy Code
	PRV03	Provider Taxonomy Code		If used, should equal the Referring Provider's taxonomy code.
2310A	REF	Referring Provider Secondary Identification		'1D' - Medicaid Provider Number is being replaced by 'G2' - Provider Commercial Number.
	REF01	Reference Identification Qualifier	G2	'G2' - Provider Commercial Number
	REF02	Referring Provider Secondary Identifier		Alabama Medicaid Provider ID.
2310B	PRV	Rendering Provider Specialty Information		
	PRV01	Provider Code	PE	'PE' - Performing
	PRV02	Reference Identification	PXC	'PXC' - Health Care Provider Taxonomy Code
	PRV03	Provider Taxonomy Code		If used, should equal the Rendering Provider's taxonomy code.
2310B	REF	Rendering Provider Secondary Identification		'1D' - Medicaid Provider Number is being replaced by 'G2' - Provider Commercial Number.
	REF01	Reference Identification Qualifier	G2	'G2' - Provider Commercial Number
	REF02	Rendering Provider Secondary Identifier		Alabama Medicaid Provider ID.
2310C	N4	Service Facility Location City, State, Zip Code		

Loop	Segment	Name	Codes	Comments
	N403	Postal Code		When reporting the ZIP code for U.S. submit the Zip + 4.
2320	SBR	Other Subscriber Information		
	SBR03	Reference Identification		Insured Group or Policy Number.
2330A	NM1	Other Subscriber Name		
	NM108	Identification Code Qualifier	MI	'MI' - Member Identification Number
	NM109	Identification Code		Other Insured Identifier; Policy Number for other insurance.
2330A	REF	Other Subscriber Secondary Identification		
	REF01	Reference Identification Qualifier	SY	'SY' - Social Security Number
	REF02	Other Subscriber Name		If the Other Subscriber SSN is known, it should be reported.
2330D	REF	Other Payer Rendering Provider Secondary Identification		'1D' - Medicaid Provider Number is being replaced by 'G2' - Provider Commercial Number.
	REF01	Reference Identification Qualifier	G2	'G2' - Provider Commercial Number
	REF02	Rendering Provider Secondary Identifier		Alabama Medicaid Provider ID.
2400	SV3	Dental Service		
	SV304	Oral Cavity Designation		Only one oral cavity designation code should be submitted per service line detail.
	SV306	Quantity		Use this segment to submit the number of units to be applied to the dental service. Expected values are 1 or greater.
2400	DTP	Date Service Date		
	DTP01	Date/Time Qualifier	472	'427' - Service
	DTP02	Date Time Period Format Qualifier	D8	
	DTP03	Date Time Period	CCYYMMDD	Service Date
2420A	REF	Rendering Provider Secondary Identification		'1D' - Medicaid Provider Number is being replaced by 'G2' - Provider Commercial Number.
	REF01	Reference Identification Qualifier	G2	'G2' - Provider Commercial Number
	REF02	Rendering Provider Secondary Identifier		Alabama Medicaid Provider ID
2420D	N4	Service Facility Location City, State, Zip Code		
	N403	Postal Code		When reporting the ZIP code for U.S. addresses submit the Zip + 4.

10.6.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

The information when applicable under this section is intended to help the trading partner understand the business context of the EDI transaction.

10.6.2 NATIONAL PROVIDER ID (NPI) VERIFICATION

Provider's should ensure the NPI submitted is valid based on the value issued by the National Plan & Provider Enumeration System (NPPES). All invalid NPI's submitted will fail a compliance check and will be returned as an error on the 999 transaction.

For more information please refer to the NPPES website:

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

10.7 005010X222A1 Health Care Claim – Professional (837 P)

This table contains one or more rows for each segment for which supplemental instruction is needed.

005010X222A1 HEALTH CARE CLAIM – PROFESSIONAL (837 P)

Loop	Segment	Name	Codes	Comments
	BHT	Beginning Hierarchial Transaction		
	BHT06	Transaction Type Code	RP	Maternity Care District Providers submitting encounter claims: Submit 'RP' Reporting to indicate the file submitted contains encounter claims. For all other claim submissions 'CH' should be submitted.
1000A	PER	Submitter EDI Contact Information		The contact information in this segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter's organization.
	PER01	Contact Function Code	IC	'IC' – Information Contact
	PER02	Name		
	PER03	Communication Number Qualifier	EM FX TE	'EM' – Electronic Mail 'FX' – Facsimile 'TE' – Telephone
	PER04	Communication Number		Email Address, Fax Number or Telephone Number (including the area code)
2000A	PRV	Billing Provider Specialty Information		
	PRV01	Provider Code	BI	'BI' – Billing
	PRV02	Reference Identification	PXC	'PXC' – Health Care Provider Taxonomy Code
	PRV03	Provider Taxonomy Code		When the rendering provider is the same as the billing provider, the billing provider's taxonomy code should be used.
2010AA		Billing Provider Name		Maternity Care District Providers submitting encounter claims: Group Provider or Individual Provider that rendered the service.
2010AA	N3	Billing Provider Address		The Billing Provider Address must be a street address.
2010AA	N4	Billing Provider City, State, Zip Code		
	N403	Postal Code		When reporting the ZIP code for U.S. addresses submit the Zip + 4.
2010BA	NM1	Subscriber Name		This is the identifier from the subscriber's identification card (ID card).
	NM101	Entity Identifier Code	IL	'IL' - Subscriber
	NM102	Entity Type Qualifier	1	'1' – Person Alabama Medicaid subscribers are individuals. '1' is the only acceptable value.
	NM108	Identification Code Qualifier	MI	'MI' - Member Identification Number
	NM109	Subscriber Primary Identifier		Alabama Medicaid Recipient ID.
2010BA	REF	Subscriber Secondary Identification		
	REF01	Reference Identification Qualifier	SY	If used, the Reference Identification Qualifier will be equal to 'SY' Social Security Number.
	REF02	Subscriber Supplemental Identifier		If used, the SSN should be entered.

Loop	Segment	Name	Codes	Comments
2010BB	REF	Billing Provider Secondary Identification		'1D' - Medicaid Provider Number is being replaced by 'G2' - Provider Commercial Number.
	REF01	Reference Identification Qualifier	G2	If used, should equal 'G2' Provider Commercial Number.
	REF02	Reference Identification		For crossover claims, REF02 will contain the Billing Provider's Medicare number. Otherwise, REF02 will contain the Billing Provider's Medicaid ID number.
2000C		Patient Hierarchical Level		Dependent Level information will not be supported by Alabama Medicaid when processing Professional Health Care Claims.
2300	CLM	Claim Information		
	CLM05-3	Claim Frequency Type Code	1,8	Maternity Care District Providers submitting encounter claims: Only new day claims and voids to originally submitted claims should be submitted.
2300	REF	Service Authorization Exception Code		If used, choose the best value to indicate the type of Maternity Override or if the service was due to an emergency.
	REF01	Reference Identification Qualifier	4N	'4N' - Special Payment Reference Number
	REF02	Service Authorization Exception Code	3 5 6 7	Alabama Medicaid will use the codes as follows: '3' - Emergency Care '5' - Bypass Maternity Care Provider Contract Check '6' - Claim exempt from Maternity Care Program edits '7' - Force into Maternity Care Program
2300	REF	Payer Claim Control Number		Use this segment if an adjustment needs to be made to a previously paid claim.
	REF01	Reference Identification Qualifier	F8	'F8' - Original Reference Number
	REF02	Payer Claim Control Number		This will equal the original Internal Control Number (ICN) that was assigned to the paid claim. Maternity Care District Providers submitting encounter claims: Submit the original Internal Control Number (ICN) that was assigned to the claim submitted or the Transaction Control Number (TCN) originally assigned to the original claim by the Maternity Care District.
2310A	REF	Referring Provider Secondary Identification		'1D' - Medicaid Provider Number is being replaced by 'G2' - Provider Commercial Number.
	REF01	Reference Identification Qualifier	G2	If used, should equal 'G2' Provider Commercial Number.
	REF02	Referring Provider Secondary Identifier		If used, should equal the Referring Provider's Medicaid ID.
2310B	PRV	Rendering Provider Specialty Information		Alabama Medicaid does use the provider's taxonomy code for adjudication.
	PRV02	Reference Identification Qualifier	PXC	'PXC' - Health Care Provider Taxonomy Code
	PRV03	Provider Taxonomy Code		When the rendering provider is different than the billing provider the rendering provider's taxonomy code should be used.

Loop	Segment	Name	Codes	Comments
2310B		Rendering Provider Name		Maternity Care District Providers submitting encounter claims: Individual Provider that rendered the service, if Billing Provider is a group, report the Individual Provider within the Group that actually rendered the service.
2310B	REF	Rendering Provider Secondary Identification		'1D' - Medicaid Provider Number is being replaced by 'G2' - Provider Commercial Number.
	REF01	Reference Identification Qualifier	G2	If used, should equal 'G2' Provider Commercial Number.
	REF02	Rendering Provider Secondary Identifier		If used, should equal the Rendering Provider's Medicaid ID.
2310C	NM1	Service Facility Location Name		To identify where the service was rendered.
	NM101	Service Facility Location	77	'77' - Service Location
	NM102	Entity Type Qualifier	2	'2' - Non-Person Entity
	NM103	Name Last or Organization Name		This should indicate the location name where the services were performed.
2310C	REF	Service Facility Location Secondary Identification		If NM109 within this loop is not submitted, REF01 should equal 'G2' and REF02 should equal the Service Facility Medicaid ID.
2310C	N4	Service Facility Location City, State, Zip Code		To identify where the service was rendered.
	N403	Postal Code		When reporting the ZIP code for U.S. addresses submit the Zip + 4.
2320	SBR	Other Subscriber Information		Maternity Care District Providers submitting encounter claims: The Maternity Care District reporting the encounter services should be reported as Other Payer on each claim.
	SBR03	Reference Identification		Group Number for other insurance.
	SBR09	Claim Filing Indicator Code		Maternity Care District Providers submitting encounter claims: ZZ – Mutually Defined
2320	CAS	Claim Level Adjustments		
	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	Adjustment Reason Code		CODE SOURCE 139: Claim Adjustment Reason Code PR*1, Deductible PR*2, Co-Insurance PR*3, Co-payment PR*66, Blood Deductible PR*122, Psychiatric Reduction CO*B4, Late Filing Maternity Care District Providers submitting encounter claims: Submit the appropriate adjustment reason code if applicable to convey adjustments between billed and paid amounts.
	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	Monetary Amount		Adjustment Amount
2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		
	AMT01	Amount Qualifier Code	D	'D' – Payer Amount Paid

Loop	Segment	Name	Codes	Comments
	AMT02	Payer Paid Amount		Other Payer Amount Paid (TPL) Maternity Care District Providers submitting encounter claims: This is the amount paid by the Maternity Care District.
2330A	NM1	Other Subscriber Name		
	NM108	Identification Code Qualifier	MI	'MI' – Member Identification Number
	NM109	Identification Code		Policy Number for other insurance.
2330A	REF	Other Subscriber Secondary Identification		
	REF01	Reference Identification Qualifier	SY	'SY' – Social Security Number
	REF02	Other Subscriber Name		If the Other Subscriber SSN is known, it should be reported.
2330B	NM1	Other Payer Name		
	NM103	Name Last or Organization Name		Maternity Care District Providers submitting encounter claims: District Provider Name (Enrolled provider name)
	NM109	Other Payer Primary Identifier		When sending Line Adjudication Information for this payer, the identifier sent in SVD01 (Payer Identifier) of Loop ID-2430 (Line Adjudication Information) must match this value. Maternity Care District Providers submitting encounter claims: District Provider NPI Number
	DTP	Claim Check or Remittance Date		
	DTP01	Date/Time Qualifier	573	'573' – Other Payer Date Claim Paid
	DTP02	Date Time Period Format Qualifier	D8	Date Expressed in Format CCYYMMDD
	DTP03	Date Time Period		Adjudication or Payment Date Maternity Care District Providers submitting encounter claims: Maternity Care District payment/adjudication date
	REF	Other Payer Claim Control Number		
	REF02	Reference Identification		Maternity Care District Providers submitting encounter claims: Internal control number or transaction control number unique to the encounter claim submitted.
2400	SV1	Professional Service		
	SV101-1		HC	'HC' – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
	SV101-2	Procedure Code		The procedure code for this service line.
	SV102	Monetary Amount		Note: If the amount is for a Drug Unit Price (formerly entered in the 2410 CTP03 element), it now is submitted in this data element.

