ALABAMA MEDICAID AGENCY

REQUEST FOR PROPOSALS

RFP Number: 2023-ACHN-01	**RFP Title: Alabama Medicaid Agency Alabama Coordinated Health Network**
RFP Due Date and Time: March 4, 2024, by 5:00pm Central Time	**Number of Pages: 134**
PROCUREMENT INFORMATION	
Project Director: LaTonya Jackson	**Issue Date: December 27, 2023**
E-mail Address: ACHNRFP@medicaid.alabama.gov **Website:** http://www.medicaid.alabama.gov	**Issuing Division: Networks Division**
INSTRUCTIONS TO VENDORS	
Return Proposal to: **Alabama Medicaid Agency** **Attn: LaTonya Jackson** **Lurleen B. Wallace Building** **501 Dexter Avenue** **PO Box 5624** **Montgomery, AL 36103-5624**	**Mark Face of Envelope/Package:** **Alabama Medicaid Agency Alabama Coordinated Health Network RFP** **RFP Number:** 2023-ACHN-01 **RFP Due Date:** March 4, 2024, by 5:00 pm CT

VENDOR INFORMATION ***(Vendor must complete the following and return with RFP response)***	
Vendor Name/Address:	Authorized Vendor Signatory: (Please print name and sign in ink)
Vendor Phone Number:	Vendor FAX Number:
Vendor Federal I.D. Number:	Vendor E-mail Address:

Section A. RFP Checklist

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

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

3. ____ **Take advantage of the "question and answer" period.** Submit your questions to the project director by the due date(s) listed in the Schedule of Events and view the answers as posted on the WEB. All addenda issued for an RFP are posted on the 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 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.

EVENT	DATE
RFP Issued	12/27/2023
Round 1 Questions Due by 5pm CT	01/08/2024
Posting of Round 1 Questions and Answers	01/26/2024
Round 2 Questions Due by 5pm CT	02/06/2024
Posting of Round 2 Questions and Answers	02/22/2024
Proposals Due by 5 pm CT	03/04/2024
Evaluation Period	03/05/2024-04/09/2024
Intent to Award Notification	04/19/2024
Selected Contractor Readiness Review	06/06/2024-09/20/2024
**Contract Review Committee	09/07/2024
Official Contract Award/Begin Work	10/01/2024

**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.

Table of Contents

I. Background

The Alabama Medicaid Agency (Agency) is requesting proposals from vendors with expertise, for a plan to promote improvement of the Alabama Medicaid's population health outcomes through comprehensive care management activities. Services required are outlined through this Request for Proposal (RFP). The Vendor shall provide assessment of risks and needs of the population, analyze data for the improvement of the care of those within the population, coordinate care for the population and leverage partnerships in order to improve the health outcomes of the population. The Vendor will be required by the state to operate under all provisions of the Omnibus Budget Reconciliation Act (OBRA) 1990, the Social Security Act, and all applicable state and federal laws. State regulatory authority is derived from Alabama Act No. 2003-297 and Alabama Medicaid Agency Administrative Code Chapter Seven. The projected implementation date of the RFP is October 1, 2024.

Currently, the Agency uses Primary Care Case Management entities (PCCM-e) to provide care coordination services to eligible recipients. Specific information can be found on the Agency's website www.medicaid.alabama.gov. The selected Vendor to whom the contract is awarded shall be responsible for the performance of all duties contained within this RFP.

All information and amendments contained in this RFP reflect the best and most accurate information available to the Agency at the time of the RFP preparation. No inaccuracies in such data shall constitute a basis for change of the payments to the Vendor or a basis for legal recovery of damages, actual, consequential, or punitive.

1. Alabama Coordinated Health Network (ACHN) Program Formation

The Agency was granted approval of a Section 1915(b) Waiver to implement a consolidated case management and care coordination system to address issues with the health status of Medicaid recipients. With this approval, the Agency established the Alabama Coordinated Health Network (ACHN) statewide in 2019 to streamline and increase access to case management and care coordination for Medicaid recipients within a single care coordination delivery system. The ACHN is comprised of seven regions:

1. Central, which includes the following counties: Autauga, Butler, Chilton, Crenshaw, Dallas, Elmore, Lowndes, Marengo, Montgomery, Perry, and Wilcox.
2. East, which includes the following counties: Blount, Calhoun, Cherokee, Clay, Cleburne, Coosa, DeKalb, Etowah, Randolph, St. Clair, Talladega, and Tallapoosa.
3. Jefferson and Shelby, which includes the following counties: Jefferson and Shelby.
4. Northeast, which includes the following counties: Cullman, Jackson, Limestone, Madison, Marshall, and Morgan.
5. Northwest, which includes the following counties: Bibb, Colbert, Fayette, Franklin, Greene, Hale, Lamar, Lauderdale, Lawrence, Marion, Pickens, Sumter, Tuscaloosa, Walker, and Winston.
6. Southeast, which includes the following counties: Barbour, Bullock, Chambers, Coffee, Covington, Dale, Geneva, Henry, Houston, Lee, Macon, Pike, and Russell.
7. Southwest, which includes the following counties: Baldwin, Choctaw, Conecuh, Clarke, Escambia, Mobile, Monroe, and Washington.

NOTE: *Vendors must respond to this RFP by identifying the specific Region in which a proposal is being submitted. A Vendor may bid on multiple Regions but must submit a separate proposal for each individual Region.*

2. ACHN Goals

The intended goals of this care management approach include:

1. A delivery system that allows for seamless person-centered case management and care coordination across eligibility categories and incentivizes quality outcomes;
2. Address statewide and regional health outcome goals;
3. Conduct outcome-focused population management activities;
4. Facilitate timeliness of key health activities (e.g., Early and Periodic Screening, Diagnostic, and Treatment [EPSDT] screenings, flu shots, early entry to prenatal care, care for substance use disorder [SUD]);
5. Focus on health literacy and educate recipients on their conditions, medications and importance of compliance, medical compliance, healthy eating and the importance of exercise in driving quality health outcomes;
6. Focus on health disparities and social determinants of health (SDoH) in an effort to reduce barriers impacting health outcomes; and
7. Flexibility to address regional quality issues (e.g., asthma in a region due to environmental issues; SUD targeted in a local area where there is a high incidence of neonatal abstinence syndrome [NAS] infants, etc.).

3. ACHN Strategy

The majority of recipients covered by Medicaid in Alabama are children, and addressing their care is important. A significant number of recipients (including children and adults) suffer high rates of chronic conditions such as heart related conditions, asthma, hypertension, diabetes and obesity.

Using lessons learned from the existing ACHN Program, a more intensive approach for improving healthcare outcomes has been designed. This approach is to improve healthcare outcomes through a triaged, step-down approach of care management intervention. This more intensive approach will include risk stratification which is a decision-making process using a combination of medical and social data to determine the recipient's care management needs. The recipient's needs are identified using a compilation of activities to include, but are not limited to, identification of SDoH, and medical history, (e.g., maternal health history, chronic illnesses, adverse pregnancy outcomes, etc.) Upon review and assessment of the data, recipients may be classified as high, medium, low or no risk. The classification status determines the intensity of care management that is needed to address current and preventive healthcare concerns.

Lessons learned also include that Alabama has room to improve:

1. Maternity outcomes in Alabama are less than optimal, and preterm birth rates and infant mortality are higher than the national average.
2. Obesity is an issue across the country, but particularly in Alabama.
3. The use of illegal drugs and the inappropriate use of legal substances, such as alcohol and tobacco, is a national crisis and is an issue in Alabama.
4. Recipients with a sickle cell disease (SCD) diagnosis need more intensive care management.

II. Scope of Work

The selected Vendor, the PCCM-e, shall provide the following in accordance with 42 C.F.R. Part 438:

- Population health management;
- Comprehensive care management to include case management and care coordination;
- On-going monitoring;
- Quality improvement programs;
- Comprehensive transitional care for recipients leaving inpatient care; and
- Network adequacy development and maintenance.

The Scope of Work Section is separated into ten segments. The PCCM-e must address the requirements in each segment. The segments are:

1. Comprehensive Care Management Program
2. Maternity Care Management Program
3. Behavioral Health Program
4. Pharmacy Program
5. Transitional Care Program
6. On-going Monitoring
7. Quality Improvement Program
8. Routine Meeting Attendance/Participation
9. Provider Participation with PCCM-e
10. Readiness Assessment

1. Comprehensive Care Management Program

A. General

The PCCM-e is responsible for developing and implementing a comprehensive person-centered care management program which includes case management and care coordination components with emphasis on population health management, health literacy and identification of SDoH. Case management and care coordination under the ACHN Program shall be provided under a triaged, tiered down approach.

The Agency will identify recipients in need of screening for possible case management and care coordination and forward on a monthly basis, to the vendor, the identified recipients for prioritization. The Vendor will also receive case management and care coordination referrals from physicians, other providers, community agencies, etc. The Vendor must evaluate the identified and referred recipients and provide care management services to those in need based on their prioritization.

B. Included and Excluded Populations

1. The following groups of eligible Medicaid recipients shall be included for care management services under the ACHN Program:
   a. Medically complex recipients;
   b. Maternity care recipients;
   c. Children under age 19;
   d. Parents or other caretaker relatives (POCR);

e. Foster children;
f. Former Foster Care;
g. Breast and Cervical Cancer; and
h. American Indians (note: may opt-out at any time).

2. The following groups of eligible Medicaid recipients shall be excluded for care management services under the ACHN Program:
   a. Medicare/Medicaid dual-eligible population;
   b. Long-term institutional care;
   c. Home and Community-Based Services waiver;
   d. Children in the custody of the Department of Youth Services;
   e. Inmates and people living in Institutions for Mental Diseases (IMDs);
   f. Aged, blind or disabled individuals receiving only optional state supplements;
   g. Individuals participating in the Program of All-Inclusive Care for the Elderly (PACE);
   h. Individuals utilizing hospice services;
   i. Individuals receiving Refugee Medical Assistance;
   j. Individuals with other commercial managed care insurance or participating in the Health Insurance Premium Payment (HIPP) program; and
   k. Individuals with limited or no Medicaid coverage (e.g., some non-citizens only eligible for emergency services, or individuals receiving short-term hospital presumptive eligibility).

3. The Agency may also provide additional lists of recipients or other Medicaid recipients that are categorized as a member of a population that is of concern or interest of the Agency (e.g., recipients with SCD). It is the expectation of the Agency that the PCCM-e provide care management services or focused monitoring of these recipients in collaboration with the Agency.

4. The PCCM-e shall establish processes to support case management and care coordination for recipients, primarily those that are at highest risk and cost. The processes shall include, but are not limited to, the following:
   a. Developing and implementing person centered holistic plans of care;
   b. Improving health literacy, health outcomes, and self-management;
   c. Promoting effective use of the healthcare system and community resources;
   d. Reducing the potential for risks of catastrophic or severe illness;
   e. Preventing disease exacerbations and complications;
   f. Minimizing inappropriate utilization;
   g. Working to identify additional key resources and incorporate these into the strategies such as partnerships with Alabama Department of Public Health (ADPH), Alabama Department of Mental Health (ADMH), and Children's Rehabilitation Services (CRS);
   h. Utilizing evidence-based clinical practice guidelines; and
   i. Promoting the importance of the Medical Home through recipient education.

C. Care Management Populations

The populations of the Agency's recipients to which the PCCM-e will serve are:

1. General. The General population mostly consists of children and adult recipients who have or who are at risk of having certain chronic conditions: asthma, diabetes, cancer, hepatitis C,

COPD, HIV, mental health conditions, SUD, transplants, SCD, BMI >25, and/or heart disease.

2. Maternity (includes postpartum). Medicaid covers over half of the births in the state and maternity outcomes in Alabama are less than optimal. Additionally, preterm birth rates and infant mortality are higher than the national average. To help improve maternal health, Medicaid evaluates the usage of benefits and maternal health outcomes (e.g., screening for clinical depression, decreasing the prevalence of hypertension and diabetes during pregnancy, and increasing the rate of contraceptive care) and the outcomes of postpartum care. Therefore, to better determine the initial and on-going needs of these recipients, all pregnant recipients must be risk stratified as high for the first three (3) months of care management.
    a. The population includes all pregnant and postpartum women from the following benefit types: full Medicaid (TXIX), full Medicaid and Medicare (XIXQ) and full Medicaid/Pregnancy through Postpartum (SBRW).
    b. Postpartum. Effective October 1, 2022, the Agency extended postpartum coverage to twelve (12) months after end of pregnancy for pregnant recipients. With this extension (previously sixty (60) calendar days), there are increased opportunities for support to the recipient through the adjustment of caring for a new baby. The postpartum recipient will continue to receive care management services throughout the postpartum period. The intensity of the care management will be determined by the assigned risk stratification level. Additionally, the PCCM-e must ensure that the recipient has been informed of their need to apply for Medicaid to determine if they qualify for Plan First (family planning services) eligibility.
3. Medically Complex. The Medically Complex population includes, but is not limited to, children with medical complexities, those recipients with a SUD and/or other mental illness diagnosis and those recipients with a SCD diagnosis.
    a. Effective January 1, 2023, the Agency implemented an initiative requiring the ACHN entities to target 100% of the population of Medicaid recipients with a diagnosis of SCD for focused intensive care coordination. Prior to implementation of this initiative, approximately 20% of the SCD population were receiving care coordination services through the ACHN program.
    b. Children with medical complexities (CMCs) require the highest level of intensity of care, and frequently numerous pediatric specialists are required to care for their conditions. These children are generally medically fragile with congenital/acquired multi-system disease. Many require medical technology to sustain their activities of daily living. They also must have a qualifying diagnosis/condition and/or social assessment to meet CMC criteria for this program. Primary Care Provider (PCPs), in concurrence with the PCCM-e Medical Director, may also identify additional recipients for this group. The medical and social care for these children is typically more extensive than other members of the general population.
4. Family Planning.
    a. Family planning promotes the well-being of families, responsible behavior, and healthy mothers and babies. Appropriate family planning care management is paramount to a recipient's life outcomes.
    b. Although the PCCM-e will not provide family planning care management services, it is expected that the PCCM-e will refer recipients to family planning services providers when needed. The PCCM-e is also expected to follow up with the recipient to determine compliance or other issues that may have developed since the initial and on-going referrals.

D. Care Management Program Components

1. Population Health Management. Population health management is the process that assesses risks and needs and analyzes data related to a given population to identify strategies, partnerships and change processes for the improvement of care for the identified population. The Centers for Disease Control and Prevention (CDC) describe population health as "as an interdisciplinary, customizable approach that allows health departments to connect practice to policy for change to happen locally".
2. Care Management. A collaborative process that facilitates communication and care coordination along a continuum that includes those connected to and/or directly involved in the care of a recipient. Members of the collaboration can include the recipient, nurses, social workers, counselors, physicians, other practitioners, caregivers and the community. The Agency's care management model is comprised of the following components: case management, care coordination, application assistance and medical monitoring review. Care management activities can be provided in person, virtually and telephonically as indicated in each population's Care Management Activity Schedule document (see Appendices G-J). Care management activities rendered to the recipients must be documented in accordance with the applicable chapters in the Agency's Administrative Code (Chapter 1: General) and Provider Manual. When provided by the state, forms, models, templates and Agency-provided data must be used.
    a. Case Management – Case management is a set of activities designed to assist recipients in managing health conditions and related psychosocial problems with the goals of improving or maintaining patients' functional health status, enhancing the coordination of care, eliminating the duplication of services, and reducing the use of unnecessary services. It also recognizes the significance of the SDoH, the complexities of care and the importance of recipients to be involved in care decisions and their right to participate in the process.
        i. Case management services must be provided by appropriately credentialed and state governing board licensed staff. Examples of appropriately credentialed staff include, but are not limited to, counselors, nurses, social workers and therapists. Examples of duties to be completed by these staff members include but are not limited to assessments, reassessments, care plan development and monitoring, referrals, case documentation, face-to-face and virtual or telephonic Encounters with recipients.
        ii. Case management activities will be provided to ACHN participants who are stratified as high risk and therefore, require a more intensive level of care management activity. This represents approximately the top six percent (6%) of the eligible ACHN population. The PCCM-e will be given stratification criteria by the Agency to determine the appropriate stratification levels for the recipients. However, the recipients within the categories below must be stratified as high:
            1. Maternity for the first three months of pregnancy or initial enrollment; and
            2. Medically complex for the first three (3) months of eligible diagnosis(es)/conditions or initial enrollment or engagement.
    b. Care Coordination – Care Coordination is a process through which assessment, planning and interventions appropriately integrate, ensure, and advance the plan of care to support positive health outcomes and successful transitions. Care coordination is the deliberate organization of health and related support activities

between two or more participants (including the Medicaid recipient) involved in the recipient's care to facilitate the appropriate delivery of needed services. Organizing care involves arranging personnel and other resources needed to carry out all required activities and is often managed by the exchange of information among participants responsible for different aspects of care.

i. Care coordination activities will be provided to ACHN recipients who are risk stratified as medium or low and therefore, require a moderate or low level of care management activity. This represents approximately the top seven to twenty percent of the eligible ACHN population.
ii. Care coordination services can be provided by appropriately credentialed professional staff. These staff are required to provide case management services. Case management services may also be provided by those staff members that meet the minimum educational and experience requirements outlined in the RFP.

c. Application Assistance – Application assistance can be offered to anyone that is interested in applying for Medicaid. The PCCM-e will have Certified Application Assisters available to assist individuals with completing the Medicaid application process, and follow-up with the person until Medicaid eligibility is determined.

i. The PCCM-e shall submit names to the Agency's Networks Division of all certified application assisters and the name(s) of the Certified Application Assisters trainers served by the Region at program implementation, within forty-five (45) calendar days of the end of the year and within thirty (30) calendar days of any change.
ii. The PCCM-e has flexibility in determining how to perform the application assister function. Care managers are not required to be Certified Application Assisters; however, the application assister function must be performed by Agency approved staff who meet the qualification as outlined in Appendix K, Key Staff and Other Positions Requirements.
iii. The Certified Application Assisters eligibility encounter must include the following:
    1. Documentation of eligibility status at screening intake.
    2. Assistance with completing the application electronically or paper format.
    3. Follow-up with the person until a Medicaid eligibility determination is made.
    4. Assistance with any other barriers to the application process.
    5. Completion of the initial screening; and
    6. Documentation of activities associated with the encounter in the Health Information Management System (HIMS), when applicable.
iv. Minimal Staff requirements: Community Health Worker

d. Medical Monitoring Review- Medical monitoring is the review and analysis of claims and electronic medical records (EMR) data for recipients outside of the top twenty percent (20%) who are not currently receiving care coordination services to determine cost efficiency, clinical appropriateness and the need for other services. The PCCM-e will be given stratification criteria by the Agency to determine when the medical monitoring review is the appropriate assignment for the recipients.

3. Recipient Assignment Process. Each month, the Agency will provide a targeted list of recipients for assignment into care management screening and assessment as well as

Medical Monitoring Review. The Agency will provide the assignment list for each PCCM-e that will be used in their care management programs. The goal will be to provide a list sufficient to reach active care management targets set by the Agency, provide fiscal stability for the PCCM-e and not overspend budgets. For details related to how the list is determined, refer to the Recipient Assignment Process document located in the Procurement Library.

a. From the assignment list, recipients will be assessed for care management assignment as indicated by the stratification mandates and/or criteria established by the Agency. All recipients must be assessed and provided care management services at the intensity that correlates with their risk stratification level as outlined in the Care Management Activity Schedule (see Appendices G-J). The needs identified in this assessment will be the basis for the recipient's comprehensive care plan.
b. All data and reports will be provided directly to the PCCM-e. Using this information, the Population Health Data Analyst, Quality Care Director and applicable staff must work closely to ensure recipients are stratified and managed appropriately.

4. Referrals. The PCCM-e will receive referrals for care management, which must be screened no later than five (5) business days from the receipt of the referral, from the following, but not limited to: PCPs; medical or psychiatric facilities; state or community agencies; and/or recipients.
    a. The PCCM-e shall use a process to screen and stratify recipients who are determined to need care management services. The PCCM-e must use the results of the screening and risk stratification to assign an initial risk level to each recipient and place those recipients into appropriate categories of risk, which will determine the timeframe of the assessment and assignment to a Care Manager.
    b. For recipients identified as needing care management services and stratified as indicated by the screening and assessment results, the PCCM-e shall provide the level of care management service for the indicated health risk in accordance with the Agency's established criteria. The health risk levels are high, medium and low.
    c. Once a recipient who needs care management services has been identified, contact must be attempted by the PCCM-e within five (5) business days of screening. At least three attempts must be made at a minimum of thirty (30) calendar days, including a written letter, mailed via postal service, to offer care management services. Proof of postal service mailing and other attempted contact methods must be maintained and documented in the HIMS for auditing and compliance purposes. A hand-delivered or mailed notification to the recipient are acceptable routes of notifications. The delivery format, when the letter was mailed or hand delivered to the recipient, and a copy of the letter must be documented and maintained in HIMS. The documentation must show all efforts to contact up to closure of the case file.
5. PCP Selection Process.
    a. General
        i. The PCCM-e must have policies and procedures in place to assist the recipient in selecting his/her choice of a PCP, to include changes in PCP selection.
    b. Changes in PCP Selection
        i. Recipients must be allowed to change a PCP once without cause within the first ninety (90) calendar days of selecting an PCP and at any time for just cause, which is defined as a valid complaint submitted verbally or in writing

to the PCCM-e.

ii. PCCM-e Responsibilities

1. The PCCM-e must inform the recipient of the recipient's rights to change PCPs, with and without cause at the initial contact and at least once per year.
2. The PCCM-e must provide, at the time of initial contact, all required information regarding rights and responsibilities, and appropriate telephone numbers.

6. Recipient Refusal of Services. The recipient has the right to refuse care management services. If the recipient refuses care management, the PCCM-e will notify the recipient that they may request care management services at any time. The notification must be documented and maintained in HIMS. For details regarding this notification requirement, refer to the Recipient Assignment Process document located in the Procurement Library.
7. Enrollments, Disenrollments and Reenrollments. The PCCM-e must have policies established to identify its processes for enrolling, disenrolling and reenrolling recipients. These policies must be in accordance with all applicable federal and state regulations and guidelines. Below are the Agency's expectations:
   a. Enrollments The PCCM-e must not, on the basis of health status or need for health care services, discriminate against recipients. This includes but is not limited to, termination of enrollment or refusal to reenroll a recipient except as permitted under this RFP, or any practice that would reasonably be expected to discourage enrollment or reenrollment by recipients whose medical condition or history indicates probable need for substantial future medical services. Violation of this requirement may result in sanctions listed in the RFP.
      i. The PCCM-e must not discriminate against recipients to enroll with the PCCM-e on the basis of any protected category listed in 42 C.F.R. § 438.3(d) and must not use any policy or practice that has the effect of discriminating on the basis of any protected category listed in 42 C.F.R. § 438.3(d).
      ii. The PCCM-e must accept new enrollment from individuals in the order in which they apply without restriction, unless authorized by the Center for Medicare and Medicaid Services (CMS), up to the limits set under the RFP in accordance with 42 C.F.R § 438.3(d)(1).
   b. Disenrollment.
      i. In accordance with 42 C.F.R. § 438.56(b)(1), the PCCM-e may request disenrollment of a recipient for the following reasons:
         1. The recipient loses Medicaid eligibility;
         2. The recipient's eligibility category changes to a category ineligible for the ACHN (e.g., recipient becomes dually-eligible for Medicare and Medicaid);
         3. The recipient otherwise becomes ineligible to participate in the ACHN;
         4. The recipient has become incarcerated;
         5. The recipient has died;
         6. The recipient moves out of the Region; or
         7. The recipient exhibits uncooperative or disruptive behavior which inhibits the PCCM-e's ability to provide services. The PCCM-e must be able to demonstrate, to the Agency's satisfaction, that it has

exhausted all reasonable efforts to effectively coordinate the recipient's care.

ii. The PCCM-e may not request disenrollment for any of the following reasons:
    1. An adverse change in the recipient's health status;
    2. The recipient's utilization of medical services;
    3. The recipient's diminished mental capacity; or
    4. The recipient's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the PCCM-e's ability to furnish services to the recipient or other recipients).

iii. The PCCM-e must not request disenrollment for reasons other than those permitted under this RFP or Contract.

iv. A recipient may request disenrollment from the PCCM-e under the following circumstances:
    1. The enrollee moves out of the PCCM-e service area;
    2. The PCCM-e does not provide care coordination services the enrollee seeks, because of moral or religious objections;
    3. Poor quality of care;
    4. Lack of access to services covered by the RFP; or
    5. Lack of access to care coordinators experienced in dealing with the enrollee's care needs.

v. A recipient (or his or her representative) requesting to be disenrolled from the PCCM-e for any reason(s) outlined in subsection iv above must:
    1. Submit an oral or written request for disenrollment to either the PCCM-e or the Agency. The PCCM-e is required to forward any requests for disenrollment to the Agency within three (3) business days of receipt.
    2. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the enrollee requests disenrollment from the PCCM-e or the PCCM-e refers the request to the Agency.
    3. If the Agency fails to make a determination within the timeframe identified in subparagraph 2 above, the disenrollment will be considered approved for the effective date that would have been established has the Agency made a determination in the specified timeframe.

