

**Announcement of Selected Vendor**  
**Medicaid Regional Care Organization Program Enrollment Broker Services**  
**Request for Proposal (RFP) Number 2015-EB-01**  
**Alabama Medicaid Agency**

On December 23, 2015 the Alabama Medicaid Agency issued an Intent to Award Notice to Automated Health Systems, Inc. for the Medicaid Regional Care Organization Program Enrollment Broker Services (RFP Number 2015-EB-01).

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: 2015-EB-01</b>	<b>RFP Title: Medicaid Regional Care Organization Program Enrollment Broker Services</b>	
<b>RFP Due Date and Time: December 2, 2015 by 5pm Central Time</b>		<b>Number of Pages: 70</b>
<b>PROCUREMENT INFORMATION</b>		
<b>Project Director: Linda Lackey</b>		<b>Issue Date: October 26, 2015</b>
<b>E-mail Address: ebrfp@medicaid.alabama.gov Website: <a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a></b>		<b>Issuing Division: Managed Care</b>
<b>INSTRUCTIONS TO VENDORS</b>		
<b>Return Proposal to:</b>  <b>Alabama Medicaid Agency Linda Lackey Lurleen B. Wallace Building 501 Dexter Avenue PO Box 5624 Montgomery, AL 36103-5624</b>		<b>Mark Face of Envelope/Package:</b> <b>RFP Number: 2015-EB-01</b> <b>RFP Due Date: December 2, 2015 by 5pm CT</b>  <b>Firm and Fixed Price</b>  <b>Annual TOTAL Cost Year 1:</b> <b>Annual TOTAL Cost Year 2:</b> <b>Annual TOTAL Cost Year 3:</b> <b>Annual TOTAL Cost Year 4:</b> <b>Annual TOTAL Cost Year 5:</b>  <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 Medicaid'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. Medicaid reserves the right, at its sole discretion, to adjust this schedule as it deems necessary. Notification of any adjustment to the Schedule of Events shall be posted on the RFP website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

<b>EVENT</b>	<b>DATE</b>
RFP Issued	10/26/15
Deadline for Questions to be submitted	11/9/15
Deadline for questions to be posted to website	11/19/15
Proposals Due by 5 pm CT	12/2/15
Evaluation Period	12/7/15 – 12/14/15
Contract Award Notification	TBD
**Contract Review Committee	TBD
Official Contract Award/Begin Work	TBD

\* \* By State law, this contract must be reviewed by the Legislative Contract Review Oversight Committee. The Committee meets monthly and can, at its discretion, hold a contract for up to forty-five (45) days. The "Vendor Begins Work" date above may be impacted by the timing of the contract submission to the Committee for review and/or by action of the Committee itself.

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## I. Background

The Alabama Medicaid Agency, hereinafter called Medicaid, an Agency of the State of Alabama, hereby solicits proposals for the procurement of services with a Vendor to perform enrollment broker services for the State's new Regional Care Organization (RCO) program that will be implemented on October 1, 2016.

Medicaid is responsible for administration of the Alabama Medicaid Program under a federally approved State Plan for Medical Assistance. The mission of Medicaid is to empower enrollees to make educated and informed decisions regarding their health and the health of their families. This goal is accomplished by providing a system which facilitates access to necessary and high quality preventive care, acute medical services, long term care, health education and related social services. Through teamwork, Medicaid strives to operate and enhance a cost efficient system by building an equitable partnership with healthcare providers, 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 Medicaid personnel located in eleven (11) district offices throughout the state and by approximately 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 Nov 2014, more than 1,050,254 Alabama citizens were eligible for Medicaid benefits through a variety of programs.

Services covered by Medicaid include, but are not limited to, the following:

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

- Home and Community Based Waiver Services
- Prenatal Clinic Services
- Mental Health Services

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

#### **A. Regional Care Organization Program**

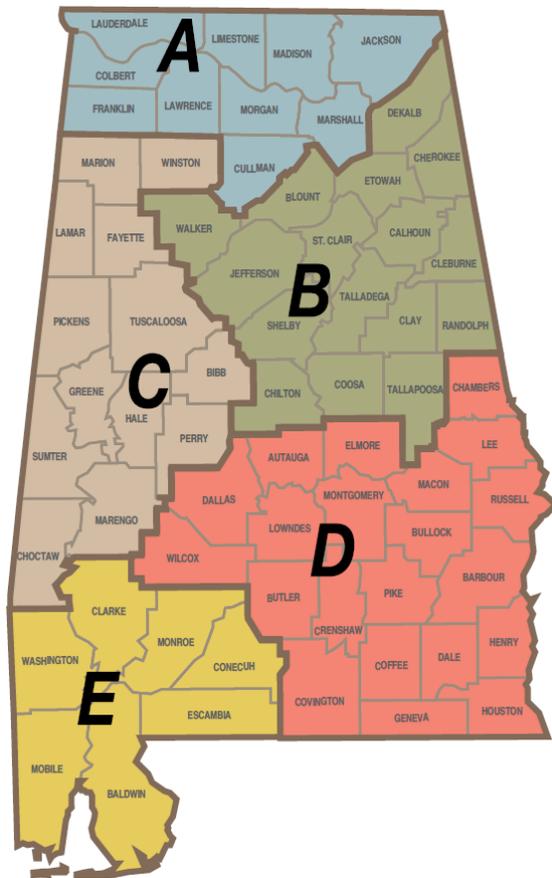
The Medicaid program currently serves over one (1) million beneficiaries, providing healthcare services to nearly one (1) in four (4) Alabama residents including one (1) in two (2) children. In addition, the Medicaid program accounts for more than half of the births in the State. As such, Medicaid is 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.

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. Alabama's objectives for Medicaid through the implementation of its managed care program are to develop an infrastructure that will continue to serve the Medicaid population by having at least one (1) RCO operating in each of five (5) RCO regions and by being in a position to continue operations beyond the five (5)-year waiver period to enroll currently excluded eligibility groups. In doing so, the RCO program will:

- Improve care coordination and reduce fragmentation in the State's delivery system
- Create aligned incentives to improve beneficiary clinical outcomes
- Improve access to healthcare providers
- Reduce the rate of growth of Medicaid expenditures

Table 1 and Figure 1, below, provides a breakdown of the state into five (5) regions, the number of anticipated RCOs in each region and the total population expected to be served by the RCOs in the region.

Figure 1. Five RCO Regions



**Table 1: RCOs and Regional Population**

Region	Anticipated # of RCOs	Region's Population
A	3	115,556
B	2	213,074
C	2	59,440
D	2	167,184
E	2	104,546

## B. RCO Program Eligibility

Medicaid will enroll most Medicaid enrollees in the RCO program on a mandatory basis to enable Medicaid to maximize its ability to better coordinate care for the highest number of enrollees. Additionally, the following Medicaid enrollees will have the option to enroll in the RCO program or to be served through the fee-for-service delivery system:

- Native Americans
- Adopted children
- Women who have been screened for breast and cervical cancer under the Center for Disease Control (CDC) Breast and Cervical Cancer Early Detection Program

The below Medicaid populations will be excluded from participation in the RCO program and will continue receiving benefits through the fee-for-service (FFS) delivery system. Medicaid may elect to expand eligible populations enrolled in RCOs through later amendment to the Demonstration Project.

- Program of All-inclusive Care for the Elderly (PACE) participants
- Children in foster care
- Children in the custody of the Department of Youth Services
- Dually eligible beneficiaries

- Individuals residing in long-term care facilities or utilizing home- and community-based waiver or hospice services
- Individuals receiving Refugee Medical Assistance
- Individuals participating in the Plan First Program
- Individuals with other commercial managed care insurance or participating in the Health Insurance Premium Payment (HIPP) program

### **C. Overview of Vendor Responsibilities**

The Enrollment Broker will be charged with operating a process that provides objective and sufficient information to enrollees and potential enrollees to make an informed RCO selection. The Enrollment Broker is expected to provide unbiased and neutral information that must not favor any particular RCO. A high-level overview of functions the Enrollment Broker will be required to perform include, but are not limited to the following:

- Provide unbiased information, via a Medicaid approved communications plan, to enrollees and potential enrollees to make informed decisions about RCO selection
- Print and mail enrollment packets and enrollment reminder notices to enrollees and potential enrollees
- Process all voluntary enrollee RCO selections received by phone, mail or online
- Enroll enrollees into RCOs
- Operate a Call Center for enrollees and potential enrollees to call for information about RCOs and to make RCO selections
- Implement and maintain an information system to track enrollment decisions and to interface with other agency or contractor systems necessary to conduct enrollment activities
- Track the timing for each enrollee to select a different RCO both for the initial ninety (90) day period after assignment as well as to determine open enrollment periods
- Provide reporting and other information as required by Medicaid for the Agency to conduct monitoring and oversight of Contractor activities
- Ensure timely and appropriate enrollment coordination for pregnant women
- Develop and maintain an Enrollment Services website for enrollees as outlined in Section II: Scope of Work, subsection U. Enrollment Services Website.
- Provide and maintain key personnel and staffing as outlined in Section II: Scope of Work, subsection C, Organizational and Staffing Plan Requirements.

### **D. Overview of Alabama Medicaid Agency Responsibilities**

Medicaid shall be expected to follow the responsibilities below. Medicaid agrees to correspond to inquiries from the Vendor in a timely and accurate manner so that the Vendor is able to respond and provide deliverables as indicated throughout this RFP.

- Medicaid shall determine a schedule for and conduct readiness reviews as determined necessary by the Agency.
- Medicaid shall be responsible for review and approval of all policies and procedures, the implementation project plan and other required materials and deliverables submitted by the Vendor.
- Medicaid or its designee shall provide daily eligibility files.

- Medicaid shall provide all eligibility transactions to the Vendor within twenty-four (24) hours after the eligibility span is transmitted to Medicaid's MMIS system.
- Medicaid shall provide access to necessary systems and information for the Vendor to conduct required services.
- Medicaid shall conduct oversight and monitoring, reviewing Vendor performance and regular reporting and provide feedback to the Vendor.
- Medicaid will notify Vendor when corrective actions are required.
- Medicaid shall provide office space for required key personnel identified in Section II: Scope of Work, subsection C, Organizational and Staffing Plan Requirements.

## **II. Scope of Work**

The following subsections provide RCO enrollment requirements for which the Vendor is responsible. The objective of the enrollment process is to assure enrollees and potential enrollees have sufficient information to make an informed RCO selection and to ensure the efficient and timely enrollment of all RCO Program enrollees.

The Vendor must demonstrate its ability to perform these key responsibilities and must submit policies and standard operating procedure documents for all tasks to Medicaid.

### **A. Implementation Project Plan and Readiness Reviews**

The Vendor must fulfill each of the following requirements (i.e. draft policies and procedures or documents deemed necessary).

1. The Vendor will provide sufficient staff devoted to implementation planning activities and the Readiness Review process.
2. The Vendor must designate a Project Director who will be staffed onsite at Medicaid's offices, unless otherwise approved by Medicaid, and other staff as necessary to assure an effective implementation.
3. The Vendor will demonstrate progress in an ongoing manner throughout Readiness Review and participate in weekly status meetings, or as otherwise scheduled, with Medicaid and other contractors, such as the fiscal agent and RCOs, as required by Medicaid.
4. The Vendor must develop an implementation project plan that identifies all required tasks, the work elements of each task, responsible parties by service area, resources assigned to each task, timeframes for completion of each task and required deliverables for operationalizing Enrollment Broker services.
5. The Vendor must submit an updated implementation work plan in an electronic format within thirty (30) business days after contract award. Medicaid will provide feedback to the Vendor, and the Vendor will revise the implementation project plan to submit to Medicaid within five (5) business days after receipt of feedback.

6. The Vendor will update and maintain the implementation project plan throughout the implementation period, and provide updates as to the status of tasks and potential risks during regular status meetings or more frequently if the risk requires immediate attention.

As part of the Proposal, the Vendor must:

1. Provide a proposed implementation project plan and narrative description of the Vendor’s plan for accomplishing required tasks, submitting deliverables and dedicating staff and other resources to implementation activities including the Readiness Review.

Activity	Date
Contractor begins contract	3/1/16
Contractor conducts implementation activities	7/1/16 – 10/1/16
Contractor participates in system testing	3/1/16 – 5/30/16
Agency conducts Readiness Review	6/1/16 – 6/30/16
Agency to provide all RCO eligible member data to Contractor	7/1/16
Contractor to begin initial RCO enrollment process	7/2/16 – 8/31/16
Contractor to conduct initial outreach to newly eligible Medicaid members	8/28/16
Agency to run auto-assignments	9/1/16
RCO Program Go-Live	10/1/16

**B. Organizational and Staffing Plan**

As part of the Proposal, the Vendor must:

1. Provide a narrative description of the Vendor’s proposed organization for this engagement, including a summary of proposed locations of key staff and call centers.
2. Provide an organizational chart with the proposal and any updated versions to Medicaid for approval prior to contract implementation. This plan must include each key personnel’s name, a breakdown of job duties and responsibilities and percentage of time each individual will spend on their assigned tasks.
3. Provide a staffing matrix identifying all staff assigned to this contract along with their respective titles, telephone numbers, email addresses and location. Any subsequent changes to the organizational plan shall be approved by Medicaid.
4. Provide the ratio of Call Center representatives to enrollees that the Vendor will assign to this contract with a description of the Vendor’s methods for determining the proposed ratio.

### C. Organizational and Staffing Plan Requirements

The Vendor must be able to secure and retain professional staff to meet contract requirements. The Vendor's proposal must demonstrate they will provide personnel comprised of staff dedicated full-time to the RCO Program. At a minimum, the Vendor must provide the following key personnel:

1. **Project Director.** The Vendor must have one (1) full time Project Director at the Medicaid offices located at 501 Dexter Avenue, Montgomery, AL during the term of this contract. Medicaid will provide office space including but not limited to telephone, email, and computer for the Project Director. This employee will serve as the onsite liaison responsible for coordination with Medicaid and other contractors, and identifying other staff members to involve based on the particular activity or discussions. The Project Director will be the primary point of contact for all program activities and charged with attending all meetings as requested by Medicaid. The Project Director must work from the Medicaid offices and be one hundred percent (100%) designated to the Medicaid RCO Program, unless otherwise approved by Medicaid. The Project Director must be capable of meeting the following qualifications and requirements:
  - a. Served as the Project Director on implementation of a new program.
  - b. Have experience with managed care enrollment and Medicaid Programs.
  - c. Have a minimum of three (3) years of experience managing projects in similar size and scope.
  - d. Provide executive direction for accomplishment of required work.
  - e. Have the authority to make decisions and be responsible for directing operations throughout the life of the Contract.
  - f. Have authority for staffing and operations decisions, with Medicaid's approval.
  - g. Possess the knowledge, skills and ability to apply new management practices and innovative methods and procedures for managing all aspects of this project.
  - h. Ensure Project Team members fulfill the following:
    - (1) Plan, schedule, track and control the project on a day-to-day basis in coordination with the Project Director.
    - (2) Provide regular status reports to the Project Director and Medicaid or its designee, including attendance at on-site meetings when necessary.
    - (3) Report any issues causing delays and/or problems on the project.
    - (4) Resolve issues reported by Medicaid within a timeframe designated by Medicaid.
    - (5) Escalate critical issues to Medicaid senior management for resolution within one (1) business day from notification of issue.
2. **Outreach Manager:** This person must have demonstrated experience in developing and implementing comprehensive communications plans and outreach materials with Medicaid populations, including the use of websites as well as electronic and social media. This person will play a critical role in the Enrollment Broker's success and should be an experienced communications professional. This person will also liaison with RCOs to obtain required information to help enrollees make informed RCO selections.

3. **Operations Manager:** This person must have demonstrated experience with enrollment and reporting operations. This person will be responsible for monitoring and oversight, including development and review of reports to identify trends and concerns that need to be addressed.
4. **Call Center Manager:** This person must have demonstrated experience and ability to manage a large volume Call Center preferably for a health care related or Medicaid program.
5. **Information Systems Manager:** This person must have demonstrated systems management skills and experience supporting a project of similar size and scope. The person must have the authority to make decisions necessary to resolve problems.
6. **Training Manager:** This person must have demonstrated experience in managing trainings of internal staff supporting Medicaid enrollment activities. This person will be responsible for developing training plans and overseeing training of new hires to assure they are well-versed on the Medicaid program and in customer satisfaction. This person will collaborate with Medicaid to develop targeted training that will better serve the program.

The Vendor must provide a sufficient number of qualified professional and technical staff to fully operate the program and satisfactorily comply with the requirements of this RFP. The Vendor must provide call center representatives to assist enrollees and potential enrollees in RCO selection in a compassionate, sensitive, efficient and unbiased manner with dignity and respect. The Vendor must also have support staff to support information systems, reporting and other required activities.

The Vendor will provide updates to proposed staffing plans and organizational charts to Medicaid for approval prior to contract implementation.

Medicaid shall have the absolute right to approve or disapprove the Vendor's and any subcontractor's key or other personnel assigned to the contract, to approve or disapprove any proposed changes in this personnel, or to require the removal or reassignment of any personnel found by Medicaid to be unwilling or unable to perform under the terms of the contract. Vendor will provide Medicaid with a resume of any members of its staff or a subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this contract. Personnel commitments made on the Vendor's response shall not be changed except as herein above provided or due to the resignation of any named individual.

As part of the Proposal, the Vendor must:

1. Provide a narrative description of the proposed staffing plan demonstrating how the Vendor will provide sufficient staffing to support the required scope of work and indicating how that staffing will differ for implementation versus ongoing activities. The staffing plan should include, at a minimum,:
  - a. an overview of involvement of corporate executive staff
  - b. job descriptions that fully outline job duties and responsibilities for staff supporting this Contract

- c. resumes of each key staff member and their qualifications.
2. Provide a detailed staffing contingency plan for handling sudden and unexpected increases in enrollment, RCO transfers and call volumes with a description on how the plan will be implemented and coordinated with Medicaid.
3. Provide a summary of best practices the Vendor will exercise to streamline the recruitment of key personnel.

#### **D. Enrollment Types and Processes**

The Vendor will conduct several types of enrollments.

As part of the Proposal, the Vendor must:

1. Describe the Vendor's overall approach to supporting enrollees and potential enrollees with enrollment decisions, including the process to ensure enrollments are processed timely and how the Vendor will meet these requirements.
2. Describe how the Vendor will provide options for enrollees to submit enrollment decisions online, by phone or via mail.
3. Describe how the Vendor will process all telephone and online enrollments in the Vendor's system on the day they are received.
4. Describe how enrollments obtained through the mail shall be processed within twenty four (24) hours of receiving the enrollment or by the end of the next Business Day, whichever is later.

#### **E. Initial RCO Program Enrollment**

The Vendor must assist the estimated 650,000 to 700,000 potential enrollees in transitioning from the FFS delivery system to the RCO program so that all enrollees have an assignment or have opted out by the program start date of October 1, 2016.

The Vendor must provide to Medicaid within thirty (30) calendar days of contract award a process for completing this initial enrollment. Medicaid would expect this process to begin around July 2016 to give potential enrollees a sixty (60) day notice.

As part of the Proposal, the Vendor must:

1. Describe the Vendor's process plan for completing initial enrollments into the RCO Program by the October 1, 2016 start date.
2. Describe in detail how the Vendor will complete the initial enrollment process to transition current FFS enrollees to the RCO program, including how this will differ from ongoing enrollment activities.

3. Describe lessons learned and best practices based on the Vendor's prior experience for initial transitioning of enrollees to a new Medicaid managed delivery system.

#### **F. New Enrollment**

1. The Vendor must contact each potential RCO enrollee at least once by mail within required timeframes and additionally by using an education and communications plan approved by Medicaid.
2. Enrollees identified as eligible to enroll with an RCO will be given a twenty (20) day choice period from the date of the enrollment broker notification. Potential enrollees may decide to stay in the FFS delivery system if enrollment is optional for their eligibility group or if only one (1) RCO operates within the Region.
3. The Vendor will also be responsible for outreaching to population groups identified by Medicaid that are out of the RCO Program but can choose to opt in to the RCO Program. Medicaid or its designee will automatically enroll individuals who do not make a selection within the required timeframe.
4. Enrollment with an RCO will be effective at 12:00 a.m. on the first (1<sup>st</sup>) Calendar Day of the month for enrollees who choose or are auto-assigned to an RCO before the twenty-first (21<sup>st</sup>) Calendar Day of the month. For enrollees who choose or are auto-assigned to the RCO on or after the twenty-first (21<sup>st</sup>) Calendar Day of the month and the last Calendar Day of the month, enrollment with a RCO will be effective on the first (1<sup>st</sup>) Calendar Day of the second (2<sup>nd</sup>) month after choice or auto-assignment.
5. The Vendor must be able to meet the following requirements:
  - a. The Vendor will electronically receive a daily 834-formatted eligibility file from the Medicaid Management Information System (MMIS) which will provide information about enrollees that the Vendor will use to identify enrollees and potential enrollees for whom an RCO assignment is needed. The Vendor will receive all eligibility transactions within twenty four (24) hours after the eligibility span is transmitted to the MMIS system. The Vendor will assist enrollees and potential enrollees to select a new RCO and process such enrollments when one (1) of the following events occurs:
    - (1) Enrollee is newly eligible for Medicaid and the RCO program
    - (2) Enrollee moves to a different region
    - (3) Enrollee completes yearly lock-in period
  - b. After receiving the file, the Vendor will provide support via mailings, information on its website, and phone conversations with potential enrollees to make an informed decision about RCO enrollment. Enrollees who do not voluntarily select an RCO or opt out of the program within that timeframe will be auto-assigned to an RCO by Medicaid or its designee using an algorithm developed by Medicaid.
  - c. The Vendor will provide enrollment information as set forth in the below sections. The Vendor will serve as the proactive and ongoing point of contact to educate individuals about options and answer questions in an impartial manner,

for example, about the RCO program and each available RCO and available providers within an RCO network.

- d. Enrollees may switch to a different RCO within the Region without cause in the first ninety (90) Calendar Days following enrollment with the RCO. The number of changes allowed will be limited to the number of RCOs within the enrollee's region. The Vendor will provide assistance to enrollees who contact the Vendor requesting to change RCOs during this time period. Following the ninety (90) Calendar Day period, enrollees will be subject to a lock-in period of twelve (12) consecutive months, in which enrollees will only be able to disenroll from the RCO for cause. The Vendor will be responsible for tracking the ninety (90) day timeframe before locking the enrollee into the RCO.

As part of the Proposal, the Vendor must:

1. Describe how the Vendor will educate potential enrollees and process voluntary selections for all newly eligible enrollees using the methods identified throughout this scope of work (e.g., mailed materials, posting information on the website, responding to questions posed to call center representatives).
2. Describe how the Vendor will utilize the auto assignment indicator from the eligibility file for outreach, plan selections and mailing of appropriate notices and packet.
3. Describe lessons learned and best practices based on the Vendor's prior experience for educating and outreach of potential enrollees to a new Medicaid managed delivery system.
4. Describe how the Vendor will process 834 eligibility transactions and adhere to the requirements listed above in F.5., a-d.

#### **G. Pregnant Women (formally known as SOBRA coverage)**

The Vendor will perform all services required by this RFP and additional outreach to pregnant women to encourage voluntary selection on a timely basis.

Pregnant enrollees who are eligible for enrollment with the RCOs solely on the basis of aid category 5A for (SOBRA) Pregnant Women will receive services deemed pregnancy-related, medically necessary and provided to treat conditions that might otherwise complicate or exacerbate the pregnancy. As of 2014, an estimated 17,821 enrollees were Medicaid-eligible through SOBRA and on average 1,700 to 1,800 newly eligible individuals are enrolled through SOBRA on a monthly basis.<sup>1</sup> These numbers are reflective of the year 2014 only for informational purposes and are subject to change.

As part of the Proposal, the Vendor must:

1. Describe initiatives and methods the Vendor will implement to identify, contact and outreach to pregnant women to encourage voluntary selection on a timely basis.

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<sup>1</sup> Note that this is an average only. For example, in 2014, in one month 2,353 women were newly eligible while in another month 1,490 became eligible.

2. Describe how the Vendor will educate pregnant women about the available options.
3. Describe challenges the Vendor anticipates when coordinating program enrollment for pregnant enrollees. This description must include innovative and successful strategies the Vendor has used or would use under this contract to address such challenges.
4. Describe how the Vendor will dedicate one (1) or more staff members to conduct enrollment activities specified in this RFP for pregnant women. The Vendor should allocate staff based on the number of staff required to effectively meet the needs for this population.
5. Describe how the Vendor will attempt to contact enrollees or potential enrollees by phone and or mail to provide enrollment information and to counsel pregnant women about RCO selection and the need to obtain timely services. The Vendor will serve as the point of contact to educate pregnant women about options, and answer questions in an impartial manner, for example about the RCO program, each available RCO and available providers within an RCO network.
6. Describe how the Vendor will track pregnant women who have not made an RCO selection and contact them by mail and/or phone to ensure that they have the opportunity to voluntarily select an RCO. The Vendor will make three (3) separate, non-consecutive attempts to contact each pregnant woman within fourteen (14) days of receiving the eligibility file. The Vendor will include in its policies and procedures information about its process for attempts to contact these enrollees.
7. Describe how the Vendor will achieve a targeted voluntary RCO selection goal of eighty percent (80%) for pregnant women.

#### **H. Enrollee Initiated “For Cause” Disenrollment/Enrollment/Transfers**

The Vendor will assist enrollees who request changes to their RCO enrollment as follows:

- a. The Vendor will approve or deny "For Cause" RCO change requests made by enrollees. The Vendor shall record in its information system and report such approvals or denials to Medicaid as set forth in section II: Scope of Work, subsection V. Enrollment Information System. The following are “for cause” criteria:
  - (1) The enrollee moves out of the RCO's service area.
  - (2) The RCO does not, because of moral or religious objections, cover the service the enrollee seeks.
  - (3) The enrollee needs related services to be performed at the same time, not all related services are available within the Provider Network, and the enrollee’s PMP or another Provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
  - (4) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the Contract or lack of access to providers experienced in dealing with the enrollee's health care needs.

- b. If the Enrollment Broker encounters a situation where an enrollee is requesting an RCO change based solely on urgent medical need, the enrollee will be referred to Medicaid's assigned Managed Care staff. Medicaid's Managed Care staff will make a determination of whether to approve or deny the enrollee's request to change RCOs for urgent medical needs.

As part of the Proposal, the Vendor must:

1. Describe how the Vendor will report incidents to Medicaid of any suspected coercive influence(s) on an enrollee in the selection of a RCO.
2. Describe the process the Vendor will use to document the incident, information about the enrollee and reason for suspicion. The Vendor is not permitted to accept any requests for RCO enrollments/disenrollments or transfers directly from an RCO; such requests will immediately be reported to Medicaid.
3. Describe how the Vendor will implement procedures and handle enrollment/disenrollments or transfers to ensure accurate and timely RCO change transactions. Staff assigned to process "For Cause" change transactions must be knowledgeable about the "For Cause" criteria.
4. Describe lessons learned and best practices based on the Vendor's prior experience for educating enrollees about issues related to requests for changes in enrollment.

#### **I. Annual Enrollment Change Period**

Enrollees must be allowed an opportunity to request changes to their RCO assignment on an annual basis.

1. Conditioned on the individual's continued eligibility, if more than one (1) RCO operates in the Region, the Vendor will notify enrollees, via a letter, at least sixty (60) Calendar Days prior to the date the enrollee's current lock-in period ends, that they have the opportunity to change enrollment to another RCO within the Region.
2. The Vendor will provide assistance and educational information to enrollees who contact the Vendor requesting information to determine whether to change to another RCO. Enrollees who do not make a choice will be deemed to have chosen to remain enrolled with their current RCO, unless the current RCO no longer participates in the RCO Program, in which case the enrollee will be auto-assigned to a new RCO.
3. The Vendor will be responsible for tracking open enrollment and lock-in timeframes for each enrollee within its systems.

As part of the Proposal, the Vendor must:

1. Describe how the Vendor will meet the requirements for the annual enrollment period.
2. Describe lessons learned and best practices based on Vendor's prior experience in outreach and education of enrollee's during open enrollment periods.

3. Describe how the Vendor will estimate additional call volumes and staffing needs for open enrollment periods.

#### **J. Agency Initiated Administrative Enrollment Changes**

Medicaid or its designee will transmit administrative enrollment changes to the Vendor in accordance with Section II: Scope of Work, subsection V. Enrollment Information System. These enrollments are due to administrative and processing issues that require Medicaid's intervention. Administrative disenrollments, for example, occur for reasons such as but not limited to: approval of an RCO request to disenroll an enrollee; systems errors; inaccurate provider directory; the Vendor enrolled or disenrolled an enrollee in error; the enrollee had multiple medical assistance numbers; or other reasons deemed appropriate by Medicaid.

As part of the Proposal, the Vendor must:

1. Describe how the Vendor will process Medicaid initiated administrative enrollment changes as required above.
2. Describe how the Vendor will coordinate with Medicaid or its designee to process administrative enrollment changes.

#### **K. Enrollment Transfers Due to RCO Changes**

In the event that an RCO withdraws from the RCO Program, Medicaid will auto-assign all enrollees to another RCO and allow the enrollees ninety (90) calendar days to change RCOs or opt out of the program if eligible to do so. Medicaid will instruct the Vendor of the actions to be taken and the specified timeframes in which the transfer of enrollees must occur.

As part of the Proposal, the Vendor must:

1. Describe how the Vendor will assist enrollees who contact the Vendor to request additional information or to change their auto-assignment.
2. Describe how the Vendor will ensure they will at all times provide uninterrupted services to newly eligible enrollees while simultaneously providing timely transfer disenrollment/enrollment services to the affected RCO enrollees as required by the RFP.
3. Describe lessons learned and best practices based on the Vendor's prior experience for addressing enrollee transfers to ensure a seamless process.

#### **L. Enrollment Materials**

The Vendor will develop and implement an enrollee education and communications plan to support enrollees and potential enrollees with RCO enrollment with the following requirements:

1. The Vendor will develop and submit for Medicaid's approval an enrollee education and communications plan for supporting enrollees and potential enrollees with RCO enrollment.
2. The Vendor will develop and produce materials for mailings to enrollees and potential enrollees, as well as to post on the Vendor's website.
3. The Vendor will also develop scripts for use by Call Center representatives in accordance with Section II: Scope of Work, subsection O. Scripts.
4. All materials will be accurate and written in a manner that does not mislead, confuse or defraud either potential enrollees, enrollees or Medicaid.
5. The Vendor will review complaints or other input from enrollees and Medicaid to identify issues raised in understanding materials and revise materials to address such issues.
6. Unless otherwise specified, the Vendor will design, develop, print and distribute materials, including scripts, as specified in this section, including any revisions.
7. The Vendor will not distribute or use any materials without prior advance written approval from Medicaid. The Vendor must submit draft materials to Medicaid for review at least forty-five (45) Calendar Days prior to intended use. Medicaid shall have thirty (30) Calendar Days to review and approve, reject or request revision from the Vendor. The Vendor will respond to Medicaid's comments for changes within five (5) Business Days of receipt of changes from Medicaid.
8. The Vendor will be fully responsible for the translation, printing, fulfillment, mailing and postage, including postal rate increases, and all costs associated with all enrollment materials specified in the RFP.
9. The Vendor will be responsible for providing, at a minimum, the enrollment materials in alternate formats and printed in both English and all other appropriate foreign languages. The appropriate foreign languages comprise all languages in the Vendor's service area spoken by approximately five percent (5%) or more of the total covered population of the Region.
10. In addition, Vendor must include appropriate instructions on all materials about how to access, or receive assistance with accessing, desired materials in an alternative format and Comply with the Americans with Disabilities Act (ADA) (42 U.S.C., Section 12101 et. Seq.) which requires the availability of appropriate alternative methods of communication for enrollees and their family members.

As part of the Proposal, the Vendor must:

1. Provide the Vendor's proposed enrollee education and communications plan.

2. Describe the Vendor's approach to assuring accurate materials that are written in a manner that does not mislead, confuse or defraud either potential enrollees, enrollees or the Agency. Include in the description a summary of the Vendor's process for reviewing complaints to determine if modifications to materials are necessary.
3. Describe the process the Vendor will implement to determine enrollee's need for providing enrollment materials in alternate formats and printed in both English and all other appropriate foreign languages.

#### **M. Enrollment Packets**

The Vendor must adhere to the following requirements for Enrollment Packets:

1. The Vendor must develop and provide to enrollees and potential enrollees unbiased materials that are in an easy to understand, culturally sensitive format and are written in a level no higher than a fifth grade level that will help the enrollee to make an informed decision about RCO program enrollment.
2. The Vendor will print and mail enrollment packets to all newly eligible enrollees within five (5) Business Days upon receipt of new eligibility transactions from Medicaid or its designee.
3. The Enrollment Packet must contain the following materials at a minimum:
  - a. A Cover Letter developed by the Vendor explaining the RCO Program and how to enroll with an RCO. The cover letter must clearly and prominently display the date by which the enrollee must choose an RCO or opt out of the program, if applicable, and indicate that Medicaid will select an RCO for the enrollee if a selection is not made by that date.
  - b. RCO Program information booklet developed by the Vendor and containing the following information:
    - (1) Identification of available RCOs in each region, their websites and telephone numbers.
    - (2) The Vendor's website link and toll-free telephone number.
    - (3) A website address to the Vendor's online Provider Directory and information about how to request a hard copy of the Provider Directory.
    - (4) The RCO selection and enrollment process, including a statement that encourages the enrollee to choose an RCO in which his/her primary care provider (PCP) or specialists participate.
    - (5) General information about the factors an enrollee or potential enrollee should consider in making an enrollment decision
    - (6) The impact and the enrollee's recourse if an RCO selection is not made (i.e., Auto-Assignment by Medicaid or its designee).
    - (7) A statement that informs enrollees about additional information that is available (and how it can be obtained) and special assistance available to enroll.
    - (8) RCO transfer policies including information about the annual open enrollment period and requesting transfers for cause.

- (9) The enrollee's right to self-refer for special medical services (such as family planning services).
  - c. Information about enrollee RCO identification cards.
  - d. An RCO Enrollment Form to be used to enroll the head of household and/or at least three (3) other enrollees of the household.
  - e. RCO brochures as reviewed and approved by Medicaid. RCOs will be responsible for providing hard copy brochures to the Vendor to include in the packet.
  - f. Postage-paid envelopes addressed to the RCO Enrollment Program for enrollees to mail their enrollment information for processing.
4. The Vendor will recommend changes to the enrollment packet materials provided on an annual basis.
  5. The Vendor will accept any Medicaid requests for changes to materials. For example, in years after the initial implementation year, Medicaid may request the Vendor to include an RCO Performance Card that demonstrates how the participating RCOs by region compare to each other in key areas. This information will be updated annually by Medicaid.

As part of the Proposal, the Vendor must:

1. Describe how the Vendor will fulfill the requirements for Enrollment Packets listed above.
2. Describe the challenges the Vendor anticipates in identifying current addresses for all enrollees for whom the Vendor receives returned mail and strategies the Vendor will use to attempt to secure appropriate addresses for these enrollees.
3. Describe best practices based on the Vendor's prior experience for developing and distributing enrollment packets.

#### **N. Notices**

The Vendor shall mail the following notices to enrollees and potential enrollees, at a minimum:

- a. Reminder notices within seven (7) calendar days of sending the enrollment packet if no response has been received explaining that the enrollee must submit RCO selection information or decision to opt out of the program, if applicable, within a specified time or be auto-assigned by Medicaid and its Fiscal Agent.
- b. Notices to enrollees whose enrollment could not be processed due to issues such as system errors or insufficient information provided by the enrollee. The Vendor will mail these notices within one (1) Business Day of resolving the issue.
- c. Confirmation notices to enrollees after assignments are made indicating the following information:
  - (1) Name and contact information for the RCO in which the enrollee is enrolled.
  - (2) Effective date of enrollment.

- (3) Information about the ability to request a change assignment for ninety (90) calendar days after the effective date of enrollment and how to request such change.
- (4) Information about importance of reporting changes, and information about the twelve (12)-month lock-in period after the 90 calendar days.

As part of the Proposal, the Vendor must:

1. Describe their process for ensuring notices are processed appropriately and within timeframes specific by Medicaid.

**O. Scripts**

1. The Vendor will develop clear and easily understood scripts for use by Call Center representatives when talking with enrollees and potential enrollees.
2. The Vendor will submit to Medicaid for prior approval a listing of issues for which scripts will address, and will modify the scripts as requested by Medicaid.
3. As part of the issue listing, the Vendor will include, but will not limited to, the following:
  - a. Explanation of the RCO program.
  - b. The enrollee's or potential enrollee's options for RCO selection and a general overview of the differences between each RCO. At Medicaid's request, the Vendor shall meet with each RCO to obtain information about the RCOs' individual operations that would be helpful to communicate to enrollees and potential enrollees.
  - c. Factors to consider when selecting an RCO.
  - d. Importance of a voluntary selection of an RCO and program enrollment, as applicable.
  - e. Collection or confirmation of the enrollee's information, including a statement indicating how the Vendor will keep the information confidential.
  - f. Instructions to help the Call Center representative to assist the enrollee or potential enrollee in determining which RCO(s) their providers are participating.
  - g. Instructions to help the Call Center representative to obtain the enrollee's or potential enrollee's selection of an RCO and decision to participate in the program, if applicable.
  - h. Instructions on how to file a complaint, if requested.
  - i. Special scripts for emergency situations.
4. The Vendor will review the scripts annually or more frequently if trends occur indicating that they may not be helpful, and will submit revisions to Medicaid for approval prior to their use.

As part of the Proposal, the Vendor must:

1. Provide three (3) sample scripts for use by Call Center representatives.
2. Provide a sample issues list.
3. Describe the methods the Vendor will employ to develop scripts that are easy to understand and are culturally sensitive.
4. Describe methods the Vendor uses to train Call Center representatives on use of scripts and how the Vendor assures Call Center representatives are following scripts as appropriate on calls.

**P. Provider Network Database and Directory**

As part of the Proposal, the Vendor must:

1. Describe how the Vendor will use provider network information to assist RCO enrollees or potential enrollees in determining in which RCOs their providers are participating.
2. Describe how the Vendor will accept and process weekly full replacement provider files from each RCO which include, at a minimum, information on maximum number of allowed enrollments in participating physicians' panels, office locations, schedules, phone numbers of participating offices and special requirements or services of the participating physicians, hospital and specialist referrals, languages and populations served.
3. Describe how the Vendor will design, develop, implement, maintain and support an RCO Participating Provider searchable database with indication of providers who have full panels for use by Call Center representatives in counseling enrollees about RCO selection.
4. Describe how the Vendor will provide an RCO Participating Provider searchable database. Minimally, searching shall be available by RCO, provider name, provider type, provider group, Provider address, zip code and county. Provider information must contain at a minimum: name, specialty, address, phone number and RCO affiliation.
5. Describe how the Vendor will distribute printed regional provider listings when requested by enrollee or potential enrollee.
6. Describe the Vendor's approach and methodology to coordinate with the RCOs to collect and transmit the automated Provider File/Directory data between all parties; to also utilize the information to fulfill enrollment activities; and to develop and implement a user-friendly web-based provider directory on the website.
7. Describe the quality checks the Vendor will implement to assure the database and directory is up to date and accurate.

## **Q. Call Center Service**

The Vendor will meet following requirements for the call center services:

1. The Vendor will establish and maintain Call Center services with a toll-free number for enrollees or potential enrollees to call for all enrollment services.
  - a. The Call Center will serve as one of the primary points of contact for enrollees and potential enrollees.
  - b. The Call Center must be located within the contiguous United States.
  - c. The Vendor must have a telephone system and sufficient staff to efficiently operate the toll-free line for the RCO Program.
  - d. The Call Center must also have a dedicated toll free number for TDD/TYY equipment.
2. The Vendor must have Call Center representatives who can:
  - a. counsel enrollees and potential enrollees about RCO selection,
  - b. respond to inquiries from enrollees, potential enrollees, and other callers, and
  - c. provide accurate information about programs and benefits administered by Medicaid.
3. The Vendor must provide accurate, consistent and timely information to enrollees and potential enrollees and reduce the need for enrollees or potential enrollees to make repeat calls or escalate their concerns to Medicaid.
4. The Vendor will develop and maintain call center policies and procedures, scripts and staff trainings for Medicaid's approval.
5. The Vendor will develop and submit to Medicaid for prior approval an initial implementation plan and a contingency plan for hiring Call Center staff to address increased call volumes and overflow calls and to maintain Call Center standards.
6. The Vendor will develop a plan for coverage for the Call Center to address the times when additional staff training may be needed or when situations arise such as staff illnesses and vacations, as well as increased call volumes due to expected and unexpected events such as open enrollment or termination of an RCO. Medicaid would expect the Vendor, at a minimum, to extend call center hours to allow enrollees and potential enrollees to call after working hours.
7. The Vendor will review the contingency plan each contract renewal term, or as directed by Medicaid, and submit modifications to Medicaid for approval prior to use.

As part of the Proposal, the Vendor must:

1. Describe the Vendor's process of establishing a call center that adheres to the requirements listed above.

2. Describe the Vendor's approaches for determining necessary updates to call center policies and procedures and scripts, as well as determining when to conduct additional staff trainings.
3. Describe how the Vendor will share call center information, such as the toll-free number, with enrollees and potential enrollees.
4. Provide the Vendor's proposed initial implementation plan and contingency plan for increased call volumes.

**R. Call Center Representative Responsibilities**

1. The Vendor will ensure that Call Center representatives operating the toll-free line have a full understanding of their responsibilities and information they must convey to enrollees, potential enrollees, and other callers.
2. The Vendor will implement a thorough training program that all Call Center representatives handling calls for the RCO program must complete prior to beginning service.
3. The Vendor's training program topics must include, but are not limited to:
  - a. Issues specific to the Medicaid program and enrollees, including sensitivity to cultural and regional dialect and slang use.
  - b. The RCO Program, including topics such as covered benefits and services, RCO provider networks and RCO service areas.
  - c. Pregnant women population requirements and enrollment process.
  - d. Customer service skills.
  - e. How to effectively use scripts.
  - f. How to counsel enrollees and potential enrollees on selection decisions, including use of all available materials (e.g., RCO comparison chart).
  - g. How to use the Vendor's system to complete enrollments for enrollees and potential enrollees who make a voluntary selection or who make a decision to opt out of the program.
  - h. How to respond to emergency calls.
  - i. How to conduct the following discussions with enrollees or potential enrollees at a minimum:
    - i. Educate eligible enrollees to ensure that each enrollee has unbiased information to make an informed and educated choice of an RCO and an awareness of what is expected upon completion of the enrollment.
    - ii. Educate eligible enrollees who may opt out of the program to ensure that each potential enrollee has necessary information to make an informed and educated decision about enrolling in the RCO program and an awareness of what to do if they opt not to enroll but change this decision at a later date.
    - iii. Explain the services covered through the RCO Program and each RCO.
    - iv. Encourage enrollees or potential enrollees to maintain their existing PCP or other provider relationships, as appropriate, when making an RCO selection.

- v. When the enrollee or potential enrollee is weighing RCO options based on RCO optional benefits, encourage the enrollee or potential enrollee to contact the RCO for additional information about those optional benefits prior to selection (e.g., limitations).
  - vi. Be able to answer questions about issues such as, but not limited to:
    - Services that may be furnished without referral from the RCO and ways to access such services.
    - Access to and use of medical services that are carved out from the RCO Program and can be obtained from fee-for-service providers, such as dental services.
    - “For Cause” reasons for which an enrollee may transfer from one RCO to another RCO, and the procedures for doing so.
  - vii. Explain that once enrolled in an RCO, enrollees should call the RCO when they have questions.
  - viii. Inform enrollees that if they have questions or experience problems accessing RCO services, they should call their assigned RCO. High call volume is not an acceptable reason to transfer calls to Medicaid. Only calls which meet criteria specified by Medicaid (e.g., non "for cause" calls, medical necessity, prescription, access to services, etc.) are to be transferred or referred to Medicaid.
4. Call Center representatives must take sufficient time with each enrollee or potential enrollee to assure adequate information is imparted to the caller.
  5. The Vendor will establish a procedure for monitoring calls to confirm Call Center representatives are providing thorough support to enrollees or potential enrollees, and establish additional training for representatives when needed.

As part of the Proposal, the Vendor must:

1. Describe in detail how the Vendor will determine the satisfaction of callers, including how it will define, address and resolve inquiries and complaints in a timely manner.
2. Provide sample Call Center training materials the Vendor has used to train new employees or ones the Vendor proposes to use for this contract.
3. Describe lessons learned and best practices based on the Vendor’s prior experience with call centers to ensure the Vendor has a full understanding operations.
4. Describe the Vendor’s proposed procedure for monitoring calls.

**S. Call Center Operations**

The Vendor will operate a Call Center in accordance with, but not limited to, the following requirements:

1. Provide the call center hours of operation, from 7:00 AM until 7:00 PM Central Time, Monday through Friday excluding Medicaid approved holidays. The Call Center will remain staffed until 7:30 PM Central Time to answer the calls remaining in the queue. Medicaid will retain the right to request and approve changes to the operating hours.
2. The Vendor shall have an automated system available every day between the hours of 7:00 p.m. and 7:00 a.m. Central Time. This automated system must provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. The Vendor must ensure that the voice mailbox has adequate capacity to receive all messages. A Vendor representative must return messages on the next Business Day.
3. Operate and maintain a toll-free line in English and all other appropriate foreign languages. The appropriate foreign languages comprise all languages in the Vendor's service area spoken by approximately five percent (5%) or more of the total covered population of the Region.
4. Provide interpreter services to the caller without cost to the caller.
5. Do not use electronic call answering methods as a substitute for staff persons to perform services during operational hours.
6. Have a telephone system with the capability to record all incoming and outgoing calls, and the staff or automated message will state to callers that the calls may be recorded.
7. Record all calls and allow Medicaid to access recordings.
8. Store all recorded incoming and outgoing calls for a minimum of one (1) year, and provide any recording that is requested by Medicaid within three (3) business days of the request, unless circumstances require a shorter response time.
9. Provide electronic call answering methods for callers to the toll-free phone line to leave messages during hours when the Call Center is not staffed. The Vendor's staff will return all after-hours calls on the next Business Day in the caller's choice of language or provide oral interpretation services.
10. Electronic call answering methods must provide electronic messages in prevalent languages, as determined by Medicaid, and refer callers to the Enrollment Services website. The recording must be first in English, and give the caller the options to hear the message repeated in another or prevalent language as determined by Medicaid.
11. Operate a call center that will have the capability to conduct three (3)-way calls to assist callers as necessary, and transfer calls to other outside lines as directed by Medicaid.
12. Use call history software to project the volume anticipated at intervals during the daily hours of operations, and calculate the number of Call Center representatives who should be staffed for each interval to attain the service levels required by Medicaid.

13. Establish a Call Center disaster recovery plan.
14. Provide, operate, monitor, maintain, and support a telephone system that meets all telephone system and call center requirements. The Vendor's telephone system shall:
  - i. Monitor, and support an Automated Call Distribution (ACD) system to process and report all enrollment related telephone activities
  - ii. Always provide the option of a live person response for all callers during the days and times of operation. This option must be prominently featured so that the caller does not have to go through multiple prompts to get to a live person.
  - iii. Have the capability of monitoring all calls
  - iv. Manage all calls received by an ACD system and assign incoming calls to available staff in an efficient manner, provide detailed analysis of the quantity, length, and types of calls received, the amount of time it takes to answer them initially, and the number of calls transferred or referred to Medicaid
  - v. Accurately measure the number of callers encountering busy signals or hanging up while on hold
  - vi. Accurately measure the number of calls in the queue at peak times
  - vii. Accurately measure the amount of time callers spend on hold
  - viii. Accurately measure the total number of calls and average calls handled per day/week/month; measure the average hours of use per day
  - ix. Accurately report and assess the busiest day by number of calls. The Vendor should use this information to provide messages to callers prompting them to consider calling during expected times of low volume.
  - x. Provide greeting message when necessary, and educational messages approved by Medicaid, while callers are on hold
  - xi. Allow calls to be real time monitored by the Vendor's supervisory level staff and Medicaid staff for the purposes of evaluating the Vendor's performance, with a message which shall inform callers that such recording and monitoring is occurring
  - xii. Within one (1) hour of discovery of an impediment to access to the primary call center, the Vendor must provide an automatic process that will route calls to a back-up site which will operate in the event of line trouble or other problems so that access to the Enrollment Telephone Help Line will not be disrupted
  - xiii. Allow calls to be "warm transferred" (person to person) to a language line (telephone translation service) without requiring the caller to make another telephone call. In addition, the system must have the ability to complete warm transfers to Medicaid and its vendors as set forth by Medicaid.
  - xiv. Provide detailed daily reports of abandonment rate, wait time, service levels, and other information.
15. Comply with all State, Federal and Agency requirements related to language services and accessibility and implement the following as detailed in its Technical Proposal:
  - i. Specific approaches that support multiple languages and cultural needs and are accessible to persons with limited English proficiency, and persons with disabilities, including persons who are blind or visually impaired, and persons who are deaf or hearing impaired.

- ii. Adherence to accessibility standards for oral and written communication, including the provision of TTY.
- iii. Means by which persons with limited English proficiency will be informed of the language services available to them and how to obtain them.
- iv. Use of translators and interpreters and bilingual staff who meet specific Vendor qualifications.
- v. Translation of enrollments materials into all appropriate foreign languages. The appropriate foreign languages comprise all languages in the Vendor's service area spoken by approximately five percent (5%) or more of the total covered population of the Region.
- vi. Placement of messages on key documents to educate enrollees about accessing or requesting information in alternative formats.

As part of the Proposal, the Vendor must:

1. Describe resources the Vendor has readily available and what the Vendor will need to acquire for operation of the Call Center.
2. Describe challenges the Vendor has experienced or anticipates could occur with Call Center operations. This should include providing innovative strategies for addressing such challenges. Include a description of the weekday and weekend hours of operation, how the Vendor will staff its Call Center, staffing rationale and coverage issues, use of script, and space and equipment setup.
3. Provide a schematic of any proposed automated call distribution the Vendor will use.

**T. Call Center Monitoring and Oversight**

1. The Vendor will submit to Medicaid for review and approval policies and procedures for monitoring Call Center activities, and will comply with Medicaid's monitoring and oversight activities. In addition to reviewing regular reports, Medicaid reserves the right to conduct monitoring activities such as conducting onsite reviews, listening to phone calls in progress and recorded, interviewing Call Center representatives to gauge their understanding of the RCO program and enrollees, or other activities as deemed necessary to assess customer services skills, as well as correctness of responses.
2. The Vendor will:
  - a. Design and implement a comprehensive call and case monitoring solution to ensure staff follows proper protocol, policies and procedures in the handling of inbound and outbound data and interactions with enrollees, potential enrollees, and callers.
  - b. Capture all telephone conversations with callers and end users to allow the Vendor and Medicaid to review their contents.
  - c. Retain conversations and be easily accessible by Medicaid in a manner that is acceptable and consistent with the requirements outlined in this RFP.
  - d. Include the approach, objectives, monitoring frequency, sample size, result reporting, quality goals and planned courses of action to be taken if the quality goal is not met.

- e. Provide Medicaid with the capability (including hardware, software, and training) to perform remote call and case monitoring to independently measure the quality of service being provided to enrollees, potential enrollees, community resources, State workers, and other service providers. The solution must allow Medicaid to perform remote call and case monitoring without notification to the Vendor. The Vendor must include specific details regarding how Medicaid will be able to conduct this monitoring.
3. The Vendor's Call Center must meet the following daily required performance standards of promptness and quality:
    - a. The Call Center must be staffed to answer at least ninety-five percent (95%) of all incoming calls within three (3) rings or fifteen (15) seconds (a call pick-up system which places the call in a queue may be used).
    - b. The wait/hold time for callers to receive a live voice response must be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls, with an average of less than two minutes hold time per month. The on hold time will be defined as the time elapsed between a call being initially answered, including answered by an Automated Caller Distribution (ACD) System, and a response by a live operator to a caller's inquiry.
    - c. The abandonment call rate must not exceed five percent (5%).
  4. The Vendor must monitor its performance regarding the Call Center's telephone line performance requirements and submit performance reports summarizing call center performance. If Medicaid determines that it is necessary to conduct onsite monitoring of the Vendor enrollee services functions, the Vendor is responsible for all reasonable costs incurred by Medicaid or its authorized designee(s) relating to such monitoring.

As part of the Proposal, the Vendor must:

1. Describe the Vendor's approach to conduct ongoing call quality assurance to ensure the minimum performance requirements are met.
2. Describe how the Vendor will collect, document and report data by program. Include in the description, the system that will be used to store caller information, and information about how the system can be used to generate statistics and/or monitoring and summary. Also provide examples of statistical and management reports the Vendor recommends collecting.
3. Describe how the Vendor will ensure excellent customer service, accuracy, consistency, and timeliness of enrollments.

**U. Enrollment Services Website**

1. The Vendor will develop and maintain an Enrollment Services website that complies with all Medicaid requirements for information systems and webpage development.

2. The Vendor will provide all webpages and posted materials in English and all other appropriate foreign languages and easily understood. The appropriate foreign languages comprise all languages in the Vendor's service area spoken by approximately five percent (5%) or more of the total covered population of the Region. Information must be provided in a format so that it is easily understandable which RCOs are participating by region.
3. The Vendor's website will comply with Medicaid requirements, to include Section 508 compatibility, compatibility with a broad range of browsers and devices and user experience.
4. The Vendor's website will:
  - a. Have a secure web portal for enrollees or potential enrollees to submit enrollment selections
  - b. Provide a secure web portal with an easily understandable enrollment form to allow enrollees eligible for the RCO Program to select an RCO or to opt out of the program, if applicable. The enrollee must be able to view timeframes in which the enrollment information must be submitted to avoid auto-assignment. The enrollment form must capture sufficient information, including email addresses, for the Vendor to process the enrollment. The Vendor must contact the enrollee or potential enrollee via e-mail, mail or phone to obtain all information necessary to complete the enrollment form if information is missing, as well as confirm the selection via e-mail, mail or phone response to the enrollee.
  - c. Provide the following, at a minimum:
    - (1) Printable RCO Enrollment Forms in addition to forms that can be submitted online. Printable forms must be capable of being filled out via a computer to maximize accuracy of information.
    - (2) A searchable provider directory
    - (3) List and map of regions with indication of RCOs in each region
    - (4) RCO Comparison Charts by region
    - (5) Links to the Medicaid website and all RCO websites
    - (6) RCO-provided materials (e.g., brochures, pamphlets, etc.)
    - (7) Frequently Asked Questions and Responses
    - (8) Area to track the progress of enrollment status and changes
  - d. Adhere to Medicaid's service level metric for the web portal real-time response.
5. The Vendor will submit to Medicaid for prior approval all materials that it proposes to post to the website.
6. The Vendor will review the website and provide recommended changes for the website for prior approval by Medicaid on a quarterly basis for the first year of operations and annually thereafter. The Vendor will also make changes to the website due to program or information changes provided by Medicaid or the RCOs.

As part of the Proposal, the Vendor must:

1. Describe how the Vendor's website will be available to enrollees and potential enrollees.

2. Describe how the Vendor's website will comply with appropriate reading level and foreign language requirements as set forth in this RFP.
3. Describe how the Vendor will ensure the security of the website.
4. Describe how the Vendor's website will accurately compile information and where the information will be stored.
5. Describe how the Vendor will assure its website complies with Medicaid requirements, to include Section 508 compatibility, compatibility with a broad range of browsers and devices and user experience.
6. Describe how the Vendor's proposed web portal will be used by enrollees and potential enrollees.
7. Describe how the Vendor will publish the database and directory to Vendor's website.

#### **V. Enrollment Information System**

The Vendor will implement and maintain an Enrollment Information System (EIS) that supports all functions of the enrollment broker process.

As part of the Proposal, the Vendor must:

1. Describe how the Vendor will provide, operate, maintain, enhance and support an Enrollment Information System (EIS) to meet all EIS requirements.
2. Describe how the Vendor will accept from Medicaid or its designee and process a daily electronic 834 file of members eligible for RCO assignment:
  - (1) Eligible members.
  - (2) Rejected enrollments.
  - (3) Cancelled enrollments.
  - (4) Demographic changes.
  - (5) Miscellaneous transactions.
3. Describe how the Vendor will accept from Medicaid or its designee a monthly electronic 834 file of:
  - (1) Confirmed and auto-assigned enrollments.
  - (2) Future month's eligibility and disenrollments.
4. Describe how the Vendor will provide Medicaid or its designee with a daily file of enrollment requests, disenrollments requests and miscellaneous enrollment broker transactions.
5. Describe how the Vendor will receive from RCOs their listing of current providers, including, but not limited to: Provider type, provider specialty, address, Medicaid provider ID, NPI and Primary Medical Provider (PMP) status. This information will be

used during enrollee or potential enrollee education and to facilitate the RCO selection process.

6. Describe how the Vendor will have adequate personnel and resources in place at all times to meet the following requirements for receipt, processing and transmission of all RCO enrollment information to and from Medicaid or its designee and to the RCOs:
  - (1) Sufficient supply of all hardware, software, communication and other equipment necessary to perform the duties specified in this RFP.
  - (2) Sufficient access to equipment, software and training necessary to accomplish its stated systems duties in a timely and efficient manner.
7. Describe how the Vendor will use the error log that will be produced and provided by Medicaid or its designee. The error log will be produced when issues with assignments are identified (e.g., member ID not on file, member location/RCO region mismatch).

#### **W. Enrollment File Transmission Requirements**

1. The Vendor must have in place connectivity and standard file transmission protocols and schedules for file transactions with Medicaid or its designee to ensure continuity with, and no disruption.
2. The file transfer process used by the Vendor to transmit enrollment data must be encrypted in accordance with HIPAA regulations.
3. The Vendor will:
  - a. Receive electronic 834 files, from Medicaid or its designee, containing information about enrollees who are eligible for RCO enrollment:
    - (1) Date they will be eligible and the region/county in which they reside.
    - (2) Enrollee's mailing address.
    - (3) Enrollees residence address, if different
    - (4) Date of birth.
    - (5) Aid category.
    - (6) Head of household information.
    - (7) Prior RCO assignment.
  - b. Transmit to Medicaid or its designee a file containing all enrollment, disenrollment, opt-out and related enrollment transactions at the close of each Business Day or, in an emergency, by no later than 10 a.m. Central Time the next Business Day. Medicaid or its designee will process these transactions nightly and transmit the results to the Vendor the following Business Day.
  - c. Review rejected enrollments returned by Medicaid or its designee, and, if appropriate, correct and resubmit them to Medicaid or its designee via the daily enrollment transaction file process.
  - d. Include Disenrollment Reason Codes established by Medicaid when transmitting disenrollment transactions to Medicaid or its designee.

As part of the Proposal, the Vendor must:

1. Describe how the Vendor will ensure compliance with HIPAA regulations.
2. Describe the method in which the Vendor will ensure accuracy and completeness in data.
3. Describe how the Vendor will process enrollment transactions by the end of each business day.
4. Describe lessons learned and best practices based on the Vendor's prior experience for addressing transmission requirements.

#### **X. Enrollment Data Reconciliation Process**

The Vendor will be responsible for the following reconciliation processes:

1. Daily enrollment transaction reconciliation to determine if the Vendor received and fully processed on its files, all appropriate transactions forwarded by Medicaid or its designee. The Vendor will:
  - (1) Perform a daily enrollment transaction reconciliation of all enrollment, disenrollment, and related transactions that it receives from Medicaid or its designee.
  - (2) Complete the daily enrollment transaction reconciliation by the close of the next Business Day, unless Medicaid approves an extension to that date.
  - (3) Report any discrepancies identified by the Vendor in the daily electronic reconciliation to Medicaid or its designee upon discovery of the discrepancy. Discrepancies caused by the Vendor will be corrected within three (3) Business Days.
  - (4) Submit a corrective action plan to Medicaid within five (5) Business Days after the discrepancies are known to the Vendor, outlining the steps the Vendor will implement to ensure that the discrepancies will not continue to occur or advise Medicaid of other appropriate corrective action.
  - (5) Provide Medicaid with a weekly summary report noting all discrepancies, the corrective action taken by the Vendor to resolve any problems, and a chart by RCO reflecting all transactions sent from Medicaid or its designee to the Vendor and processed on the Vendor's enrollment information system.
2. Weekly enrollment transaction reconciliation to determine if the Vendor received and fully processed on their files all appropriate transactions forwarded by Medicaid or its designee. The Vendor will:
  - (1) Design, develop, and implement a comprehensive weekly electronic reconciliation of all enrollment, disenrollment and related transactions that it receives from Medicaid or its designee.
  - (2) Report any discrepancies identified by the Vendor in the weekly electronic reconciliation to Medicaid upon discovery of the discrepancy. Discrepancies caused by the Vendor shall be corrected within three (3) Business Days.
  - (3) Submit a corrective action plan to Medicaid within five (5) Business Days after the discrepancies are known to the Vendor, outlining the steps the Vendor will

- implement to ensure that the discrepancies will not continue to occur or advise Medicaid of other appropriate corrective action.
- (4) Submit the weekly electronic reconciliation to Medicaid or its designee by 12:00 noon Central Time each Monday for the prior week.
  - (5) Provide Medicaid with a summary and detailed report of the weekly electronic reconciliation, as well as information concerning the correction of discrepancies and/or any other details relating to the reconciliation.
  - (6) Coordinate the requirements of the weekly reconciliation with Medicaid or its designee.
  - (7) The weekly electronic reconciliation will be a standing agenda item during status meetings between the Vendor and Medicaid.
3. Monthly enrollment transaction reconciliation to determine if the Vendor received and fully processed on its files all appropriate transactions forwarded by Medicaid or its designee. The Vendor will:
- (1) Design, develop, and implement a comprehensive monthly electronic reconciliation of all enrollment, disenrollment and related transactions that it receives and processes from Medicaid or its designee.
  - (2) Report any discrepancies identified by the Vendor in the monthly electronic reconciliation to Medicaid upon discovery of the discrepancy. Discrepancies caused by the Vendor shall be corrected within three (3) business days.
  - (3) Submit a corrective action plan to Medicaid within five (5) Business Days after the discrepancies are known to the Vendor, outlining the steps the Vendor will implement to ensure that the discrepancies will not continue to occur or advise Medicaid of other appropriate corrective action.
  - (4) Submit the monthly electronic reconciliation to Medicaid by 12:00 noon Central Time the first Monday of the month for the prior month.
  - (5) Provide Medicaid with a summary and detailed report of the monthly electronic reconciliation, as well as information concerning the correction of discrepancies and/or any other details relating to the reconciliation.
  - (6) Coordinate the requirements of the monthly reconciliation with all RCOs.

As part of the Proposal, the Vendor must:

1. Describe the method which the Vendor will adhere to for the daily, weekly and monthly enrollment transaction reconciliations.
2. Describe the method in which the Vendor will securely archive data and files for future research, resolution of discrepancies and standard and ad hoc reporting on statistics.
3. Describe the method in which the Vendor will ensure accuracy and completeness in data.

#### **Y. System Requirements**

The Enrollment Broker system must adhere to architecture guidance and the seven conditions and standards for enhanced Federal funding as provided by CMS. In alignment with this guidance, the technical solution architecture must employ a modular design, based on Service Oriented Architecture design principles and the Medicaid Information Technology

Architecture (MITA) framework. The timely bi-directional exchange of key data will be critical to the success of implementation and operation, as described in the “AMMIS Interface Standards Document” which is posted on the Medicaid Website, [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).”

The Vendor will provide advance notice of at least sixty (60) calendar days to Medicaid for any changes to its information systems and will test the new system changes with Medicaid or its designee prior to the implementation of the change.

As part of the Proposal, the Vendor must:

1. Describe how the Vendor’s proposed technical solution aligns with CMS’s Seven Conditions and Standards guidance and the Medicaid Information Technology Architecture (MITA) framework.
2. Describe the process the Vendor will utilize to ensure that the MIS will be fully operational and tested at the time of the Readiness Review.
3. Describe reports the Vendor will develop to assist in managing the enrollment services and in measuring program successes, the value the proposed reports bring to the program, including the results of the services provided, and a description of data collection and analytical techniques, summary of findings, conclusions and recommendations and supporting documentation.
4. Provide a general systems description that includes:
  - a. A systems diagram that describes each component of the Vendor’s management information system and all other systems that interface with or support it;
  - b. How each component will support the major functional areas including but not limited to: enrollments, disenrollments, plan selections and changes; and
  - c. How each component interfaces and is compatible with Medicaid and the RCOs.
  - d. Include a description of the connectivity structure and transferring of files between each of the entities.

**Z. Monitoring, Performance Standards and Corrective Action Plans**

Medicaid will monitor the Vendor’s performance according to the requirements contained within this RFP. The Vendor will submit the following reports to Medicaid for monitoring and evaluation purposes (Medicaid may request additional reports as needed).

**Table 2. Reporting Requirements**

Report Title	Frequency	Description
<i>Enrollment Activity</i>		
Completed Enrollments and Disenrollments by RCO	Monthly	Identifies number of completed enrollments by RCO by region with indication of voluntary selection rate
Completed Disenrollments by RCO	Monthly	Identifies number of completed disenrollments by RCO by reason (e.g.,

<b>Report Title</b>	<b>Frequency</b>	<b>Description</b>
<b><i>Enrollment Activity</i></b>		
		percent due to ineligibility, percent due to opt out request)
Opt out Report	Monthly	Identifies the number and percent of enrollees who elected to opt out of program participation by region
RCO Default Assignment Report	Monthly	Identifies the number and percent of enrollees who did not voluntarily select an RCO and were assigned to an RCO by the Agency, broken out by RCO, County and type of Enrollment
Default Assignment Change Requests	Monthly	Enrollees who received a default assignment who requested transfer within the initial 90 days of enrollment
Transfer For Cause Reason Code Report by RCO	Monthly	Identifies number of enrollees who requested transfer to a new RCO for cause, by RCO broken out by reason codes and percent who were approved for transfer
Transfers by RCO as approved by Medicaid	Monthly	Identified number of requests by an RCO to transfer an enrollee to another RCO and percent approved
Enrollment Method	Monthly	Enrollment counts done by phone, website, mail, etc.
<b><i>Service Information Reports</i></b>		
Number of Enrollment Packets and related materials mailed and/or distributed, including a breakdown of new Enrollment Packets mailed	Monthly	Must indicate number of eligibles who were due to receive an enrollment packet and explanation if all were not provided a packet
Annual Right to Change Mailings by RCO	Monthly	Identifies the number of annual right to change mailings sent to enrollees in the given month
Summary data for known pregnant women	Monthly	Total number of pregnant women outreached to by region, number of contacts, and total number and percent who made a voluntary selection
Summary report of discrepancies in eligibility information discovered during the preceding month (e.g. date of birth, sex, name)	Monthly	
Report of Enrollment Satisfaction Survey Results	Monthly	
Staffing Report	Monthly	Identify positions, full-time or part-time, filled or vacant, offers made, hire

<b>Report Title</b>	<b>Frequency</b>	<b>Description</b>
<b><i>Enrollment Activity</i></b>		
		date and status for any key staff vacancies
<b><i>Call Center Reports</i></b>		
Call abandonment rate	Monthly	
Call waiting time	Monthly	This is inclusive of time in queue.
Average speed for answering calls	Monthly	
Total number of calls received	Monthly	
Percentage of calls answered by a live person in sixty (60) seconds or less	Monthly	
Calls by topic/subject	Monthly	Provides a count/percent of calls by topic/subject of the call (e.g., Request for Information, Request for RCO Change, etc.)
<b><i>Website Reports</i></b>		
Website metrics	Monthly	Website stats indicating number of visits, visitors' geographic location, traffic stats for webpages, duration on webpages, etc.
Preferred method of contact	Monthly	Report that identified enrollees preferred method of contact: email, phone, text message, mail, etc.

Medicaid will provide regular feedback to the Vendor and inform the Vendor when performance does not comply with the contract requirements.

As part of the Proposal, the Vendor must:

1. Describe how the Vendor will prepare and submit for approval a corrective action plan for each identified problem within the timeframe determined by Medicaid.
2. Describe the Vendor's proposed corrective action plan including, but not be limited to:
  - a. Brief description of the findings.
  - b. Specific steps the selected Vendor will take to correct the situation or reasons why the 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 a senior executive.
3. Describe how the Vendor will implement the corrective action plan within the timeframe specified by Medicaid. Failure by the Vendor to implement corrective action plans, as required by Medicaid, may result in further action by Medicaid.

### III. Pricing

Vendor's response must specify a firm and fixed fee for completion of the Enrollment Broker development, implementation, and updating/operation process. The firm and fixed price the first year of the proposed contract (implementation year) and subsequent years must be separately stated in the RFP Cover Sheet on the first page of this document as well as the pricing sheet table (Appendix C). Vendors are to base their firm and fixed fee on providing enrollment to an average of 700,000 recipients.

The firm and fixed fee shall exclude pass-through expenses, which include development of materials, printing of materials, and postage requirements, including postal rate increases, postal preparation fees for bulk and mass mailings, and all cost associated with all outreach, education, and enrollment materials specified in the RFP. The Vendor will be responsible for determining and documenting pass-through expenses. The Vendor shall make a reasonable effort to obtain the least costly alternative for all pass-through expenses involved. The Vendor shall take advantage of high volume printing and price comparison shopping, and automation based rates and services provided by the Postal Service including zip+four, presorting, bar coding and bulk mailing. All pass-through expenses must be documented in the pricing sheet table (Appendix C).

A monthly invoice will be submitted to Medicaid for compensation for the work performed. Compensation for all approved pass-through expenses shall be paid based on documented costs.

### IV. General

This document outlines the qualifications which must be met in order for an entity to serve as Contractor. It is imperative that potential Contractors describe, **in detail**, how they intend to approach the Scope of Work specified in Section II of the RFP. The ability to perform these services must be carefully documented, even if the 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.

### V. Corporate Background and References

**Vendors submitting proposals must:**

- a. Provide evidence that the Vendor possesses the qualifications required in this RFP.
- b. Provide a description of the Vendor's organization, including
  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 list of all Medicaid agencies or other entities for which the Vendor currently performs similar work.
  7. Vendor's acknowledgment that the State will not reimburse the Contractor until: (a) the Project Director has approved the invoice; and (b) Medicaid has received and approved all deliverables covered by the invoice.
  8. Details of any pertinent judgment, criminal conviction, investigation or litigation pending against the Vendor or any of its officers, directors, employees, agents or subcontractors of which the Vendor has knowledge, or a statement that there are none. The Agency reserves the right to reject a proposal solely on the basis of this information.
- c. Have all necessary business licenses, registrations and professional certifications at the time of the contracting to be able to do business in Alabama. Alabama law provides that a foreign corporation (a business corporation incorporated under a law other than the law of this state) may not transact business in the state of Alabama until it obtains a Certificate of Authority from the Secretary of State. To obtain forms for a Certificate of Authority, contact the Secretary of State, (334) 242-5324, [www.sos.state.al.us](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.
- d. Describe experience in implementing and maintaining Enrollment Broker programs and describe how the Vendor fulfills the requirement that the Vendor has provided Enrollment Broker services for a minimum of three years.
- e. Furnish three (3) references for projects of similar size and scope, including contact name, title, telephone number, and address. Performance references must also include contract type, size, and duration of services rendered. **You 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.

## VI. 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:*** Linda Lackey  
***Address:*** Alabama Medicaid Agency  
Lurleen B. Wallace Bldg.  
501 Dexter Avenue  
PO Box 5624  
Montgomery, Alabama 36103-5624  
***E-Mail Address:*** ebrfp@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.medicicaid.alabama.gov](http://www.medicicaid.alabama.gov).

**D. Questions Regarding the RFP**

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

**E. Acceptance of Standard Terms and Conditions**

Vendor must submit a statement stating that the Vendor has an understanding of and will comply with the terms and conditions as set out in this RFP. Additions or exceptions to the standard terms and conditions are not allowed.

**F. Adherence to Specifications and Requirements**

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

**G. Order of Precedence**

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

**H. Vendor's Signature**

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

**I. Offer in Effect for 120 Days**

A proposal may not be modified, withdrawn or canceled by the Vendor for a 120-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 sheet table (Appendix C) 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. Requirement Response Structure**

The Vendor must structure its response in the same sequence, using the same labeling and numbering that appears in the RFP Section in question. For example, the Proposal would have a major Section entitled "Corporate Background and References". Within this Section, the Vendor would include their response, addressing each of the numbered Sections in sequence, as they appear in the RFP; i.e. VI.b.1, VI.b.2, VI.b.3, and so on. The response to each Section must be preceded by the Section text of the RFP followed by the Vendor's response.

#### **N. Submission of Proposals**

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

#### **O. Copies Required**

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

#### **P. Late Proposals**

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

### **Q. Performance Bond**

In order to assure full performance of all obligations imposed on a Vendor contracting with Medicaid, the Vendor will be required to provide a performance guarantee in the amount of \$1,000,000.00. The performance guarantee must be submitted by the Vendor at least ten (10) calendar days prior to the contract start date. The form of security guarantee shall be one of the following: (1) Cashier's check (personal or company checks are not acceptable); (2) Other type of bank certified check; (3) Money order; (4) An irrevocable letter of credit; (5) Surety bond issued by a company authorized to do business within the State of Alabama. This bond shall be in force from that date through the term of the operations contract and ninety (90) calendar days beyond and shall be conditioned on faithful performance of all contractual obligations. Failure of the Vendor to perform satisfactorily shall cause the performance bond to become due and payable to Medicaid. The Chief Financial Officer of Medicaid or his designee shall be the custodian of the performance bond. Said bond shall be extended in the event Medicaid exercises its option to extend the operational contract.

### **R. Disclosure of Proposal Contents**

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

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

## **VII. Evaluation and Selection Process**

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

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

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

### **B. Determination of Responsibility**

The Project Director will determine whether a Vendor has met the standards of responsibility. In determining responsibility, the Project Director may consider factors such as, but not limited to, the

vendor's specialized expertise, ability to perform the work, experience and past performance. Such a determination may be made at any time during the evaluation process and through contract negotiation if information surfaces that would result in a determination of non-responsibility. If a Vendor is found non-responsible, a written determination will be made a part of the procurement file and mailed to the affected Vendor.

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

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

### **D. Evaluation Committee**

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

### **E. Scoring**

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

<b>Evaluation Factor</b>	<b>Highest Possible Score</b>
Vendor Profile and Experience	15
Scope of Work	40
Price	45
<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 Contractor. 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.

## **VIII. General Terms and Conditions**

### **A. General**

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

The contract shall include the following:

1. Executed contract,
2. RFP, attachments, and any amendments thereto,
3. Contractor's response to the RFP, and shall be construed in accordance with and in the order of the applicable provisions of:
  - Title XIX of the Social Security Act, as amended and regulations promulgated hereunder by HHS and any other applicable federal statutes and regulations

- The statutory and case law of the State of Alabama
- The Alabama State Plan for Medical Assistance under Title XIX of the Social Security Act, as amended
- The Medicaid Administrative Code
- Medicaid's written response to prospective Vendor questions

**B. Compliance with State and Federal Regulations**

Contractor shall perform all services under the contract in accordance with applicable federal and state statutes and regulations. Medicaid retains full operational and administrative authority and responsibility over the Alabama Medicaid Program in accordance with the requirements of the federal statutes and regulations as the same may be amended from time to time.

**C. Term of Contract**

The initial contract term shall be for two years effective March 1, 2016, through February 28, 2018. Alabama Medicaid shall have three, one-year options for extending this contract if approved by the Legislative Contract Review Oversight Committee. At the end of the contract period Alabama Medicaid may at its discretion, exercise the extension option and allow the period of performance to be extended at the rate indicated on the RFP Cover Sheet. The Vendor will provide pricing for each year of the contract, including any extensions.

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

**D. Contract Amendments**

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

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

**E. Confidentiality**

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

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

1. Establishing eligibility;
2. Determining the amount of medical assistance;

3. Providing services for recipients; and
4. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan.

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

#### **F. Security and Release of Information**

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

#### **G. Federal Nondisclosure Requirements**

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

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

#### **H. Contract a Public Record**

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

#### **I. Termination for Bankruptcy**

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

**J. Termination for Default**

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

**K. Termination for Unavailability of Funds**

Performance by the State of Alabama of any of its obligations under the contract is subject to and contingent upon the availability of state and federal monies lawfully applicable for such purposes. If Medicaid, in its sole discretion, deems at any time during the term of the contract that monies lawfully applicable to this agreement shall not be available for the remainder of the term, Medicaid shall promptly notify Contractor to that effect, whereupon the obligations of the parties hereto shall end as of the date of the receipt of such notice and the contract shall at such time be cancelled without penalty to Medicaid, State or Federal Government.

**L. Proration of Funds**

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

**M. Termination for Convenience**

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

**N. Force Majeure**

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

**O. Nondiscriminatory Compliance**

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

**P. Small and Minority Business Enterprise Utilization**

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

**Q. Worker’s Compensation**

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

**R. Employment of State Staff**

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

**S. Immigration Compliance**

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

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

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

**T. Share of Contract**

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

**U. Waivers**

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

**V. Warranties Against Broker’s Fees**

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

### **W. Novation**

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

### **X. Employment Basis**

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

### **Y. Disputes and Litigation**

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

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

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

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

### **Z. Records Retention and Storage**

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

### **AA. Inspection of Records**

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

records. Contractor may require that a receipt be given for any original record removed from Contractor's premises.

**BB. Use of Federal Cost Principles**

For any terms of the contract which allow reimbursement for the cost of procuring goods, materials, supplies, equipment, or services, such procurement shall be made on a competitive basis (including the use of competitive bidding procedures) where practicable, and reimbursement for such cost under the contract shall be in accordance with 48 CFR, Chapter 1, Part 31. Further, if such reimbursement is to be made with funds derived wholly or partially from federal sources, such reimbursement shall be subject to Contractor's compliance with applicable federal procurement requirements, and the determination of costs shall be governed by federal cost principles.

**CC. Payment**

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

**DD. Notice to Parties**

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

**EE. Disclosure Statement**

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

**FF. Debarment**

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

**GG. Not to Constitute a Debt of the State**

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

**HH. Qualification to do Business in Alabama**

Should a foreign corporation (a business corporation incorporated under a law other than the law of this state) be selected to provide professional services in accordance with this RFP, it must be qualified to transact business in the State of Alabama and possess a Certificate of Authority issued by the Secretary of State at the time a professional services contract is executed. To obtain forms for a Certificate of Authority, contact the Secretary of State at (334) 242-5324 or [www.sos.state.al.us](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, [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

# Appendix A: Proposal Compliance Checklist

## NOTICE TO VENDOR:

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

---

Vendor Name

---

Project Director

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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 CORR ECT	<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 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

CONTRACT  
BETWEEN  
THE ALABAMA MEDICAID AGENCY  
AND

KNOW ALL MEN BY THESE PRESENTS, that the Alabama Medicaid Agency, an Agency of the State of Alabama, and \_\_\_\_\_, Contractor, agree as follows:

Contractor shall furnish all labor, equipment, and materials and perform all of the work required under the Request for Proposal (RFP Number \_\_\_\_\_, dated \_\_\_\_\_, strictly in accordance with the requirements thereof and Contractor's response thereto.

Contractor shall be compensated for performance under this contract in accordance with the provisions of the RFP and the price provided on the RFP Cover Sheet response, in an amount not to exceed \_\_\_\_\_. Contractor and the Alabama Medicaid Agency agree that the initial term of the contract is \_\_\_\_\_ to \_\_\_\_\_.

This contract specifically incorporates by reference the RFP, any attachments and amendments thereto, and Contractor's response.

CONTRACTOR

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

\_\_\_\_\_  
Contractor's name here

\_\_\_\_\_  
Stephanie McGee Azar  
Commissioner

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Printed Name

This contract has been reviewed for legal form and complies with all applicable laws, rules, and regulations of the State of Alabama governing these matters.

Tax ID: \_\_\_\_\_

APPROVED:

\_\_\_\_\_  
General Counsel

\_\_\_\_\_  
Governor, State of Alabama

**ALABAMA MEDICAID AGENCY  
BUSINESS ASSOCIATE ADDENDUM**

This Business Associate Addendum (this “Agreement”) is made effective the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by and between the Alabama Medicaid Agency (“Covered Entity”), an agency of the State of Alabama, and \_\_\_\_\_ (“Business Associate”) (collectively the “Parties”).

## **1. BACKGROUND**

**1.1.** Covered Entity and Business Associate are parties to a contract entitled \_\_\_\_\_

\_\_\_\_\_ (the “Contract”), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

**1.2.** The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a “business associate” within the meaning of the HIPAA Rules (as defined below).

**1.3.** The Parties enter into this Business Associate Addendum with the intention of complying with the HIPAA Rules allowing a covered entity to disclose protected health information to a business associate, and allowing a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

## **2. DEFINITIONS**

### **2.1 General Definitions**

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Electronic Protected Health Information, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

### **2.2 Specific Definitions**

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

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

**2.2.3 HIPAA Rules.** “HIPAA Rules” shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Part 160 and Part 164.

### **3. OBLIGATIONS OF BUSINESS ASSOCIATE**

Business Associate agrees to the following:

- 3.1** Use or disclose PHI only as permitted or required by this Agreement or as Required by Law.
- 3.2** Use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement. Further, Business Associate will implement administrative, physical and technical safeguards (including written policies and procedures) that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity as required by Subpart C of 45 C.F.R. Part 164.
- 3.3** Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.
- 3.4** Report to Covered Entity within five (5) business days any use or disclosure of PHI not provided for by this Agreement of which it becomes aware.
- 3.5** Ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information in accordance with 45 C.F.R. § 164.502(e)(1)(ii) and § 164.308(b)(2), if applicable.
- 3.6** Provide Covered Entity with access to PHI within thirty (30) business days of a written request from Covered Entity, in order to allow Covered Entity to meet its requirements under 45 C.F.R. § 164.524, access to PHI maintained by Business Associate in a Designated Record Set.
- 3.7** Make amendment(s) to PHI maintained by Business Associate in a Designated Record Set that Covered Entity directs or agrees to, pursuant to 45 C.F.R. § 164.526 at the written request of Covered Entity, within thirty (30) calendar days after receiving the request.
- 3.8** Make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, Covered Entity, available to Covered Entity or to the Secretary within five (5) business days after receipt of written notice or as designated by the Secretary for purposes of determining compliance with the HIPAA Rules.
- 3.9** Maintain and make available the information required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI as necessary to satisfy the Covered Entity's obligations under 45 C.F.R. § 164.528.
- 3.10** Provide to the Covered Entity, within thirty (30) days of receipt of a written request from Covered Entity, the information required for Covered Entity to respond to a request by an Individual or an authorized representative for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

- 3.11** Maintain a comprehensive security program appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities as defined in the Security Rule.
- 3.12** Notify the Covered Entity within five (5) business days following the discovery of a breach of unsecured PHI on the part of the Contractor or any of its sub-contractors, and
- 3.12.1** Provide the Covered Entity the following information:
- 3.12.1(a) The number of recipient records involved in the breach.
  - 3.12.1(b) A description of what happened, including the date of the breach and the date of the discovery of the breach if known.
  - 3.12.1(c) A description of the types of unsecure protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other type information were involved).
  - 3.12.1(d) Any steps the individuals should take to protect themselves from potential harm resulting from the breach.
  - 3.12.1(e) A description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches.
  - 3.12.1(f) Contact procedures for individuals to ask questions or learn additional information, which shall include the Business Associate's toll-free number, email address, Web site, or postal address.
  - 3.12.1(g) A proposed media release developed by the Business Associate.
- 3.12.2** Work with Covered Entity to ensure the necessary notices are provided to the recipient, prominent media outlet, or to report the breach to the Secretary of Health and Human Services (HHS) as required by 45 C.F.R. Part 164, Subpart D.;
- 3.12.3** Pay the costs of the notification for breaches that occur as a result of any act or failure to act on the part of any employee, officer, or agent of the Business Associate;
- 3.12.4** Pay all fines or penalties imposed by HHS under 45 C.F.R. Part 160, "HIPAA Administrative Simplification: Enforcement Rule" for breaches that occur as a result of any act or failure to act on the part of any employee, officer, or agent of the Business Associate.
- 3.12.5** Co-ordinate with the Covered Entity in determining additional specific actions that will be required of the Business Associate for mitigation of the breach.

#### **4. PERMITTED USES AND DISCLOSURES**

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

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

#### **5. REPORTING IMPROPER USE OR DISCLOSURE**

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

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

#### **6. OBLIGATIONS OF COVERED ENTITY**

The Covered Entity agrees to the following:

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

## 7. TERM AND TERMINATION

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

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

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

7.2.2 Immediately terminate this Agreement; or

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

### **7.3 Effect of Termination.**

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

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

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

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

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

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

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

## 7.4 Survival

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

## 8. GENERAL TERMS AND CONDITIONS

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

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

### ALABAMA MEDICAID AGENCY

Signature: \_\_\_\_\_

Printed Name: Clay Gaddis

Title: Privacy Officer

Date: \_\_\_\_\_

### BUSINESS ASSOCIATE

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

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

CONTRACT REVIEW REPORT

(Separate review report required for each contract)

Name of State Agency: Alabama Medicaid Agency

Name of Contractor:

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

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

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

Is Act 2001-955 Disclosure Form Included with this Contract? YES X NO

Does Contractor have current member of Legislature or family member of Legislator employed? YES NO

Was a lobbyist/consultant used to secure this contract OR affiliated with this contractor? YES NO

If Yes, Give Name:

Contract Number:

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

% of State Funds: % of Federal Funds: % Other Funds:

\*\*Please Specify source of Other Funds (Fees, Grants, etc.)

Date Contract Effective: Date Contract Ends:

Type of Contract: NEW: RENEWAL: AMENDMENT:

If renewal, was it originally Bid? Yes No

If AMENDMENT, Complete A through C:

(A) Original contract total \$

(B) Amended total prior to this amendment \$

(C) Amended total after this amendment \$

Was Contract secured through Bid Process? Yes No Was lowest Bid accepted? Yes No

Was Contract secured through RFP Process? Yes No Date RFP was awarded

Posted to Statewide RFP Database at http://rfp.alabama.gov/Login.aspx YES No

If no, please give a brief explanation:

Summary of Contract Services to be Provided:

Why Contract Necessary AND why this service cannot be performed by merit employee:

I certify that the above information is correct.

Signature of Agency Head

Signature of Contractor

Printed Name

Printed Name

Agency Contact: Stephanie Lindsay Phone: (334) 242-5833

Revised: 2/20/2013

**IMMIGRATION STATUS**

I hereby attest that all workers on this project are either citizens of the United States or are in a proper and legal immigration status that authorizes them to be employed for pay within the United States.

\_\_\_\_\_  
Signature of Contractor

\_\_\_\_\_  
Witness



# State of Alabama Disclosure Statement

(Required by Act 2001-955)

ENTITY COMPLETING FORM

ADDRESS

CITY, STATE, ZIP NUMBER TELEPHONE

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

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

This form is provided with:  
 Contract  Proposal  Request for Proposal  Invitation to Bid  Grant Proposal

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

Yes  No

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

STATE AGENCY/DEPARTMENT RECEIVED	TYPE OF GOODS/SERVICES	AMOUNT

Have you or any of your partners, divisions, or any related business units previously applied and received any grants from any State Agency/Department in the current or last fiscal year?

Yes  No

If yes, identify the State Agency/Department that awarded the grant, the date such grant was awarded, and the amount of the grant.

STATE AGENCY/DEPARTMENT	DATE GRANT AWARDED	AMOUNT OF GRANT

1. List below the name(s) and address(es) of all public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF PUBLIC OFFICIAL/EMPLOYEE DEPARTMENT/AGENCY	ADDRESS	STATE

2. List below the name(s) and address(es) of all family members of public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the public officials/public employees and State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF FAMILY MEMBER	ADDRESS	NAME OF PUBLIC OFFICIAL/ PUBLIC EMPLOYEE	STATE DEPARTMENT/ AGENCY WHERE EMPLOYED

If you identified individuals in items one and/or two above, describe in detail below the direct financial benefit to be gained by the public officials, public employees, and/or their family members as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

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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

***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  
Acting Commissioner

MEMORANDUM

SUBJECT: Reporting to Ethics Commission by Persons Related to Agency Employees

Section 36-25-16(b) Code of Alabama (1975) provides that anyone who enters into a contract with a state agency for the sale of goods or services exceeding \$7500 shall report to the State Ethics Commission the names of any adult child, parent, spouse, brother or sister employed by the agency.

Please review your situation for applicability of this statute. The address of the Alabama Ethics Commission is:

100 North Union Street  
RSA Union Bldg.  
Montgomery, Alabama 36104

A copy of the statute is reproduced below for your information. If you have any questions, please feel free to contact the Agency Office of General Counsel, at 242-5741.

**Section 36-25-16. Reports by persons who are related to public officials or public employees and who represent persons before regulatory body or contract with state.**

- (a) When any citizen of the state or business with which he or she is associated represents for a fee any person before a regulatory body of the executive branch, he or she shall report to the commission the name of any adult child, parent, spouse, brother, or sister who is a public official or a public employee of that regulatory body of the executive branch.
- (b) When any citizen of the State or business with which the person is associated enters into a contract for the sale of goods or services to the State of Alabama or any of its agencies or any county or municipality and any of their respective agencies in amounts exceeding seven thousand five hundred dollars (\$7500) he or she shall report to the commission the names of any adult child, parent, spouse, brother, or sister who is a public official or public employee of the agency or department with whom the contract is made.
- (c) This section shall not apply to any contract for the sale of goods or services awarded through a process of public notice and competitive bidding.
- (d) Each regulatory body of the executive branch, or any agency of the State of Alabama shall be responsible for notifying citizens affected by this chapter of the requirements of this section. (Acts 1973, No. 1056, p. 1699, §15; Acts 1975, No. 130, §1; Acts 1995, No. 95-194, p. 269, §1.)

**Instructions for Certification Regarding Debarment, Suspension,  
Ineligibility and Voluntary Exclusion**

(Derived from Appendix B to 45 CFR Part 76--Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transactions)

1. By signing and submitting this contract, the prospective lower tier participant is providing the certification set out therein.
2. The certification in this clause is a material representation of fact upon which reliance was placed when this contract was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the Alabama Medicaid Agency (the Agency) may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant shall provide immediate written notice to the Agency if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, and voluntarily excluded, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this contract is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this contract that, should the contract be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this contract that it will include this certification clause without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the Agency may pursue available remedies, including suspension and/or debarment.

State of \_\_\_\_\_ )

County of \_\_\_\_\_ )

**CERTIFICATE OF COMPLIANCE WITH THE BEASON-HAMMON ALABAMA TAXPAYER AND CITIZEN PROTECTION ACT (ACT 2011-535, as amended by Act 2012-491)**

DATE: \_\_\_\_\_

**RE Contract/Grant/Incentive (describe by number or subject):** \_\_\_\_\_ **by and between**  
\_\_\_\_\_ **(Contractor/Grantee) and Alabama Medicaid Agency (State Agency or Department or other Public Entity)**

The undersigned hereby certifies to the State of Alabama as follows:

1. The undersigned holds the position of \_\_\_\_\_ with the Contractor/Grantee named above, and is authorized to provide representations set out in this Certificate as the official and binding act of that entity, and has knowledge of the provisions of THE BEASON-HAMMON ALABAMA TAXPAYER AND CITIZEN PROTECTION ACT (ACT 2011-535 of the Alabama Legislature, as amended by Act 2012-491) which is described herein as "the Act".
2. Using the following definitions from Section 3 of the Act, select and initial either (a) or (b), below, to describe the Contractor/Grantee's business structure.  
**BUSINESS ENTITY.** Any person or group of persons employing one or more persons performing or engaging in any activity, enterprise, profession, or occupation for gain, benefit, advantage, or livelihood, whether for profit or not for profit. "Business entity" shall include, but not be limited to the following:
  - a. Self-employed individuals, business entities filing articles of incorporation, partnerships, limited partnerships, limited liability companies, foreign corporations, foreign limited partnerships, foreign limited liability companies authorized to transact business in this state, business trusts, and any business entity that registers with the Secretary of State.
  - b. Any business entity that possesses a business license, permit, certificate, approval, registration, charter, or similar form of authorization issued by the state, any business entity that is exempt by law from obtaining such a business license, and any business entity that is operating unlawfully without a business license.

**EMPLOYER.** Any person, firm, corporation, partnership, joint stock association, agent, manager, representative, foreman, or other person having control or custody of any employment, place of employment, or of any employee, including any person or entity employing any person for hire within the State of Alabama, including a public employer. This term shall not include the occupant of a household contracting with another person to perform casual domestic labor within the household.

\_\_\_\_\_(a)The Contractor/Grantee is a business entity or employer as those terms are defined in Section 3 of the Act.

\_\_\_\_\_(b)The Contractor/Grantee is not a business entity or employer as those terms are defined in Section 3 of the Act.

3. As of the date of this Certificate, Contractor/Grantee does not knowingly employ an unauthorized alien within the State of Alabama and hereafter it will not knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama;
4. Contractor/Grantee is enrolled in E-Verify unless it is not eligible to enroll because of the rules of that program or other factors beyond its control.

Certified this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_. \_\_\_\_\_

Name of Contractor/Grantee/Recipient

By: \_\_\_\_\_

Its \_\_\_\_\_

The above Certification was signed in my presence by the person whose name appears above, on this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

WITNESS: \_\_\_\_\_

\_\_\_\_\_

## Appendix C: Pricing Table

<b>Vendor:</b>					
<b>Authorized Signature:</b>				<b>Date:</b>	
	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>
<b>Implementation Cost</b>					
<b>Operating Cost</b>					
<b>Annual TOTAL Cost*</b>					
<b>TOTAL 5 Year Firm and Fixed Costs*</b>					

*\*Costs must be shown in U.S. dollars*







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GENERAL TERMS AND CONDITIONS FOR RFP FOR SERVICES v 7-9-15 rhc edit 7-28-15

**GENERAL TERMS AND CONDITIONS FOR THIS REQUEST FOR PROPOSALS - All proposals are subject to these Terms and Conditions.**

**1. PROHIBITED CONTACTS; INQUIRIES REGARDING THIS RFP** – *From the Release Date of this RFP until a contract is awarded, parties that intend to submit, or have submitted, a Proposal are prohibited from communicating with any members of the Soliciting Party’s Team for this transaction who may be identified herein or subsequent to the Release Date, or other employees or representatives of the Soliciting Party regarding this RFP or the underlying transaction except the designated contact(s) identified in {insert location in RFP where contacts are identified, such as Section S or Item 2.}*

Questions relating only to the RFP process may be submitted by telephone or by mail or hand delivery to: the designated contact. Questions on other subjects, seeking additional information and clarification, must be made in writing and submitted via email to the designated contact, sufficiently in advance of the deadline for delivery of Proposals to provide time to develop and publish an answer. A question received less than two full business days prior to the deadline may not be acknowledged. Questions and answers will be published to those parties submitting responsive proposals.

**2. NONRESPONSIVE PROPOSALS** - Any Proposal that does not satisfy requirements of the RFP may be deemed non-responsive and may be disregarded without evaluation. Clarification or supplemental information may be required from any Proposer.

**3. CHANGES TO THE RFP; CHANGES TO THE SCHEDULE** - The Soliciting Party reserves the right to change or interpret the RFP prior to the Proposal Due Date. Changes will be communicated to those parties receiving the RFP who have not informed the Soliciting Party’s designated contact that a Proposal will not be submitted. Changes to the deadline or other scheduled events may be made by the Soliciting Party as it deems to be in its best interest.

**4. EXPENSES** - Unless otherwise specified, the reimbursable expenses incurred by the service provider in the providing the solicited services, shall be charged at actual cost without mark-up, profit or administrative fee or charge. Only customary, necessary expenses in reasonable amounts will be reimbursable, to include copying (not to exceed 15 cents per page), printing, postage in excess of first class for the first one and one-half ounces, travel and preapproved consulting services. Cost of electronic legal research, cellular phone service, fax machines, long-distance telephone tolls, courier, food or beverages are not reimbursable expenses without prior authorization, which will not be granted in the absence of compelling facts that demonstrate a negative effect on the issuance of the bonds, if not authorized.

If pre-approved, in-state travel shall be reimbursed at the rate being paid to state employees on the date incurred. Necessary lodging expenses will be paid on the same per-diem basis as state employees are paid. Any other pre-approved travel expenses will be reimbursed on conditions and in amounts that will be declared by the Issuer when granting approval to travel. Issuer may require such documentation of expenses as it deems necessary.

**5. REJECTION OF PROPOSALS** - The Soliciting Party reserves the right to reject any and all proposals and cancel this Request if, in the exercise its sole discretion, it deems such action to be in its best interest.

**6. EXPENSES OF PROPOSAL** – The Soliciting Party will not compensate a Proposer for any expenses incurred in the preparation of a Proposal.

**7. DISCLOSURE STATEMENT** - A Proposal must include one original Disclosure Statement as required by Code Section 41-16-82, et seq., Code of Alabama 1975. Copies of

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the Disclosure Statement, and information, may be downloaded from the State of Alabama Attorney General’s web site at <http://ago.alabama.gov/Page-Vendor-Disclosure-Statement-Information-and-Instructions>.

**8. LEGISLATIVE CONTRACT REVIEW** - Personal and professional services contracts with the State may be subject to review by the Contract Review Permanent Legislative Oversight Committee in accordance with Section 29-2-40, et seq., Code of Alabama 1975. The vendor is required to be knowledgeable of the provisions of that statute and the rules of the committee. These rules can be found at <http://www.legislature.state.al.us/aliswww/AlaLegJointIntCommContracReview.aspx>. If a

contract resulting from this RFP is to be submitted for review the service provider must provide the forms and documentation required for that process.

**9. THE FINAL TERMS OF THE ENGAGEMENT** - Issuance of this Request For Proposals in no way constitutes a commitment by the Soliciting Party to award a contract. The final terms of engagement for the service provider will be set out in a contract which will be effective upon its acceptance by the Soliciting Party as evidenced by the signature thereon of its authorized representative. Provisions of this Request For Proposals and the accepted Proposal may be incorporated into the terms of the engagement should the Issuer so dictate. Notice is hereby given that there are certain terms standard to commercial contracts in private sector use which the State is prevented by law or policy from accepting, including indemnification and holding harmless a party to a contract or third parties, consent to choice of law and venue other than the State of Alabama, methods of dispute resolution other than negotiation and mediation, waivers of subrogation and other rights against third parties, agreement to pay attorney’s fees and expenses of litigation, and some provisions limiting damages payable by a vendor, including those limiting damages to the cost of goods or services.

**10. BEASON-HAMMON ACT COMPLIANCE.** A contract resulting from this RFP will include provisions for compliance with certain requirements of the *Beason-Hammon Alabama taxpayer and Citizen Protection Act* (Act 2011-535, as amended by Act 2012-491 and codified as Sections 31-13-1 through 35, Code of Alabama, 1975, as amended), as follows:

E- VERIFY ENROLLMENT DOCUMENTATION AND PARTICIPATION. As required by Section 31-13-9(b), Code of Alabama, 1975, as amended, Contractor that is a “business entity” or “employer” as defined in Code Section 31-13-3, will enroll in the E-Verify Program administered by the United States Department of Homeland Security, will provide a copy of its Memorandum of Agreement with the United States Department of Homeland Security that program and will use that program for the duration of this contract.

**CONTRACT PROVISION MANDATED BY SECTION 31-13-9(k):**

By signing this contract, the contracting parties affirm, for the duration of the agreement, that they will not violate federal immigration law or knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama. Furthermore, a contracting party found to be in violation of this provision shall be deemed in breach of the agreement and shall be responsible for all damages resulting therefrom.

16000000002	<b>Document Phase</b> Final	<b>Document Description</b> Medicare Regional Care Org Prog Enrollment Broker Services	<b>Page 6</b> of 6
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**ATTENTION:** Download the Medicaid Regional Care Organization Program Enrollment Broker Services RFP specifications document located on 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 [ebfp@medicaid.alabama.gov](mailto:ebfp@medicaid.alabama.gov).



## Alabama Medicaid ANSI ASC X12N HIPAA Companion Guide for 5010

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*Standard Companion Guide Communications/Connectivity Information*

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

*Companion Guide Version Number: 4.0*

*Last Updated: **Month XX**, 2015*

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[http://www.medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.3X\\_Vendor\\_Companion\\_Guide.aspx](http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.3X_Vendor_Companion_Guide.aspx)

*If referencing a downloaded copy, it is the responsibility of the reader to verify the correct version.*

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

## PREFACE

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

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

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

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

RCO DRAFT

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# 1 INTRODUCTION

## 1.1 PURPOSE

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

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

## 1.2 OVERVIEW

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

### Getting Started

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

### Testing and Certification Requirements

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

### Connectivity/Communications

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

### Contact Information

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

### Control Segments/Envelopes

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

### Acknowledgments and Reports

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

### Included ASC X12N Implementation guides

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

### Instruction Tables

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

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

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

### Additional Information

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

### Change Summary

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

#### 1.3 REFERENCES

Implementation Guides for all X12 transaction sets can be purchased from the publisher, Washington Publishing Company, at their website [www.wpc-edi.com](http://www.wpc-edi.com).

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

#### 1.4 INTENDED USE

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

## 2 GETTING STARTED

### 2.1 WORKING TOGETHER

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

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

Contacts: [http://medicaid.alabama.gov/CONTENT/8.0\\_Contact/](http://medicaid.alabama.gov/CONTENT/8.0_Contact/)

### 2.2 TRADING PARTNER REGISTRATION

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

Contact the EMC Helpdesk to register.

- **Trading Partner** is an entity engaged in the exchange or transmission of electronic transactions.
- **Vendor** is an entity that provides hardware, software and/or ongoing technical support for covered entities. In EDI, a vendor can be classified as a software vendor, billing or network service vendor or clearinghouse.
- **Software Vendor** is an entity that creates software used by billing services, clearinghouses and providers/suppliers to conduct the exchange of electronic transactions.
- **Billing Service** is a third party that prepares and/or submits claims for a provider.
- **Clearinghouse** is a third party that submits and/or exchanges electronic transactions on behalf of a provider.
- **Regional Care Organization (RCO)** is an entity that is a locally-led managed care system that will ultimately provide healthcare services to most Medicaid enrollees.
- **Enrollment Broker (EB)** is an entity that provides RCO enrollment activities for Medicaid Recipients.

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

[http://www.medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.3X\\_Vendor\\_Companion\\_Guide.aspx](http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.3X_Vendor_Companion_Guide.aspx)

### 2.3 TRADING PARTNER TESTING AND CERTIFICATION

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

#### 2.3.1 TRADING PARTNER ID

Once registration is completed the following ids will be created:

- Test Trading Partner ID
- Production Trading Partner ID

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

#### 2.3.2 WEB USER ID

Each entity that successfully completes enrollment as a trading partner will be assigned a Personal Identification Number (PIN) that allows access to the secure Web Portal. Prior to submission of EDI transactions users must access the secure web site and setup an account which once successfully completed

will allow for the uploading and downloading of electronic transactions through the Web Portal and/or Safe Harbor. PINs are issued for test and production separately and are only valid to be used in the appropriate environment.

- Web User Account Setup

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

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

### 2.3.3 USAGE INDICATOR

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

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

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

### 2.3.4 SECURE WEB UPLOAD - TRACKING NUMBER

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

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

### 2.3.5 SECURE WEB UPLOAD - ERROR MESSAGES

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

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

### 2.3.6 SECURE WEB DOWNLOAD – FILE RETENTION

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

7 Days	999, TA1, 271, 277, 278, BRF
--------	------------------------------

30 Days	277U
90 Days	835, RA

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

### 2.3.7 SAFE HARBOR PAYLOAD ID

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

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

RCO DRAFT

## 3 TESTING

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

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

The following ASC X12 transaction types are available to RCO trading partners for testing through SFTP:

- 837P Professional (HCFA) Claim
- 837I Institutional (UB) Claim
- 834 Benefit Enrollment and Maintenance (Alabama Medicaid to RCO only)
- 277CA Health Care Claim Acknowledgement
- TA1/999
- Proprietary Batch Response File (BRF)

The following ASC X12 transaction types are available to EB trading partners for testing through SFTP:

- 834 Benefit Enrollment and Maintenance (Alabama Medicaid to EB only)
- Proprietary Recipient RCO Assignment File
- Proprietary Error File

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

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

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

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

### 3.1 835 TESTING

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

### 3.2 PAYER SPECIFIC DOCUMENTATION

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

[http://www.medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.7\\_Manuals.aspx](http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx)

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

[http://www.medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.9\\_Prior\\_Authorization.aspx](http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.9_Prior_Authorization.aspx)

### 3.3 TESTING CONTACT INFORMATION

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

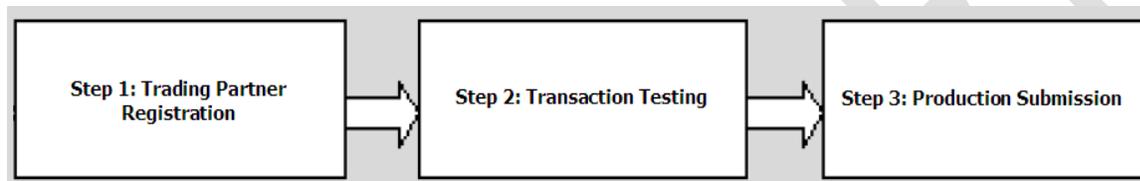
[alabamaictesting@hp.com](mailto:alabamaictesting@hp.com)

The following information should be included in the email:

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

## 4 CONNECTIVITY/COMMUNICATIONS

### 4.1 PROCESS FLOWS



### 4.2 TRANSMISSION PROCEDURES

Trading Partners may find information concerning system availability within the published schedule.

[http://www.medicaid.alabama.gov/documents/8.0\\_Contact/8.2\\_HP\\_Contact\\_Information/8.2.8\\_System\\_Availability/8.2.8\\_2014\\_Medicaid\\_System\\_Availability\\_7-25-14.pdf](http://www.medicaid.alabama.gov/documents/8.0_Contact/8.2_HP_Contact_Information/8.2.8_System_Availability/8.2.8_2014_Medicaid_System_Availability_7-25-14.pdf)

#### 4.2.1 RE-TRANSMISSION PROCEDURES

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

### 4.3 COMMUNICATION AND SECURITY PROTOCOLS

Vendors may find information regarding communication protocols in the Vendor Specifications Document.

[http://www.medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.3X\\_Vendor\\_Companion\\_Guide.aspx](http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.3X_Vendor_Companion_Guide.aspx)

### 4.4 SECURE WEB PORTAL

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

- User Acceptance Test

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

- Production

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

### 4.5 SECURE FILE TRANSFER PROTOCOL (SFTP)

RCO and EB trading partners must use SFTP to securely trade files with the Alabama Medicaid Agency.

- The SFTP option for trading files is only available to RCO and EB trading partners. This option is not available to Providers, Clearinghouses or software vendors.

- Transactions traded through this method must have unique unduplicated file names to avoid issues with transfer.
- All RCO and EB trading partners must complete an SFTP request form to obtain SFTP logon credentials.  
\*\*insert link to SFTP form here (TBD)\*\*

#### 4.6 SAFE HARBOR

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

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

#### 4.7 SAFE HARBOR BATCH SUBMISSION

##### 4.7.1 SOAP+WSDL

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

- **Production SOAP Batch**

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

- **User Acceptance Test SOAP Batch**

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

##### 4.7.2 HTTP MIME MULTIPART

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

- **Production MIME Batch**

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

- **User Acceptance Test MIME Batch**

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

#### 4.7.3 SAFE HARBOR ALLOWED INCOMING/OUTGOING BATCH PAYLOAD TYPES

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

Acknowledge Submit	X12_TA1_SubmissionRequest_005010X231A1		
		<<<<<	X12_Response_ConfirmReceiptReceived CoreEnvelopeError

#### 4.8 SAFE HARBOR REAL TIME

##### 4.8.1 SOAP+WSDL

- **Production SOAP Real Time**

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

- **User Acceptance Test SOAP REAL TIME**

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

##### 4.8.2 HTTP MIME MULTIPART

- **Production MIME Real Time**

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

- **User Acceptance Test MIME Real Time**

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

##### 4.8.3 SAFE HARBOR ALLOWED INCOMING/OUTGOING REAL TIME PAYLOAD TYPES

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

## 5 CONTACT INFORMATION

### 5.1 EDI CUSTOMER SERVICE/TECHNICAL ASSISTANCE

#### **Electronic Media Claims Helpdesk**

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

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

[http://medicaid.alabama.gov/CONTENT/8.0>Contact/8.2.2\\_Electronic\\_Media\\_Claims\\_Helpdesk.aspx](http://medicaid.alabama.gov/CONTENT/8.0>Contact/8.2.2_Electronic_Media_Claims_Helpdesk.aspx)

### 5.2 PROVIDER SERVICES

#### **Provider Relations Department**

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

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

[http://medicaid.alabama.gov/CONTENT/8.0>Contact/8.2.7\\_Provider\\_Relations\\_Team.aspx](http://medicaid.alabama.gov/CONTENT/8.0>Contact/8.2.7_Provider_Relations_Team.aspx)

#### **Provider Assistance Center**

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

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

[http://medicaid.alabama.gov/CONTENT/8.0>Contact/8.2.4\\_Provider\\_Assistance\\_Center.aspx](http://medicaid.alabama.gov/CONTENT/8.0>Contact/8.2.4_Provider_Assistance_Center.aspx)

## 6 CONTROL SEGMENTS/ENVELOPES

### 6.1 ISA/IEA

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

### 6.2 GS/GE

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

### 6.3 ST/SE

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

### 6.4 SAFE HARBOR CAQH CORE ENVELOPE

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

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

### 6.5 SAFE HARBOR CORE ENVELOPE ERRORS

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

## 7 BUSINESS RULES AND LIMITATIONS

### 7.1 SAFE HARBOR RULES OF BEHAVIOR

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

### 7.2 SAFE HARBOR CONNECTION LIMITATIONS

TBD

RCO DRAFT

## 8 ACKNOWLEDGEMENTS AND REPORTS

### 8.1 WEB PORTAL ACKNOWLEDGEMENTS AND REPORTS

#### **Interchange Acknowledgement (TA1)**

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

#### **Functional Acknowledgement (999)**

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

#### **Proprietary Batch Response File (BRF)**

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

#### **Health Care Claim Payment/Advice (835)**

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

[http://www.medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.2\\_Checkwrite\\_Schedules.aspx](http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.2_Checkwrite_Schedules.aspx)

#### **Remittance Advice**

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

#### **Health Care Payer Unsolicited Claim Status (277U)**

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

[http://www.medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.2\\_Checkwrite\\_Schedules.aspx](http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.2_Checkwrite_Schedules.aspx)

### 8.2 RCO SFTP ACKNOWLEDGMENTS AND REPORTS

#### **Interchange Acknowledgement (TA1)**

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

#### **Functional Acknowledgement (999)**

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

#### **Proprietary Batch Response File (BRF)**

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

#### **Health Care Claim Acknowledgement (277CA)**

A 277CA file is returned for each batch of claims submitted which communicates the results of pre-adjudication editing in a HIPAA format.

### 8.3 EB SFTP ACKNOWLEDGMENTS AND REPORTS

#### **Proprietary Error Response File**

A error response file is returned if there are errors with processing RCO recipient assignments with Alabama Medicaid.

### 8.4 SAFE HARBOR ACKNOWLEDGEMENTS AND REPORTS

#### **Interchange Acknowledgement (TA1)**

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

#### **Functional Acknowledgement (999)**

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

## 9 TRADING PARTNER AGREEMENTS

### 9.1 INCLUDED ASC X12 IMPLEMENTATION GUIDES

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

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

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

- 005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)
- 005010X212 Health Care Claim Status Request and Response (276/277)
- 005010X217 Health Care Services for Review and Response (278)
- 005010X218 Payroll Deducted and Other Group Premium Payment (820)
- 005010X220A1 Benefit and Enrollment Maintenance (834)
- 005010X224A2 Health Care Claim - Dental (837 D)
- 005010X222A1 Health Care Claim - Professional (837 P)
- 005010X223A2 Health Care Claim - Institutional (837 I)
- 005010X214 Health Care Claim Acknowledgement (277CA (Available only to RCO trading partners))

## 10 TRANSACTION SPECIFIC INFORMATION

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

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

#### 005010X279A1 ELIGIBILITY, COVERAGE OR BENEFIT INQUIRY (270)

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

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

**005010X279A1 ELIGIBILITY, COVERAGE OR BENEFIT INFORMATION (271)**

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

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

#### 10.1.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

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

#### 10.1.2 NATIONAL PROVIDER ID (NPI) VERIFICATION

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

For more information please refer to the NPPES website:

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

#### 10.1.3 MINIMUM REQUIREMENTS FOR ELIGIBILITY SEARCH

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

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

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

#### 10.1.4 SERVICE TYPE CODE LIST

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

Examples:

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

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

Generic Service Type Code table:

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

Explicit Service Type Code table:

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

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

### 10.1.5 NAME NORMALIZATION

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

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

Name Normalization Examples:

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

### 10.1.6 MESSAGES

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

#### Messages

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

Hearing Screening data may be returned, if applicable for service type(s):
Hearing Screening data may be returned, if applicable. Coverage is dependent on being allowed/covered by Medicare for service type(s):
Lockin data may be returned, if applicable, for service type(s):
LTC waiver data may be returned, if applicable, for service type(s):
Medical Screening data may be returned, if applicable, for service type(s):
Medical Screening data may be returned, if applicable. Coverage is dependent on being allowed/covered by Medicare for service type(s):
Only covered for family planning related services for service type(s):
Only covered for pregnancy and family planning related services for service type(s):
Service type code(s): not recognized by Alabama Medicaid
Vision Screening data may be returned, if applicable, for service type(s):
Recipient eligibility information displayed is applicable to fee-for-service related claims only. EPSDT screening information displayed includes both fee-for-service and encounter claims data. Encounter related inquiries should be directed to the RCO.

### 10.1.7 RCO INFORMATION

271 response transactions will return RCO assignment information on Recipients assigned under an RCO for the dates of service requested. The following information will be returned if applicable:

- Recipient's RCO plan assignment
- RCO plan assignment name
- RCO plan assignment effective and end dates
- RCO plan assignment 800 telephone number if available

Benefit limit information returned on the 271 response is applicable to fee for service claims only with the exception of the EPSDT screening information which will include both RCO submitted encounter claims and fee for service claims. For information or questions concerning a Recipients RCO benefit limits providers should contact the RCO.

### 10.1.8 INTERACTIVE SUBMISSIONS

For interactive processing, submit one transaction at a time.

### 10.1.9 NUMBER OF REQUEST

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

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

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

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

### 005010X212 HEALTH CARE CLAIM STATUS REQUEST (276)

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

**005010X212 HEALTH CARE CLAIM STATUS RESPONSE (277)**

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

**10.2.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS**

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

**10.2.2 NATIONAL PROVIDER ID (NPI) VERIFICATION**

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

For more information please refer to the NPPES website:

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

**10.2.3 MINIMUM DATA REQUIRED**

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

The minimum data fields for a batch submission are:

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

The minimum data fields for an interactive submission are:

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

- Internal Control Number (ICN)

#### 10.2.4 INTERACTIVE SUBMISSIONS

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

#### 10.2.5 RCO INFORMATION

277 Claim status responses will return claim status on fee for service claims only. For a status on encounter claims submitted by the RCO providers contact the RCO.

#### 10.2.6 NUMBER OF REQUEST

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

RCO DRAFT

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

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

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

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

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

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

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

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

#### 10.3.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

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

### 10.3.2 NATIONAL PROVIDER ID (NPI) VERIFICATION

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

For more information please refer to the NPPES website:

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

### 10.3.3 PRIOR AUTHORIZATION SPECIFICATIONS

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

Expected submission examples:

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

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

Unexpected submission example:

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

### 10.3.1 RCO INFORMATION

Prior Authorization (PA) request should only be submitted directly to Alabama Medicaid for the following reasons:

- Requested effective and end dates on the PA are during a period of time when the Recipient is not enrolled with an RCO.

- Requested effective and end dates on the PA are during a period of time when the Recipient is enrolled with an RCO and the service requested is not covered by the RCO.

PA request will be rejected with error code 33 “Assignment Type invalid for Recipient with RCO coverage” if the requested effective and end dates are for a Recipient within an RCO and the service is a covered service under the RCO. These PA records will not be added to the Alabama Medicaid system and will not be available online through the provider web portal for review.

RCO DRAFT

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

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

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

Loop	Segment	Name	Codes	Comments
	BPR	Financial Information		
	BPR01	Transaction Handling Code	I	'I' – Remittance Information Only
	BRP03	Credit/Debit Flag	C	'C' - Credit
	BRP04	Payment Method Code	NON	'NON' – Non-Payment Data
	BRP10	Originating Company Identifier	752548221	'752548221' - Trading Partner ID for Alabama Trading Partner.
	TRN	Reassociation Trace Number		
	TRN01	Trace Type Code	3	'3' – Financial Reassociation Trace Number
	REF	Premium Receiver's Identification Key		
	REF01	Reference Identification Qualifier	14	'14' – Master Account Number
	REF02	Reference Identification		Value assigned as the master account number.
	DTM	Coverage Period		
	DTM01	Date Time Qualifier	582	'582' – Report Period
1000A	N1	Premium Receiver's Name		
	N103	Identification Code Qualifier	FI	'FI' – Federal Taxpayer's Identification Number
	N104	Identification Code		Alabama Medicaid Federal Taxpayer ID Number
1000B	N1	Premium Payer's Name		
	N101	Entity Identifier Code	PR	'PR' - Payer
	N102	Name		'ALABAMA MEDICAID'
	N103	Identification Code Qualifier	FI	'FI' – Federal Taxpayer's Identification Number
	N104	Identification Code		'752548221'
2000B	ENT	Individual Remittance		
	ENT01	Assigned Number		Unique value. Will start at "1" and increment by1 for each occurrence of the ENT within the ST/SE.
	ENT02	Entity ID Code	2J	'2J' – Individual
	ENT03	Identification Code Qualifier	EI	'EI' – Employee Identification Number
	ENT04	Identification Code		Employee Identification Number
2100B	NM1	Individual Name		
	NM101	Entity Identifier Code	IL	'IL' – Insured or Subscriber
	NM103	Name Last		Recipient Last Name
	NM104	Name First		Recipient First Name
	NM108	Identification Code Qualifier	N	'N' – Insured's Unique Identification Number
	NM109	Identification Code		Recipient Identification Number
2300B	RMR	Individual Premium Remittance Detail		
	RMR01	Reference Identification Qualifier	AZ	'AZ' – Health Insurance Policy Number
	RMR02	Insurance Remittance Reference Number		Unique ID that is related to the recipient's history payment.
	RMR04	Detail Premium Payment Amount		Payment Amount for the recipient.
2300B	DTM	Individual Coverage Period		
	DMT01	Date Time Qualifier	582	'582' – Report Period
2320B	ADX	Individual Premium Adjustment for Current Payment		
	ADX01	Adjustment Amount		The amount of the adjustment.

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

#### 10.4.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

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

#### 10.4.1 RCO INFORMATION

This transaction is not impacted by RCO.

RCO DRAFT

10.5 005010X220A1 BENEFIT AND ENROLLMENT MAINTENANCE (834)

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

**005010X220A1 BENEFIT AND ENROLLMENT MAINTENANCE (834)**

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

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

### 10.5.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

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

- Monthly Report

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

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

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

- Daily Report

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

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

## 10.5.2 RCO INFORMATION

Please note that when a member is extracted for the 834 all applicable data will be provided, not just information that has changed. The RCO, therefore, should use the 834 data to reconcile and update the information they have previously received for the individual.

In addition, please note that the RCO will only receive assignment information applicable to themselves. If a recipient's assignment is changed from one RCO to another, the original RCO will simply receive an 834 with an ended RCO assignment while the new RCO will receive an 834 with only the new assignment information.

The following 834 X12 loops could have data:

- LOOP 2000 – MEMBER LEVEL DETAIL – This loop will contain the member identification and the maintenance type code that will indicate if this member is an addition, update or cancellation/termination. The Medicaid ID will be provided.
- LOOP 2100A - MEMBER NAME – This loop will contain the member name, residential address, and demographic information. A qualifier of 74 on the NM1 segment indicates this is the corrected name and/or demographic information for the member.
- LOOP 2100B - INCORRECT MEMBER NAME – This loop will contain data when an incorrect name or update to demographic information is to be reported. This loop will contain the incorrect information.
- LOOP 2100C - MEMBER MAILING ADDRESS – This loop will always be populated and may be the same as the residential address reported in loop 2100A –Member Name.
- LOOP 2100F - CUSTODIAL PARENT – This loop will report the parent information that comes from Third Party Liability Insurance (TPL) information.
- LOOP 2100G - RESPONSIBLE PERSON – This loop will report the head of household. The Medicaid ID will be provided.
- LOOP 2300 - HEALTH COVERAGE – This loop will contain the coverage description along with the associated dates. The plan description on the HD segment will be a string of characters that break out into plan specific information, like county, aid category, benefit plan, benefit plan description, RCO program (RCOA1, RCOA2,etc). The applicable dates in the DTP segment will follow the coverage description (HD segment).
  - Member dates will span dates at least 12 months in the past, 1 current period and 1 future period when applicable.
- LOOP 2320 – COORDINATION OF BENEFITS – This loop will contain Third Party Liability (TPL) information and will be populated when applicable.

The following 834 X12 loops/segments/data elements will be sent to RCO trading partners in order to report the following specific situations:

### 1) New RCO assignment

Loop	Segment	Name	Codes	Comments
2000A	INS03	Maintenance Type Code	021	Addition
	INS04	Maintenance Reason Code	28	Initial Enrollment
2100F		Custodial Parent		This loop will report the parent information for the Third Party Liability coverage information reported in loops 2320 and 2330.
2100G		Responsible Person		This loop will report the head of household information for the member reported. The

Loop	Segment	Name	Codes	Comments
				Medicaid ID will be provided.
2300		Health Coverage		<p>This loop will contain the coverage description along with the associated dates. Member dates can include up to 12 months prior period, 1 current period and 1 future period for a total of 14 months.</p> <p>RCO assignment dates:</p> <ul style="list-style-type: none"> <li>• RCO Program (RCOA1 for example)</li> <li>• RCO Program description</li> </ul> <p>Eligibility segments:</p> <ul style="list-style-type: none"> <li>• County</li> <li>• Aid category</li> <li>• Benefit plan and Benefit plan description</li> </ul> <p>LTC/Waiver:</p> <ul style="list-style-type: none"> <li>• Hard coded 'LWVR'</li> <li>• Benefit plan and Benefit plan description</li> </ul> <p>Opt Out:</p> <ul style="list-style-type: none"> <li>• Opt Out Code (Values still being defined)</li> <li>• Description/Reason for opt out</li> <li>• SSN will not be provided for the Member or for the Responsible Person</li> <li>• Mailing Address will always be provided</li> </ul>
2300	HD01	Maintenance Type Code	021	Addition
	HD04	Plan Coverage Description		Data string with county, aid category, plan id, plan description
	DTP01	Date/Time Qualifier	348 349 695	<p>This segment will can report up to 6 dates per Health Coverage description. If additional dates are required the Health Coverage loop will be repeated as needed.</p> <p>Dates for previous months will be reported in a date range and the current/future months will be single entries showing begin and end dates.</p> <p>348-Benefit Begin Date 349-Benefit End Date 695-Previous Period</p>
2320	COB	Coordination of Benefits		Third Party Liability information and applicable coverage dates
2330	COB	Coordination of Benefits Related Entity		Third Party Liability related address information

## 2) Change in RCO Assignment

Loop	Segment	Name	Codes	Comments
2000A	INS03	Maintenance Type Code	024	Cancellation or Termination
	INS04	Maintenance Reason Code	AI	No reason given
	INS12	Date Time Period		When applicable date of death
	DTP01	Date/Time Qualifier	357	Eligibility End
	DPT03	Date Time Period		When applicable date of death
2300	HD01	Maintenance Type Code	024	Cancellation or Termination

Loop	Segment	Name	Codes	Comments
	HD04	Plan Coverage Description		Data string with county, aid category, plan id, plan description
	DTP01	Date/Time Qualifier	349	349-Benefit End Date
2320	COB	Coordination of Benefits		Third Party Liability information and applicable coverage dates
2330	COB	Coordination of Benefits Related Entity		Third Party Liability related address information

### 3) Updates to RCO Member Information

Loop	Segment	Name	Codes	Comments
2000A	INS03	Maintenance Type Code	001	Change
	INS04	Maintenance Reason Code	AI	No reason given
	INS12	Date Time Period		When applicable date of death
2100A		Member Name		This loop will report all of the correct information on a member: <ul style="list-style-type: none"> <li>Name</li> <li>ID</li> <li>Residential Address</li> <li>Date of Birth</li> <li>Sex</li> <li>Marital Status</li> <li>Race</li> </ul>
2100B		Incorrect Member Name		This loop will report all of the incorrect information on a member: <ul style="list-style-type: none"> <li>Name</li> <li>ID</li> <li>Residential Address</li> <li>Date of Birth</li> <li>Sex</li> <li>Marital Status</li> <li>Race</li> </ul>
2100C	N3/N4	Member Mailing Address		This loop will report the correct mailing address for a member.
2300	HD01	Maintenance Type Code	001	Change
	HD04	Plan Coverage Description		Data string with county, aid category, plan id, plan description
	DTP01	Date/Time Qualifier	348 349	This segment will can report up to 6 dates per Health Coverage description. If additional dates are required the Health Coverage loop will be repeated as needed.  348-Benefit Begin Date 349-Benefit End Date
2320	COB	Coordination of Benefits		Third Party Liability information and applicable coverage dates
2330	COB	Coordination of Benefits Related Entity		Third Party Liability related address information

### 4) RCO Terminations (This occurs in situations in which an member has been identified as having two Medicaid IDs)

Loop	Segment	Name	Codes	Comments
2000A	INS03	Maintenance Type Code	024	Cancellation or Termination
	INS04	Maintenance Reason Code	AI	No reason given
	DTP01	Date/Time Qualifier	357	Eligibility End
	DPT03	Date Time Period		When applicable date of death
2300				No Health Coverabe information will be sent for terminations.

**5) RCO Monthly Full List**

This will be a full listing of the members assigned to the RCO and many of the members reported will have no changes that should be applied but are provided as a confirmation that they are still assigned to the RCO.

RCO DRAFT

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

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

**005010X224A2 HEALTH CARE CLAIM - DENTAL (837 D)**

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

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

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

### 10.6.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

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

### 10.6.2 NATIONAL PROVIDER ID (NPI) VERIFICATION

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

For more information please refer to the NPPES website:

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

10.6.1 RCO INFORMATION  
This transaction is not impacted by RCO.

RCO DRAFT

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

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

**005010X222A1 HEALTH CARE CLAIM – PROFESSIONAL (837 P)**

Loop	Segment	Name	Codes	Comments
	BHT	Beginning Hierarchical Transaction		
	BHT06	Transaction Type Code	CH, RP	RCO submitted Encounter claims: Submit 'RP' Reporting to indicate the file submitted contains encounter claims. For all other claim submissions 'CH' should be submitted.
1000A	PER	Submitter EDI Contact Information		The contact information in this segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter's organization.
	PER01	Contact Function Code	IC	'IC' – Information Contact
	PER02	Name		
	PER03	Communication Number Qualifier	EM FX TE	'EM' – Electronic Mail 'FX' – Facsimile 'TE' – Telephone
	PER04	Communication Number		Email Address, Fax Number or Telephone Number (including the area code)
2000A	PRV	Billing Provider Specialty Information		
	PRV01	Provider Code	BI	'BI' – Billing
	PRV02	Reference Identification	PXC	'PXC' – Health Care Provider Taxonomy Code
	PRV03	Provider Taxonomy Code		When the rendering provider is the same as the billing provider, the billing provider's taxonomy code should be used.
2010AA		Billing Provider Name		RCO submitted Encounter claims: Group Provider or Individual Provider that rendered the service.
2010AA	N3	Billing Provider Address		The Billing Provider Address must be a street address.
2010AA	N4	Billing Provider City, State, Zip Code		
	N403	Postal Code		When reporting the ZIP code for U.S. addresses submit the Zip + 4.
2010BA	NM1	Subscriber Name		This is the identifier from the subscriber's identification card (ID card).
	NM101	Entity Identifier Code	IL	'IL' - Subscriber
	NM102	Entity Type Qualifier	1	'1' – Person Alabama Medicaid subscribers are individuals. '1' is the only acceptable value.
	NM108	Identification Code Qualifier	MI	'MI' - Member Identification Number
	NM109	Subscriber Primary Identifier		Alabama Medicaid Recipient ID.
2010BA	REF	Subscriber Secondary Identification		
	REF01	Reference Identification Qualifier	SY	If used, the Reference Identification Qualifier will be equal to 'SY' Social Security Number.
	REF02	Subscriber Supplemental Identifier		If used, the SSN should be entered.
2010BB	REF	Billing Provider Secondary Identification		'1D' - Medicaid Provider Number is being replaced by 'G2' - Provider Commercial Number.

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

Loop	Segment	Name	Codes	Comments
	REF02	Rendering Provider Secondary Identifier		If used, should equal the Rendering Provider's Medicaid ID.
2310C	NM1	Service Facility Location Name		To identify where the service was rendered.
	NM101	Service Facility Location	77	'77' - Service Location
	NM102	Entity Type Qualifier	2	'2' - Non-Person Entity
	NM103	Name Last or Organization Name		This should indicate the location name where the services were performed.
2310C	REF	Service Facility Location Secondary Identification		If NM109 within this loop is not submitted, REF01 should equal 'G2' and REF02 should equal the Service Facility Medicaid ID.
2310C	N4	Service Facility Location City, State, Zip Code		To identify where the service was rendered.
	N403	Postal Code		When reporting the ZIP code for U.S. addresses submit the Zip + 4.
2320	SBR	Other Subscriber Information		<b>RCO submitted Encounter claims: The RCO reporting the encounter services should be reported as Other Payer on each claim.</b>
	SBR03	Reference Identification		Group Number for other insurance.
	SBR09	Claim Filing Indicator Code		<b>RCO submitted Encounter claims: 14 – Exclusive Provider Organization (EPO)</b>
2320	CAS	Claim Level Adjustments		
	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	Adjustment Reason Code		CODE SOURCE 139: Claim Adjustment Reason Code PR*1, Deductible PR*2, Co-Insurance PR*3, Co-payment PR*66, Blood Deductible PR*122, Psychiatric Reduction CO*B4, Late Filing  <b>RCO submitted Encounter claims: Submit the appropriate adjustment reason code if applicable to convey adjustments between billed and paid amounts. For denied claims a Claim Adjustment Reason code of 'A1' (claim/service denied) must be submitted.</b>
	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	Monetary Amount		Adjustment Amount
2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		
	AMT01	Amount Qualifier Code	D	'D' – Payer Amount Paid
	AMT02	Payer Paid Amount		Other Payer Amount Paid (TPL)  <b>RCO submitted Encounter claims: This is the amount paid by the RCO.</b>
2330A	NM1	Other Subscriber Name		
	NM108	Identification Code Qualifier	MI	'MI' – Member Identification Number
	NM109	Identification Code		Policy Number for other insurance.
2330A	REF	Other Subscriber Secondary Identification		
	REF01	Reference Identification Qualifier	SY	'SY' – Social Security Number

Loop	Segment	Name	Codes	Comments
	REF02	Other Subscriber Name		If the Other Subscriber SSN is known, it should be reported.
	NM1	Other Payer Name		
	NM103	Name Last or Organization Name		<b>RCO submitted Encounter claims: RCO enrolled Provider Name</b>
	NM109	Other Payer Primary Identifier		When sending Line Adjudication Information for this payer, the identifier sent in SVD01 (Payer Identifier) of Loop ID-2430 (Line Adjudication Information) must match this value.  <b>RCO submitted Encounter claims: RCO enrolled Provider NPI Number</b>
2330B	DTP	Claim Check or Remittance Date		
	DTP01	Date/Time Qualifier	573	'573' – Other Payer Date Claim Paid
	DTP02	Date Time Period Format Qualifier	D8	Date Expressed in Format CCYYMMDD
	DTP03	Date Time Period		Adjudication or Payment Date  <b>RCO submitted Encounter claims: RCO payment/adjudication date</b>
	REF	Other Payer Claim Control Number		
	REF02	Reference Identification		<b>RCO submitted Encounter claims: Internal control number or transaction control number unique to the encounter claim submitted. For claims that require an adjustment to the originally submitted encounter claim this should be the Alabama Medicaid internal control number assigned to the original claim.</b>
2400	SV1	Professional Service		
	SV101-1		HC	'HC' – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
	SV101-2	Procedure Code		The procedure code for this service line.
	SV102	Monetary Amount		Note: If the amount is for a Drug Unit Price (formerly entered in the 2410 CTP03 element), it now is submitted in this data element.
	SV111	Yes/No Condition or Response Code	Y	SV111 is early and periodic screen for diagnosis and treatment of children (EPSDT) involvement; a "Y" value indicates EPSDT involvement; an "N" value indicates no EPSDT involvement.  Note: The code value '01' which was used for 4010 for EPSDT claims, has been eliminated from Segment CLM12 for 5010, and is now billed in the SV111.
2400	QTY	Ambulance Patient Count		The new quantity segment will not be used for Alabama claims processing.
2400	QTY	Obstetric Anesthesia Additional Units		The new quantity segment will not be used for Alabama claims processing.
2410	LIN	Drug Identification		
	LIN02	Drug Identification	N4	'N4' – National Drug Code in 5-4-2 Format
	LIN03	Product/Service ID		National Drug Code
2410	CTP	Drug Quantity		

Loop	Segment	Name	Codes	Comments
	CTP04	Quantity		National Drug Unit Count
	CTP05-1	Unit or Basis for Measurement Code	F2 GR ME ML UN	'F2' - International Unit 'GR' - Gram 'ME' - Milligram 'ML' - Milliliter 'UN' - Unit
2410	REF	Prescription or Compound Drug Association Number		
	REF01	Prescription or Compound Drug Association Number	XZ	'XZ' - Pharmacy Prescription Number
2420A	REF	Rendering Provider Secondary Identification		'1D' - Medicaid Provider Number is being replaced by 'G2' - Provider Commercial Number.
	REF01	Reference Identification Qualifier	G2	If used, should equal 'G2' Provider Commercial Number.
	REF02	Rendering Provider Secondary Identifier		If used, should equal the Rendering Provider's Medicaid ID.
2420C	N4	Service Facility Location City, State, Zip Code		
	N403	Postal Code		When reporting the ZIP code for U.S. addresses submit the Zip + 4.
2430	SVD	Line Adjudication Information		
	SVD01	Other Payer Primary Identifier		This number should match one occurrence of the 2330B-NM109 identifying Other Payer.
	SVD02	Service Line Paid Amount		Enter the Third Party Payment Amount (TPL) at the line item level only. This will also be used for crossover detail paid amount.  <b>RCO submitted Encounter claims: This is the amount paid by the RCO.</b>
2430	CAS	Line Adjustment		
	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	Adjustment Reason Code		CODE SOURCE 139: Claim Adjustment Reason Code PR*1, Deductible PR*2, Co-Insurance PR*3, Co-payment PR*66, Blood Deductible PR*122, Psychiatric Reduction CO*B4, Late Filing  <b>RCO submitted Encounter claims: Submit the appropriate adjustment reason code if applicable to convey adjustments between billed and paid amounts. For a denied claim detail a Claim Adjustment Reason code of 'A1' (claim/service denied) must be submitted.</b>
	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	Monetary Amount		Adjustment Amount

### 10.7.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

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

### 10.7.2 NATIONAL PROVIDER ID (NPI) VERIFICATION

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

For more information please refer to the NPPES website:

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

### 10.7.3 MEDICARE ALLOWED AMOUNT

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

- Header

Step 1:

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

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

Step 1:

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

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

RCOs at a minimum must comply with the Alabama Medicaid Agency's current Fee-for-Service claims billing rules. Encounter claims submitted will still have the same Fee-for-Service edits, limitations, pricing, etc. rules applied during adjudication.

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

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

**005010X222A1 HEALTH CARE CLAIM – INSTITUTIONAL (837 I)**

Loop	Segment	Name	Codes	Comments
	BHT	Beginning Hierarchical Transaction		
	BHT06	Transaction Type Code	CH, RP	RCO submitted Encounter claims: Submit 'RP' Reporting to indicate the file submitted contains encounter claims. For all other claim submissions 'CH' should be submitted.
1000A	PER	Submitter EDI Contact Information		The contact information in this segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
	PER01	Contact Function Code	IC	'IC' – Information Contact
	PER02	Name		
	PER03	Communication Number Qualifier	EM FX TE	'EM' – Electronic Mail 'FX' – Facsimile 'TE' – Telephone
	PER04	Communication Number		Email Address, Fax Number or Telephone Number (including the area code)
2000A	PRV	Billing Provider Specialty Information		
	PRV01	Provider Code	BI	'BI' – Billing
	PRV02	Reference Identification	PXC	'PXC' – Health Care Provider Taxonomy Code
	PRV03	Provider Taxonomy Code		When the rendering provider is the same as the billing provider, the billing provider's taxonomy code should be used.
2010AA		Billing Provider Name		RCO submitted Encounter claims: Group Provider or Individual Provider that rendered the service.
2010AA	N3	Billing Provider Address		The Billing Provider Address must be a street address.
2010AA	N4	Billing Provider City, State, Zip Code		
	N403	Postal Code		When reporting the ZIP code for U.S. addresses submit the Zip + 4.
2010BA	NM1	Subscriber Name		This is the identifier from the subscriber's identification card (ID card).
	NM101	Entity Identifier Code	IL	'IL' – Subscriber
	NM102	Entity Type Qualifier	1	'1' – Person Alabama Medicaid subscribers are individuals 1 is the only acceptable value.
	NM108	Identification Code Qualifier	MI	'MI' – Member Identification Number
	NM109	Subscriber Primary Identifier		Alabama Medicaid Recipient ID.
2010BB	REF	Billing Provider Secondary Identification		'1D' – Medicaid Provider Number is being replaced by 'G2' – Provider Commercial Number.
	REF01	Reference Identification Qualifier	G2	If used, should equal 'G2' Commercial Provider Number.
	REF02	Reference Identification		For crossover claims, REF02 will contain the Billing Provider's Medicare number. Otherwise, REF02 will contain the Billing Provider's Medicaid ID number.
2000C		Patient Hierarchical Level		Dependent Level information will not be

Loop	Segment	Name	Codes	Comments
				supported by Alabama Medicaid when processing Institutional Health Care Claims.
2300	CL1	Institutional Claim Code		
	CL103	Patient Status Code		Must submit the Patient Status Code when submitting an inpatient claims/encounters transaction. (Reference code source: 239).
2300	REF	Service Authorization Exception Code		To indicate an emergency related claim.
	REF01	Reference Identification Qualifier	4N	Special Payment Reference Number
	REF02	Service Authorization Exception Code	3	'3' – Emergency Care
2300	REF	Payer Claim Control Number (ICN/ DCN)		Use this segment if an adjustment needs to be made to a previously paid claim.
	REF01	Reference Identification Qualifier	F8	Original Reference Number
	REF02	Payer Claim Control Number		This will equal the original Internal Control Number (ICN) that was assigned to the paid claim. <b>RCO submitted Encounter claims: Submit the original Internal Control Number (ICN) that was assigned to the claim submitted or the Transaction Control Number (TCN) originally assigned to the original claim by the RCO.</b>
2300	HI	Principal Diagnosis		Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.
2300	HI	Admitting Diagnosis		Note: Admitting Diagnosis codes can only be billed on inpatient claims. Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.
2300	HI	Patient Reason for Visit		Note: Patient Reason for Visit codes can only be billed on outpatient claims. Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.
2300	HI	External Cause of Injury		Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.
2300	HI	Other Diagnosis Information		Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.
2300	HI	Principal Procedure Information		Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is

Loop	Segment	Name	Codes	Comments
				implemented.
2300	HI	Other Procedure Information		Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.
2300	HI	Condition Information		A new CRC EPSDT Referral segment has been added for 5010. Providers should continue to bill the EPSDT indicator in the HI Value Information segment, Value Code element of A1 or X3.
2310A	NM1	Attending Provider Name		The Attending Provider information must be populated on each institutional claim.
	NM108	Identification Code Qualifier	XX	'XX' – Centers for Medicare and Medicaid Services National Provider Identifier
	NM109	Attending Provider Primary Identifier		NPI
2310A	PRV	Attending Provider Specialty Information		
	PRV01	Provider Code	AT	'AT' – Attending
	PRV02	Reference Identification	PXC	'PXC' – Health Care Provider Taxonomy Code
	PRV03	Provider Taxonomy Code		The Attending Providers taxonomy code should be used.
2310A	REF	Attending Provider Secondary Identification		
	REF01	Reference Identification Qualifier	0B	'0B' – State License Number
	REF02	Attending Provider Secondary Identifier		Alabama License Number
2310B	NM1	Operating Physician Name		
	NM108	Identification Code Qualifier	XX	'XX' – Centers for Medicare and Medicaid Services National Provider Identifier
	NM109	Operating Provider Primary Identifier		NPI
2310B	REF	Operating Physician Secondary Identification		
	REF01	Reference Identification Qualifier	0B	'0B' – State License Number
	REF02	Operating Physician Secondary Identifier		Alabama License Number
2310D		Rendering Provider Name		<b>RCO submitted Encounter claims: Individual Provider that rendered the service, if Billing Provider is a group, report the Individual Provider within the Group that actually rendered the service.</b>
2310E	NM1	Service Facility Location Name		
	NM101	Entity Identifier Code	77	'77' – Service Location
	NM102	Entity Type Qualifier	2	'2' – Non-person Entity
	NM103	Laboratory or Facility Name		The location where the services were performed.
2310E	N3	Service Facility Location Address		
	N301	Address Information		The address where the services were performed.
2310E	N4	Service Facility Location City, State, Zip Code		The City, State and Zip Code where the services were performed.
	N403	Postal Code		When reporting the ZIP code for U.S. addresses

Loop	Segment	Name	Codes	Comments
				submit the Zip + 4.
2310F	NM1	Referring Provider Name		
	NM108	Identification Code Qualifier	XX	If a Referring Provider needs to be populated on the claim, then this loop is populated with the appropriate Referring Provider information. 'XX' – Centers for Medicare and Medicaid Services National Provider Identifier.
	NM109	Attending Provider Primary Identifier		NPI
2320	SBR	Other Subscriber Information		RCO submitted Encounter claims: The RCO reporting the encounter services should be reported as Other Payer on each claim.
	SBR03	Reference Identification		Group Number for other insurance.
	SBR09	Claim Filing Indicator Code		RCO submitted Encounter claims: 14 – Exclusive Provider Organization (EPO)
2320	CAS	Case Level Adjustments		
	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	Adjustment Reason Code		CODE SOURCE 139: Claim Adjustment Reason Code PR*1, Deductible PR*2, Co-Insurance PR*3, Co-payment PR*66, Blood Deductible PR*122, Psychiatric Reduction CO*B4, Late Filing  RCO submitted Encounter claims: Submit the appropriate adjustment reason code if applicable to convey adjustments between billed and paid amounts. For denied claims a Claim Adjustment Reason code of 'A1' (claim/service denied) must be submitted.
	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	Adjustment Amount		
2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		
	AMT01	Amount Qualifier Code	D	'D' – Payer Amount Paid
	AMT02	Payer Paid Amount		Other Payer Amount Paid (TPL)  RCO submitted Encounter claims: This is the amount paid by the RCO.
2320	AMT	Remaining Patient Liability		
	AMT01	Amount Qualifier Code	EAF	'EAF' – Amount Owed
	AMT02	Remaining Patient Liability Amount		Other Payer Amount Paid (TPL)
2330A	NM1	Other Subscriber Name		
	NM108	Identification Code Qualifier	MI	'MI' – Member Identification Number
	NM109	Identification Code		Policy Number for other insurance.
2330A	REF	Other Subscriber Secondary Identification		
	REF01	Reference Identification Qualifier	SY	'SY' – Social Security Number
	REF02	Other Subscriber Name		If the Other Subscriber SSN is known, it should be reported.
2330B	NM1	Other Payer Name		

Loop	Segment	Name	Codes	Comments
	NM103	Name Last or Organization Name		RCO submitted Encounter claims: RCO enrolled Provider Name
	NM109	Other Payer Primary Identifier		When sending Line Adjudication Information for this payer, the identifier sent in SVD01 (Payer Identifier) of Loop ID-2430 (Line Adjudication Information) must match this value.  RCO submitted Encounter claims: RCO enrolled Provider NPI Number
2330B	DTP	Claim Check or Remittance Date		
	DTP01	Date/Time Qualifier	573	'573' – Other Payer Date Claim Paid
	DTP02	Date Time Period Format Qualifier	D8	Date Expressed in Format CCYYMMDD
	DTP03	Date Time Period		Adjudication or Payment Date  RCO submitted Encounter claims: RCO payment/adjudication date
	REF	Other Payer Claim Control Number		
	REF02	Reference Identification		RCO submitted Encounter claims: Internal control number or transaction control number unique to the encounter claim submitted. For claims that require an adjustment to the originally submitted encounter claim this should be the Alabama Medicaid internal control number assigned to the original claim.
2400	SV2	Institutional Service Line		
				Acceptable values for the units of service field are whole numbers that are greater than zero.
2410	LIN	Drug Identification		
	LIN02	Drug Identification	N4	'N4' – National Drug Code
	LIN03	Product/Service ID		National Drug Code in 5-4-2 format
2410	CTP	Drug Quantity		
	CTP04	Quantity		National Drug Unit Count
	CTP05-1	Unit or Basis for Measurement Code	F2 GR ME ML UN	F2 International Unit GR Gram ME Milligram ML Milliliter UN Unit
2410	REF	Prescription or Compound Drug Association Number		
	REF	Prescription or Compound Drug Association Number	XZ	Pharmacy Prescription Number
2430	SVD	Line Adjudication Information		
	SVD01	Other Payer Primary Identifier		This number should match one occurrence of the 2330B-NM109 identifying Other Payer.
	SVD02	Service Line Paid Amount		Enter the Third Party Payment Amount (TPL) at the line item level only. This will also be used for crossover detail paid amount.  RCO submitted Encounter claims: This is the amount paid by the RCO.
2430	CAS	Line Adjustment		

Loop	Segment	Name	Codes	Comments
	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	Adjustment Reason Code		CODE SOURCE 139: Claim Adjustment Reason Code PR*1, Deductible PR*2, Co-Insurance PR*3, Co-payment PR*66, Blood Deductible PR*122, Psychiatric Reduction CO*B4, Late Filing  <b>RCO submitted Encounter claims:            Submit the appropriate adjustment reason code            if applicable to convey adjustments between            billed and paid amounts. For a denied claim            detail a Claim Adjustment Reason code of 'A1'            (claim/service denied) must be submitted.</b>
	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	Adjustment Amount		

### 10.8.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

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

### 10.8.2 NATIONAL PROVIDER ID (NPI) VERIFICATION

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

For more information please refer to the NPPES website:

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

### 10.8.3 MEDICARE ALLOWED AMOUNT

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

- Inpatient

Step 1:

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

Step 2:

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

- Outpatient

Step 1:

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

**Month** 2015

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

### 10.8.1 RCO INFORMATION

RCOs at a minimum must comply with the Alabama Medicaid Agency's current Fee-for-Service claims billing rules. Encounter claims submitted will still have the same Fee-for-Service edits, limitations, pricing, etc. rules applied during adjudication.

RCO DRAFT

10.9 005010X214 Health Care Claim Acknowledgement (277CA)

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

**005010X214 Health Care Claim Acknowledgement (277CA)**

Loop	Segment	Name	Codes	Comments
		TBD		

10.9.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

The information when applicable under this section is intended to help the trading partner understand the business context of the EDI transaction. This transaction is only currently available to RCO trading partners.

RCO DRAFT

10.10 005010X221A1 Health Care Claim Payment/Advice (835)

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

**005010X221A1 HEALTH CARE CLAIM PAYMENT/ADVICE (835)**

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

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

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

### 10.10.1 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

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

#### 10.10.1 RCO INFORMATION

835 will report capitation payments, kick payments, and financial recoupment transactions.

# 11 APPENDICES

## 11.1 BUSINESS SCENARIOS

### 11.1.1 SAFE HARBOR BATCH SUBMIT

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

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

### 11.1.2 SAFE HARBOR BATCH RETRIEVAL

The BatchSubmitAckRetrievalTransaction and BatchResultsRetrievalTransaction operations can be used to retrieve a specific acknowledgement or response file by using the Payload ID of the originally submitted batch file. The original transaction's Payload ID should appear as the Payload ID on the request transaction. Alabama Medicaid will respond with the specified file in the Payload if an acknowledgement or batch response file can be found with that Payload ID. Otherwise, the response from Alabama Medicaid will have the Payload Type X12\_005010\_Response\_NoBatchAckFile or X12\_005010\_Response\_NoBatchResultsFile.

### 11.1.3 SAFE HARBOR GENERIC BATCH RETRIEVAL

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

### 11.1.4 SAFE HARBOR BATCH ACKNOWLEDGEMENT SUBMISSION

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

### 11.1.5 SAFE HARBOR REAL TIME SUBMISSION

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

## 11.2 TRANSMISSION EXAMPLES

### 11.2.1 SAFE HARBOR BATCH SUBMIT

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

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

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

*Safe Harbor Sample Envelope for Batch Submission using SOAP+WSDL*

```
<COREEnvelopeBatchSubmission xmlns="http://www.caqh.org/SOAP/WSDL/ CORERule2.2.0.xsd">
```

```
<PayloadType>X12_270_Request_005010X279A1</PayloadType>
```

```
<ProcessingMode>Batch</ProcessingMode>
```

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

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

Safe Harbor Sample Envelope for Batch Submission using HTTP MIME Multipart

```

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

11.2.2 SAFE HARBOR BATCH RETRIEVAL

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

<COREEnvelopeBatchResultsRetrievalRequest xmlns="http://www.caqh.org/SOAP/  
 WSDL/CORERule2.2.0.xsd">  
 <PayloadType>X12\_005010\_Request\_Batch\_Results\_271</PayloadType>  
 <ProcessingMode>Batch</ProcessingMode>

<PayloadID>6957a55b-8ad6-4503-89f6-ce8db70c9a9f</PayloadID>  
<TimeStamp>2014-02-28T12:32:31Z</TimeStamp>  
<SenderID>64634</SenderID>  
<ReceiverID>77027</ReceiverID>  
<CORERuleVersion>2.2.0</CORERuleVersion>  
</COREEnvelopeBatchResultsRetrievalRequest>

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

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

-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve  
Content-Disposition: form-data; name="SenderID"  
64634  
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve  
Content-Disposition: form-data; name="Password"  
SamplePassword123  
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve  
Content-Disposition: form-data; name="ProcessingMode"  
Batch  
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve  
Content-Disposition: form-data; name="ReceiverID"  
77027  
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve  
Content-Disposition: form-data; name="CORERuleVersion"  
2.2.0  
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve  
Content-Disposition: form-data; name="TimeStamp"  
2013-05-25T19:13:58Z  
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve  
Content-Disposition: form-data; name="PayloadID"  
03171c34-bab8-4a17-8e1b-03ccd74a3090  
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve  
Content-Disposition: form-data; name="UserName"  
SampleUserName123  
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve  
Content-Disposition: form-data; name="PayloadType"  
X12\_005010\_Request\_Batch\_Results\_271  
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve--

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

### 11.2.3 SAFE HARBOR GENERIC BATCH RETRIEVAL

Safe Harbor Generic Batch Retrieval using SOAP+WSDL

The GenericBatchRetrievalTransaction operation will retrieve a list of Payload IDs for all available batch files for the specified Payload Type and Sender ID. Trading Partners can use this operation to identify the

Payload ID for a desired file, and then use the BatchSubmitAckRetrievalTransaction or BatchResultsRetrievalTransaction operations to retrieve the specified file using that Payload ID.

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

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

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

Safe Harbor Generic Batch Retrieval using HTTP MIME Multipart

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

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

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

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

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

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

## 11.2.4 REAL TIME SUBMISSION

### Sample Envelope for Real Time Request using SOAP+WSDL

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

### Sample Envelope for Real Time Request using HTTP MIME Multipart

```
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="SenderID"
64634
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="Password"
SamplePassword123
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="ProcessingMode"
RealTime
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="ReceiverID"
77027
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="CORERuleVersion"
2.2.0
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="TimeStamp"
2014-02-23T14:28:29Z
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="PayloadID"
e85886b0-5c8e-4701-9ecf-642c3862b013
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="UserName" SampleUserName123
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="PayloadType"
X12_270_Request_005010X279A1
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve
Content-Disposition: form-data; name="Payload"
<![CDATA[ISA*00**00*ZZ...]]>
-----1c1sqqxvv2z4w1khvyofix6nzq-1xbrjh7adw5ve--
```

## 11.3 FREQUENTLY ASKED QUESTIONS

[http://medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.4\\_FAQ.aspx](http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.4_FAQ.aspx)

## 11.4 CHANGE SUMMARY

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

DATE	DOCUMENT VERSION	AUTHOR	Section/Page	DESCRIPTION OF CHANGE
07/19/2011	0.1	Sarah Viswambaran		Creation of Initial Document.
08/16/2011	0.2	Sarah Viswambaran	Added sections 2.4 and 3.4. Updated sections 6, 8.1.1.3, 8.2.1.3, 8.5.1.	Revised to respond to Agency comments from walkthrough held on 07/29/2011.
08/23/2011	1.0	Sarah Viswambaran		Agency approved
10/31/2011	1.1	Sarah Viswambaran	Updated Section 8.7  Updated Section 8.3	8.7: Added in a comment for REF Service Facility Secondary Identification.  8.3: Updated Loop 2010EA to 2010EC.
11/01/2011	1.2	Sarah Viswambaran	Updated Section 8.3.1	Added the following information: Pharmacy Prior Authorizations are created outside of the 278 process and therefore a service type code of '88' is not expected and will be denied.  Alabama Medicaid expects only a Procedure Code to be submitted within an SV1 segment and only a Revenue Code within an SV2 segment.
11/03/2011	1.2	Sarah Viswambaran	Updated Sections 8.6, 8.7, 8.8	Added N3 information for the Billing Provider that only a street address can be submitted in loop 2010AA.
05/30/2012	1.3	Sarah Viswambaran	Added Sections 8.1.1.1, 8.2.1.1, 8.3.1.1, 8.6.1.1, 8.7.1.1, 8.8.1.1	Added National Provider ID (NPI) verification information and website for National Plan & Provider Enrollment (NPPES).
02/27/2013	1.4	Sarah Viswambaran	Updated Section 8.8	Added the Operating Provider NPI information as both NPI and License are required.
10/16/2013	1.5	Sarah Viswambaran	Updated Page 1 Title Page Updated Page 3 Preface Updated Section 8.1 Added Sections 8.1.1.3, 8.1.1.4, 8.1.1.5 Added Section 9	Changes made to accommodate CORE requirements. <a href="http://caqh.org/benefits.php">http://caqh.org/benefits.php</a>  Section 8.1 added additional information to both the 270 and 271 tables.  Section 8.1.1.3 added new section concerning the use of Service Type Codes. Section 8.1.1.4 added new section concerning the process of last name normalization. Section 8.1.1.5 added new additional messages potentially returned on the 271 response.  Section 9 added new section for Additional Information.
11/04/2013	1.5.1	Sarah Viswambaran	Updated Section 8.3	Section 8.3 added additional information concerning submitting ICD version qualifiers for 2000E-HI-Patient Diagnosis (Health Care Information Codes).
02/04/2014	1.5.2	Sarah Viswambaran	Updated Sections 8.7.1.2 8.8.1.2	Both sections updated with information concerning two percent sequestration reduction for crossover claims.
05/07/2014	1.5.3	Sarah Viswambaran	Updated Sections 8.1.1.7 8.9	8.1.1.7 Updated the maximum allowed values and information. 8.9 CLP04 added for compound drug claims.
09/03/2014	2.0	Sarah Viswambaran	ACA Updates	Baseline ACA Safe Harbor version. The following sections have been updated:

DATE	DOCUMENT VERSION	AUTHOR	Section/Page	DESCRIPTION OF CHANGE
				1.2, 1.3, 2.3.2, 3, 4.2 The following sections have been added: 4.5, 4.6, 4.7, 6.4, 6.5, 7, 8.2, 11.1, 11.2
03/23/2015	3.0	Sarah Viswambaran	Maternity Care Encounter Processing Updates	Maternity Care District Providers submitting encounter claim updates made to section 10.7 for 837 Professional.
	4.0	Sarah Viswambaran	Regional Care Organization Updates	

RCCO DRAFT

**Amendment I to RFP 2015-EB-01**

**11/19/2015**

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

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

I. Section B, Schedule of Events, page 3, change as follows:

Currently Reads as:

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

<b>EVENT</b>	<b>DATE</b>
RFP Issued	10/26/15
Deadline for Questions to be submitted	11/9/15
Deadline for questions to be posted to website	11/19/15
Proposals Due by 5 pm CT	12/2/15
Evaluation Period	12/7/15 – 12/14/15
Contract Award Notification	TBD
**Contract Review Committee	TBD
Official Contract Award/Begin Work	TBD

\* \* By State law, this contract must be reviewed by the Legislative Contract Review Oversight Committee. The Committee meets monthly and can, at its discretion, hold a contract for up to forty-five (45) days. The “Vendor Begins Work” date above may be impacted by the timing of the contract submission to the Committee for review and/or by action of the Committee itself.

Revised as:

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

<b>EVENT</b>	<b>DATE</b>
RFP Issued	10/26/15
Deadline for Questions to be submitted	11/9/15
Deadline for Questions to be posted to website	11/19/15
Deadline for Second Round Questions to be submitted by noon CT	11/23/15

Deadline for Second Round Questions to be posted to website	11/30/15
Proposals Due by 5 pm CT	12/3/15
Evaluation Period	12/7/15 – 12/14/15
Contract Award Notification	TBD
**Contract Review Committee	TBD
Official Contract Award/Begin Work	TBD

\* \* By State law, this contract must be reviewed by the Legislative Contract Review Oversight Committee. The Committee meets monthly and can, at its discretion, hold a contract for up to forty-five (45) days. The “Vendor Begins Work” date above may be impacted by the timing of the contract submission to the Committee for review and/or by action of the Committee itself.

II. Section II, Scope of Work, page 12, change as follows:

Currently Reads as:

**B. Organizational and Staffing Plan**

As part of the Proposal, the Vendor must:

3. Provide a staffing matrix identifying all staff assigned to this contract along with their respective titles, telephone numbers, email addresses and location. Any subsequent changes to the organizational plan shall be approved by Medicaid.

Revised as:

**B. Organizational and Staffing Plan**

As part of the Proposal, the Vendor must:

3. Provide a staffing matrix identifying all key personnel assigned to this contract along with their respective titles, telephone numbers, email addresses and location. At a minimum, key personnel includes the positions described in Subsection C. Organizational and Staffing Requirements. Any subsequent changes to the organizational plan shall be approved by Medicaid.

III. Section II, Scope of Work, page 17, change as follows:

Currently Reads as:

## **F. New Enrollment**

5. The Vendor must be able to meet the following requirements:
  - d. Enrollees may switch to a different RCO within the Region without cause in the first ninety (90) Calendar Days following enrollment with the RCO. The number of changes allowed will be limited to the number of RCOs within the enrollee's region. The Vendor will provide assistance to enrollees who contact the Vendor requesting to change RCOs during this time period. Following the ninety (90) Calendar Day period, enrollees will be subject to a lock-in period of twelve (12) consecutive months, in which enrollees will only be able to disenroll from the RCO for cause. The Vendor will be responsible for tracking the ninety (90) day timeframe before locking the enrollee into the RCO.

### Revised as:

5. The Vendor must be able to meet the following requirements:
  - d. Enrollees may switch to a different RCO within the Region without cause in the first ninety (90) Calendar Days following enrollment with the RCO. The number of changes allowed will be limited to the number of RCOs within the enrollee's region. The Vendor will provide assistance to enrollees who contact the Vendor requesting to change RCOs during this time period. Following the ninety (90) Calendar Day period, enrollees will be subject to a lock-in period of twelve (12) consecutive months, in which enrollees will only be able to disenroll from the RCO for cause. This twelve (12) month lock-in period is inclusive of the ninety (90) Calendar Day period. The Vendor will be responsible for tracking the ninety (90) day timeframe before locking the enrollee into the RCO.

## **IV. Section III, Pricing, page 41, change as follows:**

### Currently Reads as:

Vendor's response must specify a firm and fixed fee for completion of the Enrollment Broker development, implementation, and updating/operation process. The firm and fixed price the first year of the proposed contract (implementation year) and subsequent years must be separately stated in the RFP Cover Sheet on the first page of this document as well as the pricing sheet table (Appendix C). Vendors are to base their firm and fixed fee on providing enrollment to an average of 700,000 recipients.

The firm and fixed fee shall exclude pass-through expenses, which include development of materials, printing of materials, and postage requirements, including postal rate increases, postal preparation fees for bulk and mass mailings, and all cost associated with all outreach, education, and enrollment materials specified in the RFP. The Vendor will

be responsible for determining and documenting pass-through expenses. The Vendor shall make a reasonable effort to obtain the least costly alternative for all pass-through expenses involved. The Vendor shall take advantage of high volume printing and price comparison shopping, and automation based rates and services provided by the Postal Service including zip+four, presorting, bar coding and bulk mailing. All pass-through expenses must be documented in the pricing sheet table (Appendix C).

A monthly invoice will be submitted to Medicaid for compensation for the work performed. Compensation for all approved pass-through expenses shall be paid based on documented costs.

Revised as:

Vendor's response must specify a firm and fixed fee for completion of the Enrollment Broker development, implementation, and updating/operation process. The firm and fixed price the first year of the proposed contract (implementation year) and subsequent years must be separately stated in the RFP Cover Sheet on the first page of this document as well as the pricing sheet table (Appendix C). Vendors are to base their firm and fixed fee on providing enrollment to an average of 700,000 recipients.

The firm and fixed fee shall exclude pass-through expenses, which include development of materials, printing of materials, and postage requirements, including postal rate increases, postal preparation fees for bulk and mass mailings, and all cost associated with the printing of all outreach, education, and enrollment materials specified in the RFP. Pass-through expenses must not include any Vendor overhead costs. The Vendor will be responsible for determining and documenting pass-through expenses. The Vendor shall make a reasonable effort to obtain the least costly alternative for all pass-through expenses involved. The Vendor shall take advantage of high volume printing and price comparison shopping, and automation based rates and services provided by the Postal Service including zip+four, presorting, bar coding and bulk mailing.

A monthly invoice will be submitted to Medicaid for compensation for the work performed. Compensation for all approved pass-through expenses shall be paid based on documented costs.

V. Section VII, Evaluation and Selection Process, page 46, change as follows:

E. Scoring

Currently Reads as:

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>
Vendor Profile and Experience	15
Scope of Work	40
Price	45
<b>Total</b>	<b>100</b>

Revised as:

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 and References	15
Scope of Work	40
Price	45
<b>Total</b>	<b>100</b>

I hereby acknowledge the receipt of Addendum I to RFP 2015-EB-01.

\_\_\_\_\_  
Authorized Vendor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Vendor Organization

**RFP # 2015-EB-01****Medicaid Regional Care Organization Program Enrollment Broker Services RFP****Vendor Questions and Medicaid Answers****11/19/15****Note:** Questions and/or Section References are posted as submitted.

<b>Question ID:</b>	1
<b>Date Question Asked:</b>	10/26/2015
<b>Question:</b>	I received notification earlier today that the “Medicaid Regional Care Organization Program Enrollment Broker Services RFP” had been released but I can’t find a copy of the specifications at the page references in the notice. Can you advise?
<b>Section Number:</b>	General
<b>RFP Page Number:</b>	N/A
<b>Medicaid Answer:</b>	The RFP was posted on the Medicaid Procurement website at <a href="http://www.medicaid.alabama.gov">www.medicaid.alabama.gov</a> on 10/26/2015.
<b>Question ID:</b>	2
<b>Date Question Asked:</b>	11/06/2015
<b>Question:</b>	What are the top challenges Medicaid would like to address with this procurement?
<b>Section Number:</b>	General
<b>RFP Page Number:</b>	N/A
<b>Medicaid Answer:</b>	Section II. Scope of Work identifies the areas of responsibilities the Enrollment Broker will conduct.
<b>Question ID:</b>	3
<b>Date Question Asked:</b>	11/06/2015
<b>Question:</b>	What other places outside of this procurement does the State have for marketing the transition to the RCO model?
<b>Section Number:</b>	General
<b>RFP Page Number:</b>	N/A
<b>Medicaid Answer:</b>	Section II. Scope of Work identifies the areas of responsibilities the Enrollment Broker will conduct.
<b>Question ID:</b>	4
<b>Date Question Asked:</b>	11/06/2015
<b>Question:</b>	Please confirm that the difference between the one million eligible on page 7 and the 660,000 anticipated enrollees on

	Table 1 is explained by the excluded populations identified in Section B.
<b>Section Number:</b>	IB RCO Program Eligibility
<b>RFP Page Number:</b>	Page 9
<b>Medicaid Answer:</b>	Population groups identified by Medicaid that are out of the RCO Program but can choose to opt in to the RCO Program are not included in the estimated count of 650,000 to 700,000.
<b>Question ID:</b>	5
<b>Date Question Asked:</b>	11/06/2015
<b>Question:</b>	What is the anticipated intent-to-award date?
<b>Section Number:</b>	II A Implementation
<b>RFP Page Number:</b>	12
<b>Medicaid Answer:</b>	As described in Section B. Schedule of Events, any contract must be reviewed by the Legislative Contract Review Oversight Committee. Medicaid anticipates a contract start date of 03/01/2016 as described in Section VIII. General Terms and Conditions, Subsection C. Term of Contract.
<b>Question ID:</b>	6
<b>Date Question Asked:</b>	11/06/2015
<b>Question:</b>	Are Contractors free to stagger initial enrollment activities (mail and phone outreach) on a weekly regional basis during July and August, provided all standards for mail and outreach timeliness are met?
<b>Section Number:</b>	II-A Implementation
<b>RFP Page Number:</b>	12
<b>Medicaid Answer:</b>	As identified in the chart on page 12 of Section II. Scope of Work, Subsection A. Implementation Project Plan and Readiness Reviews, the initial RCO enrollment process is to be conducted 7/2/16 through 8/31/16. Vendors are asked to describe their approach in response to Section II. Scope of Work.
<b>Question ID:</b>	7
<b>Date Question Asked:</b>	11/06/2015
<b>Question:</b>	Please confirm that the cost and pricing pages are part of the proposal and are not to be separately sealed.
<b>Section Number:</b>	III Pricing
<b>RFP Page Number:</b>	41
<b>Medicaid Answer:</b>	The cost and pricing pages are part of the proposal and not to be separately sealed.

<b>Question ID:</b>	8
<b>Date Question Asked:</b>	11/06/2015
<b>Question:</b>	Section III Pricing indicates that pass-through expenses should be included in the Pricing Table. Based on review of the pricing tables, please confirm that Section II is incorrect and that bidders are not to include pass-through expenses with their price submission.
<b>Section Number:</b>	III Pricing
<b>RFP Page Number:</b>	41
<b>Medicaid Answer:</b>	Refer to Amendment I posted on the Medicaid website on 11/19/2015. Pass-through expenses are not to be included with the pricing submission.
<b>Question ID:</b>	9
<b>Date Question Asked:</b>	11/06/2015
<b>Question:</b>	May bidders submit their electronic copies in a searchable PDF format instead of Word?
<b>Section Number:</b>	VI. O Copies Required
<b>RFP Page Number:</b>	44
<b>Medicaid Answer:</b>	No.
<b>Question ID:</b>	10
<b>Date Question Asked:</b>	11/06/2015
<b>Question:</b>	Please confirm that other than the original hard copy, there are no additional hard copies required.
<b>Section Number:</b>	VI O Copies Required
<b>RFP Page Number:</b>	44
<b>Medicaid Answer:</b>	That is correct.
<b>Question ID:</b>	11
<b>Date Question Asked:</b>	11/06/2015
<b>Question:</b>	May bidders place the "CONFIDENTIAL" label at the top of the page rather than the bottom?
<b>Section Number:</b>	IV. R Disclosure of Proprietary Contents
<b>RFP Page Number:</b>	45
<b>Medicaid Answer:</b>	No, the label must be on the bottom of the page as stated in Section VI. R. Disclosure of Proposal Contents.
<b>Question ID:</b>	12
<b>Date Question Asked:</b>	11/06/2015

<b>Question:</b>	Please assign start and end dates for each year to the pricing table.
<b>Section Number:</b>	Appendix C
<b>RFP Page Number:</b>	70
<b>Medicaid Answer:</b>	As described in Section VIII. General Terms and Conditions, Subsection C. Terms of Contract, the initial contract term shall be for two years effective March 1, 2016, through February 28, 2018.
<b>Question ID:</b>	13
<b>Date Question Asked:</b>	11/06/2015
<b>Question:</b>	What is the "Print Name of Witness"?
<b>Section Number:</b>	Appendix C
<b>RFP Page Number:</b>	70
<b>Medicaid Answer:</b>	"Print Name of Witness" goes with the previous page (Attachment G). It should not be included with the submission of the Pricing Table.
<b>Question ID:</b>	14
<b>Date Question Asked:</b>	11/9/2015
<b>Question:</b>	<p>It is important for vendors to understand what is included in their price submission and what costs they are responsible for. Item 8 states that the vendor is fully responsible for postage, printing, and all costs associated with enrollment materials. Section III for pricing indicates that the firm and fixed fee excludes pass through printing and postage costs, but the cost sheet does not accommodate providing anything but a fixed fee.</p> <p>Please explain:</p> <ul style="list-style-type: none"> <li>• If the cost sheets are supposed to include printing and postage.</li> <li>• If so, where?</li> </ul> <p>Please describe in detail whether the State or the vendor is responsible for the variance in these costs.</p>
<b>Section Number:</b>	Section III
<b>RFP Page Number:</b>	41
<b>Medicaid Answer:</b>	Refer to Amendment I posted on the Medicaid website on 11/19/2015. Printing and postage are not to be included on the cost sheet.
<b>Question ID:</b>	15
<b>Date Question Asked:</b>	11/09/2015

<b>Question:</b>	The daily 834-formatted eligibility file that is received from MMIS will need to include indicators for mandatory RCO enrollment, auto-assignment, pregnancy (SORBA), etc. Does the Department have a proposed schema for these extensions to the standard 834 format that the vendor must support?
<b>Section Number:</b>	Section II.F.5.a
<b>RFP Page Number:</b>	16
<b>Medicaid Answer:</b>	The 834 file will contain all information necessary to perform the Enrollment Broker functions. Medicaid will provide a comprehensive companion guide that will provide the necessary details.
<b>Question ID:</b>	16
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	The Provider Network database includes the maximum number of allowed enrollments in participating physicians' panels. Is the vendor system expected to manage the capacity of the panel and track enrollments to it, such that the provider is no longer available once the panel is full?
<b>Section Number:</b>	Section II.P.2
<b>RFP Page Number:</b>	25
<b>Medicaid Answer:</b>	No, the Vendor is not expected to manage the capacity of the panel.
<b>Question ID:</b>	17
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Is Vendor expected to print and distribute entire provider directories for one or more networks if requested by a potential enrollee?
<b>Section Number:</b>	Section II.P.5
<b>RFP Page Number:</b>	25
<b>Medicaid Answer:</b>	Yes, refer to Section II. Scope of Work, Subsection P. Provider Network Database and Directory.
<b>Question ID:</b>	18
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Please provide a list of the "appropriate foreign languages" that must be supported on the enrollment services website. Will the Department or the Vendor be responsible for all translation of content?
<b>Section Number:</b>	Section II.U.2
<b>RFP Page Number:</b>	33

<b>Medicaid Answer:</b>	As described in Section II. Scope of Work, Subsection U. Enrollment Services Website, the appropriate foreign languages comprise all languages in the Vendor's service area spoken by approximately five percent (5%) or more of the total covered population of the Region. The Vendor will provide all webpages and posted material in appropriate foreign languages. At this point, Alabama does not currently have a Region where a foreign language is spoken by 5% or more of the population.
<b>Question ID:</b>	19
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Please provide further details or examples of RCO Comparison Charts?
<b>Section Number:</b>	Section II.U.4.c.4
<b>RFP Page Number:</b>	33
<b>Medicaid Answer:</b>	An RCO Comparison Chart gives a comprehensive look at the options available to the enrollee through different RCOs in a region.
<b>Question ID:</b>	20
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Are there differences in the enrollment process for members who are outside of RCO but chose to opt in?
<b>Section Number:</b>	Section II.F.3
<b>RFP Page Number:</b>	16
<b>Medicaid Answer:</b>	No.
<b>Question ID:</b>	21
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Can the state clarify whether it is the Enrollment Broker's responsibility to interface with RCOs, in transmitting 834 enrollment/disenrollment requests?
<b>Section Number:</b>	Section II.W
<b>RFP Page Number:</b>	35
<b>Medicaid Answer:</b>	As described in Section II. Scope of Work, Subsection W. Enrollment File Transmission Requirements, the Vendor will receive and transmit file transactions to Medicaid or its designee. This does not include RCOs but will include the MMIS.
<b>Question ID:</b>	22
<b>Date Question Asked:</b>	11/09/2015

<b>Question:</b>	<p>We have some advanced enrollment functionality that is not included within the scope of the RFP that we would like to include in our proposal. However, we do not want our cost or technical score adversely affected by the inclusion of additional functionality (and potentially cost).</p> <p>Is Medicaid interested in advanced functionality not currently included in the scope of the RFP?</p> <p>May a vendor include advanced functionality as an option that would be priced separately?</p> <p>Would the cost of such optional functionality be excluded from the cost scoring for proposal evaluation purposes?</p>
<b>Section Number:</b>	Section III
<b>RFP Page Number:</b>	41
<b>Medicaid Answer:</b>	Medicaid is only interested in functionality included in the RFP. Such an option must not be priced separately. The firm and fixed pricing must include all services proposed.
<b>Question ID:</b>	23
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Does the RFP require the call center to be located in Alabama?
<b>Section Number:</b>	Q. Call Center Services
<b>RFP Page Number:</b>	26
<b>Medicaid Answer:</b>	No.
<b>Question ID:</b>	24
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	How many vendors are to be selected to fulfill the requirements of the RFP?
<b>Section Number:</b>	I. Background
<b>RFP Page Number:</b>	7
<b>Medicaid Answer:</b>	One Vendor will be selected to fulfill the requirements of this RFP.
<b>Question ID:</b>	25
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	The RFP mentions total initial volume of accounts and daily on-going volumes. If multiple vendors are selected, then what would be the expected split of the total volume?

<b>Section Number:</b>	I. Background
<b>RFP Page Number:</b>	7
<b>Medicaid Answer:</b>	One Vendor will be selected to fulfill the requirements of this RFP.
<b>Question ID:</b>	26
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	How will the vendor identify people who are optional for enrollment?  Will the daily file contain all Medicaid enrollees, or just those targeted for mandatory enrollment?
<b>Section Number:</b>	I.B, II.F.3
<b>RFP Page Number:</b>	9, 16
<b>Medicaid Answer:</b>	Members who may opt in will be communicated on the 834 file.  The daily file will only contain those targeted for mandatory enrollment.
<b>Question ID:</b>	27
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	The RFP states that individuals participating in the Plan First Program are excluded from participating in the RCO Program. The Plan First website states that "Most women who have children on SOBRA Medicaid are automatically enrolled in Plan First." Can you please clarify the eligibility/exclusion requirements?
<b>Section Number:</b>	I.B
<b>RFP Page Number:</b>	10
<b>Medicaid Answer:</b>	The Plan First Program is an 1115 Demonstration Waiver that extends family planning and birth control services to eligible women ages 19 through 55 and men age 21 or older (for only vasectomies) who would not otherwise qualify for full Medicaid coverage.
<b>Question ID:</b>	28
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Will Medicaid MMIS transmit files 5, 6, or 7 days a week?
<b>Section Number:</b>	I.D
<b>RFP Page Number:</b>	11
<b>Medicaid Answer:</b>	Files will be transmitted Monday through Friday.
<b>Question ID:</b>	29

<b>Date Question Asked:</b>	11/09/2015														
<b>Question:</b>	The RFP requests that the vendor provide a staffing matrix identifying all staff assigned along with respective titles, emails addresses, and locations. While we intend to identify this information for our key personnel we will not know this information for the remainder of our project team at time of proposal submission. Will Medicaid consider limiting this requirement to include key personnel only?														
<b>Section Number:</b>	II.B.3														
<b>RFP Page Number:</b>	12														
<b>Medicaid Answer:</b>	Refer to Amendment 1 posted on the Medicaid website on 11/19/2015. This requirement has been limited to key personnel.														
<b>Question ID:</b>	30														
<b>Date Question Asked:</b>	11/09/2015														
<b>Question:</b>	What is the average potential enrollee household size?														
<b>Section Number:</b>	II.E														
<b>RFP Page Number:</b>	15														
<b>Medicaid Answer:</b>	The estimated average potential enrollee household size is as follows:  <table border="1"> <thead> <tr> <th><u>Medicaid Eligibility Group</u></th> <th><u>Average</u></th> </tr> </thead> <tbody> <tr> <td>CHIP</td> <td>1.3</td> </tr> <tr> <td>Disabled</td> <td>1.0</td> </tr> <tr> <td>Former Foster</td> <td>1.0</td> </tr> <tr> <td>MLIF</td> <td>2.1</td> </tr> <tr> <td>SOBRAKids</td> <td>1.7</td> </tr> <tr> <td>SOBRAWomen</td> <td>1.0</td> </tr> </tbody> </table>	<u>Medicaid Eligibility Group</u>	<u>Average</u>	CHIP	1.3	Disabled	1.0	Former Foster	1.0	MLIF	2.1	SOBRAKids	1.7	SOBRAWomen	1.0
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<b>Question ID:</b>	31														
<b>Date Question Asked:</b>	11/09/2015														
<b>Question:</b>	The Vendor will also be responsible for outreaching to population groups identified by Medicaid that are out of the RCO Program but can choose to opt in to the RCO Program. How will these populations be identified for the vendor?														
<b>Section Number:</b>	II.F														
<b>RFP Page Number:</b>	16														
<b>Medicaid Answer:</b>	Members who may opt in will be communicated in the 834 file.														
<b>Question ID:</b>	32														
<b>Date Question Asked:</b>	11/09/2015														

<b>Question:</b>	Would the state consider allowing the vendor to stagger the initial enrollment mailing throughout July and August?
<b>Section Number:</b>	General
<b>RFP Page Number:</b>	
<b>Medicaid Answer:</b>	As identified in the chart on page 12 of Section II. Scope of Work, A. Implementation Project Plan and Readiness Reviews, the initial RCO enrollment process is to be conducted 7/2/16 through 8/31/16. Vendors are asked to describe their approach in response to Section II. Scope of Work.
<b>Question ID:</b>	33
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	The RFP states: "The Vendor will also be responsible for outreaching to population groups identified by Medicaid that are out of the RCO Program but can choose to opt in to the RCO Program." Are these potential enrollees included in the estimated count of 650,000 to 700,000?  How large is this opt-in population and how will they be identified?
<b>Section Number:</b>	II.F.3
<b>RFP Page Number:</b>	16
<b>Medicaid Answer:</b>	Population groups identified by Medicaid that are out of the RCO Program but can choose to opt in to the RCO Program are not included in the estimated count of 650,000 to 700,000.  Medicaid is finalizing the count, but we expect the opt-in number to be around 10,000.
<b>Question ID:</b>	34
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Will the vendor need to send 834 Enrollment Transactions to the RCOs and/or the MMIS?
<b>Section Number:</b>	II.F.5
<b>RFP Page Number:</b>	16
<b>Medicaid Answer:</b>	As described in Section II. Scope of Work, Subsection W. Enrollment File Transmission Requirements, the Vendor will receive and transmit file transactions to Medicaid or its designee. This does not include RCOs but will include the MMIS.
<b>Question ID:</b>	35
<b>Date Question Asked:</b>	11/09/2015

<b>Question:</b>	<p>The RFP states, “The Vendor will electronically receive a daily 834-formatted eligibility file from the Medicaid Management Information System (MMIS) which will provide information about enrollees that the Vendor will use to identify enrollees and potential enrollees for whom an RCO assignment is needed.”</p> <p>a. Has the State already defined a specific 834 Companion Guide for the ASC X12 Benefit Enrollment and Maintenance (834) transaction based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda?</p> <p>b. Or is the State expecting the Vendor to provide a recommendation for a Companion Guide to supplement ASC X12 definition for this type of EDI interchange?</p>
<b>Section Number:</b>	II.F.5.a
<b>RFP Page Number:</b>	16
<b>Medicaid Answer:</b>	Medicaid maintains a companion guide for the 5010 834 per the standards referenced in the question. The companion guide has been updated for the Enrollment Broker project and has been added to the Medicaid website.
<b>Question ID:</b>	36
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	When will the State provide the selected vendor with the auto-assignment algorithm?
<b>Section Number:</b>	F.5.b
<b>RFP Page Number:</b>	16
<b>Medicaid Answer:</b>	As described in Section II. Scope of Work, Subsection F. New Enrollment, Medicaid or its designee will use an algorithm to auto assign enrollees who do not voluntarily select an RCO. Medicaid’s fiscal agent will run the auto-assignment process, therefore, the algorithm will not be provided to the selected Vendor.
<b>Question ID:</b>	37
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	What is the auto assignment indicator in the eligibility file?
<b>Section Number:</b>	II.F.2
<b>RFP Page Number:</b>	17
<b>Medicaid Answer:</b>	When enrollees are auto-assigned, a new 834 file will be produced with the assignment and sent to the Enrollment Broker. Medicaid’s designee will run the auto-assignment

	process monthly for unassigned enrollees who are outside of their choice periods.
<b>Question ID:</b>	38
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	The RFP states: "Following the ninety (90) Calendar Day period, enrollees will be subject to a lock-in period of twelve (12) consecutive months, in which enrollees will only be able to disenrollment from the RCO for cause." Is the 12 consecutive month period inclusive of the first 90 days? Or is it a total of 15 months?
<b>Section Number:</b>	II.F.5.d
<b>RFP Page Number:</b>	17
<b>Medicaid Answer:</b>	Refer to Amendment I posted on the Medicaid website on 11/19/2015. The twelve (12) consecutive month period is inclusive of the ninety (90) Calendar Day period.
<b>Question ID:</b>	39
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Will the State send the vendor an indication that the eligible consumer is also pregnant?
<b>Section Number:</b>	II.G
<b>RFP Page Number:</b>	17
<b>Medicaid Answer:</b>	All information will be included in the 834 file.
<b>Question ID:</b>	40
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Will the State continue its outreach program(s) to pregnant women or will the enrollment broker be expected to provide all outreach to this population?
<b>Section Number:</b>	II.G.4
<b>RFP Page Number:</b>	17
<b>Medicaid Answer:</b>	As described in Section II. Scope of Work, Subsection G. Pregnant Women (formally known as SOBRA coverage), the Vendor will perform outreach to pregnant women.
<b>Question ID:</b>	41
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	The RFP suggests that the vendor will reach out to consumers 60 days prior to the end of their lock-in period. Because the state will be enrolling 700,000 consumers on October 1 <sup>st</sup> , would the state be open to capitalizing on efficiencies by staggering open enrollment periods by region?
<b>Section Number:</b>	II.I Annual Enrollment Change Period

<b>RFP Page Number:</b>	19
<b>Medicaid Answer:</b>	The requirements are defined within the RFP.
<b>Question ID:</b>	42
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Will the State please identify the foreign languages spoken by approximately five percent (5%) or more of the total covered population of each Region and throughout the State?
<b>Section Number:</b>	II.L.9; II.U.2
<b>RFP Page Number:</b>	21
<b>Medicaid Answer:</b>	As described in Section II. Scope of Work, Subsection U. Enrollment Services Website, the appropriate foreign languages comprise all languages in the Vendor's service area spoken by approximately five percent (5%) or more of the total covered population of the Region. The Vendor will provide all webpages and posted material in appropriate foreign languages. At this point, Alabama does not currently have a Region where a foreign language is spoken by 5% or more of the population.
<b>Question ID:</b>	43
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Please clarify if the State would like the vendor to identify the process it will use to identify the languages and formats the consumer needs or if the State would like the vendor to list the languages and formats it will provide.
<b>Section Number:</b>	II.L
<b>RFP Page Number:</b>	22
<b>Medicaid Answer:</b>	The Vendor must describe the process used.
<b>Question ID:</b>	44
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	How many times a year should vendors assume that they will update materials?
<b>Section Number:</b>	Section II M #5
<b>RFP Page Number:</b>	23
<b>Medicaid Answer:</b>	As described in Section II. Scope of Work, Subsection M. Enrollment Packets, information will be updated annually by Medicaid.
<b>Question ID:</b>	45
<b>Date Question Asked:</b>	11/09/2015

<b>Question:</b>	Would the State consider an alternative notification method such as phone call or email?
<b>Section Number:</b>	Section II N b
<b>RFP Page Number:</b>	23
<b>Medicaid Answer:</b>	As described in Section II. Scope of Work, Subsection N. Notices, at a minimum, the Vendor will mail these notices within one (1) Business Day of resolving the issue.
<b>Question ID:</b>	46
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Can the vendor propose a uniform provider file format for all RCOs?
<b>Section Number:</b>	II.P
<b>RFP Page Number:</b>	25
<b>Medicaid Answer:</b>	As described in Section II. Scope of Work, Subsection P. Provider Network and Directory, the Vendor must describe the Vendor's approach and methodology to coordinate with the RCOs to collect and transmit Provider File/Directory data between all parties.
<b>Question ID:</b>	47
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	What is the deadline for the RCOs to provide their provider network file to the vendor prior to program roll-out?
<b>Section Number:</b>	II.P.2
<b>RFP Page Number:</b>	25
<b>Medicaid Answer:</b>	A deadline has not been established at this time. However, Medicaid estimates that this information will be provided to the Enrollment Broker in June 2016.
<b>Question ID:</b>	48
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Does the State collect consumer's email addresses and can/will they be passed to the vendor on the daily eligible file?
<b>Section Number:</b>	II.T
<b>RFP Page Number:</b>	31
<b>Medicaid Answer:</b>	Medicaid does not collect email addresses.
<b>Question ID:</b>	49
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Please confirm that the vendor should provide a website in English and Spanish.
<b>Section Number:</b>	II.U.2

<b>RFP Page Number:</b>	33
<b>Medicaid Answer:</b>	As described in Section II. Scope of Work, Subsection U. Enrollment Services Website, the appropriate foreign languages comprise all languages in the Vendor's service area spoken by approximately five percent (5%) or more of the total covered population of the Region. The Vendor will provide all webpages and posted material in appropriate foreign languages. At this point, Alabama does not currently have a Region where a foreign language is spoken by 5% or more of the population.
<b>Question ID:</b>	50
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Will the monthly electronic 834 file ONLY contain confirmed and auto-assigned enrollments and Future month's eligibility and disenrollments? Or, will the monthly 834 file actually be a full "replacement" or "master" file that should be used to reconcile the vendor's entire Medicaid population?
<b>Section Number:</b>	II.V.3
<b>RFP Page Number:</b>	34
<b>Medicaid Answer:</b>	As described in Section II. Scope of Work, Subsection V. Enrollment Information System, the Vendor will accept from Medicaid or its designee a monthly electronic 834 file of: (1) confirmed and auto-assigned enrollments, (2) future month's eligibility and disenrollments.
<b>Question ID:</b>	51
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Define what can be considered miscellaneous EB transactions?
<b>Section Number:</b>	II.V.4
<b>RFP Page Number:</b>	34
<b>Medicaid Answer:</b>	Miscellaneous transactions may include but are not limited to members manually assigned to an RCO by Medicaid or its designee and any error files.
<b>Question ID:</b>	52
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Will the State provide the preferred method of contact? Or will the vendor develop this value based on past contact with the consumer?
<b>Section Number:</b>	II.Z Table 2
<b>RFP Page Number:</b>	40

<b>Medicaid Answer:</b>	Medicaid will not provide the preferred method of contact. It is Medicaid's intent that this information will be collected through the proposed website.
<b>Question ID:</b>	53
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	This section states that "all pass-through expenses must be documented in the pricing sheet table (Appendix C)." However, Appendix C does not have an obvious place to provide this information. Could the Agency clarify where to provide this information?
<b>Section Number:</b>	III
<b>RFP Page Number:</b>	41
<b>Medicaid Answer:</b>	Refer to Amendment I posted on the Medicaid website on 11/19/2015.
<b>Question ID:</b>	54
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Please confirm that vendors are to base their firm and fixed fee on providing enrollments for up to 700,000 recipients.
<b>Section Number:</b>	III
<b>RFP Page Number:</b>	41
<b>Medicaid Answer:</b>	As described in Section III. Pricing, Vendors are to base their firm and fixed fee on providing enrollment to an average of 700,000 recipients.
<b>Question ID:</b>	55
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	If outreach and all mailing costs are pass-through expenses, is the vendor expected to allocate fringe, overhead and G&A for the outreach and notice development efforts as part of the fixed-fee price?
<b>Section Number:</b>	III
<b>RFP Page Number:</b>	41
<b>Medicaid Answer:</b>	Yes, the Vendor is expected to allocate fringe, overhead and G & A for the outreach and notice development efforts as part of the fixed-fee price.
<b>Question ID:</b>	56
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Will the State reconsider its position on negotiating additional terms and conditions presented as part of the proposal, provided such terms and conditions do not directly conflict with the State's standard terms?

<b>Section Number:</b>	VI.E
<b>RFP Page Number:</b>	43
<b>Medicaid Answer:</b>	No.
<b>Question ID:</b>	57
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Is it the intent for the State to receive the pricing sheet table (Appendix C) along with the Technical proposal, sealed and packaged together in the same binder?
<b>Section Number:</b>	VI.L and VI.N
<b>RFP Page Number:</b>	44
<b>Medicaid Answer:</b>	Yes, the cost and pricing pages are part of the proposal and not to be separately sealed.
<b>Question ID:</b>	58
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Please confirm that pass through costs will not be part of the Price Evaluation.
<b>Section Number:</b>	VII.E
<b>RFP Page Number:</b>	46
<b>Medicaid Answer:</b>	Refer to Amendment I posted on the Medicaid website on 11/19/2015.
<b>Question ID:</b>	59
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Is the State interested in optional value added innovations which are not priced and not a part of the core solution but included for the states consideration? If so, how would the State like these items to be distinguished in the response?
<b>Section Number:</b>	General
<b>RFP Page Number:</b>	
<b>Medicaid Answer:</b>	Medicaid is only interested in functionality included in the RFP. The firm and fixed pricing must include all services proposed.
<b>Question ID:</b>	60
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Section II.E talks about giving initial enrollees 60 days to make their decision.  Section II.F talks about giving new enrollees 20 days to make their decision.  Can the State confirm that initial potential enrollees will be given 60 days to make their decision during program rollout

	and then any subsequent new potential enrollees will be given 20 days?.
<b>Section Number:</b>	Section II.E, Section II.F
<b>RFP Page Number:</b>	15,16
<b>Medicaid Answer:</b>	That is correct.
<b>Question ID:</b>	61
<b>Date Question Asked:</b>	11/09/2015
<b>Question:</b>	Will consumers who are not on the initial 7/1/16 eligibility file go down the roll-out enrollment path or the standard new consumer enrollment path (e.g. if they are received on the 7/15 enrollment file)?
<b>Section Number:</b>	General
<b>RFP Page Number:</b>	
<b>Medicaid Answer:</b>	<p>We interpret this as a question on the timing of the initial production member submission to the Enrollment Broker with respect to the Managed Care go-live date.</p> <p>Currently, Medicaid expects the initial 834 file to be submitted to the Enrollment Broker on or around 7/1/2016. This will contain all members eligible for assignment in the RCO at go-live (10/1/2016). The Enrollment Broker should begin outreach to these members as defined in this RFP. The next member file will be sent to the Enrollment Broker in late July or early August. From this point, Medicaid's fiscal agent will begin sending daily files to the Enrollment Broker. The Enrollment Broker should begin outreach to these members as defined in the RFP. Since there is a 20 day choice period, Medicaid expects members submitted to the Enrollment Broker before September 8<sup>th</sup> to be assigned at the go-live date of 10/1/16 as well.</p>

**RFP # 2015-EB-01****Medicaid Regional Care Organization Program Enrollment Broker Services RFP****Second Round Vendor Questions and Medicaid Answers****11/24/15****Note:** Questions and/or Section References are posted as submitted.

<b>Question ID:</b>	62
<b>Date Question Asked:</b>	11/23/2015
<b>Question:</b>	It's come to our attention that CMS and IRS security audits are being enforced in a number of states. Should the vendor assume costs associated with the following security requirements: MARS-E CMS document, IRS Tax Information Security Guidelines for Federal, State, and Local Agencies (Publication 1075), and the CMSR Moderate Impact Level Data requirements. We have noted that vendors incur substantial costs associated with supporting these audit activities.
<b>Section Number:</b>	General
<b>RFP Page Number:</b>	N/A
<b>Medicaid Answer:</b>	The Vendor should be prepared for any expenses related to security audits or any other audits that may be required.
<b>Question ID:</b>	63
<b>Date Question Asked:</b>	11/23/2015
<b>Question:</b>	Can the state clarify whether "enrollment broker notification" means the date when 834 eligibility file is sent to the enrollment broker, or the date when enrollment broker mails out the notification to the enrollee?
<b>Section Number:</b>	II.F.2
<b>RFP Page Number:</b>	16
<b>Medicaid Answer:</b>	Enrollment broker notification refers to the date the enrollment broker mails out the notification to the enrollee.
<b>Question ID:</b>	64
<b>Date Question Asked:</b>	11/23/2015
<b>Question:</b>	Does the enrollment broker need to notify MMIS the date when lock-in period begins, after annual enrollment period and/or initial enrollment period?
<b>Section Number:</b>	II.I.1
<b>RFP Page Number:</b>	19

<b>Medicaid Answer:</b>	No, Medicaid's designee is responsible for tracking lock-in periods and will notify the enrollment broker of the next enrollment period.
<b>Question ID:</b>	65
<b>Date Question Asked:</b>	11/23/2015
<b>Question:</b>	Is the 90 day RCO change period based on the coverage start date with the RCO or based on the date of RCO selection?
<b>Section Number:</b>	II.F.5.d
<b>RFP Page Number:</b>	17
<b>Medicaid Answer:</b>	The ninety (90) day RCO change period is based on the RCO coverage start date.
<b>Question ID:</b>	66
<b>Date Question Asked:</b>	11/23/2015
<b>Question:</b>	The response to Q-60 and Q-61 appears to conflict. Could the State clarify whether all of the members will be given a 20 day choice period for those members included in the file that will be sent to the vendor on or around 7/1/2016 as well as the subsequent files that will be sent late July or early August 2016?
<b>Section Number:</b>	N/A
<b>RFP Page Number:</b>	N/A
<b>Medicaid Answer:</b>	The initial potential enrollees will be given sixty (60) days to make their decision during the initial program rollout. After the initial program rollout, subsequent member files will be sent by Medicaid's designee and these potential enrollees will have a twenty (20) day choice period. Therefore, question 60 and question 61 do not conflict.