Loop	Segment	Name	Codes	Comments
	SV111	Yes/No Condition or Response Code	Y	SV111 is early and periodic screen for diagnosis and treatment of children (EPSDT) involvement; a “Y” value indicates EPSDT involvement; an “N” value indicates no EPSDT involvement. Note: The code value ‘01’ which was used for 4010 for EPSDT claims, has been eliminated from Segment CLM12 for 5010, and is now billed in the SV111.
2400	QTY	Ambulance Patient Count		The new quantity segment will not be used for Alabama claims processing.
2400	QTY	Obstetric Anesthesia Additional Units		The new quantity segment will not be used for Alabama claims processing.
2410	LIN	Drug Identification		
	LIN02	Drug Identification	N4	‘N4’ – National Drug Code in 5-4-2 Format
	LIN03	Product/Service ID		National Drug Code
2410	CTP	Drug Quantity		
	CTP04	Quantity		National Drug Unit Count
	CTP05-1	Unit or Basis for Measurement Code	F2 GR ME ML UN	‘F2’ - International Unit ‘GR’ – Gram ‘ME’ – Milligram ‘ML’ – Milliliter ‘UN’ – Unit
2410	REF	Prescription or Compound Drug Association Number		
	REF01	Prescription or Compound Drug Association Number	XZ	‘XZ’ – Pharmacy Prescription Number
2420A	REF	Rendering Provider Secondary Identification		‘1D’ – Medicaid Provider Number is being replaced by ‘G2’ – Provider Commercial Number.
	REF01	Reference Identification Qualifier	G2	If used, should equal ‘G2’ Provider Commercial Number.
	REF02	Rendering Provider Secondary Identifier		If used, should equal the Rendering Provider’s Medicaid ID.
2420C	N4	Service Facility Location City, State, Zip Code		
	N403	Postal Code		When reporting the ZIP code for U.S. addresses submit the Zip + 4.
2430	SVD	Line Adjudication Information		
	SVD01	Other Payer Primary Identifier		This number should match one occurrence of the 2330B-NM109 identifying Other Payer.
	SVD02	Service Line Paid Amount		Enter the Third Party Payment Amount (TPL) at the line item level only. This will also be used for crossover detail paid amount. Maternity Care District Providers submitting encounter claims: This is the amount paid by the Maternity Care District.
2430	CAS	Line Adjustment		

Loop	Segment	Name	Codes	Comments
	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	Adjustment Reason Code		CODE SOURCE 139: Claim Adjustment Reason Code PR*1, Deductible PR*2, Co-Insurance PR*3, Co-payment PR*66, Blood Deductible PR*122, Psychiatric Reduction CO*B4, Late Filing Maternity Care District Providers submitting encounter claims: Submit the appropriate adjustment reason code if applicable to convey adjustments between billed and paid amounts.
	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	Monetary Amount		Adjustment Amount

10.7.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

The information when applicable under this section is intended to help the trading partner understand the business context of the EDI transaction.

10.7.2 NATIONAL PROVIDER ID (NPI) VERIFICATION

Provider's should ensure the NPI submitted is valid based on the value issued by the National Plan & Provider Enumeration System (NPPES). All invalid NPI's submitted will fail a compliance check and will be returned as an error on the 999 transaction.

For more information please refer to the NPPES website:

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

10.7.3 MEDICARE ALLOWED AMOUNT

Alabama Medicaid will follow the calculations listed here to figure the Medicare Allowed Amount for crossover claims.

- Header

Step 1:

Original Medicare Paid Amount (2320, AMT) *after 2% reduction	+	Sequestration Amount, CAS*CO*253	=	Medicare Paid Amount
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Step 2:

Medicare Paid Amount	+	2320, Claim Level Adjustments (CAS) Sum the following: PR*1, Deductible PR*2, Co-Insurance PR*3, Co-payment PR*66, Blood Deductible PR*122, Psychiatric Reduction CO*B4, Late Filing	=	Medicare Allowed Amount
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- Detail

Step 1:

Original Medicare Paid Amount (2430, SVD02) *after 2% reduction	+	Sequestration Amount, CAS*CO*253	=	Medicare Paid Amount
--	---	----------------------------------	---	----------------------

Step 2:

Medicare Paid Amount	+	2430, Claim Level Adjustments (CAS) Sum the following: PR*1, Deductible PR*2, Co-Insurance PR*3, Co-payment PR*66, Blood Deductible PR*122, Psychiatric Reduction CO*B4, Late Filing	=	Medicare Allowed Amount
----------------------	---	---	---	-------------------------

10.8 005010X223A2 Health Care Claim – Institutional (837 I)

This table contains one or more rows for each segment for which supplemental instruction is needed.

005010X222A1 HEALTH CARE CLAIM – INSTITUTIONAL (837 I)

Loop	Segment	Name	Codes	Comments
1000A	PER	Submitter EDI Contact Information		The contact information in this segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
	PER01	Contact Function Code	IC	'IC' – Information Contact
	PER02	Name		
	PER03	Communication Number Qualifier	EM FX TE	'EM' – Electronic Mail 'FX' – Facsimile 'TE' – Telephone
	PER04	Communication Number		Email Address, Fax Number or Telephone Number (including the area code)
2000A	PRV	Billing Provider Specialty Information		
	PRV01	Provider Code	BI	'BI' – Billing
	PRV02	Reference Identification	PXC	'PXC' – Health Care Provider Taxonomy Code
	PRV03	Provider Taxonomy Code		When the rendering provider is the same as the billing provider, the billing provider's taxonomy code should be used.
2010AA	N3	Billing Provider Address		The Billing Provider Address must be a street address.
2010AA	N4	Billing Provider City, State, Zip Code		
	N403	Postal Code		When reporting the ZIP code for U.S. addresses submit the Zip + 4.
2010BA	NM1	Subscriber Name		This is the identifier from the subscriber's identification card (ID card).
	NM101	Entity Identifier Code	IL	'IL' – Subscriber
	NM102	Entity Type Qualifier	1	'1' – Person Alabama Medicaid subscribers are individuals 1 is the only acceptable value.
	NM108	Identification Code Qualifier	MI	'MI' – Member Identification Number
	NM109	Subscriber Primary Identifier		Alabama Medicaid Recipient ID.
2010BB	REF	Billing Provider Secondary Identification		'1D' – Medicaid Provider Number is being replaced by 'G2' – Provider Commercial Number.
	REF01	Reference Identification Qualifier	G2	If used, should equal 'G2' Commercial Provider Number.
	REF02	Reference Identification		For crossover claims, REF02 will contain the Billing Provider's Medicare number. Otherwise, REF02 will contain the Billing Provider's Medicaid ID number.
2000C		Patient Hierarchical Level		Dependent Level information will not be supported by Alabama Medicaid when processing Institutional Health Care Claims.
2300	CL1	Institutional Claim Code		
	CL103	Patient Status Code		Must submit the Patient Status Code when submitting an inpatient claims/encounters transaction. (Reference code source: 239).
2300	REF	Service Authorization Exception Code		To indicate an emergency related claim.

Loop	Segment	Name	Codes	Comments
	REF01	Reference Identification Qualifier	4N	Special Payment Reference Number
	REF02	Service Authorization Exception Code	3	'3' – Emergency Care
2300	REF	Payer Claim Control Number (ICN/ DCN)		Use this segment if an adjustment needs to be made to a previously paid claim.
	REF01	Reference Identification Qualifier	F8	Original Reference Number
	REF02	Payer Claim Control Number		This will equal the original Internal Control Number (ICN) that was assigned to the paid claim.
2300	HI	Principal Diagnosis		Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.
2300	HI	Admitting Diagnosis		Note: Admitting Diagnosis codes can only be billed on inpatient claims. Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.
2300	HI	Patient Reason for Visit		Note: Patient Reason for Visit codes can only be billed on outpatient claims. Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.
2300	HI	External Cause of Injury		Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.
2300	HI	Other Diagnosis Information		Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.
2300	HI	Principal Procedure Information		Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.
2300	HI	Other Procedure Information		Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.
2300	HI	Condition Information		A new CRC EPSDT Referral segment has been added for 5010. Providers should continue to bill the EPSDT indicator in the HI Value Information segment, Value Code element of A1 or X3.
2310A	NM1	Attending Provider Name		The Attending Provider information must be populated on each institutional claim.
	NM108	Identification Code Qualifier	XX	'XX' – Centers for Medicare and Medicaid

Loop	Segment	Name	Codes	Comments
				Services National Provider Identifier
	NM109	Attending Provider Primary Identifier		NPI
2310A	PRV	Attending Provider Specialty Information		
	PRV01	Provider Code	AT	'AT' – Attending
	PRV02	Reference Identification	PXC	'PXC' – Health Care Provider Taxonomy Code
	PRV03	Provider Taxonomy Code		The Attending Providers taxonomy code should be used.
2310A	REF	Attending Provider Secondary Identification		
	REF01	Reference Identification Qualifier	0B	'0B' – State License Number
	REF02	Attending Provider Secondary Identifier		Alabama License Number
2310B	NM1	Operating Physician Name		
	NM108	Identification Code Qualifier	XX	'XX' – Centers for Medicare and Medicaid Services National Provider Identifier
	NM109	Operating Provider Primary Identifier		NPI
2310B	REF	Operating Physician Secondary Identification		
	REF01	Reference Identification Qualifier	0B	'0B' – State License Number
	REF02	Operating Physician Secondary Identifier		Alabama License Number
2310E	NM1	Service Facility Location Name		
	NM101	Entity Identifier Code	77	'77' – Service Location
	NM102	Entity Type Qualifier	2	'2' – Non-person Entity
	NM103	Laboratory or Facility Name		The location where the services were performed.
2310E	N3	Service Facility Location Address		
	N301	Address Information		The address where the services were performed.
2310E	N4	Service Facility Location City, State, Zip Code		The City, State and Zip Code where the services were performed.
	N403	Postal Code		When reporting the ZIP code for U.S. addresses submit the Zip + 4.
2310F	NM1	Referring Provider Name		
	NM108	Identification Code Qualifier	XX	If a Referring Provider needs to be populated on the claim, then this loop is populated with the appropriate Referring Provider information. 'XX' – Centers for Medicare and Medicaid Services National Provider Identifier.
	NM109	Attending Provider Primary Identifier		NPI
2320	SBR	Other Subscriber Information		
	SBR03	Reference Identification		Group Number for other insurance.
2320	CAS	Case Level Adjustments		
	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	Adjustment Reason Code		CODE SOURCE 139: Claim Adjustment Reason Code PR*1, Deductible PR*2, Co-Insurance PR*3, Co-payment PR*66, Blood Deductible PR*122, Psychiatric Reduction CO*B4, Late Filing
	CAS03	Adjustment Amount		

Loop	Segment	Name	Codes	Comments
	CAS06 CAS09 CAS12 CAS15 CAS18			
2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		
	AMT01	Amount Qualifier Code	D	'D' – Payer Amount Paid
	AMT02	Payer Paid Amount		Other Payer Amount Paid (TPL)
2320	AMT	Remaining Patient Liability		
	AMT01	Amount Qualifier Code	EAF	'EAF' – Amount Owed
	AMT02	Remaining Patient Liability Amount		Other Payer Amount Paid (TPL)
2330A	NM1	Other Subscriber Name		
	NM108	Identification Code Qualifier	MI	'MI' – Member Identification Number
	NM109	Identification Code		Policy Number for other insurance.
2330A	REF	Other Subscriber Secondary Identification		
	REF01	Reference Identification Qualifier	SY	'SY' – Social Security Number
	REF02	Other Subscriber Name		If the Other Subscriber SSN is known, it should be reported.
2400	SV2	Institutional Service Line		
				Acceptable values for the units of service field are whole numbers that are greater than zero.
2410	LIN	Drug Identification		
	LIN02	Drug Identification	N4	'N4' – National Drug Code
	LIN03	Product/Service ID		National Drug Code in 5-4-2 format
2410	CTP	Drug Quantity		
	CTP04	Quantity		National Drug Unit Count
	CTP05-1	Unit or Basis for Measurement Code	F2 GR ME ML UN	F2 International Unit GR Gram ME Milligram ML Milliliter UN Unit
2410	REF	Prescription or Compound Drug Association Number		
	REF	Prescription or Compound Drug Association Number	XZ	Pharmacy Prescription Number
2430	SVD	Line Adjudication Information		
	SVD01	Other Payer Primary Identifier		This number should match one occurrence of the 2330B-NM109 identifying Other Payer.
	SVD02	Service Line Paid Amount		Enter the Third Party Payment Amount (TPL) at the line item level only. This will also be used for crossover detail paid amount.
2430	CAS	Line Adjustment		
	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	Adjustment Reason Code		CODE SOURCE 139: Claim Adjustment Reason Code PR*1, Deductible PR*2, Co-Insurance PR*3, Co-payment PR*66, Blood Deductible PR*122, Psychiatric Reduction CO*B4, Late Filing
	CAS03 CAS06	Adjustment Amount		

Loop	Segment	Name	Codes	Comments
	CAS09 CAS12 CAS15 CAS18			

10.8.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

The information when applicable under this section is intended to help the trading partner understand the business context of the EDI transaction.

10.8.2 NATIONAL PROVIDER ID (NPI) VERIFICATION

Provider's should ensure the NPI submitted is valid based on the value issued by the National Plan & Provider Enumeration System (NPPES). All invalid NPI's submitted will fail a compliance check and will be returned as an error on the 999 transaction.

For more information please refer to the NPPES website:

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

10.8.3 MEDICARE ALLOWED AMOUNT

Alabama Medicaid will follow the calculations listed here to figure the Medicare Allowed Amount for crossover claims.

- Inpatient

Step 1:

Original Medicare Paid Amount (2320, AMT) *after 2% reduction	+	Sequestration Amount, CAS*CO*253	=	Medicare Paid Amount
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Step 2:

Medicare Paid Amount	+	2320, Claim Level Adjustments (CAS) Sum the following: PR*1, Deductible PR*2, Co-Insurance PR*3, Co-payment PR*66, Blood Deductible PR*122, Psychiatric Reduction CO*B4, Late Filing	=	Medicare Allowed Amount
----------------------	---	---	---	-------------------------

- Outpatient

Step 1:

Original Medicare Paid Amount (2430, SVD02) *after 2% reduction	+	Sequestration Amount, CAS*CO*253	=	Medicare Paid Amount
--	---	----------------------------------	---	----------------------

Step 2:

Medicare Paid Amount	+	2430, Claim Level Adjustments (CAS) Sum the following: PR*1, Deductible PR*2, Co-Insurance PR*3, Co-payment PR*66, Blood Deductible PR*122, Psychiatric Reduction CO*B4, Late Filing	=	Medicare Allowed Amount
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10.9 005010X221A1 Health Care Claim Payment/Advice (835)

This table contains one or more rows for each segment for which supplemental instruction is needed.