8. Network Adequacy Development and Maintenance. The PCCM-e must develop, maintain and distribute a provider directory to recipients as detailed in the Recipient Materials Requirements - Provider Directory documents located in the Procurement Library. The Provider Directory must meet the requirements in 42 C.F.R. § 438.10(h).
9. Non-Emergency Transportation (NET) Coordination.
    a. General. The PCCM-e does not provide NET services; however, the entity may assist recipients in arranging transportation or coordinating with the Agency's NET program for transportation services. A recipient or his/her representative may arrange transportation for the recipient receiving care management services, or request assistance through the PCCM-e by contacting their assigned care management staff. Any staff member with the PCCM-e may assist with

coordinating NET services.

b. PCCM-e responsibilities. The PCCM-e must:
    i. Ensure the Agency does not pay for NET services if the recipient has access to free transportation;
    ii. Determine availability of and least costly means of transportation to include, but not limited to, free transportation, including the recipient's vehicle, transportation by relative or friend, or volunteer services;
    iii. Establish recipient's eligibility for date of service five (5) calendar days prior to appointments or within twenty-four (24) hours after urgent care appointments to ensure transportation is provided for Medicaid covered services only;
    iv. Confirm the least expensive mode of transportation that meets the needs of the recipient, such as:
        1. Automobile;
        2. Transporter; or
        3. Other.

c. Contact the NET Coordinator in the area or the Medicaid Recipient Call Center to arrange transportation if the recipient cannot make the contact on their own;

d. Assist recipients in submitting the necessary receipts or confirmation of expenses required for reimbursement for overnight travel;

e. Coordinate in-state and out-of-state commercial, bus, train, or air transportation for review to Medicaid on a case-by-case basis to include but not limited to requesting and receiving necessary support documentation from the PCP for any out-of-state services to assure that such services cannot be obtained in-state; and

f. Validate appointment with provider by confirming the date, time, and attendance of appointment with the Medicaid provider.

10. Enrollee Rights. The PCCM-e must have written policies guaranteeing each enrollee's right to:
    a. Receive information on the PCCM-e into which he/she is enrolled.
    b. Be treated with respect and with due consideration for his or her dignity and privacy.
    c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
    d. Participate in decisions regarding his or her health care, including the right to refuse treatment.
    e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
    f. Request and receive a copy of his or her medical records, and to request that they be amended or corrected.
    g. Freely exercise his or her rights without the PCCM-e treating the recipient adversely.

E. Care Plan Development

1. Actively managed recipients will receive a care plan which must be person-centered (i.e., recipient/caregiver-centered) with a team approach, including not only the PCCM-e's staff, but also PCPs, state agencies, behavioral health entities, and/or other community resources, as appropriate. See the Care Management Care Plan

Requirements document located in the Procurement Library for details.

2. The recipient's comprehensive care plan shall be current and contain, at a minimum, the following identified five components:
    a. the assessment of identified needs,
    b. goals,
    c. interventions,
    d. rationales, and
    e. evaluations.

    The care plan shall be evaluated and/or revised as applicable, with documentation to support the completion of an evaluation and/or revision process.
3. As the recipient's needs are identified or goals are met, the recipient's risk level may change. The PCCM-e will complete a risk reassessment including a SDoH assessment to redetermine the recipient's risk level. A risk assessment using the Agency approved reassessment tool(s) must be completed in accordance with the Care Management Activity Schedule. Documentation to support the need for a change in the risk level not captured during the risk assessment/reassessment, must be appropriately documented within the HIMS, with new goals and interventions documented in the care plan.
4. Additional assessments required for each recipient receiving care management include:
    a. PHQ-A for recipients ages 12-17;
    b. PHQ-2 for recipients age 18 and older;
    c. PHQ-9 for recipients age 18 and older that score a four or higher on the PHQ-2;
    d. SUD screening tool approved by the Agency; <u>and</u>
    e. CRAFFT – A health screening tool designed to identify SUD, substance-related riding/driving risk, and SUD among youth between the ages 12 and 18, <u>or</u>
    f. UNCOPE – A six question screening tool used as a quick means of identifying whether a person, age 18 and over, is at risk for abuse or dependence for alcohol and other drugs.
    g. If the recipient is between the ages of 18 and 21 but is still in high school or otherwise considered a dependent, then the ACHN should use CRAFFT and recommendations would be made for adolescent treatment. If the recipient is between the ages of 18 and 21 but has graduated high school or obtained a GED, use UNCOPE to provide a recommendation for adult treatment services.
5. Multidisciplinary Care Team (MCT). The PCCM-e will be required to arrange and participate in MCT meetings for all recipients who are risk stratified as high and for others when deemed necessary. The PCCM-e must establish MCTs and MCT meetings with the applicable recipients enrolled in care management.
    a. The MCT allows for health professionals from different disciplines to work together to provide coordinated and individualized care to patients with complex or chronic needs. The team collaborates on a detailed care plan, communicates regularly, and accesses a range of health and community services to support the recipient's goals and well-being. The team also works to prevent unnecessary hospital care and adapts to the changing needs and circumstances of the recipient over time.
    b. The MCT meeting is defined as a setting where all of the attendees are present at the same time to discuss the identified issue(s) collaboratively. Examples of an appropriate MCT meeting setting:
        i. In-person/face-to-face (preferred)
        ii. Virtual with, at a minimum, audio capability; audio and visual preferred

c. Recipients and/or their representative(s) must be included in the MCT meetings.
d. MCT meetings are held in accordance with the Care Management Activity Schedule.
e. Staff requirement:
    i. Care manager and/or
    ii. transitional care management staff

These activities must be completed as outlined in the MCT Policy located in the Procurement Library.

F. Care Management Goals

1. Although it is understood that the number of recipients within each population that are assigned and managed by the PCCM-e varies from month to month, there are care management goals identified for each of the populations. The PCCM-e must evaluate the identified and referred recipients and provide care management services to those in need based on their prioritization and risk stratification.
2. The PCCM-e's failure to meet the goals may result in a sanction as determined by the Agency.
3. Beginning after the second quarter of PCCM-e operations, if the PCCM-e fails to provide the below stated level of care management services to recipients, the Agency will require the PCCM-e to submit a corrective action plan (CAP) within fifteen (15) business days of the end of the quarter in which the PCCM-e failed to care manage the required percent of recipients.
4. The PCCM-e is expected to meet the below care management goals for each population. Care management goals are subject to change. The PCCM-e will be notified prior to the effective date if there are changes.
5. Population Goals
    a. General Population

Population: The assigned General Population is approximately 695,000 recipients annually.

Care Management Goals *Care management activities must be completed in timeframes indicated in the Care Management Activity Schedule.*	
Care Management Activity	**Annual Care Management Goals**
Assigned population management	1% of the assigned population must receive a psychosocial assessment
High-risk population management	70% of the high-risk stratified recipients must receive a psychosocial assessment
Annual Reassessment	20% of those with a completed Care Plan Review received an annual reassessment
Care Management Activity	**Monthly Care Management Goals**
Initial Assessment	80% of those enrolled received an initial psychosocial assessment
Care Plan Review	90% of those who received an initial psychosocial assessment participated in a Care Plan Review
MCT (high)	50% of those who participated in a Care Plan Review received an MCT
1st Periodic Follow-up	90% of those who participated in a Care Plan Review received a 1st periodic follow-up

b. Medically Complex Population

Population: The assigned Medically Complex Population is approximately 130,000 recipients annually. *This population has traditionally been included within the General Population.*

Care Management Goals *Care management activities must be completed in timeframes indicated in the Care Management Activity Schedule.*	
Care Management Activity	**Annual Care Management Goals**
Assigned population management	6% of the assigned population must receive a psychosocial assessment
High-risk population management	100% of those who received a psychosocial assessment must be managed as high-risk stratification for the first three months
Annual Reassessment	15% of those who participated in completed Care Plan Review received an annual reassessment
Care Management Activity	**Monthly Care Management Goal**
Initial Assessment	85% of the enrolled received an initial psychosocial assessment
Care Plan Review	90% of those who received an initial psychosocial assessment participated in a Care Plan Review
MCT (high)	90% of those who received a Care Plan Review received an initial MCT
1st follow-up	90% those who received a Care Plan Review received a 1st follow-up encounter

c. Maternity Population

Population: The assigned Maternity population is approximately 73,000 pregnant and postpartum recipients annually. The Agency estimates that approximately 47,000 will be pregnant recipients.

Care Management Goals *Care management activities must be completed in timeframes indicated in the Care Management Activity Schedule.*	
Care Management Activity	**Annual Care Management Goals**
Assigned population management	40% of the assigned pregnant population must receive a psychosocial assessment
High-risk population management	100% of those who received a psychosocial assessment must be managed as high-risk stratification for the first three months
Delivery Encounter	95% of those who participated in a Care Plan Review received a Delivery Encounter
Care Management Activity	**Monthly Care Management Goals**
Initial Assessment	60% of the enrolled population received an initial psychosocial assessment

Care Plan Review	70% of those who received an initial psychosocial assessment participated in a Care Plan Review
MCT (high)	25% of those who received a Care Plan Review received an initial MCT
1st follow-up (high and low)	90% those who received a Care Plan Review received a 1st follow-up encounter
In-home Postpartum Encounter (twenty (20) calendar days post-delivery)	80% of those with a Delivery Encounter received an In-home Postpartum Encounter
3rd Postpartum Encounter	80% of those with an In-home Postpartum Encounter
Family planning encounter with 6 months of delivery date	80% of those with a Delivery Encounter had a family planning related encounter within six months of the delivery date
Family planning referral with 6 months of pregnancy loss	80% of those enrolled within a pregnancy loss (no Delivery Encounter) had a family planning referral within six months of pregnancy loss

Although on average, only 60% of maternity recipients deliver, in the attempt to ensure every recipient has a healthy pregnancy and delivery, it should be the goal of the PCCM-e to provide care management to every pregnant recipient regardless of if she carries to term or not.

2. Maternity Care Management Program

A. General

The PCCM-e must implement a program approved by the Agency to integrate and manage all maternal health care management including family planning, interconception care, prenatal care, and postnatal (postpartum) care. The goal of the program is to reduce maternal and infant morbidity and mortality and improve birth outcomes. The recipient will be notified at the time of Medicaid application of the requirement to participate and engage in the PCCM-e Maternity Care Management Program.

1. The Maternity Care Management Program must include the following:
    a. Provide maternity care management under a hybrid methodology of face-to-face and telephonic case management and care coordination, as clinically appropriate and delineated in the Maternity Care Management Activity Schedule.
    b. Include the ACHN Maternity Care Provider (MCP) Participation Agreement with the regional PCCM-e for the collaborative provision of maternity services. The agreement will delineate the duties and responsibilities of the MCP. These responsibilities shall include, but are not limited to, the following:
        1. Data entry;
        2. Care plan participation; and
        3. Participation in the MCP selection and referral process. If the MCP does not elect to enter into an agreement with a PCCM-e, the MCP will not be reimbursed by Medicaid for services provided.
    c. Current pregnant recipients will be notified of the Agency's requirement to participate and engage with the PCCM-e in their Region for their maternity case

management and care coordination. Pregnant Women (previously SOBRA) will be notified of this requirement within the eligibility award letter.

d. The PCCM-e must advise all MCPs, and include language in the ACHN MCP Participation Agreement, of the requirement for pregnant recipients to participate in the network for maternity care management in order for the Agency to consider the recipient's maternity care a covered service.

e. The PCCM-e must have processes in place to:
    1. Engage recipients in the care management program;
    2. Assist with establishing Medicaid eligibility by providing assistance through Certified Application Assisters (referenced in Key Staff and Other Position Requirements Policy, Appendix K to this RFP) with the Medicaid application process;
    3. Develop and implement person-centered holistic plans of care;
    4. Assist with accessing MCPs;
    5. Complete screenings and psychosocial assessments;
    6. Conduct face-to-face encounter visits and home visits when indicated;
    7. Reduce the potential for risks of adverse pregnancy outcomes;
    8. Assist with appointments and appointment reminders, to include making prenatal and postpartum appointments and providing recipients appointment cards/appointment reminders;
    9. Collaborate with MCPs to ensure recipients receive high-risk care as appropriate;
    10. Coordinate and make appropriate referrals including, but not limited to:
        - Plan First/family planning referral;
        - Tobacco cessation counseling and referral;
        - ADPH Quitline;
        - Screening, Brief Intervention and Referral to Treatment (SBIRT);
        - Evidence based home visiting resources, e.g., Nurse-Family Partnership (NFP).
    11. Track recipients throughout pregnancy and postpartum periods;
    12. Follow-up with providers and recipients to ensure prenatal and postpartum appointments are kept;
    13. Transition recipients to non-maternal health care management within forty-five (45) calendar days after the last required encounter during the postpartum period is completed (if applicable);
    14. Provide care management in versatile settings to include, but not limited to, the recipient's home, community, doctor's office, public facilities (as requested by the recipient), or clinics;
    15. Assist with the coordination of non-emergency transportation needs;
    16. Improve health literacy, health outcomes, and self-management;
    17. Promote effective use of the healthcare system and community resources;
    18. Reduce potential for risks of catastrophic or severe illness;
    19. Reduce disease exacerbations and complications;
    20. Reduce inappropriate utilization with emergency departments and hospital inpatient services;
    21. Identify additional key resources and incorporate them (such as partnerships with ADPH and ADMH);
    22. Use evidence-based clinical practice guidelines;

23. Promote the use of a Medical Home through the education of recipients on its importance;
24. Improve identification of individuals for possible clinical depression using PHQ-2, PHQ-9, and PHQ-A:
    - PHQ-A for recipients age 12-17.
    - PHQ-2 for recipients age 18 and older.
    - PHQ-9 for recipients age 18 and older that score a four (4) or higher on the PHQ- 2.
25. Comply with the Agency's requirements for data collection and entry into an approved HIMS; and
26. Comply with the Agency's quality, utilization and auditing processes.

f. The PCCM-e must provide maternal health care management to all recipients as outlined in Care Management Activity Schedule.
g. The PCCM-e will provide care management based on the level of need and risk stratification. The risk stratification is based on the recipient's maternal health severity of disease or chronic illnesses, SDoH and history of adverse pregnancy outcomes.
h. The maternal health risk assessment and screening process must:
    1. Include a maternal health risk identification strategy;
    2. Include a maternal health screening with the recipient as outlined in the Care Management Activity Schedule;
    3. Include a maternal Health Risk and Psychosocial Assessment for all recipients as outlined in the Care Management Activity Schedule.
i. Stratify all pregnant recipients, after the first three (3) months of initial engagement, to the appropriate risk level based on the Agency established stratification criteria (See Maternity Risk Stratification Criteria in the Procurement Library). The risk stratification levels are:
    - High
    - Low
j. Recipients who received no prenatal care prior to the delivery date will automatically be stratified as High Risk. This risk stratification requirement does not apply to individuals granted emergency Medicaid due to their non-citizen status.
k. The PCCM-e must develop a maternal health care plan for all pregnant recipients. The care plan must:
    1. Be initiated and completed by the Care Manager within the timeframe outlined in the Care Management Activity Schedule;
    2. Be person-centered/caregiver-centered with a team approach; and
    3. Include the PCPs/community agencies as appropriate.
l. The PCCM-e must offer care management services to mothers and their newborn in cases where the mother delivered with no prenatal care. The face-to-face inpatient delivery encounter with the mother includes but is not limited to:
    1. Counseling on contraception and family planning services; and
    2. Counseling on appropriate postpartum care.
m. The PCCM-e must develop a MCP Network and collaborative relationships with MCPs. To have an effective selection and choice process for coordinating maternity care, the PCCM-e has the responsibility of establishing a comprehensive network of

MCPs within at least fifty (50) miles of all areas in their region that can provide prenatal, delivery and postpartum care in a coordinated care delivery system.

n. The PCCM-e must continually monitor the provider network to ensure that the capacity is sufficient to meet the needs of all recipients and to ensure that availability and accessibility to services are not hindered. The PCCM-e must submit documentation to the Agency when there are changes in its maternity provider network.

B. MCP Notification

1. The PCCM-e shall notify the MCP of the recipient's selection within five (5) Business Days for maternity care.
2. The PCCM-e shall provide each MCP a monthly listing of pregnant recipients who have selected that particular MCP for their maternity care. The PCCM-e shall provide this list prior to the first day of each month.
3. MCP Selection Process. The PCCM-e must have policies and procedures in place to assist the recipients in selecting a MCP of her choice for maternity care services from a list of Medicaid enrolled providers. Recipients may not in any way be influenced when selecting an MCP.
4. The PCCM-e must inform, in writing, MCPs who shall be involved in the recipient's care.
5. If the recipient does not want to choose an MCP on the first day of engaging with the PCCM- e, then the PCCM-e must inform the recipient that there are five business days allowed to choose an MCP, or the PCCM-e shall select a MCP for the recipient from the MCP choice list maintained by the PCCM-e.
6. In the event the recipient refuses to choose an MCP or fails to choose an MCP within the designated time frame, the PCCM-e must select, for the recipient, an MCP based on equivalent distribution among the MCPs with available openings to serve additional recipients. This process must include consideration of the distance the recipient lives from the MCP's office and prior relationships. The PCCM-e shall notify the recipient and the MCP of the selection.
7. If the MCP has no availability for additional patients, the PCCM-e must work with the recipient to have an MCP selected within two business days of notification that the selected MCP has no availability.
8. The PCCM-e must demonstrate network adequacy to meet the medically necessary maternity needs of recipients in their contracted Region. The provider network shall include obstetricians/gynecologists, other physicians, or providers with credentials to perform prenatal, delivery, and postpartum care within fifty (50) miles, when possible, of all areas of the contracted Region or as otherwise directed by the Agency.
9. The PCCM-e must:
    a. Identify, develop, and maintain an MCP Network report demonstrating network adequacy to include the MCP's delivering hospitals;
    b. Continually monitor the provider network to ensure capacity is sufficient to meet the needs of recipients, ensuring accessibility to maternity services are not hindered; and
    c. Submit documentation to the Agency when there are changes in the provider network or changes in the provider's hospital delivering privileges.
10. The PCCM-e must develop, implement, and maintain policies and procedures addressing network adequacy for the Agency's approval.
11. The PCCM-e shall:

a. Comply with the network adequacy requirements;
b. Submit a Network Adequacy Report to include the name of MCP and group practice (if applicable), provider specialty, location of practice address, county of practice, telephone number, email address, fax number, and delivering hospital;
c. Monitor participating providers regularly to determine compliance with the Participation Agreement and the requirements of this RFP; and
d. Take corrective action if there is a failure to comply with this RFP.

12. The PCCM-e must submit the documentation of network adequacy no less frequently than the following:
    a. At the time of readiness;
    b. On an annual basis; and
    c. At any time there is a change in the PCCM-e's MCP provider network.
13. Changes in the Selection Process
    a. General – Recipients must be allowed to change a MCP once without cause within the first ninety (90) calendar days of selecting an MCP and at any time for just cause, which is defined as a valid complaint submitted verbally or in writing to the PCCM-e.
    b. PCCM-e Responsibilities
        i. The PCCM-e must inform the recipient of the recipient's rights to change MCPs, with and without cause at the initial contact and at least once per year.
        ii. The PCCM-e must provide, at the time of initial contact all required information regarding rights and responsibilities, and appropriate telephone numbers.
14. Tribal Population – If an enrollee is an American Indian and is eligible to receive services from an Indian health care provider (IHCP) MCP participating as a network provider, the enrollee is permitted to choose that IHCP as their MCP, as long as that provider has capacity to provide the services.

C. MCP Selection Referral Process

1. The PCCM-e must comply with the MCP selection referral process. No maternity claims will be paid/reimbursed unless a MCP receives a selection referral and the PCCM-e's National Provider Identifier (NPI) number is on the MCP's claim.
2. The PCCM-e must provide a written referral to the MCP and the recipient for the MCP selected during the MCP selection process.
3. If a change in the MCP is made by the recipient as outlined in the MCP selection process, a written referral shall be provided to the MCP immediately by the PCCM-e, or no later than four hours of the change in the MCP.
4. If a recipient arrives at the maternity provider's office with no MCP selection referral and the recipient has not engaged with the PCCM-e for care management, the PCCM-e may issue a one-time referral for the first visit. Then, the MCP must redirect the recipient to the PCCM-e for initiation of care management. A permanent referral shall be granted after the recipient engages with the PCCM-e for care management.
5. To expedite services and prevent barriers, the PCCM-e may generate verbal MCP selection referrals. If verbal referrals are generated by the PCCM-e, written referral must be provided within 24 hours of giving a verbal referral.
6. The PCCM-e must document all verbal MCP selection referrals and must maintain written referrals in the HIMS to assist in claim reimbursement and auditing purposes.
7. PCCM-e shall mandate, in the ACHN MCP Participation Agreement, for maternity providers to maintain copies of all referrals at the provider level for auditing purposes.

3. Behavioral Health Program

1. The PCCM-e must implement a program approved by the Agency to integrate behavioral health services, including both mental health and SUD, and medical services for recipients.
2. The Behavioral Health Program must have applicable care management staff to support the Behavioral Health Program.
3. PCCM-e responsibilities of the Behavioral Health Program must include:
    a. A screening and assessment for appropriateness of care management services;
    b. Education of recipients regarding services provided through the PCCM-e;
    c. Linkage of recipients to appropriate services to integrate behavioral health and medical care such as behavioral health and SUD related providers as needed;
    d. Community Mental Health Centers (CMHCs) as needed;
    e. Consultation to the MCT regarding behavioral health issues or topics and resources in the area;
    f. Transitional care for recipients requiring care management services who transition from a psychiatric facility to the community; and
    g. Integration of behavioral health and medical care including professionals such as behavioral health nurses, PCPs, PCCM-e care management staff, community mental health center staff, and SUD providers collaborating to ensure services are provided to recipients with SUDs, chronic illnesses, and mental health conditions.
4. The PCCM-e will provide the following behavioral and physical health integration elements in training participating providers and PCCM-e staff:
    a. Joint sponsorship of trainings with community stakeholders;
    b. Development and sharing of resources and tools to support participating providers; and
    c. Prevention of SUD.

4. Pharmacy Program

A. General

1. The PCCM-e must have a Pharmacy Program to develop, coordinate, implement, and manage education of community, transitional, and all pharmacists and PCPs within the PCCM-e and Agency pharmacy initiatives.
2. The PCCM-e must develop, coordinate, engage within, and manage staff to implement programs that advance the Medical Home.
3. The PCCM-e must have a Pharmacy Director, Community Pharmacist, and Transitional Pharmacist on staff to support the development of the Medication List and to complete the Medication Reconciliation Review Process (see Appendix K, the Key staff and Other Positions Requirements Policy, for additional requirements).

B. Medication List

Completion of a Medication List must be performed by the assigned care manager, i.e., Transitional Care staff, Behavioral Health, Care Manager, Pharmacist, Community Health Worker (CHW), or other personnel with adequate skill and competency.

1. The Medication List shall include, but is not limited to:
    a. Discharge instructions, including medications, from hospital/facility;
    b. Current provider's orders from the PCP and/or MCP's chart or electronic health record (EHR);
    c. Fill history (can be retrieved from the Pharmacy Home and/or the PCCM-e's

HIMS);
    d. Information from any pharmacy on medication the recipient has used within the last year; and
    e. Over-the-counter/non-legend drugs, dietary/herbal supplements, etc. Information may need to be obtained through the medication reconciliation process.
2. The Medication List must be reviewed by the applicable pharmacist for Medication Reconciliation Review in accordance with the Care Management Activity Schedule. Contraindications must be reviewed by a Pharmacist and the Pharmacist must be available to the PCCM-e staff and others as needed for consultation.
3. The care manager shall review the Medication List with the recipient as outlined in the Care Management Activity Schedule to enhance drug use information gathering. The caregiver or family may be present at the interview. The Medication List shall include all of the recipient's currently prescribed and over-the-counter medications.

C. Medication Reconciliation Review Process

1. Medication Reconciliation Review is the process of gathering, organizing, and sharing with providers drug use information from multiple sources, including the recipient, medical chart, prescription fill history, and discharge instructions, to identify and resolve drug duplications, interactions, possible adverse events, contraindications, poor adherence, or other suboptimal drug-taking behaviors.
2. Medication Reconciliation must be completed for all recipients in the general population stratified as medium or high risk, and maternity recipients stratified as high risk. In addition, medication reconciliations are to be completed on all Transitional Care recipients. A medication reconciliation will be provided to actively managed recipients as outlined in the Care Management Activity Schedule.
3. Required Staff: Pharmacists-Community and Transitional

5. Transitional Care Program

A. General

PCCM-e must develop a Transitional Care Program to support recipients discharging from an inpatient or residential setting to ensure continued management of care. The intensity of care management services needed will be identified by use of the stratification criteria. See the appropriate Care Management Activity Schedule for guidelines related to care management activities plan.

B. Transitional Process

1. The Transitional Care Team will establish processes to assist recipients in their transition from a facility to the community setting to include, but not be limited to, the following:
    a. Reviewing daily census at inpatient or residential settings to identify recipients needing support at discharge;
    b. Collaborating with appropriate hospital or facility discharge staff in preparation for recipients returning to the community; and
    c. Educating recipients regarding the services provided by the PCCM-e.
2. When possible, begin the transitional care process with the recipient during hospitalization to initiate services, and provide transitional care services to recipients identified as needing care management services while transitioning back to the community. Transitional Care staff will render services in accordance with the applicable Care Management Activity Schedule as determined by the recipient's risk stratification in addition to the following:

a. Assist with environmental adaptations, equipment, and technology the recipient needs for a successful care setting transition;
b. Provide transitional care services until all goals are met;
c. Coordinate with the Maternity Care Manager to ensure a smooth transition of recipients to non-maternal healthcare prior to the end of the postpartum period (as applicable); and
d. Ensure proper transition and coordination with ADMH, the Agency, and with CMHCs when recipients are moving to or from a mental health facility.

