

Announcement of Selected Vendor  
RFP # 2016-MQR-02  
Medical and Quality Review (2) RFP  
Alabama Medicaid Agency

On August 4, 2016, the Alabama Medicaid Agency issued an Intent to Award Notice to Qualis Health for the Medical and Quality Review (2) RFP (RFP Number 2016-MQR-02).

The final award of this contract is subject to review by the Legislative Oversight Committee and signature by Governor Bentley.



# ALABAMA MEDICAID AGENCY REQUEST FOR PROPOSALS

<b>RFP Number: 2016-MQR-02</b>	<b>RFP Title: Medical and Quality Review (2) RFP</b>
<b>RFP Due Date and Time: June 22, 2016 by 5pm Central Time</b>	<b>Number of Pages: 57</b>
<b>PROCUREMENT INFORMATION</b>	
<b>Project Director: Theresa Carlos</b>	<b>Issue Date: May 17, 2016</b>
<b>E-mail Address: <a href="mailto:MedicalReview-RFP@medicaid.alabama.gov">MedicalReview-RFP@medicaid.alabama.gov</a> Website: <a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a></b>	<b>Issuing Division: Clinical Services and Support Division</b>
<b>INSTRUCTIONS TO VENDORS</b>	
<b>Return Proposal to:</b>  Theresa Carlos Alabama Medicaid Agency Lurleen B. Wallace Building 501 Dexter Avenue PO Box 5624 Montgomery, AL 36103-5624	<b>Mark Face of Envelope/Package:</b> <b>RFP Number: 2016-MQR-02</b> <b>RFP Due Date: June 22, 2016 by 5pm CT</b>  <b>Firm and Fixed Price:</b>  Annual TOTAL Cost Year 1: Annual TOTAL Cost Year 2: Annual TOTAL Cost Year 3: Annual TOTAL Cost Year 4: Annual TOTAL Cost Year 5:  <b>TOTAL 5 Year Firm and Fixed Costs:</b>
<b>VENDOR INFORMATION</b> <i>(Vendor must complete the following and return with RFP response)</i>	
<b>Vendor Name/Address:</b>	<b>Authorized Vendor Signatory: (Please print name and sign in ink)</b>
<b>Vendor Phone Number:</b>	<b>Vendor FAX Number:</b>
<b>Vendor Federal I.D. Number:</b>	<b>Vendor E-mail Address:</b>

## Section A. RFP Checklist

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

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

## Section B. Schedule of Events

The following RFP Schedule of Events represents the State'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 State 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](http://www.medicaid.alabama.gov).

<b>EVENT</b>	<b>DATE</b>
RFP Issued	5/17/16
Deadline for Submitting Round 1 Questions	5/24/16
Posting of Round 1 Questions and Answers	6/1/16
Deadline for Submitting Round 2 Questions	6/8/16
Posting of Round 2 Questions and Answers	6/15/16
Proposals Due by 5 pm CT	6/22/16
Evaluation Period	6/22/16 – 7/13/16
Contract Award Notification	July 2016
**Contract Review Committee	9/1/16
Official Contract Award/Begin Work	10/1/16

\* \*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. 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 (HCBS)
- Prenatal Clinic Services
- Mental Health Services

Additional program information can be found at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

The Medicaid program currently serves over one million beneficiaries, providing healthcare services to nearly one in four Alabama residents including one in two children. In addition, the Medicaid program accounts for more than half of the births in the State. As such, Medicaid is a vital part of the State's healthcare delivery system. However, the current Medicaid program and the State overall face significant challenges related to quality, access and cost. These challenges are heightened because in the current environment, providers are largely not appropriately incented to coordinate across the continuum to manage the total cost of care, improve health outcomes, reduce avoidable hospital care and improve physical and behavioral health coordination. In addition, Alabama providers have limited means of sharing essential medical information through information technology. To address these challenges, Medicaid will implement Regional Care Organizations (RCOs). RCOs are organizations of healthcare Providers that contract with Medicaid to provide a comprehensive package of Medicaid benefits to enrollees in a defined Region of the State and that meet the requirements set forth in Section 22-6-150, et seq. of the Alabama Code. RCOs will be accountable for managing the full cost of Medicaid services and related care coordination for a defined population. The RCOs are to be fully operational on a future date to be determined.

## **II. Background**

In compliance with Section 1902 (a) 30 of the Social Security Act, Medicaid must implement methods and procedures relating to the utilization of and payment for care and services. The methods should prevent unnecessary utilization and help to ensure payments are consistent with efficiency, economy and quality of care.

Medicaid is requesting proposals from a qualified Quality Improvement Organization (QIO) or QIO-like entity to review prior authorizations (PA), nursing home, hospice, post-extended care (PEC), swing bed, and inpatient psychiatric facility records.

Therefore, medical and quality review requires the Vendor to complete reviews for three service areas: prior authorization, institutional facilities and hospice. The Vendor shall review PA requests from providers for durable medical equipment, surgeries, laboratory tests, eye exams and eyeglasses and private duty nursing for all eligible recipients. The Vendor shall utilize Medicaid PA criteria to ensure the requested service or item is medically necessary.

Institutional reviews include those of long term residents in the skilled nursing facility (nursing facility), in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), PEC and swing beds and inpatient psychiatric hospitals. Swing beds are hospital beds that can be used for either skilled nursing facility (SNF) or hospital acute care levels of care on an as needed basis if the hospital has obtained a swing bed approval from the Department of Health and Human Services. Inpatient psychiatric admissions for adults ages 21-64 are covered only in an acute care hospital, or under the Medicaid Emergency Psychiatric Demonstration (MEPD). The MEPD extension is pending Centers for Medicare and Medicaid Services (CMS) approval. However, Medicaid does cover inpatient psychiatric facilities, including residential treatment facilities (RTFs) for recipients under 21 and age 65 and over.

Records for hospice shall be reviewed to ensure medical criteria are met and comply with all state and federal regulations. Hospice records are received from providers for recipients who have Medicaid-only.

### **III. Scope of Work**

The Scope of Work section is separated into three areas. Vendors must address the requirements in each area.

#### **1. Institutional Record Reviews**

The primary goal of the Institutional record review process is to ensure the appropriate utilization of services for admissions to the Institutional programs by performing reviews of medical record documentation for admissions, re-admissions, and transfers to the facilities. Institutional providers include nursing facilities, PEC, swing bed, ICF/IIDs, inpatient psychiatric hospitals, including RTFs for recipients under age 21, inpatient psychiatric facilities for recipients over the age of 65 and potentially inpatient psychiatric facilities participating in the CMS MEPD for adults between the ages of 21-64. Inpatient psychiatric admissions are otherwise only covered in acute care hospitals for adults ages 21-64. Criteria for these facilities are documented in the following resources: Alabama Medicaid Administrative Codes Chapter 10, Long Term Care (LTC), for nursing facilities; Chapter 7, Hospitals, for PEC admissions and continued stays; Chapter 46, for Swing Beds; Chapter 5, for Psychiatric Facilities for Individuals 65 or Over; Chapter 41, for Psychiatric Facilities for Individuals Under Age 21; and Provider Manual Chapter 102, for ICF/IID. Policies and procedures for MEPD are documented in the MEPD Operational Manual. The Vendor will utilize the monthly report, LTC-0007-M, generated by Medicaid's fiscal agent, Hewlett-Packard Enterprise (HPE) for the nursing facilities and ICF/IIDs reviews. A query is utilized for the inpatient psychiatric reviews. All MEPD admissions, re-admissions and continued stays shall be reviewed. A five percent random sample of admissions and re-admissions in inpatient psychiatric facilities, including RTFs shall be reviewed. For inpatient psychiatric requests, including the MEPD, the Vendor shall review cases for which the Medicaid eligibility is pending. For all other Institutional record reviews (nursing home, PEC and swing-bed), the recipient must be Medicaid eligible.

Nursing facility, ICF/IID, PEC, swing bed, and psychiatric providers electronically submit records to HPE. These records are stored in a document repository. Nursing facilities who fail to submit a requested record timely for review may be assessed a penalty, as per Rule No. 560-X-10-.07. Recipients in a nursing facility, ICF/IID, PEC, swing bed, and those participating in the MEPD are denoted in the Medicaid Management Information System (MMIS) by a "LTC segment" with the begin and end dates of the stay. Nursing facility and ICF/IID providers utilize the HPE LTC software to enter dates for recipients. However, there may be instances when these providers are not able to enter segments, or they may have entered dates incorrectly. Therefore, nursing facility, PEC and swing-bed providers will submit a LTC Request for Action Form (Form 161B) to the Vendor for assistance in updating the LTC segment for recipients. The Vendor will utilize both the HPE LTC software and the MMIS to update LTC segments.

In calendar year (CY) 2015, there were a total of 2,483 reviews completed for the nursing facility, ICF/IID, PEC, and swing bed records. The monthly average is approximately 207 records. Please see Appendix B Attachment H for the number of currently enrolled providers. Based on claims and actual reviews, retrospective inpatient psychiatric record reviews should

average approximately 28 per month. There were four inpatient psychiatric facilities that participated in the MEPD. The Demonstration was officially terminated by CMS on June 30, 2015. However, due to funding, Medicaid stopped enrolling recipients on April 13, 2015. The monthly average for records reviewed in 2015 was approximately 97.

The selected Vendor will:

- Comply with the applicable requirements of Alabama Medicaid Administrative Code and any revisions thereof.
- Comply with the applicable requirements of the Alabama Medicaid Provider Manual and any revisions thereof.
- Review retrospectively a 10 percent sample of admissions, re-admissions, and transfers, for all nursing facilities, and ICF/IIDs and five percent admissions and re-admissions for the inpatient psychiatric facilities, including RTFs, on a monthly basis to ensure medical criteria are met.
- Review concurrently 100 percent of MEPD admissions, re-admissions and continued stays to ensure criteria are met.
- Adhere to and comply with policies and procedures as per the current MEPD Operational Manual and any revisions thereof to ensure data required by CMS for the demonstration are captured accurately.
- Review concurrently 100 percent of recipients admitted to a PEC or swing bed to ensure medical criteria are met. Vendor staff will submit dates for approved records through the HPE LTC software.
- Send the initial request letter to the facilities within seven business days of the first day of the month. A copy of the letter must be retained by the Vendor.
- Ensure reviews are performed by a health care professional with a minimum qualification of an RN with three years of institutional or medical surgical experience.
- Ensure professional staffs review the medical documentation to ensure compliance with state and federal requirements governing the Institutional Programs and to ensure that the documentation supports Alabama Medicaid medical criteria.
- Complete medical reviews within 30 calendar days of receipt and if necessary, submit request to the Institutional providers for additional documentation regarding any non-compliance issues and/or lack of required documentation to support the admission, re-admission or transfer.
- Complete reviews of additional information within 10 calendar days of receipt.
- Send a denial letter for any record determined not to meet criteria to the provider within one business day of review. The letter shall contain the recipient's name, Medicaid number, date of service, denial reason (should be indicated in plain language and a reference code or number), and rights to the appeal process which include both the informal review and a fair hearing.
- Provide a monthly summary report of any pending cases and institutional medical denials.
- If clinical staff is unable to make a medical determination, forward the record to the Physician Advisor for an approval or denial.
- Provide a description of how the Vendor will receive and address LTC Request for Action Forms (Form 161B) from nursing facility, PEC and swing-bed

providers within five business days of receipt. These forms may require placing a segment to “history” so that the nursing facility can submit the appropriate date through the HPE LTC software.

- Generate a monthly report, no later than 10 business days after the end of the month, to include but not limited to the following:
  - Number of Institutional reviews.
  - Number of Institutional Review denials.
  - Number of Institutional Reviews not processed within the specified timeframes.
  - Number of Institutional appeals.
  - Number of nursing facilities submitting records untimely.

As part of the Proposal, the Vendor must:

1. Provide a description of how the institutional reviews will be performed by professional clinical staff and a physician, as necessary, to ensure medical criteria are met.
2. Describe procedures to select the 10 percent random sample from the LTC-0007-M report each month for nursing facility and ICF/IIDs reviews, as well as the procedures to notify staff that PEC, swing bed and inpatient psychiatric records are available for review.
3. Explain and provide samples of the audit request, request for additional information, acknowledgement, and denial letters to the facilities. The initial audit request letter shall be sent to the facilities within seven business days of the first day of the month. A copy of the letter must be retained by the Vendor. The denial letter shall contain the recipient’s name, Medicaid number, date of service, denial reason (should be indicated in plain language and reference code or number), and rights to the appeal process which include both the informal review and a fair hearing.
4. Describe the procedures to verify receipt by the provider of the Vendor’s initial audit request and the request for additional information, if necessary.
5. Provide a description of how the Form 161Bs will be addressed and how the requesting provider will be notified of the action taken.

## **2. Hospice Records Reviews**

The primary goal of the Hospice record review process is to ensure the appropriate utilization of services for admissions to the hospice program by performing 100 percent concurrent review of medical record documentation for initial certifications and six month re-certifications for hospice benefits according to Medicaid approved medical criteria. Criteria for hospice are documented in the following resource: Alabama Medicaid Administrative Codes Chapter 51, Hospice Care, which includes specific diagnoses. For diagnoses not found Chapter 51, for cases with evidence of other co-morbidities and the evidence of rapid decline, and for pediatric cases, medical necessity review will be conducted on a case-by-case basis by the Physician Advisor.

Hospice providers also electronically submit records to HPE. These records are stored in the document repository. Medicaid-only recipients require a medical review by professional staff, and if the record is approved, the Vendor will submit approved dates through the HPE LTC software for a six month period. The Vendor will also document the dates for the election periods and revocation dates, if applicable, for approved records through the MMIS. If the six month recertification is approved, the LTC file will be extended for another six months. If clinical staff is unable to make a determination the record shall be forwarded to the Physician Advisor for an approval or denial. Hospice providers may request an informal review within 30 calendar days from the date of the denial letter or request a fair hearing within 60 days from the date of the denial letter. The Vendor's physician must prepare for and attend hospice fair hearings.

Hospice providers submit the Hospice Recipient Status Change Form, the 165B, for admissions to hospice when the recipient is in a nursing home for room and board payment. This form is utilized for dually eligible recipients and those recipients with third party insurance. Hospice providers also submit the Form 165B for discharges. For dually eligible recipients, the Vendor must verify Medicare Part A eligibility in the MMIS. The Vendor will submit approved dates through the HPE LTC software.

The selected Vendor will:

- Comply with the applicable requirements of Alabama Medicaid Administrative Code and any revisions thereof.
- Comply with the applicable requirements of the Alabama Medicaid Provider Manual and any revisions thereof.
- Review the appropriate cabinet in the document repository daily to determine what records have been received.
- Ensure reviews are performed by a health care professional with a minimum qualification of a RN with three years hospice experience within 30 calendar days of receipt, and within five business days of receipt of a request for an informal review.
- Submit the dates through the HPE LTC software for all approved records within five business days of the approval.
- Submit the dates of the election periods in the MMIS for Medicaid-only recipients.
- Ensure criteria are consistently applied to all reviews, and that for records for which the clinical staff are unable to make a determination, or are for recipients under 21, or for which Medicaid has no criteria, are forwarded to the Physician Advisor for review.
- Ensure all reviews are documented. The physician approval or denial must also be documented and evidence-based research must support the decision and/or consultation must be done with Medicaid.
- Generate notification of the approval or denial to the hospice provider within two business days of completion of the review. The letter shall contain the recipient's name, Medicaid number, date of service, denial reason (should be indicated in

plain language and reference the appropriate Rule of the Administrative Code or policy), and rights to the appeal process which include both the informal review and a fair hearing.

- Ensure the Physician Advisor and other personnel shall be readily available at Medicaid's request during regular business hours to provide justification for the denial, prepare for, and participate in any informal reviews and fair hearings. The physician and other appropriate personnel must be physically available to attend hearings at a minimum of four days per month, if the hearing case load dictates this level.
- Receive and process Form 165B's and return notification to the provider of the action taken within five business days of receipt.
- Generate a monthly report, no later than 10 business days after the end of the month, to include but not limited to the following:
  - Number of Hospice reviews not processed within the specified timeframes.
  - Number of Hospice reviews requiring physician review.
  - Number of Hospice approvals.
  - Number of Hospice denials with the diagnosis submitted with the record
  - Number of Hospice appeals.
  - Number of Hospice Recipient Status Change Forms processed.
  - Report by Medicaid ID, hospice provider ID, date received by the Vendor, and status of hospice request

As part of the proposal, the Vendor must:

1. Provide a detailed description for an approach to review hospice admissions and re-certifications to ensure hospice criteria are met.
2. Provide a detailed description of the process to ensure records are reviewed timely, as per the timeframes provided above.
3. Provide procedures to ensure staff, including physician consultants are available for informal reviews and/or fair hearings, including preparation for hearings, during regular business hours, at Medicaid's request.
4. Provide a description of the process to ensure Hospice Recipient Status Change Forms are addressed accurately within five business days of receipt and how the provider will be notified of the action taken.

### **3. Prior Authorization (PA) Reviews**

The primary goal of the PA program is to promote the most appropriate utilization of select medical services, supplies and equipment. PA serves as a cost-monitoring, utilization review and quality assurance mechanism for Medicaid. A single PA request may contain multiple lines or details for medical services, supplies and equipment. The Vendor shall use criteria approved by Medicaid to determine approval or denial of PA requests. Medicaid does not currently utilize auto-adjudication. In addition to performing PA functions, the Vendor shall review existing PA criteria and make recommendations for change to Medicaid based on clinical

review of current medical literature, other states' Medicaid program criteria, Medicare and other organizations' criteria including, but not limited to, BCBS of Alabama, and Alabama Quality Assurance Foundation (AQAF). Medicaid shall provide Vendor with existing approved PA criteria and forms in electronic format.

The Vendor shall review and process PA requests from physicians, DME providers, and other appropriate Medicaid providers for medical procedures, equipment, and services requiring PA. These PAs will be submitted for all eligible Medicaid recipients. The number of monthly PAs reviewed for CY 2015 averaged approximately 2,050. The first four months of calendar year 2016 average is 2,065 PAs per month. The count for March 2016 is 2,329. As of November 1, 2015, SOBRA women who previously were eligible for only pregnancy-related services, now have full Medicaid benefits. Therefore, PAs may be submitted for these recipients. The PAs are initially submitted to the Fiscal Agent and the Vendor accesses the information electronically for review. See Appendix B Attachment I for the Prior Authorizations Policy Table of Contents for the policies for which the Vendor is responsible to review at the time of this RFP. This list may change, based upon policy decisions made by Medicaid. See Medicaid Provider Manual Chapter 4, Obtaining Prior Authorization in the Provider Manual for information about the PA process. The Vendor will enter the PA decision in the MMIS. Providers may submit a Form 471, the PA Change Request Form, to submit simple revisions to a PA in evaluation or approved status, such as the addition of a modifier. It is not to be used for denied PAs. The number of Form 471s average approximately 20 per week.

The selected Vendor will:

- Comply with the applicable requirements of Alabama Medicaid Administrative Code and any revisions thereof.
- Comply with the applicable requirements of the Alabama Medicaid Provider Manual and any revisions thereof.
- Review and apply Medicaid PA criteria uniformly to PAs for medical procedures, services, equipment, laboratory tests and private duty nursing
- Ensure reviews are completed for initial and reconsideration requests of denied PAs within 30 calendar days of receipt of the PA by HPE.
- Ensure manual wheelchair with accessories, all power wheelchair and all wheelchair requests for children are reviewed by a qualified physical therapist.
- Ensure reviews are performed and documented by a RN with a minimum of three years of institutional or medical surgical experience.
- Ensure requests for which the RN reviewer is unable to render a decision, is forwarded to a qualified physician.
- Ensure Form 471s are addressed accurately within five business days of receipt.
- Generate a monthly report, no later than 10 business days after the end of the month, to include but not limited to the following:
  - Number of PA requests not processed within the specified timeframes.
  - Number of requests requiring a physician review.
  - Number of PAs requiring a physical therapist review.
  - Number of PA approvals.
  - Number of PA denials categorized by reason for denial.

As part of the proposal, the Vendor must:

1. Provide a detailed description of the process for reviewing services and items that require a PA, using Medicaid criteria.
2. Provide a detailed description of the process to forward to a physician, any request for which the nurse reviewer is unable to render a decision. The description must also include the process of forwarding reviews to a physical therapist, when appropriate, such as those for power wheelchairs.
3. Provide a detailed description of the process to ensure initial requests and reconsiderations are reviewed within 30 calendar days of the addition of the PA into the HPE system.
4. Provide a plan to submit questions and make recommendations to Medicaid about existing PA policies, or to recommend a new policy, based on peer-reviewed literature.
5. Provide a plan to address the Form 471. This form is submitted by providers to request a simple update to a PA in evaluation or approved status, such as an extension to the authorized end date, or the addition of modifiers.

## **IV. General Requirements**

### **A. Informal Review and Fair Hearing**

All adverse review decisions made by the selected Vendor may be subject to an appeal by the requesting provider or recipient (Aggrieved Party). An Aggrieved Party may request an informal review and a fair hearing for denied Medicaid benefits. However, an informal review must be requested and adjudicated before advancing to a fair hearing. The Vendor shall make appropriate personnel available for an informal review and/or fair hearing process in the event such need should arise.

#### **a. Informal Review**

An Aggrieved Party may request a review of an adverse decision through the informal review process by filing a written request with the selected Vendor within 15 business days of the date of the denial letter. Upon receipt of an informal review request, the selected Vendor's consulting Physician Advisor shall review the documentation and render a decision based on Medicaid-approved criteria within five business days of receipt of a complete informal review request. The selected Vendor shall mail notice of the decision to the Aggrieved Party. For PAs, providers have 30 calendar days from the date of the PA decision letter to request reconsideration of the denied PA. The Vendor shall complete review of the additional documentation within 30 days of receipt by HPE.

#### **b. Fair Hearing**

An Aggrieved Party may request a Fair Hearing by filing a written request with the Medicaid Administrative Hearings Office within 60 days from the date of the Informal Review notice of action by the selected Vendor, or the PA decision letter for the reconsideration. The selected Vendor's consulting Physician Advisor and other appropriate personnel who were involved in the denial shall be available at Medicaid's request Monday through Friday, from 8:00 am to 5:00 pm, to provide justification for the denial and participate in any Fair Hearings as scheduled by Medicaid.

## **B. Additional Vendor Responsibilities**

The selected Vendor shall coordinate with the Medicaid Project Coordinator throughout the term of this contract for any questions and further direction as it relates to the requirements of this RFP.

- a. For a period of six months after the beginning of the Contract, Medicaid will schedule weekly conference calls with the selected Vendor. These meetings will address items such as project status, policy questions, and/or data analysis. Following the initial six month period, Medicaid will schedule at a minimum, monthly conference calls.
- b. The selected Vendor will be responsible for creating meeting documents (e.g. agenda, reports, and other supporting documents) for Medicaid approval.
- c. The selected Vendor will make presentations to groups/associations or others regarding this contract and work hereunder only with request and prior approval of Medicaid.
- d. Make recommendations to Medicaid for provider education and outreach as it relates to information and data obtained from requesting providers.
- e. Make recommendations for changes to existing criteria across all programs based on clinical data from approved peer review literature. Recommendations shall also include the addition of new procedures, services or equipment for approval to increase efficiency, program effectiveness, and appropriate utilization as it relates to this RFP.
- f. Respond to inquiries from Medicaid within two business days.

## **C. Staffing/Organizational Plan**

The selected Vendor must be prepared to recruit credentialed/licensed staff, and to implement all aspects of the work required in this RFP within the stated time frames. All physicians, RNs and physical therapists must be licensed in the State of Alabama. The selected Vendor shall ensure that all cases not meeting medical necessity criteria for all program services are reviewed by a Physician Advisor. Staffing levels must be sufficient to complete the responsibilities outlined in this RFP. Vendor's key personnel must include a Project Manager, Clinical Director, Physician Advisors, Physical Therapists, and at a minimum of eight full time RNs. Key positions must meet any requirements defined in the Scope of Work.

The selected Vendor shall submit an organizational chart to Medicaid for approval prior to contract implementation. This plan shall include a breakdown of job duties and responsibilities of all staff members including contracted Physician Advisors. Any subsequent changes to the organizational plan shall be approved by Medicaid.

## **D. Monitoring Performance Standards and Corrective Action Plans**

Medicaid will monitor the selected Vendor's performance according to the requirements contained within this RFP.

Medicaid will inform the selected Vendor when performance does not comply with the contract requirements and of any liquidated damage assessments. The Vendor must prepare and submit for approval a corrective action plan for each identified problem within 10 business days or a timeframe determined by Medicaid. The corrective action plan must include, but is not limited to:

- a. Brief description of the findings.
- b. Specific steps the selected Vendor will take to correct the situation or reasons why the selected Vendor believes corrective action is not necessary.
- c. Name(s) and title(s) of responsible staff person(s).
- d. Timetable for performance of each corrective action step.
- e. Signature of the Clinical Director.

The Vendor must implement the corrective action plan within 10 business days or the timeframe specified by Medicaid. Failure by the selected Vendor to implement corrective action plans, as required by Medicaid, will result in the assessment of liquidated damages.

#### **E. Damages for Cost Associated with Breach of Contract/Liquidated Damages**

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

In the event that Vendor fails to meet the requirements of this RFP and contract requirements, Medicaid will recover damages for cost associated with breach of contract. Medicaid has discretion to assess the actual cost to the Agency associated with the breach, or Medicaid may impose specific amounts as discussed below for a breach of contract. The Vendor agrees to pay Medicaid the sums set forth below unless waived by Medicaid.

Medicaid may impose breach of contract/liquidated damages for the following:

- Failure to deliver requisite reports/services/deliverables as defined by the RFP by the date specified by Medicaid. - \$100 per day per report or review.
- Failure to provide documentation as required by the RFP - \$1000 per instance.
- Failure to comply with any other requirement of the RFP - \$1000 per instance.
- Failure to submit an acceptable required corrective action plan - \$1000 per instance.
- Failure to follow Medicaid criteria and/or directives in approval/denial of PA requests, institutional or hospice reviews - submission of corrective action plan for first instance, then \$1,000 for the next instance. Each subsequent instance shall be increased by \$ 1,000, not to exceed \$ 5,000 per instance.
- Failure to maintain adequate staffing levels necessary to perform the requirements of the RFP - \$1,000 per instance.
- Misrepresentation of falsification of information furnished to CMS, to the State, to an enrollee, potential enrollee or health care provider -\$5,000 per instance.

- Unauthorized use of information shall be subject to the imposition of damages for cost associated with breach of contract in the amount of \$10,000 per instance.
- Failure to safeguard confidential information of providers, recipients or the Medicaid program shall be subject to the imposition of \$10,000 per instance for damages for cost associated with breach of contract and any penalties incurred by Medicaid for said infractions.

In addition,

- The selected Vendor shall be liable for any penalties or disallowance of Federal Financial Participation incurred by Medicaid due to the Vendor's failure to comply with the terms of the contract. Total dollars may include state funds as well as federal funds.
- Imposition of damages for cost associated with breach of contract and/or liquidated damages may be in addition to other contract remedies and does not waive Medicaid's right to terminate the contract.
- Vendor shall receive written notice from Medicaid upon a finding of failure to comply with contract requirements, which contains a description of the events that resulted in such a finding.
- Vendor shall be allowed to submit rebuttal information or testimony in opposition to such findings.
- Medicaid shall make a final decision regarding implementation of damages for cost associated with breach of contract.

#### **F. Operational Requirements**

Vendor shall have hours of operation of Monday-Friday, between 8:00 a.m. through 5:00 p.m., Central Standard Time, excluding holidays as listed below:

- Thanksgiving Day
- Christmas Day
- New Year's Day
- Fourth of July
- Labor Day
- Memorial Day

Vendor shall be responsible for maintaining a minimum of two toll-free lines for direct access by callers for telephone inquiry and a minimum of two dedicated FAX lines for written inquiries and forms. A telephone message shall be provided requesting callers to leave messages. It shall also notify callers during off-hours of the established business hours.

The Vendor agrees to enter into a contract with Medicaid's Fiscal Agent, HPE, to ensure a secure virtual private network (VPN) connection (See Appendix B Attachment L). The Vendor will be responsible for entering and/or interfacing with Medicaid's Decision Support System (DSS) for claims data.

Vendor shall install and maintain the necessary hardware, software, and secure, encrypted data connections necessary to access the Medicaid system. A high-speed VPN connection to the Medicaid Agency Fiscal Agent's Orlando Data Center (ODC) is recommended. Current charges for site to site VPN to the ODC include a setup fee of \$1,600 and quarterly maintenance of \$1,350. HPE will bill subscriber to maintain the site to site VPN connection. Subscriber agrees to pay within 30 days of the date of the invoice. Any prorated amounts will be determined by mutual agreement. HPE shall re-evaluate charges every twelve months. The minimum requirements for configuration of a desktop to be used to access the Medicaid system are as follows:

CPU- 3.0GHz, P4, 800FSB  
Cache- IMB 1.2 Cache  
Connectivity- 10/100/1000 NIC  
Microsoft Windows 8.1  
Microsoft Internet Explorer for access to InterChange MMIS

The Vendor system responsibilities include:

1. Submission of requests for employee passwords for the Medicaid system.
2. Notifying Medicaid when an issued password is no longer needed due to termination of employment or change in duties within five days.
3. Ensuring that its employees are informed of importance of system security and confidentiality.
4. Documenting and notifying Medicaid of system problems to include type of problem, action(s) taken by Vendor to resolve problem and length of system down-time within eight hours of problem identification. Vendor shall ensure that problem is resolved within 24 hours of system down time.
5. Compliance with the requirements of the AMMIS Interface Standards Document and any revisions thereof.

Medicaid system responsibilities include:

1. Obtain security passwords from the Fiscal Agent upon Vendor request.
2. Serve as liaison between Vendor and Fiscal Agent.

Vendor must have a HIPAA-compliant system with effective security measures to prevent the unauthorized use of, or access to, data. The selected Vendor must maintain confidentiality and only use information from the Agency to fulfill its contractual obligations. The Vendor shall utilize appropriate on-line screens maintained within the MMIS to verify recipient eligibility, including Medicare eligibility, provider eligibility, procedure code coverage and enter approval/denial of a PA request. The Vendor shall have access to the Fiscal Agent's Feith document repository where medical documents are maintained, as well as the system-generated PA decision letters and reports to be utilized by the Vendor.

## **G. Work Plan and Implementation Schedule**

Within 30 business days of contract award, the selected Vendor must provide a work plan and implementation schedule to Medicaid electronic format for approval.

Vendor shall complete all prospective, concurrent and retrospective reviews and prior approval requests of medical equipment, procedures, and inpatient psychiatric services not completed by previous vendor, and shall provide support for any pending fair hearings as directed by Medicaid.

The work plan must identify major tasks, the work elements of each task, the resources assigned to the task, the time allotted to each element and the deliverable items the selected Vendor will produce.

#### **H. Medicaid Responsibilities**

Medicaid will provide oversight of the selected Vendor's activities as follows:

- a. Medicaid will perform a random sample audit of charts, records and forms that have been reviewed or processed by the selected Vendor. The audit schedule will be determined by Medicaid; but no more frequently than every three months.
- b. Medicaid will include in the audit a review of referred charts and records.
- c. Medicaid will provide policy changes for all programs to the Vendor as soon as they are made available.
- d. Medicaid will monitor and evaluate the selected Vendor's compliance with the requirements of the contract and impose sanctions when necessary.
- e. Medicaid agrees to correspond to inquiries from the selected Vendor in a timely and accurate manner interpreting Medicaid policy so that the selected Vendor is able to respond and provide deliverables as indicated throughout this RFP.
- f. Medicaid shall review and approve any changes in the form of communication to the Provider by the selected Vendor which may include, but is not limited to, changes in form letters, report formats, new forms or new reports, audit or review tools to be used by the selected Vendor.
- g. Medicaid shall review the selected Vendor's denials of records, at Medicaid's discretion and shall notify the selected Vendor and Provider when Medicaid deems the record shall be approved.
- h. Medicaid shall review the selected Vendor staff credentials during audits.

#### **V. Pricing**

Vendor's response must specify a firm and fixed fee for the services sought under this RFP. The Firm and Fixed Price for each year of the proposed contract and optional extensions must be separately stated in the Pricing Template in Appendix C and the RFP Cover Sheet on the first page of this document.

## VI. General

This document outlines the qualifications which must be met in order for an entity to serve as Vendor. It is imperative that potential Vendors describe, **in detail**, how they intend to approach the Scope of Work specified in Section III of the RFP. The ability to perform these services must be carefully documented, even if the Vendor has been or is currently participating in a Medicaid Program. Proposals will be evaluated based on the written information that is presented in the response. This requirement underscores the importance and the necessity of providing in-depth information in the proposal with all supporting documentation necessary.

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

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

## VII. Transmittal Letter

As part of this proposal, the Vendor must submit a Transmittal Letter. The Transmittal Letter must be an offer from the Vendor in the form of a standard business letter on business letterhead. The Proposal Transmittal Letter must reference and respond to the following subsections in sequence and include corresponding documentation as required. Following the cover sheet and table of contents, the Transmittal Letter must be the first page of the Proposal.

1. The letter must be signed by a company officer empowered to bind the Vendor to the provisions of this RFP and any contract awarded pursuant to it.
2. The letter must provide the name, physical location address (a PO Box address is unacceptable), e-mail address, and telephone number of the person Medicaid should contact regarding the Proposal.
3. The letter must state that the Proposal remains valid for at least one hundred and eighty (180) days subsequent to the Proposal Due Date (Section B, RFP Schedule of Events) and thereafter in accordance with any resulting Contract between the Vendor and Medicaid.
4. The letter must contain 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.
5. The letter must contain a statement stating that the Vendor has an understanding of and will comply with the specifications and requirements described in this RFP.
6. The letter must include a statement identifying any and all subcontractors, if any, who are needed in order to satisfy the requirements of this RFP.
7. The Vendor must acknowledge and state their compliance with the requirements listed in Section 4.6 - Liquidated Damages.

## VIII. 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 Senior Managers and Partners in regards to this contract.
  5. A list of all similar projects the Vendor has completed within the last three years.
  6. A detailed breakdown of proposed staffing for this project, including names and education background of all employees that will be assigned to this project.
  7. Describe any experience relating to Medicaid agencies or other entities for which the Vendor previously or currently performs similar work.
  8. Vendor's acknowledgment that the State will not reimburse the Vendor until:  
(a) the Project Director has approved the invoice; and (b) the Agency has received and approved all deliverables covered by the invoice.
  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.
  10. Must be a Federally Designated QIO under contract with the CMS at the time the contract is awarded, thereby enabling the state to qualify for the 75 percent federal financial participation as established in 42 CFR 433.15(b)(6)(i). The Vendor must provide verification of status as a QIO, e.g., CMS award or contract as the QIO for a state.
- 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](http://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. Within the last three years, describe the overall ability medical and quality utilization review including the technologies, special techniques, skills or abilities of the

organization necessary to accomplish the project requirements, data processing and analysis capabilities.

- 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. **The Vendor may not use any Alabama Medicaid Agency personnel as a reference.** 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.

## IX. 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:

*Project Director:*

**Theresa Carlos**

*Address:*

**Alabama Medicaid Agency**

**Lurleen B. Wallace Bldg.**

**501 Dexter Avenue**

**PO Box 5624**

**Montgomery, Alabama 36103-5624**

*E-Mail Address:*

**MedicalReview-RFP@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](http://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 as described in the Schedule of Events.

#### **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 180 Days**

A proposal may not be modified, withdrawn or canceled by the Vendor for a 180-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 Pricing Templates and the RFP Cover Sheet to indicate the firm and fixed price for the implementation and updating/operation phase to complete the scope of work.

#### **M. Submission of Proposals**

Proposals must be sealed and labeled on the outside of the package to clearly indicate that they are in response to 2016-MQR-02. 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.

#### **N. Copies Required**

Vendors must submit one original hardcopy Proposal with original signatures in ink in binder form, plus two electronic copies of the Proposal on CD/DVD or flash drive clearly labeled with the Vendor name. One electronic copy MUST be a complete Microsoft Word version of the Vendor's response. The Vendor may submit PDF copies for Vendor attachments or forms requiring signatures (e.g. RFP Coversheet, Transmittal Letter, or Pricing Template). The second electronic copy MUST be a complete PDF copy of the Proposal with any information asserted as confidential or proprietary removed. Vendor must identify the original hard copy clearly on the outside of the Proposal.

#### **O. Late Proposals**

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

#### **P. Proposal Format**

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

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

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

#### **Q. Proposal Withdrawal**

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

#### **R. Proposal Amendment**

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

#### **S. Proposal Errors**

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

#### **T. Proposal Clarifications**

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

#### **U. Disclosure of Proposal Contents**

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

other works of authorship, know-how, improvements, discoveries, developments, designs and techniques.

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

## **X. 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 perform a compliance review to determine Vendor’s compliance with the requirements of the RFP and to ensure the standards of responsibility are met. 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.

### **C. Opportunity for Additional Information**

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

### **D. Evaluation Committee**

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

### **E. Scoring**

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

<b>Evaluation Factor</b>	<b>Highest Possible Score</b>
Corporate Background	10
References	5
Scope of Work	45
Price	40
<b>Total</b>	<b>100</b>

**F. Determination of Successful Proposal**

The Vendor whose proposal is determined to be in the best interest of the State will be recommended as the successful Vendor. The Project Director will forward this Vendor’s proposal through the supervisory chain to the Commissioner, with documentation to justify the Committee’s recommendation.

When the final approval is received, the State will notify the selected Vendor. If the State rejects all proposals, it will notify all Vendors. The State will post the award on the Agency website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov). The award will be posted under the applicable RFP number.

**XI. 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 one year effective October 1, 2016, through September 30, 2017. Alabama Medicaid shall have four, 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 the 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 the 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](http://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.

# 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	<b>BASIC PROPOSAL REQUIREMENTS</b>
<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.
<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 Medical and Quality Review program as outlined in the request for proposal regarding each element listed in the scope of work.
<input type="checkbox"/>	10. 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.

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

*Attachment H:* Active Providers

*Attachment I:* Prior Authorizations Policy Table of Contents

*Attachment J:* Virtual Private Network Subscriber Agreement

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 [REDACTED], 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 [REDACTED], dated [REDACTED], 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 [REDACTED].

Contractor and the Alabama Medicaid Agency agree that the initial term of the contract is [REDACTED] to [REDACTED].

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

**2.1.1.** 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

**2.1.2.** Business Associate. “Business Associate” shall generally have the same meaning as the term “business associate” at 45 C.F.R. § 160.103

**2.1.3.** Covered Entity. “Covered Entity” shall generally have the same meaning as the term “covered entity” at 45 C.F.R. § 160.103.

**2.1.4.** 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

TELEPHONE NUMBER

( )

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

Alabama Medicaid Agency

ADDRESS

501 Dexter Avenue, Post Office Box 5624

CITY, STATE, ZIP

Montgomery, Alabama 36103-5624

TELEPHONE NUMBER

(334) 242-5833

This form is provided with:

- Contract   
  Proposal   
  Request for Proposal   
  Invitation to Bid   
  Grant Proposal

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

- Yes   
  No

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

STATE AGENCY/DEPARTMENT 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.)

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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.)

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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

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***By signing below, I certify under oath and penalty of perjury that all statements on or attached to this form are true and correct to the best of my knowledge. I further understand that a civil penalty of ten percent (10%) of the amount of the transaction, not to exceed \$10,000.00, is applied for knowingly providing incorrect or misleading information.***

Signature \_\_\_\_\_ Date \_\_\_\_\_

Notary's Signature \_\_\_\_\_ Date \_\_\_\_\_ Date Notary Expires \_\_\_\_\_  
 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  
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

**Active, Enrolled Medicaid Providers, as of March 17, 2016**

<b>Nursing Facility:</b>	<b>225</b>
<b>Hospice:</b>	<b>151</b>
<b>PEC/Swing Bed:</b>	<b>4</b>
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## Virtual Private Network Subscriber Agreement

**AGREEMENT BETWEEN**  
**HP ENTERPRISE SERVICES, LLC**  
**AND**  
**SUBSCRIBER**

This Agreement, by and between HP ENTERPRISE SERVICES, LLC (hereafter referred to as “HPES”), and approved value added network suppliers and certain health care providers (hereafter referred to as “SUBSCRIBERS”), for the provision of a connection to the Alabama Medicaid Management Information System (AMMIS).

**WHEREAS**, the Alabama Medicaid Agency (the “State Agency”) designated by Alabama law to administer the medical assistance program for the State of Alabama as provided for in Title XIX of the Social Security Act (Medicaid); and

**WHEREAS**, the Alabama Medicaid Agency operates AMMIS through its fiscal agent to allow verification of eligibility, benefits coverage and other insurance, as well as submission of claims for Medicaid recipients by Medicaid providers;

**WHEREAS**, HPES is the fiscal agent of the AMMIS system;

**NOW THEREFORE**, in consideration of the mutual promises herein contained, the parties have agreed and do hereby enter into this agreement according to the provisions set out herein:

### **A. TERM**

This agreement shall be effective upon signature of both parties and shall remain in effect until terminated by either party upon at least thirty (30) days prior written notice to the other party. HPES may terminate this agreement immediately in the event of a violation by SUBSCRIBERS of any term of the agreement.

### **B. SITE TO SITE VPN CONNECTION**

**Connection** – Connection between Subscriber and the AMMIS system is a site to site VPN over the public internet. It is the responsibility of the clearinghouse to provide their own connection to the public internet at a size and speed suitable for the traffic intended at their facility. HPES will provide the connection to the public internet for Alabama Medicaid MMIS system for the purposes of this connection.

**Connection Termination** – Service may be terminated by either party. A written 30 day notice is required for termination with the exception of the following circumstances:

- Should the Subscriber not pay their account within terms, the connection will be severed.
- Should HPES require the connection to be severed per the State Agency, Subscriber will comply within the cancellation terms herein.
- To restore the connection, Subscriber must cure breach or make the account current and pay the setup fee detailed in the **Charges** section of this document.

**Response Time** – The maximum expected response time by HPES is 30 minutes Monday through Friday (8AM to 5PM central time) and 2 hours otherwise. Actual incident recovery time will be dependent on the resolution of the incident. Subscriber should thoroughly test Subscriber owned equipment and connection before contacting HPES for testing.

**Charges** (“Charges”) – HPES will bill Subscriber \$ 1,350.00 per quarter (3 month period) to maintain the site to site VPN connection. A setup fee of \$1,600.00 is required to establish the connection and test. Subscriber agrees to pay within 30 days of the date of the invoice. Any prorated amounts will be determined by mutual agreement. HPES shall reevaluate charges every twelve (12) months. Subscriber agrees that the acceptance of market driven increases shall be a condition of continued performance under this agreement.

**C. INDEMNIFICATION**

The SUBSCRIBERS agrees to indemnify, defend, save and hold harmless HPES from all claims, demands, liabilities, and suits of any breach of this agreement by the SUBSCRIBERS, its Subscribers or employees, including but not limited to any occurrence of omission or negligence of the SUBSCRIBERS, its Subscribers or employees, and more specifically, without limitations:

1. Any claims or losses for services rendered by a subcontractor, consultant, person or firm performing or supplying services, materials or supplies in connection with the performance of the contract;
2. Any claims or losses to any person or firm injured or damaged by the erroneous or negligent acts, including disregard of Federal or State regulations or Federal statutes, of the SUBSCRIBERS, its Subscribers, consultants, officers and employees, or subcontractors in the performance of this agreement;
3. Any claims or losses resulting to any person or firm injured or damaged by the publications, translation, reproduction, delivery, performance, use or disposition of any data processed under the contract in any manner not authorized by the contract, or Federal or State regulations or statutes; and
4. Any failure of the SUBSCRIBERS, its officers, Subscribers, consultants, employees, or subcontractors to observe State or Federal laws, including but not limited to labor laws and minimum wage laws.

**D. NON-EXCLUSIVITY**

HPES shall not be in any way limited from entering into similar contracts with other Subscribers desiring to provide the same or similar service, nor shall HPES be in any way limited from providing the same or similar service directly to health care providers. HPES shall in no way be limited in its use of any information it obtains from the SUBSCRIBERS in connection with this Agreement, and the parties hereto agree that no such information shall be considered proprietary or trade secret information of the SUBSCRIBERS.

**E. Changes and Amendment Language**

Requests for changes will be submitted to the other party in writing for consideration of feasibility and the likely effect on the cost and schedule for performance of the Services. The parties will mutually agree, in writing, upon any proposed changes, including resulting equitable adjustments to costs and performance of the Services

**F. ENTIRE AGREEMENT**

This written Agreement constitutes the entire Agreement between the parties, and no additional representatives, writings or documents are a part hereof, unless specifically referred to herein above. The requirements in the Alabama Data Switch Agreement are hereby incorporated. This Agreement may be amended by written agreement of the parties hereto.

**G. CONTACT PERSONS**

HPES:  
Lamar Smith  
Systems Supervisor  
301 Technacenter Drive  
Montgomery, AL 36117

Phone: (334) 215-4201

SUBSCRIBER:  
Contact: \_\_\_\_\_  
E-Mail: \_\_\_\_\_  
Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State and Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**IN WITNESS WHEREOF**, the parties have by their duly authorized representatives set their signatures.

**SUBSCRIBER**

\_\_\_\_\_  
(sign)  
BY: \_\_\_\_\_  
(print)  
TITLE: \_\_\_\_\_  
DATE: \_\_\_\_\_

**HP ENTERPRISE SERVICES, LLC**

\_\_\_\_\_  
BY: \_\_\_\_\_  
TITLE: \_\_\_\_\_  
DATE: \_\_\_\_\_

## Appendix C: Pricing Forms

### Pricing Template I

Scope of Work Area	Year 1	Year 2	Year 3	Year 4	Year 5
Medical and Quality Reviews					
TOTAL 5 Year Firm and Fixed Costs					

Pricing Template II

During the course of the contract, Medicaid may identify additional work that was not included in the original scope of work but of importance to the progression of the project. Vendors must provide hourly rates for various roles to be used through the end of the project. These rates must be classified by position; i.e., Project Manager, Clinical Director, Physician Advisors, Registered Nurse, etc. The Vendor must provide the hourly rates, inclusive of travel and living expenses and include a brief description of the position. The proposed hourly rates must be effective through the end of the original contract term including the four (4) one (1) year options for extension as described in Section X.C – Term of Contract.

<b>Vendor:</b>		
<b>Authorized Signature:</b>		<b>Date:</b>
<b><u>Staff Title</u></b>	<b><u>Description and Typical Activities</u></b>	<b><u>Hourly Rate</u></b>



## Evaluation Criteria

The following criteria will be used when determining the award of this solicitation.

Evaluation Criteria Group			
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<b>Group:</b> 1	Default		
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<b>Criteria</b>	<b>Description</b>	<b>Response Type</b>	<b>Weight</b>
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1600000014	<b>Document Phase</b> Final	<b>Document Description</b> Medical and Quality Review (2)	<b>Page 3</b> 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

1600000014	<b>Document Phase</b> Final	<b>Document Description</b> Medical and Quality Review (2)	<b>Page 4</b> of 5
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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.

1600000014	<b>Document Phase</b> Final	<b>Document Description</b> Medical and Quality Review (2)	<b>Page 5</b> of 5
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**ATTENTION:** Alabama Medicaid intends to post the Medical and Quality Review (2) RFP specifications document by the close of business on 5/17/16, to the Alabama Medicaid website at:

[http://www.medicaid.alabama.gov/CONTENT/2.0\\_newsroom/2.4\\_Procurement.aspx](http://www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.4_Procurement.aspx).

All questions concerning this RFP must be directed to:

[MedicalReview-RFP@medicaid.alabama.gov](mailto:MedicalReview-RFP@medicaid.alabama.gov)

**Amendment I to RFP 2016-MQR-02**

**06/01/2016**

NOTE THE FOLLOWING AND ATTACHED ADDITIONS, DELETIONS AND/OR CHANGES TO THE REQUIREMENTS FOR THE REQUEST FOR PROPOSAL NUMBER: 2016-MQR-02. 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. Section IV.C, General Requirements - Staffing/Organizational Plan page 15, change as follows:

Currently reads as:

### **C. Staffing/Organizational Plan**

The selected Vendor must be prepared to recruit credentialed/licensed staff, and to implement all aspects of the work required in this RFP within the stated time frames. All physicians, RNs and physical therapists must be licensed in the State of Alabama. The selected Vendor shall ensure that all cases not meeting medical necessity criteria for all program services are reviewed by a Physician Advisor. Staffing levels must be sufficient to complete the responsibilities outlined in this RFP. Vendor's key personnel must include a Project Manager, Clinical Director, Physician Advisors, Physical Therapists, and at a minimum of eight full time RNs. Key positions must meet any requirements defined in the Scope of Work.

The selected Vendor shall submit an organizational chart to Medicaid for approval prior to contract implementation. This plan shall include a breakdown of job duties and responsibilities of all staff members including contracted Physician Advisors. Any subsequent changes to the organizational plan shall be approved by Medicaid.

Revised as:

### **C. Staffing/Organizational Plan**

The selected Vendor must be prepared to recruit credentialed/licensed staff, and to implement all aspects of the work required in this RFP within the stated time frames. All physicians, RNs and physical therapists must be licensed in the state in which they practice. The selected Vendor shall ensure that all cases not meeting medical necessity criteria for all program services are reviewed by a Physician Advisor. Staffing levels must be sufficient to complete the responsibilities outlined in this RFP. Vendor's key personnel must include a Project Manager, Clinical Director, Physician Advisors, Physical Therapists, and at a minimum of eight full time RNs. Key positions must meet any requirements defined in the Scope of Work and the General Requirements.

**Project Manager (PM).** Vendor shall propose a PM with a minimum of an undergraduate degree and minimum of five years' experience in project management, who shall have day-to-day responsibility for supervising the performance and obligations under this Contract, as well as receive policy direction from the Medicaid Contract Administrator. The PM shall have previous experience in a variety of peer review and utilization review activities and PA review process, preferably for a Medicaid program. In addition, the PM shall demonstrate overall understanding of the technical requirements, professional clinical determinations, customer service and quality improvement requirements requested in order to successfully fulfill the obligations of this Contract. In the event the PM does not meet the requirements of Medicaid before or after

implementation, Vendor shall recommend a candidate to Medicaid who is capable of performing contract obligations. Vendor shall not change its PM without prior written approval from Medicaid, and such approval shall not be unreasonably delayed or withheld. Vendor shall make a good faith effort to use the PM for not less than 12 months to ensure successful contract performance. Vendor shall furnish with its response to the RFP a resume for the proposed PM which shall include the individual's name, current address, current title and position, experience with Vendor, experience in implementation or performing PA functions, experience with provider relations, experience with medical and quality review, relevant education and training and management experience. Vendor shall provide a minimum of two work references for the PM.

**Clinical Director.** The Vendor shall assign a Full Time Equivalent (FTE) Clinical Director with five years of medical surgical experience. The Clinical Director shall be a Registered Nurse (RN), Certified Nurse Practitioner (CNP) or Physician. The Clinical Director shall possess superior clinical competence and demonstrate proficiency in medical and quality reviews. Vendor shall furnish with its response to the RFP a resume for the proposed Clinical Director.

Clinical Director which shall include the individual's name, current address, current title and position, experience with Vendor, experience in implementing or performing utilization review functions, relevant education and training, and management experience. Vendor shall provide a minimum of two work references for the Clinical Director. The Clinical Director assigned under this contract, shall be responsible for clinical functions and contract duties. Vendor shall make good faith effort to use the Clinical Director for not less than 12 months to ensure successful contract performance and consistency. Vendor shall notify Medicaid in writing of any proposed change in Clinical Director at least 30 calendar days prior to the change, if possible. Whenever Clinical Director is not reasonably available, Vendor shall provide a designated alternate fully capable of meeting the requirements of this RFP.

**Physician Advisor(s).** Vendor shall furnish with its proposal to the RFP a Physician Advisor(s) with five years clinical practice with specialty of Internal Medicine, Pediatrician or Family Practice. Physician Advisor(s) shall, at a minimum, equal one-half FTE. Experience in utilization management, disease management or hospice is desirable, but not required. A resume for the proposed Physician Advisor(s) shall include the individual's name, current address, current title and position, experience with the Vendor, experience as it relates to the duties described in this RFP, and relevant education and training. A minimum of two work references shall also be included. Physician Advisor(s) shall be available to meet all requirements under this contract. Vendor shall make a good faith effort to use physician (s) for not less than 12 months to ensure successful contract performance and consistency. Vendor shall notify Medicaid in writing of any proposed change in physician (s) at least 30 calendar days prior to the change, if possible.

**Consulting Physical Therapist(s) (PT).** Vendor shall furnish with its proposal to the RFP a consulting PT with a minimum of five years' experience post graduate degree in

the field of physical therapy including evaluation of mobility devices. A resume shall be submitted to Medicaid including the individual's name, current address, current title and position, experience with Vendor, experience as it relates to the duties described in this RFP, and relevant education and training. At a minimum of two work references shall also be included. Consulting PT duties should not constitute one FTE. Vendor shall make good faith effort to use the consulting PT for not less than 12 months to insure successful contract performance. Vendor shall notify Medicaid in writing of any proposed change in consulting PT at least 30 calendar days prior to the change, if possible.

The selected Vendor shall submit an organizational chart to Medicaid for approval prior to contract implementation. This plan shall include a breakdown of job duties and responsibilities of all staff members including contracted Physician Advisors. Any subsequent changes to the organizational plan shall be approved by Medicaid.

II. Appendix C, Pricing Forms – Pricing Template II page 15, change as follows:

Currently reads as:

Pricing Template II

During the course of the contract, Medicaid may identify additional work that was not included in the original scope of work but of importance to the progression of the project. Vendors must provide hourly rates for various roles to be used through the end of the project. These rates must be classified by position; i.e., Project Manager, Clinical Director, Physician Advisors, Registered Nurse, etc. The Vendor must provide the hourly rates, inclusive of travel and living expenses and include a brief description of the position. The proposed hourly rates must be effective through the end of the original contract term including the four (4) one (1) year options for extension as described in Section X.C – Term of Contract.

Revised as:

Pricing Template II

During the course of the contract, Medicaid may identify additional work that was not included in the original scope of work but of importance to the progression of the project. Vendors must provide hourly rates for various roles to be used through the end of the project. These rates must be classified by position; i.e., Project Manager, Clinical Director, Physician Advisors, Registered Nurse, etc. The Vendor must provide the hourly rates, inclusive of travel and lodging associated with travel and include a brief description of the position. The proposed hourly rates must be effective through the end of the original contract term including the four (4) one (1) year options for extension as described in Section X.C – Term of Contract.

I hereby acknowledge the receipt of Addendum I to RFP 2016-MQR-02.

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Authorized Vendor Signature

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Date

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Vendor Organization

# ALABAMA MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION OPERATIONAL MANUAL

## EFFECTIVE JULY 1, 2012

For questions or policy clarifications, please contact:

Solomon Williams

Associate Director, Institutional Services

Alabama Medicaid Agency

501 Dexter Avenue or P. O. Box 5624

Montgomery, Alabama 36103-5624

Phone: 334-353-3206--Fax: 334-353-2309

Email: Solomon.Williams @medicaid.alabama.gov

**OPERATIONAL MANUAL  
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1. Psychiatric Admission Form
2. Request for Continued Stay
3. Discharge Plan
4. Post Discharge Follow-up
5. CMS Qualitative Monitoring Report and Data Collection
6. CMS Payment File
7. CMS Lists of Information for Monitoring and Payment

## I. OVERVIEW

The Medicaid Emergency Psychiatric Demonstration Operational Manual is provided as a resource tool for participating providers. This is a 3-year Demonstration that will permit Alabama Medicaid to provide payment to private psychiatric hospitals for inpatient emergency psychiatric care in IMDs to recipients age 21 to 64 who have expressed suicidal or homicidal thoughts or gestures or determined to be dangerous to themselves or others.

The goal of the Demonstration is to assess whether this expansion of Medicaid coverage to include services provided in private, free-standing inpatient psychiatric facilities improves access to and quality of medically necessary care and whether this change in reimbursement policy is cost-effective. For any questions or clarification of requirements of the Demonstration, you may contact the Clinics/Mental Health Services Associate Director.

### A. Emergency Inpatient Hospital Psychiatric Authority

The Emergency Inpatient Hospital Psychiatric Demonstration project was awarded to Medicaid by CMS. The state has been given statutory waiver authority to allow for payment and Federal matching funds for current IMD exclusion qualifying services.

### B. Participating Freestanding Psychiatric Hospitals

The following hospitals will be participating in the demonstration

<b>Participating Freestanding Psychiatric Hospitals</b>
Mountain View Hospital-Gadsden, AL
Baypointe Hospital-Mobile, AL
Eastpointe Hospital-Mobile, AL
Hill Crest Behavioral Health Services-Birmingham, AL

### C. Recipients to be Served

All participating providers must verify recipient eligibility before services can be billed to Medicaid. Recipients must be between the ages of 21-64, have a psychiatric emergency medical condition of expressing suicidal or homicidal thoughts or gestures, or determined to be dangerous to self or others by means other than suicidal or homicidal thoughts and/or gestures.

These recipients will be allowed to participate and must either have full Medicaid, be Medicaid eligible, or have SOBRA pregnant women coverage on the day of admission. Dual eligible recipients (Medicare/Medicaid) will also be included.

## Emergency Psychiatric Demonstration Operational Manual

All enrolled providers must follow non-discriminatory standards of care for all recipients regardless of eligibility category. Ensuring that no person shall, on the grounds of race, color, creed, national origin, age, health status or handicap, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program of services provided by Medicaid.

Compliance with Federal Civil Rights and Rehabilitation Acts is required of providers participating in the Alabama Medicaid Agency.

## II. DEFINITIONS

### **Active treatment**

The implementation of a professionally developed, supervised, and individualized plan of care. At least one professional member of the interdisciplinary treatment team must be involved in providing active intervention for an unresolved or active problem as noted on the plan of care. Appropriate members of the treatment team must document active intervention when a patient's placement options are unresolved.

### **Care Coordinator**

A registered nurse working for Medicaid's contractor who will determine the appropriateness of the admission and the required stabilization of the patient.

### **Clean Claim**

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

### **CMS**

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

### **Continuity of Care**

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

### **Debarment**

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

### **Disclosing Entity**

The entity is a Medicaid provider or a fiscal agent.

### **Eligible**

A person eligible to receive Medicaid benefits, or certified as eligible to receive Medicaid benefits and who has been issued a Medicaid identification number. For the purposes of this demonstration, eligibility will also be defined as an individual having a psychiatric emergency medical condition of expressing suicidal or homicidal thoughts or gestures, or is determined to be dangerous to self or others by means other than suicidal or homicidal thoughts and/or

gestures.

**Eligibility**

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

**Fiscal Agent**

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

**Fiscal Year**

Defined as October 1 through September 30.

**Follow Up Coordinator**

May be a non-clinical staff member responsible for updating a tracking log with all post discharge information.

**Grievance**

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

**Healthcare Acquired Conditions**

Healthcare Acquired Conditions include Hospital Acquired Conditions (HACs).

**Homicidal**

**Expressing homicidal thoughts or gestures,**

**Hospital Acquired Condition (HAC)**

A condition that is reasonably preventable and not present or identified at the time of admission, but is either present at discharge or documented after admission.

**Indicator**

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

**Institution for Mental Disease (IMD)**

An inpatient psychiatric facility with 17 or more beds in which more than half of the residents between the ages of 21 through 64 have a primary or secondary mental health diagnosis.

**Material Omission**

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

**Medicaid**

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

**Medically Necessary**

Appropriate and necessary services as determined by health care practitioners according to national or community standards. For the purposes of the demonstration, the primary criteria for determining medical necessity will be that the patient is in an emergency psychiatric condition and has not been stabilized.

**Medical Record**

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

**MEPD Eligibility**

For purposes of the Medicaid Emergency Psychiatric Demonstration, only those patients who meet the specific criteria as set forth by Section 2707 of the Affordable Care Act of 2010 which states, “in the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others”, would be considered to have an emergency psychiatric condition. If these conditions are not met, the patient does not meet the terms of an admission.

**Other Provider Preventable Conditions (OPPCs)**

The OPPC’s for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition.

**Per Diem**

An all-inclusive daily rate paid to participating providers for inpatient psychiatric services, including physician services.

**Performance Measure**

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

**Present on Admission (POA)**

A set of specified conditions that are present at the time the order for inpatient hospital occurs. Conditions that develop during an outpatient encounter, including the emergency room, observation or outpatient surgery are considered POA.

**Provider Preventable Conditions (PPCs)**

Defines reportable conditions into two separate categories, Healthcare Acquired Conditions and Other Provider Preventable Conditions (OPPCs).

**Psychiatric Emergency Medical Condition**

A situation in which an individual who expresses suicidal or homicidal thoughts or gestures or is determined to be dangerous to self or others.

**Quality Assurance**

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

**Recipients**

Medicaid eligibles between the ages of 21 through 64 with an emergency psychiatric condition.

**Release of Information Form**

Each participating IMD must have a 'release of information form' signed by the recipient or a representative for the recipient in order for the patient information to be shared with Alabama Medicaid.

**Remittance Advice**

A document that provides a detailed explanation of the transactions that resulted in payment(s) or other financial activity each financial cycle (checkwrite).

**SOBRA**

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

**Stabilization**

A condition in which the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

**Substance Abuse**

Regular use of a substance that results in negative consequences in social, health, or occupational areas.

**Suicidal**

Expressing suicidal thoughts or gestures.

**Third Party Liability (TPL)**

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

**Utilization Review**

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

### III. RECIPIENT CHOICE

#### A. Recipient Choice, Rights and Responsibilities

Recipients must be allowed to select the enrolled inpatient psychiatric hospital of their choice. The enrolled psychiatric hospital must accept all eligible Medicaid recipients between the ages of 21 through 64 with a psychiatric emergency. The following will apply to all recipients served in the Demonstration:

1. Recipients must be provided with all required information regarding rights and responsibilities, grievance process and fair hearing process, and telephone numbers, at the time of enrollment.
2. The hospital must ascertain if a recipient also has third party liability. If TPL is available, obtain the name of the insurance company, the name on the policy (insured), recipient relationship to the insured, address, phone number and policy number. If possible, ascertain from the recipient what type of coverage the policy provides. Verify the information with the insurance company or Medicaid and record all information in the file. Some of this information may be available through the online eligibility systems maintained by Medicaid's Fiscal Agent. **It is vital that this type of information be collected at the beginning of the inpatient stay.**

## **IV. HOSPITAL ENROLLMENT REQUIREMENTS**

### **A. Hospital Enrollment**

The following guidelines apply for Hospital Enrollment in the Demonstration:

1. The hospital must be a private, non-governmental, Institution for Mental Disease (IMD).
2. The hospital must enroll with Medicaid specifically for the Demonstration with a new NPI number
3. Each hospital must sign a 'Memorandum of Understanding' of their responsibilities based on CMS's Terms and Conditions.
4. Each hospital will be assigned by Medicaid a specialty number. This specialty number will allow Medicaid to obtain data related to the Demonstration.

### **B. Facilities Selected by Medicaid for Demonstration**

There are four free-standing, non-governmental, psychiatric inpatient facilities selected by Medicaid for participation in the Demonstration. Each of the facilities has a strong history of providing excellent mental health services in their communities and has worked with both Medicaid and the Alabama Department of Mental Health (ADMH) for a number of years. Since they are located in separate geographic locations within the state, this will enhance recipient access to care.

The following provides additional information about these facilities:

#### **Hill Crest Behavioral Health Services**

6869 5th Avenue South, Birmingham, 35212  
(205) 833-9000  
CEO – Steve McCabe

Hill Crest Behavioral Health Services, an operating unit of parent company Universal Health Services, Inc. (UHS), is a 94-bed facility dedicated to mental health for more than seven decades. Hill Crest is a fully licensed, psychiatric and residential treatment facility which operates out of a three-story, 88,000 square-foot hospital complex. The medical staff manages separate programs in adult, adolescent, and child psychiatry, adolescent residential treatment programs, and intensive adolescent therapeutic group homes located in Jefferson County, Alabama. This facility primarily serves citizens in Jefferson and Shelby Counties, but also covers a wide number of other counties including: Blount, Saint Clair, Walker, Talladega, Cullman, Perry, Tallapoosa, Elmore, Coosa, Marshall, Chilton, Etowah, Bibb, Clay, Dallas, Cherokee,

Calhoun, Tuscaloosa, Winston and DeKalb.

**Mountain View Hospital**

3001 Scenic Drive  
Gadsden, 35902-8406  
(256) 546-9265  
CEO – Dr. Michael Sheehi  
Administrator – Sara Romano

Mountain View Hospital is a 68-bed private freestanding psychiatric hospital located in Gadsden, Alabama. The hospital provides comprehensive inpatient and outpatient psychiatric services for children through adults, along with chemical dependency programs, partial hospitalization, and therapeutic foster care. The hospital serves patients throughout Alabama, primarily serving the northern and central part of the state. This includes Etowah County primarily, as well as the surrounding counties of DeKalb, Marshall, Madison, St. Clair, Calhoun, and Cherokee.

**BayPointe Hospital**

5750-A Southland Drive, Mobile, Alabama 36693  
(251) 661-0153  
CEO – Tuerk Schlesinger  
Administrator – Angela Ferrara

BayPointe Hospital opened its doors in 2001, currently has a 24 bed capacity to serve adults in psychiatric crisis. Accredited by The Joint Commission, BayPointe presently serves Mobile, Baldwin and Washington Counties as the primary service area and the following counties as secondary service areas: Choctaw, Marengo, Dallas, Wilcox, Clarke, Monroe, Autauga, Lowndes, Montgomery, Macon, Elmore, Lee, Russell, Bullock, Pike, Barbour, Henry, Dale, Houston, Geneva, Coffee, Covington, Crenshaw, Butler, Conecuh, Escambia, and Monroe Counties.

**EastPointe Hospital**

7400 Roper Lane, Daphne, Alabama 36526  
CEO – Tuerk Schlesinger  
Administrator – Jarrett Crum

EastPointe Hospital, a 66-bed facility in Daphne, AL., opened in January 2012. It offers inpatient psychiatric services to adults in psychiatric crisis. EastPointe Hospital will serve Mobile, Baldwin and Washington Counties as the primary service area and the following counties as secondary service areas: Choctaw, Marengo, Dallas, Wilcox, Clarke, Monroe, Autauga, Lowndes, Montgomery, Macon, Elmore, Lee, Russell, Bullock, Pike, Barbour, Henry, Dale, Houston, Geneva, Coffee, Covington, Crenshaw, Butler, Conecuh, Escambia, and Monroe Counties.

## **V. DEMONSTRATION PROCEDURES**

### **A. Staff Designation and Roles for Medicaid Contractor**

The Project Coordinator will manage the program to ensure the goals of the project are met, deadlines are adhered to and that CMS is provided the information needed to identify the progress of the Demonstration, to include outcomes data and other information. The Project Coordinator will also be responsible for reviewing/discussing outcomes data with the Alabama Department of Mental Health and CMS.

The Project Coordinator assigned to the emergency psychiatric demonstration for the Alabama Medicaid Agency is Solomon Williams, Associate Director, Clinics/Mental Health Services.

Medicaid will utilize an existing contractual arrangement with a recognized peer review organization to manage concurrent authorization of admission, continued stay and discharge of all recipients upon stabilization, thus meeting the requirements of the demonstration.

A Care Coordinator, who is a registered nurse, will determine the appropriateness of the admission and the continued stay based on the MEPD criteria. It is the responsibility of the Care Coordinator to assure that all emergency psychiatric admissions and continued stays have been reviewed to allow for appropriate billing to Medicaid. For each participating IMD, the designated reviewer will submit the required admission and continued stay review information to the Care Coordinator in order to make a determination. The IMD facility reviewer may be a registered nurse, licensed practical nurse, social worker or have a degree in a related field such as psychology.

A Follow-up Coordinator, who may be non-clinical, will be responsible for updating a tracking log with all post discharge information.

It is the responsibility of both the Care Coordinator and the Follow-up Coordinator to assess whether any of the enrolled inpatient psychiatric hospitals are having difficulty in meeting the Demonstration requirements for stabilizing and transitioning patients based on the data submitted. Both the Care Coordinator and the Follow-up Coordinator (these may or may not be the same person) will report outcomes data received from the participating IMD's on a tracking document to the Program Coordinator on a monthly basis.

### **B. Admission**

A psychiatric emergency medical condition is defined as a situation in which an individual who expresses suicidal or homicidal thoughts or gestures or is determined to be dangerous to self or others. For purposes of the Medicaid Emergency Psych Demonstration, only those patients who meet the specific criteria as set forth by Section 2707 of the Affordable Care Act of 2010 which

## Emergency Psychiatric Demonstration Operational Manual

states, “In the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, or determined dangerous to self or others”, would be considered to have an emergency psychiatric condition. If these conditions are not met, the patient does not meet the terms of an admission.

Upon admission to an IMD, the attending physician will conduct a thorough mental and physical examination of the patient to determine the admitting diagnosis, any contributing factors and to develop a plan of care that will stabilize the patient and provide for a smooth transition to any post-acute care needed. This information, along with an estimate of the number of days needed for stabilization, will be recorded on the Psychiatric Admission Form and signed by the physician.

The Psychiatric Admission Form must be forwarded to Medicaid’s contracted Medical and Quality Review Contractor (hereafter referred to as “Contractor”) **and** Medicaid’s Fiscal Agent, Hewlett Packard (hereafter referred to as HP) within 24 hours of admission. A correctly completed coversheet must be sent with the record mailed to HP. The coversheet is found on Medicaid’s website at this link,

[http://medicaid.alabama.gov/documents/5.0\\_Resources/5.4\\_Forms\\_Library/5.4.3\\_LTC\\_Services/5.4.3\\_MEPD\\_Psych\\_Cover\\_Sheet\\_8-16-12.pdf](http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.3_LTC_Services/5.4.3_MEPD_Psych_Cover_Sheet_8-16-12.pdf). The Contractor’s Care Coordinator will then review the admission to ensure it meets the criteria of the demonstration and that a plan for stabilization is established.

Providers must indicate the referral source on the coversheet as accurately as possible. This data will be collected and submitted to CMS.

The Care Coordinator will have one working day to review this information and send approval or denial to HP and the participating IMD. The approval to the participating IMD must indicate the timeframe that is approved based on the estimated time needed to stabilize the patient. This review will ensure the participating provider meets the intent of the Affordable Care Act, and prior to the third day, a process is in place to ensure the patient is stabilized prior to discharge.

The standardized Psychiatric Admission Form (Attachment No. 1) includes, at a minimum, the following information:

1. Events leading to present hospitalization
2. Diagnosis (within the range of 290-316)
3. History and physical, to include any evidence of substance abuse
4. Mental and physical capacity
5. Summary of present medical findings including prognosis

6. Plan for stabilization\* to include estimated number of inpatient days needed to stabilize the patient.

*\*All patients participating in this Demonstration must be involved in active treatment. "Active treatment" is defined as implementation of a professionally developed and supervised individualized plan of care. At least one professional member of the interdisciplinary treatment team must be involved in providing active intervention for an unresolved or active problem as noted on the plan of care. Appropriate members of the treatment team must document active intervention when a patient's placement options are unresolved.*

### **C. Admission Criteria**

The following criteria will be assessed to determine if a patient meets the definition of a psychiatric emergency medical condition:

- (a) Expressing suicidal or homicidal thoughts or gestures, or determined to be dangerous to self or others by means other than suicidal or homicidal thoughts and/or gestures.

### **D. Continued Stay Review**

If the patient requires additional inpatient treatment beyond the original estimated length of stay due to the fact that the patient's condition has not been stabilized, the participating IMD must forward a request for a continued stay. This request must be sent to the Contractor/Care Coordinator via secure e-mail or fax indicating the specified number of additional days on the standardized Continued Stay Form (Attachment No. 2). This must be done 24-hours prior to the end of the original estimated length of stay. The participating IMD must also mail this to HP, with a completed coversheet. The Contractor/Care Coordinator will have one working day to review and approve or deny the continued stay request and notify the participating IMD.

Stabilization is defined as a condition in which the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

A continued stay may be granted if the patient is still considered to be in a psychiatric emergency situation as evidenced by:

- (a) Expressing suicidal or homicidal thoughts or gestures, or is determined to be a danger to self or others.

### Outliers

An outlier Length of Stay (LOS) is defined as any stay beyond 20 days. In most psychiatric emergencies the average LOS is between 7-10 days. If a patient's LOS exceeds 20 days, the facility must document all steps in the medical record that have been taken to transition the patient to another level of care. In order to qualify for additional days, the patient must continue to meet the criteria for continued stay. Medicaid's Contractor will notify the Agency through the Agency tracking log of all outliers on a monthly basis.

In the case of a commitment to the Department of Mental Health, the patient will be discharged from the MEPD project within 14 days of the commitment date.

### **E. Discharge**

If the physician believes the patient is stabilized, is no longer expressing suicidal or homicidal thoughts or gestures, and no longer considered to be dangerous to self or others, and is ready for discharge, the participating IMD will complete a standardized Discharge Form (Attachment No. 3). The Discharge Form must be signed by the attending physician. The information on this form will provide documentation for a discharge plan of care. Within 3 days after discharge, this form, with a completed coversheet, must be mailed to HP and submitted via secure e-mail or fax, with a completed coversheet, to the Contractor for review by the Follow-up Coordinator.

The Follow-up Coordinator will review the discharge plan to ensure that the patient is appropriately discharged from inpatient care, understands the discharge plan, and intends to follow through with post-acute treatment plan.

### **F. Care Coordination/Management**

The designated IMD reviewer can be a Registered Nurse, Licensed Practical Nurse, Social Worker, or have a degree in a related field such as psychology at the participating IMD will be responsible for the following after the patient is discharged:

- (a) Reporting all information on the Post Discharge Wellness Check Form. (Attachment No. 4)
- (b) All post discharge follow-up forms must be securely e-mailed or faxed to the Contractor within seven working days after the 3 day contact, 21 day contact and 90 day contact. These forms must also be mailed to HP, with a completed coversheet.

The Follow-up Coordinator will be responsible for the following:

- (a) Updating a tracking log with all post discharge information, along with the Care Coordinator
- (b) Forwarding all follow up logs/tracking documents to the Project Coordinator on a monthly basis.

## **G. Outreach**

Notify Providers and other key stakeholders of the purpose of the Demonstration and method for accessing emergency care at one of the participating IMDs.

1. Submit all outreach materials to CMS prior to distribution for approval.
2. Coordination with local community mental health centers, other agencies, and service providers to ensure awareness of the program and to identify other services available to meet the needs of the Medicaid recipient.

## **H. Participating Provider Education**

Medicaid will provide training for each participating IMD which includes, but is not limited to:

1. Program requirements based on CMS's Terms and Conditions
2. Concurrent review procedures
3. Billing procedures
4. Expectations for discharge planning process

## **I. Billing Inquiries/Claims Resolution**

All claims must be filed with HP. A provider representative from HP will assist in resolving claims issues.

Claims will only be accepted for a complete inpatient episode of care. A claim may not be split across two quarters (e.g., a patient starts treatment in one quarter and ends treatment in the next quarter). Hold the claim until the entire episode has been completed and then submit it to Medicaid as it cannot be submitted to CMS otherwise.

All claims that are billed with a patient status that indicates "still a patient" will initiate a review and may be denied.

Participating IMDs shall only refer claim inquiries to Medicaid that require an administrative review and cannot be resolved by HP.

Providers may refer to the Provider Manual Chapter 5 – Filing Claims for information regarding filing claims for all UB-04 claims and to Provider Manual Chapter 44 – Emergency Psychiatric IMD’s (ages 21 -64), for information on policy.

## **J. Appeals Process**

All adverse review decisions made by the Contractor may be subject to an appeal by the requesting provider or recipient (Aggrieved Party). An Aggrieved Party may request an informal review and a fair hearing for denied Medicaid benefits. However, an informal review must be requested and adjudicated before advancing to a fair hearing.

### **a. Informal Review**

An Aggrieved Party may request reconsideration of an adverse decision through the informal review process by filing a written request with Contractor within 30 calendar days of the date of the denial letter. Upon receipt of a reconsideration request, the Contractor’s consulting physician shall review the documentation and render a decision based on Medicaid-approved criteria within five working days of receipt of a complete reconsideration request. Contractor shall mail notice of the reconsideration decision to the Aggrieved Party and enter the decision into the system.

### **b. Fair Hearing**

An Aggrieved Party may request a Fair Hearing by filing a written request with the Medicaid Administrative Hearings Office within 60 calendar days of the date of the reconsideration denial notice by the Contractor. The Contractor’s consulting physician and other appropriate personnel who were involved in the denial shall be available at Medicaid’s request to attend any Fair Hearings and provide justification for the denial.

Refer to Provider Manual Chapter 7, Understanding Your Rights and Responsibilities as a Provider for details on requesting an informal review or a fair hearing.

## VI. ADVERSE EVENTS

### A. Payment Adjustment for Provider Preventable Conditions (PPCs)

Effective for Dates of Service October 1, 2011, and thereafter; Medicaid is mandated to meet the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for Provider-Preventable Conditions (PPC's).

Provider Preventable Conditions are clearly defined into two separate categories: Healthcare Acquired Conditions and Other Provider Preventable Conditions (OPPC's).

Healthcare Acquired Conditions include Hospital Acquired Conditions (HACs). Other Provider Preventable Conditions refer to OPPCs.

No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the identified PPCs would otherwise result in an increase in payment. It is the responsibility of the **provider** to identify and report any PPC and **not seek payment** from Medicaid for any additional expenses incurred as a result from the PPC. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

To be reportable, PPC's must meet the following criteria:

- The PPC must be reasonably preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.
- The PPC must be clearly and unambiguously the result of a preventable mistake made and provider procedures not followed, and not an event that could otherwise occur.
- The PPC must result in significant harm. The OPPCs for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for

more than 30 days, is not present at the time services were sought and is not related to the presenting condition.

- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some adverse events may be clear, most would require further investigation and internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

OPPCs **must be reported to Medicaid** by encrypted emailing of the required information to:

[AdverseEvents@medicaid.alabama.gov](mailto:AdverseEvents@medicaid.alabama.gov). Providers that do not currently have a password for the Adverse Event reporting may request one by contacting Solomon Williams at [Solomon.Williams@medicaid.alabama.gov](mailto:Solomon.Williams@medicaid.alabama.gov) or via phone at 334-353-3206.

The following information is required for reporting:

- Recipient first and last name
- Date of birth
- Medicaid number
- Date event occurred
- Event type

A sample form is on the Alabama Medicaid Agency website at [www.medicicaid.alabama.gov](http://www.medicicaid.alabama.gov) under Programs/Medical Services/Hospital Services. Providers may submit their own form as long as it contains all of the required information.

Inpatient Psychiatric Hospitals are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Hospital-Acquired Condition (HAC) and not seek payment for any additional days that have lengthened a recipient's stay due to a HAC. These days should be reported on the UB-04 claim with a value code of '81' and an amount greater than '0'.

## **B. Reporting HACs and Present on Admission (POA) on the UB-04 Claim Form**

Inpatient psychiatric hospitals should use the POA indicator on claims for HACs listed below; with the exception of Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients as identified by

## Emergency Psychiatric Demonstration Operational Manual

Medicare. If no claim is submitted for the HAC, then the Alabama Medicaid Agency is to be notified via encrypted e-mail at [AdverseEvents@medicaid.alabama.gov](mailto:AdverseEvents@medicaid.alabama.gov). (See reporting information above)  
Below are HACs with ICD-9 Codes that hospitals are required to report on the UB-04 claim form:

<b>Selected HAC</b>	<b>CC/MCC (ICD-9-CM Codes)</b>
Foreign Object Retained After Surgery	998.4 (CC) and 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) and 707.24 (MCC)
Falls and Trauma: -Fracture -Dislocation -Intracranial Injury -Crushing Injury -Burn -Electric Shock	Codes within these ranges on the CC/MCC list: 800-829.1 830-839.9 850-854.1 925-929.9 940-949.5 991-994.9
Catheter-Associated Urinary Tract Infection (UTI)	996.64—Also excludes the following from acting as a CC/MCC: 112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC), 590.81 (CC), 595.0 (CC), 597.0 (CC), 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of poor glycemic control	250.10-250.13 (MCC), 250.20-250.23 (MCC), 251.0 (CC), 249.10-249.11 (MCC), 249.20-249.21 (MCC)
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) and one of the following procedure codes: 36.10-36.19.
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) OR 998.59 (CC) and one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85.

<b>Selected HAC</b>	<b>CC/MCC (ICD-9-CM Codes)</b>
Surgical Site Infection Following Bariatric Surgery for Obesity	Principal Diagnosis code-278.01 OR 998.59 (CC) and one of the following procedure codes: 44.38,44.39, or 44.95
Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)	996.61 (CC) or 998.59 (CC) and one of the following procedure codes: 00.50, 00.51, 00.52, 00.53, 00.54, 37.74, 37.75, 37.76, 37.77, 37.79, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, 37.96, 37.98
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC), 415.19 (MCC), or 453.40-453.42 and one of the following procedure codes: 81.51-81.52, 81.54.
Iatrogenic Pneumothorax with Venous Catheterization	512.1 (CC) and the following procedure code: 38.93

The hospital may use documentation from the physician’s qualifying diagnoses to identify POA which must be documented within 72 hours of the occurrence. Medicaid also recommends that the PPC be reported to Medicaid on the claim or via e-mail within 45 days of occurrence.

Medicaid will accept all POA indicators as listed below:

- **Y**-Yes. Diagnosis was present at time of inpatient admission.
- **N**-No. Diagnosis was not present at time of inpatient admission.
- **U**-No information in the record. Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- **W**-Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

Hospital records will be retroactively reviewed by Medicaid’s contracted Quality Improvement Organization (QIO). If any days are identified that are associated with a lengthened stay due to a PPC; then Medicaid will initiate recoupment for the identified overpayment.

It is the hospital’s responsibility to include all supporting documentation with the chart for a review to be conducted by Medicaid’s contracted Quality Improvement Organization (QIO). Submission of a root cause analysis is not

required but may be submitted as part of the documentation to support billing.

### **C. Reporting of Serious Adverse Events**

Serious Adverse Events occurring during an IMD stay include death, physical injury whether self-induced or accidental, nosocomial infection, or illness and any emergency admission to an acute care hospital for any reason. Adverse Events are to be reported on the IMD Discharge Plan Form which must be signed by the attending physician. Within 3 days after discharge, this information must be reported to the Alabama Medicaid Agency by encrypted emailing of the discharge form to:

[AdverseEvents@medicaid.alabama.gov](mailto:AdverseEvents@medicaid.alabama.gov). Providers that do not currently have a password for the Adverse Event reporting may request one by contacting Solomon Williams at [Solomon.Williams@medicaid.alabama.gov](mailto:Solomon.Williams@medicaid.alabama.gov) or via phone at 334-353-3206.

## **VII. PAYMENT FOR SERVICES**

### **A. Provider Payment**

Participating IMDs will submit claims through HP, Medicaid's fiscal agent. Hospitals will be paid a flat per diem rate and will be paid as per the existing Medicaid checkwrite schedules, which usually occur twice a month. This will be a global type fee arrangement. Each hospital will be responsible for negotiating physician payments as part of the global reimbursement. There will be no additional compensation for the inpatient care of these recipients.

### **B. CMS-State Payment Process**

Medicaid has agreed to meet CMS's Terms and Conditions for data submissions and claims submissions. CMS will monitor the Demonstration and requires the following from Medicaid:

1. Medicaid will submit to CMS quarterly, based on the Federal Fiscal year, pertinent data and information for payment and monitoring purposes within 30 days of the end of each payment quarter. The information requirement is in Attachment Number's 5, 6, and 7.
2. CMS will provide Federal matching funds for Medicaid payments made to participating IMDs for inpatient services to Medicaid beneficiaries aged 21 to 64 for services provided to stabilize an emergency psychiatric condition. CMS will provide the Federal matching payment to Medicaid on a quarterly basis at the regular Federal Medical Assistance Percentage (FMAP).
3. CMS or its contractual representative will notify Medicaid if the data are

## Emergency Psychiatric Demonstration Operational Manual

clean and accepted for payment, or notify the State within 30 days of submission that corrective actions or supplemental data are needed. Medicaid will have up to 10 days to resubmit claims to CMS. Payments will only be issued upon the clearance of submitted data. If CMS determines that data quality is inadequate for the claim payment in the quarter submitted, the claim will be rejected; however, the State may resubmit the claim for payment the next quarter.

4. The monitoring and claims information data provided quarterly by Medicaid will be submitted through encrypted spreadsheets that meet the 256-bit Advanced Encryption Standard (AES). Quarterly claims information will be forwarded to the IMPAQ International at [MEPD@impaquint.com](mailto:MEPD@impaquint.com). IMPAQ will send the data to the Office of Financial Management (OFM). In order to provide CMS and Medicaid with some indication of the distribution of funding vis-à-vis the funding limit and to provide for a fair and equitable spending target for each State, a mechanism will be implemented to provide a continual estimate of anticipated expenditures for each State and to set and adjust spending limits for each State based on real and anticipated patient admissions and costs. This mechanism will be used to set and adjust spending guides or limits to help to assure that all States are allowed to participate for the full three years of the Demonstration without exceeding the total funding limitation. States will be provided with these readjusted, predicted spending limits on a quarterly basis. In this way, both CMS and the States will be able to assess their cumulative expenditures relative to the total Demonstration funding limitation.
5. All State claims for FMAP subject to the Demonstration spending limit (including all settlements) must be made within 1 year after the calendar quarter in which the State incurred the expenditure. Furthermore, all claims for services rendered during the Demonstration period (including any cost settlements) must be made within 1 year after the conclusion of termination of the Demonstration.
6. Should data be audited by CMS, the State will be held responsible for return of funding for claims submitted that cannot be substantiated.
7. In no case will the aggregate amount of payments made by CMS to all eligible States under the Demonstration exceed the total Federal spending limit for the Demonstration. Medicaid understands that if CMS finds that the volume or cost of services substantially deviates from that agreed upon in the beginning of the Demonstration, it reserves the right to adjust patient census and expenditure estimates, reset State-level spending limits, and reapportion funds at its discretion.
8. Any payments to Alabama Medicaid by CMS made in error or in excess of

state-level spending limits under the Demonstration will be returned to CMS. Medicaid is aware that CMS reserves the right to withhold up to 20 percent of payments in the last payment quarter of the Demonstration in order to offset any funds that would have to be recouped. If no errors or excess spending occurs, withheld payments will be returned to Medicaid.

9. Medicaid agrees that information about services provided under the Demonstration will not be included on the CMS Form 64. Any duplicative Federal matching payment made as a result of any such an inclusion will be recouped by CMS.

## **VIII. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT**

Medicaid is responsible for developing quality of care measures and reporting treatment outcomes to CMS. Measures that have been identified include but are not limited to the following:

1. Identifying the percentage of Medicaid eligibles who are admitted to participating IMDs compared with admissions to other facilities (i.e. acute care hospitals, state hospitals, etc.).
2. Decrease the number psychiatric boarding patients.
3. Increase continuity of care through discharge planning/follow-up care.
4. Improve patient access to emergency mental health and healthcare services.

Medicaid will measure the outcomes in several ways:

1. By obtaining data from all acute care hospitals at beginning and end of Demonstration to determine number of psychiatric admissions and emergency room visits.
2. By tracking admissions to the state facilities to see if they decrease during the Demonstration.
3. By tracking access to community mental health and/or substance abuse services to determine the impact of a more seamless transition from inpatient to community care.
4. By surveying community providers to gain their perceptions of Demonstration's impact on continuity of care, particularly with respect to patients with co-occurring conditions.

The Care Coordinator/Follow-up Coordinator will assist the Program Coordinator in providing this data to CMS and the Department of Mental Health.

## **IX. RECORDS AND REPORTS**

### **A. Qualitative Monitoring Report and Data Collection**

On a quarterly basis Medicaid will report to CMS any updates or changes in the areas listed below. These changes will be reported for every upcoming quarter on the attached CMS Qualitative Monitoring Report and Data Collection Report. The following are areas that are addressed in this report:

1. Staff Designations and Roles
2. Administration and Management
3. Institutions of Mental Diseases
4. Program Implementation
5. Qualitative Monitoring Report and Data Collection
6. Enrollment and Expenditure Tracking
7. Serious Adverse Events
8. Evaluation Support
5. Other Updates

## **X. MEDICAID OVERSIGHT**

### **A. General**

Medicaid shall monitor all participating IMD's performance through a combination of performance measures, medical record reviews and administrative reviews. The purpose of oversight activities is to ensure that contract requirements are being met; standards of care are being implemented and enforced.

**RFP # 2016-MQR-02**  
**Medical and Quality Review (2) RFP**  
**Round 1**  
**Vendor Questions and Medicaid Answers**  
**June 1, 2016**

<b>Question ID:</b>	1
<b>Date Question Asked:</b>	May 23, 2016
<b>Question:</b>	May I know who is the incumbent or current service provider for this project?
<b>Section Number:</b>	N/A
<b>RFP Page Number:</b>	N/A
<b>Medicaid Answer:</b>	The current vendor is Qualis Health.
<b>Question ID:</b>	2.
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Please indicate the number of days available for implementation/transition activities after the new contract is signed and approved by the state.
<b>Section Number:</b>	Section B. Schedule of Events
<b>RFP Page Number:</b>	3
<b>Medicaid Answer:</b>	There would be approximately 60 days for implementation transition activities.
<b>Question ID:</b>	3
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	The RFP provides historical volume of cases from 2015. Is this the volume that bidders should anticipate during the new contract? Please provide the number of reviews per year, for the five years period of performance, in each institutional review category that should be used for budgeting purposes.
<b>Section Number:</b>	3.1 Scope of Work Institutional Record Reviews
<b>RFP Page Number:</b>	8, 9

<b>Medicaid Answer:</b>	Calendar Year	Nursing Facility	Hospice	Inpatient Psychiatric Facility (does not include MEPD) <sup>1</sup>	Prior Authorizations
	2012	2,853	1,636	4,319	18,011
	2013	2,795	1,429	166	18,827
	2014	2,631	1,353	178	21,179
	2015	2,476	1,786	155	23,117
<sup>1</sup> Inpatient psychiatric facility reviews were revised to a 5% retrospective review, rather than a prior authorization process, effective in 2012. There were 3,309 recipients for whom a claim was filed for a date of service in calendar year 2015 (does not include MEPD). The current Vendor started reviews July 2011, so the four full calendar years are provided.					
<b>Question ID:</b>	4				
<b>Date Question Asked:</b>	May 24, 2016				
<b>Question:</b>	What process should be used to provide review results for individual cases to the state? Will review results be submitted to the MMIS?				
<b>Section Number:</b>	3.1 Scope of Work Institutional Record Reviews				
<b>RFP Page Number:</b>	9				
<b>Medicaid Answer:</b>	The Vendor should have an audit tool to document the individual cases reviewed. These should be available at Medicaid's request.				
<b>Question ID:</b>	5				
<b>Date Question Asked:</b>	May 24, 2016				
<b>Question:</b>	Please provide the anticipated number of reviews per year, for the five year period of performance, that should be used for budgeting purposes.				
<b>Section Number:</b>	3.2 Scope of Work Hospice Records Reviews				
<b>RFP Page Number:</b>	10				
<b>Medicaid Answer:</b>	Below are estimates only; based on an approximate 9 % change.				
	Calendar Year	Estimated Hospice Reviews			
	2017	2130			
	2018	2326			
	2019	2540			
	2020	2773			
	2021	3028			
<b>Question ID:</b>	6				
<b>Date Question Asked:</b>	May 24, 2016				
<b>Question:</b>	Is the state open to the Hospice providers sending records directly to the vendor?				

<b>Section Number:</b>	3.2 Scope of Work Hospice Records Reviews													
<b>RFP Page Number:</b>	11													
<b>Medicaid Answer:</b>	No.													
<b>Question ID:</b>	7													
<b>Date Question Asked:</b>	May 24, 2016													
<b>Question:</b>	The historical volume of Prior Authorization reviews has grown significantly since 2015. Please provide the anticipated number of Prior Authorization reviews per year, for the five years period of performance, that should be used for budgeting purposes.													
<b>Section Number:</b>	3.3 Scope of Work Prior Authorization (PA) Reviews													
<b>RFP Page Number:</b>	13													
<b>Agency Answer:</b>	<table border="1"> <thead> <tr> <th>Calendar Year</th> <th>Estimated Number of Pas</th> </tr> </thead> <tbody> <tr> <td>2017</td> <td>25,198</td> </tr> <tr> <td>2018</td> <td>27,465</td> </tr> <tr> <td>2019</td> <td>29,937</td> </tr> <tr> <td>2020</td> <td>32,632</td> </tr> <tr> <td>2021</td> <td>38,770</td> </tr> </tbody> </table>	Calendar Year	Estimated Number of Pas	2017	25,198	2018	27,465	2019	29,937	2020	32,632	2021	38,770	Above are estimates only; based on an approximate 9% change.
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2017	25,198													
2018	27,465													
2019	29,937													
2020	32,632													
2021	38,770													
<b>Question ID:</b>	8													
<b>Date Question Asked:</b>	May 24, 2016													
<b>Question:</b>	The RFP indicates the state does not currently use auto-adjudication. Would the state allow the successful bidder to use an auto-adjudication process as part of the new contract?													
<b>Section Number:</b>	3.3 Scope of Work Prior Authorization (PA) Reviews													
<b>RFP Page Number:</b>	12													
<b>Medicaid Answer:</b>	No.													
<b>Question ID:</b>	9													
<b>Date Question Asked:</b>	May, 24, 2016													
<b>Question:</b>	For informal reviews, the physician advisor must complete the review in five days. For reconsiderations, the physician advisor must complete the review in 30 days. Please clarify the difference in the time frames.													
<b>Section Number:</b>	4.A General Requirements Informal Review and Fair Hearing													
<b>RFP Page Number:</b>	14													
<b>Agency Answer:</b>	"Reconsiderations" apply to prior authorization reviews only.													
<b>Question ID:</b>	10													
<b>Date Question Asked:</b>	May 24, 2016													
<b>Question:</b>	Please provide the anticipated number of informal reviews, reconsiderations, and fair hearings per year that should be used for budgeting purposes.													
<b>Section Number:</b>	4.A General Requirements Informal Review and Fair Hearing													

<b>RFP Page Number:</b>	14																																																
<b>Medicaid Answer:</b>	<p>There were only 22 fair hearings requested for PAs in CY 2015. Twenty of the fair hearings were for PDN services and only two were for other services. All the fair hearings were either withdrawn or denied. The estimates below are for PDN PAs only.</p> <table border="1"> <thead> <tr> <th>Calendar Year</th> <th>Estimated Number of PDN Denials</th> <th>Estimated Number of PDN Fair Hearings Requested</th> </tr> </thead> <tbody> <tr> <td>2017</td> <td>47</td> <td>22</td> </tr> <tr> <td>2018</td> <td>52</td> <td>24</td> </tr> <tr> <td>2019</td> <td>57</td> <td>26</td> </tr> <tr> <td>2020</td> <td>62</td> <td>29</td> </tr> <tr> <td>2021</td> <td>68</td> <td>32</td> </tr> </tbody> </table> <p>The table below are estimates for reconsiderations for all PAs.</p> <table border="1"> <thead> <tr> <th>Calendar Year</th> <th>Estimated Number of Reconsiderations</th> </tr> </thead> <tbody> <tr> <td>2017</td> <td>2456</td> </tr> <tr> <td>2018</td> <td>3295</td> </tr> <tr> <td>2019</td> <td>4422</td> </tr> <tr> <td>2020</td> <td>5933</td> </tr> <tr> <td>2021</td> <td>4961</td> </tr> </tbody> </table> <p>Providers requested a fair hearing for approximately 18% of denied hospice records for calendar year (CY) 2015. Approximately 20% of hospice records were denied for CY 2015. Of the 63 hospice fair hearings requested for CY 2015, 31 were withdrawn or denied. Based on this and estimates provided for question 5, please see estimates below. Medicaid is unable to provide the exact number of informal reviews requested.</p> <table border="1"> <thead> <tr> <th>Calendar Year</th> <th>Estimated Number of Hospice Denials</th> <th>Estimated Number of Hospice Fair Hearings Requested</th> </tr> </thead> <tbody> <tr> <td>2017</td> <td>426</td> <td>77</td> </tr> <tr> <td>2018</td> <td>465</td> <td>84</td> </tr> <tr> <td>2019</td> <td>508</td> <td>91</td> </tr> <tr> <td>2020</td> <td>555</td> <td>100</td> </tr> <tr> <td>2021</td> <td>606</td> <td>109</td> </tr> </tbody> </table>	Calendar Year	Estimated Number of PDN Denials	Estimated Number of PDN Fair Hearings Requested	2017	47	22	2018	52	24	2019	57	26	2020	62	29	2021	68	32	Calendar Year	Estimated Number of Reconsiderations	2017	2456	2018	3295	2019	4422	2020	5933	2021	4961	Calendar Year	Estimated Number of Hospice Denials	Estimated Number of Hospice Fair Hearings Requested	2017	426	77	2018	465	84	2019	508	91	2020	555	100	2021	606	109
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<b>Question ID:</b>	11																																																
<b>Date Question Asked:</b>	May 24, 2016																																																
<b>Question:</b>	Please clarify the difference between a informal review and a reconsideration.																																																
<b>Section Number:</b>	4.A General Requirements Informal Review and Fair Hearing																																																
<b>RFP Page Number:</b>	14																																																

<b>Medicaid Answer:</b>	“Informal review” pertains to nursing home, hospice PEC swing-bed, inpatient psychiatric hospital records. “Reconsideration” pertains to prior authorizations.
<b>Question ID:</b>	12
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Does reference to a physician advisor using Medicaid approved criteria mean: 1) Advisors use criteria to make decisions, or 2) do Physician Advisors use standard of care guidelines and their medical judgement to render peer to peer determinations?
<b>Section Number:</b>	4.A General Requirements Informal Review and Fair Hearing
<b>RFP Page Number:</b>	14
<b>Medicaid Answer:</b>	Advisors use Medicaid criteria to make decisions.
<b>Question ID:</b>	13
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	What is the timeline for the Hearings Office to notify the vendor of a Fair Hearing request?
<b>Section Number:</b>	4.A General Requirements Informal Review and Fair Hearing
<b>RFP Page Number:</b>	14
<b>Medicaid Answer:</b>	The Hearing Officer notifies the appropriate Agency staff when a fair hearing request is received. Medicaid staff will in turn notify the Vendor to forward securely any review documents not available in the document repository. There is no set timeframe. The timeframe can vary from case to case.
<b>Question ID:</b>	14
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	The RFP indicates the state MMIS produces decision letters for Prior Authorization cases. Does the MMIS produce decision letters for any other review types?
<b>Section Number:</b>	4.F General Requirements Operational Requirements
<b>RFP Page Number:</b>	18
<b>Medicaid Answer:</b>	No.
<b>Question ID:</b>	15
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Please provide the estimated number of reviews not completed by the previous vendor that will be trasfered to the successful bidder. If possible, please provide the estimated review volume for the transferred cases sorted by review category.
<b>Section Number:</b>	4.G General Requirements Work Plan and Documentation Schedule
<b>RFP Page Number:</b>	19

<b>Medicaid Answer:</b>	The incumbent Vendor is currently up to date for all the review types. It is feasible that the backlog may consist of one month's average for each review type.
<b>Question ID:</b>	16
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Appendix C does not provide a place to record start up costs. How should bidders document start up costs incurred during the implementation period?
<b>Section Number:</b>	Appendix C Pricing Forms
<b>RFP Page Number:</b>	56
<b>Medicaid Answer:</b>	All costs need to be included in the pricing templates. Medicaid does not allow the Vendor to bill for costs incurred before the execution date of the contract.
<b>Question ID:</b>	17
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	What was the total amount paid to the current vendor during the last state fiscal year? Is the scope of work and review volume of the current contract substantially the same as described in the RFP for the new contract?
<b>Section Number:</b>	N/A
<b>RFP Page Number:</b>	N/A
<b>Medicaid Answer:</b>	The total amount paid for FY 2015 was \$1,470,651.64. Yes.
<b>Question ID:</b>	18
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Has the state identified an expected contract amount or maximum contract value for the current procurement? If so, please provide that information.
<b>Section Number:</b>	N/A
<b>RFP Page Number:</b>	N/A
<b>Medicaid Answer:</b>	No.
<b>Question ID:</b>	19
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Does the state reimburse providers for the cost of supplying records for review? If so, how should these costs be reflected in the the Pricing Form? How much funding should be included in the budget for provider reimbursement?
<b>Section Number:</b>	N/A
<b>RFP Page Number:</b>	N/A
<b>Medicaid Answer:</b>	No, Medicaid does not reimburse providers for the cost of supplying records for review.
<b>Question ID:</b>	20
<b>Date Question Asked:</b>	May 24, 2016

<b>Question:</b>	Would the state consider changing the hourly labor rates to be exclusive of travel and living expenses so you would have more of a true time and material (T&M) rate structure. Depending of the additional work being requested by the state, it may cost the state less in the short run and in the long run using T&M rates and reimbursement of actual travel costs.
<b>Section Number:</b>	Appendix C Pricing Forms
<b>RFP Page Number:</b>	57
<b>Medicaid Answer:</b>	Please refer to Amendment I posted on the Medicaid Website on 6/1/2016.
<b>Question ID:</b>	21
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Are any of the key personnel positions required to be full time other than the eight full time RNs.
<b>Section Number:</b>	4.C General Requirements Staffing/Organizational Plan
<b>RFP Page Number:</b>	15
<b>Medicaid Answer:</b>	The Clinical Director is required to be full-time.
<b>Question ID:</b>	22
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Can we bid less than eight full time RNs if our internal operating metrics indicate we can adequately perform the scope of work with fewer RNs
<b>Section Number:</b>	4.C General Requirements Staffing/Organizational Plan
<b>RFP Page Number:</b>	No.
<b>Question ID:</b>	23
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	The released RFP deleted the requirements for Inpatient Medical Record Reviews and implementation of HCBS Waiver Reviews. Was there a reason for this change, and can the State estimate the reduction in level of effort in terms of percentage? For example, is the new level of effort approximately 30% of the previous scope?
<b>Section Number:</b>	General
<b>RFP Page Number:</b>	N/A
<b>Medicaid Answer:</b>	Deletion of the requirements for inpatient medical records and HCBS waiver records reviews was deleted due to the delay in the implementation of the Regional Care Organizations (RCOs). Medicaid cannot estimate the reduction in level of effort.
<b>Question ID:</b>	24
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Please provide a list of review volumes?
<b>Section Number:</b>	General
<b>RFP Page Number:</b>	N/A
<b>Medicaid Answer:</b>	Please see Medicaid Answer to question 3.

<b>Question ID:</b>	25
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Are the Medicaid PA criteria developed by Alabama, and if so, does the QIO have responsibility to assist with their development?
<b>Section Number:</b>	II. Medical and Quality Reviews
<b>RFP Page Number:</b>	7
<b>Medicaid Answer:</b>	Yes, the PA criteria are developed by Medicaid. Please refer to General Requirements, B. Additional Vendor Responsibilities, e.
<b>Question ID:</b>	26
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	<ul style="list-style-type: none"> <li>a) Is there a six-month time lag for the sampling frame for these reviews? If so, would Medicaid consider a more concurrent timeframe based on billing?</li> <li>b) Would the State consider additionally targeting the sample on areas that would provide feedback to providers relevant to the RCO when it is implemented</li> </ul>
<b>Section Number:</b>	III.1 Institutional Record Reviews
<b>RFP Page Number:</b>	8-9
<b>Medicaid Answer:</b>	<ul style="list-style-type: none"> <li>a) Please clarify and resubmit this question for Medicaid to review and answer.</li> <li>b) No, not at this time.</li> </ul>
<b>Question ID:</b>	27
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	The RFP states, "a query is utilized" for inpatient psychiatric reviews. Can the State provide additional detail on the content of the query, and what entity conducts it?
<b>Section Number:</b>	III.1 Institutional Record Reviews
<b>RFP Page Number:</b>	8
<b>Medicaid Answer:</b>	The Vendor would have access to and be trained to run the query in Desktop Intelligence, Decision Support System (DSS) that is maintained by the fiscal agent. The query results contain the Medicaid recipient ID, the provider ID and dates of service.
<b>Question ID:</b>	28
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	<ul style="list-style-type: none"> <li>a. Is the LTC-0007-M report electronic or hardcopy?</li> <li>b. Is it possible to get a de-identified example of the LTC-0007-M report?</li> <li>c. If electronic, what format is the report provided in?</li> </ul>
<b>Section Number:</b>	III.1.2 Institutional Record Reviews
<b>RFP Page Number:</b>	10
<b>Medicaid Answer:</b>	<ul style="list-style-type: none"> <li>a. The LTC-0007-M is an electronic report stored in the document repository.</li> <li>b. No.</li> </ul>

	c. It is a raw text file that may be viewed as a pdf file.
<b>Question ID:</b>	29
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	How many LTC Request for Action Forms did the Vendor receive in 2015, and approximately how long does it take to update the LTC segments?
<b>Section Number:</b>	III.2.1 Institutional Record Reviews
<b>RFP Page Number:</b>	10
<b>Medicaid Answer:</b>	There were 1,837 LTC Request for Action Forms received in calendar year 2015. The process to update the LTC segments should take only a few minutes. Verification must be performed to ensure segments are updated correctly, such as no overlap in dates.
<b>Question ID:</b>	30
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	What is the frequency of concurrent review for recipients receiving MEPD or PEC/swing bed services?
<b>Section Number:</b>	III.1 Institutional Record Reviews
<b>RFP Page Number:</b>	8
<b>Medicaid Answer:</b>	The average monthly record reviews for the MEPD was approximately 97. CMS has not yet officially resumed this demonstration. PEC and swing bed reviews for calendar year 2015 averaged two per quarter.
<b>Question ID:</b>	31
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Please provide an example of Form 161B.
<b>Section Number:</b>	III.1 Institutional Record Reviews
<b>RFP Page Number:</b>	8
<b>Medicaid Answer:</b>	This form can be found on the Medicaid website, <a href="http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.3_LTC_Services/5.4.3_LTC_Request_For_Action_Form_161B_6-29-11.pdf">http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.3_LTC_Services/5.4.3_LTC_Request_For_Action_Form_161B_6-29-11.pdf</a>
<b>Question ID:</b>	32
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Is the monthly report format a spreadsheet?
<b>Section Number:</b>	III.1 Institutional Record Reviews
<b>RFP Page Number:</b>	10
<b>Medicaid Answer:</b>	See answer to question 28.
<b>Question ID:</b>	33
<b>Date Question Asked:</b>	May 24, 2016

<b>Question:</b>	Does the sentence “ <i>The Vendor will also document the dates for the election periods and revocation dates, if applicable, for approved records through the MMIS</i> ” mean that an electronic file transfer is available to transmit findings for this and other services as well?
<b>Section Number:</b>	III.2.2 Hospice Records Reviews
<b>RFP Page Number:</b>	11
<b>Medicaid Answer:</b>	The dates are to be documented in the Medicaid Hospice Election and Physician’s Certification Form, 165 and the hospice record submitted by the provider.
<b>Question ID:</b>	34
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Does the sentence “ <i>The Vendor will submit approved dates through the HPE LTC software.</i> ” mean that electronic files will be transmitted or is the HPE LTC software accessible only manually?
<b>Section Number:</b>	III.2.2 Hospice Records Reviews
<b>RFP Page Number:</b>	18
<b>Medicaid Answer:</b>	The vendor will have access to the HPE LTC Admission Notification software through which the approved dates are entered manually.
<b>Question ID:</b>	35
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	How does the current Vendor access the MMIS to verify Medicare Part A eligibility?
<b>Section Number:</b>	III.2 Hospice Record Reviews
<b>RFP Page Number:</b>	11
<b>Medicaid Answer:</b>	The Vendor accesses the recipient panel in the MMIS to verify the Medicare Part A eligibility. It is a “screen” with recipient eligibility information.
<b>Question ID:</b>	36
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Please provide additional information concerning the HPE LTC software: a. How does the Vendor access the software? b. How does the Vendor access the MMIS system?
<b>Section Number:</b>	III.2 Hospice Record Reviews
<b>RFP Page Number:</b>	11
<b>Medicaid Answer:</b>	The HPE LTC software is downloaded onto the Vendor’s computers. Per the Operational Requirements on page 17, the Vendor agrees to enter into a contract with Medicaid’s Fiscal Agent, HPE, to ensure a secure virtual private network (VPN) connection, through which the MMIS may be accessed.
<b>Question ID:</b>	37
<b>Date Question Asked:</b>	May 24, 2016

<b>Question:</b>	What is the average number of initial certifications for hospice benefits per month?
<b>Section Number:</b>	III.2 Hospice Records Reviews
<b>RFP Page Number:</b>	10
<b>Medicaid Answers</b>	The average number of hospice reviews for initial certification is not available; rather the total number of records reviewed is provided.
<b>Question ID:</b>	38
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	What is the average number of re-certifications for hospice benefits per month and what is the frequency for concurrent review?
<b>Section Number:</b>	III.2 Hospice Records Reviews
<b>RFP Page Number:</b>	10
<b>Medicaid Answers</b>	The average number of hospice reviews for re-certification is not available; rather the total number of records reviewed is provided. Concurrent reviews for calendar year 2015 averaged 149 per month.
<b>Question ID:</b>	39
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	What is the average number of hospice recipients in a nursing home, per month?
<b>Section Number:</b>	III.2 Hospice Records Reviews
<b>RFP Page Number:</b>	10
<b>Medicaid Answers</b>	The monthly average count of hospice recipients in a nursing facility is 1,181. The vast majority of these residents are dually eligible for Medicare and Medicaid.
<b>Question ID:</b>	40
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Is the Form 165B an electronic or hardcopy form? Is it faxed or electronically transmitted.
<b>Section Number:</b>	III.2 Hospice Records Reviews
<b>RFP Page Number:</b>	11
<b>Medicaid Answers</b>	The Form 165B is electronic. The electronic form is faxed to the Vendor.
<b>Question ID:</b>	41
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	The RFP requires the Vendor to document the review, including evidence-based research to support the decision and/or discussion with Medicaid. Is this documentation entered into the MMIS or HPE LTC software?
<b>Section Number:</b>	III.2 Hospice Record Reviews
<b>RFP Page Number:</b>	11
<b>Medicaid Answers</b>	No.
<b>Question ID:</b>	42

<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Please provide information about the volume of hearings requiring Vendor attendance during the past contract.
<b>Section Number:</b>	III.2 Hospice Record Reviews
<b>RFP Page Number:</b>	12
<b>Medicaid Answers</b>	There were 63 hospice fair hearings received for calendar year 2015. However, 30 of the hearings were withdrawn or denied prior to the hearing date. Up to three hearings may be scheduled on one day.
<b>Question ID:</b>	43
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	<ul style="list-style-type: none"> <li>a. Since the review determinations are entered in to the MMIS directly, does the current Vendor maintain documentation on the basis for the determination?</li> <li>b. If so, does the Vendor use a proprietary system or is part of the MMIS used for this purpose?</li> </ul>
<b>Section Number:</b>	III.3 Prior Authorization
<b>RFP Page Number:</b>	13
<b>Medicaid Answers</b>	<ul style="list-style-type: none"> <li>a. The provider submits the documentation to meet the PA criteria to the fiscal agent, where the documents are stored electronically in the document repository. The Vendor is responsible for maintaining staff review or audit tools. The audit tools or review sheets must be available upon Medicaid's request.</li> <li>b. See answer a.</li> </ul>
<b>Question ID:</b>	44
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Can the MMIS information system generate the required monthly report, or is a Vendor information system used for this process
<b>Section Number:</b>	III.3 Prior Authorizations
<b>RFP Page Number:</b>	13
<b>Medicaid Answers</b>	No, the Vendor generates the required monthly report.
<b>Question ID:</b>	45
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Does "The PAs are initially submitted to the Fiscal Agent and the Vendor accesses the information electronically for review," mean that the successful contractor will be able to receive the PA request to review it in the contractor's own system via file transfer and transmit the decision back to HPE?
<b>Section Number:</b>	III.3 Prior Authorizations
<b>RFP Page Number:</b>	13
<b>Medicaid Answers</b>	No, the Vendor will have access to the document repository maintained by the fiscal agent to view the PA documents electronically.

<b>Question ID:</b>	46
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	The turnaround time for prior authorizations seems lengthy; please confirm the Vendor has 30 calendar days to complete a PA.
<b>Section Number:</b>	III.3 Prior Authorization
<b>RFP Page Number:</b>	13
<b>Medicaid Answers</b>	Please refer to Section III.3 of the RFP.
<b>Question ID:</b>	47
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Does the Vendor have any responsibility to conduct outreach or education?
<b>Section Number:</b>	IV.B.d Additional Vendor Responsibilities
<b>RFP Page Number:</b>	15
<b>Medicaid Answers</b>	Yes, the Vendor may be requested to speak to provider associations, such as the Nursing Home Associations, or the Alabama Hospice Organizations about the applicable review process.
<b>Question ID:</b>	48
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Please provide additional information about the level of effort associated with this scope of work activity. For example, what is the timing of review, who conducts it, and how often are criteria updated?
<b>Section Number:</b>	IV.B.e Additional Vendor Responsibilities
<b>RFP Page Number:</b>	15
<b>Medicaid Answers</b>	Medicaid does not determine the level of effort as associated with the requirements in this RFP.
<b>Question ID:</b>	49
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	The Scope of Work requires extensive sampling for review selection that varies between review categories, but the staffing model does not seem to include analytic support. Does the current Vendor include data analysts as part of its staffing model?
<b>Section Number:</b>	IV.C Staffing/Organizational Plan
<b>RFP Page Number:</b>	15
<b>Medicaid Answers</b>	Medicaid does not require information of non-key positions utilized by the current Vendor. Please refer to Section IV.C of the RFP.
<b>Question ID:</b>	50
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Can the Vendor include in this list ongoing projects?
<b>Section Number:</b>	VIII. Corporate Background, Item b.5
<b>RFP Page Number:</b>	21
<b>Medicaid Answers</b>	Yes.

<b>Question ID:</b>	51
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	A non-incumbent vendor may not have current staff to name in its response to this section. Can vendors provide information about, for example, transition staff, corporate staff with similar backgrounds, and/or job descriptions for specific project positions, especially since Section IV.C indicates that the Vendor should submit its proposed organizational structure to Medicaid after award.
<b>Section Number:</b>	VIII. Corporate Background, Item b.6
<b>RFP Page Number:</b>	21
<b>Medicaid Answers</b>	Yes.
<b>Question ID:</b>	52
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Please provide an outline or other direction concerning the organization and required content of proposals to ensure comparability of responses.
<b>Section Number:</b>	IX.P Proposal Format
<b>RFP Page Number:</b>	24
<b>Medicaid Answers</b>	The requirements listed in the RFP determine what content is needed from the Vendor and the order the submitted proposals should be in.
<b>Question ID:</b>	53
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Item 7 includes a mandatory requirement that references be in a specified format and order; please clarify this requirement, since Section VIII.e does not seem to specify a format and order for reference data.
<b>Section Number:</b>	Appendix A: Proposal Compliance Checklist
<b>RFP Page Number:</b>	35
<b>Medicaid Answers</b>	The Vendor needs to include the information requested in RFP Section VIII.e. The Proposal Compliance Checklist is a guide to help the Vendors ensure a complete proposal is submitted.
<b>Question ID:</b>	54
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Item 9 requests a “detailed description of the plan to design, implement, monitor, and address special situations related to a new Medical and Quality Review program.” Please clarify: <ul style="list-style-type: none"> <li>a. This program seems to have been in place during at least one contract cycle; are there new components?</li> <li>b. What are “special situations” in the context of this program?</li> <li>c. The Section where should Offerors include the description of the plan in their responses.</li> </ul>
<b>Section Number:</b>	Appendix A: Proposal Compliance Checklist
<b>RFP Page Number:</b>	35
<b>Medicaid Answers</b>	a. No.

	<p>b. Please refer to Appendix A, Item 9 of the RFP.</p> <p>c. The requirements listed in the RFP determine what content is needed from the Vendor. Please refer to Section III of the RFP.</p>
<b>Question ID:</b>	55
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Does Medicaid intend that the cost of providing the scope of work described in IV.A Informal Review and Fair Hearing and IV.B Additional Vendor Responsibilities be distributed over the items in Pricing Template I?
<b>Section Number:</b>	Appendix C: Pricing Forms
<b>RFP Page Number:</b>	56
<b>Medicaid Answers:</b>	Yes.
<b>Question ID:</b>	56
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	How will Medicaid include the rates on Pricing Template II in the evaluation of the Cost Proposal? For example, one proposer might propose a lower rate for the Registered Nurse Reviewer than other proposer but a higher rate for the Clinical Director.
<b>Section Number:</b>	Appendix C: Pricing Forms
<b>RFP Page Number:</b>	57
<b>Medicaid Answers:</b>	Please refer to Amendment I posted on the Medicaid Website on 6/1/2016. Medicaid does not disclose the details of the evaluation of the proposals until the execution of the contract.
<b>Question ID:</b>	57
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Should Pricing Template II include a rate for a Medical Director?
<b>Section Number:</b>	Appendix C: Pricing Forms
<b>RFP Page Number:</b>	57
<b>Medicaid Answers:</b>	Medicaid does not determine the positions needed for Pricing Template II.
<b>Question ID:</b>	58
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	What is the anticipated budget for this scope of work?
<b>Section Number:</b>	General
<b>RFP Page Number:</b>	N/A
<b>Medicaid Answers:</b>	There is no predetermined budget.
<b>Question ID:</b>	59
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Please describe any initiatives or program changes that the Agency anticipates will affect Medicaid enrollment, covered services, or any other areas that might impact the scope of work or anticipated review volumes.
<b>Section Number:</b>	General

<b>RFP Page Number:</b>	N/A
<b>Medicaid Answers:</b>	Please see the information about the RCOs under General Medicaid Information. RCOs will be responsible for the PA process for covered services for enrollees. In addition, State legislation passed in 2015 established a competitively bid, integrated network to provide long-term care services to Medicaid recipients. Patterned after Regional Care Organization legislation, the new law creates a provider-organized, at-risk system that is to begin no later than October 1, 2018. Impact is still being determined.
<b>Question ID:</b>	60
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Is there a requirement for the Vendor to have an office in Alabama?
<b>Section Number:</b>	General
<b>RFP Page Number:</b>	N/A
<b>Medicaid Answers:</b>	No.
<b>Question ID:</b>	61
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	<ol style="list-style-type: none"> <li>a. Will RCOs be phased in over time or will all RCOs become operational at once?</li> <li>b. Does the Agency intend to modify the contract resulting from this RFP as RCOs become operational? If so, please describe any potential modifications that might be made.</li> <li>c. Is there a possibility that the contract resulting from this RFP will be terminated early due to RCOs becoming operational? If so, how much notice will the Vendor be given?</li> <li>d. How many Alabama citizens are expected to continue receiving benefits through the fee-for-service (FFS) delivery system after RCOs are fully operational?</li> <li>e. Will the Vendor be allowed to reduce the number of number of RNs required under Section IV.C–Staffing/Organizational Plan (RFP Page 15) in relation to review volume decrease as the Medicaid population is transitioned to the RCOs? If so, what will be the mechanism for this reduction to occur?</li> <li>f. Does the State expect there will be higher acuity levels in the Medicaid populations excluded from participation in the RCO program and remaining in the FFS delivery system after RCOs are fully implemented?</li> </ol>
<b>Section Number:</b>	General Medicaid Information
<b>RFP Page Number:</b>	7
<b>Medicaid Answers:</b>	As Medicaid is seeking a delay in the October 1, 2016 implementation date, information related to RCOs will be provided at a time deemed appropriate by Medicaid.
<b>Question ID:</b>	62

<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	What is the anticipated volume of each review type described in the scope of work? Are AllKids and/or ACA recipients included in these projected volumes?
<b>Section Number:</b>	Section III, Scope of Work
<b>RFP Page Number:</b>	8-14
<b>Medicaid Answer:</b>	Please see Medicaid Answers to questions 5 and 7. The count of nursing facility reviews is expected to remain fairly constant.
<b>Question ID:</b>	63
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	What are the anticipated volumes for reviews of MEPD admissions, readmissions, and continued stay reviews?
<b>Section Number:</b>	Scope of Work, Section 1–Institutional Record Reviews, Paragraph #1
<b>RFP Page Number:</b>	9
<b>Medicaid Answers:</b>	Medicaid is unable to anticipate the volume without additional information from CMS. Please refer to the volume provided in the RFP.
<b>Question ID:</b>	64
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	The RFP states that a single PA request may contain multiple lines or details for medical services, supplies, and equipment. We have the following questions: <ul style="list-style-type: none"> <li>a. Are PAs with multiple lines counted as a single PA in the PA review volume numbers cited on Page 13?</li> <li>b. What is the average number of line items per PA review request?</li> </ul>
<b>Section Number:</b>	Scope of Work, Section 3–Prior Authorization (PA) Reviews, Page 12, Paragraph #1
<b>RFP Page Number:</b>	12
<b>Medicaid Answers:</b>	<ul style="list-style-type: none"> <li>a. Yes.</li> <li>b. Medicaid is unable to provide this answer as PA requests are so varied.</li> </ul>
<b>Question ID:</b>	65
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	What are the PA requirements for SOBRA women?
<b>Section Number:</b>	Scope of Work, Section 3–Prior Authorization (PA) Reviews, Paragraph #1:
<b>RFP Page Number:</b>	13
<b>Medicaid Answer:</b>	PA requests for SOBRA women must meet the same requirements as for all other eligible recipients. They are no longer limited to pregnancy-related services.
<b>Question ID:</b>	66
<b>Date Question Asked:</b>	May 24, 2016

<b>Question:</b>	What procedure codes pertaining to medical procedures, services, equipment, laboratory tests, and private duty nursing require prior authorization?
<b>Section Number:</b>	Scope of Work, Section 3–Prior Authorization (PA) Reviews
<b>RFP Page Number:</b>	13
<b>Medicaid Answer:</b>	Please refer to the appropriate chapter for the procedure codes as listed in the Alabama Medicaid Provider Manual and any revisions thereof located on the Medicaid Website.  <a href="http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals/6.7.2_Provider_Manuals_2016/6.7.2.2_April_2016.aspx">http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals/6.7.2_Provider_Manuals_2016/6.7.2.2_April_2016.aspx</a>
<b>Question ID:</b>	67
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	What are the required qualifications for the physical therapist?
<b>Section Number:</b>	Scope of Work, Section 3–Prior Authorization (PA) Reviews
<b>RFP Page Number:</b>	13
<b>Medicaid Answer:</b>	The PT must have an active license in the state in which he/she is practicing. Please refer to Amendment I posted on the Medicaid Website on 6/1/2016.
<b>Question ID:</b>	68
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	What is the notification process that the Form 471 has been completed?
<b>Section Number:</b>	Scope of Work, Section3–Prior Authorization (PA) Reviews, Bullet #8
<b>RFP Page Number:</b>	13
<b>Medicaid Answer:</b>	Once completed, a new PA decision letter is sent systematically.
<b>Question ID:</b>	69
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	<ol style="list-style-type: none"> <li>a. Does the Agency consider the current reconsideration and fair hearing rates to be higher than normal for a Medicaid population?</li> <li>b. What percentage of reviews performed currently undergo reconsideration and fair hearing?</li> <li>c. Does the Vendor need to have Alabama-licensed physicians and professional staff onsite in attendance at all Fair Hearings?</li> <li>d. If so, is onsite presence required at any site other than in Montgomery?</li> <li>e. How much time is required for pre-hearing work prior to the day of hearing and does this work include the preparation of documentation packets?</li> <li>f. What is the average time expenditure for participation in each Fair Hearing?</li> </ol>

	<ul style="list-style-type: none"> <li>g. How many Fair Hearings are anticipated in the non-RCO population for each review type?</li> <li>h. What is the process and timeline for notification when a Fair Hearing is canceled?</li> </ul>
<b>Section Number:</b>	Section IV–General Requirements, Subsection A–Informal Review and Fair Hearing
<b>RFP Page Number:</b>	14
<b>Medicaid Answer:</b>	<ul style="list-style-type: none"> <li>a. Medicaid has not compared its programs with other State’s Medicaid programs of similar size and scope.</li> <li>b. Medicaid does not have the percentages for reconsideration and fair hearings as stated in the question.</li> <li>c. Yes, the Vendor must have appropriate personnel in attendance at the fair hearing, including the licensed Physician Advisor.</li> <li>d. The hearing location is determined by Medicaid. The vast majority of hearings for which the Vendor reviews have been scheduled at Medicaid’s Central Office in Montgomery.</li> <li>e. The time to prepare for a hearing varies, depending on the amount of medical records submitted for review. The selected Vendor must have their staff available for legal preparation with Medicaid Staff and Attorneys. This does not include time for staff to review the documents.</li> <li>f. Fair hearings vary depending on the parties. The Vendor is expected to arrive at least one hour prior to the start of the fair hearing to meet with Legal staff.</li> <li>g. As the majority of fair hearings are for an RCO-excluded program (hospice), it is anticipated that the fair hearings requests would remain fairly constant.</li> <li>h. The requestor of the fair hearing must submit a request in writing to Medicaid to withdraw the fair hearing request. As soon as Medicaid is notified that a fair hearing has been withdrawn or canceled, the appropriate Medicaid staff is notified; staff in turn notifies the Vendor as soon as possible.</li> </ul>
<b>Question ID:</b>	70
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	<ul style="list-style-type: none"> <li>a. In addition to being licensed in the State of Alabama, must all physicians, RNs, and physical therapists used for the contract be located in Alabama?</li> <li>b. May one person serve as both the Project Manager and Clinical Director?</li> <li>c. What are the required qualifications for the Clinical Director position?</li> <li>d. Would the Agency consider imposing a minimum full-time equivalent (FTE) requirement for Physician Advisor or Medical Director time on the contract?</li> </ul>

<b>Section Number:</b>	Section IV–General Requirements, Subsection C–Staffing/Organizational Plan
<b>RFP Page Number:</b>	15
<b>Medicaid Answer:</b>	<ul style="list-style-type: none"> <li>a. No.</li> <li>b. Yes, the same person may serve as both the Project Manager and Clinical Director.</li> <li>c. Please refer to Amendment I posted on the Medicaid Website on 6/1/2016.</li> <li>d. Vendors should determine staffing needs based on the information provided.</li> </ul>
<b>Question ID:</b>	71
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Will the Vendor be responsible for answering provider queries for services outside of those pertaining to institutional record reviews, hospice record reviews, and provider authorization reviews? If so, what types of telephone inquiries from providers will the Vendor be responsible for having staff available to handle during established business hours?
<b>Section Number:</b>	Section IV.F–Operational Requirements
<b>RFP Page Number:</b>	17
<b>Medicaid Answer:</b>	Medicaid’s fiscal agent maintains a Provider Assistance Center (PAC) phone line. When calls are received that are outside the responsibilities of the vendor, the caller should be provided with the number to the PAC Unit for assistance. Inquiries are varied form whether a code requires a PA to provider enrollment issues.
<b>Question ID:</b>	72
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	The RFP asks for evidence the Vendor possesses the qualification required in the RFP. Other than the requirement to be a QIO or QIO-like entity, are there other specific qualifications the Agency requires the Vendor to prove?
<b>Section Number:</b>	Section VIII–Corporate Background and References, Item a.
<b>RFP Page Number:</b>	21
<b>Medicaid Answer:</b>	Please refer to Section VIII Items d. and e.
<b>Question ID:</b>	73
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Does the Agency want Bidders to separately acknowledge and address each of the general term and conditions specified in the body of its proposal response, or is it sufficient to acknowledge them within the Transmittal Letter?
<b>Section Number:</b>	Section IX–Submission Requirements, Items A through JJ
<b>RFP Page Number:</b>	27-34
<b>Medicaid Answer:</b>	Please refer to Section VII of the RFP.

<b>Question ID:</b>	74
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	This section says to label pages with proprietary or confidential material as "CONFIDENTIAL" and to state the legal authority as to why that material has been marked as confidential. Would it be acceptable to provide the legal authority rationale as a separate Attachment to the proposal, or does this rationale need to be provided following the "CONFIDENTIAL" markings on the pages so marked?
<b>Section Number:</b>	Section IX–Submission Requirements, Item #U
<b>RFP Page Number:</b>	25
<b>Medicaid Answer:</b>	Medicaid does not have a preference as to format. Please refer to Section IX Item U of the RFP.
<b>Question ID:</b>	75
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	The Evaluation Factor/Scoring Table shows that four sections—Corporate Background, References, Scope of Work, and Price—will be evaluated and scored. We have the following questions related to Section IV–General Requirements (RFP Pages 14 – 19), which is not listed as an evaluated and scored factor but will include important information pertaining to a Bidder's approach to Informal Reviews and Fair Hearings, Denials and Reconsiderations, Meeting Additional Vendor Responsibilities, Staffing/Organizational Plan, Operational Requirements, and Work Plan and Implementation Schedule: <ul style="list-style-type: none"> <li>g. How will information submitted to address General Requirements factor into the scoring?</li> <li>h. How many of the 100 total points possible will be allotted to the staffing plan and the other items listed in Section IV?</li> <li>i. Should Section IV be included in the proposal response as its own separate section, or should it be included within Section III–Scope of Work?</li> </ul>
<b>Section Number:</b>	Section X–Evaluation and Selection Process, Item #E
<b>RFP Page Number:</b>	27
<b>Medicaid Answer:</b>	<ul style="list-style-type: none"> <li>g. Medicaid does not disclose the details of the evaluation of the proposals until the execution of the contract.</li> <li>h. Medicaid does not disclose the details of the evaluation of the proposals until the execution of the contract.</li> <li>i. Medicaid does not have a preference as to format.</li> </ul>
<b>Question ID:</b>	76
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	Please describe how points will be awarded for proposals that do not have the lowest overall total cost proposed. Will they be assigned a portion of the maximum score based on the lowest cost proposal, or will they receive zero out of the 40 points possible?
<b>Section Number:</b>	Section X. Evaluation and Selection Process, Item #E

<b>RFP Page Number:</b>	
<b>Medicaid Answer:</b>	Medicaid does not disclose the details of the evaluation of the proposals until the execution of the contract.
<b>Question ID:</b>	77
<b>Date Question Asked:</b>	May 24, 2016
<b>Question:</b>	If a termination occurs pursuant to this section will the state confirm that it will endeavor to give the maximum notice possible under the circumstances?
<b>Section Number:</b>	Section XI–General Terms and Conditions, Item #M
<b>RFP Page Number:</b>	30
<b>Medicaid Answer:</b>	Please refer to Section XI Item M of the RFP.

**RFP # 2016-MQR-02**  
**Medical and Quality Review (2) RFP**  
**Round 2**  
**Vendor Questions and Medicaid Answers**  
**June 15, 2016**

<b>Question ID:</b>	78
<b>Date Question Asked:</b>	May 24, 2016 (after 5 pm)
<b>Question:</b>	Is the Vendor granted access to the document repository to review the medical information submitted by the Hospice provider, or does HPE provide copies?  If there are copies, are they electronic or in paper form?
<b>Section Number:</b>	2.2 Hospice Records Reviews
<b>RFP Page Number:</b>	11
<b>Medicaid Answer:</b>	Yes, the Vendor will have access to the document repository to review the medical documentation electronically.
<b>Question ID:</b>	79
<b>Date Question Asked:</b>	May 24, 2016 (after 5 pm)
<b>Question:</b>	Are the approved dates submitted to HPE in the form of a claims data extract file, or are the approved dates / auth number entered directly into the HPE LTC software?
<b>Section Number:</b>	2.2 Hospice Records Reviews
<b>RFP Page Number:</b>	11
<b>Medicaid Answer:</b>	The approved dates are entered directly into the HPE LTC software.
<b>Question ID:</b>	80
<b>Date Question Asked:</b>	May 24, 2016 (after 5 pm)
<b>Question:</b>	Is there any consideration or time that the appropriate personnel could attend the hearing telephonically, or must it always be in person?
<b>Section Number:</b>	2.2 Hospice Records Reviews
<b>RFP Page Number:</b>	12
<b>Medicaid Answer:</b>	The appropriate personnel must be present in person.
<b>Question ID:</b>	81
<b>Date Question Asked:</b>	May 24, 2016 (after 5 pm)

<b>Question:</b>	Does the Vendor access the information electronically through a specific Web portal or HPE software, or is the information housed in the Fiscal Agent's MMIS system?
<b>Section Number:</b>	3. Prior Authorization (PA) Reviews
<b>RFP Page Number:</b>	13
<b>Medicaid Answer:</b>	The Vendor accesses the information in a document repository maintained by the fiscal agent.
<b>Question ID:</b>	82
<b>Date Question Asked:</b>	May 24, 2016 (after 5 pm)
<b>Question:</b>	Does the State still anticipate that eight, full-time RNs are required to complete this work after the reduction of responsibilities from first RFP to this one? Or, can the vendor propose staffing levels sufficient to complete the responsibilities outlined in this RFP?
<b>Section Number:</b>	IV. General Requirements
<b>RFP Page Number:</b>	15
<b>Medicaid Answer:</b>	Eight, full-time RNs are required.
<b>Question ID:</b>	83
<b>Date Question Asked:</b>	May 24, 2016 (after 5 pm)
<b>Question:</b>	It is our understanding that both QIO's and QIO-Like entities will enable the State to qualify for the 75 percent federal financial participation as established in 42 CFR 433.15(b)(6)(i). Can the State please confirm that our QIO-like status letter will serve as a sufficient verification of status to meet the requirement on RFP Page 21, Section VIII.b.10?
<b>Section Number:</b>	Section VIII.b.10
<b>RFP Page Number:</b>	21
<b>Medicaid Answer:</b>	Yes.
<b>Question ID:</b>	84
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	1. Will OBRA/Preadmission Screening Resident Reviews (PASRR) be part of the Institution record review process? If so, we have the following questions: a. What will the Vendor's PASRR responsibilities include? b. Please provide details on any OBRA/PASSR training to be provided for Vendor staff. c. Are training documents available related to OBRA/PASRR requirements? d. What is the estimated amount of time required to complete a review for OBRA/PASRR requirements?
<b>Section Number:</b>	Section 3.1, Institutional Reviews

<b>RFP Page Number:</b>	9-10
<b>Medicaid Answer:</b>	Yes. <ul style="list-style-type: none"> <li>a. The Vendor will assess that the record complies with Administrative Code Chapter 10, Long Term Care, Rule No. 560-X-10-.16. Preadmission Screening and Resident Review.</li> <li>b. The OBRA PASRR Office has regularly scheduled training sessions that the Vendor may attend.</li> <li>c. Yes.</li> <li>d. This will vary depending upon what is submitted for the review.</li> </ul>
<b>Question ID:</b>	85
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	a. Does the time it takes to complete the Form involve any provider calls to clarify information?
<b>Section Number:</b>	Section 3.1, Institutional Reviews, #5
<b>RFP Page Number:</b>	10
<b>Medicaid Answer:</b>	Yes.
<b>Question ID:</b>	86
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	1. What is the Vendor notification process and timeframe when changes are made to the Administrative Code?
<b>Section Number:</b>	Section 3.1, Institutional Reviews
<b>RFP Page Number:</b>	10
<b>Medicaid Answer:</b>	The Agency staff notifies the Vendor of possible changes to appropriate Administrative Code sections when the possible revisions are in draft form via email and/or by phone.
<b>Question ID:</b>	87
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	<ul style="list-style-type: none"> <li>a. Does the Agency have a contact data base of institutional facility providers?</li> <li>b. If a provider has not submitted medical records based on the specified timeframe, will the vendor be required to follow up with the provider?</li> <li>c. Will the vendor be require to provide any tracking documentation related to the medical record request process, for example, the number of attempts made to obtain medical records, number of request for additional information, number of request sent for physician advisor reviews?</li> <li>d. How responsive are providers related to the initial request for medical records?</li> </ul>
<b>Section Number:</b>	Section 3.1, Institutional Reviews, #2
<b>RFP Page Number:</b>	10

<b>Medicaid Answer:</b>	<ul style="list-style-type: none"> <li>a. Yes.</li> <li>b. Yes.</li> <li>c. Please refer to Section III Scope of Work, Institutional Record Reviews, page 10 of the RFP.</li> <li>d. This varies with the facility, but in general the providers are responsive to the initial request for medical records.</li> </ul>
<b>Question ID:</b>	88
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	<p>The MEPD Operational Provider Manual discuss tracking of discharge data and we have the following questions:</p> <ul style="list-style-type: none"> <li>a. How will discharge data be received by the vendor?</li> <li>b. Will a nurse be required to complete the discharge data?</li> <li>c. Can you provide the volume of discharges completed for each year of the MEPD program?</li> <li>d. What is the time frame for entering MEPD admission and discharge information in the Agency MMIS system?</li> <li>e. What is the estimate time to complete an admission related to MEPD?</li> <li>f. Will the number of MEPD facilities increase?</li> <li>g. The MEPD Operational Manual indicates that the facilities will submit admissions and discharges within 24 hours. Will the vendor be required to complete the review on weekends and holidays?</li> </ul>
<b>Section Number:</b>	Section 3.1, Institutional Reviews,
<b>RFP Page Number:</b>	9
<b>Medicaid Answer:</b>	<ul style="list-style-type: none"> <li>a. Please refer to page 16, E. Discharge, in the MEPD Operational Manual of the RFP.</li> <li>b. Please refer to page 13, A. Staff Designation and Roles for Medicaid Contractor of the RFP.</li> <li>c. For the last two full CYs of the MEPD, the number of discharges were: CY 2013 - 461 CY 2014 - 480</li> <li>d. Please refer to page 14, B. Admission, of the MEPD Operational Manual of the RFP.</li> <li>e. The time will vary, depending upon the information submitted in the record.</li> <li>f. Medicaid cannot answer this question, pending information from CMS.</li> <li>g. No.</li> </ul>
<b>Question ID:</b>	89

<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	<p>a. Will the vendor be responsible for discussing the content of the letter with a provider or physician? For example, if a procedure is denied and the Agency's Provider Representative is not able to assist the provider, will the Vendor be responsible for discussing the denial rationale?</p> <p>b. Will the Vendor be responsible for discussing prior authorization processing questions with a provider or physician? If so, what were the annual provider call volumes?</p> <p>c. How are recipient inquires be handled since they receive a copy of the prior authorization letter that includes phones numbers of several Vendors along with the Agency HPE representatives' numbers?</p>
<b>Section Number:</b>	Section IV.F, Operational Requirements
<b>RFP Page Number:</b>	18
<b>Medicaid Answer:</b>	<p>a. Yes.</p> <p>b. Yes.  Provider Call Volumes for the complete Calendar Years were:  2012 - 5437  2013 - 5316  2014 - 4883  2015 - 5976</p> <p>c. The recipient should be referred to the Recipient Inquiry Unit, a call center which is maintained by the fiscal agent.</p>
<b>Question ID:</b>	90
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	What is the process and frequency for performance monitoring?
<b>Section Number:</b>	Section IV.D, Monitoring Performance Standards
<b>RFP Page Number:</b>	15
<b>Medicaid Answer:</b>	Please refer to IV. General Requirements, page 19, H. Medicaid Responsibilities a. of the RFP.
<b>Question ID:</b>	91
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	<p>a. Is there a process to validate that the date information was submitted successfully?</p> <p>b. Does the Agency have any information related to the time it takes to complete a Hospice review, including the submission process? If so, what is the time involved?</p> <p>c. Does the time it takes to complete the Form 165B involve any provider calls to clarify information?</p> <p>d. What is the volume of Form 165Bs per month?</p>

	e. If a Vendor is unable to complete the Form, what is the process for notifying the Agency?
<b>Section Number:</b>	Section III 2.2, Hospice Reviews
<b>RFP Page Number:</b>	11
<b>Medicaid Answer:</b>	<p>a. There are separate reports in the HPE LTC software of submissions from the previous day that either were accepted or rejected.</p> <p>b. The review time will vary, depending on the complexity and volume of the record submitted. Entering dates through the HPE LTC software should take no more than five to 10 minutes.</p> <p>c. Yes.</p> <p>d. For the following complete Calendar Years (CYs), the average number was:  CY 2012 - 764  CY 2013 - 680  CY 2014 - 410  CY 2015 - 497</p> <p>e. The Vendor should either call, send a secure email or fax the form to Medicaid which was not completed.</p>
<b>Question ID:</b>	92
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	<p>a. Is there a specific report required to identify each PA by type request, for example, surgeries, DME, private duty nursing?</p> <p>b. Since a prior authorization may have several lines items, will each line item require the vendor to reference the Administrative Code, Chapter 4 Obtaining Prior Authorizations, Internal Resource Policy, Fee schedule, and other Specific Chapters to complete each line item of the prior authorization?</p> <p>c. If the medical record documentation is not in the MMIS but the prior authorization request is in the system, can the prior authorization be denied for no documentation? If not, is there a grace period for the medical record to be loaded in the system?</p> <p>d. Does the process for completing private duty nursing requests require physician advisor review involvement or can the nurse reviewer complete the process?</p> <p>e. Related to private duty nursing requests: Are there any system-generated letters batched to the providers and what types of other letters are sent to the providers and/or recipients?</p>

	<p>f. Can the Agency provide any information related to the time it takes to complete a private duty nursing initial or re-certification prior authorization request?</p> <p>g. Are there any requirements to send certified letters to a recipient? If so, please explain.</p> <p>h. Under what circumstances can a nurse reviewer complete a prior authorization for a wheelchair request?</p> <p>i. What is the estimated volume of reviews completed by a physical therapist reviewer?</p> <p>j. Are there any requests for an expedited reviews? If so, please describe the circumstances?</p>
<b>Section Number:</b>	Section III, 3 Prior Authorization
<b>RFP Page Number:</b>	12-13
<b>Medicaid Answer:</b>	<p>a. Please refer to page 13, III Scope of Work, 3. Prior Authorization (PA) Reviews of the RFP.</p> <p>b. This will vary depending on what the procedure codes are on the line items. Usually, the line items are all found in the same PA policy.</p> <p>c. Yes. Per Chapter 4, Obtaining Prior Authorization the Provider Manual on Medicaid's website, "If attachments are required for PA review, the attachments must be sent to HPE within 48 hours to be scanned into the system to prevent a delay in review and/or a denial for "no documentation to support the PA request."</p> <p>d. Private duty nursing requires physician advisor review.</p> <p>e. Private duty nursing (PDN) PAs are also generated systematically within the fiscal agent system. There is a letter template to be utilized when PDN hours are to be decreased.</p> <p>f. The review time will vary, depending upon the complexity and volume of the record submitted.</p> <p>g. g. Yes, the letter to notify of a decrease in PDN hours is sent by certified mail.</p> <p>h. The nurse reviewer may complete a wheelchair PA when it is for a simple basic wheelchair without accessories, other than those items for safety, for example E1130. Most PAs for wheelchair rentals are also able to be completed by the nurse reviewer.</p> <p>i. The following are estimates only for the number of PT reviews (based on a five percent increase)</p> <p style="padding-left: 40px;">CY 2017 - 189</p> <p style="padding-left: 40px;">CY 2018 - 198</p> <p style="padding-left: 40px;">CY 2019 - 208</p> <p style="padding-left: 40px;">CY 2020 - 218</p> <p style="padding-left: 40px;">CY 2021 - 229</p>

	<p>j. Yes, there are requests for expedited reviews, for good cause, e.g., the surgery is scheduled within a short time frame, or the recipient has decubitus ulcers and is need of a new wheelchair or replacement parts. The above list is an example and not a comprehensive list.</p>																									
<b>Question ID:</b>	93																									
<b>Date Question Asked:</b>	June 8, 2016																									
<b>Question:</b>	Given there will be a 60 day implimentation period, can you clarify on what date does the implimentation period start?																									
<b>Section Number:</b>	Round 1 Q&As, Question #2 (in RFP Section B. Schedule of Events)																									
<b>RFP Page Number:</b>	3																									
<b>Medicaid Answer:</b>	Please refer to Section B. Schedule of Events of the RFP.																									
<b>Question ID:</b>	94																									
<b>Date Question Asked:</b>	6/8/16																									
<b>Question:</b>	This round one question asked for institutional record review volumes for the five year period of performance for budgeting purposes. Your answer provided historical volumes. Please provide projected review volumes for all institutional record reviews (nursing facilities, inpatient psychiatric facilities, etc.) for the five year period of performance for budgeting purposes.																									
<b>Section Number:</b>	Round 1 Q&As, Question #3 (Section III Scope of Work, Institutional Record Reviews)																									
<b>RFP Page Number:</b>	page 2 of Q & A, Round 1																									
<b>Medicaid Answer:</b>	<table border="1"> <thead> <tr> <th><b>Calendar Year</b></th> <th><b>Estimated number of Nursing Facility Reviews</b></th> </tr> </thead> <tbody> <tr> <td>2017</td> <td>2235</td> </tr> <tr> <td>2018</td> <td>2123</td> </tr> <tr> <td>2019</td> <td>2017</td> </tr> <tr> <td>2020</td> <td>1916</td> </tr> <tr> <td>2021</td> <td>1820</td> </tr> </tbody> </table> <p>Nursing facility review estimates are based on a five percent decrease.</p> <table border="1"> <thead> <tr> <th><b>Calendar Year</b></th> <th><b>Estimated number of Inpatient Psych Reviews (not including MEPD)</b></th> </tr> </thead> <tbody> <tr> <td>2017</td> <td>177</td> </tr> <tr> <td>2018</td> <td>190</td> </tr> <tr> <td>2019</td> <td>203</td> </tr> <tr> <td>2020</td> <td>217</td> </tr> <tr> <td>2021</td> <td>233</td> </tr> </tbody> </table>		<b>Calendar Year</b>	<b>Estimated number of Nursing Facility Reviews</b>	2017	2235	2018	2123	2019	2017	2020	1916	2021	1820	<b>Calendar Year</b>	<b>Estimated number of Inpatient Psych Reviews (not including MEPD)</b>	2017	177	2018	190	2019	203	2020	217	2021	233
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	Inpatient psychiatric facilities review estimates are based on a seven percent increase.													
<b>Question ID:</b>	95													
<b>Date Question Asked:</b>	June 8, 2016													
<b>Question:</b>	Does the inpatient psych query on the DSS include RTF?													
<b>Section Number:</b>	Round 1 Q&As (3.1 Scope of Work Institutional Record Reviews)													
<b>RFP Page Number:</b>	page 2 of Q & A, Round 1													
<b>Medicaid Answer:</b>	Yes.													
<b>Question ID:</b>	96													
<b>Date Question Asked:</b>	6/8/16													
<b>Question:</b>	Can the inpatient psych query on the DSS save to the vendor system or is it view only? Can we print or save since electronic data transfers are not allowed. Does this query get updated with data daily or only monthly? What format is the medical record in?													
<b>Section Number:</b>	Round 1 Q&As, Question #3 (3.1 Scope of Work Institutional Record Reviews)													
<b>RFP Page Number:</b>	page 2 of Q & A, Round 1													
<b>Medicaid Answer:</b>	Yes, the query may be saved by the Vendor. The Vendor will have access to Decision Support System to refresh the query. It may be converted to an Excel file. Data is normally updated after every checkwrite, approximately every two weeks. Medical records will be electronically stored in the document repository maintained by the fiscal agent.													
<b>Question ID:</b>	97													
<b>Date Question Asked:</b>	June 8, 2016													
<b>Question:</b>	Your year 2017, PA volume of 25,198 is 9% greater than your PA volume of 23,117 from year 2015. Since you indicate a projected 9% increase each year we would have expected year 2017 PA volume to be approximately 27,465 (23,117 times 9% times 9%). Please confirm your PA volumes for years 2017 through 2021.													
<b>Section Number:</b>	Round 1 Q&As, Question #7													
<b>RFP Page Number:</b>	Page 3 of Q & A, Round 1													
<b>Medicaid Answer:</b>	<table border="1"> <thead> <tr> <th>Calendar Year</th> <th>Estimated number of PA Reviews</th> </tr> </thead> <tbody> <tr> <td>2017</td> <td>27,465</td> </tr> <tr> <td>2018</td> <td>29,937</td> </tr> <tr> <td>2019</td> <td>32,632</td> </tr> <tr> <td>2020</td> <td>35,568</td> </tr> <tr> <td>2021</td> <td>38,770</td> </tr> </tbody> </table>		Calendar Year	Estimated number of PA Reviews	2017	27,465	2018	29,937	2019	32,632	2020	35,568	2021	38,770
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<b>Question ID:</b>	98
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	This round one question indicates that review criteria used in the PA process were developed by the state and will be used by the vendor for performing all PA reviews. However, information included in the Alabama Administrative code and Provider Manual mention Interqual criteria. Will the vendor be able to use other criteria (such as Milliman Care Guidelines) when conducting reviews? Please specify any criteria the state will require the vendor to use.
<b>Section Number:</b>	Round 1 Q&As, Question #25
<b>RFP Page Number:</b>	Page 8 of Q & A, Round 1
<b>Medicaid Answer:</b>	The Vendor will use the criteria approved by Medicaid. Criteria are found in the confidential PA policies that will be provided to the Vendor.
<b>Question ID:</b>	99
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	Will the vendor be able to copy/download/duplicate the medical record from the FA repository for institutional reviews? Is vendor access to medical records view only?
<b>Section Number:</b>	Round 1 Q&As, Question #27
<b>RFP Page Number:</b>	Page 8 of Q & A, Round 1
<b>Medicaid Answer:</b>	The records may be downloaded and saved as a pdf files. Yes, access is "view only."
<b>Question ID:</b>	100
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	Is the LTC-0007-M report view only or can the PDF be saved to the vendors system?
<b>Section Number:</b>	Round 1 Q & As, Question #28
<b>RFP Page Number:</b>	Page 8 of Q & A, Round 1
<b>Medicaid Answer:</b>	The report may be downloaded and saved as a pdf file.
<b>Question ID:</b>	101
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	How are concurrent reviews for PEC, Swing Bed and MEPD identified? Do all requests route through FA first? Is there a query in DSS?
<b>Section Number:</b>	Round 1 Q & A, Question #38
<b>RFP Page Number:</b>	Page 11 of Q & A, Round 1
<b>Medicaid Answer:</b>	The Vendor will review the document repository to determine if a PEC or swing bed record had been submitted. Please refer to Section III Scope of Work 1. Institutional Record Reviews

	and to page 14, B. Admission, of the MEPD Operational Manual of the RFP.
<b>Question ID:</b>	102
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	What is the turnaround time for the FA to scan and load medical records to the repository that are not uploaded through the HPE LTC software?
<b>Section Number:</b>	Round 1 Q&As, Question #45
<b>RFP Page Number:</b>	Page 12, of Q & A, Round 1
<b>Medicaid Answer:</b>	The fiscal agent currently has two business days to load medical records to the document repository. However, effective mid- November 2016, almost all medical records for a PA must be electronically submitted by providers. There are a few exceptions, such as photos. The HPE LTC software is not a part of the PA process.
<b>Question ID:</b>	103
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	"Q: May one person serve as both the Project Manager and Clinical Director? A: Yes, the same person may serve as both the Project Manager and Clinical Director."  Please explain how this scenario would work and what would be the impact on the budget.
<b>Section Number:</b>	Amend 1 "The Vendor shall assign a Full Time Equivalent Clinical Director."
<b>RFP Page Number:</b>	3
<b>Medicaid Answer:</b>	Medicaid cannot dictate vendor proposals, nor address a possible pricing impact. It is expected that the duties of both positions shall be fulfilled if submitting one person for both positions.
<b>Question ID:</b>	104
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	We follow industry standards in protecting the identities of our Physician Advisors to ensure confidentiality. Would a bid be considered non-responsive for a vendor to omit such personally identifiable information?
<b>Section Number:</b>	Amend 1, "A resume for the proposed Physician Advisor(s) shall include the individual's name, current address...A minimum of two work references shall also be included."
<b>RFP Page Number:</b>	3
<b>Medicaid Answer:</b>	Yes. Please refer to Amendment 1, C. Staffing/Organizational Plan.

<b>Question ID:</b>	105
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	The table on page 27 of the RFP does not mention Staffing/Organizational Plan as one of the Evaluation Factors. How is this section factored into the Evaluation Committee's scoring system?
<b>Section Number:</b>	E. Scoring
<b>RFP Page Number:</b>	27
<b>Medicaid Answer:</b>	Medicaid does not disclose the details of the evaluation of the proposals until the execution of the contract.
<b>Question ID:</b>	106
<b>Date Question Asked:</b>	June 8, 2016
<b>Question:</b>	Is there any consideration or time that the appropriate personnel could attend the hearing telephonically, or must it always be in person?
<b>Section Number:</b>	2.2 Hospice Records Review
<b>RFP Page Number:</b>	19
<b>Medicaid Answer:</b>	Appropriate personnel must attend hearings in person. Please see page 12, Section III Scope of Work, 2. Hospice Record Reviews.