005010X221A1 HEALTH CARE CLAIM PAYMENT/ADVICE (835)

Loop	Segment	Name	Codes	Comments
	ISA	Interchange Control Header		
	ISA05	Interchange ID Qualifier	ZZ	'ZZ' will be sent.
	ISA06	Interchange Sender ID		'752548221' will be sent.
	ISA07	Interchange ID Qualifier	ZZ	'ZZ' will be sent as the Interchange ID Qualifier (ISA07), which is associated with the Interchange Receiver ID
	ISA08	Interchange Receiver ID		The Trading Partner ID assigned by Alabama Medicaid followed by the appropriate number of spaces to meet the minimum/maximum data element requirement of 15 bytes will be populated in the Interchange Receiver ID.
	ISA11	Repetition Separator		^
	GS	Functional Group Header		
	GS02	Application Sender's Code		'752548221' will be sent.
	GS03	Application Receiver's Code		The Provider's Submitter ID assigned by Alabama Medicaid will be sent.
	GS08	Version / Release / Industry Identifier Code	005010X221A1	
	BPR	Financial Information		
	BPR01	Transaction Handling Code	I	'I' will be sent as the Transaction Handling Code (BPR01).
	BPR03	Credit/Debit Flag Code	C	'C' will be sent as the Credit/Debit Flag Code (BPR03).
	BPR04	Payment Method Code		Either 'ACH', 'CHK', or 'NON' will be sent as the Payment Method Code (BPR04).
	BPR05	Payment Format Code		If the Payment Method Code is 'ACH' (BPR04), then the Payment Format Code will be 'CCP' (BPR05), for all other codes this data element will not be used.
	BPR06	(DFI) ID Number Qualifier		If the Payment Method Code is 'ACH' (BPR04), then the Depository Financial Institution (DFI) Identification Number Qualifier will be '01' (BPR06), for 'CHK' and 'NON' this data element will not be used.
	BPR12	(DFI) ID Number Qualifier	01	If the Payment Method Code is 'ACH' (BPR04), then the Depository Financial Institution (DFI) Identification Number Qualifier will be '01' (BPR12), for 'CHK' and 'NON' this data element will not be used.
	BPR16	Date	CCYYMMDD	The Date (BPR16) will be the check write date.
	REF	Receiver Identification		

Loop	Segment	Name	Codes	Comments
	REF02	Reference Identification (Receiver Identification)		Provider NPI.
	DTM	Production Date		
	DTM02	Date	CCYYMMDD	Financial check write date
1000A	N1	Payer Identification		
	N102	Name (Payer Name)		Alabama
	N104	Identification Code (Payer Identifier)		12233
1000B	N1	Payee Identification		
	N102	Name (Payee Name)		The Provider's Name will be sent.
	N103	Identification Code Qualifier	XX	Use 'XX' – Centers for Medicare and Medicaid Services National Provider Identifier.
	N104	Identification Code (Payee Identification Code)		The National Provider Identification will be returned.
1000B	REF	Payee Additional Identification		
	REF01	Reference Identification Qualifier	PQ	'PQ' – Payee Identification
	REF02	Additional Payee Identifier		
2100	CLP	Claim Payment Information		
	CLP02	Claim Status Code		Either '1', '2', '3', '4', or '22' will be sent. Previously in 4010 a '4' would be returned for denied claims, but for 5010 this will only be returned if subscriber is not found.
	CLP04	Monetary Amount Claim Payment Amount		For Compound Drug Claims paid amount will be returned in this field and not in the detail paid amount fields (2110/SVC). The paid amount returned here reflects the total paid for the claim which factors in a dispensing fee, copay and third party liability amounts.
	CLP06	Claim Filing Indicator Code	MC	'MC' – Medicaid
	CLP08	Facility Code Value		The bill type submitted in CLM05-1 on the 837 claim will be returned in CLP08.
2100	NM1	Patient Name		
	NM108	Identification Code Qualifier	MR	'MR' – Medicaid Recipient Identification Number
	NM109	Patient Identifier		Alabama Medicaid Recipient ID.
2100	REF	Other Claim Related Identification		
	REF01	Reference Identification Qualifier	EA SY F8	If submitted on the 837 health care claim the following will be returned: 'EA' – Medical Record Identification Number 'SY' – Social Security Number For Adjustment or Voided claims 'F8' followed by the original ICN will be sent with the adjustment record. 'F8' – Original Reference Number

Loop	Segment	Name	Codes	Comments
	REF02	Other Claim Related Identification		Only 12 digits of the Medical Record Number will be returned on the 835.
2100	DTM	Statement From or To Date		
	DTM01	Date/Time Qualifier	232 233	'232' – Claim Statement Period Start '233' – Claim Statement Period End
2110	SVC	Service Payment Information		
	SVC01-1	Product/Service ID Qualifier	AD HC N4 NU	'AD' – American Dental Association Codes 'HC' - Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes 'N4' – National Drug Code in 5-4-2 Format 'NU' – National Uniform Billing Committee (NUBC) UB04 Codes
2110	REF	Rendering Provider Information		
	REF01	Reference Identification Qualifier	HPI	'HPI' – Centers for Medicare and Medicaid Services National Provider Identifier
	REF02	Rendering Provider Identifier		NPI
2110	LQ	Health Care Remark Codes		
	LQ01	Code List Qualifier Code	HE	'HE' – Claim Payment Remark Codes
2110	PLB	Provider Adjustment		
	PLB03-1	Adjustment Reason Code	LS FB	'LS' – Lump Sum 'FB' – Forwarding Balance

10.9.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

The information when applicable under this section is intended to help the trading partner understand the business context of the EDI transaction.

11 APPENDICES

11.1 BUSINESS SCENARIOS

11.1.1 SAFE HARBOR BATCH SUBMIT

The BatchSubmitTransaction operation will allow Trading Partners to submit a single batch file through Safe Harbor for processing. Alabama Medicaid will respond with a message indicating whether the submission was accepted or encountered an error using the same operation.

The response from Alabama Medicaid to a BatchSubmitTransaction request is not an ASC X12 acknowledgement transaction, such as 999 or TA1. Acknowledgement transactions can be retrieved by the Trading Partner using the BatchSubmitAckRetrievalTransaction operation.

11.1.2 SAFE HARBOR BATCH RETRIEVAL

The BatchSubmitAckRetrievalTransaction and BatchResultsRetrievalTransaction operations can be used to retrieve a specific acknowledgement or response file by using the Payload ID of the originally submitted batch file. The original transaction's Payload ID should appear as the Payload ID on the request transaction. Alabama Medicaid will respond with the specified file in the Payload if an acknowledgement or batch response file can be found with that Payload ID. Otherwise, the response from Alabama Medicaid will have the Payload Type X12_005010_Response_NoBatchAckFile or X12_005010_Response_NoBatchResultsFile.

11.1.3 SAFE HARBOR GENERIC BATCH RETRIEVAL

If the Payload ID of the original transaction is not known then trading partners can use the Generic Batch Retrieval services to see a list of available files.

11.1.4 SAFE HARBOR BATCH ACKNOWLEDGEMENT SUBMISSION

The BatchResultsAckSubmit operation can be used to submit an ASC X12 Implementation Acknowledgement (999) or an ASC X12 Interchange Acknowledgement (TA1) for receipt of the batch response file. Alabama Medicaid will respond with a message indicating whether the submission was accepted or encountered an error.

11.1.5 SAFE HARBOR REAL TIME SUBMISSION

The RealTimeTransaction operation will allow Trading Partners to submit individual 270 or 276 requests and receive the 271 or 277 results immediately.

11.2 TRANSMISSION EXAMPLES

11.2.1 SAFE HARBOR BATCH SUBMIT

Additional examples may be found by referencing CAQH CORE Rule 270.

<http://caqh.org/pdf/CLEAN5010/270-v5010.pdf>

It is expected that the web portal username and password will be submitted in the SOAP envelope header security protocols. For specific examples of this please refer to the CAQH CORE Rule 270 guide.

- *Safe Harbor Sample Envelope for Batch Submission using SOAP+WSDL*
<COREEnvelopeBatchSubmission xmlns="http://www.caqh.org/SOAP/WSDL/CORERule2.2.0.xsd">
 <PayloadType>X12_270_Request_005010X279A1</PayloadType>

```

<ProcessingMode>Batch</ProcessingMode>
<PayloadID>6957a55b-8ad6-4503-89f6-ce8db70c9a9f</PayloadID>
<PayloadLength>533</PayloadLength>
<TimeStamp>2014-02-27T15:56:38Z</TimeStamp>
<SenderID>64634</SenderID>
<ReceiverID>77027</ReceiverID>
<CORERuleVersion>2.2.0</CORERuleVersion>
<Checksum>229147227BFFF64DF9500096AA9CE58DE0A7CD8B</Checksum>
<Payload>SVNBKjAwKiAg...</Payload>
</COREEnvelopeBatchSubmission>

```

Note: On submission, payload must be sent as an MTOM encapsulated MIME part.

- Safe Harbor Sample Envelope for Batch Submission using HTTP MIME Multipart

```

-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="SenderID"
64634
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="Password"
SamplePassword123
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="ProcessingMode"
Batch
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="ReceiverID"
77027
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="CORERuleVersion"
2.2.0
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="TimeStamp"
2013-05-23T14:28:29Z
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="PayloadID"
03171c34-bab8-4a17-8e1b-03ccd74a3090
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="UserName"
SampleUserName123
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="PayloadType"
X12_270_Request_005010X279A1
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve Content-Disposition:
form-data; name="Payload"; filename="test270_5010_request.txt"
Content-Type: text/plain
ISA*00* *00* *ZZ*...
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve--

```

11.2.2 SAFE HARBOR BATCH RETRIEVAL

- *Safe Harbor Sample Envelope for Batch Results Retrieval using SOAP+WSDL*

```
<COREEnvelopeBatchResultsRetrievalRequest xmlns="http://www.caqh.org/SOAP/
WSDL/CORERule2.2.0.xsd">
  <PayloadType>X12_005010_Request_Batch_Results_271</PayloadType>
  <ProcessingMode>Batch</ProcessingMode>
  <PayloadID>6957a55b-8ad6-4503-89f6-ce8db70c9a9f</PayloadID>
  <TimeStamp>2014-02-28T12:32:31Z</TimeStamp>
  <SenderID>64634</SenderID>
  <ReceiverID>77027</ReceiverID>
  <CORERuleVersion>2.2.0</CORERuleVersion>
</COREEnvelopeBatchResultsRetrievalRequest>
```

Note: The Payload ID of this transaction matches the Payload ID of the submitted file in “Sample Envelope for Batch Submission using SOAP+WSDL”. This is a demonstration of the Alabama Medicaid method for linking Safe Harbor batch transactions by Payload ID.

- *Safe Harbor Sample Envelope for Batch Results Retrieval using HTTP MIME Multi- part*

```
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="SenderID"
64634
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="Password"
SamplePassword123
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="ProcessingMode"
Batch
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="ReceiverID"
77027
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="CORERuleVersion"
2.2.0
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="TimeStamp"
2013-05-25T19:13:58Z
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="PayloadID"
03171c34-bab8-4a17-8e1b-03ccd74a3090
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="UserName"
SampleUserName123
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="PayloadType"
X12_005010_Request_Batch_Results_271
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve--
```

Note: The Payload ID of this transaction matches the Payload ID of the submitted file in “Sample Envelope for Batch Submission using HTTP MIME Multipart”. This is a demonstration of the Alabama Medicaid method for linking Safe Harbor batch transactions by Payload ID.

11.2.3 SAFE HARBOR GENERIC BATCH RETRIEVAL

- Safe Harbor Generic Batch Retrieval using SOAP+WSDL

The GenericBatchRetrievalTransaction operation will retrieve a list of Payload IDs for all available batch files for the specified Payload Type and Sender ID. Trading Partners can use this operation to identify the Payload ID for a desired file, and then use the BatchSubmitAckRetrievalTransaction or BatchResultsRetrievalTransaction operations to retrieve the specified file using that Payload ID.

The response payload to a Generic Batch Retrieval request will have the following format:

```
<FileList>
  <File>
    <PayloadType>X12_999_Response_005010X231A1</PayloadType>
    <ResultTimestamp>20140207100222</ResultTimestamp>
    <PayloadID>b4bf62da-e1fa-4571-a1c6-aca887a54aeb</PayloadID>
  </File>
  <File>
    <PayloadType>X12_999_Response_005010X231A1</PayloadType>
    <ResultTimestamp>20140207103002</ResultTimestamp>
    <PayloadID>e70eeaf5-32b7-4a70-a21e-cd1d0701a291</PayloadID>
  </File>
</FileList>
```

Note: A file will no longer appear on the Generic Batch Retrieval list after the transaction has been explicitly retrieved by the Trading Partner.

- Safe Harbor Generic Batch Retrieval using HTTP MIME Multipart

As described in “Generic Batch Retrieval using SOAP+WSDL”, the SOAP+WSDL method specifically calls the GenericBatchRetrievalTransaction operation in order to retrieve a list of available files for a specified Payload Type and Sender ID. In order to invoke the same functionality using HTTP MIME Multipart, the Trading Partner must enter the term “FILELIST” in the Payload field of the request.

The following is an abbreviated example of Generic Batch Retrieval using HTTP MIME Multipart:

```
...
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="PayloadType"
X12_270_Request_005010X279A1
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="Payload";
FILELIST
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve--
```

The response payload to a Generic Batch Retrieval request will have the following format:

```
<FileList>
  <File>
    <PayloadType>X12_999_Response_005010X231A1</PayloadType>
```

```

<ResultTimestamp>20130110150549</ResultTimestamp>
<PayloadID>4d594f7a-d694-416a-bad6-5706dc9dc9</PayloadID>
</File>
<File>
<PayloadType>X12_999_Response_005010X231A1</PayloadType>
<ResultTimestamp>20121210160802</ResultTimestamp>
<PayloadID>285438f8-fefc-4cbc-b7df-ca7a401b2f48</PayloadID>
</File>
</FileList>

```

A file will no longer appear on the Generic Batch Retrieval list after the transaction has been explicitly retrieved by the Trading Partner.

11.2.4 REAL TIME SUBMISSION

- Sample Envelope for Real Time Request using SOAP+WSDL

```

<COREEnvelopeRealTimeRequest xmlns="http://www.caqh.org/SOAP/WSDL/
CORERule2.2.0.xsd">
  <PayloadType>X12_270_Request_005010X279A1</PayloadType>
  <ProcessingMode>RealTime</ProcessingMode>
  <PayloadID>b220b650-0b00-439d-8b26-4d5b53d5fed7</PayloadID>
  <TimeStamp>2014-01-09T10:13:54Z</TimeStamp>
  <SenderID>64634</SenderID>
  <ReceiverID>77027</ReceiverID>
  <CORERuleVersion>2.2.0</CORERuleVersion>
  <Payload><![CDATA[ISA*00**00*ZZ...]]></Payload>
</COREEnvelopeRealTimeRequest>

```

- Sample Envelope for Real Time Request using HTTP MIME Multipart

```

-----1c1sqqxvv2z4w1khvyofix6nzc-1xbrjh7adw5ve
Content-Disposition: form-data; name="SenderID"
64634
-----1c1sqqxvv2z4w1khvyofix6nzc-1xbrjh7adw5ve
Content-Disposition: form-data; name="Password"
SamplePassword123
-----1c1sqqxvv2z4w1khvyofix6nzc-1xbrjh7adw5ve
Content-Disposition: form-data; name="ProcessingMode"
RealTime
-----1c1sqqxvv2z4w1khvyofix6nzc-1xbrjh7adw5ve
Content-Disposition: form-data; name="ReceiverID"
77027
-----1c1sqqxvv2z4w1khvyofix6nzc-1xbrjh7adw5ve
Content-Disposition: form-data; name="CORERuleVersion"
2.2.0
-----1c1sqqxvv2z4w1khvyofix6nzc-1xbrjh7adw5ve
Content-Disposition: form-data; name="TimeStamp"
2014-02-23T14:28:29Z
-----1c1sqqxvv2z4w1khvyofix6nzc-1xbrjh7adw5ve
Content-Disposition: form-data; name="PayloadID"
e85886b0-5c8e-4701-9ecf-642c3862b013

```

```

-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="UserName"
SampleUserName123
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="PayloadType"
X12_270_Request_005010X279A1
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="Payload"
<![CDATA[ISA*00**00*ZZ...]]>
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve--

```

11.3 FREQUENTLY ASKED QUESTIONS

http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.4_FAQ.aspx

11.4 CHANGE SUMMARY

This section details the changes between this version and the previous versions.

DATE	DOCUMENT VERSION	AUTHOR	Section/Page	DESCRIPTION OF CHANGE
07/19/2011	0.1	Sarah Viswambaran		Creation of Initial Document.
08/16/2011	0.2	Sarah Viswambaran	Added sections 2.4 and 3.4. Updated sections 6, 8.1.1.3, 8.2.1.3, 8.5.1.	Revised to respond to Agency comments from walkthrough held on 07/29/2011.
08/23/2011	1.0	Sarah Viswambaran		Agency approved
10/31/2011	1.1	Sarah Viswambaran	Updated Section 8.7 Updated Section 8.3	8.7: Added in a comment for REF Service Facility Secondary Identification. 8.3: Updated Loop 2010EA to 2010EC.
11/01/2011	1.2	Sarah Viswambaran	Updated Section 8.3.1	Added the following information: Pharmacy Prior Authorizations are created outside of the 278 process and therefore a service type code of '88' is not expected and will be denied. Alabama Medicaid expects only a Procedure Code to be submitted within an SV1 segment and only a Revenue Code within an SV2 segment.
11/03/2011	1.2	Sarah Viswambaran	Updated Sections 8.6, 8.7, 8.8	Added N3 information for the Billing Provider that only a street address can be submitted in loop 2010AA.
05/30/2012	1.3	Sarah Viswambaran	Added Sections 8.1.1.1, 8.2.1.1, 8.3.1.1, 8.6.1.1, 8.7.1.1, 8.8.1.1	Added National Provider ID (NPI) verification information and website for National Plan & Provider Enrollment (NPPES).
02/27/2013	1.4	Sarah Viswambaran	Updated Section 8.8	Added the Operating Provider NPI information as both NPI and License are required.
10/16/2013	1.5	Sarah Viswambaran	Updated Page 1 Title Page Updated Page 3 Preface Updated Section 8.1 Added Sections 8.1.1.3, 8.1.1.4, 8.1.1.5 Added Section 9	Changes made to accommodate CORE requirements. http://caqh.org/benefits.php Section 8.1 added additional information to both the 270 and 271 tables.

DATE	DOCUMENT VERSION	AUTHOR	Section/Page	DESCRIPTION OF CHANGE
				Section 8.1.1.3 added new section concerning the use of Service Type Codes. Section 8.1.1.4 added new section concerning the process of last name normalization. Section 8.1.1.5 added new additional messages potentially returned on the 271 response. Section 9 added new section for Additional Information.
11/04/2013	1.5.1	Sarah Viswambaran	Updated Section 8.3	Section 8.3 added additional information concerning submitting ICD version qualifiers for 2000E-HI-Patient Diagnosis (Health Care Information Codes).
02/04/2014	1.5.2	Sarah Viswambaran	Updated Sections 8.7.1.2 8.8.1.2	Both sections updated with information concerning two percent sequestration reduction for crossover claims.
05/07/2014	1.5.3	Sarah Viswambaran	Updated Sections 8.1.1.7 8.9	8.1.1.7 Updated the maximum allowed values and information. 8.9 CLP04 added for compound drug claims.
09/03/2014	2.0	Sarah Viswambaran	ACA Updates	Baseline ACA Safe Harbor version. The following sections have been updated: 1.2, 1.3, 2.3.2, 3, 4.2 The following sections have been added: 4.5, 4.6, 4.7, 6.4, 6.5, 7, 8.2, 11.1, 11.2
03/23/2015	3.0	Sarah Viswambaran	Maternity Care Encounter Processing Updates	Maternity Care District Providers submitting encounter claim updates made to section 10.7 for 837 Professional.
12/21/2015	3.1	Sarah Viswambaran	Updated Section 10.7	Added loop header number within the table to correctly define where loop 2330B instruction begins.

RFP # 2015-EVVM-01**Electronic Visit Verification and Monitoring System****Round 1****Proposer Questions and Agency Answers****March 15, 2016**

Question ID:	1
Date Question Asked:	2/26/2016
Question:	<p>#9 states: <i>“Prepare to sign and return the Contract, Contract Review Report, Business Associate Agreement and other documents to expedite the contract approval process. The selected vendor’s contract will have to be reviewed by Medicaid’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.”</i></p> <p>Appendix B, Contract and Attachments, Page 29 states: <i>“The following are the documents that must be signed AFTER contract award and prior to the meeting of the Legislative Contract Oversight Committee Meeting.”</i></p> <p>The checklist indicates additional documents (i.e. Item 4, disclosure statement, Item 8, Contract, etc.) need to be returned with the proposal submission. Yet, Appendix B indicates that these documents are to be signed after award.</p> <p>Please confirm that the Contract, Contract Review Report, Business Associate Agreement, Financial disclosure statement, and other documents do not need to be signed and returned as part of this submission.</p>
Section Number:	A
RFP Page Number:	2
Medicaid Answer:	The selected Vendor must provide the documents in Appendix B after contract award and prior to the meeting of the Legislative Contract Oversight Committee Meeting.

Question ID:	2
Date Question Asked:	2/26/2016
Question:	<p>Requirement f., states: <i>“Document the resources and capability for completing the work necessary to implement the new EVVM system. The Vendor proposal must include a chart outlining the proposed tasks needed to complete the implementation within 30 days of Contract Award as well as outline follow-up and routine reporting deliverables and staff needed to complete the proposed tasks.”</i></p> <p>Does this mean we need to submit the chart within 30 days of being awarded, or does it mean we have to submit a chart now that shows we can launch in 30 days of contract award?</p> <p>Please clarify what specifically needs to be complete within 30 days of Contract Award (10/1/16 per Section B. Schedule of Events on page 3).</p>
Section Number:	VI
RFP Page Number:	16
Medicaid Answer:	Refer to Amendment I posted 3/15/2016 on the Medicaid Website.
Question ID:	3
Date Question Asked:	2/26/2016
Question:	<p>Please clarify the timeline:</p> <ol style="list-style-type: none"> Is the Evaluation Period the timeframe where demonstrations / onsite presentations will be held? Please confirm that the period between Vendor Selection Announcement (5/17/16) and Contract Review Committee (9/1/16) is the period for contract negotiations. There is a 30 day period between Contract Review Committee and Official Contract Award/Begin Work, although the statement underneath the schedule table indicates this period could be up to 45 days. Should the vendor expect to begin work on 10/1/16? Does the Begin Work date of 10/1/16 indicate the start of the implementation? What is the expected go-live date for the system?
Section Number:	B
RFP Page Number:	3
Medicaid Answer:	<ol style="list-style-type: none"> Medicaid does not anticipate demonstrations/onsite presentations with this RFP. No. Medicaid will not conduct contract negotiations. This timeframe is for CMS review before final award. Refer to Amendment I posted 3/15/2016 on the Medicaid Website. Refer to Amendment I posted 3/15/2016 on the Medicaid Website. The selected Vendor will work with Medicaid to establish an agreed upon go-live date for the system.

Question ID:	4
Date Question Asked:	2/26/2016
Question:	<p>a) Please clarify if self-directed recipients will be included in the EVVM program.</p> <p>b) If yes, please break out EVVM membership by those recipients who are self-directed and non-self-directed.</p> <p>c) If yes, please break out the providers by agency and self-directed.</p> <p>d) Please clarify which waivers are included in the EVVM program.</p> <p>e) Please clarify if a recipient can be a member of more than one waiver or more than one Program simultaneously.</p> <p>f) Is the membership number (14,500) FFS only or does it also include Managed Care?</p> <p>g) Is the provider number (175) FFS only or does it also include Managed Care?</p>
Section Number:	I
RFP Page Number:	6
Medicaid Answer:	<p>PROGRAM</p> <p>a) Self-directed recipients will not be included in the EVVM Program.</p> <p>b) Not applicable</p> <p>c) Not applicable</p> <p>d) Refer to the waiver matrix document posted 3/15/2016 on the Medicaid Website.</p> <p>e) A recipient cannot be a member of more than one Waiver or Program simultaneously.</p> <p>f) The 14,500 FFS members only number does not include Managed Care.</p> <p>g) The 175 FFS providers only number does not include Managed Care.</p>
Question ID:	5
Date Question Asked:	2/26/2016
Question:	<p>The 1st bullet states: <i>“Tracking, verifying, recording, and reconciling the real time, electronic entry of start and end times of Personal Assistant and Homemaker Providers”</i></p> <p>What is meant by reconciling?</p>
Section Number:	I
RFP Page Number:	6
Medicaid Answer:	Reconciling means having the capability to correct and or modify entry errors.

Question ID:	6
Date Question Asked:	2/26/2016
Question:	<p>The 3rd bullet states: <i>“Verifying the presence of the Provider at the client’s location providing service as noted in the service plan”</i></p> <p>a) Does the service plan specify the location of service or is this the client’s primary address? b) Can there be multiple service locations in the service plan?</p>
Section Number:	I
RFP Page Number:	6
Medicaid Answer:	<p>a. Yes, the service plan specifies the service location. b. Yes.</p>
Question ID:	7
Date Question Asked:	2/26/2016
Question:	<p>The 4th bullet states: <i>“Preventing Providers from electronically starting a work shift if:</i></p> <p><i>o the Provider is not an approved vendor;</i> <i>o there are no hours left in the monthly service plan</i> <i>o the Provider is not approved for that client; or</i> <i>o the Provider is not physically present at the client location”</i></p> <p>a) What defines a provider as an ‘approved vendor’? b) Are all services authorized at a monthly level? If no, please provide detail on how they are authorized. c) Are providers approved at the agency level or at the direct service worker level? d) Is client location provided as part of the service plan?</p>
Section Number:	II
RFP Page Number:	6
Medicaid Answer:	<p>a) An approved vendor has all required certifications and an executed contract with Operating Agency to perform the services required. b) No, services may be authorized as described in recipient’s care plan. c) Providers are approved at the Operating Agency level. d) Yes.</p>

Question ID:	8
Date Question Asked:	2/26/2016
Question:	<p>Requirement 2. States: <i>“The system must provide real time jurisdictional views for Medicaid, other state agencies, and Area Agencies on Aging.”</i></p> <p>What are the requirements for the jurisdictional views for the Area Agencies on Aging?</p>
Section Number:	III
RFP Page Number:	7
Medicaid Answer:	As part of the Vendor’s proposed solution, the Vendor should include the system’s capabilities for this requirement.
Question ID:	9
Date Question Asked:	2/26/2016
Question:	<p>Requirement 2. Role-Based Access states: <i>“The system must have the capability to limit providers’ authority to modify service entries or input manual service entries based on program rules which may vary between programs. This must include limiting the number or percentage of manual service entries a provider is allowed to enter.”</i></p> <p>a) Please provide the specific rules around this requirement. b) Please provide an example of the limits requested. c) Is the number or percentage based on a single visit or all visits over a period of time? d) If the provider reaches the limit, what happens to their ability to bill for services? e) Is there a requirement for an override process?</p>
Section Number:	IV
RFP Page Number:	7 and 8
Medicaid Answer:	<p>a) As part of the Vendor’s proposed solution, the Vendor should include the system’s capabilities for this requirement. b) As part of the Vendor’s proposed solution, the Vendor should include the system’s capabilities for this requirement. c) It can be either (1) a single visit or (2) over a period of time. d) The provider’s ability to bill for services is temporarily suspended. e) Refer to Amendment I posted 3/15/2016 on the Medicaid Website.</p>

Question ID:	10
Date Question Asked:	2/26/2016
Question:	<p>The second paragraph at the top of this page states: <i>“Allow for only certain providers to enter service tasks, based on program needs and rules. Certain programs may require service tasks to be entered in the EVVM system for only certain provider types, whereas others may require providers to document service tasks through the current paper process or other alternative process.”</i></p> <p>a) Please give an example of how such providers are identified. b) Please provide which program(s) requires service task entry. c) Which provider types require this?</p>
Section Number:	II
RFP Page Number:	8
Medicaid Answer:	There is no historical information regarding this requirement. As part of the Vendor’s proposed solution, the Vendor should include the system’s capabilities for this requirement.
Question ID:	11
Date Question Asked:	2/26/2016
Question:	<p>Requirement 3.1 states: <i>”Describe how the Vendor proposes to allow for multiple groups or lists of acceptable service task activities to be billed and/or recorded, based on program needs and rules.”</i></p> <p>a) Please define ‘service tasks’. b) Please provide the list of acceptable service tasks and the rules for each program. c) Please clarify if DHS expects providers to bill for “tasks” (i.e., Bathing) in addition to “services” (i.e., S5130: Homemaker Service)</p>
Section Number:	II
RFP Page Number:	8
Medicaid Answer:	<p>a) Service tasks are the service activities being provided to the recipient during the visit. b) Refer to the Waiver Matrix document for services approved by each Waiver Program posted 3/15/2016 on the Medicaid Website c) DHS is not affiliated with this Procurement. As part of the Vendor’s proposed solution, the Vendor should include the system’s capabilities for this requirement.</p>

Question ID:	12
Date Question Asked:	2/26/2016
Question:	<p>Requirement 3.2 states: “Describe how the Vendor proposes to provide the capability for direct service/in-home workers to denote the recipient’s status or need for other assistance in the EVVM system and to require such notation where necessary based on program needs and rules.”</p> <p>a. Will the types of status/needs differ by program? b. Please list all the entities that will need to receive status information.</p>
Section Number:	II
RFP Page Number:	8
Medicaid Answer:	<p>a) No, recipient status is not dependent on the program. b) Entities include the Direct Service Provider and any entity identified by Medicaid.</p>
Question ID:	13
Date Question Asked:	2/26/2016
Question:	<p>Requirement 3.3 states: “Describe how the Vendor proposes to permit the fiscal/employer agent to load various rates of pay for individual direct service workers.”</p> <p>a) Please define ‘rates of pay’. I.e. Is this for billing or payroll?</p>
Section Number:	II
RFP Page Number:	8
Medicaid Answer:	a) Rate of pay is for payroll.
Question ID:	14
Date Question Asked:	2/26/2016
Question:	<p>Requirement 3.4 states: “Describe how the Vendor proposes to permit certain other providers to bypass entering a worker schedule, based on program-specific rules. Certain programs/services may require providers to enter workers’ schedule, whereas other program/services may not require such.”</p> <p>a) Please provide the rules that distinguish which providers can bypass a schedule.</p>
Section Number:	III
RFP Page Number:	8
Medicaid Answer:	a) Providers that have supervisory authority for workers may bypass a schedule.

Question ID:	15
Date Question Asked:	2/26/2016
Question:	Requirement 3.5 states: <i>“Describe how the Vendor proposes to handle multiple procedure codes, modifiers, and rates.”</i> Please provide a list of procedure codes, modifiers and rates.
Section Number:	II
RFP Page Number:	8
Medicaid Answer:	See the Home and Community Based Waiver Service Utilization document posted 3/15/2016 on the Medicaid Website.
Question ID:	16
Date Question Asked:	2/26/2016
Question:	Requirement 3.9 states: <i>“Describe how the Vendor proposes to handle automatic loading of provider and recipient files.”</i> a) Please detail all possible sources and frequency of provider and recipient files. b) Please detail all the possible sources and frequency of authorizations. c) Please provide a file specification for the electronic authorization file.
Section Number:	II
RFP Page Number:	8
Medicaid Answer:	a) The provider and recipient files will come from the State’s Fiscal Agent, and the frequency will be based on the Vendor’s needs. b) Fiscal Agent and the frequency will be based on the Vendor needs. c) All HIPAA Standard Transaction formats are specified in the Medicaid’s HIPAA Companion Guide for 5010. http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.3X_Vendor_Companion_Guide.aspx

Question ID:	17
Date Question Asked:	2/26/2016
Question:	The first paragraph states: <i>“The system must allow for review/approval of time by the client or a client designee.”</i> a) Please clarify if this requirement is for all recipients/clients or just self-directed clients.
Section Number:	II
RFP Page Number:	9
Medicaid Answer:	a) Self-directed recipients will not be included in the EVVM Program.
Question ID:	18
Date Question Asked:	2/26/2016
Question:	This requirement states: <i>“The system must provide real-time multi-level escalating alerts of pending late and missed visits to the provider, support coordination agency, and other entities as determined by Medicaid.”</i> a) Please provide the rules and the hierarchy for the multi-level escalating alerts. b) Please provide an example.
Section Number:	II
RFP Page Number:	9
Medicaid Answer:	a) As part of the Vendor’s proposed solution, the Vendor should include the system’s capabilities for this requirement. b) When a service provider is late or has missed a scheduled visit, the provider agency is alerted.

Question ID:	19
Date Question Asked:	2/26/2016
Question:	<p>Requirement 6.3 states: “Describe how the Vendor proposes to provide reports on claims filed and unbilled encounters including activity by recipient, agency, support coordination agency, managed care organization, and direct service worker.”</p> <p>a) Please clarify if Managed Care Organizations will require a Jurisdictional View. b) Is DHS the sole contracting agent for this procurement, or will MCOs also be required to contract with the awarded vendor? c) Will the MCOs be sending data for recipients, providers, service plans? d) Will the system need to submit claims to the MCOs for adjudication? e) How many MCOs are there? f) Please detail the programs and services that are or will be covered by the MCOs.</p>
Section Number:	II
RFP Page Number:	10
Medicaid Answer:	<p>a) No. b) No, Medicaid is the sole contracting agency. c) No. d) No. e) Not Applicable. f) None.</p>
Question ID:	20
Date Question Asked:	2/26/2016
Question:	<p>Requirement 6.3 states: “Describe how the Vendor proposes to provide reports on claims filed and unbilled encounters including activity by recipient, agency, support coordination agency, managed care organization, and direct service worker.”</p> <p>a) Please clarify if Support Coordination Agencies will require a Jurisdictional View.</p>
Section Number:	III
RFP Page Number:	10
Medicaid Answer:	Yes.

Question ID:	21
Date Question Asked:	2/26/2016
Question:	<p>Requirement 6.4 states: “Describe how the Vendor proposes to provide Claims/Authorizations/Services reconciliation reports.”</p> <p>a) Please define the specific reconciliation steps expected of the Vendor.</p> <p>b) Please clarify whether adjudication information for these reporting requirements can be satisfied by using the Monthly Claims Extract, as described in AMMIS Interface Standards Document (version 1.4)?</p> <p>c) If the monthly claims extract will not be sufficient to satisfy the reporting needs for claim adjudications, please clarify what other information sources would be required.</p> <p>d) Please provide data element specifics and associated reconciliation requirements.</p>
Section Number:	II
RFP Page Number:	10
Medicaid Answer:	<p>a) There are no historical reconciliation steps. As part of the Vendor’s proposed solution, the Vendor should include the system’s capabilities for this requirement.</p> <p>b) Yes, it can be satisfied by using the Monthly Claims Extract.</p> <p>c) Yes, it can be satisfied by using the Monthly Claims Extract.</p> <p>d) The data elements are to include but not limited to date of service, units billed, procedure code, and modifiers. There are no historical reconciliation requirements. As part of the Vendor’s proposed solution, the Vendor should include the system’s capabilities for this requirement.</p>

Question ID:	22
Date Question Asked:	2/26/2016
Question:	<p>Regarding Requirement s 6.3 and 6.4.</p> <p>Please provide more detail on what is required for reconciliation. For example,</p> <p style="padding-left: 40px;">a) Does it include return of 999 or 277 information? b) What reporting elements are considered required for reporting on 837 claims submission, 999/277 rejection advice, 835 remittance advice?</p>
Section Number:	V
RFP Page Number:	10
Medicaid Answer:	<p>a) The returns include TA1, 999, and 277U. b) All HIPAA Standard Transaction formats are specified in Medicaid's HIPAA Companion Guide for 5010. http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.3X_Vendor_Companion_Guide.aspx</p>
Question ID:	23
Date Question Asked:	2/26/2016
Question:	<p>For Requirements 6.1-6.5 will the Vendor's EVVM system be the sole source for authorization and Service and visit information for these reports?</p> <p>If the Vendor's EVVM system will not be the sole source, please specify the source of this data for each report.</p>
Section Number:	II
RFP Page Number:	9-10
Medicaid Answer:	Yes, the selected Vendor's EVVM system will be the sole source.
Question ID:	24
Date Question Asked:	2/26/2016
Question:	Pricing information appears on both the Cover Sheet and in Section III or the response. Please confirm that pricing does not need to be submitted in a separate sealed envelope from the technical response.
Section Number:	II
RFP Page Number:	14
Medicaid Answer:	The Vendor's Pricing information does not need to be submitted in a separate sealed envelope.

Question ID:	25
Date Question Asked:	2/26/2016
Question:	<p>Section M. Requirement for Response Structure states: <i>“The Vendor must structure its response in the same sequence, using the same labeling and numbering that appears in the RFP Section in question.”</i></p> <p>Please confirm vendors are expected to provide responses to Sections II. Scope of Work, III. Pricing, V. General, and Section VI. Corporate Background and References and that all other sections do not require a response.</p>
Section Number:	
RFP Page Number:	18
Medicaid Answer:	The RFP defines the requirements needed for a submission to be deemed responsive. It is the Vendor’s responsibility to identify the areas requiring response.
Question ID:	26
Date Question Asked:	2/26/2016
Question:	<p>#4 states: <i>“The Proposal is a complete and independent document, with no references to external documents or resources.”</i></p> <p>Please confirm it is acceptable for vendors to provide supplemental attachments in the same binder as the proposal for additional information/clarity.</p>
Section Number:	Attachment A
RFP Page Number:	28
Medicaid Answer:	All necessary Vendor documents and information must be provided as part of the submitted proposal.

Question ID:	27
Date Question Asked:	2/26/2016
Question:	<p>Pricing Schedule C shows 1,400,000 transactions for YR1 (assumes 6 months of operations per Pricing Schedule B). YR2 and beyond shows 5,700,000 transactions.</p> <p>a) Please define “transaction”.</p> <p>b) Please explain the difference in transaction volume between Y1 and Y2.</p> <p>c) What is the assumed monthly visit volume per recipient?</p>
Section Number:	Appendix C
RFP Page Number:	44
Medicaid Answer:	<p>a) A transaction is defined as (a) any telephony call into the EVVM system or (b) the recording by the EVVM system of any of the following (i) the start of a visit, (ii) the end of a visit, (iii) the duration of a visit, (iv) a service performed during a visit, or (v) corrections to any data in the EVVM system.</p> <p>b) Transaction volume differs to account for implementation and training time.</p> <p>c) The estimated monthly visit volume is an average of 33 transactions per recipient.</p>
Question ID:	28
Date Question Asked:	2/26/2016
Question:	<p>Pricing Schedule b shows Fixed Operational costs for YR1 assumes 6 months of operation.</p> <p>Please clarify that the implementation timeframe is 6 months.</p>
Section Number:	Appendix 6
RFP Page Number:	44
Medicaid Answer:	The implementation timeframe is 6 months after contract start.
Question ID:	29
Date Question Asked:	2/26/2016
Question:	Please clarify what line item in which pricing schedule should contain the cost for post-turnover services.
Section Number:	Appendix C
RFP Page Number:	44
Medicaid Answer:	The Vendor may identify and include this charge on the Appendix C - Pricing Form where it best fits their pricing structure.

Question ID:	30
Date Question Asked:	2/26/2016
Question:	<p>The second paragraph of this section states <i>“A question received less than two full business days prior to the deadline may not be acknowledged.”</i></p> <p>Please clarify that as long as the second round of bidders’ questions is received by the Project Director by March 16, they will be answered by March 30th.</p>
Section Number:	STAARS Document
RFP Page Number:	3
Medicaid Answer:	The Vendor should use the dates in Section B – Schedule of Events. Refer to Amendment I posted 03/15/2016 on the Medicaid Website.
Question ID:	31
Date Question Asked:	2/26/2016
Question:	<p>This section states <i>“Cost of electronic legal research, cellular phone service, fax machines, long-distance telephone tolls, courier, food or beverage 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.”</i></p> <p>Please confirm that customary, necessary food and beverage expenses incurred during the delivery of contracted services will be paid by Medicaid.</p>
Section Number:	STAARS Document
RFP Page Number:	3
Medicaid Answer:	These expenses will not be paid by Medicaid.
Question ID:	32
Date Question Asked:	2/26/2016
Question:	<p>The second paragraph of this section states <i>“Necessary lodging expenses will be paid on the same per-diem basis as state employees are paid.”</i></p> <p>Please provide the state employee per-diem lodging amount.</p>
Section Number:	STAARS Document
RFP Page Number:	3
Medicaid Answer:	These expenses will not be paid by Medicaid.

Question ID:	33
Date Question Asked:	2/26/2016
Question:	Where should the Disclosure Statement be included in the proposal?
Section Number:	Solicitation Overview
RFP Page Number:	3
Medicaid Answer:	The selected Vendor must provide the documents in Appendix B after contract award at a date specified by Medicaid.
Question ID:	34
Date Question Asked:	2/26/2016
Question:	How many visits per week, on average, do the 14,500 individuals will be using EVVM receive?
Section Number:	I
RFP Page Number:	6
Medicaid Answer:	It varies depending on the individual recipient's care plan. Visits can range from two to twelve visits per week.
Question ID:	35
Date Question Asked:	2/26/2016
Question:	Does the State have predetermined standards or business rules when it comes to limiting the percentage or number of manual edits that a provider would be allowed?
Section Number:	2
RFP Page Number:	7
Medicaid Answer:	No.
Question ID:	36
Date Question Asked:	2/26/2016
Question:	Item b.7 states that audited financial statements must be included in the proposal. Would the Agency allow these statements to be provided on a CD instead of hard copies?
Section Number:	VI
RFP Page Number:	15
Medicaid Answer:	Yes.
Question ID:	37
Date Question Asked:	2/26/2016
Question:	Please confirm that if no confidential or proprietary information is being included in the proposal, only one (1) CD is required.
Section Number:	O
RFP Page Number:	19
Medicaid Answer:	Refer to Section VII – Submission Requirements of the RFP for submission requirements for confidential information.

Question ID:	38
Date Question Asked:	2/26/2016
Question:	This question is directed to HP, regarding the data the EVVM system will receive: can we specify a “where” clause for our extracts so they are limited to relevant data under HIPAA? Or do we have to accept a full dump of all Medicaid for the State and extract what we need?
Section Number:	General
RFP Page Number:	
Medicaid Answer:	Where possible, Medicaid will provide standard extract to all vendors requiring an extract. However, Medicaid will work with the selected Vendor to determine their extract needs and whether limited data meets the selected Vendor’s needs.
Question ID:	39
Date Question Asked:	2/26/2016
Question:	Regarding provider set up/enrollment: does the State assign Medicaid IDs to their providers by location, by specialty, or both?
Section Number:	General
RFP Page Number:	
Medicaid Answer:	Medicaid provider IDs are computer generated and randomly assigned as applications are approved.
Question ID:	40
Date Question Asked:	2/26/2016
Question:	Where do Plan of Care Authorizations come from? (They are not listed in the extracts from HP.)
Section Number:	General
RFP Page Number:	
Medicaid Answer:	Plan of Care Authorizations will be provided to the Vendor by Medicaid or service provider agency.
Question ID:	41
Date Question Asked:	2/26/2016
Question:	Can the State provide documents or links to documents for the 837P and 835 EDI guides?
Section Number:	General
RFP Page Number:	
Medicaid Answer:	All HIPAA Standard Transaction formats are specified in the Medicaid’s HIPAA Companion Guide for 5010. http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.3X_Vendor_Companion_Guide.aspx

Question ID:	42
Date Question Asked:	2/26/2016
Question:	Can the State provide information on obtaining a submitter ID (for claims billing out of the EVVM system)
Section Number:	General
RFP Page Number:	
Medicaid Answer:	Medicaid does not assign submitter IDs.
Question ID:	43
Date Question Asked:	2/26/2016
Question:	What other programs, if any, does the State anticipate adding to the contract resulting from this RFP?
Section Number:	General
RFP Page Number:	
Medicaid Answer:	Medicaid does not anticipate adding other programs.
Question ID:	44
Date Question Asked:	2/26/2016
Question:	Can vendors submit a transmittal letter and/or an executive summary to ensure the State receive an overview of the solution proposed?
Section Number:	General
RFP Page Number:	
Medicaid Answer:	Yes.
Question ID:	45
Date Question Asked:	2/26/2016
Question:	Will contract negotiations be held following notification of award for this deal?
Section Number:	General
RFP Page Number:	
Medicaid Answer:	Medicaid will not conduct contract negotiations.

Question ID:	46
Date Question Asked:	2/26/2016
Question:	<p>RFP Section I. Background states “The total firm and fixed price from Attachment E must be entered on the RFP Coversheet.” However, RFP Section III. Pricing states “The Firm and Fixed Price of the first year of the proposed contract (implementation phase) and subsequent years (updating/operation phase) must be separately stated in the RFP Cover Sheet on the first page of this document as well as the pricing form (Appendix C).” and RFP Section VII.L states “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.”</p> <p>Please confirm that there are two numbers that should be included in this box (a total Implementation Cost from Schedule A of Appendix C: Pricing Form and a total Operational Cost from Schedule B of Appendix C: Pricing Form).</p> <p>If this is incorrect, please clarify what pricing numbers are expected to appear on the Cover Sheet.</p>
Section Number:	RFP Cover Sheet
RFP Page Number:	1
Medicaid Answer:	Refer to Amendment I posted 03/15/2016 on the Medicaid Website.
Question ID:	47
Date Question Asked:	2/26/2016
Question:	<p>Item #4 in the RFP Checklist mentions a disclosure statement as an example of the forms that should be used.</p> <p>Please confirm that the Disclosure Statement referenced was only an example, and because it is part of the Contract (Appendix B), does not need to be submitted with the proposal.</p>
Section Number:	A
RFP Page Number:	2
Medicaid Answer:	Yes.

Question ID:	48
Date Question Asked:	2/26/2016
Question:	<p>Would the State consider extending the due date for this proposal to ensure that vendors can include or make adjustments to their proposals after reviewing the answers received on 3/30/2016?</p> <p>Taking into consideration that most vendors will have to ship the proposal to the State, the schedule only allows two to three calendar days for any necessary adjustments.</p>
Section Number:	B
RFP Page Number:	3
Medicaid Answer:	Refer to Amendment I posted 03/15/2016 on the Medicaid Website.
Question ID:	49
Date Question Asked:	2/26/2016
Question:	<p>The schedule shows there is only one day between answers to questions received by the State for round one and the submittal of round two questions by vendors.</p> <p>Would the State consider extending the due date for round two questions for a few more days to allow vendors to thoroughly review the answers from round one so they can include all necessary clarifying questions in round two?</p>
Section Number:	B
RFP Page Number:	3
Medicaid Answer:	Refer to Amendment I posted 03/15/2016 on the Medicaid Website.
Question ID:	50
Date Question Asked:	2/26/2016
Question:	This section refers to Attachment E. Should this reference be to Appendix C: Pricing Form?
Section Number:	I
RFP Page Number:	6
Medicaid Answer:	Refer to Amendment I posted 03/15/2016 on the Medicaid Website.
Question ID:	51
Date Question Asked:	2/26/2016
Question:	How are payments distributed to the Agency service providers (weekly, bi-weekly, monthly, etc.) and what is the average payment amount?
Section Number:	I
RFP Page Number:	6
Medicaid Answer:	Service provider agencies receive payments at least monthly from the Operating Agency. Medicaid does not have information on payment amounts received by service provider agencies.

Question ID:	52
Date Question Asked:	2/26/2016
Question:	Are there any required certifications or independent audits for the standards mentioned?
Section Number:	II
RFP Page Number:	6
Medicaid Answer:	No.
Question ID:	53
Date Question Asked:	2/26/2016
Question:	How is it determined which providers require a paper or other alternative process for task entry or documentation of service tasks? Could a provider have a mixed (paper/online) process for a single client?
Section Number:	II.3
RFP Page Number:	8
Medicaid Answer:	It has not been determined which providers will require a paper or alternative process. Yes, a provider may have a mixed process for a client.
Question ID:	54
Date Question Asked:	2/26/2016
Question:	Is the pay rate at the service provider or worker level?
Section Number:	II.3.3
RFP Page Number:	8
Medicaid Answer:	Pay rate is at the worker level.
Question ID:	55
Date Question Asked:	2/26/2016
Question:	If a provider is required to document service tasks through the paper process or other alternative process, are these tasks ever recorded in the EVVM system?
Section Number:	II.3
RFP Page Number:	8
Medicaid Answer:	If needed at a future date, the expectation is that these tasks would have the option to be uploaded.

Question ID:	56
Date Question Asked:	2/26/2013
Question:	<p>Does the State intend for the successful EVVM contractor to accept files only from the State Medicaid Agency or is the new EVVM contractor expected to receive files from managed care providers?</p> <p>If contractors are expected to receive files from multiple sources, would the State confirm that all sources will use the same file format?</p>
Section Number:	II.3.9
RFP Page Number:	8
Medicaid Answer:	The Vendor will receive files only from Medicaid.
Question ID:	57
Date Question Asked:	2/26/2016
Question:	<p>Would the State confirm that the Claims/Authorization/Services reconciliation report is an individual provider reconciliation report?</p> <p>If not, please provide additional details of the reports they are expecting to receive.</p>
Section Number:	II.6.4
RFP Page Number:	10
Medicaid Answer:	Yes, it is an individual provider reconciliation report.
Question ID:	58
Date Question Asked:	2/26/2016
Question:	<p>Is the contractor responsible for calculating payment, based on the services rules, and sending files to the fiscal agent which will actually issue the provider payment? As such the contractor system would become the system of record.</p> <p>If this is not the State's intent, please provide clarification on the contractor's responsibilities for determining payment for the fiscal agent.</p>
Section Number:	II.7.2
RFP Page Number:	10
Medicaid Answer:	The contractor is not responsible for calculating payments.

Question ID:	59
Date Question Asked:	2/26/2016
Question:	Sections II.11.1 and II.11.5 seem to be very similar requirements. Should II.11.5 be deleted? If not, please clarify the expectations for each requirement and how they differ.
Section Number:	II.11.1, II.11.5
RFP Page Number:	13
Medicaid Answer:	Refer to Amendment I posted 03/15/2016 on the Medicaid Website.
Question ID:	60
Date Question Asked:	2/26/2016
Question:	This requirement refers to number of employees and resources . Please clarify what would be considered resources for this requirement.
Section Number:	VI.b.3
RFP Page Number:	15
Medicaid Answer:	Contractors and Sub-Contractors would be considered resources for this requirement.
Question ID:	61
Date Question Asked:	2/26/2016
Question:	Given the length of our audited financial statements, can vendors provide these documents in electronic format only?
Section Number:	VI
RFP Page Number:	15
Medicaid Answer:	Yes.
Question ID:	62
Date Question Asked:	2/26/16
Question:	This section details how vendors should structure their response. Since some of the sections in the RFP are for informational purposes only, please clarify which sections vendors must respond to in their proposals. Sections II, III, V (which really is responding to Section II) and VI appear to be the only sections that need a response from vendors.
Section Number:	VII.M
RFP Page Number:	18
Medicaid Answer:	The RFP defines the requirements needed for a submission to be deemed responsive. It is the Vendor's responsibility to identify the areas requiring response.

Question ID:	63
Date Question Asked:	2/26/2016
Question:	Is it permissible for vendors to submit documents not available in Microsoft Word format in Adobe PDF format only (e.g., project plans, audited financial statements, insurance documentation, signed forms, etc.)?
Section Number:	VII.O
RFP Page Number:	19
Medicaid Answer:	Yes.
Question ID:	64
Date Question Asked:	2/26/2016
Question:	May vendors submit their redacted electronic proposals in PDF format?
Section Number:	VII.O
RFP Page Number:	19
Medicaid Answer:	Yes.
Question ID:	65
Date Question Asked:	2/26/2016
Question:	Please clarify where in vendors' responses for the justification for confidential content should be provided.
Section Number:	VII.Q
RFP Page Number:	19
Medicaid Answer:	The Vendor may include justification for any "Confidential" information with the response where they deem appropriate.
Question ID:	66
Date Question Asked:	2/26/2016
Question:	Proposed Additional Term: Would the State please confirm that the Contractor retains exclusive ownership of all hardware and software tools used to perform the services?
Section Number:	IX
RFP Page Number:	21
Medicaid Answer:	No.
Question ID:	67
Date Question Asked:	2/26/2016
Question:	Proposed Additional Term: Please confirm that the contract resulting from this solicitation will be a "services only" contract, with no expected transfer of vendor hardware or software at the end of the term.
Section Number:	IX
RFP Page Number:	21
Medicaid Answer:	No.

Question ID:	68
Date Question Asked:	2/26/2016
Question:	Proposed Additional Term: Would the State agree to negotiate a reasonable aggregate limitation on Contractor's liability in connection with this program?
Section Number:	IX
RFP Page Number:	21
Medicaid Answer:	No.
Question ID:	69
Date Question Asked:	2/26/2016
Question:	This program requires that Contractor expend significant costs during the implementation phase. Would the State agree to modify this provision such that, in the event of a termination for convenience, Contractor will receive payment for services performed, as well as payment for unamortized (non-billed) start-up costs and reasonable and necessary wind down expenses?
Section Number:	IX.M
RFP Page Number:	23
Medicaid Answer:	Medicaid will not alter Section IX General Terms and Conditions.
Question ID:	70
Date Question Asked:	2/26/2016
Question:	Given the firm fixed price nature of this agreement, would the State please confirm that the cost principles referenced to in this paragraph do not apply to this procurement?
Section Number:	IX.BB
RFP Page Number:	26
Medicaid Answer:	The terms and conditions in Section IX are not amendable and apply to this RFP.
Question ID:	71
Date Question Asked:	2/26/2016
Question:	Please confirm that, as stated in the first paragraph of Appendix B: Contract and Attachments – page 29, that Attachments A through F are required only AFTER contract award and do not need to be included in the vendor's proposal.
Section Number:	Appendix B
RFP Page Number:	29
Medicaid Answer:	The RFP defines the requirements needed for a submission to be deemed responsive. It is the Vendor's responsibility to identify the areas requiring response.

Question ID:	72
Date Question Asked:	2/26/2016
Question:	How many transactions does the Medicaid Agency currently process each month for the 14,500 individuals identified in the RFP?
Section Number:	Appendix C
RFP Page Number:	44
Medicaid Answer:	We have no historical transaction information.
Question ID:	73
Date Question Asked:	2/26/2016
Question:	Please define the Agency's expectation of a transaction in the Pricing Form, Appendix C?
Section Number:	Appendix C
RFP Page Number:	44
Medicaid Answer:	A transaction is defined as (a) any telephony call into the EVVM system or (b) the recording by the EVVM system of any of the following (i) the start of a visit, (ii) the end of a visit, (iii) the duration of a visit, (iv) a service performed during a visit, or (v) corrections to any data in the EVVM system.
Question ID:	74
Date Question Asked:	2/26/2016
Question:	Is a hosted solution required, or should the proposal assume the state will host the environment?
Section Number:	
RFP Page Number:	
Medicaid Answer:	Refer to Amendment I posted 03/15/2016 on the Medicaid Website.
Question ID:	75
Date Question Asked:	2/26/2016
Question:	Can the required 3 years of experience in EVVM be in a system that closely resembles the requirements for EVVM?
Section Number:	
RFP Page Number:	
Medicaid Answer:	Yes.
Question ID:	76
Date Question Asked:	2/26/2016
Question:	What's the total budget for this project?
Section Number:	
RFP Page Number:	
Medicaid Answer:	Medicaid will not release this information.

Question ID:	77
Date Question Asked:	2/26/2016
Question:	Are there data migration requirements?
Section Number:	
RFP Page Number:	
Medicaid Answer:	Yes, refer to the AMMIS document on the Medicaid Website.
Question ID:	78
Date Question Asked:	2/26/2016
Question:	Is the RFP the only document at this time, or are there supporting documents?
Section Number:	
RFP Page Number:	
Medicaid Answer:	All supporting documents are posted on the Medicaid Website.
Question ID:	79
Date Question Asked:	2/26/2016
Question:	Is there a business/technical requirements matrix that should be used in the response?
Section Number:	
RFP Page Number:	
Medicaid Answer:	No.
Question ID:	80
Date Question Asked:	2/26/2016
Question:	Would the state consider extending the due date for the Proposal?
Section Number:	
RFP Page Number:	
Medicaid Answer:	Refer to Amendment I posted 03/15/2016 on the Medicaid Website.
Question ID:	81
Date Question Asked:	2/26/2016
Question:	Does the state or the providers use any evidence based models to manage clients? If so, what are they?
Section Number:	
RFP Page Number:	
Medicaid Answer:	No.

Question ID:	82
Date Question Asked:	2/26/2016
Question:	Does the Agency have a current vendor that provides this scope of work? If yes, please provide vendor name and current contract scope.
Section Number:	II
RFP Page Number:	6
Medicaid Answer:	No.
Question ID:	83
Date Question Asked:	2/26/2016
Question:	What is the current funding available for this service by Fiscal Year?
Section Number:	II
RFP Page Number:	6
Medicaid Answer:	Medicaid will not release this information.
Question ID:	84
Date Question Asked:	2/26/2016
Question:	For instance, support coordination agencies serve recipients across multiple provider agencies and must be able to access information across provider agencies, but only for those individuals that the support coordination agency serves. Are support coordinators assigned specific provider agencies and should the coordinators only be able to see the information of those individuals serviced by those providers?
Section Number:	II
RFP Page Number:	7
Medicaid Answer:	Support coordinators should only be allowed to access their assigned clients despite the provider agency they are assigned.
Question ID:	85
Date Question Asked:	2/26/2016
Question:	The system must provide real time jurisdictional views for Medicaid, other state agencies, and Area Agencies on Aging What information should be part of the jurisdictional views?
Section Number:	II
RFP Page Number:	7
Medicaid Answer:	As part of the Vendor's proposed solution, the Vendor should include the system's capabilities for this requirement.

Question ID:	86
Date Question Asked:	2/26/2016
Question:	<p>2.3 Describe how the Vendor proposes to provide role based access controls to limit providers' authority to modify service entries or input manual service entries based on program rules which may vary between programs to include limiting the number or percentage of manual service entries a provider is allowed to enter.</p> <p>What are the specific program rules that will be implemented?</p>
Section Number:	II
RFP Page Number:	7
Medicaid Answer:	There is no historical information regarding specific program rule implementation. As part of the Vendor's proposed solution, the Vendor should include the system's capabilities for this requirement.
Question ID:	87
Date Question Asked:	2/26/2016
Question:	<p>3.2 Describe how the Vendor proposes to provide the capability for direct service/in-home workers to denote the recipient's status or need for other assistance in the EVVM system and to require such notation where necessary based on program needs and rules.</p> <p>Please elaborate on the different "recipient statuses or need for assistance".</p>
Section Number:	II
RFP Page Number:	8
Medicaid Answer:	Recipient status in this section refers to the condition of the recipient upon arrival of the direct service/in home worker.
Question ID:	88
Date Question Asked:	2/26/2016
Question:	<p>Vendor's response must specify a firm and fixed fee for completion of the EVVM development, implementation, and updating/operation process. The Firm and Fixed Price of the first year of the proposed contract (implementation phase) and subsequent years (updating/ operation phase) must be separately stated in the RFP Cover Sheet on the first page of this document as well as the pricing form (Appendix C).</p> <p>Please confirm that Total Evaluated Price required on the Cover Sheet is the Total Evaluated Price from Pricing Schedule D.</p>
Section Number:	Cover Sheet and III
RFP Page Number:	13
Medicaid Answer:	Yes.

Question ID:	89
Date Question Asked:	2/26/2016
Question:	<p>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.</p> <p>Please confirm that the Certificate of Authority is required from the Vendor and is not required to be included for any subcontractors proposed.</p>
Section Number:	VI
RFP Page Number:	15
Medicaid Answer:	<p>Refer to Amendment I posted 3/15/2016 on the Medicaid Website.</p> <p>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.</p>
Question ID:	90
Date Question Asked:	2/26/2016
Question:	<p>Please confirm that Vendor's must format the response according to the below outline:</p> <ul style="list-style-type: none"> • RFP Cover Sheet • Transmittal Letter • II. Scope of Work • III. Pricing/Appendix C • VI. Corporate Background and References • Signed Addenda to RFP • Required Forms
Section Number:	VII
RFP Page Number:	17
Medicaid Answer:	The requirement is defined in Section VII.M.

Question ID:	91
Date Question Asked:	2/26/2016
Question:	Appendix C, Schedule C, requires that Vendors provide a Transaction Fee. Please define "Transaction" from the State's perspective. This may be either a single "clock-in" or "clock-out" or is a transaction defined as a complete EVV visit verification set? Or, might your definition of a transaction mean the production of a claim? Please define further.
Section Number:	Appendix C, Schedule C
RFP Page Number:	44
Medicaid Answer:	A transaction is defined as (a) any telephony call into the EVVM system or (b) the recording by the EVVM system of any of the following (i) the start of a visit, (ii) the end of a visit, (iii) the duration of a visit, (iv) a service performed during a visit, or (v) corrections to any data in the EVVM system.
Question ID:	92
Date Question Asked:	2/26/2016
Question:	Requirement 3.7 states: <i>"Describe how the Vendor proposes to limit providers' authority to modify service information and create program rules as to how many modifications can be made by providers because they may differ based on the population or service/program."</i> a) What are the specific rules regarding modification limitations? b) What types of service information is included in the limitation rules? c) What happens to visits that exceed the maximum limit? d) Please provide use cases for this requirement.
Section Number:	III
RFP Page Number:	7-8
Medicaid Answer:	There is no historical information. As part of the Vendor's proposed solution, the Vendor should include the system's capabilities for this requirement.

RFP # 2015-EVVM-01
Electronic Visit Verification and Monitoring System
Round 2
Proposer Questions and Agency Answers
April 5, 2016

Question ID:	1
Date Question Asked:	3/8/2015
Question:	
Section Number:	I would like to bid on the Alabama Medicaid Agency Electronic Visit Verification and Monitoring System. We offer these solution and are licensed by the AESBL and the State. Please let me know what I need to do to get on the bid list.
RFP Page Number:	
Agency Answer:	See the Alabama Comptroller's Office website at http://comptroller.alabama.gov/
Question ID:	2
Date Question Asked:	3/14/2016
Question:	I submitted a few questions to the procurement site on March 8 for the EVVM RFP. I have not seen answers posted for those questions. Can you tell me when they will be answered?
Section Number:	
RFP Page Number:	
Agency Answer:	This information was posted on the Medicaid website on 3/15/2016.

Question ID:	3
Date Question Asked:	3/15/2016
Question:	<p>My company is very interested in responding to the above mentioned RFP. Finding out about this opportunity a little late we missed out on the first round of questions but very much want to participate in the second round of questions.</p> <p>According to the RFP schedule the answers to the first round of questions were to be posted yesterday but I have yet to see them online. With such a short turnaround for the second round of questions I was hopeful you can assist me where to find these. Thank you in advance for your time on this matter.</p>
Section Number:	
RFP Page Number:	
Agency Answer:	This information was posted on the Medicaid website on 3/15/2016.
Question ID:	4
Date Question Asked:	3/15/2016
Question:	<p>Can you please tell me when answers will be posted for the EVVM RFP?</p> <p>We would like to submit follow-up questions on 3/16 based on responses to our first questions.</p>
Section Number:	
RFP Page Number:	
Agency Answer:	This information was posted on the Medicaid website on 3/15/2016.
Question ID:	5
Date Question Asked:	3/19/2016
Question:	Question: is there a way to submit our response to the EVVM RFP electronically via email or a website ?
Section Number:	
RFP Page Number:	
Agency Answer:	Electronic responses to the RFP are not accepted. Proposals must be submitted as described in Section VII – Submission of Requirements of the RFP.

Question ID:	6										
Date Question Asked:	3/22/2016										
Question:	Can the Contractor be enrolled in E-Verify Employer Agent Access, formerly known as Designated Agent Access, or does it have to be enrolled in E-Verify Employer Access?										
Section Number:	Section IX General Terms and Conditions S: Immigration Compliance										
RFP Page Number:	24										
Agency Answer:	Additions or exceptions to the standard terms and conditions are not allowed. See Section VII. Submission Requirements, E. Acceptance of Standard Terms and Conditions.										
Question ID:	7										
Date Question Asked:	3/22/2016										
Question:	<p>These three items reflect conflicting monthly transactional volumes:</p> <table border="1" data-bbox="613 829 1344 1228"> <thead> <tr> <th></th> <th>Appendix C</th> <th>Round 1 Q&A: Page 14</th> <th>Round 1 Q&A: Page 16</th> </tr> </thead> <tbody> <tr> <td>Transactions per month per recipient</td> <td> 16 transactions in Year 1 (1,400,000/14,500/6) 32 transactions in Year 2 - 5 (7,700,000/14,500/12) </td> <td>33</td> <td> 16 – 96 (2 or 12 visits x 4 weeks x 2 transactions per visit) </td> </tr> </tbody> </table> <p>Please provide the number of monthly transactions per recipient for each of the five program years that should be used in determining fixed pricing for the EVVM program.</p>				Appendix C	Round 1 Q&A: Page 14	Round 1 Q&A: Page 16	Transactions per month per recipient	16 transactions in Year 1 (1,400,000/14,500/6) 32 transactions in Year 2 - 5 (7,700,000/14,500/12)	33	16 – 96 (2 or 12 visits x 4 weeks x 2 transactions per visit)
	Appendix C	Round 1 Q&A: Page 14	Round 1 Q&A: Page 16								
Transactions per month per recipient	16 transactions in Year 1 (1,400,000/14,500/6) 32 transactions in Year 2 - 5 (7,700,000/14,500/12)	33	16 – 96 (2 or 12 visits x 4 weeks x 2 transactions per visit)								
Section Number:	44: Appendix C/Pricing Form; Round 1 Q&A page 14; Round 1 Q&A page 16, Transactional Volume to be used for Pricing										
RFP Page Number:	44										
Agency Answer:	Appendix C – Pricing Schedule C has the number of transactions that should be used in determining pricing. In your table, the number on Page 14 refers to transactions, while the number on Page 16 refers to visits. Visits do not accurately translate into transactions.										

Question ID:	8																		
Date Question Asked:																			
Question:	<p>The Waiver Matrix shows the following:</p> <table border="1"> <thead> <tr> <th>Waiver</th> <th>Maximum Enrollment</th> </tr> </thead> <tbody> <tr> <td>Elderly & Disabled Waiver</td> <td>9,205</td> </tr> <tr> <td>Intellectual Disabilities Waiver</td> <td>5,260</td> </tr> <tr> <td>Living at Home Waiver</td> <td>569</td> </tr> <tr> <td>State of Alabama Independent Living Waiver</td> <td>660</td> </tr> <tr> <td>Technology Assistance for Adults Waiver</td> <td>40</td> </tr> <tr> <td>HIV/AIDs Waiver</td> <td>150</td> </tr> <tr> <td>Alabama Community Transition Waiver</td> <td>200</td> </tr> <tr> <td>Total maximum enrollment</td> <td>16,044</td> </tr> </tbody> </table> <p>a) Should we base our pricing on 14,500 or 16,044 recipients?</p> <p>b) Will the Technology Assistance for Adults Waiver be included in the EVVM program?</p>	Waiver	Maximum Enrollment	Elderly & Disabled Waiver	9,205	Intellectual Disabilities Waiver	5,260	Living at Home Waiver	569	State of Alabama Independent Living Waiver	660	Technology Assistance for Adults Waiver	40	HIV/AIDs Waiver	150	Alabama Community Transition Waiver	200	Total maximum enrollment	16,044
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Section Number:																			
RFP Page Number:	6 of main RFP document; Waiver Matrix posted on AL procurement site on 3/15/16, Program Enrollment																		
Agency Answer:	<p>a) 14,500.</p> <p>b) Yes.</p>																		

Question ID:	9
Date Question Asked:	3/22/2016
Question:	<p>a) Are Provider Agencies contracted directly with Medicaid?</p> <p>b) Are Provider agencies contracted directly with Operating Agencies?</p> <p>1) If Yes, can a Provider agency be contracted with more than one Operating Agency?</p> <p>c) Are service coordination agencies and Area Agencies on Aging (“AAAs”) the same entities?</p> <p>d) Can a Provider agency be contracted with more than one service coordination entity?</p>
Section Number:	General
RFP Page Number:	N/A
Agency Answer:	<p>a) Only for the Technology Assisted Waiver.</p> <p>b) Provider agencies contract with either the Operating Agency or its service coordination agency.</p> <p>b.1) Yes.</p> <p>c.) The Area Agencies on Aging is a service coordination agency. It was named to provide an example.</p> <p>d) Yes.</p>

Question ID:	10								
Date Question Asked:	3/22/2016								
Question:	<p>These three items reflect conflicting information regarding the source of Plan of Care/Authorization information:</p> <table border="1" data-bbox="618 485 1338 672"> <thead> <tr> <th></th> <th>Page 8</th> <th>Page 17</th> <th>Page 22</th> </tr> </thead> <tbody> <tr> <td>Source of file transmission</td> <td>Fiscal Agent</td> <td>Medicaid or service provider agency</td> <td>Medicaid</td> </tr> </tbody> </table> <p>a) Please supply a definition of ‘service plan’. b) Please supply a definition of ‘Plan of Care’. c) Please supply a definition of ‘Authorization’. d) What is the number of potential sources for the service plan information being sent to the EVV vendor? e) Please list the sources of the service plan information being sent to the EVV vendor. f) Please provide the file layout specification for the service plan information.</p>		Page 8	Page 17	Page 22	Source of file transmission	Fiscal Agent	Medicaid or service provider agency	Medicaid
	Page 8	Page 17	Page 22						
Source of file transmission	Fiscal Agent	Medicaid or service provider agency	Medicaid						
Section Number:	Service Plan/Plan of Care/Authorization								
RFP Page Number:	Pages 8, 17 and 22 of Round 1 Q&A								

Agency Answer:	<p>a and b) In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant.</p> <p>c) A plan of care authorization is the mechanism used to approve or modify a service plan.</p> <p>d) The number of potential sources sending the EVVM Vendor service plan information could range from 4-43. There is no historical information regarding service plan/plan of care file transmission. As part of the Vendor's proposed solution, the Vendor should include the system's capabilities for this requirement.</p> <p>e) Currently, 4 State Operating Agencies and 43 service coordination agencies house service plan/plan of care information. Medicaid and the selected Vendor will work together to determine how service plan information will be received.</p> <p>f) If it is determined that the actual plan of care document will be transferred to the EVVM Vendor the file layout will be specified at that time.</p>
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Question ID:	11
Date Question Asked:	3/22/2016
Question:	<p>a) How will service location be specified on the service plan (Plan of Care/Authorization) record that is transmitted to the EVV vendor?</p> <p>b) Will the service plan (Plan of Care/Authorization) specify a list of valid locations for the duration of that particular client's service plan?</p> <p>c) Will valid locations be tied to specific dates and specific services within the client's plan of care record?</p>
Section Number:	Question ID #6
RFP Page Number:	Page 4 of Round 1 Q&A
Agency Answer:	<p>a) Medicaid does not currently have a method to transmit this information to the EVV vendor. The Vendor should describe in their proposal the method used by their solution.</p> <p>b) Medicaid's current service plan does not include this information. The Vendor should describe in their proposal the method used by their solution.</p> <p>c) Medicaid's current service plan does not include this information. The Vendor should describe in their proposal the method used by their solution.</p>
Question ID:	12
Date Question Asked:	3/22/2016
Question:	<p>In referencing the answer to Question ID 27, submitted during the first round of questions, we are requesting further clarification on what actions constitute a single "transaction".</p> <p>The start time of a visit, the end time of a visit, and the services performed during a visit accounts for how many transactions according to the State? One, two, or three?</p>
Section Number:	
RFP Page Number:	
Agency Answer:	Three transactions.

Question ID:	13
Date Question Asked:	3/22/2016
Question:	<p>The utilization data provided in the Home and Community Based Waiver Service Utilization by Procedure and Modifier Code document, posted on the AL procurement website, suggests roughly double the transactions indicated on the cost proposal sheet, Appendix C.</p> <p>Can the State clarify the estimated transaction counts provided? Does the State plan to utilize EVVM for a subset of the in-home Providers, thus the discrepancy in the transaction count?</p>
Section Number:	
RFP Page Number:	
Agency Answer:	<p>The units in the waiver utilization document do not translate into transactions. The units represent increments of time.</p> <p>No, the State does not plan to utilize EVVM only for a subset of the in-home Providers.</p>
Question ID:	14
Date Question Asked:	3/22/2016
Question:	<p>The State's responses to Question IDs 66 and 67, submitted during the first round of questions, indicated that the State would not confirm that the Contractor retains exclusive ownership of all hardware and software tools used to perform services and that the State would not confirm that the contract resulting from this solicitation will be a "services only" contract, with no expected transfer of vendor hardware or software at the end of the term.</p> <p>Does the State seek to procure an EVVM system from a contractor and assume proprietary ownership over the data and the EVVM solution upon the contract's end?</p>
Section Number:	
RFP Page Number:	
Agency Answer:	<p>Medicaid's intent is for the Vendor's solution to be non-proprietary; Medicaid does not intend to own the solution at the end of the contract.</p> <p>However, Medicaid does own the data in the system, which will need to be transferred to Medicaid upon the contract's end.</p>

Question ID:	15
Date Question Asked:	3/22/2016
Question:	<p>This requirement states that the vendor solution must provide for the following: Verifying the presence of the Provider at the client's location providing service as noted in the service plan,</p> <p>Is the data exchange interface for the service plan, or list of authorized services, documented within the AMMIS Interface Standards, or does a standard currently exist for the Alabama MMIS? Or will developing this interface be a part of the Vendor solution?</p>
Section Number:	RFP Section II
RFP Page Number:	
Agency Answer:	No, the Service Plan is not in or part of the AMMIS Interface. The Vendor will be responsible for developing an interface.
Question ID:	16
Date Question Asked:	3/22/2016
Question:	<p>This requirement states that the vendor solution must provide for the following: Filing of Claims to the Medicaid Fiscal Agent.</p> <p>Are there any program rules, processes or instances (e.g. required attachments) that will require claims to be filed manually? For EVVM administered services are any formats used for manual claims other than the UB-04?</p>
Section Number:	RFP Section II
RFP Page Number:	
Agency Answer:	<p>It would be possible if, for example, the client had third party insurance which was denied. This would require the claim to be filed manually.</p> <p>Medicaid does not anticipate this to occur frequently in HCBS.</p>

Question ID:	17
Date Question Asked:	3/22/2016
Question:	<p>This requirement states that the vendor solution must provide for the following: Filing of Claims to the Medicaid Fiscal Agent.</p> <p>Other than the standard submission of an electronic claim, are there any other parts of the standard claims processing cycle that are the responsibility of the EVVM solution Vendor, such as care coordination or claims adjustments?</p>
Section Number:	RFP Section II
RFP Page Number:	
Agency Answer:	No.
Question ID:	18
Date Question Asked:	3/22/2016
Question:	<p>The requirement states that the system must have the ability to track and report modifications to the EVVM system data input elements after the direct service worker has called in their time or services, including the name of the provider staff making the changes and the reason for changes.</p> <p>Are the data elements to be modified included in the service plan, or only in EVVM collected data? What data elements are permitted by the state to be modified?</p> <p>Could any of the data elements modified lead to the need for a claim adjustment?</p>
Section Number:	RFP Section II.2
RFP Page Number:	
Agency Answer:	<p>Data elements may be included in both the service plan and EVVM collected data. These data elements have not been identified by Medicaid. The Vendor should include in their proposal the data elements used by their solution.</p> <p>It is possible that modified data elements could lead to a claim adjustment to be performed by the fiscal agent.</p>

Question ID:	19
Date Question Asked:	3/22/2016
Question:	Please provide a definition and reporting structure for the following individuals/agency used in this RFP: support coordinators (II.2.4); fiscal/employer agent (II.3.3); support coordination agency (II.5).
Section Number:	RFP Sections II.2.4, II.3.3, and II.5
RFP Page Number:	
Agency Answer:	Support coordinators are the care coordinators responsible for developing client plans of care. The fiscal/employer agent is either the Operating Agency or the support coordination entity that employs the care coordinators. A support coordination agency is a subcontractor to the Operating Agency for the provision of care coordination services. For example, the Department of Senior Services contracts with Area Agencies on Aging to provide care coordination.
Question ID:	20
Date Question Asked:	3/22/2016
Question:	This requirement states, "Describe how the Vendor proposes to provide the capability for direct service/in-home workers to denote the recipient's status or need for other assistance in the EVVM system and to require such notation where necessary based on program needs and rules." Does this imply that the system should allow free text notes for the worker to describe the client condition and enter case notes?
Section Number:	Proposal Section II.3.2
RFP Page Number:	
Agency Answer:	Vendor should provide their system's capability to meet the requirement whether it is free text notes, radio buttons or a drop down menu for users to denote the recipient's status or need for other assistance.

Question ID:	21
Date Question Asked:	3/22/2016
Question:	<p>In answers to the first round of questions, the answer to Question #13 states, "Rate of pay is for payroll."</p> <p>Is the provider payroll system also a part of the EVVM system or can we meet this with just a report by worker of time spent serving clients?</p>
Section Number:	Proposal Section II.3.3
RFP Page Number:	
Agency Answer:	The provider payroll system is not a part of the EVVM system. This requirement may be met with a report by worker.
Question ID:	22
Date Question Asked:	3/22/2016
Question:	<p>This requirement states, "Describe how the Vendor proposes to handle multiple procedure codes, modifiers, and rates."</p> <p>Will the codes and modifiers transmitted by the fiscal agent be translated by the fiscal agent or will the Vendor have to maintain a crosswalk of codes in order to display translated codes?</p> <p>Does the state prescribe any local codes either externally or within industry standard code sets that will need to be maintained by the Vendor?</p>
Section Number:	RFP Section II.3.5
RFP Page Number:	
Agency Answer:	<p>The codes will be translated by the fiscal agent.</p> <p>No.</p>

Question ID:	23
Date Question Asked:	3/22/2016
Question:	<p>These requirements refer to alerts for gaps in care and alerts for monitoring purposes.</p> <p>Please clarify the difference between alerts for gaps in care vs. alerts for monitoring purposes.</p>
Section Number:	RFP Sections II.3.8 and II.5
RFP Page Number:	
Agency Answer:	Gaps in care occur when approved services are not rendered according to the care plan. Monitoring alerts would be communicated when there are inconsistencies in service delivery such as no shows; no claims entered; missed visits or attempted visits.
Question ID:	24
Date Question Asked:	3/22/2016
Question:	Does the Medicaid Agency have a list of standard reports required?
Section Number:	RFP Section II.6
RFP Page Number:	
Agency Answer:	No.
Question ID:	25
Date Question Asked:	3/22/2016
Question:	<p>This requirement refers to the vendor's rules based billing and scheduling software platform.</p> <p>If the EVVM system is developing the claim based on recorded procedures and modifiers what is the purpose of a separate billing system?</p>
Section Number:	RFP Section II.7.1
RFP Page Number:	
Agency Answer:	The intent is to ensure that submitted data is consistent with approved services in the care plan.

Question ID:	26
Date Question Asked:	3/22/2016
Question:	<p>What are the requirements for adjusting provider payment, if necessary?</p> <p>Since payment is calculated at the fiscal agent can we assume any adjustment will be made through their system?</p> <p>How will the adjustment be communicated back to the vendor system for reporting and audit purposes?</p>
Section Number:	RFP Section II.7.1
RFP Page Number:	
Agency Answer:	<p>The EVVM vendor will not be responsible for adjusting provider payments.</p> <p>Yes.</p> <p>The Operating Agency will communicate to the EVVM Vendor.</p>
Question ID:	27
Date Question Asked:	3/22/2016
Question:	<p>Is the State 1) requesting approval of all staffing turnover activity, including the right to approve the project team by person or key personnel, or 2) is this only related to during the turnover time period of the system to a new contractor?</p> <p>If the latter, does the State reserve the right to approve the manager we place in charge of doing the turnover process to a new contractor? If the project manager is unchanged (for example, the last 12 months prior to turnover), could the State reject that person prior to turnover beginning, and require us to bring on a new person that they can approve or reject?</p>
Section Number:	Contract Turnover Requirements, 11.3
RFP Page Number:	13
Agency Answer:	<p>This requirement is related to the turnover time period of the system to a new contractor. The State reserves the right to approve the manager in charge of turnover activities. If the project manager is unchanged, it is not expected that the State would require Contractor to bring on a new manager for turnover activities.</p>

Question ID:	28
Date Question Asked:	3/22/2016
Question:	Our organization will be proposing a complex system involving hardware and software handling confidential information. We feel that ten (10) calendar days is not a realistically sufficient timeframe for curing a default. Would the State agree to change this to a period of thirty (30) days?
Section Number:	J. Termination for Default
RFP Page Number:	23
Agency Answer:	Additions or exceptions to the standard terms and conditions are not allowed. See Section VII. Submission Requirements, E. Acceptance of Standard Terms and Conditions.
Question ID:	29
Date Question Asked:	3/22/2016
Question:	Would the State provide a post-award opportunity to negotiate mutually agreeable provisions for this clause?
Section Number:	Y. Disputes and Litigation
RFP Page Number:	25
Agency Answer:	Additions or exceptions to the standard terms and conditions are not allowed. See Section VII. Submission Requirements, E. Acceptance of Standard Terms and Conditions.
Question ID:	30
Date Question Asked:	3/22/2016
Question:	Would the State provide a post-award opportunity to negotiate mutually agreeable provisions to retention and storage policies?
Section Number:	Z. Records Retention and Storage
RFP Page Number:	26
Agency Answer:	Additions or exceptions to the standard terms and conditions are not allowed. See Section VII. Submission Requirements, E. Acceptance of Standard Terms and Conditions.