6. Ongoing Monitoring

A. Agency Responsibilities

1. The Agency will conduct ongoing monitoring related to the performance of the following in accordance with 42 C.F.R. §438.66:
    a. Administration and management;
    b. Appeal and grievance systems;
    c. Claims management;
    d. Enrollee materials and customer services, including the activities of the recipient support system;
    e. Finance;
    f. Information systems, including encounter data reporting;
    g. Marketing in accordance with 42 C.F.R. § 438.104;
    h. Medical management, including utilization management and case management;
    i. Program Integrity;
    j. Provider network management, including provider directory standards;
    k. Availability and accessibility of services, including network adequacy standards;
    l. Quality improvement; and
    m. All other provisions of the RFP, as appropriate.
2. The Agency shall conduct ongoing monitoring and supervision as required by 42 C.F.R. § 438.66 to address all aspects of the PCCM-e including determining the PCCM-e's ability to provide services to recipients and resolve any identified operational deficiencies. Monitoring and supervision may include, but shall not be limited to, conducting quarterly documentation review audits, administrative audits, and site visits as determined by the Agency. The ongoing monitoring and supervision shall ensure care management services and program operations are provided according to the Agency, state and federal regulations and guidelines.
3. The Agency may require the PCCM-e to develop and implement CAPs acceptable to the Agency, demonstrating the PCCM-e's ability to satisfy the Agency, state and federal requirements.
4. If findings are identified during the monitoring and supervision activities, including documentation review audits, the Agency may seek recoupment of paid funds, recovery of misspent Medicaid funds, and recovery of erroneously paid benefits recoverable under federal law.

B. PCCM-e Responsibilities

1. The PCCM-e must cooperate with the Agency in the ongoing monitoring and supervision, including but not limited to:
    a. Providing all information, data, or reports the Agency requires or requests under the Contract, including but not limited to the Agency's annual report to CMS on

the PCCM-e as required by 42 C.F.R. § 438.66(e)(1); and
   b. Allowing the Agency reasonable access to the PCCM-e's facilities, staff, leadership, and HIMS.
2. The PCCM-e shall review all audit/monitoring findings and reports to determine the areas in which care management needs improvement and areas where staff needs additional training. If the PCCM-e does not agree with the audit/monitoring results or findings, the PCCM-e may request, in writing, an audit/monitoring reconsideration according to guidelines provided by the Agency.

7. Quality Improvement Program

A. General

1. The PCCM-e must implement a Quality Improvement Program to improve health outcomes by:
   a. Systematic data analysis to target recipients with chronic medical and/or behavioral health conditions and providers for outreach, education, and intervention;
   b. Monitoring access to care, services, and treatment including linkage to a Medical Home;
   c. Monitoring quality and effectiveness of interventions;
   d. Facilitating quality improvement activities that educate, support, and monitor providers regarding evidence-based care for best practices; and
   e. Implementing clinical management initiatives identified as priorities by the Agency.
2. The Quality Improvement Program is guided and directed by the PCCM-e's Quality Improvement Plan. The Program incorporates various components including, but not limited to, the Quality Improvement Projects, Quality Improvement Plan and its annual evaluation, External Quality Review reports, quality measure performance, quality committees, and any other components that support the continued improvement of the health outcomes of the recipients and the success of the PCCM-e.
3. The PCCM-e will employ or contract with a Medical Director that is part time.
4. The PCCM-e will employ a Quality Care Director that will work with practices and community providers in the implementation of the Quality Improvement Program.
5. In accordance with 42 C.F.R. Part 438, Subparts D and E and the Alabama Medicaid Administrative Code Chapter 560-X-37, the PCCM-e must have an ongoing Quality Assessment and Performance Improvement Program that executes a Quality Improvement Plan to systematically monitor and evaluate the quality and appropriateness of care and services rendered to recipients and promote and improve quality of care and health outcomes for its recipients.
6. The PCCM-e must develop, implement and maintain written policies and procedures which address components of effective healthcare management including but not limited to anticipation, identification, monitoring, measurement and evaluation of recipient's healthcare needs, and effective action to promote quality of care.
7. The PCCM-e must develop and implement improvements in processes that enhance clinical efficiency, provide effective utilization, care management and focus on improved outcomes management.

B. Quality Improvement Plan

1. The PCCM-e must develop and submit a written Quality Improvement Plan herein referred to as "Improvement Plan", to the Agency within thirty (30) calendar days from

execution of the Contract and resubmit it to the Agency annually by October 1st of each year for written approval. The Improvement Plan must also be submitted at least thirty (30) days prior to anticipated change to the Plan. These changes must be approved by the Agency prior to implementation of the anticipated change.

a. The PCCM-e must annually:
    i. Measure and report to the Agency on its performance, using the quality measures required by the Agency; or
    ii. Submit data, specified by the Agency, which enables the Agency to calculate the PCCM-e's performance using the quality measures identified by the Agency.

2. The Quality Improvement Plan must:
    a. Include a detailed overview of all elements that encompass the Quality Improvement Program in order to serve as a guiding document for the PCCM-e.
    b. Include processes for the investigation and resolution of individual performance or quality of care issues whether identified by the PCCM-e or the Agency that:
        i. Allow for the tracking and trending of issues on an aggregate basis pertaining to problematic patterns of care;
        ii. Collect and submit performance measurement data in accordance with 42 C.F.R. § 438.330(c);
        iii. Implement mechanisms to detect both underutilization and overutilization of services and identify potential disparities in care;
        iv. Monitor the delivery of care management services provided, including but not limited to, an assessment of care between care settings;
        v. An Assessment of the level of care management provided; and
        vi. Health outcomes of the recipient.

C. External Quality Reviews

1. The PCCM-e must, as required by 42 C.F.R. Part 438, Subpart E:
    a. On at least an annual basis, cooperate fully with any and all independent assessments as authorized by the Agency and/or conducted by the Agency's contracted External Quality Review Organization (EQRO) or other designee to assess the PCCM-e's performance including quality outcomes, timeliness of, and access to services.
    b. Provide to the EQRO all information the EQRO deems to be necessary in performing its review of the PCCM-e.
    c. Independent assessments must include, but not be limited to, validation of PCCM-e submitted quality measure rates via an EQRO, or other designee conducted audit, any independent evaluation required by Federal or State statute or regulation, and any other independent evaluation required by the Agency.

D. Performance Monitoring and Improvement Process

1. The PCCM-e must cooperate and participate, as requested by the Agency, in the Agency's performance monitoring and improvement process. At a minimum, this may include the following activities: the review of monthly, quarterly, and annually reported quality and performance measure data, including PCCM-e quality measures as specified by the Agency, CMS-required performance standards and other measures as deemed appropriate by the Agency to manage the PCCM-e.
2. The Agency shall track and provide PCCM-e quality measure results to the PCCM-e to evaluate program performance and outcomes.

3. Upon request by the Agency, the PCCM-e shall provide all relevant information necessary to evaluate the performance and outcomes.
4. At least quarterly, and upon request by the Agency, the PCCM-e must attend a meeting with the Agency to share performance results and to discuss performance successes and challenges to aid the Agency in determining the effectiveness of the PCCM-e's quality improvement activities.
5. Quality Monitoring by the Agency. The Agency shall review, at least annually, the impact and effectiveness of the PCCM-e's Quality Improvement Plan. The items the Agency shall review include, but are not limited to, the PCCM-e quality measures performance, the PCCM-e's most current annual Quality Improvement Plan, the PCCM-e's most current Quality Improvement Plan evaluation for the previous calendar year, and the PCCM-e's Medical Management Committee minutes.
6. At least sixty (60) calendar days prior to the Agency's review, the PCCM-e shall provide to the Agency:
    a. The PCCM-e's most current annual Quality Improvement Plan;
    b. The PCCM-e's most current Quality Improvement Plan evaluation for the previous calendar year; and
    c. All other information requested by the Agency to facilitate the Agency's review of the PCCM-e's compliance standards defined in the Agency's quality strategy.

E. Quality Improvement Projects

1. Quality Improvement Projects (QIPs) comprise one component of the overall PCCM-e Quality Improvement Program. The purpose of a QIP is to focus on and improve the PCCM-e processes and the health outcomes of the recipients. Annually and for subsequent revisions within the year, the PCCM-e must submit for the Agency's approval, a description of its QIPs which it has chosen to implement to address each of the topic categories chosen by the Agency. If an additional QIP is required after the annual submission due to Agency or CMS demands, the PCCM-e will be notified as soon as possible and given appropriate time to develop the project. At a minimum, the PCCM-e must develop a QIP to address the following topics:
    a. Prevention of childhood obesity;
    b. Infant mortality and/or adverse birth outcomes; and
    c. SUD.
2. The PCCM-e must successfully meet all requirements within each QIP category as determined by the Agency.
3. The PCCM-e can choose a QIP approved by the Agency.
4. The PCCM-e must work with the Agency designated entities to develop, implement and evaluate the PCCM-e's annual QIPs. This includes participating in in-person meetings, conference calls, providing data to the PCCM-e and any other required activities to implement successful QIPs.
5. Each QIP must contain the following sections:
    a. Targeted quality measure(s)
    b. Project goal(s)
    c. Project variable(s)
    d. Direct benefit to the recipient
    e. Expected cost of the project
    f. Representative and generalizable sample
    g. Sound sampling methods
    h. Reliable data collection

i. Measurement of performance using objective quality indicators
j. Implementation of system interventions to achieve improvement in quality
k. Evaluation of the effectiveness of the interventions; and
l. Planning and initiation of activities for increasing or sustaining improvements

6. Performance withholds. The monthly per member per month (PMPM) payment will be subject to a withhold amount. The withhold shall be 10 percent (10%) of the QIP portion of the payment. The withhold will be retained by the Agency until the period for determination of return of the withhold to the PCCM-e. The performance standards related to the withholds are as follows:

Performance Standard	Description Summary	Amount of Performance Withhold at Risk
1	Percent of QIP Funds expended directly to beneficiaries	60%
2	Completion of PCCM-e proposed QIP's	20%
3	Completion of Proposed QIP Outcomes	20%

Refer to the Quality Improvement Project Requirements Policy, Appendix L, for more details.

F. PCCM-e Quality Incentive Program

Ensuring quality outcomes for Medicaid recipients is one of the primary goals of the ACHN program. Quality efforts should reflect a partnership between the PCCM-e, the providers, and the Agency. To promote quality improvement within the ACHN program, the Agency has implemented a Quality Incentive Payment Program. The PCCM-e will have the opportunity to earn incentives based upon the achievement towards Agency determined benchmarks for each of the identified quality measures. Refer to the Quality Incentive Payment Methodology Policy, Appendix M, for more information.

1. The PCCM-e will have the opportunity to participate in an Incentive Program based upon the achievement of Agency determined benchmarks for each of the quality measures. Starting in Fiscal Year 2026, the Agency will distribute earned incentive funds based on the PCCM-e's performance for the incentive measures of the previous calendar year. For the first year of implementation, if the PCCM-e is operational for a minimum of ten (10) months or more, the PCCM-e's performance will be evaluated on the full calendar year's outcomes.

2. If the PCCM-e achieves the minimum necessary of the annual benchmarks, it will be eligible to receive up to a fifteen percent (15%) incentive payment. The Quality Measures document (Appendix N lists the quality measures). These measures are subject to change. If there is a change, the Agency will notify the PCCM-e of the change.

8. Routine Meeting Attendance/Participation

A. Region Medical Management Committee

1. The PCCM-e must establish and is responsible for a Region Medical Management Committee which satisfies the following requirements:
   a. Chaired by the Medical Director, and
   b. Composed of all participating providers who must have at least one representative (PCP, Physician Assistant, or Nurse Practitioner) from its medical practice to participate over a 12-month period in at least three (3) quarterly Medical Management Meetings with the PCCM-e's Medical Director.

(Reference the Medical Management Meetings requirements in the Procurement Library.)

2. The purpose of the Region Medical Management Committee is to:
    a. Implement and supervise program initiatives centered around quality measures,
    b. Review utilization data with PCPs as needed to achieve quality goals of the PCCM-e,
    c. Review and assist the PCCM-e in implementing and evaluating its QIPs, and
    d. Discuss and, when appropriate, resolve any issues the PCPs or the PCCM-e encounter in providing care management services to their recipients.

B. PCCM-e Quality Collaborative

The PCCM-e must participate in the Agency-led PCCM-e Quality Collaborative ("Collaborative") that is minimally composed of the Agency, PCCM-e from each Region, and other state agency representative(s) when appropriate. See Appendix L, Quality Improvement Project Requirements for details.

9. Provider Participation with PCCM-e

A. PCP Participation with the PCCM-e

1. PCP practices will be required to sign participation agreements with the PCCM-e outlining responsibilities for the PCP to work with the PCCM-e to achieve program goals. The PCCM-e must allow requesting FQHCs and RHCs to engage in active participation with the PCCM-e by signing a participation agreement with the PCCM-e. The PCCM-e shall provide inbound files for PCP enrollment to a third-party administrator no later than the fifteenth (15th) calendar day of the month to enroll the PCP for the following month. The Agency will provide a template for the participation agreement. As part of monitoring, the PCCM-e shall provide monthly reports of PCP enrollment by submitting copies of inbound files for PCP enrollment to the Agency by the fifteenth (15th) calendar day of the month.
2. Active Participation will be a requirement for a PCP practice participating with the PCCM-e. Active Participation requirements are as follows:
    a. Participates as needed in the PCCM-e's MCT and the development of an individualized and comprehensive care plan;
    b. Over a twelve (12) month period, participates in person in at least three (3) quarterly Medical Management Meetings with the PCCM-e's Medical Director.
        i. Attendance requirements can be met by having one PCP or Nurse Practitioner/Physician Assistant from the group attend.
    c. Participates in PCCM-e initiatives centered around quality measures; and
    d. Reviews data provided by the PCCM-e to help achieve Agency and PCCM-e quality goals.
3. The PCCM-e must provide the Agency with quarterly and annual reports of those PCP practices meeting the active participation requirements. The quarterly reports shall be submitted to the Agency no later than the fifteenth (15th) business day after the quarter ending date. The annual reports shall be submitted to the Agency no later than the fifteenth (15th) business day after the end of the last quarter of the contract year.

B. MCP Participation with the PCCM-e

1. The MCPs will be required to sign participation agreements with the PCCM-e outlining responsibilities for the MCP to work with the PCCM-e to achieve program goals. The Agency will provide a template for the participation agreement. The PCCM-e shall provide inbound files for MCP enrollment to a third-party administrator no later than

the 15th calendar day of the month to enroll the MCP for the following month. As part of monitoring, the PCCM-e shall provide monthly reports of MCP enrollment by submitting copies of inbound files for MCP enrollment to the Agency by the fifteenth (15th) calendar day of the month.

2. Active participation will be a requirement for an MCP participating with the PCCM-e. Active participation requirements are as follows:
    a. Providing data to the PCCM-e;
    b. Participating in the development of the recipient's care plan; and
    c. Participating in the MCP selection and referral process.
3. The PCCM-e must provide the Agency with a quarterly and annual report of those MCPs meeting the active participation requirements. The quarterly report shall be submitted to the Agency no later than the fifteenth (15th) business day after the quarter ending date. The annual report shall be submitted to the Agency no later than the fifteenth (15th) business day after the end of the last quarter of the contract year.

10. Readiness Assessment

A. Agency Responsibilities

1. The Agency shall conduct readiness assessments as required by 42 C.F.R § 438.66 and in accordance with applicable Alabama Medicaid Administrative Code to determine the PCCM-e's readiness and ability to provide services to its recipients and resolve any identified operational deficiencies prior to the implementation date of the program. The Agency may require the PCCM-e to develop and implement CAPs acceptable to the Agency demonstrating the PCCM-e's readiness to satisfy the requirements of this RFP.
2. The Agency will conduct a readiness review for each PCCM-e as follows:
    a. Start at least three (3) months prior to the effective date of the program; and
    b. Will include both desk and on-site reviews.

B. PCCM-e Responsibilities

1. The PCCM-e must cooperate with the Agency in the Agency's readiness assessments, including but not limited to:
    a. Providing all information, data, policies, procedures and reports the Agency requires or requests that are within the scope of the readiness assessments;
    b. Allowing the Agency reasonable access to the PCCM-e's facilities, staff, and leadership;
    c. If the PCCM-e has more than one location, all readiness requirements would also apply to that additional location(s); and
    d. Participating in readiness reviews, onsite and virtually, as conducted by the Agency.
2. The PCCM-e acknowledges and understands that it shall neither provide services to recipients nor be paid until the Agency has determined, in its sole discretion, that the PCCM-e has demonstrated readiness to satisfy the requirements of this RFP and until the effective date. The Agency will provide a written notice to the PCCM-e when the PCCM-e has met all requirements of the RFP and can provide services to the recipients.

III. General Requirements

1. PCCM-e Organizational Requirements

The PCCM-e must meet all RFP guidelines and comply with all authoritative documents and any revisions thereto. The PCCM-e must:

1. Be organized as a nonprofit entity under Alabama law, with an office located in the Region where the PCCM-e operates;
2. Have an Alabama domicile;
3. Provide documentation that the PCCM-e is operating as a nonprofit entity in Alabama (or such status has been applied for), to including, a copy of its nonprofit articles of incorporation, and bylaws;
4. Submit the PCCM-e's governing bylaws, board composition, organization documents, policies, and procedures for review and approval by the Agency; and
5. Maintain all necessary business licenses, registrations, and certifications to be able to conduct business in Alabama.

A. Governing Board

The PCCM-e must establish or have established a Governing Board that:

1. Meet at least once in the second quarter, and at least once in the fourth quarter;
2. Keep minutes of meetings and other records to document that the Governing Board is effectively discharging its obligations. All records must be maintained for not less than ten (10) years;
3. Submit minutes of the Governing Board meetings no later than the fifteenth (15th) calendar day of the month following the Governing Board meeting, and other records as requested to the Agency;
4. Notify the Agency's Networks Division within ten (10) business days of any substantial or material corrections or updates to the information provided related to the Governing Board, including but not limited to organizational or governing documents;
5. Notify the Agency within ten (10) business days of any vacancies or additions to the Governing Board and identify the replacement to fill any vacancies within sixty (60) calendar days of the vacated position;
6. Receive a verbal report from the Consumer Advisory Committee (CAC) at each Governing Board meeting; and
7. Have the following Governing Board composition:
    a. Fifty percent (50%) of the Governing Board must be primary care physicians (including at least one MCP) who practice in the Region and engage in active participation with the PCCM-e. Up to two of these PCPs can be employed by a hospital; and
    b. Representative(s) from each of the following:
        i. At least two (2) representatives of in-Region hospitals representing more than one system, if more than one system exists in a Region;
        ii. At least one (1) representative of a Community Mental Health Center located in the Region;
        iii. At least one (1) representative of a Substance Use Treatment Facility located in the Region;
        iv. At least one (1) Consumer Representative (e.g., recipient, parent of a recipient or advocacy organization representative) who lives in the Region; and

v. At least one (1) representative of a Federally Qualified Health Center located in the Region.
vi. At the PCCM-e's discretion and subject to Agency approval, no more than two (2) additional representatives who are not employed by or subcontracted with, either directly or indirectly, an organization as described above.

8. The PCCM-e must meet with their Governing Board quarterly to report barriers to service provision, progress on QIP interventions, network, solicit input on partnering opportunities to assist the PCCM-e in driving improved quality outcomes.

B. Consumer Advisory Committee (CAC)

1. The PCCM-e must have a CAC that shall:
   a. Advise the PCCM-e on ways the PCCM-e may be more efficient/effective in providing quality care to its recipients;
   b. Carry out other functions and duties assigned to it by the PCCM-e and approved by the Agency;
   c. Be selected in a method established by the PCCM-e and approved by the Agency;
   d. Meet at least once in the first (1st) quarter, and at least once in the third (3rd) quarter each year;
   e. Consist of at least six members. Twenty percent (20%) of the members must be recipients and/or parent/care takers of recipients residing in the Region served by the PCCM-e;
   f. Include members who are representatives of Medicaid recipients or low-income advocacy organizations;
   g. Include only persons who live in the Region the PCCM-e plans to serve;
   h. Elect a chair; and
   i. Provide a verbal report at each Governing Board meeting.
2. The PCCM-e must:
   a. Obtain all necessary approvals, consents or waivers from Medicaid recipients and comply with all applicable laws regarding privacy and confidentiality related to such information before providing it to the Agency;
   b. Notify the Agency within ten (10) business days of any vacancies or additions to CAC and identify the replacement to fill any vacancies within sixty (60) calendar days of the vacated position;
   c. Submit CAC minutes to the Agency, no later than the fifteenth (15th) calendar day of the month following the CAC meeting, and other records as requested by the Agency; and
   d. Ensure that the CAC maintains all records for a period of ten (10) years.

3. The PCCM-e must have at implementation and maintain the organization, management, and administrative systems necessary to fulfill all requirements of this RFP and comply with any other applicable state and federal laws and regulations. The PCCM-e must demonstrate to the Agency's satisfaction, via submission of a staffing plan and resumes, that it has the required staffing, by function and qualifications, to fulfill its obligations under this RFP.
4. The PCCM-e shall notify within ten (10) business days the Agency's Networks Division of any change within the PCCM-e's organizational structure and key staff.

2. Financial

1. The PCCM-e shall review annually and ensure compliance with the state guidelines for nonprofit organizations receiving state funds.
2. The PCCM-e shall prepare and submit an annual operating budget to the Agency, using the Agency's approved template, for approval at least thirty (30) calendar days prior to the start of each state fiscal year. The operating budget shall differentiate general and administrative expenses versus program expenses.
3. The fiscal year for the PCCM-e will be the same as the state fiscal year, October 1 through September 30.
4. The PCCM-e must obtain written approval from the Agency's Networks Division prior to revising any budget line-item more than ten percent (10%).
5. The PCCM-e must maintain accurate records of expenditures in accordance with federal financial reporting and governmental accounting standards as defined by Generally Accepted Accounting Principles (GAAP).
6. The PCCM-e must annually submit within ninety (90) calendar days of the end of the state fiscal year an audit performed by an independent certified public accountant prepared in accordance with GAAP and Generally Accepted Auditing Standards. The audit must contain a "Statement of Functional Expenses" or include a functional expense analysis in the footnotes of the audited statements.
7. The PCCM-e shall submit quarterly financial reports using a template provided by the Agency. The reports shall be due no later than the fifteenth (15th) business day following the last day of the quarter.
8. The PCCM-e shall on a monthly basis submit an accounting flash report, using a template provided by the Agency that gives a high-level summary of monthly revenues and expenses. The flash report shall be due ten (10) business days following the last day of the preceding month. At the discretion of the Agency, if the PCCM-e incurs two (2) consecutive months with expenses greater than revenues, the PCCM-e will submit to the Agency a CAP that details the actions the PCCM-e will enact to enable the PCCM-e to decrease expenses below revenues. The CAP must be submitted within ten (10) business days following receipt of Agency notification that a CAP is required.
9. To assure full performance of all obligations imposed on a PCCM-e contracting with the State of Alabama, the PCCM-e must provide a performance guarantee in an amount equal to two hundred and fifty thousand dollars ($250,000). The performance guarantee must be submitted by the PCCM-e at least ten (10) calendar days prior to the Contract start date. This performance guarantee must be in force through the term of the Contract and ninety (90) calendar days beyond and must be conditioned on faithful performance of all contractual obligations.
10. The form of performance guarantee shall be one of the following:
    a. An irrevocable letter of credit;
    b. Surety bond issued by a company authorized to do business within the State of Alabama; or
    c. By maintaining at all times, a minimum capital and surplus consisting of admitted assets comprised of at least one the following:
        i. Cash, including the true balance of deposits in solvent banks and trust companies;
        ii. Bonds, notes, warrants, debentures, and other evidences of indebtedness which are direct obligations of the United States of America for which the full faith and credit of the United States of America is pledged for the

payment of principal and interest ("U.S. Treasury Securities");

iii. Investment grade bonds or other evidence of indebtedness other than U.S. Treasury Securities, satisfying standards approved by the Medicaid Agency; or

iv. Marketable equity securities, satisfying standards approved by the Medicaid Agency.

11. Failure to perform satisfactorily shall cause the performance guarantee to become due and payable to the state. The Agency's Chief Financial Officer or his/her designee shall be custodian of the performance guarantee. The performance guarantee shall be extended in the event the Agency exercises its option to extend the Contract.
12. In accordance with the provisions of 45 C.F.R. Part 74 and Paragraph 9 of the Federal Office of Management and Budget (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.
13. The PCCM-e 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.
14. The PCCM-e shall maintain, during the life of the Contract, Worker's Compensation insurance for all its employees under the Contract or any subcontract thereof, if required by state law.
15. The PCCM-e shall maintain financial records, supporting documents, statistical records, care management information contained in the PCCM-e's HIMS, and all other records pertinent to the Agency's Program for a period of ten (10) years from the date of the final payment made by the Agency to the PCCM-e 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 ten-year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the ten-year period, the records shall be retained until resolution. Such information shall be provided within thirty (30) business days to the Agency upon request by the Agency.
16. Subcontracts for services with a value over $10,000 per year must be prior approved in writing by the Agency. This includes subcontracts through any potential third-party administrator.

3. Staffing/Organizational Plan

1. The PCCM-e must have appropriate care management (case management and care coordination) staff. Care management is a professional skill that must be supported by the PCCM-e. The skills and functions employed by care management staff include community orientation, population health, population health management, health literacy and SDoH knowledge, the ability to locate, augment, and develop resources including information on services offered by other agencies, conduct needs assessments and the ability to develop, implement, and evaluate, and document within a person (recipient)-centered care plan as part of an MCT. Case management and care coordination staff includes Case Managers, Care Coordinators, Community Health Workers, etc.
2. The PCCM-e(s) must:
    a. Have sufficient and appropriate staff;

b. Ensure staff are properly licensed and credentialed;
c. Ensure staff operates within their professional scope;
d. Ensure staff responds to needs of recipients;
e. Provide appropriate training to all staff; and
f. Submit potential staff resumes for review by the Agency to ensure appropriate experience requirements are met.

4. Key Personnel

1. The Agency must approve all Key Staff prior to hiring, and the PCCM-e must notify the Agency, in writing, within three (3) business days of their awareness of a vacated Key Staff position. The PCCM-e must identify and fill, with Medicaid's approval, any vacated Key Staff position within sixty (60) business days of its vacancy.
2. A resume, documentation of education, and appropriate licensure, as applicable, must be submitted to the Agency for approval.
3. Changes to Key Staff, including individuals, job description, and/or duties, must be approved in advance by the Agency.
4. The PCCM-e must designate individuals who will serve in the Key Staff positions. Refer to the Key Staff and Other Positions Requirements Policy (see Appendix K). Key Staff include:
    a. Executive Director;
    b. Medical Director;
    c. Pharmacy Director;
    d. Population Health Data Analyst;
    e. Quality Care Director; and
    f. Care Management Director.

5. Operational Requirements

Vendor shall have hours of operation Monday-Friday between 8:00am through 5:00pm Central Time, excluding holidays as listed below:

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

A. Place of Business and Hours of Operation

1. PCCM-e must provide reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions in accordance with 42 C.F.R. § 438.3. Although, the business office can be open 8am-5pm, the Agency expects the following regarding care coordination services' place of business and hours of operation:
    a. at least one physical office location for in-person encounters with recipient within the region. The location must be in compliance with all applicable safety and access regulations.
    b. care coordination services be rendered at a location and time amenable to the recipient. (Meet the recipient where they are, i.e., where to meet, what time to meet that may be later than 5pm, etc.)

2. Additionally, PCCM-e must allow care management staff to work outside of the above listed office hours to accommodate the schedules of those to whom case management and care coordination are provided. This can include after work hours, evenings and weekends.
3. Out of state operations
    a. The PCCM-e shall ensure the location of any staff or operational functions outside of the state does not compromise the delivery of integrated services and a seamless experience for recipient and providers.
    b. The PCCM-e shall ensure all staff functions conducted outside of the state are readily reportable to the Agency at all times to ensure the location of staff functions does not hinder the Agency's ability to monitor the PCCM-e's performance and compliance with RFP requirements.
    c. The PCCM-e shall ensure that care management staff conducting care management activities outside of the state must have a professional license, where appropriate, in the state where the care management activity occurred.

B. HIMS Requirements

1. Vendor agrees to install and maintain the necessary hardware, software and secure encrypted data.
2. The Agency requires a HIMS that maintains care management documentation. The system must be able to validate all records with an electronic or digital system per Rule No. 560-X-1-.18 of the Alabama Administrative Code. The HIMS should allow for sequential documentation with the ability to delineate a new note, revised note, or addendum note. It should have the ability to check Medicaid eligibility. The HIMS should be able to accept Admission/Discharge/Transfer (ADT) feeds and have Health Information Exchange (HIE) capability. Failure to input Maternity data and case management and care coordination documentation for each recipient with a 95% accuracy rate up to closure into the Health Information System/Database may result in Sanctions (see Sanctions, Section III.12).
3. The PCCM-e shall submit complete and accurate maternity delivery data for each recipient who delivers while enrolled in the ACHN Program. The data shall be submitted to Medicaid or Medicaid's designee in the format specified in the Maternity Data Field form. All delivery data must be submitted within ninety (90) calendar days of the delivery date.
4. The PCCM-e must develop and maintain a Contingency and Continuity Plan. Refer to the Contingency and Continuity Requirements, Appendix O.

6. Functional Requirements

A. The PCCM-e shall utilize the Agency's Alabama One Health Record® (ALOHR), Alabama's Health Information Exchange, to receive ADTs.
B. If the PCCM-e does not utilize ALOHR, the PCCM-e must identify the alternative approach (i.e., third-party solution) that will be used to receive ADTs and how the ADT data not provided by ALOHR will be reported to the Agency.
C. The PCCM-e will be responsible for reporting to the Agency how many ADTs the PCCM-e is acting upon each month and how both the ADT notification and its information is being utilized.
D. The Agency will provide to the PCCM-e HIMS summary level reports for guiding quality improvement, supporting Providers, and general population health monitoring.
E. The Agency will provide data about specific recipients in the PCCM-e Region.

F. The PCCM-e may request an ad-hoc research request from the Agency through the PCCM-e's primary contact with the Networks Division. Upon review, the Networks Division will forward to the Analytics Division for further review, scope development and prioritization.
G. The PCCM-e must ensure all Protected Health Information (PHI) data is protected per federal and state laws, and the Business Associates Agreement (BAA).
H. The PCCM-e must ensure that the HIMS is fully operational and tested by the PCCM-e, Agency, and/or Agency designee, prior to the completion of the Agency's readiness assessment pursuant to Section II.10. The PCCM-e must ensure prior to the completion of the Agency's readiness assessment that it's HIMS be operational and have completed:
    1. Design;
    2. Testing; and
    3. Training of staff on the HIMS.
I. The PCCM-e HIMS must comply with the following:
    1. The system must provide the Agency a monthly extract of data in the format prescribed by the Agency.
    2. The system must use specifications from the Agency to document user information and case management (see Section III.7.A).
    3. The Agency, directly or through the HIMS, will provide to the PCCM-e the following data for recipients in the Region:
        i. Paid claims data at least monthly or at most after each check write;
        ii. Pharmacy data daily;
        iii. Eligibility data;
        iv. Provider data; and
        v. Reference data.
J. The system will allow the Agency to have access to the system for reviewing case management data and to review security and management components.

7. Technical Requirements

A. System Compliance and Security Management

1. The HIMS Contractor hosting solution shall support the Agency's vision of security requirements. At a minimum, the HIMS Contractor must ensure all solution components and necessary environments comply with the security specifications as described in the Medicaid Enterprise Security Policy, which is based upon the OMB Circular A-130, National Institute for Standards and Technology (NIST) Federal Information Processing Standard (FIPS) 200, NIST Special Publication 800-53: Security and Privacy Controls for Federal Information Systems and Organizations, and other applicable NIST publications. Temporary access to the Medicaid Enterprise Security Policy will be granted to qualified Vendors for preparation of their response to this RFP.
2. System Compliance and Security Management. It is the Agency's expectation that the HIMS Contractor ensures the comprehensive HIMS solution meets the Security Specifications as described in the Medicaid Enterprise Security Policy, which is based on OMB Circular A-130, NIST FIPS 200, NIST Special Publication 800-53: Security and Privacy Controls for Federal Information Systems and Organizations, and other applicable NIST Special Publications. Adherence to the Medicaid Enterprise Security Policy is maintained in the Medicaid Governance, Risk, and Compliance (GRC) management platform. The HIMS Contractor shall document

the HIMS Solution System Security Plan in the GRC management platform. The GRC management platform will be made available to the HIMS Contractor through VPN access upon Contract start. The current policy for proposal purposes will also be available in an access-controlled SharePoint site. The Agency's GRC management platform is the Enterprise repository for all security documentation.

3. The HIMS Contractor's Information System Security Officer (ISSO) and/or Information System Security Manager (ISSM) will be given access to the GRC management platform and shall be responsible for entering security documentation in the GRC. The HIMS Contractor shall review and update the security documentation according to the continuous monitoring strategy defined by the Agency ISSO, as well as any time the HIMS Contractor's system is modified. The initial entry of this information can be a time-consuming effort and the HIMS Contractor must plan accordingly. As a part of the response to this RFP, the PCCM-e must describe how they plan to perform System Compliance and Security Management and all related requirements located in the Medicaid Enterprise Security Policy located in the access-controlled SharePoint site.
4. The PCCM-e must demonstrate the ability to receive and report on ADTS for care coordination and case management, including any sent by ALOHR. The PCCM-e must also demonstrate their ability to digest, at a minimum, the Health Level 7 (HL7) version 2.5 message standard.
5. The PCCM-e HIMS Contractor must be compliant with the specifications of the Alabama Medicaid Vendor Interface Specifications located in the procurement library.

Note: *Proposed Rules CMS-0057-P and CMS-0053-P, which potentially could be effective for calendar year 2026, would require the PCCM-e to have a bi-directional interface. In addition, the HIMS will need to be able to demonstrate their strategy for compliance with the upcoming CMS NPRM 0053-P per the FHIR standard for (Payer-to-Payer Care Plan exchange) and demonstrate how they are effectively leveraging the ADTs that are being sent by ALOHR and consumed by the HIMS.*

B. Services Telephone Line

1. The PCCM-e shall provide and maintain a number allowing toll-free calls from PCPs, MCPs, and potential and current recipients in the PCCM-e. This is to provide health related support and access. This line shall be available on business days, between the hours of 8:00 a.m. and 5:00 p.m. CT (central time). The PCCM-e must also have policies and procedures for handling emergency calls.
2. The PCCM-e must develop, implement, and maintain policies and procedures, which must be submitted to the Agency for prior written approval, for operating the toll-free recipient services telephone line, or equivalent, that include, but are not limited to, staffing, hours of operation, call response and hold times, abandonment rate, transfer protocols and monitoring.
3. The PCCM-e shall develop, implement, and monitor performance standards for the toll-free recipient services telephone line. Such standards and monitoring activities must be submitted to the Agency for approval.
4. The Agency shall monitor the Vendor call center through call center reports. The Vendor shall submit to the Agency quarterly call center reports using an Agency approved template. The call center report shall be due no later than the fifteenth (15th) business day of the month following the end of the quarter.

5. The PCCM-e must conduct ongoing call quality assurance to ensure these minimum performance standards are met. If the Agency determines, in its sole discretion, that it is necessary to conduct onsite monitoring of the PCCM-e's recipient services telephone line functions, the PCCM-e will be responsible for all reasonable costs incurred by the Agency or its authorized designee(s) relating to such monitoring.
6. The toll-free recipient services telephone line must have the capability to handle calls from any language for non-English speaking recipients, as well as recipients with communications impairment, including the use of translators, auxiliary aids such as the telecommunications relay service (TRS), and text telephone (TTY)/telecommunication device for the deaf (TDD) lines.
7. The PCCM-e shall have an automated system available every business day between the hours of 5:00 p.m. and 8:00 a.m. CT and during weekends and legal holidays. The automated system must include a voice mailbox for callers to leave messages. The PCCM-e shall ensure that the voice mailbox has adequate capacity to receive the reasonably anticipated maximum volume of messages. The PCCM-e must return messages on the next business day. This automated system must provide callers with operating instructions on what to do in case of an emergency which must include, at a minimum, the following information in accordance with 42 C.F.R. § 438.10(g)(2)(v):
    a. what constitutes an emergency medical condition and emergency services; and
    b. that the recipient has a right to use any hospital or other setting for emergency care.
8. Noncompliance with requirements for the recipient services telephone line may result in sanctions.

8. Information Requirements

A. General

1. The PCCM-e shall develop, implement, and maintain policies, procedures, and forms designed to clearly and thoroughly explain, in a manner and format that may be easily understood and is readily accessible, the process to accept and decline services, the rights and responsibilities of recipients, and to help recipients understand the requirements and benefits of the ACHN program. The terms "readily accessible" and "limited English proficient" or "LEP" shall have the meanings set forth in 42 C.F.R. § 438.10(a). In addition, the PCCM-e must notify recipients that the right to free and timely language assistance services applies to translated documents and verbal interpretation and how to access those services.
2. Information critical to obtaining services (including, at a minimum, directories, enrollee handbook, and notices) has to be available in the prevalent non-English languages in the specific regions, see Appendix P Top 15 Prevalent Non-English Languages Spoken in Alabama. Prevalent Non-English Languages is defined as, at a minimum, the top 15 languages spoken in the state by individuals with LEP.
3. The PCCM-e shall provide information to potential recipients and enrolled recipients in accordance with 42 C.F.R. § 438.10 and Section 1557 of the Affordable Care Act.
4. The PCCM-e must inform recipients that oral interpretation service is available for any language and written translation is available in each Prevalent Non-English Language, as defined in Subsection 2 above, upon request. The PCCM-e shall provide, free of

charge, interpreters for recipients whose primary language is any non- English language, not just those non-English languages spoken by five percent (5%) or more of the total covered population of the Region. The PCCM-e shall also provide auxiliary aids free of charge to recipients with disabilities.

5. The PCCM-e shall at the time services are accepted by a recipient, request recipients to inform the PCCM-e of primary non-English language and any language assistance requirements.
6. The PCCM-e must make all written material in a font size no smaller than 12-point and in an easily understandable language that meets the requirements of this section, in English, and all other Prevalent Non-English Languages as defined in Subsection 2 above. Auxiliary aids and services must be made available at no cost to a recipient upon his or her request, including toll free numbers, TTY/TDY and American Sign Language. Tag lines and large print (no smaller than 18-point font) must be used by the PCCM-e in connection with such written Materials in accordance with 42 C.F.R. § 438.10(d)(3)-(6) and 45 C.F.R. § 92.8.
7. Upon request by and at no charge to recipients, the PCCM-e must make all written material available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The PCCM-e must inform recipients that written information is available in alternative formats and how to access these formats.
8. In accordance with 42 C.F.R. § 438.10(c)(4)(i), the PCCM-e must use the Agency developed definitions as outlined in the Managed Care Terminology and Definitions document in Appendix D, in its Recipient Materials described in Section III.8.A and recipient notices.
9. The PCCM-e must give each recipient notice of any significant changes, as determined by the state, in the written material and the information required by this subsection and by 42 C.F.R. § 438.10, at least thirty (30) Calendar Days before the intended effective date of the change.
10. The recipient must be informed that information is available in paper form without charge and the PCCM-e shall provide the information to the recipient upon request within five (5) business days.

B. Recipient Materials

1. Materials for use by recipients are to be developed in accordance with State and Federal Guidelines, including information as required in 42 C.F.R. §§ 438.10 and 438.102 and 45 C.F.R. § 147.200. When provided by the state, templates must be used.
2. On or before the first visit for case management and care coordination services, recipients must be provided with Materials that describe the services provided by the PCCM-e and how to access and effectively use those services as set forth in 42 C.F.R. § 438.10(g)(2)(3).
3. Information required by this section to be provided by the PCCM-e shall be considered properly provided if the PCCM-e:
    a. Mails a printed copy to recipient's mailing address;
    b. Provides the information by email after obtaining recipient's written consent to do so; or
    c. Provides the information in person;
    d. Posts the information on the Web site of the PCCM-e and advises the enrollee in paper or electronic form that the information is available on the

Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

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

4. All recipient materials, including subsequent updates and changes, must be sent to the Agency at least forty-five (45) calendar days prior to intended publication or dissemination to recipient for review and approval.
5. The PCCM-e shall communicate to its recipients significant changes as defined by the Agency. Such changes shall be communicated to recipients no later than thirty (30) calendar days before the intended effective change and can be electronically transmitted.
6. Distribution of recipient materials that have not been approved or contain materially false information may result in sanctions.
7. All recipient materials should be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency as required by 42 C.F.R. § 438.10, including but not limited to:
    a. Information on how to access and use PCCM-e services;
    b. Recipient rights and responsibilities, to include the Agency's Grievance process;
    c. Participating provider list;
    d. Recipient handbook (see the Enrollee Manual Model in the Procurement Library);
    e. Privacy information (including Health Insurance Portability and Accountability Act (HIPAA) information);
    f. Advance Directives;
    g. Educational documents approved by the Agency; and
    h. Recipient's MCT notification letter.

C. Outreach and Education Program

1. General
    a. The PCCM-e must develop and implement effective recipient education and outreach programs which support health outcome initiatives and encompasses all identified populations (i.e., General, Maternity [includes postpartum recipients] and Medically Complex).
    b. The PCCM-e must provide the Agency with a written description of all planned health education activities and targeted implementation dates at a frequency and in a format determined by the Agency. The PCCM-e must receive express written approval from the Agency prior to use of all educational Materials.
    c. The PCCM-e must describe the requirements and benefits of the PCCM-e's services consistent with Section II.1 of this RFP and 42 C.F.R. § 438.10.
    d. The PCCM-e must address the prevention of illness and disease, disease management, and healthy lifestyles consistent with Section II of this RFP and 42 C.F.R. § 438.10.

e. The PCCM-e must specifically inform recipients about the availability of transportation services and educating recipients about how to access Non-Emergency Transportation (NET) services.
f. The PCCM-e must make PCPs, recipients, and the community aware of the purpose and the services offered by the PCCM-e. Materials identified or developed for use shall be reviewed and approved by the Agency, including, but not limited to, letters, educational materials, programs, promotional, on-line content, and forms.
g. The PCCM-e must provide semi-annual outreach and education to MCPs. At a minimum, program guidelines, updates from the Agency, and referral processes must be addressed.
h. The PCCM-e must maintain documentation to support compliance with this requirement.

2. Marketing
   a. PCCM-e must provide marketing materials in accordance with 42 C.F.R. § 438.104 and the information requirements in 42 C.F.R. § 438.10.
   b. The PCCM-e must submit its initial and ongoing marketing plan to the Agency. The plan must be approved by the Agency prior implementation.
   c. The PCCM-e must not distribute any marketing materials without prior approval from the Agency.
   d. Marketing materials distributed by the PCCM-e must be distributed to its entire service area as indicated in the contract.
   e. The PCCM-e must not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
   f. The PCCM-e must not directly or indirectly engage in door-to-door, telephone, e- mail, texting, or other cold-call marketing activities.
3. Eligible Recipient Incentives
   a. The PCCM-e may provide an incentive program to its recipients based on health/education activities or for compliance with health-related recommendations, including but not limited to:
      i. Finishing all prenatal and postpartum visits;
      ii. Participating in a smoking cessation program; and
      iii. Completing a health goal.
   b. The incentive program may include, but is not limited to:
      i. Health-related gift items;
      ii. Gift certificate in exchange for merchandise; and
      iii. Cash or redeemable coupons with a cash value prohibited.
   c. The PCMM-e's incentive program, including related material for recipient use, shall be proposed in writing and prior approved by the Agency.
   d. The aggregate value of health-related gifts to a recipient shall not exceed $240.00 per recipient per calendar year.

D. Community Resource Guide

1. The PCCM-e must identify community, social, and recovery support services that are available at the county level and develop a resource guide which contains a listing of the support services agencies, services provided, hours of operation, address, contact numbers, and any applicable eligibility criteria (e.g., age limitations).

2. The community resource guide must be updated at least annually and made available to the PCCM-e's case management and coordination staff who have contact with recipients.
3. Upon request, the community resource guide must be made available to recipients in hard copy form or on the PCCM-e website. Guides must be in a printer friendly format (i.e., PDF) and available via the PCCM-e website.

E. PCCM-e Website

1. The PCCM-e must maintain a website that, at a minimum, provides public access to minimum essential information needed by recipients, including, but not limited to:
    a. Description of services available from the PCCM-e and how a recipient may access or be referred for those services;
    b. Lists of Medicaid-enrolled providers who have signed agreements to participate with the PCCM-e, specifically PCPs, MCPs, and specialty providers. (Providing a link to the Agency's website does not satisfy this requirement.);
    c. Prominent statement that recipients may see any participating PCP or MCP for services, regardless of location, but that care management services will be provided by the PCCM-e serving the recipient's county of residence;
    d. List of case managers and care coordinators with contact information;
    e. Copy of Community Resource Guide by county;
    f. Copy of the PCCM-e's Enrollee Handbook as described in 42 C.F.R. § 438.10(g)(2)(v). Refer to the model handbook in the Procurement Library
    g. Contact information for the PCCM-e, including telephone, mailing, fax and encrypted email form;
    h. Forms and instructions on how to file a complaint/grievance;
    i. Instructions on how to set up and arrange for a ride through the Medicaid Non-Emergency Transportation Program;
    j. Commonly used forms/documents to access PCCM-e services;
    k. How to update personal information with the Agency;
    l. Links to recipient-related content on the Agency website, e.g., covered services, Non-Emergency Transportation, eligibility forms, educational materials; and
    m. Other items as required within this RFP.
2. The PCCM-e must ensure that the website reflects the use of modern standards to make the website readily accessible as defined in 42 C.F.R. § 438.10(a). The website also must comply with 45 C.F.R. § 92.8(f)(1)(iii) in that the notice offering language assistance must be in a conspicuous place on the home page of the website.
3. If the Agency determines that the PCCM-e's web presence will be incorporated to any degree to the Agency's or the state's web presence, the PCCM-e must conform to any applicable Agency or state standard for website structure, coding, and presentation.
4. Website content must be approved in advance by the Agency. Website content is to be accurate, current, and designed so that recipients and providers may easily locate all relevant information. If directed by the Agency, the PCCM-e must establish appropriate links on the PCCM-e's website that direct users back to the Agency's website.

F. Electronic Communication

1. Information required to be provided herein may not be provided electronically, unless all of the following are met in accordance with 42 C.F.R. § 438.10(c)(6):
    a. The format is readily accessible;
    b. The information is placed in a location on the PCCM-e's website that is prominent and readily accessible;
    c. The information is provided in an electronic form which can be electronically retained and printed; and
    d. The information is consistent with the content and language requirements.
2. In addition to the requirements of Section III.8 of this RFP, the PCCM-e may only use electronic methods of communication with a recipient if:
    a. The recipient has provided an email address to the PCCM-e and has not requested to no longer receive electronic methods of communication;
    b. The recipient has requested or approved electronic transmittal;
    c. The identical information is available in written format upon request;
    d. Language and alternative format accommodations are available; and
    e. HIPAA requirements are satisfied with respect to PHI.

G. Enrollee Handbook

1. The PCCM-e is required to utilize the model enrollee handbook developed by the state and in accordance with 42 C.F.R. § 438.10 that includes information:
    a. On benefits provided by the PCCM-e. This includes information about the EPSDT benefit and how to access component services if individuals under age 21 entitled to the EPSDT benefit are enrolled;
    b. About how transportation is provided for any benefits carved out of the PCCM-e contract and provided by the state;
    c. Counseling or referral services that the PCCM-e does not cover because of moral or religious objections;
    d. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
    e. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's PCP;
    f. Information regarding the extent to which, and how, after-hours care is provided and information regarding emergency services, including:
        i. how emergency care is provided;
        ii. what constitutes an emergency medical condition;
        iii. what constitutes an emergency service;
        iv. That prior authorization is not required for emergency services; and
        v. That the enrollee has a right to use any hospital or other setting for emergency care;
    g. Any restrictions on the enrollee's freedom of choice among network providers;
    h. The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
    i. Information regarding the enrollee's rights as outlined in Section II.1.D.10 above.
    j. The process of selecting and changing the enrollee's PCP.
    k. Information regarding:

i. The recipient's right to file grievances;
ii. The requirements and timeframes for filing grievances; and
iii. Information on the availability of assistance in the filing process for grievances.

l. How to access auxiliary aids and services, including additional information in alternative formats or languages.
m. The toll-free telephone number for member services.
n. The toll-free telephone number for medical management.
o. The toll-free telephone number for any other unit providing services directly to recipients.
p. Information on how to report suspected fraud or abuse.

2. The PCCM-e must provide each enrollee the enrollee handbook within forty-five (45) calendar days after receiving notice of the beneficiary's enrollment.

9. Fraud and Abuse

1. General Requirements
   a. The PCCM-e must comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and Children's Health Insurance Programs (CHIP).
   b. The PCCM-e must cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, Abuse, or waste. At any time during normal business hours any state or federal agency, and/or their designee(s), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the RFP and any other applicable rules for as often as they may deem necessary during the contract period and for a period of ten (10) years from the expiration date of the contract (including any extensions to the contract).
   c. The PCCM-e and its subcontractors must make all program and financial records and service delivery sites open to the representative or any designees of the above. Each federal and state agency must have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with PCCM-e recipients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by this RFP. The rights of access in this subsection are not limited to the required retention period but must last as long as records are retained. The PCCM-e must provide originals and/or copies (at no charge) of all records and information requested. Requests for information must be compiled in the form and the language requested.
   d. PCCM-e's employees and its contractors and their employees must cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre- trial conferences, hearings, trials, and in any other process.
   e. The PCCM-e must certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The PCCM-e must not submit for

payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the RFP, and Agency policy.

f. The PCCM-e must report to the Agency, within three (3) business days, when discovered that any PCCM-e employees, subcontractor, or subcontractor's employees have been excluded, suspended, or debarred from any state or federal healthcare benefit program.

2. Prohibited Affiliations
   a. In accordance with 42 C.F.R. § 438.608(b) and 42 C.F.R. § 438.608(c)(1)-(3), the PCCM- e must comply with all regulations regarding Provider screening and enrollment requirements, and disclosure requirements.
   b. In accordance with 42 C.F.R. § 438.610 and 42 C.F.R. § 457.935, the PCCM-e must not knowingly have a relationship of the type described in this section with the following:
      i. An individual or entity who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non- procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or
      ii. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in this section.
   c. The PCCM-e must not have a relationship with an individual or entity or be controlled by an individual or entity that is excluded from participation in any Federal healthcare program under Sections 1128 or 1128A of the Social Security Act.
3. "Relationship," is defined as follows:
   a. A director, officer, or partner of the PCCM-e;
   b. A subcontractor;
   c. A person with beneficial ownership of five percent (5%) or more of the PCCM-e's equity; or
   d. A Provider in the PCCM-e's network or person with an employment, consulting or other arrangement with the PCCM-e for the provision of items and services that are significant and material to the PCCM-e's obligations under this RFP Contract.
4. The PCCM-e must provide written disclosure to the Agency of any of the above prohibited affiliations.
5. If the Agency learns that the PCCM-e has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in Federal healthcare programs, the Agency:
   a. Must notify the Secretary of HHS of the noncompliance;
   b. May continue an existing agreement with the PCCM-e unless the Secretary of HHS directs otherwise; and
   c. May not renew or extend the existing Contract with the PCCM-e unless the Secretary of HHS provides to the Agency and to Congress a written statement describing compelling reasons that exist for renewing or extending the Contract despite the prohibited affiliations.
6. Nothing in this section must be construed to limit or otherwise affect any remedies

available to the United States under Sections 1128, 1128A, or 1128B of the Social Security Act.

7. The PCCM-e must disclose to CMS and the Agency, and to recipients upon reasonable request, information on ownership and control, business transactions and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The PCCM-e must obtain federally required disclosures from all Participating Providers and applicants in accordance with 42 C.F.R. Part 455 Subpart B and 42 C.F.R. § 1002.3, and as specified by Medicaid including but not limited to obtaining such information through Provider enrollment forms.
8. The PCCM-e must notify the Agency within three (3) business days of the time it receives notice that action is being taken against the PCCM-e or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the PCCM-e or a contractor from the Medicaid or CHIP programs, or any program listed in Executive Order 12549.
9. The PCCM-e and its subcontractors must disclose to the Agency, any persons or corporations with an ownership or control interest in the PCCM-e that:
    a. Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more in a disclosing entity;
    b. Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the PCCM-e if that interest equals at least five percent (5%) of the value of the disclosing entity;
    c. Is an officer or director of a PCCM-e organized as a corporation; or
    d. Is a partner in a disclosing entity organized as a partnership.
10. In accordance with 42 C.F.R. § 455.104(b), the PCCM-e must disclose the following to the Agency:
    a. The name and address of any individual or corporation with an ownership or control interest in PCCM-e and its subcontractors. The address for corporate entities must include an applicable primary business address, every business location, and P.O. Box address;
    b. Date of birth and Social Security Number of any individual with an ownership or control interest in the PCCM-e and its subcontractors;
    c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the PCCM-e and/or in any subcontractor in which the PCCM-e has a five percent (5%) or more interest;
    d. Whether the individual or corporation with an ownership or control interest in the PCCM- e is related to another person with ownership or control interest in the PCCM-e as a spouse, parent, child, or sibling; or whether the individual or corporation with an ownership or control interest in any subcontractor in which the PCCM-e has a five percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling;
    e. The name of any other disclosing entity (or the Agency's Fiscal Agent or other managed care entity) in which an owner of the PCCM-e has an ownership or control interest; and
    f. The name, address, date of birth, and Social Security Number of any managing employee of the PCCM-e.
11. In accordance with 42 C.F.R. § 455.104(c), disclosures from the PCCM-e and its

subcontractors are due at any of the following times:

a. Upon the PCCM-e submitting a proposal in accordance with the Agency's procurement process;
b. Upon execution, renewal, or extension of a Contract with the Agency; or
c. Within thirty-five (35) Calendar Days after any change in ownership of the PCCM-e.

12. In accordance with 42 C.F.R. § 455.104(d), all disclosures must be provided to the Agency.
13. The Agency will review the ownership and control disclosures submitted by the PCCM-e and any of the PCCM-e's subcontractors.
14. In accordance with 42 C.F.R. § 455.104(e), Federal financial participation (FFP) is not available in any amounts made to a PCCM-e that fails to disclose ownership or control information as required by said section. FFP is also not available for any amounts paid to the PCCM-e that could be excluded from participation in Medicare or Medicaid for any of the following reasons:
    a. The PCCM-e is controlled by a sanctioned individual;
    b. The PCCM-e has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services either directly or indirectly, with an individual convicted of certain crimes as described in Section 1128(b)(8)(B) of the Social Security Act; or
    c. The PCCM-e employs or contracts, directly or indirectly, for the furnishing of healthcare, utilization review, medical social work, or administrative services, with one of the following:
        i. Any individual or entity excluded from participation in Federal healthcare programs; or
        ii. Any entity that would provide those services through an excluded individual or entity.
15. The PCCM-e must maintain such disclosed information in a manner in which can be periodically searched by the PCCM-e for exclusions and provided to the Agency in accordance with this RFP and relevant federal and state laws and regulations. In addition, the PCCM-e must comply with all reporting and disclosure requirements of 42 U.S.C. § 1396b(m)(4)(A) if the PCCM-e is not a federally qualified health maintenance organization under the Public Health Service Act. The PCCM-e must also comply with all reporting and disclosure requirements set forth in any federal or state statute or regulation.

10. Administrative Requirements

A. Staff Requirements

1. Administrative Staff Requirements. The PCCM-e must:
    a. Have sufficient and appropriate staff;
    b. Ensure staff are properly licensed and credentialed;
    c. Ensure staff operates within their professional scope;
    d. Ensure staff responds to needs of recipients;
    e. Provide appropriate training to all staff;
    f. Submit potential staff resumes for review by the Agency to ensure appropriate experience requirements are met; and

g. Participate in any Agency-required training, meeting, or teleconference as related to specific staff.

2. The PCCM-e must employ a full-time Executive Director to serve as primary administrative liaison between the PCCM-e and the Agency (the Executive Director position is a Key Staff position; additional Key Staff positions are listed in the Key Staff and other Positions Requirements document). The PCCM-e is required to submit resumes of all Key Staff to the Agency for review and approval as part of the RFP response. The Executive Director must have the authority to make all day-to-day program decisions. Such decisions shall be consistent with the terms of the Contract, within the policies and procedures of the PCCM-e and the budget approved by the PCCM-e's Governing Board. Duties will include hiring, firing, and financial decisions.

B Reporting Requirements

1. The PCCM-e must follow reporting requirements:
   a. Monthly, quarterly, and yearly reports shall be submitted to the Agency, as required, in the format and the route requested by the Agency. All reports shall be submitted on standardized Agency approved templates or forms, when indicated. The Agency reserves the right to request additional reporting, modify templates, or alter reporting timeframes to facilitate program operations. If additional reporting is requested, the information must be reported in a format approved by the Agency.
   b. The PCCM-e will provide the Agency with the following monthly reports, in the format, prescribed by the Agency and according to the established guidelines:

Monthly Reports	Due Dates
Copies of inbound files for PCP enrollment in lieu of signed copies of PCP Agreements to the Agency	No later than the fifteenth (15th) calendar day of the month
Copies of inbound files for MCPs enrollment in lieu of signed copies of MCPs Agreements to the Agency	No later than the fifteenth (15th) calendar day of the month
ADT Report	No later than the fifteenth (15th) calendar day of the month
Flash Report	No later than ten (10) business days following the last day of the preceding month
Terminated Providers Report	Monthly and as submitted to the Agency for processing

c. The PCCM-e will provide the Agency with the following quarterly reports, in the format, prescribed by the Agency and according to the established guidelines:

Quarterly Reports	Due Dates
Quarterly Financial Report	No later than fifteen (15th) business days following the last day of the quarter
Quarterly Minutes from Governing Board Meeting once in the second (2nd) and fourth (4th) quarter	No later than the fifteenth (15th) of the month following the Governing Board meeting
Quarterly Minutes from CAC meetings once in the first (1st) and third (3rd) quarter	No later than the fifteenth (15th) of the month following the CAC meeting
Quarterly Active Participation for PCPs Report	No later than the fifteenth (15th) business day of the month following the end of the quarter
Quarterly Active Participation for MCPs Report	No later than the fifteenth (15th) business day of the month following the end of the quarter
Call Center Report	No later than the fifteenth (15th) business day of the month following the end of the quarter
Grievance Log	No later than the fifteenth (15th) business day of the month following the end of the quarter
Clinical Pharmacy Activity Report	No later than the fifteenth (15th) business day of the month following the end of the quarter

d. The PCCM-e will provide the Agency with the following yearly reports, in the format, prescribed by the Agency and according to the established guidelines:

Quarterly Reports	Due Dates
Annual Operating Budget	At least thirty (30) calendar days prior to the start of each state fiscal year
Audit Report (performed by an independent certified public accountant)	Within ninety (90) calendar days of the end of the state fiscal year – December 31st
Quality Improvement Plan and Evaluation	Within thirty (30) calendar days from execution of the contract and annually by October 1st of each year
Quality Improvement Projects	At least thirty (30) calendar days prior to the start of the contract year
Quality Improvement Project Budget	At least thirty (30) calendar days before the implementation of the QIP
Annual Training Plan and Training Evaluation Summaries	No later than October 1st of each contract year
Application Assisters Report	At program implementation; thereafter, within forty-five (45) calendar days of the contract year; and within thirty (30) calendar days of any change
MCP Network Adequacy Report	At program implementation; thereafter, within forty-five (45) calendar days of the contract year; and within thirty (30) calendar days of any change
Annual Active Participation for PCPs Report	No later than the fifteenth (15th) business day of the month following the end of the last quarter of the contract year
Annual Active Participation for MCPs Report	No later than the fifteenth (15th) business day of the month following the end of the last quarter of the contract year.
Annual Governing Board Member Report	At program implementation; thereafter, within fifteen (15) calendar days of the month following the end of the last quarter of the contract year; and within thirty (30) calendar days of any change
Annual CAC Member Report	At program implementation; thereafter, within fifteen (15) calendar days of the month following the end of the last quarter of the contract year; and within thirty (30) calendar days of any change

C. Staff Training

1. The PCCM-e shall conduct formal training sessions on a specified basis. The PCCM-e must provide the Agency with an annual training plan prior to the start of the Program Year as well as a training evaluation summary at the conclusion of the Program Year.

2. The Agency defines formal training as any training in which the objective or purpose is defined and delivered to a targeted audience. This training includes, but is not limited to, classroom instruction, web-based training, remote labs, e-learning courses, workshops, seminars, and webinars. Formal training does not include training that occurs away from a structured, formal environment such as activities including, but is not limited to, viewing videos, self-study, reading articles, participating in forums and chat rooms, performance support, coaching sessions, and games.
3. The PCCM-e must provide, annually and/or as requested, the Agency with the training materials used for formal training sessions. Training materials include but are not limited to, training agendas with the objective, purpose, date, and time; attendance rosters with trainer identified; and training instruction materials. Unutilized training instructional materials are recommended for submission to the Agency but is not required.
4. The PCCM-e staff required by the Agency will attend all training sessions provided by the Agency. The PCCM-e will ensure that designated staff are trained by Agency approved curriculum for the medically complex population. This population includes, but is not limited to, the SCD population and children with medical complexities (CMC).

D. Grievances and Dispute Resolution

1. Grievances.
    a. The PCCM-e must have a grievance process in place to address recipients' complaints/grievances regarding, but not limited to, the following:
        i. Dissatisfaction with care management other PCCM-e staff;
        ii. Complaints related to PCPs, providers; and
        iii. Denial of care management services.
    b. The PCCM-e must submit a quarterly to the Agency an approved grievance log on an Agency approved template. The log must detail complaints and grievances. The Agency establishes that the word complaint and grievance may be used interchangeably and are not considered to be separate in definition or response. The PCCM-e has the discretion to create and utilize an internal log for their purposes, but that log does not take the place of the Agency-approved Grievance Log required to be submitted to the Agency.
    c. Grievances against the PCCM-e will be reviewed and addressed by the Agency. Grievances can be filed with the Agency in writing or verbally. Recipients can request assistance with filing a grievance from the PCCM-e.
    d. Upon submitting a grievance, the Agency will investigate complaints against the PCCM-e. If necessary, the complainant will be interviewed.
    e. A summary and, if necessary, a request for a CAP will be sent from the Agency for all complaints reported within thirty (30) calendar days of receiving the complaint. If requested, The PCCM-e must forward their CAP to the Agency. The Agency will evaluate the CAP within seven (7) calendar days of receipt. If the CAP is not responsive to the complaint, it will be returned to the PCCM-e within two (2) business days. The revised CAP will be resubmitted to the Agency within two (2) business days. If the summary or CAP carried out is found not to be responsive, the PCCM-e will have up

to forty-five (45) calendar days to revise the plan and carry out the appropriate action.

f. Appropriate parties must initiate action within twenty-four (24) hours if it appears that a recipient's health and safety are at risk.
g. The response to the Grievance by the Agency shall be in writing in a format and language that at a minimum, meets the requirements of 42 C.F.R. § 438.10, and fully explains the decision and reasons for each part of the Grievance presented.
h. The Agency, as needed, will update the PCCM-e of grievances received by the Agency and/or the status of pending grievances.

2. Dispute Resolution
    a. The Agency does operate another dispute resolution process, which is the informal conference process, which offers recipients the opportunity to appeal decisions that adversely affect their services. An informal request must be received in writing by the Agency within thirty (30) calendar days of the date of their Notice of Action.
    b. During this process, the recipient may present the information or may be represented by a friend, relative, attorney, or other spokesperson of their choice. The Agency will provide the recipient their decision and/or recommendation within ten (10) business days of the date the informal conference is held.
    c. When a request for an informal conference is received by the Agency, the manager over the Region will review the request. If the request is unresolved, the manager will schedule the informal conference to include all parties involved.
    d. The Agency will notify the recipient in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

11. Agency Intervention

If a problem is identified by the Agency regarding the quality of services received, the Agency will intervene as indicated below:

1. Provide education and informal mailings to recipients and PCCM-e;
2. Initiate telephone and/or mail inquiries and follow-up;
3. Request PCCM-e's response to identified problems;
4. Refer to program staff for further investigation;
5. Send warning letters to PCCM-e; and/or
6. Institute CAPs and follow-up.

12. Sanctions

1. In accordance with Alabama Medicaid Administrative Code Chapter 37, the Agency may impose sanctions on the PCCM-e if the Agency determines, in its sole discretion, that the PCCM-e has violated any applicable federal or state law or regulation, the Alabama Medicaid State Plan, this RFP, any policies, procedures, written interpretations, or other guidance of the Agency, or for any other applicable reason described in 42 C.F.R. Part 438, Subpart I or Alabama Medicaid Administrative Code Chapter 37, including, but not limited to, a determination by the Agency that a PCCM-e acts or fails to act as follows:

a. Acts to discriminate among recipients on the basis of their health status or need for healthcare services (including termination of enrollment or refusal to reenroll a recipient, except as permitted under the Agency's program, or any practice that would reasonably be expected to discourage enrollment by recipient whose medical condition or history indicates probable need for substantial future medical services);
b. Misrepresents or falsifies information that it furnishes to Agency or to CMS;
c. Misrepresents or falsifies information that it furnishes to a recipient, potential recipient, or healthcare provider;
d. Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved in writing by the Agency or that contain false or materially misleading information;
e. Fails to submit a CAP that is acceptable to the Agency within the time period specified by the Agency's written notice or does not implement or complete the corrective action within the established time period;
f. Violates, as determined by the Agency, any requirement of sections 1932 or 1905(t) of the Social Security Act or any implementing regulations;
g. Violates, as determined by the Agency, any applicable requirement of the Alabama Code or the Alabama Medicaid Administrative Code;
h. Unauthorized use of information; or
i. Failure to safeguard confidential information of providers, recipients or the Medicaid program.

2. The sanctions imposed by the Agency against the PCCM-e are as follows:
    a. Requiring the PCCM-e to develop and implement a CAP that is acceptable to the Agency;
    b. The intermediate sanctions described in 42 U.S.C. § 1396u-2(e)(2) and 42 C.F.R. Part 438, Subpart I, including but not limited to civil monetary penalties up to the maximum amounts set forth in 42 C.F.R. § 438.704;
    c. Grant recipients the right to disenroll without cause (the Agency may notify the affected recipients of their right to disenroll);
    d. Suspend all new enrollment, including auto-assignment, after the date HHS or the Agency notifies the PCCM-e of a determination of a violation of any requirement under Sections 1932 or 1905(t) of the Social Security Act;
    e. Suspend payment for recipients enrolled after the effective date of the Sanction until CMS or the Agency is satisfied that the reason for the imposition of the Sanction no longer exists and is not likely to recur;
    f. For acts or omissions which are not addressed by 42 C.F.R. Part 438, Subpart I, other provisions of Alabama Medicaid Administrative Code Chapter 37, or the Contract, RFP, and appendices thereto, and which, in the opinion of the Agency, constitute willful, gross, or fraudulent misconduct, the assessment of a monetary penalty amount up to $100,000 per act or omission;
    g. Any other sanction available under federal or state law or regulation, including without limitation Alabama Medicaid Administrative Code Rule 560-X-37-.01;
    h. Termination of the Contract, in accordance with Section IX.K. of this RFP; and
    i. Any other Sanction reasonably designed to remedy noncompliance and/or compel future compliance with the Contract or federal or state law or regulation, pursuant to the Agency's authority under 42 C.F.R. § 438.702(b), including but not limited to:

Performance Standard	Intermediate Sanction
Distribution of unapproved marketing material or those that contain false or materially misleading information	Up to $25,000 for each determination
Unauthorized use of information	Up to $25,000 for each determination
Failure to safeguard confidential information of providers, recipients or the Medicaid program	Up to $25,000 for each determination
Misrepresents or falsifies information furnished to the Agency or CMS	Up to $100,000 for each determination
Failure to submit an acceptable CAP	Up to $1,000 per instance
Failure to comply with the Agency approved CAP	Up to $1,000 per instance
Failure to deliver quarterly reports as defined by the RFP by the date specified	Up to $100 per day for each day delinquent per report or review
Failure to provide reports as required by the RFP regarding PCP and MCP participation	Up to $100 per day for each day delinquent
Failure to input Maternity Data for each recipient with a 95% accuracy rate into the Health Information System/Database	Up to $100 per instance
Failure to meet technical requirements	Up to $1,000 per instance
Failure to maintain adequate case load levels necessary to perform the requirements of the contract	Up to $1,000 per instance
Insufficient or absence of care management documentation	Up to $500 per instance
Discriminate based on health status or need for healthcare services	Up to $25,000 per instance
Noncompliance with requirements for the recipient services telephone line	Up to $500 per instance

j. Before the Agency imposes a sanction, with the exception of developing and implementing a CAP that is acceptable to the Agency, it will give the PCCM-e timely written notice explaining:

i. The basis and nature of the sanction; and
ii. The PCCM-e's right to request a fair hearing under Alabama Medicaid Administrative Code Chapter 37.

3. Except as otherwise required by applicable law, in the event of an imposed sanction in the form of a civil monetary penalty, the amount of the sanction imposed will be reduced by thirty five percent (35%) if the PCCM-e waives, in writing, its right to a fair hearing within thirty (30) calendar days from the date of notice imposing the sanction. The reduction under this section only applies to sanctions that could be appealed under Alabama Medicaid Administrative Code Chapter 37 and not to any other outstanding sanctions imposed on the PCCM-e by the Agency.
4. Before terminating the Contract as a sanction under this Section, Alabama Medicaid Administrative Code Chapter 37, and 42 C.F.R. § 438.708, the Agency will provide the PCCM-e with a pre-termination hearing to be conducted in accordance with the procedures for fair hearings set forth in Alabama Medicaid Administrative Code Chapter 3. Prior to such pre-termination hearing, the Agency will, in accordance with 42 C.F.R. § 438.710:
    a. Give the PCCM-e written notice of the Agency's intent to terminate the Contract, the reason or reasons for termination of the Contract, and the time and place of the hearing;
    b. After the hearing, give the PCCM-e written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination; and
    c. For a decision affirming the determination to terminate the Contract, give recipients of the PCCM-e notice of the termination and information, consistent with 42 C.F.R. § 438.10, on their options for receiving Medicaid services following the effective date of termination.
5. The imposition of a single sanction by the Agency does not preclude the imposition of any other sanction or combination of sanctions or any remedy authorized under the Contract for the same deficiency. The Agency may impose sanctions under this rule in addition to or in lieu of exercising any other right, remedy, or authority that the Agency may exercise under other rules promulgated by Medicaid, other applicable state and federal laws and regulations, or any contract between Medicaid and the PCCM-e. Nothing in this Section shall restrict or prevent the Agency or the state from obtaining declaratory, injunctive or equitable relief, or from recovering damages from the PCCM-e and/or any other person or entity for breach of contract or any other cause of action.

13. Recoupments.

The Agency may seek recoupments when it identifies an overpayment related that a case management activity has been paid that did not comply with federal, state, and/or Agency guidelines outside the scope of this RFP. In most instances, the entire amount paid per case management activity will be the total amount recouped per activity.

IV. Pricing

A. General

Vendors must respond to this RFP by identifying the specific Region (see Background Section) for which a proposal is being submitted. The maximum amount payable for direct services under this RFP is capped per region and is the total dollar amount paid to the PCCM-e in each contract year.

The PCCM-e will receive revenue based on the following:

1. The PCCM-e will receive a monthly PMPM to cover the costs of QIPs and general administration. The monthly revenue received by the PCCM-e will be dependent on the number of recipients that are assigned to the Region.
2. The care management activity payments for all populations are separated by risk stratification levels and are the same amount for all Regions.
3. The maximum amount payable per Region for PMPM payments and care management services during contract Year 1 are detailed in the following chart:

Region	**Year 1** **(Includes CM and PMPM)**
Central	$ 7,157,699
East	$ 7,907,359
Jefferson/Shelby	$ 8,369,137
Northeast	$ 7,900,620
Northwest	$ 7,370,114
Southeast	$ 7,707,043
Southwest	$ 9,222,645

In addition to these maximum payable amounts, the PCCM-e will be eligible for an incentive payment if quality metrics are met. Quality metrics will be measured on a yearly basis. A PCCM-e that meets all quality metrics will be eligible to receive an incentive payment.

B. Payment

1. The PCCM-e shall receive monthly, an assignment list of recipients from the Agency from which the PCCM-e will prioritize their screening and assessment work. The PCCM-e payment model is based on monthly payments that reflect care management activities occurring in a given month. Payments would be for the entire month (as opposed to each individual activity) and payments would not occur for months in which there is no documented activity. Payments for care management services are limited to the months when services are provided. (See Care Management Activity Schedules, Appendixes G-J, and the Alabama Medicaid Case management Activity Guide V4.0 located in the procurement library for additional details).
2. General Care Management: In the care management for the General population, payments will be made when a contact is documented in a given calendar month.
3. Medically Complex Care Management: In the Medically Complex population, payments also will be made when a contact is documented in a given calendar month.
4. Maternity Care Management: The maternity population will have specific care management milestones that would trigger a payment based on actual contact.
5. PMPM payment: There will also be a monthly payment for all recipients in the General,

Maternity, and Medically Complex populations to fund quality improvement projects and administrative costs. Medicaid will determine the percentage of recipients to be care managed in theses populations. Each population will have an average target percentage range based on the average population per region as listed below (averages may vary on a monthly basis based on changes in population). There will also be a performance withhold that will be retained by the Agency until the period for determination of the return of the withhold to the PCCM-e. The PMPM payments are further detailed in the Quality Improvement Project Policy in Appendix L.

a. The Agency may, at its option, review the PMPM component on a quarterly basis throughout the duration of the agreement to determine if an adjustment is need for the following reasons, including but not limited to:
    i. Changes in enrollment associated with any public health emergency;
    ii. Changes in enrollment associated with economic activity or economic outlook; and
    iii. Changes in the required PCCM-e staffing composition as directed by the Agency.
b. The Agency's evaluation may result in decreases or increases in the capitated component paid by the Agency to the PCCM-e. If the Agency implements a change to the capitated component, it will be implemented prospectively.
c. In the event the Agency initiates changes in the administrative and quality incentive payment PMPM during the term of this Agreement, the Agency shall, prior to initiating such change, provide the PCCM-e with as much notice possible, given the circumstance, of the change and the effect it will have on the compensation and payment to the PCCM-e.

V. General

The 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 healthcare services rendered to low-income individuals through a partnership with healthcare providers and other healthcare 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 11 district offices throughout the state and by 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 Agency serves more than 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 to 20 and pregnant adults
- Home Health Care Services and Durable Medical Equipment
- Family Planning Services
- Nurse-Midwife Services
- Federally Qualified Health Center Services
- Hospice Services
- Prescription Drugs
- Optometric Services
- Transportation Services
- Hearing Aids
- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Prosthetic Devices
- Outpatient Surgical Services
- Renal Dialysis Services
- Home and Community Based Waiver Services
- Prenatal Clinic Services
- Mental Health Services

Additional program information can be found at www.medicaid.alabama.gov.

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

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

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

VI. Corporate Background and References

Entities submitting proposals must:

a. Provide evidence that the Vendor possesses the qualifications required in this RFP. If a subcontractor is warranted, the Contractor must identify the percentage of work, as measured by the total Proposal price, to be performed by the subcontractor. *All contractor and subcontractor employees must work in the continental United States.*

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 regard to this contract.
5. A list of all similar projects the Vendor has completed within the last three years.
6. A detailed breakdown of proposed staffing for this project, including names and education background of all employees that will be assigned to this project.
7. A list of all Medicaid agencies or other entities for which the Vendor currently performs similar work.
8. Evidence that the Vendor is financially stable and that it has the necessary infrastructure to complete this contract as described in the Vendor's Proposal. The Vendor must provide audited financial statements for the last three years, or similar evidence of financial stability for the last three years.
9. Vendor's acknowledgment that the state will not reimburse the Contractor 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. The contractor and sub-contractor must 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 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. Furnish three (3) professional references for the Executive Director position, including contact name, title, organization, address, phone number, and E-mail address. Professional references must be submitted in accordance with Appendix D: Key Personnel Resume Sheet. The state reserves the right to use any information or additional references deemed necessary to establish the ability of the Vendor to perform the conditions of the RFP. **You may not use any Alabama Medicaid Agency personnel as a reference.**

The state reserves the right to use any information or additional references deemed necessary to establish the ability of the Vendor to perform the conditions of the contract.

VII. Submission Requirements

Procurement Library

The Agency established a Procurement Library that contains the necessary documents and artifacts needed for a Vendor to complete their proposal. The documents are available for downloading from the Alabama Medicaid Procurement website;
(https://medicaid.alabama.gov/content/2.0_Newsroom/2.4_Procurement.aspx)

The documents in the Procurement Library will be reflected in the Agency's Provider Manual, Chapter 40. The Provider Manual is updated on a quarterly basis and when changes to the ACHN Program's policies are made, those changes will be reflected in the applicable chapter(s) of the Provider Manual. The Agency expects that the selected ACHN vendors to adhere to all federal, state and Agency regulations, policies and guidelines.

A. Authority

This RFP is issued under the authority of Section 41-4-110 et. seq. of the Alabama Code and 45 C.F.R. Part 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 C.F.R. Part 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:

Project Director:	**LaTonya Jackson**
Address:	**Alabama Medicaid Agency** **Lurleen B. Wallace Bldg.** **501 Dexter Avenue** **PO Box 5624** **Montgomery, Alabama 36103-5624**
E-Mail Address:	**ACHNRFP@medicaid.alabama.gov**

C. RFP Documentation

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

D. Questions Regarding the RFP

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

F. Adherence to Specifications and Requirements

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

G. Order of Precedence

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

H. Vendor's Signature

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

I. Offer in Effect for 90 Days

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

J. State Not Responsible for Preparation Costs

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

K. State's Rights Reserved

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

- Cancel or terminate this RFP;
- Reject any or all of the proposals submitted in response to this RFP;
- Change its decision with respect to the selection and to select another proposal;
- Waive any minor irregularity in an otherwise valid proposal which would not jeopardize the overall program and to award a contract on the basis of such a waiver (minor irregularities are those which will not have a significant adverse effect on overall project cost or performance);

- Negotiate with any Vendor whose proposal is within the competitive range with respect to technical plan and cost;
- Adopt to its use all, or any part, of a Vendor's proposal and to use any idea or all ideas presented in a proposal;
- Amend the RFP (amendments to the RFP will be made by written addendum issued by the state and will be posted on the RFP website);
- Not award any contract.

L. Price

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

M. E-Verify Memorandum of Understanding

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

N. Proposal Format

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

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

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

O. 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.

P. Proposal Amendment

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

Q. 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.

R. Disclosure of Proposal Contents

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

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

S. Submission of Proposals

Proposals must be sealed and labeled on the outside of the package to clearly indicate that they are in response to 2023-ACHN-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.

The proposal submitted in response to this RFP to be considered responsive, vendors must provide evidence within a transmittal letter a reference to the section and page number of the proposal that describes how the below requirements will be met.

T. 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 jump drive clearly labeled with the Vendor name. One electronic copy (Word and searchable PDF format) MUST be a complete version of the Vendor's response and the second electronic (searchable PDF format) copy MUST have any information asserted as confidential or proprietary removed. Vender must identify the original hard copy clearly on the outside of the proposal.

U. 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.

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.

VIII. Evaluation and Selection Process

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

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

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

B. Determination of Responsibility

The Project Director will determine whether a Vendor has met the standards of responsibility. In determining responsibility, the Project Director may consider factors such as, but not limited to, the vendor's specialized expertise, ability to perform the work, experience and past performance. Such a determination may be made at any time during the evaluation process and through contract negotiation if information surfaces that would result in a determination of non-responsibility. If a Vendor is found non-responsible, a written determination will be made a part of the procurement file and mailed to the affected Vendor.

C. Opportunity for Additional Information

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

D. Evaluation Committee

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

E. Scoring

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

Evaluation Factor	Highest Possible Score
Corporate Background	10
References	10
Scope of Work	50
Key Personnel	30
Total	**100**

F. Determination of Successful Proposal

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

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

IX. General Terms and Conditions

A. General

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

The contract shall include the following:

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

B. Compliance with State and Federal Regulations

Contractor shall perform all services under the RFP in accordance with applicable federal and state statutes and regulations. The Agency 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.

Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the PCCM-e must do no work on that part after the effective date of the loss of program authority. The state must adjust payments to remove costs that are specific to any program or activity that is no longer authorized by law. If the PCCM-e works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the PCCM-e will not be paid for that work. If the state paid the PCCM-e in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the PCCM-e worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the PCCM-e, the PCCM-e may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

C. Term of Contract

The initial contract term shall be for one-year effective October 1, 2024, through September 30, 2025. The Agency 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, the Agency may at its discretion, exercise the extension option and allow the period of performance to be extended at the rate indicated on the RFP Cover Sheet. The Vendor will provide pricing for each year of the contract, including any extensions.

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

D. Contract Amendments

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

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

E. Subcontracts

Notwithstanding any relationship(s) it may have with any subcontractor, the Vendor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this RFP, but may enter into Subcontracts for the performance of work required under this

Contract. No Subcontract which the Vendor enters into with respect to performance under the Contract shall in any way relieve the Vendor of any responsibility for the performance of duties under this Contract. The Vendor shall assure that all tasks related to the Subcontract are performed in accordance with the terms of this RFP. The Vendor shall identify in its Subcontracts any aspect of service that may be further subcontracted by the subcontractor.

Each Subcontract shall be a written agreement between Vendor and subcontractor which specifies the activities or obligations, and related reporting responsibilities, delegated to the subcontractor, and shall provide the conditions for terminating the Subcontract or imposing other Sanctions if the subcontractor's performance is inadequate. Contracts between the Vendor and the subcontractor must require the subcontractor to agree to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.

Each Subcontract must require the subcontractor to agree to the following audit requirements:

1) The Agency, CMS, the DHHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's Vendor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Vendor's Contract with the Agency.
2) The subcontractor will make available, for purposes of an audit, evaluation, or inspection under this section of the RFP, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid EIs.
3) The right to audit under this section of this RFP will exist through ten (10) years from the final date of the Contract term or from the date of completion of any audit, whichever is later.
4) If the Agency, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Agency, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

F. Confidentiality

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

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

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

Pursuant to requirements of the Health Insurance Portability and Accountability Act (HIPAA) of

1996 (Public Law 104-191), the successful Contractor shall sign and comply with the terms of a Business Associate agreement with the Agency (Appendix B).

G. Security and Release of Information

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

H. 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 C.F.R. 301.6103(n).

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

I. Contract a Public Record

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

J. Termination for Bankruptcy

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

terminated and proceed to seek appropriate relief from Contractor.

K. Termination for Default

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

L. Termination for Unavailability of Funds

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

M. 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.

N. Termination for Convenience

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

O. Force Majeure

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

P. Nondiscriminatory Compliance

Contractor shall comply with Title VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, the Americans with Disabilities Act, Section 1557 of the Patient Protection and Affordable Care Act, 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.

Q. Conflict of Interest

The parties acknowledge and agree that the Contractor 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 Contractor and Medicaid agree that each has no conflict of interest preventing the execution of this Contract amendment or the requirements of the original contract, and said parties will abide by applicable state and federal regulations, specifically those requirements found in the Office of Federal Procurement Policy Act. 41 U.S.C.A. 2101 through 2107.

R. Boycott Clauses

In compliance with Ala. Act No. 2023-409, Contractor provides written verification that Contractor, without violating controlling law or regulation, does not and will not, during the term of the contract engage in economic boycotts as the term "economic boycott" is defined in Section 1 of the Act.

In compliance with Act 2016-312, the contractor 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.

S. Small and Minority Business Enterprise Utilization

In accordance with the provisions of 45 C.F.R. 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.

T. Worker's Compensation

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

U. Employment of State Staff

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

V. Immigration Compliance

Contractor will not knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama. Contractor shall comply with the requirements of the Immigration Reform and Control Act of 1986 and the Beason-Hammon Alabama Taxpayer and Citizen Protection Act (Ala, Act 2012- 491 and any amendments thereto) and certify its compliance by executing Attachment G. Contractor will document that the Contractor is enrolled in the E-Verify Program operated by the US Department of Homeland Security as required by Section 9 of Act 2012-491. During the performance of the contract, the Contractor shall participate in the E-Verify program and shall verify every employee that is required to be verified according to the applicable federal rules

and regulations. Contractor further agrees that, should it employ or contract with any subcontractor(s) in connection with the performance of the services pursuant to this contract that the Contractor will secure from such subcontractor documentation that subcontractor is enrolled in the E-Verify program prior to performing any work on the project. The subcontractor shall verify every employee that is required to be verified according to the applicable federal rules and regulations. This subsection shall only apply to subcontractors performing work on a project subject to the provisions of this section and not to collateral persons or business entities hired by the subcontractor. Contractor shall maintain the subcontractor documentation that shall be available upon request by the Alabama Medicaid Agency.

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

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

W. 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.

X. 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.

Y. Warranties Against Broker's Fees

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

Z. Novation

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

AA. Employment Basis

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

BB. Disputes and Litigation

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

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

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

CC. Records Retention and Storage

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

DD. Inspection of Records

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

EE. 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 C.F.R., Chapter 1, Part 31. Further, if such reimbursement is to be made with funds derived wholly or partially from federal sources, such reimbursement shall be subject to Contractor's compliance with applicable federal procurement requirements, and the determination of costs shall be governed by federal cost principles.

FF. Notice to Parties

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

GG. Disclosure Statement

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

HH. Debarment

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

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

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. 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. AMMIS Interface Standards

Contractor hereby certifies that any exchange of MMIS data with the Agency's fiscal agent will be accomplished by following the AMMIS 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.*

☒ IF CORRECT	**BASIC PROPOSAL REQUIREMENTS**
☐	1. Vendor's original proposal received on time at correct location.
☐	2. Vendor submitted the specified copies of proposal and in electronic format.
☐	3. The Proposal includes a completed and signed RFP Cover Sheet.
☐	4. The Proposal is a complete and independent document, with no references to external documents or resources.
☐	5. Vendor submitted signed acknowledgement of any and all addenda to RFP.
☐	6. The Proposal includes written confirmation that the Vendor understands and shall comply with all of the provisions of the RFP.
☐	7. The Proposal includes required client references (with all identifying information in specified format and order).
☐	8. The Proposal includes a corporate background.
☐	9. The Proposal includes a detailed description of the plan to design, implement, monitor, and address special situations related to the 2023-ACHN-01 program as outlined in the request for proposal regarding each element listed in the scope of work.
☐	10. The response includes (if applicable) an Application of Registration or letter/form showing the application has been made with the Secretary of State.
☐	11. The response includes an E-Verify MOU with the Department of Homeland Security.

Appendix B: Contract and Attachments

The following are the documents that must be signed AFTER contract award and prior to the meeting of the Legislative Contract Oversight Committee Meeting.

Sample Contract
Attachment A: Contract Review Report for Submission to Oversight Committee
Attachment B: Business Associate Addendum
Attachment C: Immigration Status
Attachment D: Instructions for Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion
Attachment E: Letter Regarding Reporting to Ethics Commission
Attachment F: Disclosure Statement
Attachment G: Beason-Hammon Certificate of Compliance
Attachment H: Governor's Additional Contract Questions

Contract Number #####

CONTRACT
BETWEEN
THE ALABAMA MEDICAID AGENCY
AND
Contractor's Name

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

Contractor shall furnish all labor, equipment, and materials and perform all of the work required under the Enter Request for Proposal or Invitation to Bid (Enter Acronym for Contract Type) Number Enter RFP , dated Enter date of RFP 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 Enter Acronym for Contract Type and the price provided on the Enter Acronym for Contract Type Cover Sheet response, in an amount not to exceed Enter Not to Exceed Amount.

Contractor and the Alabama Medicaid Agency agree that the initial term of the contract is Enter Begin Date to Enter End Date.

This contract specifically incorporates by reference the Enter Acronym for Contract Type, any attachments and amendments thereto, and Contractor's response.

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.

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

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.

In compliance with Act 2016-312, the contractor 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.

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

CONTRACTOR NAME

Alabama Medicaid Agency

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

_____
Contractor Signature

Tax ID: _____

Date signed: _____

_____
Stephanie McGee Azar
Commissioner

Date signed: _____

APPROVED:

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.

_____
Kay Ivey
Governor, State of Alabama

_____
Legal Counsel

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

CONTRACT REVIEW REPORT

(Separate review report required for each contract)

Contractor Information

Name of Governmental Body or Purchasing Agency:_____

Name of Contractor:_____

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

Is Contractor a Sole Source? YES _____ NO _____ **(If Yes, Attach Sole Source Approval from the Chief Procurement Officer)**

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

If No, is Contractor Registered with Alabama Secretary of State to do Business in Alabama? YES _____ NO _____

List the Members/Owners (e.g. John Smith) of the Contracting Entity_____

Is Contractor a minority-owned business? YES _____ NO _____ Is Contractor a woman-owned business? YES _____ NO _____

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

Is a Lobbyist/Consultant Affiliated with this Contractor OR Used to Secure this Contract? YES _____ NO _____

If Yes, Give Name: _____

Contract Information

Contract Number: __ __ __ __ __ __ __ __ __ __ **(See Fiscal Policies & Procedures Manual)**

Contract Amount: $_____ **(Put Amount You Are Asking For Today Only; See Fiscal Policies & Procedures Manual)**

% 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 AMENDMENT or RENEWAL, Complete A through C: If AMENDMENT, will it extend time? YES _____ NO_____

[A] **ORIGINAL** contract amount total $ _____

[B] Contract Amount Total prior to this amendment or renewal $ _____

[C] Contract Amount Total after this amendment or renewal $ _____

RFP:
Was Contract Secured through RFP Process? YES ____ NO ____ **If RFQ, Answer RFQ Questions Below.**
Date the RFP was solicited:_____ AND Date the RFP was awarded: _____.
Was Contract Posted to Statewide RFP Database at http://rfp.alabama.gov/Login.aspx? YES____ NO ____
If NO, give a brief explanation, including any statutory exemption, as to why not:
_____

RFQ:
Was Contract Secured through RFQ Process? YES ____ NO ____ Date RFQ was solicited: _____ Date RFQ awarded:_____
Posted to Division of Construction Management Website? http://dcm.alabama.gov/ae_qualifications.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 Governmental or Agency Head Signature of Contractor

_____ _____
Printed Name of Governmental or Agency Head Printed Name of Contractor

Governmental or Agency Contact: _____ Phone:_____

Revised 12/28/2022

ALABAMA MEDICAID AGENCY

BUSINESS ASSOCIATE AGREEMENT

Revised 06/2019

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.** Business Associate agrees to perform the following services for or on behalf of Covered Entity: [Enter a description below of the service(s) to be provided with sufficient detail to ensure clarity. Delete this parenthetical guidance from the document prior to execution.]

     _____

     _____

   - **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 Agreement with the intention of complying with the HIPAA Rules allowing a covered entity to disclose protected health information to a business associate, and allowing a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.
2. **DEFINITIONS**

   2.1 General Definitions

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

   2.2 Specific Definitions

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

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

   2.2.3 HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Part 160 and Part 164 of the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, and the implementing regulations promulgated thereunder from time to time by the U.S. Department of Health and Human Services (HHS).

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 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, Business Associate may

4.1. Use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as agreed to, 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 Business Associate'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 Business Associate no longer provides agreed upon services to the Covered Entity.

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, 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 Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the HIPAA Rules.

8.2 A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the services of the Business Associate.

8.3 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 Date

Clay Gaddis
Printed Name

Privacy Officer
Title

BUSINESS ASSOCIATE

_____ _____
Signature Date

_____
Printed Name

_____
Title

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

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

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

1. By signing and submitting this contract, the prospective lower tier participant is providing the certification set out therein.

2. The certification in this clause is a material representation of fact upon which reliance was placed when this contract was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the Alabama Medicaid Agency (the Agency) may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant shall provide immediate written notice to the Agency if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, and voluntarily excluded, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this contract is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this contract that, should the contract be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this contract that it will include this certification clause without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the Agency may pursue available remedies, including suspension and/or debarment.

Alabama Medicaid Agency

501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

www.medicaid.alabama.gov
e-mail: almedicaid@medicaid.alabama.gov

KAY IVEY
Governor

Telecommunication for the Deaf: 1-800-253-0799

334-242-5000 1-800-362-1504

STEPHANIE MCGEE AZAR
Commissioner

MEMORANDUM

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

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

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

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

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

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

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

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 TELEPHONE NUMBER
Montgomery, Alabama 36103-5624 (334) 242-5833

This form is provided with:

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

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

☐ Yes ☐ No

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

STATE AGENCY/DEPARTMENT	TYPE OF GOODS/SERVICES	AMOUNT RECEIVED

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

☐ Yes ☐ No

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

STATE AGENCY/DEPARTMENT	DATE GRANT AWARDED	AMOUNT OF GRANT

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

NAME OF PUBLIC OFFICIAL/EMPLOYEE **DEPARTMENT/AGENCY**	ADDRESS	STATE

_____
_____
_____

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

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

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

_____
_____

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

_____
_____

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

NAME OF PAID CONSULTANT/LOBBYIST	ADDRESS

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

_____
Signature Date

_____
Notary's Signature Date Date Notary Expires

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

State of _____)

County of _____)

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

DATE:_____

RE Contract/Grant/Incentive (*describe by number or subject):* Enter brief contract description **by and between** Enter Contractor Name **(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

Governor's Additional Contract Questions
FOR PROFESSIONAL AND PERSONAL SERVICES CONTRACTS

PART I. Procurement method. Mark boxes as appropriate.

- ☐ **Competitive sealed bids/ITBs (§ 41-4-132)**
  - ☐ This is a professional-services contract; CPO approval for use of ITB is attached.
    Alabama Buys/STAARS solicitation number: _____
  - ☐ This is not a professional-services contract; no CPO approval for use of ITB required.
  - ☐ Adequate public notice of ITB was given for a reasonable time prior to bid opening.
  - ☐ Bids were opened publicly in the presence of one or more witnesses at time and place designated in the ITB.
- ☐ **Competitive sealed proposals/RFPs (§ 41-4-133)**
  - ☐ Number of providers the RFP was distributed to: _____
  - ☐ Number of responses/proposals the agency reviewed: _____
  - ☐ RFP was posted to online database as required by § 41-4-66
    Alabama Buys/STAARS solicitation number: _____
  - ☐ A written determination was made that accepted proposal is "most advantageous to the state."
  - ☐ Public notice of award was given promptly after contract award.
  - ☐ This is a contract for services governed by a DCM fee schedule.
    - ☐ Contract fees are within the approved DCM fee schedule.
    - ☐ DCM Director's approval for exceeding DCM fee schedule is attached.
  - ☐ This is a contract for an architect, landscape architect, engineer, land surveyor, or geoscientist.
    - ☐ A competitive, qualifications-based process was used per § 41-4-133(j).
- ☐ **Small purchases (§ 41-4-134)**
  - ☐ Contract fees are below the small-purchase thresholds set forth in Rule 355-4-3-.05.
  - ☐ Lowest acceptable quote chosen from three written quotes solicited.
    Solicitation number in Alabama Buys/STAARS is: _____
  - ☐ Per Rule 355-4-3-.05, no quotes required because: _____
- ☐ **Sole-source procurement (§ 41-4-135)**
  - ☐ Written determination by CPO that there is only one source for the required professional service is attached.
- ☐ **Emergency procurements (§ 41-4-136)**
  - ☐ Written determination for basis of the emergency and selection of the contractor attached.
  - ☐ Approval attached from CPO or agency head (not subject to delegation).
- ☐ **Special procurements (§ 41-4-137)**
  - ☐ Written determination for basis of the emergency and selection of the contractor attached.
  - ☐ Approval attached from CPO or agency head.
- ☐ **Physicians (§ 41-4-125.01)** – provider selected from Medical Licensure Commission list.
- ☐ **Attorneys (§ 41-4-125)**
  - ☐ Litigation (Hourly)
    - ☐ DAG appointment letter attached.
    - ☐ Governor's rate approval letter attached. (See EO 726, ¶ 3.b.)
  - ☐ Litigation (Contingency Fee)
    - ☐ DAG appointment letter attached.
    - ☐ Written determination attached as required by § 41-4-125(d)(1).
    - ☐ Fee within limits prescribed by § 41-4-125(d)(2)-(3) or AG/Governor written authorization for exceeding limits is attached as required by § 41-4-125(d)(5).
    - ☐ AG's standard contract addendum attached per § 41-4-125(d)(7).
  - ☐ Non-litigation
    - ☐ Justification letter attached for not using in-house counsel or AG.

Please call the Governor's Legal Office at (334) 242-7120 for questions about this form. Revised September 2023

- ☐ Governor's approval attached. (See EO 726, ¶ 3.b.)
- ☐ Attorney's scope of services is described with particularity. (See EO 726, ¶ 3.c.)

☐ **Litigation experts (§ 41-4-125(b))** – retained for litigation or avoidance of litigation.

☐ **Exempt Contract.** Explanation of the exemption and citation to statutory authority:

_____

_____

PART II. IT (information technology) questions. **Check one.**

☐ Contract is for IT supplies or services and written approval of OIT attached per § 41-4-285.

☐ Contract is not for IT supplies or services.

☐ If exemption from OIT approval is claimed, please explain basis and provide citation to statutory authority:

_____

_____

PART III. Personal services (employer-employee relationship) questions. **Check one.**

☐ Approved by State Personnel Department or its Board in accordance with the Alabama Fiscal Policy and Procedures Manual.

☐ Contract is not for personal services.

PART IV. Fiscal Policy and Procedures Manual requirements and additional questions. **Complete for all contracts.**

☐ Contract does not contain a waiver of sovereign immunity.

☐ Contract does not require the state to indemnify.

☐ Contract does not require a COVID-19 vaccination. (See EO 724, ¶ 4.)

☐ Contract contains all required clauses:

- ☐ Early termination clause on page: _____
- ☐ Alternative Dispute Resolution clause on page: _____
- ☐ Merit System Exclusion clause on page: _____
- ☐ Beason-Hammon (immigration) clause on page: _____
- ☐ No-boycott (free trade) clause on page: _____
- ☐ Economic boycott clause (per § 8-1-251) on page: _____
  - ☐ If exempt from economic boycott clause, explain and cite statutory authority:

    _____

☐ This contract is for administrative services.

- ☐ Ethics/nepotism clause (per EO 726, ¶ 4) on page: _____

☐ Disclosure statement required by § 41-16-82 is attached (or contract is for $5,000 or less).

☐ Immigration documentation attached (e.g., E-Verify/Certificate of Compliance). (See FPPM.)

I certify that all the information provided on this form is true, correct, and complete to the best of my knowledge.

_____ _____

Agency/Department Head Signature Name of Agency/Department

Name & Phone # of Agency Contact: _____

Please call the Governor's Legal Office at (334) 242-7120 for questions about this form. Revised September 2023

Appendix C: Acronyms

The below are commonly referenced acronyms within the Alabama Medicaid Agency.

ADA	Americans with Disabilities Act
ADPH	Alabama Department of Public Health
ADT	Admission/Discharge/Transfer
AHRQ	Agency for Healthcare Research and Quality
BA	Bachelor of Arts
BAA	Business Associate Agreement
BS	Bachelor of Science
BSN	Bachelor of Science in Nursing
BSW	Bachelor of Social Work
C.F.R.	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMC	Children with Medical Complexity
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CoIIN	Collaborative Improvement and Innovation Network
CT	Central Time
CY	Calendar Year
DMH	Department of Mental Health
DO	Doctor of Osteopathic Medicine
DUR	Drug Utilization Review
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
FFP	Federal Financial Participation
FFS	Fee-for-Service
FIPS	Federal Information Processing Standard
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAAS	Generally Accepted Auditing Standards
GED®	General Educational Development
GRC	Governance, Risk, and Compliance
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	United States Department of Health and Human Services
HIE	Health Information Exchange
HIMS	Health Information Management System
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health Act

ISSM	Information System Security Manager
ISSO	Information System Security Officer
IT	Information Technology
MARA	Milliman Advanced Risk Adjusters
MCP	Maternity Care Provider
MCT	Multidisciplinary Care Team
M.D.	Medical Doctor
MMIS	Medicaid Management Information System
MSW	Master of Social Work
NET	Non-Emergency Transportation
NIST	National Institute for Standards and Technology
NF	Nursing Facility
NP	Nurse Practitioner
PCCM-e	Primary Care Coordination Management Entity
PCP	Primary Care Provider
P&T	Pharmacy and Therapeutics
PA	Physician Assistant
Pharm. D.	Doctor of Pharmacy
PHI	Protected Health Information
PHQ-A	Patient Health Questionnaire for Adolescents
PHQ-2	Patient Health Question-2
PHQ-9	Patient Health Question-9
PMP	Primary Medical Provider
PMPM	Per Member Per Month
QAC	Quality Assurance Committee
QIP	Quality Improvement Project
SUD	Substance Use Disorder
SBIRT	Screening, Brief Intervention and Referral to Treatment
SCHIP	State Children's Health Insurance Program
SSA	Social Security Administration
STC	Special Terms and Conditions
TRS	Telecommunications Relay Service
TTY/TTD	Text Telephone/Telecommunication Device for the Deaf
UM	Utilization Management
USC	United States Code
TRS	Telecommunications Relay Service
TTY/TTD	Text Telephone/Telecommunication Device for the Deaf
UM	Utilization Management
USC	United States Code

Appendix D: Managed Care Terminology and Definitions

In accordance with 42 C.F.R. Part 438.10, the following managed care terminology definitions must be used to provide consistency in the information provided to recipients:

Terminology	Definition
Appeal	A request for your health insurance company or the Health Insurance Marketplace® to review a decision that denies a benefit or payment.
Co-Payment	Portion of incurred medical expenses, usually a fixed percentage, that the patient must pay out-of-pocket. Also referred to as a coinsurance. A cost sharing arrangement in which a covered person pays a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the healthcare is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital service. Some copayments are referred to as coinsurance, with the distinguishing characteristics that copayments are flat or variable dollar amounts and coinsurance is a defined percentage of the charges for services rendered. Also called copay.
Durable Medical Equipment	Equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness of injury and is suitable for use in any setting in which normal life activities take place, as defined in 42 C.F.R. § 440.70(c)(1).
Emergency Medical Condition	A medical condition manifesting itself by Acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An Emergency Medical Condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a healthcare professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence
Emergency Medical Transportation	Ground or air transportation in a vehicle specifically designed and equipped for transporting the wounded, injured, ill, or sick for an Emergency Medical Condition

Emergency Room Care	Covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish these services under 42 C.F.R. § 438.114 and needed to evaluate or stabilize an Emergency Medical Condition
Emergency Services	Covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish these services under 42 C.F.R. § 438.114 and needed to evaluate or stabilize an Emergency Medical Condition.
Excluded Services	Healthcare services that your health insurance or plan doesn't pay for or cover.
Grievance	An expression of dissatisfaction about any matter. Grievances may include, but are not limited to, the quality of care or Covered Services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the EI's rights regardless of whether remedial action is requested.
Rehabilitation Services and Devices	HealthCare services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Health Insurance	A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.
Home Health Care	Comprehensive, medically necessary range of health services provided by a recognized provider organization to a patient in the home.
Hospice Services	Care provided to terminally ill patients and their families that emphasizes emotional needs and coping with pain and death.
Hospitalization	Admission to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient with the expectation that he or she will remain in the hospital at least overnight and occupy a bed.
Hospital Outpatient Care	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a Physician or dentist at a licensed hospital.
Informal Support Systems	Any recipient-identified persons the recipient deem helpful and supportive in their life and wellness journey.

Medically Necessary	Healthcare services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
Maternity Care Provider	A licensed physician or nurse midwife who is qualified to perform deliveries, prenatal care, and postpartum care.
Network	The facilities, providers and suppliers your health insurer or plan has contracted with to provide healthcare services.
Non-Participating Provider	Any Provider that is not part of the ACHN's Provider/MCP Network.
Physician Services	Healthcare services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.
Plan	A benefit your employer, union or other group sponsor provides to you to pay for your healthcare services.
Preauthorization	Approval provided by Medicaid for specified services for a specific recipient to a specific provider, or the process of obtaining prior approval as to the appropriateness of the service or medication. Prior authorization does not guarantee coverage.
Participating Provider	A provider who has contracted with the health plan to deliver medical services to covered persons. The provider may be a hospital, pharmacy or other facility, or a physician who has contractually accepted the terms and conditions as set forth by the health plan.
Premium	The amount you pay for your health insurance every month.
Prescription Drug Coverage	Health insurance or plan that helps pay for prescription drugs and medications. All Marketplace plans cover prescription drugs.
Prescription Drugs	Drugs and medications that, by law, require a prescription by a healthcare professional licensed to prescribe such drugs.
Primary Care Physician	Physician (M.D. or D.O.) that practices in the specialty designation of family medicine, general internal medicine, pediatrics, or general medicine and OB/GYN
Primary Care Provider	Physician (M.D. or D.O.), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of healthcare services.
Provider	An institution, facility, agency, person, partnership, corporation or association which is approved and certified by the Agency as authorized to provide the recipients the services specified in the State Plan at the time services are rendered.

Rehabilitation Services and Devices	Rehabilitative services are specialized services of a medical or remedial nature delivered by uniquely qualified practitioners designed to treat or rehabilitate persons with mental illness or SUD diagnoses.
Skilled Nursing Care	Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.
Specialist	A Physician or Doctor of Osteopathic Medicine that has obtained the education and qualifications, as well as the authority under the laws and regulations of the applicable licensure state or the State of Alabama, to hold himself or herself out as such.
Urgent Care	Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

Appendix E: RFP Documentation

Procurement Library Contents at the time of RFP release are listed below. Please refer to the Alabama Medicaid Procurement website for any updates to the Procurement Library.

(https://medicaid.alabama.gov/content/2.0_Newsroom/2.4_Procurement.aspx)

1. PL01_Consumer Advisory Committee Policy
2. PL02_Care Management Care Plan Requirements Policy
3. PL03_Recipient Materials Requirements
4. PL04_ Recipient Materials Requirements-Provider Directory
5. PL05_Recipient Notice Model
6. PL06_Regions Map
7. PL07_Multidisciplinary Care Team
8. PL08_Care Management Guidelines
9. PL09_General Risk Stratification Chart
10. PL10_Medically Complex Stratification Chart
11. PL11_ Maternity Risk Stratification Chart
12. PL12_Medical Monitoring Risk Stratification chart
13. PL13_Enrollments, Disenrollments and Reenrollments
14. PL14_Recipient Assignment Process
15. PL15_Training Requirements for Staff who Provide Care Management Services for the Medically Complex Population
16. PL16_Enrollee Manual Model
17. PL17_ Quarterly Grievance Reporting Template
18. PL18_Alabama Medicaid Vendor Interface Specifications
19. PL 19_Alabama Medicaid Case Management Activity Guide V4.0
20. PL 20_Medical Management Meetings

Appendix F: Scored Items and Compliance Acknowledgment

ALABAMA MEDICAID AGENCY
Request for Proposal RFP# 2023-ACHN-01

Instructions: In accordance with Section VII, Vendors must provide a hard and soft copy narrative response to the Section II – Scope of Work (Scored Items), listed below. The vendor's response should include:

- HOW do you intend to complete the requirement?
- WHAT problems/issues need to be resolved?
- WHAT assistance will be needed from the Agency?
- WHO will execute the requirement?
- WHAT additional information would you like to submit?

The response to each requirement, listed below, must not exceed two (2) pages. Attached documents, including graphics, flow charts, diagrams, and other descriptive information should only be used to support the information in the narrative response. Attachments not directly referenced in the narrative response, will not be reviewed. Attachments, including graphics, charts, and other supplemental information must not exceed ten (10) pages for the entirety of this document. Pages in excess of the stated page limits (including supplemental pages), will not be reviewed.

Requirements, listed below, may be paraphrased. Refer to RFP document for complete description.

SCOPE OF WORK		
Section Title	Section	Requirement (Provide Description for :)
SCOPE WORK		
1. Comprehensive Care Management Program		
Population Health Management	II.D.1	Describe how the Vendor will develop, implement, and maintain its strategy for Population Health Management including, at a minimum, the following: • Identifying staff involved in population health management activities • Identifying and addressing SDoH • Identifying, evaluating, and reducing health disparity
Comprehensive Care Management Services	II: 1	Describe how the Vendor will provide seamless coordination between General Care Coordination, Medically Complex Care Coordination, and Maternity Care Coordination to better achieve quality outcomes. Include organizational structure, flow charts, policy on staff cross-training (if applicable), and oversight procedures to ensure quality outcomes and seamless coordination.

Solutions to Regional Barriers	II	Describe how the Vendor will overcome regional barriers to healthcare, such as transportation and other access to care issues. In addition to the minimum requirements of this RFP, include the following: • what types of programs, • how many programs, • how many individuals will be affected, and • what is the expected financial impact of those programs to address these issues will be an important component of your response.
Care Management Staff	II	Submit an organization chart and staffing plan for Care Management (case management and care coordination) staff.
Partnership with Community Agencies	II	Describe the Vendor's plan to develop and maintain partnerships with community agencies especially for the following populations/issues: • SUD • nutrition/obesity • high-risk pregnancies • support for mother/parents with adverse birth outcomes • recipients with a SCD diagnosis • children with medical complexities • mental health disorders • family planning • interconception services • health literacy/education collaborators Submit collaboration/support letters from existing partnerships
Process for selecting a PCP	II.D.5	Describe the Vendor's plan to assist recipients in selecting a PCP.
NET Coordination	II.D.9 III. 8. C. 1.e	Describe the process for assisting recipients with NET.
Care Management Stratification of Recipients	II.D.2	Describe the screening and stratification process for recipients receiving care Management services for the following populations: • General • Maternity • Medically Complex

		• Medical Monitoring
Assessment and Care Planning-All Populations	II.D.	Describe the assessment, reassessment, and care planning process for recipients for care management for the populations- General, Medically Complex and Maternity.
Children with Medical Complexity (CMC)	II.D.2	Describe the process to coordinate care for children with medical complexities.
Multidisciplinary Care Team (MCT)	II.1.E.5	Describe the role and process of the MCT for recipients receiving Care Management/Coordination services.
Application Assisters	II.2.c	Describe how the Vendor will assist recipients to complete Medicaid applications through application assisters.
Family Planning Referrals	II.C.4	Describe the Vendor's for assessing and referring recipients to family planning services.
Closed Loop Referrals	II.D.4	Describe the Vendor's process to develop, implement, maintain and monitor a closed loop process for recipients including, at a minimum, the following: • Initial referral • Communication of recipient's needs to referral resource (to and from referrals) • Follow-up with the referral source • Follow-up with the recipient • Timeliness of follow-up with the referral source and the recipient
2. Maternity Care Management Program		
Maternity Care Management Program	II.2 Maternity Care Plan Activity Schedule	Describe the Vendor's plan to develop, implement, and maintain a Maternity Care Management Program, including the following: • identifying staff involved with the Maternity Care Management Program • identifying recipients that are eligible for the Maternity Care Management Program • Process for providing services to pregnant and postpartum recipients women
Collaboration with MCPs	II.2	Describe the Vendor's process regarding how it will collaborate with MCPs to provide care management services to pregnant and postpartum women.

Care Management for newborns delivered with no prenatal care	II.2.A.l	Describe the plan to provide care management for newborns delivered without prenatal care.
Selection of MCP	II.2.B II.2.C.	Describe the process recipients will follow when selecting or changing in MCP.
Maternity Care Provider Referral Process	II.2. D.	Describe the Vendor's process for MCP giving and receiving referrals for maternity recipients.
3. Behavioral Health Program		
Behavioral Health Program	II.3	Describe the Vendor's plan to develop, implement, and maintain a Behavioral Health Program, including the following: • identifying staff involved with the behavioral health program. • identifying recipients that are eligible for the behavioral health program
4. Pharmacy Program		
Pharmacy Program - Medication List	II.4.B	Describe the Vendor's plan to complete medication lists for recipients receiving care management services.
Medication Reconciliation	II.4.C	Describe the process for medication reconciliations for recipients receiving Care Management/Coordination services.
5. Transitional Care Program		
Transitional Care Program	II.5.B	Describe the development of the Transitional Care Program to include the development of the transitional care team.
Transitional Care Process	II.5.B	Describe the Vendor's transitional care process to assist recipients with transition from a facility to a community setting, including the following: • identifying recipients in need of transitional care • identify staff involved in transition care management and discharge planning • how staff will interact with hospitals and inpatient facilities ensuring that post-discharge planning involves appropriate housing support and coordination when appropriate for the recipient's needs
Transitional Plan – General Care Management	II.5.B	Provide the Vendor's plan to ensure continuity of care for recipients in the General Population transitioning to the Vendor's care management program.

Transitional Plan – Maternity Care Coordination	II.5.B	Provide the Vendor's plan to ensure continuity of care for recipients in the Maternity Population transitioning to the Vendor's care management program.
Transition of recipients between PCCM-e entities	II.5.B	Describe how the Vendor will facilitate the transitioning of a recipient from one Region to another ensuring continuity of care for recipient.
7. Quality Improvement Program		
Quality Improvement Program	II.7.A	Provide the plan to implement and monitor a Quality Improvement Program and Population Health Management practices as specified within this RFP
Quality Improvement Plan	II.7.B	Describe the development, implementation, monitoring, and reporting of the Vendor's Quality Improvement Plan.
Quality Improvement Projects	II.7.E	Describe the process of development and implementation of Quality Improvement Projects.
8. Routine Meeting Attendance/Participation		
Region Medical Management Committee	II.8.A	Describe the Vendor's development and implementation of the Region Medical Management Committee including a description of the quarterly meetings.
III. GENERAL REQUIREMENTS		
Organizational Requirements		
PCCM-e Organizational Requirements	III: 1	Describe the Vendor's organizational background and experience, i.e., date established, ownership, Governing Board composition, CAC composition.
3. Staffing/Organizational Plan		
Staffing	III: 3 Appendix K	In addition to the required staff as stated in Appendix K, will the Vendor contract with or hire other staff to enhance care management services provided to the recipients? If so, describe positions, including number of staff, qualifications, and functions.
4. Key Personnel		
Key Staff	III: 4	Submit an organizational chart, staffing plan with staffing experience requirements for key staff, and resumes for existing key staff.
5. Operational Requirements		
Care Management staff Work Hours	**III: 5.A**	Describe the Vendor's plan for care management staff to work outside of the

		8am-5pm office hours to accommodate the recipients' schedules.
Health Information Management System (HIMS)	III: 5.B	Describe the Vendor's HIMS including the functional and technical requirements.
Contingency and Continuity Plan	III: 5.B.4; Appendix O	Describe the Vendor's Contingency and Continuity Plan during a disaster.
7. Technical Requirements		
Services Telephone Line	III.B. 1	Describe the plan to implement and maintain a number allowing toll free calls from PCPs, MCPs and potential and current recipients. This plan should also include how the Vendor will monitor compliance with this technical requirement component.
8. Information Requirements		
Information Requirements	III.8. A	Describe the Vendor's plan to develop and provide access to information regarding the program to recipients and PCPs.
Recipient Materials	III.8. B	Describe the Vendor's plan to develop and provide access to the required materials to the recipients.
Outreach and Education	III.8. C.1 III.8. C.2	Describe the Outreach and Education Plan for recipients, participating providers, i.e., PCPs, MCPs, and the PCCM-e's marketing/advertising plan.
PCCM-e Website	III.E	Describe the Vendor's plan to develop and maintain the contractual website requirements.

CONTRACTOR ACKNOWLEDGMENT STATEMENT

The Contractor acknowledges and agrees to comply with all terms, conditions and requirements set forth in this RFP.

_____ _____

Print Name of Vendor Representative Print Title of vendor Representative

_____ _____

Signature Date

Appendix G: Care Management Activity Schedule- General Population

General Population Care Management (CM) Activity Schedule									
ACTIVITY CODE	Description (title subject to change)	Case Management Stratification			ACTIVITY TYPE		Schedule		Activity Requirement
		HIGH	MODERATE	LOW	Face to Face (F2F)	Telephonic	Frequency	Month	All documentation to support completion of the activity must be present in the HIMS before submission for payment
TBD	Initial Encounter: Eligibility Assistance (inc. Screening)	X	X	X	X	X	1/ enrollment	0-1	Application assistance and screening for care management services.
TBD	Initial Encounter (Screening)	X	X	X	N/A	X	1/ ACHN enrollment	0-1	Screening for care management services.
TBD	Initial Assessment Psychosocial	X	X	X	X	N/A	1/ enrollment	0-1	Completion of a Health Risk and Psychosocial Assessment within 21 days of screening. Stratification determination. Medication list completion. PHQ assessment (required for the General population for ages 12 and older), Substance Abuse Screening (required for the General population for ages 12 and older). Initial determination of medical, social, and behavioral health needs along with the barriers to achieving optimal health. Requires completion of all forms and a progress note before requesting payment.
TBD	Medication Reconciliation & Education Follow-Up (completed during care plan review)	X	X		N/A	X	1/yr	0-1	Complete within 5 days of Psychosocial Assessment. Pharmacist reconcilies the medication list and provides recommendations to the care manager for discussion and education of the recipient.
TBD	Care Plan completion	X	X	X	X	N/A	1/ enrollment	0-1	Complete within 15 days of the Initial Psychosocial Assessment. Development a recipient centered plan of care. The goals and interventions must focused on increasing the recipient's knowledge, compliance and confidence to navigate the healthcare system while decreasing physical, mental, social and economic barriers and disparities. Development of interventions geared to aiding the recipient to achieve their goals. Documentation must include but is not limited to the care plan, phone calls with recipient, the primary care provider, and community resource agencies to gather information to complete the Care Plan. All documentation must be complete before requesting payment for services. **(Payment of this code is included in the payment of Care Plan Review)**
TBD	Care Plan Review (with/rec; signature required) incl Med Rec education and additional follow-ups with rec	X	X	X	X	N/A	1/yr	2	Complete within 15 days of Care Plan (CP) completion activity. Discussion with recipient regarding pharmacist recommendations. Review and amend (i f necessary) the CP with the recipient which includes agreement and signing of CP.) Completion of a Progress note. All documentation must be complete before requesting payment for services. **Payment includes the Care plan completion activity and a 30 day follow- up call to be completed after CP review to evaluate progress. (Recipient signature required**
TBD	Care Plan Review Follow up	X	X	X		X	1/yr	3	Phone call with recipient 30 days after care plan review to evaluate progress, reassess stratification level and address any new needs or concerns. Requires progress note.
TBD	Multi-disciplinary Care Team (MCT)	X	N/A	N/A	X	VIRTUAL	1/yr	4	F2F or virtual meeting to include the PCCM-e staff, recipient, health professionals and other community agencies to discuss the recipient's health and psychosocial needs, barriers, and develop a solution plan. 30 days after care plan review follow up for High and medium risk recipients. Requires a progress note.
TBD	1st Periodic Reassessment Follow-up	X	X	X	N/A	X	1/yr	6	Telephonic Encounter with recipient to assess progress to goals. Assess for needs and barriers to success. Evaluate the Care plan and assess need to implement new interventions and strategies to achieve goals. Provide education and informal counseling. Assist with referrals and directives of the medical provider; Update the medication list and assist with the medication reconciliation process (as applicable); Assist with follow-up appointments and provide appointment/mail appointment card reminders. Assist with communication with community resource agencies. Requires a progress note.
TBD	2nd Periodic Reassessment Follow-up	X	X	X	X	N/A	1/yr	7 or 8	Encounter with recipient to assess progress to goals. Assess for needs and barriers to success. Evaluate the care plan (goal progress, intervention (un)successful). Update Care Plan with implementation of new goals and interventions and strategies as dictated by the recipient's needs (***Recipient signature required***). Provide education and informal counseling. Assist with referrals and directives of the medical provider; Update the medication list and assist with the medication reconciliation process (as applicable); Assist with follow-up appointments and provide appointment/mail appointment card reminders.

General Population Care Management (CM) Activity Schedule									
ACTIVITY CODE	Description (title subject to change)	Case Management Stratification			ACTIVITY TYPE		Schedule		Activity Requirement
		HIGH	MODERATE	LOW	Face to Face (F2F)	Telephonic	Frequency	Month	All documentation to support completion of the activity must be present in the HIMS before submission for payment
TBD	3rd Periodic Reassessment Follow-up	X	N/A	N/A	N/A	X	1/yr	9 or 10	Encounter with recipient to access progress to goals. Assess for needs and barriers to success. Evaluate the Care plan and assess need to implement new interventions and strategies to achieve goals. Provide education and informal counseling. Assist with referrals and directives of the medical provider; Update the medication list and assist with the medication reconciliation process (as applicable); Assist with follow-up appointments and provide appointment/mail appointment card reminders.
TBD	2nd Multi-disciplinary Care Team (MCT)	X	N/A	N/A	X	VIRTUAL	1/yr	11	F2F or virtual meeting to include the CC, recipient, health professionals and other community agencies to discuss the recipient's health and psychosocial needs, barriers, and develop a solution plan. 30 DAYS AFTER 3RD PERIODIC FOLLOW-UP **(Recipient signature required)**
TBD	Annual Re-Assessment	X	X	X	X	N/A	1/yr	12	Completion of a face-to-face Health Risk and Psychosocial Assessment. Stratification determination. Medication list completion. PHQ assessment (required for the General population for ages 12 and older), Substance Abuse Screening (required for the General population for ages 12 and older). Redetermination of needs and barriers. Requires a progress note. **(Recipient signature required)**
TBD	Community Care Support Coordination	X	X	X	N/A	X	4/mo	N/A	A successful Community Care Support Coordination encounter which shall include but is not limited to providing and linking the recipient with community resources assistance which should include phone calls or visits to community agencies by the CC. Professional phone communication on behalf of the recipient to any medical provider such as a specialist, counselor, or educator, excluding the PCP. Calls made by the CC to assist the recipient with transportation requests. Requires a progress note. ***Cannot be billed without a successful completion of a periodic or inter-periodic encounter within 30 days.***
TBD	Inter-periodic Follow up Encounter	X	X	X	N/A	X	3/yr	N/A	Encounter with recipient to access progress to goals. Assess for needs and barriers to success. Evaluate the Care plan and assess need to implement new interventions and strategies to achieve goals. Provide education and counseling. Assist with referrals and directives of the medical provider; Assist with follow-up appointments and provide appointment/mail appointment card reminders. Requires a progress note. ***Activity cannot be billed in the same month as a periodic encounter.***

Appendix H: Care Management Activity Schedule- Medically Complex Population

Medically Complex Population Care Management (CM) Activity Schedule									
ACTIVITY CODE	Description (title subject to change)	Case Management Stratification			ACTIVITY TYPE		Schedule		Activity Requirement
		HIGH	MODERATE	LOW	Face to Face (F2F)	Telephonic	Frequency	Month	All documentation to support completion of the activity must be present in the HIMS before submission for payment
TBD	Initial Encounter: Eligibility Assistance (inc. Screening)	X	N/A	N/A	X	X	1/ enrollment	0-1	Application assistance and screening for care management services.
TBD	Initial Encounter (Screening)	X	N/A	N/A	N/A	X	1/ ACHN enrollment	0-1	Screening for care management services.
TBD	Initial Assessment Psychosocial	X	N/A	N/A	X	N/A	1/ enrollment	0-1	Completion of a Health Risk and Psychosocial Assessment within 21 days of screening. Stratification determination. Medication list completion. PHQ assessment (required for the General population for ages 12 and older), Substance Abuse Screening (required for the General population for ages 12 and older). Initial determination of medical, social, and behavioral health needs along with the barriers to achieving optimal health. Requires completion of all forms and a progress note before requesting payment.
TBD	Medication Reconciliation & Education Follow-Up (completed during care plan review)	X	N/A	N/A	N/A	X	1/yr	0-1	Complete within 5 days of Psychosocial Assessment. Pharmacist reconciles the medication list and provides recommendations to the care manager for discussion and education of the recipient.
TBD	Care Plan completion	X	N/A	N/A	X	N/A	1/ enrollment	0-1	Complete within 15 days of the initial Psychosocial Assessment. Development a recipient centered plan of care. The goals and interventions must be focused on increasing the recipient's knowledge, compliance and confidence to navigate the healthcare system while decreasing physical, mental, social and economic barriers and disparities. Development of interventions geared to aiding the recipient to achieve their goals. Documentation must include but is not limited to the care plan, phone calls with recipient, the primary care provider, and community resource agencies to gather information to complete the Care Plan. All documentation must be complete before requesting payment for services. **Payment of this code is included in the payment of Care Plan Review.**
TBD	Care Plan Review (with/rec; signature required) incl Med Rec education and additional follow-ups with rec	X	N/A	N/A	X	N/A	1/yr	2	Complete within 15 days of Care Plan (CP) completion activity. Discussion with recipient regarding pharmacist recommendations. Review and amend (if necessary) the CP with the recipient which includes agreement and signing of CP. Completion of a Progress note. All documentation must be complete before requesting payment for services. **Payment includes the care plan completion activity and a 30 day follow-up call to be completed after CP review to evaluate progress. Recipient signature required**
TBD	Care Plan Review Follow up	X	N/A	N/A		X	1/yr	3	Phone call with recipient 30 days after care plan review to evaluate progress, reassess stratification level and address any new needs or concerns. Requires progress note.
TBD	Multi-disciplinary Care Team (MCT)	X	N/A	N/A	X	VIRTUAL	1/yr	4	F2F or virtual meeting to include the PCCM- e staff, recipient, health professionals and other community agencies to discuss the recipient's health and psychosocial needs, barriers, and develop a solution plan. 30 days after care plan review follow up for High and medium risk recipients. Requires a progress note.
TBD	1st Periodic Reassessment Follow-up	X	X	X	N/A	X	1/yr	6	Telephonic Encounter with recipient to assess progress to goals. Assess for needs and barriers to success. Evaluate the Care plan and assess need to implement new interventions and strategies to achieve goals. Provide education and counseling. Assist with referrals and directives of the medical provider; Update the medication list and assist with the medication reconciliation process (as applicable); Assist with follow-up appointments and provide appointment/mail appointment card reminders. Assist with communication with community resource agencies. Requires a progress note.
TBD	2nd Periodic Reassessment Follow-up	X	X	X	X	N/A	1/yr	7 or 8	Encounter with recipient to assess progress to goals. Assess for needs and barriers to success. Evaluate the care plan (goal progress, intervention (un)successful). Update Care Plan with implementation of new goals and interventions and strategies as dictated by the recipient's needs (***Recipient signature required***). Provide education and counseling. Assist with referrals and directives of the medical provider; Update the medication list and assist with the medication reconciliation process (as applicable); Assist with follow-up appointments and provide appointment/mail appointment card reminders.

Medically Complex Population Care Management (CM) Activity Schedule									
ACTIVITY CODE	Description	Case Management Stratification			ACTIVITY TYPE		Schedule		Activity Requirement
		HIGH	MODERATE	LOW	Face to Face (F2F)	Telephonic	Frequency	Month	All documentation to support completion of the activity must be present in the HIMS before submission for payment
TBD	3rd Periodic Reassessment Follow-up	X	N/A	N/A	N/A	X	1/yr	9 or 10	Encounter with recipient to assess progress to goals. Assess for needs and barriers to success. Evaluate the Care plan and assess need to implement new interventions and strategies to achieve goals. Provide education and counseling. Assist with referrals and directives of the medical provider; Update the medication list and assist with the medication reconciliation process (as applicable). Assist with follow-up appointments and provide appointment card reminders.
TBD	2nd Multi-disciplinary Care Team (MCT)	X	N/A	N/A	X	VIRTUAL	1/yr	11	F2F or virtual meeting to include the CC, recipient, health professionals and other community agencies to discuss the recipient's health and psychosocial needs, barriers, and develop a solution plan. 30 DAYS AFTER 3RD PERIODIC ASSESSMENT **(Recipient signature required)**
TBD	Annual Re-assessment	X	X	X	X	N/A	1/yr	12	Completion of a face-to-face Health Risk and Psychosocial Assessment. Stratification determination. Medication list completion, PHQ assessment (required for ages 12 and older), Substance Abuse Screening (required for ages 12 and older). Redetermination of needs and barriers. Requires a progress note. **(Recipient signature required)**
TBD	Community Care Support Coordination	X	X	X	N/A	X	4/mo	N/A	A successful Community Care Support Coordination encounter which shall include but is not limited to providing and linking the recipient with community resources assistance which should include phone calls or visits to community agencies by the CC. Professional phone communication on behalf of the recipient to any medical provider such as a specialist, counselor, or educator, excluding the PCP. Calls made by the CC to assist the recipient with transportation requests. Requires a progress note. **Cannot be billed without a successful completion of a periodic or inter-periodic encounter within 30 days.**
TBD	Inter-periodic Follow up Encounter	X	X	X	N/A	X	3/yr	N/A	Encounter with recipient to access progress to goals. Assess for needs and barriers to success. Evaluate the Care plan and assess need to implement new interventions and strategies to achieve goals. Provide education and counseling. Assist with referrals and directives of the medical provider; Assist with follow-up appointments and provide appointment/mail appointment card reminders. Requires a progress note. ***Activity cannot be billed in the same month as a periodic encounter.***

Appendix I: Care Management Activity Schedule- Maternity/Postpartum Population

Maternity/Postpartum Population
Care Management (CM) Activity Schedule

ACTIVITY CODE	Description (title subject to change)	Case Management Stratification		ACTIVITY TYPE		Schedule		Activity Requirement
		HIGH	LOW	Face to Face (F2F)	Telephonic	Frequency	Month	All documentation to support completion of the activity must be present in the HIMS before submission for payment
TBD	Initial Encounter (Screening)	X	N/A	N/A	X	1/ Pregnancy	0-1	Screening for care management services. Typically completed in 1 hour
TBD	Initial Assessment Psychosocial	X	N/A	X	N/A	1/ Pregnancy	0-1	Completion of a Health Risk and Psychosocial Assessment within 21 days of screening. Stratification determination. Medication list completion. PHQ assessment (required for the General population for ages 12 and older), Substance Abuse Screening (required for the General population for ages 12 and older). Initial determination of medical, social, and behavioral health needs along with the barriers to achieving optimal health. Requires completion of all forms and a progress note before requesting payment. Typically completed in 2 hours
TBD	Medication Reconciliation & Education Follow-Up (completed during care plan review)	X	N/A	N/A	X	1/ Pregnancy	0-1	Complete within 5 days of Psychosocial Assessment. Pharmacist reviews and reconciles the medication list and provides recommendations to the care manager for discussion and education of the recipient.
TBD	Care Plan completion	X	N/A	X	N/A	1/ Pregnancy	0-1	Complete within 15 days of the Initial Psychosocial Assessment. Development a recipient centered plan of care. The goals and interventions must be focused on increasing the recipient's knowledge, compliance, and confidence to navigate the healthcare system while decreasing physical, mental, social and economic barriers and disparities. Development of interventions geared to aiding the recipient to achieve their goals. Documentation must include but is not limited to the care plan, phone calls with recipient, the primary care provider, and community resource agencies to gather information to complete the care plan. All documentation must be complete before requesting payment for services. **(Payment of this code is included in the payment of care plan Review.)**
TBD	Care Plan Review (with/rec; signature required) incl Med Rec education and additional follow-ups with rec	X	N/A	X	N/A	1/ Pregnancy	2	Complete within 15 days of care plan (CP) completion activity. Discussion with recipient regarding pharmacist recommendations. Review and amend (if necessary, the CP with the recipient which includes agreement and signing of CP.) Completion of a Progress note. All documentation must be complete before requesting payment for services. **Payment Includes the Care plan completion activity and a 30 day follow- up call to be completed after CP review to evaluate progress. Recipient signature required.**
TBD	Care Plan Review Follow up	X	N/A		X	1/ Pregnancy	3	Phone call with recipient 30 days after care plan review to evaluate progress, reassess stratification level and address any new needs or concerns. Requires progress note.
TBD	Multi-disciplinary Care Team (MCT)	X	N/A	X	N/A	1/ Pregnancy	4	F2F or virtual meeting to include the CC, recipient, health professionals and other community agencies to discuss the recipient's health and psychosocial needs, barriers, and develop a solution plan. 30 days after care plan review follow up for High and medium risk recipients. Requires a progress note.
TBD	1st Periodic Reassessment Follow-up	X	X	X	N/A	1/ Pregnancy	5-6	Telephonic Encounter with recipient to assess progress to goals. Assess for needs and barriers to success. Evaluate the Care plan and assess need to implement new interventions and strategies to achieve goals. Provide education and informal counseling. Assist with referrals and directives of the medical provider; Update the medication list and assist with the medication reconciliation process (as applicable); Assist with follow-up appointments and provide appointment/mail appointment card reminders. Assist with communication with community resource agencies. Requires a progress note.
TBD	2nd Periodic Reassessment Follow-up	X	X	N/A	X	1/ Pregnancy	7 or 8	Encounter with recipient to access progress to goals. Assess for needs and barriers to success. Evaluate the care plan (goal progress, intervention (un)successful). Update care plan with implementation of new goals, interventions, and strategies as dictated by the recipient's needs (***Recipient signature required).*** Provide education and informal counseling. Assist with referrals and directives of the medical provider; Update the medication list and assist with the medication reconciliation process (as applicable); Assist with follow-up appointments and provide appointment/mail appointment card reminders.

Maternity/Postpartum Population
Care Management (CM) Activity Schedule

ACTIVITY CODE	Description	Case Management Stratification		ACTIVITY TYPE		Schedule		Activity Requirement
		HIGH	LOW	Face to Face (F2F)	Telephonic	Frequency	Month	All documentation to support completion of the activity must be present in the HIMS before submission for payment
TBD	3rd Periodic Reassessment Follow-up	X	N/A	N/A	X	1/ Pregnancy	9 or 10	Encounter with recipient to access progress to goals. Assess for needs and barriers to success. Evaluate the Care plan and assess need to implement new interventions and strategies to achieve goals. Provide education and informal counseling. Assist with referrals and directives of the medical provider; Update the medication list and assist with the medication reconciliation process (as applicable);Assist with follow-up appointments and provide appointment/mail appointment card reminders.
TBD	Delivery Encounter	X	X	X	N/A	1/ Pregnancy	20 days post delivery	Face to face encounter with the recipient within 20 days of delivery or end of pregnancy to assess needs and pregnancy outcome. Provide education on birth spacing, contraceptive care, safe sleep, breastfeeding and any other individual needs of mother and infant. Review discharge summary with patient to ensure patient understands prescribed plan of care. Assess infant for General care management. Visit may take place either prior to discharge from the hospital or in the recipient's home.
TBD	1st Postpartum Encounter (In home)	X	X	X	N/A	1/ Pregnancy	30-45 days post MHP01	Face to face visit with the recipient 30-45 days after completion of the delivery encounter to assess needs, risks, health and physical and emotional well-being of mother and infant, offer support and encourage follow-up with MCP as needed. Update CP to reflect PP needs. Assess and stratify for Maternal health visits
TBD	2nd Postpartum follow-up Encounter	X	X	X	N/A	1/ Pregnancy	60-75 days Post MHP02	Visit with the recipient 60-75 days after completion of the first in- home postpartum encounter to access needs, risks, health and physical and emotional well-being of mother and infant, offer support and encourage follow-up with provider as needed. ***Assess and stratify for General Care management.***
TBD	3rd Postpartum follow-up Encounter	X	N/A	N/A	X	1/ Pregnancy	60-75 days Post MHP03	Visit with the recipient 60-75 days after completion of the second in- home postpartum encounter to access needs, risks, health and physical and emotional well-being of mother and infant, offer support and encourage follow-up with MCP as needed. ***Assess and stratify for General Care management.***
TBD	Community Care Support Coordination	X	X	N/A	X	4/mo		A successful Community Care Support Coordination encounter which shall include but is not limited to providing and linking the recipient with community resources assistance which should include phone calls or visits to community agencies and other outreach activities by the CC. Professional phone communication on behalf of the recipient to any medical provider such as a specialist, counselor, or educator, excluding the MCP. Calls made by the CC to assist the recipient with transportation requests. Requires a progress note. ***Cannot be billed without a successful completion of a periodic or inter-periodic encounter within 30 days.***
TBD	Inter-periodic Follow up Encounter	X	X	N/A	X	3/Pregnancy		Encounter with recipient to access progress to goals. Assess for needs and barriers to success. Evaluate the Care plan and assess need to implement new interventions and strategies to achieve goals. Provide education and informal counseling. Assist with referrals and directives of the medical provider; Assist with follow-up appointments and provide appointment/mail appointment card reminders. Requires a progress note. ***Activity cannot be billed in the same month as a periodic encounter.***

Appendix J: Care Management Activity Schedule- Monitoring

General Population - Monitoring Care Management (CM) Activity Schedule									
ACTIVITY CODE	Description	Case Management Stratification			ACTIVITY TYPE		Schedule		Activity Requirement
		HIGH	MODERATE	LOW	Face to Face (F2F)	Telephonic	Frequency	Month	All documentation to support completion of the activity must be present in the HIMS before
TBD	Monitoring	N/A	N/A	N/A	N/A	N/A	1/ enrollment	0-1	Screening for care management services for recipients that do not qualify for enrollment due to stratification levels. Bill this code for recipients not stratified to receive care management/coordination.

Appendix K: Key Staff and other Positions Requirements

Executive Director

Requirements

- Full-time;
- Possess excellent organizational and administrative skills; and
- Must maintain a full-time office in the PCCM-e Region.

Education/Experience

- Possess a B.S. degree in Business Administration, Finance, Accounting or related field from an accredited college or university (preferred);
- Have a minimum of three years management experience in managed healthcare (to include population health management) and experience working with low-income populations; or
- In lieu of a bachelor's degree, the individual may have 10 years management experience in managed healthcare.

Primary responsibilities include, but are not limited to:

- Authority to make all day-to-day program decisions including hiring, firing, and financial decisions consistent with the terms of the Contract, within the policies and procedures of the PCCM-e and the budget approved by the PCCM-e's Governing Board.
- Leads and maintains a team of qualified staff to ensure quality of services are provided in accordance with state and federal requirements and regulations; Agency and program goals and objectives are met; and desired health outcomes are achieved; and
- Serves as primary administrative liaison between the PCCM-e and the Agency.

Medical Director

Requirements

- Be a practicing physician within the Region for which he or she serves as Medical Director. If the Medical Director practices in more than one Region, he or she will only be eligible to serve (as Medical Director) in the Region of his or her main practice site.
- Part-time.

Education/Experience

- Be a licensed physician in the State of Alabama (required); and
- Have three (3) years of experience with low-income populations.

Primary responsibilities include, but are not limited to:

- Maintain contact with local providers.
- Represent the PCCM-e in person at select meetings as required by the Agency and/or the PCCM-e.
- Address local issues at the community level.
- Lead quarterly Medical Management Meetings in the Region; and
- Approve the Quality Initiatives and Quality Improvement Plan of PCCM-e.

Pharmacy Director

Requirements

- Possess excellent organizational and administrative skills;
- Full time;
- Current Alabama pharmacy license in good standing; and
- Work within the Region; live within the Region (preferred).

Education/Experience

- Holds at a minimum a B.S. degree in Pharmacy; and
- Must have a minimum of five years of pharmacist experience within the past six years; supervisory experience (preferred).

Primary responsibilities include

- Provide leadership and oversight of the Pharmacy Program for the PCCM-e, including supervision of the Community Pharmacist, Transitional Pharmacist, and any pharmacy staff (pharmacists or certified pharmacy technicians) within the Region.
- May serve simultaneously as either the Transitional Pharmacist or Community Pharmacist but must meet the educational/professional criteria for both positions held.
- Serve as the primary point of contact with the Agency for all meetings and coordination in all pharmacy related matters.
- Develop, coordinate, implement, and manage education of community, inpatient, transitional, and all pharmacists and PCPs within the PCCM-e and Agency pharmacy initiatives.
- Develop, coordinate, engage within, and manage staff to implement programs that advance the Medical Home.
- Work with the PCCM-e's management team to determine ways to support pharmacists and prescribers with management of drug costs and policies.
- Create and manage programs that address new policies as the Agency implements them.
- Attend and present at various local PCCM-e and Agency meetings as requested, such as Steering Committee meetings, Medical Management meetings, Alabama Medicaid Pharmacy and Therapeutics (P&T) and Drug Utilization Review (DUR) meetings, and PCCM-e Director's Meetings.
- Serve as a resource to PCPs and care managers on general drug information and Agency pharmacy policy issues.
- Develop and implement a Medication Reconciliation standard for both Community and Transitional Pharmacists to follow and maintain. Implementing medication reconciliation in concert with the PCP and Pharmacists to assure continuation of needed therapy following inpatient discharge to ensure a seamless transition back into the community.
- Educate, train or coordinate the education and training of staff on processes to be developed, such as Medication Reconciliation.
- Coordinate efforts with the Alabama Medicaid Academic Detailing Program regarding obtaining administrative detailing sessions for the PCCM-e's network PCPs.
- Participate in regular status calls with Agency Pharmacy Program staff.
- Complete, oversee, be responsible for, and submit all reports for the PCCM-e Pharmacy Program.

Population Health Data Analyst

Requirements

- Ensures analytics supports the quality improvement plan, projects, activities and clinical management initiatives identified as priorities by the Agency and the PCCM-e.
- Lead the design, implementation, dissemination, and interpretation of population health analysis and reporting.
- Utilizes claims and administrative data to identify and measure key metrics for improving the quality of care and health outcomes of Medicaid recipients.
- Develops strong, collaborative relationships and communications with internal and external partners in clinical, administrative, financial, and technical matters.
- Self-starter, independent worker, collaborative, and the ability to work under tight deadlines.

Education/Experience

- Minimum – B.S degree in a science, public health, or statistical-related field with seven (7) years of relevant experience in public health data analysis, epidemiology, or statistical analysis
- Preferred – Doctorate or Master's degree in a science, public health, or statistical-related field with a minimum of 3-5 years of relevant experience in public health data analysis, epidemiology, or statistical analysis
- Qualifications and Skills
    - Must have 5 years of experience writing SQL queries or similar languages with knowledge of database design, data entry, and data management.
    - Must have 5 years of experience managing large, complex, and longitudinal datasets; moving and merging data files from different platforms cleaning and aggregating data and performing quality control.
    - Must demonstrate the ability to use statistical software such as SAS, SPSS, or R for statistical analysis.
    - Ability to use Tableau, Microsoft EXCEL, and Power BI to manipulate, analyze, and visualize data for dashboards and presentations.
    - Knowledge and/or experience with external data sources such as Department of Public Health and Centers for Disease Control (CDC).

- Primary responsibilities include
    - Assists the Quality Care Director in effectively managing quality improvement projects, by providing consultative, technical, and subject matter expertise, and actively designing and executing analyses.
    - Conducts analyses, interpret results, and summarize and present findings to relevant stakeholders.
    - Communicates analytic advice and statistical methodology effectively with clients, management, and staff.
    - Analyzes and understands stakeholder's needs and translate them into formal requirements.
    - Maintains public health management expertise; stays abreast of industry changes and trends.

Quality Care Director
Requirements

- Works and lives in the region.

Education/Experience

- Certified Professional in Healthcare Quality (CPHQ) or equivalent experience related to healthcare quality.
- Bachelor's degree in public health, public administration or healthcare quality and safety, master's degree preferred. Relevant work experience can be substituted for master's degree.
- Clinical background preferred.
- Prior experience, at least one year, working with the Medicaid population.
- Familiarity with Healthcare Effectiveness Data and Information Set (HEDIS®), CAHPS, and other standardized quality measures/assessments
- Proficiency in quantitative data analysis
- At least 3 years' experience related to population health management, including interpretation and presentation of data; identifying opportunities for improvement; and developing strategic plans to address quality deficits.
- Population Health Management strategies – Oversees the PCCM-e quality Improvement Plan by:
    - Systematic data analysis to target Medicaid recipients and providers for outreach, education, and intervention to improve health outcomes.
    - Monitoring system access to care, services, and treatment including linkage to a Medical Home.
    - Monitoring quality and effectiveness of interventions to the population.
    - Facilitating quality improvement activities that educate, support, and monitor Providers regarding evidence-based care for best practice.
    - Implementing clinical management initiatives identified as priorities by the Agency and the PCCM-e.

Primary responsibilities include but are not limited to:

- Oversee the development of the Quality Improvement Plan.
- Work with practices and community providers in the implementation of the Quality Improvement Program.
- Ensure the PCCM-e completes the required QIP and meets required benchmarks.
- Review and report data to the Medical Director, and conveys information related to Quality Measures, QIPs, and any Agency directed quality initiatives adopted by the Agency to the PCCM-e.
- Support the care coordination activities of those in the Region that are at the highest risk and cost along with other areas of focus as chosen by the PCCM-e; and
- Ensure quality of services are provided in accordance with state and federal regulations.

Care Management Director
Requirements

- Is full time, and
- works and lives within the Region.

Education/Experience

- Master of Social Work (MSW) degree from an accredited school of Social Work, and minimum Licensed Graduate Social Worker (LGSW); or

- Minimum of Bachelor of Science in Nursing (BSN) degree with appropriate license; Master of Science in Nursing (MSN) degree with appropriate license (preferred), or
- Master of Counseling degree from an accredited school and a minimum licensed professional counselor (LPC) designation.
- Minimum of three (3) years' experience in care coordination/case management working with low-income and diverse populations; must include experience working with individuals in the specific Medicaid population(s) receiving care coordination/case management services.

Primary responsibilities include:

- Develops, implements, and provides oversight of the PCCM-e's Care Management Program including utilization review, intake or discharge planning, and managed care in accordance with the Medicaid program rules and state and federal regulations.
- Supervise, recruit and train qualified care management staff that include Care Coordinators, Case Managers, Community Health Workers, and Behavioral Health and Transitional Care staff.
- Evaluates patient data to ensure the provision of quality care coordination services in accordance with clinical guidelines while improving cost effectiveness.

Other Positions

Community Pharmacist

Requirements:

- Current Alabama Pharmacy license in good standing.
- Must hold a current Alabama Preceptor certification (at the time of or within six months of start of contract or employment).
- Works within the PCCM-e Region; live within the Region preferred.
- Possesses excellent organizational and administrative skills.

Education/Experience

- Holds at a minimum a B.S. in Pharmacy; Pharm.D. preferred.
- Must have three years of community pharmacy experience within the past four years; supervisory experience preferred.

Primary responsibilities:

- Coordinate and support outpatient pharmacy initiatives, such as dispensing of 90-day supply for maintenance medications, pharmacist vaccine administration, opioid use and disorder

Appendix L: Quality Improvement Project Requirements Policy

The purpose of a QIP is to allow the PCCM-e to develop region specific projects to focus on and increase the likelihood of improved health outcomes of the recipients within the Region.

Annually and for subsequent revisions within the year, the PCCM-e must submit for the Agency's approval, a description of its QIPs which it has chosen to implement to address each of the topic categories chosen by the Agency. If an additional QIP is required after the annual submission due to Agency or CMS demands, the PCCM-e will be notified as soon as possible and given appropriate time to develop the project.

At a minimum, the PCCM-e must develop a QIP to address the following topics: Prevention of childhood obesity; Infant mortality and/or adverse birth outcomes; and SUDs.

The PCCM-e must submit to the Agency for approval the full plan and proposed budget for each of the QIPs annually (and/when QIP is revised) within 30 calendar days before the implementation of the QIP.

Each QIP must contain the following sections:

1. Targeted Quality Measure(s). Each of the submitted QIPs must target improvement in one of the three areas the Agency has selected to focus on, including: prevention of childhood obesity, infant mortality and/or adverse birth outcomes, and SUD. It is expected that the PCCM-e will submit a minimum of three QIPs, a separate QIP for each targeted area of focus, for the Agency to review and approve. The measure must be appropriate to effectively evaluate the outcomes of the QIP, align with the PCCM-e and/or provider incentive metrics, and should be nationally recognized or validated whenever possible.
2. Project Goal(s). The project goal(s) must be clear, concise, and answerable. The project goal(s) identifies the focus of the QIP and sets the framework for data collection, analysis and interpretation. Potential sources of information to help form the project goal include:
    a. State data relevant to the measure and/or outcome;
    b. PCCM-e data relevant to the measure and/or outcome; and
    c. Relevant clinical literature;
3. Project variables(s). A study variable is a measurable characteristic, quality, trait or attribute of a particular individual, object or situation being studied.
4. The PCCM-e must include in each proposed QIP how at least 80% of PCCM-e expenditures for the QIP will be expended and included description of the data/information that will support evaluation of this requirement.
5. The PCCM-e can choose a QIP approved by the Agency from a list provided by the Agency designated entities. If the PCCM-e chooses to not pick a QIP from the provided list, the PCCM-e may submit an additional plan of their design but must get Agency and the Agency designated entity's approval of their proposed plan with accompanying budget.
6. Expected cost of project. The PCCM-e must submit detailed budget and expected cost to implement the project. Each Agency approved QIP from the option list will have an estimated cost associated with implementing that certain project. The amount given for each project will be the suggested amount provided by the Agency designated entities. For projects of the PCCM-e's own design, a detailed project budget will be required that includes staffing, material costs, travel, partnership expenses, etc. The use of other funds

including external funding sources must be identified and approved by the Agency.

After receiving the Agency's approval for the QIP and its associated budget, the PCCM-e may implement the QIP. The Agency may audit the expenditures on a quarterly basis, associated with the implementation of the QIP as described in the approved budget to validate all expenditures are appropriately being utilized. All Quality Improvement PMPM funds approved in the PCCM-e's QIP budget must be able to be identified and the use justified by the PCCM-e.

7. Representative and generalizable sample. Measurement and improvement efforts must be system wide. The QIP must clearly identify the "system" or study population, also referred to as the universe. Once the population is identified, the PCCM-e will determine whether to study data for the entire population or a sample of that population. A representative sample of the identified population is acceptable.
8. Sound sampling methods (if sampling is used). Proper sampling methods are necessary to provide valid and reliable (generalizable) study results. HEDIS® measures and HEDIS® sampling methodology is generally considered valid and reliable.
9. Reliable data collection. Data collection procedures must ensure that the data used to measure an indicator of performance are valid and reliable. A valid measure is one that measures what it intends to measure, while a reliable measure that provides consistent results is an indication that the data will produce consistent, repeatable or reproducible measurements. Potential sources of data include:
    a. Administrative data (e.g., membership, enrollment, claims, Encounters);
    b. Medical records;
    c. Tracking logs;
    d. Results of any provider interviews; and
    e. Results of any recipient interviews and surveys.
10. Measurement of performance using objective quality indicators. Real, sustained improvements result from a continuous cycle of measuring and analyzing performance and developing and implementing system-wide improvements. Actual improvements depend on thorough analysis and implementation of appropriate solutions.
11. Implementation of system interventions to achieve improvement in quality Data analysis begins with examining the performance on the selected clinical or non-clinical indicators, including the collection and calculation of baseline rates and ongoing remeasurement. The examination should be initiated using statistical analysis techniques defined in a data analysis plan.
12. Evaluation of the effectiveness of the interventions. It is important to determine if a reported change represents "real" change or is an artifact of a short-term event unrelated to the intervention or random chance. The PCCM-e must demonstrate whether the cause for improvement was due to the interventions and improvement strategies implemented.
13. Planning and initiation of activities for increasing or sustaining improvement. