# ALABAMA MEDICAID AGENCY
## REQUEST FOR PROPOSALS

<table>
<thead>
<tr>
<th>RFP Number:</th>
<th>2021-MQR-01</th>
</tr>
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<tr>
<td>RFP Title:</td>
<td>Medicaid Medical and Quality Review</td>
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<table>
<thead>
<tr>
<th>RFP Due Date and Time:</th>
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<tbody>
<tr>
<td>March 24, 2021 by 5:00 pm Central Time</td>
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<table>
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<tr>
<th>Number of Pages:</th>
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<td>125</td>
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## PROCUREMENT INFORMATION

<table>
<thead>
<tr>
<th>Project Director:</th>
<th>Thomas Stedham</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-mail Address:</td>
<td><a href="mailto:MQRRFP@medicaid.alabama.gov">MQRRFP@medicaid.alabama.gov</a></td>
</tr>
<tr>
<td>Website:</td>
<td><a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a></td>
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<table>
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<tr>
<th>Issue Date:</th>
<th>January 22, 2021</th>
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<tbody>
<tr>
<td>Issuing Division:</td>
<td>Clinical Services and Support Division</td>
</tr>
</tbody>
</table>

## INSTRUCTIONS TO VENDORS

**Return Proposal to:**

Thomas Stedham  
Alabama Medicaid Agency  
Lurleen B. Wallace Building  
501 Dexter Avenue  
PO Box 5624  
Montgomery, AL 36103-5624

**Mark Face of Envelope/Package:**

- RFP Number: 2020-MQR-01  
- RFP Due Date: March 24, 2021 by 5:00pm CT  
- Firm and Fixed Price: $  

## VENDOR INFORMATION

*(Vendor must complete the following and return with RFP response)*

<table>
<thead>
<tr>
<th>Vendor Name/Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorized Vendor Signatory: (Please print name and sign in ink)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vendor Phone Number:</th>
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</thead>
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<tr>
<td>Vendor FAX Number:</td>
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</table>

<table>
<thead>
<tr>
<th>Vendor Federal I.D. Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vendor E-mail Address:</td>
</tr>
</tbody>
</table>
Section A. RFP Checklist

1. **Read the entire document.** Note critical items such as: mandatory requirements; supplies/services required; submittal dates; number of copies required for submittal; licensing requirements; contract requirements (i.e., contract performance security, insurance requirements, performance and/or reporting requirements, etc.).

2. **Note the project director’s name, address, phone numbers and e-mail address.** This is the only person you are allowed to communicate with regarding the RFP and is an excellent source of information for any questions you may have.

3. **Take advantage of the “question and answer” period.** Submit your questions to the project director by the due date(s) listed in the Schedule of Events and view the answers as posted on the WEB. All addenda issued for an RFP are posted on the State’s website and will include all questions asked and answered concerning the RFP.

4. **Use the forms provided,** i.e., cover page, disclosure statement, etc.

5. **Check the State’s website for RFP addenda.** It is the Vendor’s responsibility to check the State’s website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) for any addenda issued for this RFP, no further notification will be provided. Vendors must submit a signed cover sheet for each addendum issued along with your RFP response.

6. **Review and read the RFP document again** to make sure that you have addressed all requirements. Your original response and the requested copies must be identical and be complete. The copies are provided to the evaluation committee members and will be used to score your response.

7. **Submit your response on time.** Note all the dates and times listed in the Schedule of Events and within the document, and be sure to submit all required items on time. Late proposal responses are *never* accepted.

8. **Prepare to sign and return the Contract, Contract Review Report, Business Associate Agreement and other documents** to expedite the contract approval process. The selected Vendor’s contract will have to be reviewed by the State’s Contract Review Committee which has strict deadlines for document submission. Failure to submit the signed contract can delay the project start date but will not affect the deliverable date.

This checklist is provided for assistance only and should not be submitted with Vendor’s Response.
Section B. Schedule of Events

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

<table>
<thead>
<tr>
<th>EVENT</th>
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<tbody>
<tr>
<td>RFP Issued</td>
<td>1/22/21</td>
</tr>
<tr>
<td>Questions Due by 5:00 PM Central Time</td>
<td>2/10/21</td>
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<tr>
<td>Final Posting of Questions and Answers</td>
<td>3/10/21</td>
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<tr>
<td>Proposals Due by 5:00 PM Central Time</td>
<td>3/24/21</td>
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<tr>
<td>Evaluation Period</td>
<td>3/26/21-4/19/21</td>
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<tr>
<td>Contract Award Notification</td>
<td>5/11/21</td>
</tr>
<tr>
<td><strong>Contract Review Committee</strong></td>
<td>9/9/21</td>
</tr>
<tr>
<td>Official Contract Award/Begin Work</td>
<td>10/1/21</td>
</tr>
</tbody>
</table>

** 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

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

Medicaid is requesting proposals from a qualified Quality Improvement Organization (QIO) or QIO-like entity to review prior authorizations (PA), and to review records of nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), hospice, post-extended care (PEC), swing bed, and inpatient psychiatric facilities.

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

Institutional reviews include those of long term residents in a skilled nursing facility (SNF), ICF/IID, PEC and swing beds and inpatient psychiatric hospitals. Swing beds are hospital beds that can be used for either skilled nursing facility (SNF) or hospital acute care levels of care on an as needed basis if the hospital has obtained a swing bed approval from the Department of Health and Human Services. Inpatient psychiatric admissions for adults ages 21-64 are covered only in an acute care hospital, or as a part of an approved 1115 IMD exclusion waiver. However, Medicaid does cover inpatient psychiatric facilities, including Psychiatric Residential Treatment Facilities (PRTFs) for recipients under 21 and age 65 and over.

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

Calendar days are to include holidays. Should a holiday fall within or on a deadline, the requirement shall be provided to Medicaid or the Contractor prior to the holiday.

II. Scope of Work

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

1. Institutional Record Reviews
The primary goal of the Institutional Record Review process is to ensure the appropriate utilization of services for admissions, readmissions and transfers to the Institutional facilities by performing retrospective reviews of the medical records. Institutional providers include nursing facilities, Post Hospital Extended Care (PEC), swing bed, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), inpatient psychiatric hospitals, including Residential Treatment Facilities (PRTFs) for recipients under age 21, inpatient psychiatric facilities for recipients over the age of 65 and potentially inpatient psychiatric facilities participating in an 1115 IMD exclusion waiver for adults between the ages of 21-64. Inpatient psychiatric admissions are otherwise only covered in acute care hospitals for adults ages 21-64. Criteria for these facilities are documented in the following chapters of the Alabama Medicaid Administrative Code:

Chapter 10 for Nursing Facilities and ICF/IIDs
Chapter 7 Hospitals for PEC admissions and continued stays
Chapter 46 for Swing Beds
Chapter 5 for Psychiatric Facilities for Individuals 65 or Over;
Chapter 41 for Psychiatric Facilities for Individuals Under Age 21

A query is utilized for the inpatient psychiatric reviews. A five percent random sample of admissions and re-admissions in inpatient psychiatric facilities, including RRTFs shall be reviewed.

Nursing facility, ICF/IID, PEC, swing bed, and psychiatric providers electronically submit records to the fiscal agent. These records are stored in a document repository. Nursing facility and ICF/IID providers submit admission dates for Medicaid recipients through the fiscal agent’s software. There may be instances when the admission dates or end dates are not accepted by the fiscal agent’s software. Therefore, the nursing facility and ICF/IID, providers will submit a LTC Request for Action Form (Form 161B) according to the Long Term Care Division Nursing Facility-ICF/IID Request for Action Policy provided in Appendix B to update or make corrections to the LTC segment for recipients.

Please see below for CY 2019 statistics. The monthly average for LTC records reviewed in 2019 were approximately 24.

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<td>Psych/PRTF Retro</td>
<td>264</td>
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The selected Vendor will:

- Comply with the applicable requirements of Alabama Medicaid Administrative Code and any revisions thereof.
- Comply with the applicable requirements of the Alabama Medicaid Provider Manual and any revisions thereof.
- Follow the Long Term Care Division Policy and Procedures located in Appendix B to complete the retrospective medical reviews for the Nursing facilities, and ICF/IIDs, and complete 100 percent concurrent reviews for the PEC and Swing Bed programs. Below are
summaries for each program; more information is located in each policy in the Appendix.

- The Alabama Medicaid Contractor will perform retrospective utilization reviews for Nursing Facility new admissions, readmissions, and transfers. On a monthly basis the Contractor will perform a retrospective review by selecting a 10% sample of Medicaid recipient new admissions, readmissions, and transfers provided on the LTC-0007-M report. Nursing Facilities RN staff makes the initial assessment and obtains medical documentation to support the admission criteria as outlined in Chapter 10 of the Alabama Medicaid Administrative Code. Then the Nursing Facility submits the new admission, readmission, or transfer date via the Fiscal Agent’s software. The admission dates, recipient and provider information is captured on the LTC-0007-M report for the Contractor to select a sample for review. Reviews shall be performed by a health care professional with a minimum qualifications of a Registered Nurse with three years of medical surgical or Long Term Care experience.

- The Alabama Medicaid Contractor will perform retrospective utilization reviews for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) new admissions, readmissions, and transfers. On a monthly basis the Contractor will perform a retrospective review of 100% of Medicaid recipient new admissions and readmissions provided on the LTC-0007-M report. ICF/IID’s makes the initial assessment and obtains medical documentation to support the admission criteria as outlined in Chapter 10 of the Alabama Medicaid Administrative Code. Then the ICF/IID submits an admission or readmission date via the Fiscal Agent’s software. The admission dates, recipient and provider information is captured on the LTC-0007-M report. Reviews shall be performed by a Qualified Intellectual Disability Professional (QIDP) with two years of experience.

- Inpatient hospital services rendered at an inappropriate level of care (lower than acute) are considered post-hospital extended care services. The patient must have received a minimum of three consecutive days of acute care services in the hospital requesting Post-Hospital Extended Care (PEC) reimbursement. Intra-facility transfers will not be authorized for reimbursement as PEC services. These services include care ordinarily provided by a nursing facility. Prior to the hospital admitting a patient to one of these beds, the hospital must first determine that there is no nursing facility bed available within a reasonable proximity. Hospital providers of PEC services are required to submit a completed Medicaid Status Notification Form (Form 199) to the Contractor within 60 days from the date Medicaid coverage is requested. The Vendor will submit approved dates through the fiscal agent’s LTC software.

- Swing beds are defined as hospital beds that can be used for either skilled nursing facility (SNF) or hospital acute care levels of care on an as needed basis if the hospital has obtained a swing bed approval from the Department of Health and Human Services. In order to receive swing bed services recipients must require SNF level of care on a daily basis. The Contractor will perform admission reviews of all Medicaid admissions to ensure the necessity and appropriateness of the admission and that a physician has certified on the date of admission, the need for swing bed care. Hospital providers of Swing Beds Services are required to submit a completed Medicaid Status Notification Form (LTC- Form 199) to the Contractor within 60 days from the date Medicaid coverage is requested. The Vendor will submit approved dates through the fiscal agent’s LTC software.
- Review retrospectively a 5 percent admissions and re-admissions for the inpatient psychiatric facilities, including PRTFs, on a monthly basis to ensure medical criteria are met.
- Collaborate with the Long Term Care Division to develop a Standard of Operations Manual and Audit Tools.
- Unless otherwise stated in policy or this RFP, send the initial request letter to the facilities within seven business days of the first day of the month. A copy of the letter must be retained by the Vendor.
- Unless otherwise stated in policy or this RFP, ensure reviews are performed by a health care professional with a minimum qualification of an RN with three years of institutional or medical surgical experience.
- Ensure professional staffs review the medical documentation to ensure compliance with state and federal requirements governing the Institutional Programs and to ensure that the documentation supports Alabama Medicaid medical criteria.
- Unless otherwise stated in policy or this RFP, complete medical reviews within 30 calendar days of receipt and if necessary, submit request to the Institutional providers for additional documentation regarding any non-compliance issues and/or lack of required documentation to support the admission, re-admission or transfer.
- Unless otherwise stated in policy or this RFP, complete reviews of additional information within 10 calendar days of receipt.
- Unless otherwise stated in policy or this RFP, send a denial letter for any record determined not to meet criteria to the provider within one business day of review. The letter shall contain the recipient’s name, Medicaid number, date of service, denial reason (should be indicated in plain language and a reference code or number), and rights to the appeal process which include both the informal review and a fair hearing.
- Unless otherwise stated in policy or this RFP, provide a monthly summary report of any pending cases and institutional medical denials.
- If clinical staff is unable to make a medical determination, forward the record to the Vendor’s Physician Advisor for an approval or denial.
- Generate a monthly report, no later than 10 business days after the end of the month, to include but not limited to the following:
  - Number of Institutional Completed Reviews by type.
  - Number of Institutional Review denials by type.
  - Number of Institutional Pending Reviews by type.
  - Number of Institutional Reviews submitted for the Vendor’s Physician determination.
  - Number of Institutional Reviews not processed within the specified timeframes by type.
  - Number of Institutional appeals by type.
  - Number of nursing facilities submitting records untimely.
  - Number of Request for Action (Form 161B) processed to include reason for the change.

As part of the Proposal, The Vendor must:
1. Provide a description of how the institutional reviews will be performed by professional clinical staff and a physician, as necessary, to ensure medical criteria are met. Refer to the LTC Policies and Procedures in Appendix B for the Nursing facilities, ICF/IID, PEC and Swing Bed programs.

2. Describe procedures to select the 10 percent random sample from the LTC-0007-M report each month for nursing facility and ICF/IID reviews, as well as the procedures to notify staff that PEC, swing bed and inpatient psychiatric records are available for review. Refer to the LTC Policies and Procedures in Appendix B.

3. Explain and provide samples of the audit request, request for additional information, and denial letters to the inpatient psychiatric facilities. The audit request letter shall be sent to the facilities within seven business days of the first day of the month. A copy of the letter must be retained by the Vendor. Unless otherwise stated in policy or this RFP, the denial letter shall contain the recipient’s name, Medicaid number, date of service, denial reason (should be indicated in plain language and reference code or number), and rights to the appeal process which include both the informal review and a fair hearing.

4. Vendor shall describe/define the timeframe and deadlines for the request, reviews, and subsequent notifications.

5. Provide samples of the audit request notice, request for additional information, and denial letters and according to the LTC Policies and Procedures included in Appendix B for Nursing Facilities, ICF/IIDs, PEC and Swing Bed reviews.

6. Provide a detailed plan for staffing.

7. Describe the procedures to verify receipt by the provider of the Vendor’s initial audit request and the request for additional information, if necessary.

2. Hospice Records Reviews

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

Hospice providers also electronically submit records to the fiscal agent. These records are stored in the document repository. Medicaid-only recipients require a medical review by professional staff, and if the record is approved, the Vendor will submit approved dates through the fiscal agent’s LTC software for a six month period. The Vendor will also document the dates for the election periods and revocation dates, if applicable, for approved records through the MMIS. If the six month recertification is approved, the LTC file will be extended for another six months. If clinical staff is unable to make a determination the record shall be forwarded to the Physician Advisor for an approval or denial. Hospice providers may request an informal review within 15 calendar days from the date of the denial letter. The Vendor’s nurse reviewers of any Hospice informal review must respond to the informal review within 5 days of receipt. The Vendor’s physician must prepare for and attend hospice fair hearings.
Hospice providers submit the Hospice Recipient Status Change Form 165B for dual eligible individuals in the nursing home, change Hospice providers, or elects to revoke hospice care. Form 165B is also used to update the LTC segment when a provider begin/end dates overlap. For dually eligible recipients, the Vendor must verify Medicare Part A eligibility in the MMIS. The Vendor will submit approved dates through the fiscal agent’s LTC software.

Please see below for CY 2019 statistics. The average number of monthly hospice reviews are approximately 90.

**CY 2019 Hospice Reviews**

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<th>CY2019</th>
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<th>Total</th>
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<tbody>
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<td>Hospice</td>
<td>813</td>
<td>286</td>
<td>804</td>
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<td>1,903</td>
</tr>
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The selected Vendor will:

- Comply with the applicable requirements of Alabama Medicaid Administrative Code and any revisions thereof.
- Comply with the applicable requirements of the Alabama Medicaid Provider Manual and any revisions thereof.
- Follow the Long Term Care Division Hospice Concurrent Review Policy to complete the Hospice Initial Certifications and Re-certification approvals located in Appendix B. Below is a summary for this program; more information is located in the Hospice policy in the Appendix.
  - The Alabama Medicaid Contractor will perform 100% concurrent medical record reviews for Hospice initial certification requests and six month recertification requests for Medicaid only eligible recipients. Hospice providers makes the initial assessment and obtains medical documentation to support the admission criteria as outlined in Chapter 51 of the Alabama Medicaid Administrative Code. The Hospice provider then loads the documentation along with the Medicaid Hospice Election and Physician’s Certification Form (FORM 165) in Medicaid’s Fiscal Agents software for review.
  - Unless otherwise stated in policy or this RFP, complete hospice medical reviews within 14 calendar days of receipt.
- Ensure reviews are performed by a health care professional with a minimum qualification of a RN with three years hospice experience.
- Ensure criteria are consistently applied to all reviews, and that for records for which the clinical staff are unable to make a determination, or are for recipients under 21, or for which Medicaid has no criteria, are forwarded to the Vendor’s Physician Advisor for review.
- Ensure all reviews are documented. The physician approval or denial must also be documented and evidence-based research must support the decision and/or consultation must be done with Medicaid.
- Ensure the Vendor’s Physician Advisor and other personnel shall be readily available at Medicaid’s request during regular business hours to provide justification for the denial, prepare for, and participate in any informal reviews and fair hearings. The physician and other appropriate personnel must be physically available to attend hearings at a minimum of four days per month, if the hearing case load dictates this level.
• Receive and process Form 165B’s according to the Long Term Care Division Hospice Request for Action Policy included in Appendix B.
• Generate a monthly report, no later than 10 calendar days after the end of the month, to include but not limited to the following:
  o Number of Hospice reviews not processed within the specified timeframes.
  o Number of Hospice reviews requiring physician review.
  o Number of Hospice approvals.
  o Number of Hospice denials with the diagnosis submitted with the record
  o Number of Hospice appeals.
  o Number of Hospice Recipient Status Change Forms (Form 165B) processed.
  o Report by Medicaid ID, hospice provider ID, date received by the Vendor, and status of hospice request.

As part of the proposal, the Vendor must:

1. Provide a detailed description for an approach to review hospice admissions and recertifications to ensure hospice criteria are met according to the Long Term Care Division Hospice Policy located in Appendix B.
2. Provide a detailed description of the process to ensure records are reviewed timely, as per the policy in Appendix B. Vendor shall describe/define the timeframe and deadlines for the request, reviews, and subsequent notifications.
3. Provide procedures to ensure staff, including physician consultants are available for informal reviews and/or fair hearings, including preparation for hearings, during regular business hours, at Medicaid’s request.
4. Provide a description of the process to ensure Hospice Recipient Status Change Forms (165B) are addressed accurately as located in Appendix B.
5. Provide a detailed plan on staffing.
6. Provide samples of the following letters: Approval of Initial Certifications and Recertifications; Denials of Initial Certifications, Recertifications, Technical denials, Untimely Informal Reviews and No Medicaid Eligibility. Refer to the Hospice policies located in Appendix B.

3. Prior Authorization (PA) Reviews

The primary goal of the PA program is to promote the most appropriate utilization of select medical services, supplies and equipment. PA serves as a cost-monitoring, utilization review and quality assurance mechanism for Medicaid. A single PA request may contain multiple lines or details for medical services, supplies and equipment. The Vendor shall use criteria approved by Medicaid to determine approval or denial of PA requests. Medicaid does not currently utilize auto-adjudication but is open to Vendor recommendations on automation of functional processess. In addition to performing PA functions, the Vendor shall review, on an annual basis as well as ad hoc, existing PA criteria and make recommendations for change to Medicaid based on clinical review of current medical literature, other states’ Medicaid program criteria, Medicare and other organizations’ criteria including, but not limited to, BCBS of Alabama, and Alabama Quality Assurance Foundation (AQAF). Medicaid shall provide Vendor with existing approved PA criteria and forms in electronic format.
The Vendor shall review and process PA requests from physicians, DME providers, and other appropriate Medicaid providers for medical procedures, equipment, and services requiring PA. These PAs will be submitted for all eligible Medicaid recipients. See below for CY 2019 statistics. The PAs are initially submitted to the Fiscal Agent and the Vendor accesses the information electronically for review. See Appendix B for the Prior Authorizations Policy Table of Contents for the policies for which the Vendor is responsible to review at the time of this RFP. This list may change, based upon policy decisions made by Medicaid. See Medicaid Provider Manual Chapter 4, Obtaining Prior Authorization in the Provider Manual for information about the PA process. If the Vendor has questions on a submitted PA request, or if information is missing from the PA request, the Vendor shall call the provider during business hours to inquire or obtain the missing information before a denial is issued. The Vendor will enter the PA decision in the MMIS.

Providers may submit a Form 471, the PA Change Request Form, to submit simple revisions to a PA in evaluation or approved status, such as the addition of a modifier. It is not to be used for denied PAs. The number of Form 471s during CY 20 average approximately 122 per month.

CY 2019 Prior Authorizations

<table>
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<th>Denied</th>
<th>Evaluation</th>
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<tbody>
<tr>
<td>PA</td>
<td>14,782</td>
<td>4,691</td>
<td>582</td>
<td>59</td>
<td>19,989</td>
</tr>
</tbody>
</table>

At the time of writing this RFP, the Centers for Medicare and Medicaid Services (CMS) has released a proposed rule (based on the Interoperability and Patient Access final rule CMS-9115-F) which may impact the prior authorization portion of this RFP. In summary, CMS is proposing:

- Require denial reasons on prior authorization denials to facilitate better communication and understanding between the provider and payor,
- Require payors to send prior authorization decisions within 72 hours for urgent requests and 7 calendar days for standard requests, and
- Require payors to publicly report prior authorization metrics.

If CMS implements these and other requirements through a federal mandate, the Vendor shall be responsible for implementing all aspects in the time frame required by CMS. Please see more information regarding the federal proposal here: [https://www.cms.gov/files/document/2020-12-16-promoting-interoperability-presentation.pdf](https://www.cms.gov/files/document/2020-12-16-promoting-interoperability-presentation.pdf)

PA Reviews to be included in this contract, but not included in the CY 2019 PA utilization above are described below. All current criteria for additional PA reviews a) through f) below are found in Appendix B.

a) **Temporomandibular Joint Disorders/Orthognathic Surgery**

The vendor shall review Current Procedural Terminology (CPT) codes listed in Policy 19-01 – Temporomandibular Joint (TMJ) Disorders and Policy 20-06 – Orthognathic Surgery. These reviews shall be performed and documented by a Consulting Physician who is FACP certified and licensed to practice medicine in Alabama. If the Vendor has questions on a submitted PA request, or if information is missing from the PA request, the Vendor shall call the provider during business hours to inquire or obtain the missing information before a denial is issued. Appeals of denials will be sent to the Alabama Medicaid Assistant Medical Director for review.

In CY 2019 there were approximately 100 Temporomandibular Joint Disorders and Orthognathic Surgery prior authorization requests reviewed.
b) **Rehab Option Reviews**

Rehabilitative services are specialized medical services delivered by uniquely qualified practitioners designed to treat or rehabilitate persons with mental illness, substance abuse, or co-occurring mental illness and substance abuse diagnoses. These services are provided to recipients on the basis of medical necessity. Providers must enroll through State Agencies. The Department of Mental Health (DMH), The Department of Human Resources (DHR) and The Department of Youth Services (DYS) are currently contracted with Medicaid to provide rehab services to these targeted adults and children. For the purposes of this RFP, only the Departments of Mental Health and Youth Services providers will be submitting PA requests.

The selected Contractor will review and make determination for PA requests for Rehabilitative Services unit limitation override. The request can be an initial request, or for additional units beyond an initial request approval. This service is designed to be performed by a Registered Nurse, but can be completed by a physician/psychiatrist or clinical psychologist. There is criteria that is listed in the Internal AMA policy in which to make the decision. The information will also need to be entered onto an excel spreadsheet for tracking and trending purposes. This review process has been set in place since October 2018, is currently being managed by Agency staff, and only 2 (two) requests has been received to date.

c) **Miscellaneous E1399 Prior Authorization Reviews**

The Agency receives various prior authorizations for miscellaneous codes. The Vendor will review these requests for medical necessity and will render a decision based on FDA guidelines, national/clinical guidelines and recommendations, Alabama Medicaid policy and/or peer reviewed literature. Appeals of denials will be sent to the Alabama Medicaid Assistant Medical Director for review. In CY 2019 there were approximately 283 prior authorization requests reviewed.

d) **Maximum Allowable Reviews**

The Agency receives various requests for Maximum Allowable Override. The Vendor will review these requests for medical necessity and will render a decision based on FDA guidelines, national/clinical guidelines and recommendations, National Correct Coding Iniative (NCCI), Alabama Medicaid policy, and/or peer reviewed literature. Appeals of denials will be sent to the Alabama Medicaid Assistant Medical Director for review. In CY 2019 there were approximately 40 prior authorization requests reviewed.

e) **Non-invasive Prenatal Testing for Fetal Aneuploidy (NIPT)**

Noninvasive prenatal testing that uses cell free fetal DNA from the plasma of pregnant women offers potential as a screening tool for fetal aneuploidy. Circulating cell free fetal DNA, which comprises approximately 5-20% of the total cell free maternal DNA, is thought to be derived primarily from the placenta. Cell free fetal DNA/Non-Invasive Prenatal Testing (NIPT) analysis technology is known as massively parallel genomic sequencing and has been reported to accurately detect trisomy 13, trisomy 18, and trisomy 21 as early as the 10th week of pregnancy.

Cell free fetal DNA/NIPT testing should be an informed patient choice after pretest counseling and should not be part of routine prenatal laboratory assessment. Cell free fetal DNA testing should not be offered to low-risk women or women with multiple gestations due to lack of sufficient evaluation in these groups. A negative cell free fetal DNA test result does not ensure an unaffected
pregnancy. A patient with a positive test result should be referred for genetic counseling and should be offered invasive prenatal diagnosis for confirmation of test results. This is a new PA service for Alabama Medicaid, and at the writing of this RFP, the anticipated number of PAs is estimated to be 250-300 annually (estimated as a gradual influx to the projected total annual number).

For PA reviews, the selected Vendor will:

- Comply with the applicable requirements of Alabama Medicaid Administrative Code and any revisions thereof.
- Comply with the applicable requirements of the Alabama Medicaid Provider Manual and any revisions thereof.
- Review and apply Medicaid PA criteria uniformly to PAs for medical procedures, services, equipment, laboratory tests and private duty nursing, and all aspects listed in this section of the RFP.
- Conduct self audits as described in this RFP in section D, Monitoring Performance Standards and Corrective Action Plans.
- Annually review all PA criteria for clinical appropriateness and make recommendations on potential updates.
- Ensure reviews are completed for initial and reconsideration requests of denied PAs within 30 calendar days of receipt of the PA by fiscal agent, with a goal of completion by 15 calendar days of receipt.
- Ensure manual wheelchair with accessories, all power wheelchair and all wheelchair requests for children are reviewed by a qualified physical therapist. See “Staffing” section of this RFP for more information.
- Ensure reviews are performed and documented by a RN with a minimum of three years of institutional or medical surgical experience. See “Staffing” section of this RFP for more information.
- Ensure requests for which the RN reviewer is unable to render a decision, is forwarded to a qualified physician. See “Staffing” section of this RFP for more information.
- Ensure Form 471s are addressed accurately within five business days of receipt.
- Generate a monthly report for each PA type as well as total PAs, no later than 10 business days after the end of the month, to include but not limited to the following:
  - Number of PA requests not processed within the specified timeframes.
  - Number of requests requiring a physician review.
  - Number of PAs requiring a physical therapist review.
  - Number of PA approvals.
  - Number of PA denials categorized by reason for denial.

As part of the proposal, the Vendor must:

1. Provide a detailed description of the process for reviewing services and items that require a PA, using Medicaid criteria.
2. Provide a detailed description of the process to forward to a physician, any request for which the nurse reviewer is unable to render a decision. The description must also include the process of forwarding reviews to a physical therapist, when appropriate.
such as those for power wheelchairs.

3. Provide a detailed description of the process to ensure initial requests and reconsiderations are reviewed within 30 calendar days of the addition of the PA into the fiscal agent’s system.

4. Provide a plan to submit questions and make recommendations to Medicaid about existing PA policies, or to recommend a new policy, based on peer-reviewed literature.

5. Provide a plan to address the Form 471. This form is submitted by providers to request a simple update to a PA in evaluation or approved status, such as an extension to the authorized end date, or the addition of modifiers.

6. Provide a detailed plan with timelines for receiving, reviewing, and responding to PA requests.

7. Provide a detailed plan on proposed staffing.

8. Provide understanding of any updates mandated by CMS to the prior authorization process as a result of pending proposed federal rules.

III. General Requirements

A. Informal Review and Fair Hearing

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

a. Informal Review

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

b. Fair Hearing

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

B. Additional Vendor Responsibilities

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

a. During the Contract period, the Vendor will schedule weekly conference calls/virtual meetings with Medicaid. These meetings will address items such as project status, policy questions, and/or data analysis.

b. The selected Vendor will be responsible for creating meeting documents (e.g. agenda, reports, and other supporting documents) for Medicaid approval for all applicable meetings (weekly, association, ad hoc, etc).

c. The selected Vendor will make presentations to groups/associations or others regarding this contract and work here under only with request and prior approval of Medicaid.

d. Proactively make recommendations to Medicaid for provider education and outreach as it relates to information and data obtained from requesting providers.

e. Annually and other times as needed, make recommendations for changes to existing criteria across all programs based on clinical data from approved peer review literature. Recommendations shall also include the addition of new procedures, services or equipment for approval to increase efficiency, program effectiveness, patient/provider feedback, national and state standards and policy, and appropriate utilization as it relates to this RFP.

f. Respond to inquiries from Medicaid within two business days with a goal of one business day.

g. Within 45 days of contract start, Vendor shall complete all prospective, concurrent and retrospective reviews and prior approval requests of medical equipment, procedures, and inpatient psychiatric services not completed by previous vendor, and shall provide support for any pending fair hearings as directed by Medicaid.

h. Transition Period (July 1, 2021 – November 1, 2021)
1. The Contractor will appoint an individual to work with the Incumbent Vendor and Medicaid to ensure the integrity of the proposed solution is maintained and is viable through the switchover period. The Contractor’s build up will include, but are not limited to:
   i. Coding and testing for claims and prior authorization/override processing
   ii. Coordination of nursing facility/hospice reviews
   iii. Technical coordination with the fiscal agent
iv. Other coordination as outlined in this RFP

2. The Contractor will provide reports as required reflecting progress being made to initiate delivery of all services, effective November 1, 2021. The incoming Contractor will not be compensated for any preparation activity conducted in advance of the operations switchover to the new service which will occur effective November 1, 2021.

C. Staffing/Organizational Plan

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

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

I. Key Personnel

Contractor must maintain sufficient staffing levels to meet program requirements. At a minimum, Contractor's key personnel must include the following positions:

a. Project Manager (PM)

Contractor shall propose a PM with a minimum of an undergraduate degree who shall have day-today responsibility for supervising the performance and obligations under this Contract, as well as receive policy direction from the Medicaid Contract Administrator. The PM must be located within Alabama. The PM shall be the person assigned under this contract who is responsible for operation of contract duties including the PA review process, help desk functions, Hospice responsibilities, Institutional responsibilities, all other review/audit responsibilities, and correspondence. In the event the PM does not meet the requirements of Medicaid before or after implementation, Contractor shall recommend a candidate to Medicaid who is capable of performing contract obligations. Contractor shall not change its PM without prior written approval from Medicaid, and such approval shall not be unreasonably delayed or withheld. Contractor shall use the PM for not less than 12 months to ensure successful contract performance. Contractor shall notify Medicaid in writing of any proposed change in Project Manager at least 30
days prior to change. Contractor shall furnish with its bid response to the RFP a resume/curriculum vitae (CV) for the proposed PM which shall include the individual’s name, current address, current title and position, experience with Contractor, experience in implementation or performing PA functions, LTC experience, and Hospice experience, experience with provider relations, experience with reporting, educational background, and supervisory experience. Contractor shall provide a minimum of two work references for the PM.

Contractor’s PM shall serve as liaison between Medicaid and Contractor and shall be available and responsible for consultation and assistance with issues arising out of the scope of the Contract. PM shall attend, upon request, Medicaid meetings, fair hearings, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers. PM shall provide timely and informed responses when operational and administrative issues arise in relations to obligations under this contract. Whenever the PM is not available, Contractor shall provide a designated alternate fully capable of meeting the requirements of this RFP.

Additional responsibilities of the PM include but are not limited to:

1. Assure timely compliance with all contract responsibilities and deliverables.
2. Attend weekly and monthly contract status meetings and other meetings upon Medicaid request.
3. Notify Medicaid’s Contract Administrator of any proposed changes in personnel; organizational changes; any system problems; within time period specified within this RFP.
4. Attend quarterly provider associational meeting(s) to provide a quarterly update and answer questions from the provider community.

**b. Registered Nurses/CRNP**

Contractor shall propose at minimum 8 FTE Registered Nurse(s) (or CRNPs) to work with the Hospice, Institutional, and PA programs who shall have day-today responsibilities of review obligations under this Contract, as well as receive policy direction from the PM. The RNs/CRNPs must be located and licensed within Alabama and must be in good standing with the Alabama Board of Nursing and Board of Medical Examiners (if applicable). The Nurses must be available for work on the contract within business hours of minimum 9am – 4pm and may not hold a concurrent working relationship with a Medicaid-enrolled provider while working on the Contract. Contractor shall strive to use RNs/CRNPs for not less than 12 months to ensure successful contract performance. Contractor shall submit a request with CV any/all RNs/CRNPs at least 30 days prior to hire. Contractor shall furnish within 30 days of award of the RFP a resume/curriculum vitae (CV) for each proposed RN/CRNP which shall include the individual’s name, current address, license, current title and position, experience with Contractor, experience in implementation or performing PA functions, LTC/Institutional experience, and Hospice experience, experience with provider relations, experience with reporting, educational background. Contractor shall provide a minimum of two work references for each Nurse.
Nurses shall attend, upon request, Medicaid meetings, fair hearings, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers. Nurses are not routinely called for these meetings.

c. Physical Therapists
Contractor shall propose at minimum 4 Part Time Physical Therapists (PTs) with a vast knowledge base of Medicare and Medicaid wheelchair policy to work with the PA program. The PTs shall have day-today responsibilities of review obligations under this Contract, as well as receive policy direction from the PM. The PTs must be located and licensed within Alabama and must be in good standing with the Alabama Board of Physical Therapy and Board of Medical Examiners (if applicable). The PTs must be available for work on the contract within business hours of minimum 9am – 4pm and may not hold a concurrent working relationship with a Medicaid-enrolled provider while working on the Contract. Contractor shall strive to use PTs for not less than 12 months to ensure successful contract performance. Contractor shall submit a request with CV any/all PTs at least 30 days prior to hire. Contractor shall furnish within 30 days of award of the RFP a resume/curriculum vitae (CV) for each proposed PT which shall include the individual’s name, current address, license, current title and position, experience with Contractor, experience in implementation or performing PA functions, wheelchair experience, experience with provider relations, experience with reporting, and educational background. Contractor shall provide a minimum of two work references for the PT.

PT(s) shall attend, upon request, Medicaid meetings, fair hearings, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers. PT(s) are not routinely called for these meetings.

d. Consulting Physician(s)
Contractor shall furnish with its response to the RFP a Consulting Physician. The Consulting Physician shall be FACP certified and licensed to practice medicine in Alabama. A resume for the proposed Consulting Physician(s) shall include the individual’s name, current address, current title and position, experience with Contractor, experience as it relates to the duties described in this RFP, and relevant education and training. A minimum of three work references shall also be included. Consulting Physician(s) shall be available to meet all requirements under this contract. The Consulting Physician duties do not constitute an FTE. Contractor shall use Consulting Physician(s) for not less than 12 months to ensure successful contract performance and consistency. Contractor shall notify Medicaid in writing of any proposed change in Consulting Physician(s) at least 30 calendar days prior to the change, if possible.

Responsibilities of the consulting physician shall include, but are not limited to:

1. Work with PM to conduct clinical research and development to ensure Agency criteria is up to date.
2. Provide recommendations on additional areas of program improvement such as criteria, reviews, and all aspects of the RFP.
3. Review prior authorization and override appeal requests and make a decision for approval or denial based on Medicaid approved criteria and supporting evidenced-based medicine documentation. All reviews must follow the pre-determined timeline.
4. Provide clinical support to PTs, Nurses, and PM when needed.
5. Meet with Medicaid staff and/or provider groups (with Medicaid in attendance) upon request.
6. Attend, participate, and represent Medicaid at fair hearings.

e. **Provider/Recipient Liaison**

Contractor shall provide a Provider/Recipient Liaison. Upon award of the contract, a resume shall be submitted to Medicaid including the individual’s name, current address, current title and position, experience with Contractor, experience as it relates to the duties described in this RFP, and relevant education and training. A minimum of three work references shall also be included. The Provider/Recipient Liaison shall be a nurse (LPN minimum), social worker, or administrative staff with excellent communication and organization skills. The Provider/Recipient Liaison must be located within the state of Alabama, licensed within the State of Alabama if applicable, and must be in good standing with his/her respective professional Board, if applicable.

The Provider/Recipient Liaison shall demonstrate the utmost professionalism, patience, and respect while conducting duties listed in this section. Contractor shall use the Provider/Recipient Liaison for not less than 12 months to ensure successful contract performance. Contractor shall notify Medicaid in writing of any proposed change in Provider/Recipient Liaison at least 30 calendar days prior to the change, if possible.

The Provider/Recipient Liaison will accept calls from recipients with questions regarding PA and appeal requests, approvals, and denials, as well as coverage and PA policy questions. The Provider/Recipient Liaison will also take calls from various provider offices (to include, but not limited to, LTC/Institutional facilities, physician offices, DME providers, etc) to coordinate various aspects of the contract, and any other administrative duties related to the contract responsibilities requested by Medicaid. The Provider/Recipient Liaison shall be given his/her own extension of the toll-free help desk number, will have access to the Medicaid internal system to be able to see recipient status, and will also take calls referred from Medicaid and the fiscal agent help desk. The Provider/Recipient Liaison may be a Nurse Reviewer and review requests/data entry while not taking calls, but recipient/provider assistance shall be his/her first priority. Base hours the Provider/Recipient Liaison shall be available are 8:00am – 5:00pm Central Time Monday – Friday.

**Responsibilities of the Provider/Recipient Liaison shall include, but are not limited to:**

1. Assist recipients with PA issues, contact providers to provide forms and PA policy, and coordinate with providers to ensure recipients receive items and services covered by Medicaid.
2. Assist providers (to include, but not limited to, LTC/Institutional facilities, physician offices, DME providers, etc) to coordinate various aspects of the contract, and any other
administrative duties related to the contract responsibilities requested by Medicaid. For example, the liaison shall take calls from LTC facilities to assist with ‘locked’ files.

3. Return messages left by providers and/or recipients within two hours.

4. Provide support to Project Manager when needed.

5. Access internal systems to assist recipients and providers with general questions on eligibility, coverage of products, and PA policy.

6. Meet with Medicaid staff, providers, and associations upon request.

f. QIDP

Contractor shall propose at minimum 1 Part-time or PRN Qualified Intellectual Disabilities Professional (QIDP). The QIDP must have at least two years of experience working directly with people with Intellectual disabilities and meet the minimum federal educational requirements for a QIDP as outlined in Chapter 42 of the Code of Federal Regulations Section 483.430. The QIDP must be located within Alabama and provide documentation of both education and experience. Contractor shall strive to use QIDP’s for not less than 24 months to ensure successful contract performance.

Contractor shall submit a request with a curriculum vitae (CV) any/all QIDP’s at least 30 days prior to hire. Contractor shall furnish within 30 days of award of the RFP a resume/CV for each proposed QIDP which shall include the individual’s name, current address, license, current title and position, experience with Contractor, experience in implementation or performing ICF/IID Reviews. Contractor shall provide a minimum of two work references for each QIDP.

QIDP’s shall attend, upon request, Medicaid meetings, fair hearings, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers. QIDP’s are not routinely called for these meetings.

D. Monitoring Performance Standards and Corrective Action Plans

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

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

a. Brief description of the findings.

b. Specific steps the selected Vendor will take to correct the situation or reasons why the selected Vendor believes corrective action is not necessary.

c. Name(s) and title(s) of responsible staff person(s).

d. Timetable for performance of each corrective action step.

e. Signature of the Project Manager.

The Vendor must implement the corrective action plan within 10 business days or the timeframe specified by Medicaid. Failure by the selected Vendor to implement corrective action plans, as required by Medicaid, will result in the assessment of liquidated damages.
Self-Audits
Vendor must conduct self-audits of the work described in this RFP on a quarterly basis, and submit findings to Medicaid no later than the 20th calendar day of the month after quarter end. Self-audits must include a random sampling of institutional reviews, hospice reviews, psych reviews, and each type of PA (ie DME PA, rehab, TMJ, max unit, miscellaneous, NIPT, ICC, etc) review. Medicaid shall approve the number of self-audit reviews; it is anticipated at the time of writing this RFP that the Vendor will self-audit from 10 to 25 records each quarter of each sample type (ie institutional, hospice, psych, DME PA, rehab, TMJ, max unit, miscellaneous, NIPT, etc) each quarter. Corrective Action Plans shall be submitted for negative findings.

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

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

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

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

- Failure to deliver requisite reports/services/deliverables as defined by the RFP by the date specified by Medicaid. - $100 per day per report or review.
- Failure to provide documentation as required by the RFP - $1000 per instance.
- Failure to comply with any other requirement of the RFP - $1000 per instance.
- Failure to submit an acceptable required corrective action plan - $1000 per instance.
- Failure to follow Medicaid criteria and/or directives in approval/denial of PA requests, institutional or hospice reviews - submission of corrective action plan for first instance, then $1,000 for the next instance. Each subsequent instance shall be increased by $ 1,000, not to exceed $ 5,000 per instance.
- Failure to maintain adequate staffing levels necessary to perform the requirements of the RFP - $1,000 per instance.
- Misrepresentation of falsification of information furnished to CMS, to the State, to an enrollee, potential enrollee or health care provider -$5,000 per instance.
- Unauthorized use of information shall be subject to the imposition of damages for cost associated with breach of contract in the amount of $10,000 per instance.
- Failure to safeguard confidential information of providers, recipients or the Medicaid program shall be subject to the imposition of $10,000 per instance for damages for cost associated with breach of contract and any penalties incurred by Medicaid for said infractions.

In addition,

- The selected Vendor shall be liable for any penalties or disallowance of Federal Financial Participation incurred by Medicaid due to the Vendor’s failure to comply with the terms of the contract. Total dollars may include state funds as well as federal funds.
• Imposition of damages for cost associated with breach of contract and/or liquidated damages may be in addition to other contract remedies and does not waive Medicaid’s right to terminate the contract.

• Vendor shall receive written notice from Medicaid upon a finding of failure to comply with contract requirements, which contains a description of the events that resulted in such a finding.

• Vendor shall be allowed to submit rebuttal information or testimony in opposition to such findings.

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

F. Operational Requirements

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

• Thanksgiving Day
• Christmas Day
• New Year’s Day
• Fourth of July
• Labor Day
• Memorial Day

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

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

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

CPU- 3.0GHz, P4, 800FSB
Cache- IMB 1.2 Cache
Connectivity- 10/100/1000 NIC
Microsoft Windows 10
Microsoft Edge for access to InterChange MMIS
The Vendor system responsibilities include:

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

Medicaid system responsibilities include:

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

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

G. Work Plan and Implementation Schedule

Within 30 business days of contract award, the selected Vendor must provide a work plan and implementation schedule to Medicaid electronic format for approval. Within 45 days of contract start, Vendor shall complete all prospective, concurrent and retrospective reviews and prior approval requests of medical equipment, procedures, and inpatient psychiatric services not completed by previous vendor, and shall provide support for any pending fair hearings as directed by Medicaid.

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

H. Medicaid Responsibilities

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

IV. Pricing

All proposals must state a firm and fixed price for the services described under this RFP, which shall include system upgrades and modifications required by Medicaid to comply with changes to regulations, state policies, and CMS directives. The Firm and Fixed Price for each year of the proposed contract and optional extensions must be separately stated in the Pricing Template in Appendix C and the RFP Cover Sheet on the first page of this document.

V. General Medicaid Information

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

Medicaid’s central office is located at 501 Dexter Avenue in Montgomery, Alabama. Central office personnel are responsible for data processing, program management, financial management, program integrity, general support services, professional services, and recipient eligibility services. For certain recipient categories, eligibility determination is made by Agency personnel located in eleven (11) district offices throughout the state and by one hundred forty (140) out-stationed workers in designated hospitals, health departments and clinics. Medicaid eligibility is also determined through established policies by the Alabama Department of Human Resources and the
Social Security Administration. The Alabama Medicaid Agency serves approximately 1,000,000 Alabama citizens each year 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
- 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.

VI. General

This document outlines the qualifications which must be met in order for an entity to serve as Vendor. It is imperative that potential Vendors describe, in detail, how they intend to approach the Scope of Work specified in Section 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.

VII. Corporate Background and References

Entities submitting proposals and all subcontractors must:

   a. Provide evidence that the Vendor possesses the qualifications required in this RFP.

   b. Provide a description of the Vendor’s organization, including:

      1. Date established.
      2. Ownership (public company, partnership, subsidiary, etc.). Include an organizational chart depicting the Vendor’s organization in relation to any parent, subsidiary or related organization.
      3. Number of employees and resources.
      4. Names and resumes of Senior Managers and Partners in regards to this contract.
      5. A list of all similar projects the Vendor has completed within the last three years.
      6. A detailed breakdown of proposed staffing for this project, including names and education background of all employees that will be assigned to this project.
      7. A list of all Medicaid agencies or other entities for which the Vendor currently performs similar work.
      8. Details demonstrating independence from any ACHN and/or MCO contracted with the State as defined in CFR438.354 (c).
      9. Vendor’s acknowledgment that the State will not reimburse the Vendor until: (a) the Project Director has approved the invoice; and (b) the Agency has received and approved all deliverables covered by the invoice.
     10. 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. All companies submitting proposals in response to this RFP must be qualified to transact business in the State of Alabama in accordance with to include, but not be limited to, Code of Alabama 1975, 10A-1-7.01 et seq., and shall have filed and possess a valid “Application for Registration” issued by the Secretary of State at the time of responding to this RFP. To obtain forms for the application, contact the Secretary of State, (334) 242-5324, www.sos.state.al.us.

   d. Within the last three years, describe the overall ability medical and quality utilization review including the technologies, special techniques, skills or abilities of the organization necessary to accomplish the project requirements, data processing and analysis capabilities.

   e. Furnish three (3) references for projects of similar size and scope, including contact name, title, telephone number, and address. Performance references should also include contract
type, size, and duration of services rendered. **You may not use any Alabama Medicaid Agency personnel as a reference.**

**VIII. Submission Requirements**

A. **Authority**

This RFP is issued under the authority of Section 41-16-72 of the Alabama Code and 45 CFR 75. 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 75, 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:

<table>
<thead>
<tr>
<th>Project Director:</th>
<th>Thomas Stedham</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Alabama Medicaid Agency</td>
</tr>
<tr>
<td></td>
<td>Lurleen B. Wallace Bldg.</td>
</tr>
<tr>
<td></td>
<td>501 Dexter Avenue</td>
</tr>
<tr>
<td></td>
<td>PO Box 5624</td>
</tr>
<tr>
<td></td>
<td>Montgomery, Alabama 36103-5624</td>
</tr>
<tr>
<td>E-Mail Address:</td>
<td><a href="mailto:MQRRFP@medicaid.alabama.gov">MQRRFP@medicaid.alabama.gov</a></td>
</tr>
</tbody>
</table>

C. **RFP Documentation**

All documents and updates to the RFP including, but not limited to, the actual RFP, questions and answers, addenda, etc., will be posted to the Agency’s website at www.medicaid.alabama.gov.

D. **Questions Regarding the RFP**

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

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. Any addition or exception to the terms and conditions are considered severed, null and void, and may result in the Vendor’s bid being deemed non-responsive.

F. Adherence to Specifications and Requirements

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

G. Order of Precedence

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

H. Vendor’s Signature

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

I. Offer in Effect for 90 Days

A proposal may not be modified, withdrawn or canceled by the Vendor for a 90-day period following the deadline for proposal submission as defined in the Schedule of Events, or receipt of best and final offer, if required, and Vendor so agrees in submitting the proposal.

J. State Not Responsible for Preparation Costs

The costs for developing and delivering responses to this RFP and any subsequent presentations of the proposal as requested by the State are entirely the responsibility of the Vendor. The State is not liable for any expense incurred by the Vendor in the preparation and presentation of their proposal or any other costs incurred by the Vendor prior to execution of a contract.

K. State’s Rights Reserved

While the State has every intention to award a contract as a result of this RFP, issuance of the RFP in no way constitutes a commitment by the State to award and execute a contract. Upon a
determination such actions would be in its best interest, the State, in its sole discretion, reserves the right to:

- Cancel or terminate this RFP;
- Reject any or all of the proposals submitted in response to this RFP;
- Change its decision with respect to the selection and to select another proposal;
- Waive any minor irregularity in an otherwise valid proposal which would not jeopardize the overall program and to award a contract on the basis of such a waiver (minor irregularities are those which will not have a significant adverse effect on overall project cost or performance);
- Negotiate with any Vendor whose proposal is within the competitive range with respect to technical plan and cost;
- Adopt to its use all, or any part, of a Vendor’s proposal and to use any idea or all ideas presented in a proposal;
- Amend the RFP (amendments to the RFP will be made by written addendum issued by the State and will be posted on the RFP website);
- Not award any contract.

L. Price

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

M. Submission of Proposals

Proposals must be sealed and labeled on the outside of the package to clearly indicate that they are in response to 2021-MQR-01. Proposals must be sent to the attention of the Project Director and received at the Agency as specified in the Schedule of Events. It is the responsibility of the Vendor to ensure receipt of the Proposal by the deadline specified in the Schedule of Events.

N. Copies Required

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

O. Late Proposals

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

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

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 $40,000.00. 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. Proposal Format

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

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 “Scope of Work.” Within this section, the Vendor would include their response, addressing each of the numbered sections in sequence, as they appear in the RFP. The response to each section must be preceded by the section text of the RFP followed by the Vendor’s response.

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

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

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

T. Proposal Amendment

The Agency will not accept any amendments, revisions, or alterations to proposals after the deadline for submitting proposals unless the Agency formally requested in writing.

U. Proposal Errors

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

V. Proposal Clarifications

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

W. Disclosure of Proposal Contents

Proposals and supporting documents are kept confidential until the evaluation process is complete, a Vendor has been selected, and the Contract has been fully executed. The Vendor should be aware that any information in a proposal may be subject to disclosure and/or reproduction under Alabama law. Designation as proprietary or confidential may not protect any materials included within the proposal from disclosure if required by law. The Vendor should mark or otherwise designate any material that it feels is proprietary or otherwise confidential by labeling the page as “CONFIDENTIAL”. The Vendor must also state any legal authority as to why that material should not be subject to public disclosure under Alabama open records law and is marked as Proprietary Information. By way of illustration but not limitation, “Proprietary Information" may include trade secrets, inventions, mask works, ideas, processes, formulas, source and object codes, data, programs, other works of authorship, know-how, improvements, discoveries, developments, designs and techniques.
Information contained in the Pricing Section may not be marked confidential. It is the sole responsibility of the Vendor to indicate information that is to remain confidential. The Agency assumes no liability for the disclosure of information not identified by the Vendor as confidential. If the Vendor identifies its entire proposal as confidential, Medicaid may deem the proposal as non-compliant and may reject it.

IX. 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-responsive, a written determination will be made a part of the procurement file and mailed to the affected Vendor.

C. Opportunity for Additional Information

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

D. Evaluation Committee

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

E. Scoring

The Evaluation Committee will score the proposals using the scoring system shown in the table below. The highest score that can be awarded to any proposal is 100 points.
<table>
<thead>
<tr>
<th>Evaluation Factor</th>
<th>Highest Possible Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Background and Experience</td>
<td>10</td>
</tr>
<tr>
<td>Scope of Work</td>
<td>45</td>
</tr>
<tr>
<td>References</td>
<td>5</td>
</tr>
<tr>
<td>Price</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

**F. Determination of Successful Proposal**

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

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

**X. General Terms and Conditions**

**A. General**

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

The contract shall include the following:

1. Executed contract,
2. RFP, attachments, and any amendments thereto,
3. Vendor’s response to the RFP, and shall be construed in accordance with and in the order of the applicable provisions of:
   - Title XIX of the Social Security Act, as amended and regulations promulgated hereunder by HHS and any other applicable federal statutes and regulations
   - The statutory and case law of the State of Alabama
   - The Alabama State Plan for Medical Assistance under Title XIX of the Social Security Act, as amended
   - The Medicaid Administrative Code
   - Medicaid’s written response to prospective Vendor questions

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

C. Term of Contract

The initial contract term shall be for one year effective October 1, 2021, through September 30, 2022. Alabama Medicaid shall have four, one-year options for extending this contract if approved by the Legislative Contract Review Oversight Committee. At the end of the contract period Alabama Medicaid may at its discretion, exercise the extension option and allow the period of performance to be extended at the rate indicated on the RFP Cover Sheet. The Vendor will provide pricing for each year of the contract, including any extensions.

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

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

Vendor shall ensure safeguards that restrict the use or disclosure of information concerning individuals to purposes directly connected with the administration of the Plan in accordance with 42 CFR Part 431, Subpart F, as specified in 42 CFR § 434.6(a)(8). Purposes directly related to the Plan administration include:
1. Establishing eligibility;
2. Determining the amount of medical assistance;
3. Providing services for 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 Vendor shall sign and comply with the terms of a Business Associate agreement with the Agency (Appendix B).

F. Security and Release of Information

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

G. Federal Nondisclosure Requirements

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

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

H. Contract a Public Record

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

I. Termination for Bankruptcy

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

J. Termination for Default

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

K. Termination for Unavailability of Funds

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

L. Proration of Funds

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

M. Termination for Convenience

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

**N. Force Majeure**

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

**O. Nondiscriminatory Compliance**

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

**P. Conflict of Interest**

The parties acknowledge and agree that the Vendor must be free of conflicts of interest in accordance with all federal and state regulations while performing the duties within the contract and this amendment. The Vendor, as External Quality Reviewer for the State of Alabama and Medicaid agree that each has no conflict of interest preventing the execution of this Contract amendment or the requirements of the original contract, and said parties will abide by applicable state and federal regulations, specifically those requirements found in the Office of Federal Procurement Policy Act. 42 U.S.C.A. 2101 through 2107.

**Q. Open Trade**

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

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

In accordance with the provisions of 45 CFR Part 75.330 and OMB Circular A-102, affirmative steps shall be taken to assure that small and minority businesses are utilized when possible as sources of supplies, equipment, construction, and services.

**S. Worker’s Compensation**

Vendor shall take out and maintain, during the life of this contract, Worker’s Compensation Insurance for all of its employees under the contract or any subcontract thereof, if required by state law.
T. Employment of State Staff

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

U. Immigration Compliance

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

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

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

V. Share of Contract

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

W. Waivers

No covenant, condition, duty, obligation, or undertaking contained in or made a part of the contract shall be waived except by written agreement of the parties.
X. Warranties Against Broker’s Fees

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

Y. Novation

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

Z. Employment Basis

All services rendered by Vendor and/or subcontractor shall be as an independent Vendor and not as an employee (merit or otherwise) of the State of Alabama, and Vendor shall not be entitled to or receive Merit System benefits.

AA. Disputes and Litigation

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

In the event of any dispute between the parties, senior officials of both parties shall meet and engage in a good faith attempt to resolve the dispute. Should that effort fail and the dispute involves the payment of money, a party’s sole remedy is the filing of a claim with the Board of Adjustment of the State of Alabama.

For any and all other disputes arising under the terms of this contract which are not resolved by negotiation, the parties agree to utilize appropriate forms of non-binding alternative dispute resolution including, but not limited to, mediation. Such dispute resolution shall occur in Montgomery, Alabama, utilizing where appropriate, mediators selected from the roster of mediators maintained by the Center for Dispute Resolution of the Alabama State Bar.

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

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

CC. Inspection of Records

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

DD. Use of Federal Cost Principles

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

EE. Payment

Vendor shall submit to Medicaid 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.

FF. Notice to Parties

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

GG. Disclosure Statement

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

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

II. Not to Constitute a Debt of the State

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

JJ. Qualification to do Business in Alabama

Should a foreign corporation (a business corporation incorporated under a law other than the law of this state) be selected to provide professional services in accordance with this RFP, it must be qualified to transact business in the State of Alabama and possess a valid “Application of Registration” issued by the Secretary of State at the time a professional services contract is executed. To obtain forms for an “Application for Registration”, contact the Secretary of State at (334) 242-5324 or [www.sos.state.al.us](http://www.sos.state.al.us). The “Application for Registration” showing application has been made must be submitted with the proposal.

KK. Choice of Law

The construction, interpretation, and enforcement of this contract shall be governed by the substantive contract law of the State of Alabama without regard to its conflict of laws provisions. In the event any provision of this contract is unenforceable as a matter of law, the remaining provisions will remain in full force and effect.

LL. Alabama interChange Interface Standards

Vendor hereby certifies that any exchange of MMIS data with the Agency’s fiscal agent will be accomplished by following the Alabama interChange Interface Standards Document, which will be posted on the Medicaid website.
Appendix A: Proposal Compliance Checklist

NOTICE TO VENDOR:

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

Vendor Name

Project Director                     Review Date

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

<table>
<thead>
<tr>
<th>IF CORRECT</th>
<th>BASIC PROPOSAL REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Vendor’s original proposal received on time at correct location.</td>
</tr>
<tr>
<td></td>
<td>2. Vendor submitted the specified copies of proposal and in electronic format.</td>
</tr>
<tr>
<td></td>
<td>3. The Proposal includes a completed and signed RFP Cover Sheet.</td>
</tr>
<tr>
<td></td>
<td>4. The Proposal is a complete and independent document, with no references to external documents or resources.</td>
</tr>
<tr>
<td></td>
<td>5. Vendor submitted signed acknowledgement of any and all addenda to RFP.</td>
</tr>
<tr>
<td></td>
<td>6. The Proposal includes written confirmation that the Vendor understands and shall comply with all of the provisions of the RFP.</td>
</tr>
<tr>
<td></td>
<td>7. The Proposal includes required client references (with all identifying information in specified format and order).</td>
</tr>
<tr>
<td></td>
<td>8. The Proposal includes a corporate background.</td>
</tr>
<tr>
<td></td>
<td>9. The Proposal includes a detailed description of the plan to design, implement, monitor, and address special situations related to a new Medical and Quality Review program as outlined in the request for proposal regarding each element listed in the scope of work.</td>
</tr>
<tr>
<td></td>
<td>10. Vendor must submit a statement that the Vendor has an understanding of and will comply with the terms and conditions as set out in the RFP. Additions or exceptions to the standard terms and conditions are not allowed. Any addition or exception to the terms and conditions are considered severed, null and void, and may result in the Vendor’s bid being deemed non-responsive.</td>
</tr>
<tr>
<td></td>
<td>11. The response includes (if applicable) an Application of Registration or showing application has been made with the Secretary of State.</td>
</tr>
<tr>
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<tr>
<td></td>
<td>12. The response must include an E-Verify Memorandum of Understanding with the Department of Homeland Security.</td>
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</tbody>
</table>
Appendix B: Contract and Attachments

The following are the documents that must be signed AFTER contract award and prior to the meeting of the Legislative Contract Oversight Committee Meeting. The current copy of these documents can be found on the Q drive in the LEGAL/Contract Forms folder.

Sample Contract
Attachment A: Business Associate Addendum
Attachment B: Contract Review Report for Submission to Oversight Committee
Attachment C: Immigration Status
Attachment D: Disclosure Statement
Attachment E: Letter Regarding Reporting to Ethics Commission
Attachment F: Instructions for Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion
Attachment G: Beason-Hammon Certificate of Compliance
Attachment H: Number of Currently Enrolled Providers
Attachment I: Prior Authorizations Policy Table of Contents
Attachment J: Rehab Program Documents
Attachment K: VPN Agreement
Attachment L: NIPT
Attachment M: LTC Policies
Attachment N: TMJ
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.

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: _________________________________
Attachment B

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

**CONTRACT REVIEW REPORT**
(Separate review report required for each contract)

Name of State Agency: Alabama Medicaid Agency

Name of Contractor:

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

Is Contractor a Sole Source? YES____ NO____
Is Contractor organized as an Alabama Entity in Alabama? YES____ NO____
Is Contractor a minority and/or woman-owned business? YES____ NO____
If so, is Contractor certified as such by the State of Alabama? YES____ NO____
Check all that apply: ALDOT _______ ADECA_________ OTHER (Name)______________________
Is Contractor Registered with Alabama Secretary of State to do Business as a Corporation in Alabama? YES____ NO____
IF LLC, GIVE NAMES OF MEMBERS: ______________________________________________________________________

Is Act 2001-955 Disclosure Form Included with this Contract? YES____ X_____ NO____
Does Contractor have current member of Legislature or family member of Legislator employed? YES____ NO____
Was a Lobbyist/Consultant used to secure this contract OR affiliated with this Contractor? YES______ NO____
IF YES, GIVE NAME: ________________________________________________________________________________

Contract Number: C_________ (See Fiscal Policies & Procedures Manual, Page 5-8)

Contract/Amendment Amount: $______ (PUT AMOUNT YOU ARE ASKING FOR TODAY ONLY)

% State Funds: ________ % Federal Funds: ________ % Other Funds: ________ **

**Please Specify Source of Other Funds (Fees, Grants, etc.) __________________________________________________________________________

Date Contract Effective: ____________ Date Contract Ends: ____________

Type of Contract: NEW: ____________ RENEWAL: ____________ AMENDMENT: ____________

If Renewal, was it originally Bid? YES___ NO____

If AMENDMENT, Complete A through C:
(A) ORIGINAL contract amount $__________
(B) Amended total prior to this amendment $__________
(C) Amended total after this amendment $__________

Was Contract secured through Bid Process? YES____ NO____ Was lowest Bid accepted? YES____ NO____
Was Contract secured through RFP Process? YES____ NO____ Date RFP was awarded: ____________

Posted to Statewide RFP Database at http://rfp.alabama.gov/Login.aspx? YES_____ NO____

If NO, give a brief explanation as to why not: __________________________________________________________________________

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 of Agency Head  Printed Name of Contractor
IMMIGRATION STATUS

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

_______________________________________
Signature of Contractor

_______________________________________
Witness
State of Alabama Disclosure Statement
Required by Article 3B of Title 41, Code of Alabama 1975

ENTITY COMPLETING FORM

ADDRESS

CITY, STATE, ZIP

TELEPHONE NUMBER

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

Alabama Medicaid Agency

ADDRESS
501 Dexter Avenue, Post Office Box 5624

CITY, STATE, ZIP
Montgomery, Alabama 36103-5624

TELEPHONE NUMBER
(334) 242-5833

This form is provided with:

☐ Contract ☐ Proposal ☐ Request for Proposal ☐ Invitation to Bid ☐ Grant Proposal

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

☐ Yes ☐ No

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

<table>
<thead>
<tr>
<th>STATE AGENCY/DEPARTMENT</th>
<th>TYPE OF GOODS/SERVICES</th>
<th>AMOUNT RECEIVED</th>
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<tr>
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<td></td>
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</table>

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.

<table>
<thead>
<tr>
<th>STATE AGENCY/DEPARTMENT</th>
<th>DATE GRANT AWARDED</th>
<th>AMOUNT OF GRANT</th>
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</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th>NAME OF PUBLIC OFFICIAL/EMPLOYEE</th>
<th>ADDRESS</th>
<th>STATE DEPARTMENT/AGENCY</th>
</tr>
</thead>
</table>
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.)

<table>
<thead>
<tr>
<th>NAME OF FAMILY MEMBER</th>
<th>ADDRESS</th>
<th>NAME OF PUBLIC OFFICIAL/PUBLIC EMPLOYEE</th>
<th>STATE DEPARTMENT/AGENCY WHERE EMPLOYED</th>
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</thead>
<tbody>
<tr>
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If you identified individuals in items one and/or two above, describe in detail below the direct financial benefit to be gained by the public officials, public employees, and/or their family members as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Describe in detail below any indirect financial benefits to be gained by any public official, public employee, and/or family members of the public official or public employee as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

_________________________________________________________________________

_________________________________________________________________________

List below the name(s) and address(es) of all paid consultants and/or lobbyists utilized to obtain the contract, proposal, request for proposal, invitation to bid, or grant proposal:

<table>
<thead>
<tr>
<th>NAME OF PAID CONSULTANT/LOBBYIST</th>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

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

Signature

Date

Notary’s Signature

Date

Date Notary Expires

Article 3B of Title 41, Code of Alabama 1975 requires the disclosure statement to be completed and filed with all proposals, bids, contracts, or grant proposals to the State of Alabama in excess of $5,000.
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

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

DATE:____________

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

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

1. The undersigned holds the position of _________________________ with the Contractor/Grantee named above, and is authorized to provide representations set out in this Certificate as the official and binding act of that entity, and has knowledge of the provisions of THE BEASON-HAMMON ALABAMA TAXPAYER AND CITIZEN PROTECTION ACT (ACT 2011-535 of the Alabama Legislature, as amended by Act 2012-491) which is described herein as “the Act”.

2. Using the following definitions from Section 3 of the Act, select and initial either (a) or (b), below, to describe the Contractor/Grantee’s business structure.
   BUSINESS ENTITY. Any person or group of persons employing one or more persons performing or engaging in any activity, enterprise, profession, or occupation for gain, benefit, advantage, or livelihood, whether for profit or not for profit. "Business entity" shall include, but not be limited to the following:
   a. Self-employed individuals, business entities filing articles of incorporation, partnerships, limited partnerships, limited liability companies, foreign corporations, foreign limited partnerships, foreign limited liability companies authorized to transact business in this state, business trusts, and any business entity that registers with the Secretary of State.
   b. Any business entity that possesses a business license, permit, certificate, approval, registration, charter, or similar form of authorization issued by the state, any business entity that is exempt by law from obtaining such a business license, and any business entity that is operating unlawfully without a business license.
   EMPLOYER. Any person, firm, corporation, partnership, joint stock association, agent, manager, representative, foreman, or other person having control or custody of any employment, place of employment, or of any employee, including any person or entity employing any person for hire within the State of Alabama, including a public employer. This term shall not include the occupant of a household contracting with another person to perform casual domestic labor within the household.

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

3. As of the date of this Certificate, Contractor/Grantee does not knowingly employ an unauthorized alien within the State of Alabama and hereafter it will not knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama;

4. Contractor/Grantee is enrolled in E-Verify unless it is not eligible to enroll because of the rules of that program or other factors beyond its control.

Certified this _____ day of ______________ 20____.

Name of Contractor/Grantee/Recipient

By: __________________________________________

Its __________________________________________

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

WITNESS: __________________________________

__________________________________________

Print Name of Witness
## Active, Enrolled Medicaid Providers, as of January 2021

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<td>Hospice:</td>
<td>160</td>
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<td>PEC/Swing Bed:</td>
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<td>Impatient Psychiatric Hospitals:</td>
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<tr>
<td>(includes the four facilities that participated in MEPD)</td>
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Prior Authorizations Policy Table of Contents for the policies for which the Vendor is responsible to review at the time of this RFP. This list is not an all inclusive list as additional policies may be added at the award of this contract.

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Policies will be made available at award of contract.

Positioning Vest and Support Collars (Hensinger) – E1399
CPT, 77525, 67950, 67912, 61782
L5331, L5856, L5858, L5859, L5969, L6882, L6925, L7368
Request for Additional Units

Rendering State Agency NPI: ________________________________

Recipient Name: ___________________________ DOB: ___________ Admission date: _________________

Recipient Medicaid ID: ____________________________

Physician: ________________________________

Additional number of units requested: _______________

Reason(s) for request for additional units (check all that apply):

□ Active intervention by at least one member of the interdisciplinary treatment team for an unresolved program on the patient’s treatment plan

□ Medication changes, administration of PRN medications, medications in liquid form (for suspected noncompliance)

□ Episodes of inappropriate behavior requiring intervention

□ Noncompliance with treatment regimen

□ Suicidal ideation, threat, gesture or attempt

Additional information to support request: ________________________________

__________________________________________________________

Current medications: ________________________________________

__________________________________________________________

Participation in groups and other therapies: ______________________

__________________________________________________________

Most recent MD note: ____________________________

__________________________________________________________

Progress made: __________________________________________

__________________________________________________________

Physician signature: __________________________ Date: ________________

Reviewer’s name: __________________________________ Date of review: ________________

PLEASE DO NOT WRITE BELOW THIS LINE
<table>
<thead>
<tr>
<th>Medicaid ID</th>
<th>Provider</th>
<th>State Agency</th>
<th>Recipient Medicaid ID #</th>
<th>Recipient Name</th>
<th>Procedure Code Requested</th>
<th>Approved? Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
Prior Approval – Behavioral Health

Karen Watkins-Smith, R.N., B.S.N., ETN
Associate Director
Clinic Services and Mental Health Programs
September 6, 2017
Topics for Today

- Prior Authorization Requirements
- What forms are to be used?
- What documentation is needed at the time of the request?
- What is the process for requesting a PA?
PA Request Requirements

- When must a PA be requested?
- Who must request it?
- Timeframe for requesting a PA?
PA Request Forms and Documentation

• One form
  – Posted together on the website under Forms Library > Prior Authorization Forms
  – 9.4.14_PA_Form_BH_Rehab_Combined_9-1-17

• Documentation
  – Clinical notes / Statement
  – Treatment Plan / Rationale
  – Copy of Prescription, if a medication change
  – Other supporting documents
The PA Process in Three Basic Steps

Step 1
- Request and obtain a PA Request Number via the online Provider Portal

Step 2
- Prepare all forms and documentation for upload to Provider Portal

Step 3
- Obtain a bar code sheet by entering the PA Request Number and all supporting forms and documentation into the Provider Portal
Prior Authorization – Behavioral Health

OBTAINING A PA REQUEST NUMBER
Obtaining a PA Request Number
Obtaining a PA Request Number

The Alabama Medicaid Interactive secure site is intended for providers, clerks and billing agents.

For first time users who have received a Personal Identification Number (PIN) letter, click the Setup Account button. First time users who have not received a PIN letter must contact the EMC Helpdesk for support. Refer to the Contact Us page, from the Information menu, for contact information.

User Name*
Password*

If you have forgotten your password, please click the Reset Password button.
Obtaining a PA Request Number

➢ Locate Prior Authorization in the drop-down menu
➢ Select New
Obtaining a PA Request Number

- Enter the Recipient ID, PA Assignment and Servicing Provider Number, then Click NEXT
Obtaining a PA Request Number

Basic steps

➢ Click on the A on the top right of the page.
➢ Select Procedure Code from the Service Type Code drop down
➢ Enter a specific Procedure code in the Procedure box
➢ Any Modifiers will go in the Modifier box
Obtaining a PA Request Number

(continued)
Obtaining a PA Request Number

➢ Any comments are to be added in the Description box, then Click Next
Obtaining a PA Request Number

- No action is needed on this page.
- DO NOT add any attachment
- Click Save
Obtaining a PA Request Number

- If your request is successful, you will see a message generated at the top of the page.

- Save the PA number where it is easy to locate, you will need it for the next steps.
Secure Provider Portal

PREPARING DOCUMENTS FOR SUBMISSION
Preparing Documents for Submission

• Use the Correct Form
  – Combined Prior Authorization Form for Behavioral Health – Rehab + Request for Additional Units

Find the forms on the Agency website at:
www.medicaid.alabama.gov
Look at the drop down menu under Resources > Forms Library > Prior Authorization Forms
Step 3: Send/Save Bar Code Sheet

REHABILITATIVE SERVICES PA SUPPORTING DOCUMENTATION

Instructions:
Please complete all form fields below. Supporting documentation may be uploaded or faxed upon successful form submission.

Upon completing the form below, a fax coversheet will be generated.

It is imperative that you save a copy of this coversheet, should you be requested to submit additional documentation for this packet.

Reminders:
A listing of approved supporting documents for Rehabilitative Services PAs is provided in certain chapters of the Provider Manual, such as Chapter 105 (Rehabilitative Services).
The required file format for document upload is PDF. Documents submitted in any other format will be rejected.
Do not fax double-sided pages.
Fax supporting documents with the barcode coversheet as page 1 and supporting documents following to 334-215-7416.

➢ Submission is successful when:
  ➢ Message displays
  ➢ Bar coded sheet is generated automatically
Log in to the Medicaid Interactive Web portal by entering your username and password.
## Prior Authorization Companion Document for Additional Units

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Service Description</th>
<th>Billing Unit</th>
<th>Maximum Units Allowed</th>
<th>Number of Units Requested</th>
<th>Number of Units Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Intake Evaluation</td>
<td>Episode</td>
<td>Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H0004</td>
<td>Medical Assessment and Treatment</td>
<td>15 minutes</td>
<td>6 per day, 52 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H2011</td>
<td>Crisis Intervention</td>
<td>15 minutes</td>
<td>12 per day, 4380 per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90832</td>
<td>Individual Counseling</td>
<td>1 unit</td>
<td>1 per day, 52 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90834</td>
<td>Individual Counseling</td>
<td>1 unit</td>
<td>1 per day, 52 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90837</td>
<td>Individual Counseling</td>
<td>1 unit</td>
<td>1 per day, 52 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90846</td>
<td>Family Counseling (Mental Illness)</td>
<td>1 episode=minimum of 60 minutes</td>
<td>1 episode per day, 104 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90847</td>
<td>Family Counseling (Mental Illness)</td>
<td>1 episode=minimum of 60 minutes</td>
<td>1 episode per day, 104 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90849</td>
<td>Family Counseling (Mental Illness)</td>
<td>1 episode=minimum of 60 minutes</td>
<td>1 episode per day, 104 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90853</td>
<td>Group Counseling (Mental Illness)</td>
<td>1 episode=minimum of 60 minutes</td>
<td>1 episode per day, 104 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90853</td>
<td>Group Counseling (Substance Abuse)</td>
<td>1 episode=minimum of 90 minutes</td>
<td>1 episode per day, 104 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>96372</td>
<td>Medication Administration</td>
<td>Episode</td>
<td>1 per day, 365 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H00330</td>
<td>Medication Monitoring</td>
<td>15 minutes</td>
<td>2 per day, 52 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H0034</td>
<td>Partial Hospitalization Program</td>
<td>A minimum of 4 hours</td>
<td>1 per day, 130 days per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H0035</td>
<td>Adult Intensive Day Treatment</td>
<td>1 hour</td>
<td>4 per day, 1040 hours per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H2012</td>
<td>Adult Rehabilitative Day Program</td>
<td>15 minutes</td>
<td>16 per day, 4160 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Duration</td>
<td>Frequency</td>
<td></td>
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<tr>
<td>H2012</td>
<td>Child and Adolescent Mental Illness Day Treatment</td>
<td>1 hour</td>
<td>4 per day, 1040 hours per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H0032</td>
<td>Treatment Plan Review</td>
<td>15 minutes</td>
<td>1 event with up to 2 units per quarter, 8 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H0046</td>
<td>Mental Health Care Coordination</td>
<td>15 minutes</td>
<td>24 per day, 312 per year</td>
<td></td>
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</tr>
<tr>
<td>H2021</td>
<td>Adult In-home Intervention</td>
<td>15 minutes</td>
<td>24 per day, 2016 per year</td>
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<tr>
<td>H2022</td>
<td>Child and Adolescent In-Home Intervention</td>
<td>One day</td>
<td>140 per year</td>
<td></td>
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</tr>
<tr>
<td>H0031</td>
<td>Mental Health and Substance Use Disorders Update</td>
<td>15 minutes</td>
<td>8 per day, 56 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H0002</td>
<td>Behavioral Health Placement Assessment</td>
<td>30 minutes</td>
<td>4 per day, 16 per year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| H0036  | Basic Living Skills                                   | 15 minutes | 2080 per year
|        |                                                       |          | 20 per day (individual)            |
|        |                                                       |          | 8 per day (group)                  |
| H2027  | Psychoeducational Services                            | 15 minutes | 416 units per year
|        |                                                       |          | 8 per day for services provided to an individual recipient’s family
<p>|        |                                                       |          | 8 per day for services provided to a group of recipients’ families |
| H0040  | Assertive Community Treatment (ACT)                   | One day   | 365 days per year                  |
| H0046-HQ | Program for Assertive Community Treatment (PACT)   | One day   | 365 days per year                  |
| H0020  | Opioid Use Disorder Treatment                         | One day   | 365 days per year                  |
| H0013  | Outpatient Detoxification                             | One day   | 365 days per year                  |
| H0014  |                                                       |          |                                    |
| H0038  | Peer Support Services - Youth                         | 15 minutes | Limited to 20 units per day (individual) and 8 units per day (group). 2,080 units per year for group services and |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
<th>Time Unit</th>
<th>Units per Year or Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0038</td>
<td>Peer Support Services - Adult</td>
<td>15 minutes</td>
<td>Limited to 20 units per day (individual) and 8 units per day (group). 2,080 units per year for group services and 2,080 units per year for individual services</td>
</tr>
<tr>
<td>H0038</td>
<td>Peer Support Services – Youth Parent</td>
<td>15 minutes</td>
<td>Limited to 20 units per day (individual) and 8 units per day (group). 2,080 units per year for group services and 2,080 units per year for individual services</td>
</tr>
<tr>
<td>H2025</td>
<td>Psychosocial Rehabilitation Services – Working Environment</td>
<td>15 minutes</td>
<td>32 units per day, 320 units per month</td>
</tr>
<tr>
<td>H0049</td>
<td>Screening</td>
<td>Episode</td>
<td>2 units (episodes) per year</td>
</tr>
<tr>
<td>H0050</td>
<td>Brief Intervention</td>
<td>15 minutes</td>
<td>8 units (episodes) per year</td>
</tr>
<tr>
<td>T1001</td>
<td>Nursing Assessment and Care</td>
<td>15 minutes</td>
<td>2 units per day; 732 units per year</td>
</tr>
<tr>
<td>T1002</td>
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<tr>
<td>T1003</td>
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<tr>
<td>H2019</td>
<td>Therapeutic Mentoring</td>
<td>15 minutes</td>
<td>416 per year (416 units per year for individual and 416 units per year for group) 8 units (unit = 15 minutes) per day, individual 8 units (unit = 15 minutes) per day, group</td>
</tr>
</tbody>
</table>

***Diagnostic Testing Codes not included as they are non-applicable/shaded codes have no override ability***
ALABAMA MEDICAID AGENCY PRIOR REVIEW AND AUTHORIZATION REQUEST

Rehab Option
DMH MI ( ) DMH SA ( ) DYS ( )
Servicing State Agency NPI # _______________________

<table>
<thead>
<tr>
<th>Provider Information:</th>
<th>Recipient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Servicing Provider NPI:</td>
<td>Name:</td>
</tr>
<tr>
<td>Name of Provider:</td>
<td>Address:</td>
</tr>
<tr>
<td>Phone with Area Code:</td>
<td>City/State/Zip:</td>
</tr>
<tr>
<td>Fax with Area Code:</td>
<td>DOB:</td>
</tr>
<tr>
<td>Address:</td>
<td>Admission to Service Date MM/DD/CCYY:</td>
</tr>
<tr>
<td>City/State/Zip:</td>
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</tbody>
</table>

First Diagnosis: __________ Second Diagnosis: __________

- Intake Evaluation (always has modifier attached)
- Treatment Plan Review
- Pre-hospitalization Screening
- Crisis Intervention
- Physician/Medical Assessment/Treatment
- Group Counseling
- Medication Monitoring
- Individual Counseling
- Basic Living Skills
- Family Counseling
- Basic Living Skills
- Family Support/Psychoeducational Services
- Mental Health Care Coordination
- Adult Partial Hospitalization Program
- Diagnostic Testing
- Adult Intensive Day Treatment
- Adult Rehabilitative Day Program
- Child/Adolescent Mental Illness Day Treatment
- Adult In-Home intervention Model
- CPS – Adult
- C&A In-Home Intervention Model
- CPS- Youth
- Therapeutic Mentoring
- Nursing Assessment & Treatment
- CPS- Youth Parent
- Brief Intervention (SA only)
- Screener

Initial Request for Extended Units for listed Rehabilitative Services
Additional Request for Extended Units for listed Rehabilitative Services

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>SERVICE DESCRIPTION</th>
<th>MODIFIER (Check all that apply)</th>
<th>AMOUNT OF EXTENDED UNITS REQUESTED</th>
<th>PLACE OF SERVICE</th>
</tr>
</thead>
<tbody>
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<td>HE HF HQ HA HD HH</td>
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</table>

Clinical Statement: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes, as to the necessity, effectiveness and goals of therapy services and medical necessity to request of extended units for rehabilitative service(s). This is required for each of the Rehabilitative Services areas marked above. This documentation must be attached.

__________________________
Signature of Requesting Provider

Date ____________________
Virtual Private Network Subscriber Agreement

AGREEMENT BETWEEN

DXC TECHNOLOGY SERVICES AND

SUBSCRIBER

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

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

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

WHEREAS, DXC is the fiscal agent of the AMMIS system;

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

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

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

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

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

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

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

C. INDEMNIFICATION
The SUBSCRIBERS agrees to indemnify, defend, save and hold harmless DXC from all claims, demands, liabilities, and suits of any breach of this agreement by the SUBSCRIBERS, its Subscribers or employees, including but not limited to any occurrence of omission or negligence of the SUBSCRIBERS, its Subscribers or employees, and more specifically, without limitations:
1. Any claims or losses for services rendered by a subcontractor, consultant, person or firm performing or supplying services, materials or supplies in connection with the performance of the contract;
2. Any claims or losses to any person or firm injured or damaged by the erroneous or negligent acts, including disregard of Federal or State regulations or Federal statutes, of the SUBSCRIBERS, its Subscribers, consultants, officers and employees, or subcontractors in the performance of this agreement;
3. Any claims or losses resulting to any person or firm injured or damaged by the SUBSCRIBERS, its Subscribers, consultants, officers, employees, or subcontractors by the publications, translation, reproduction, delivery, performance, use or disposition of any data processed under the contract in any manner not authorized by the contract, or Federal or State regulations or statutes; and
4. Any failure of the SUBSCRIBERS, its officers, Subscribers, consultants, employees, or subcontractors to observe State or Federal laws, including but not limited to labor laws and minimum wage laws.

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

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

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

G. CONTACT PERSONS
DXC:
Lamar Smith
ITO Account Delivery Manager
301 Technacenter Drive
Montgomery, AL 36117
Phone: (334) 215-4201

SUBSCRIBER:
Contact: ____________________________
Mail: __________________________
Company: _________________________
Address: _________________________
City, State and Zip: ____________________
Phone: ____________

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.
Noninvasive prenatal testing that uses cell free fetal DNA from the plasma of pregnant women offers potential as a screening tool for fetal aneuploidy. Circulating cell free fetal DNA, which comprises approximately 5-20% of the total cell free maternal DNA, is thought to be derived primarily from the placenta. Cell free fetal DNA/Non-Invasive Prenatal Testing (NIPT) analysis technology is known as massively parallel genomic sequencing and has been reported to accurately detect trisomy 13, trisomy 18, and trisomy 21 as early as the 10th week of pregnancy.

Cell free fetal DNA/NIPT testing should be an informed patient choice after pretest counseling and should not be part of routine prenatal laboratory assessment. Cell free fetal DNA testing should not be offered to low-risk women or women with multiple gestations due to lack of sufficient evaluation in these
groups. A negative cell free fetal DNA test result does not ensure an unaffected pregnancy. A patient with a positive test result should be referred for genetic counseling and should be offered invasive prenatal diagnosis for confirmation of test results.

Policy:

Women with singleton gestations considered at increased risk for fetal aneuploidy in whom cell free fetal DNA may be used as a **primary screening option** must meet at least one of the criteria listed below:

- Maternal age 35 years or older at delivery; **OR**
- Fetal ultrasonographic findings indicating an increased risk of aneuploidy; **OR**
- History of a prior pregnancy with a trisomy; **OR**
- Parental balanced Robertsonian translocation with increased risk of fetal trisomy 13 or trisomy 21; **OR**
- Positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or a quadruple screen.

Noninvasive prenatal testing by cell free fetal DNA/NIPT is not a covered benefit for women who do not meet at least one of the listed criteria

Additional prior authorization supporting documentation must include the following:

- Evidence that pretest counseling included patient education inclusive of the following:
  - Cell-free DNA testing is the most sensitive and specific **screening** test for the common fetal aneuploidies (Trisomy 13, 18, and 21). Cell-free DNA testing is not equivalent to diagnostic testing (Chorionic Villus sampling or Amniocentesis).
  - A family history to determine if the patient should be offered other forms of screening or prenatal diagnosis for familial genetic disease.

Considerations:

- Cell free fetal DNA/NIPT testing can be used as a follow up test in women who have a positive first trimester or second trimester screening test result.
- NIPT in appropriately selected patients should be an informed patient choice after pretest counseling.
- If a fetal structural anomaly is identified on ultrasound examination, invasive prenatal diagnosis should be offered as the preferred test, although if a patient declines invasive prenatal diagnosis, cell free fetal DNA can be considered.
- A negative NIPT result does not ensure an unaffected pregnancy.
A patient with a positive test result should be referred for genetic counseling and offered invasive prenatal diagnosis for confirmation of test results.

NIPT does not replace the accuracy and diagnostic precision of prenatal diagnosis with chorionic villus sampling (CVS) or amniocentesis, which remain an option for women. For patients who desire a diagnostic test, CVS or amniocentesis should be offered rather than Cell Free DNA/NIPT testing.

**Limitations:**

- Cell free fetal DNA testing should **not** be offered to low-risk women or women with multiple gestations due to lack of sufficient evaluation in these groups.

Approved: Solomon Williams  
Associate Director  
Medical Services

Approved: Beverly Churchwell  
Director, Medical Services

Approved: Melinda G. Rowe, MD, MPH  
Assistant Medical Director

Approved: Kathy Hall  
Deputy Commissioner  
Program Administration
Criteria Approved: ________________

**PREREQUISITE CRITERIA (Required)**

- Provider enrolled as an Alabama Medicaid Agency provider,
- Recipient Medicaid number, eligibility status, and service usage verified,
- The Form 342 completed and signed by the provider,
- Documentation of medical necessity, and diagnosis,
- Recipient has a singleton pregnancy, and **not** a woman with multiple gestations.

**Medical Criteria met as follows:**

- 1. Maternal age 35 or older at delivery; **OR**
- 2. Fetal ultrasonographic findings indicating an increased risk of aneuploidy; **OR**
- 3. History of a prior pregnancy with a trisomy; **OR**
- 4. Parental balanced Robertsonian translocation with increased risk of fetal trisomy 13 or trisomy 21; **OR**
- 5. Positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or a
quadruple screen.

Additional prior authorization supporting documentation must include the following:

- 6. Evidence that pretest counseling included patient education inclusive of the following:

  Cell-free DNA testing is the most sensitive and specific **screening** test for the common fetal aneuploidies (Trisomy 13, 18, and 21). Cell-free DNA testing is not equivalent to diagnostic testing (Chorionic Villus sampling or Amniocentesis).

- 7. A family history to determine if the patient should be offered other forms of screening or prenatal diagnosis for familial genetic disease.
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SUMMARY:
The Alabama Medicaid Contractor will perform 100% concurrent medical record reviews for Hospice initial certification requests and six month recertification requests. Hospice providers makes the initial assessment and obtains medical documentation to support the admission criteria as outlined in Chapter 51 of the Alabama Medicaid Administrative Code. The Hospice provider then loads the documentation along with the Medicaid Hospice Election and Physician’s Certification Form (FORM 165) in Medicaid’s Fiscal Agents software for review.

PROCEDURE:
1. The Contractor will access the Alabama Medicaid FEITH/COLD database daily to retrieve Hospice records.

2. The Contractor qualified staff member will verify the applicant’s eligibility in the MMIS.

3. The Contractor’s Nurse Reviewer (CNR) will perform the review using the AMA approved Hospice Audit Tool and review the medical documentation to support the Hospice initial certification or recertification.

4. If the CNR determines the Hospice record meets the criteria, the CNR will enter the approval dates in the Fiscal Agent’s software within five business days of the approval. Medicaid only recipient’s election end dates will also be entered in the MMIS system.

5. If the CNR is unable to approve the Hospice initial certification or recertification, the provider is contacted by phone and/or email and asked to submit additional documentation. If the documentation is not received within fifteen business days from the date of the notice; the
6. The contractor will issue a Technical Denial. Technical denials result in the recoupment of paid claims. The Provider has six months to provide the missing/incomplete documentation. If the documentation is approved an approval letter will be sent to the Provider by certified mail and email. The letter will also be sent to AMA by email to reverse the recoupment.

7. If the CNR is not able to approve or deny the record with the additional documentation, the CNR will forward the complete record to the Contractor’s Physician to make the determination. The Contractor’s Physician will also review cases of diagnoses not found in the Alabama Medicaid Administrative Code with evidence of other comorbidities and the evidence of rapid decline, and for pediatric cases medical necessity.

8. If the Hospice record is approved, the CNR will enter the approval dates in the Fiscal Agents software within five business days of the approval. Medicaid only recipient’s election dates will also be entered in the MMIS system.

9. If the Hospice record is denied the Contractor will send a denial notice by email and certified mail to the Hospice provider within two business days of the decision. The letter will include the reason for denial and appeal rights.

Approved By:

______________________________                        _________________
Name, Associate Director                                           Monica Abron, Division Director
LTC-Provider Management and Support                                 Long Term Care (LTC) Division
SUMMARY:
The Alabama Medicaid Contractor will perform retrospective utilization reviews for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) admissions, readmissions, and transfers. On a monthly basis the Contractor will perform a retrospective reviewing 100% of Medicaid recipient admissions and readmissions provided on the LTC-007-M report. ICF/IID’s makes the initial assessment and obtains medical documentation to support the admission criteria as outlined in Chapter 10 of the Alabama Medicaid Administrative Code. Then the ICF/IID submit an admission or readmission date via the Fiscal Agent’s software. The admission dates, recipient and provider information is captured on the LTC-007-M report. Reviews shall be performed by a Qualified Intellectual Disability Professional (QIDP) with three years of experience.

PROCEDURE:

1. The Contractor will access the Alabama Medicaid FEITH/COLD database to retrieve the LTC-007-M Report monthly. The Contractor will also receive an internal report from the Alabama Medicaid Agency that list any admissions, readmissions, or transfers that were not captured on the LTC-007-M Report. This list is small and should be joined with the LTC-007-M-Report. Note: There are only two ICF/IID facilities in the State so there may be times when reviews are not required.

2. The Contractor will send a certified letter to the selected ICF/IID requesting the admission requirements outlined in Chapter 10 of the Alabama Medicaid Administrator code. The letter must include the recipient’s name, Medicaid ID, Admission type and date, providers name, NPI, audit timeframe, provider’s fax and email contact (just in case follow-up communication is requested) and the deadline date the requested information is to be received by the Contractor.

3. The QIDP will perform the utilization reviews using the AMA approved ICF/IID audit tool.

4. If the QIDP determines that additional information is needed or that the submission did not include all of the required documents; the QIDP will specify what is needed in a follow-up for additional information request to the provider. This letter is sent to the providers by fax or email. The provider has ten business days to submit the requested information. The follow-up information is submitted by fax or email to the Contractor.
5. If a ICF/IID fails to provide the required initial requested information or the additional requested information for audit review within the ten business days the Contractor will send a certified penalty letter that includes the following:
   - Day one through day seven- a rate of one hundred dollars per recipient record/per day will be recouped from the provider.
   - Day eight through day fourteen- a rate of two hundred dollars per recipient record/per day will be recouped from the provider.
   - If the requested records have not been submitted by the fifteenth day after the established due date, then the Medicaid’s recipient segment/file will be locked/end-dated until the records are received and penalties paid. The penalties is not a reimbursable Medicaid cost.

The Contractor will copy the Associate Director of the LTC- Provider Management and Support Unit on this notice. The Contractor will also send a letter of penalty determination to the Associate Director of the LTC- Provider Management and Support Unit when a ICF/IID submits the requested. This letter will have indicate the date the records were received and the penalty amount that AMA will need to recoup. If the determination is found to have no records received by the fifteenth deadline date, then the letter will indicate the date to lock/end-date the recipient’s file.

6. If the QIDP determines a record does not meet the ICF/IID admission requirements then the QIDP will send a letter to the ICF/IID within two business days by certified mail and copy to AMA by email. The letter will include the reason for denial and appeal rights. If the review also finds that the recipient did not meet the OBRA/PASRR requirements; then Contractor must also send a Non-compliance letter to the Alabama Department of Mental Health/OBRA Office and copy AMA.

Approved By:

______________________________                        ______________________________
Name, Associate Director                        Monica Abron, Division Director
LTC-Provider Management and Support                        Long Term Care (LTC) Division
LTC Forms

Form 154- Nursing Facility/Resident Agreement-

Form 161- LTC Admission & Evaluation Data Form-

Form 161 Instructions-
https://medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.8_LTC_Forms/9.4.8_Form_161_LTC_I_Instructions_4-1-15.pdf

Form 161-B- Request for Action Form-

Form 199- Medicaid Patient Status Notification-
https://medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.8_LTC_Forms/9.4.8_Form_199_LTCPatient_Status_Notification_2-13-08.pdf

Form 361- ICF/IID LOC Evaluation-

Form 165- Hospice Election and Physician’s Certification Form-
SUMMARY:
The Alabama Medicaid Contractor will perform retrospective utilization reviews for Nursing Facility admissions, readmissions, and transfers. On a monthly basis the Contractor will perform a retrospective review by selecting a 10% sample of Medicaid recipient admissions and readmissions provided on the LTC-007-M Report. Nursing Facilities makes the initial assessment and obtains medical documentation to support the admission criteria as outlined in Chapter 10 of the Alabama Medicaid Administrative Code. Then the Nursing Facility submit an admission or readmission date via the Fiscal Agent’s software. The admission dates, recipient and provider information is captured on the LTC-007-M report for the Contractor to pull a sample for review. Reviews shall be performed by a health care professional with a minimum qualification of a Registered Nurse with three years of medical surgical or Long Term Care experience.

PROCEDURE:
7. The Contractor will access the Alabama Medicaid FEITH/COLD database to retrieve the LTC-007-M Report monthly. The Contractor will also receive an internal report from the Alabama Medicaid Agency that list admissions, readmissions, or transfers that were not captured on the LTC-007-M Report. This list is small and should be joined with the LTC-007-M Report. The Contractor will use these reports to develop their sampling methodology for selecting the 10% sample of Medicaid recipient records to review.

8. The Contractor will send a certified letter to the selected Nursing Facilities requesting the following information:
   - LTC-9/Form 161-Admission and Evaluation Data Form
   - OBRA/PASRR Level 1 Screening and Results and Level II Determination if applicable.
   - Physician Medical Documentation to support Nursing Facility Level of Care
   - Minimum Data Set (MDS)
   - Hospital History and/or Discharge Summary if admitted from the Hospital
   - Any Medical Documentation submitted at the time of Admission.

The letter must include the recipient’s name, Medicaid ID, Admission type and date, providers name, NPI, audit timeframe, provider’s fax and email contact (just in case follow-up communication is requested) and the deadline date the requested information is to be received by the Contractor.
9. The Contractor’s Nurse Reviewer (CNR) will perform the utilization reviews using the AMA approved Nursing Facility audit tool.

10. If the CNR determines that additional information is needed or that the submission did not include all of the required documents; the CNR will specify what is needed in a follow-up for additional information request to the provider. This letter is sent to the providers by fax or email. The provider has ten business days to submit the requested information. The follow-up information is submitted by fax or email to the Contractor.

11. If a Nursing Facility fails to provide the required initial requested information or the additional requested information for audit review within the ten business days the Contractor will send a certified penalty letter that includes the following:
   - Day one through day seven- a rate of one hundred dollars per recipient record/per day will be recouped from the provider.
   - Day eight through day fourteen- a rate of two hundred dollars per recipient record/per day will be recouped from the provider.
   - If the requested records have not been submitted by the fifteenth day after the established due date, then the Medicaid’s recipient segment/file will be locked/end-dated until the records are received and penalties paid. The penalties is not a reimbursable Medicaid cost.

The Contractor will copy the Associate Director of the LTC- Provider Management and Support Unit on this notice. The Contractor will also send a letter of penalty determination to the Associate Director of the LTC- Provider Management and Support Unit when a Nursing Facility submits the requested. This letter will have indicate the date the records were received and the penalty amount that AMA will need to recoup. If the determination is found to have no records received by the fifteenth deadline date, then the letter will indicate the date to lock/end-date the recipient’s file.

12. If the CNR determines a record does not meet the Nursing Facility admission requirements then the CNR will send a letter to the Nursing Facility within two business days by certified mail and copy to AMA by email. The letter will include the reason for denial and appeal rights. If the review also finds that the recipient did not have an OBRA/PASRR level one screening before admission; the Contractor must send a Non-compliance letter to the Alabama Department of Mental Health/OBRA Office and copy AMA.

Approved By:

Name, Associate Director
LTC-Provider Management and Support

Monica Abron, Division Director
Long Term Care (LTC) Division
SUMMARY:
Inpatient hospital services rendered at an inappropriate level of care (lower than acute) are considered post-hospital extended care services. The patient must have received a minimum of three consecutive days of acute care services in the hospital requesting Post-Hospital Extended Care (PEC) reimbursement. Intra-facility transfers will not be authorized for reimbursement as PEC services. These services include care ordinarily provided by a nursing facility. Prior to the hospital admitting a patient to one of these beds, the hospital must first determine that there is no nursing facility bed available within a reasonable proximity. Hospital providers of PEC services are required to submit a completed Medicaid Status Notification Form (Form 199) to the Contractor within 60 days from the date Medicaid coverage is requested.

PROCEDURE:
1. The hospital is required to submit a fully completed Form 199 through Medicaid’s Fiscal Agent’s software for the Contractor for review. This includes all documentation certified by the applicant’s attending physician to support the need for nursing home level of care.

2. The hospital requesting approval for PEC Services must submit documentation certifying the applicant has received inpatient acute care services in the facility for not less than three consecutive days immediately prior to the PEC request in their facility. The days must have met the Medicaid Agency’s approved acute care criteria.

3. The PEC hospital must submit documentation certifying contact was made with each nursing facility within a reasonable proximity to determine bed availability prior to or on the date PEC coverage is sought.

4. Reviews shall be performed by a health care professional with a minimum qualification of a Registered Nurse with three years of experience in Institutional level of care or medical surgical nursing.

5. The Contractor shall complete the reviews within thirty calendar days of receipt using the AMA approved audit tool. If there is lack of required documentation to support the initial and subsequent thirty day reviews for PEC, the Contractor shall request additional documentation.

6. Upon approval, the Contractor will notify the PEC provider in writing by email or fax. Notice must be sent within one business day of the review decision. The notice shall contain the recipient’s name, Medicaid number, date of service(s), approval reason if applicable.
7. If the applicant is medically denied PEC Services, denial letters will be sent to the PEC provider (by email or fax), the Medicaid District Office (by email or fax), and the applicant or sponsor (by certified mail). Notice must be sent within one business day of the review decision. The notice shall contain the recipient’s name, Medicaid number, date of service, denial reason (should be indicated in plain language and reference code or number), and rights to the appeal process which include both the informal review and a fair hearing.

8. Nursing facility availability must be verified and documented every 15 days and submitted to the Contractor every 30 days with the recertification request.

9. Recertification for the PEC program must be made every 30 days.

Approved By:

_________________________________________  ____________________________
Name, Associate Director                        Monica Abron, Division Director
LTC-Provider Management and Support              Long Term Care (LTC) Division
**SUMMARY:**
Swing beds are defined as hospital beds that can be used for either skilled nursing facility (SNF) or hospital acute care levels of care on an as needed basis if the hospital has obtained a swing bed approval from the Department of Health and Human Services. In order to receive swing bed services recipients must require SNF level of care on a daily basis. The Contractor will perform admission reviews of all Medicaid admissions to ensure the necessity and appropriateness of the admission and that a physician has certified on the date of admission, the need for swing bed care. Hospital providers of Swing Beds Services are required to submit a completed Medicaid Status Notification Form (LTC-Form 199) to the Contractor within 30 days from the date Medicaid coverage is requested.

**PROCEDURES:**

1. The hospital is required to submit a completed LTC-Form 199 to the Contractor for review. This includes all documentation certified by the applicant’s attending physician to support the need for nursing home level of care.

2. Reviews shall be performed by a health care professional with a minimum qualification of a Registered Nurse with three years of experience in Institutional level of care or medical surgical nursing.

3. The Contractor shall complete the reviews within thirty calendar days of receipt using the AMA approved audit tool. If there is lack of required documentation to support the initial and subsequent thirty day reviews for Swing Beds services, the Contractor shall request additional documentation.

4. Upon approval, the Contractor will notify the Swing Bed provider in writing by email or fax that the applicant is medically eligible for services. Notice must be sent within one business day of the review decision. However, financial eligibility must also be determined for final approval. The applicant and sponsor must be advised in the notice to contact the appropriate Medicaid District Office to determine financial eligibility. The notice must also contain the recipient’s name, Medicaid number, date of service(s), approval reason if applicable.

5. If the applicant is medically denied, a denial letter will be sent to the Swing Bed provider (by email or fax), the Medicaid District Office (by email or fax) and the applicant or sponsor (by certified mail). The notice shall contain the recipient’s name, Medicaid
number, date of service, denial reason (should be indicated in plain language and reference code or number), and rights to the appeal process which include both the informal review and a fair hearing.

6. Swing Bed providers should conduct recertification at 30, 60 and 90 day intervals after admission and every 60 days thereafter. Swing Bed providers should keep documentation in the patient’s records.

7. The physician must state “certify the need for skilled care and continued skilled care.”

Approved By:

______________________________                        ______________________________
Name, Associate Director                                             Monica Abron, Division Director
LTC-Provider Management and Support                                      Long Term Care (LTC) Division
Attachment N

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Description:

TMJ is typically considered a dental disorder and dental procedures (typically CDT-4 codes) are not covered for adults. Also due to the potential abuse of such a procedure, prior authorization is required regardless of age. The above CPT codes are used to diagnose and treat TMJ disorders.

Policy:

The above noted CPT codes will only be covered when a medical condition or injury is present which has caused or is suspected to have caused the TMJ Disorder.

In order to meet approval A and B, C, or D must be met.

A. Progress notes that demonstrate the medical necessity of the procedure with documentation that the following conditions exist:

- Progress notes indicating significant pain i.e. affects daily activities; or
- Progress notes indicating that function i.e. eating or speaking has been impeded; or
- Progress notes which demonstrate traumatic injury; or
- Documentation of prior TMJ surgery with continued pain and symptoms.
- Progress notes indicting painful clicking and popping in the joint(reciprocal click)
- Progress notes indicting episodes of jaw locking
- Progress notes indicting limited jaw opening
- Progress notes indicting the inability to recapture disc

AND (either B, C, or D)

B. Each of the following is present:
• Copy of x-ray report obtained in the last 3 months indicating panoramic radiographic evidence of bony erosion (cortical plate) in juvenile arthritic TMJ; and
• There is evidence that other forms of treatment; hard, flat splints, anti-inflammatory medication, and physical therapy have not worked.

OR

C. Diagnosis of Juvenile Idiopathic Arthritis
   1. Panoramic radiographic evidence of bony erosion (cortical plate)*
   2. MRI evidence of Panus formation*
   3. Recipient must present with a symptomatic joint (pain, locking, etc.)*
   4. Solution to be injected must be ONLY saline and/or a steroid for CPT 20605*

*For approval for procedure 20605, all three of the above criteria must be present. CPT 20605 has a maximum coverage of one unit per PA request and is only approved for saline and/or a steroid.

OR

D. Diagnosis of Bone spur

Limitations:

Codes in this policy will only be covered after other treatment options have proven unsuccessful.

Note:
Claims should be submitted on a current CMS 1500 form.

Attachments: (1) Checklist

Approved: ____________________________ 7-11-16
Dr. Robert Moon, Medical Director and Deputy Commissioner Health Systems

_______________________________ 7-19-16
Dr. Melinda Rowe, Assistant Medical Director Health Systems

_______________________________ 7-14-16
Kathy Hall, Deputy Commissioner, Program Administration

_______________________________
Dr. Danny Rush, Dental Consultant
MRI Authorization

A. Progress notes that demonstrate the medical necessity of the procedure with
documentation that the one or more following conditions exist:

☐ Progress notes indicating significant pain i.e. affects daily activities; or
☐ Progress notes indicating that function i.e. eating or speaking has been
  impeded; or
☐ Progress notes which demonstrate traumatic injury; or
☐ Documentation of prior TMJ surgery with continued pain and symptoms.
☐ Progress notes indicting painful clicking and popping in the
  joint(reciprocal click)
☐ Progress notes indicting episodes of jaw locking
☐ Progress notes indicting limited jaw opening
☐ Progress notes indicting the inability to recapture disc

AND (either B, C, or D)

B. Each of the following is present:

☐ Copy of x-ray report obtained in the last 3 months indicating
  panoramic radiographic evidence of bony erosion (cortical plate) in
  juvenile arthritis TMJ; and
☐ There is evidence that other forms of treatment; hard, flat splints,
  anti-inflammatory medication, and physical therapy have not
  worked.

OR

C. Diagnosis of Juvenile Idiopathic Arthritis

☐ Panoramic radiographic evidence of bony erosion (cortical plate)*
☐ MRI evidence of Panus formation*
☐ Recipient must present with a symptomatic joint (pain, locking,
  etc.)*
Solution to be injected:

*For approval for procedure 20605, all three of the above criteria must be present. CPT 20605 has a maximum coverage of one unit per PA request. ONLY approved solution(s) for CPT 20605 must be saline and/or a steroid.

OR

D. Diagnosis of Bone spur
Orthognathic Surgery

Review Date ______________________ PA # ________________  □ Approved  □ Denied
Comments ____________________________  Signature ____________

Reconsideration Date ________________  □ Approved  □ Denied
Comments ____________________________  Signature ____________

Section One

Recipients must meet all of the following in order to review medical necessity:

- Procedure Code Requested between range 21120-21296; and
- List procedure ________________
- Patient is Medicaid eligible.

And

Section Two

Recipient must meet all of criteria in either A or B below:

A. Recipient has been approved for orthodontia:
   1. Check PAR screen to see if there are any approved prior authorization requests for orthodontia services, D8080 or D8060. PA # __
      If Yes
      2. Indicate START and STOP date and whether active orthodontia services (Approved PA).
         Start Date ___________________________ Stop Date ___________________________
      3. Print screens (PAR, PAUD if applicable).
      4. Approve PA request if Approved PA found for orthodontia services.

   If No current prior authorization for orthodontia, go to B.

B. If no active orthodontia PA, request must have ALL the following:
   1. Diagnosis of at least one of the following:

Criteria Approved: July 1, 2005
- Cleft palate or cleft lip deformities
- Cleft lip with alveolar process involvement
- Velopharyngeal incompetence
- Short palate
- Submucous cleft
- Alveolar notch

and
2. Documentation from the multidisciplinary team supporting the medical necessity. □ Yes □ No

and
3. Photos □ Yes □ No

and/or
4. Radiographs □ Yes □ No

If recipient has all the necessary documentation and attachments, send request for physician review. If required documentation is not submitted, deny request. Either photos or x-rays may be sufficient depending on the case. In some cases, both will be required to determine medical necessity. Send for physician review if either is submitted and all other criteria in A or B are met.

OR

Section Three:
If recipient does not meet medical necessity for orthodontia, documentation submitted must demonstrate either A or B.

A. If immediate repair post trauma, PA request must document all of the following

☐ Acute facial trauma (within last 90 days):
  Date of Injury _______________________________
  Type of Injury _______________________________

B. Severe facial anomaly or deformities with evidence of disabling or handicapping condition with at least ONE of the following:

☐ Severe sleep apnea documented by sleep apnea study (Must have been performed in the last 6 months)
  Date of Study _______________________________

OR

☐ Weight loss or failure to thrive; records must document problems with chewing, failure of non-surgical intervention e.g. splints, dietary changes and medications. Weight, height over a period of six months or more or growth chart must be included.

☐ OR

☐ Other conditions as determined by medical necessity review by Medical Director
If the answer to both A and B is No, Deny request and forward for physician sign off. Once signed off by the physician. Deny request and enter in system.

If answer to either, A or B is yes, Send Packet to physician for sign-off. PA Request requires photos, x-rays, and medical records. Once signed off by the physician. Approve request and enter in system.
### Appendix C: Pricing Form

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Pricing Template II

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

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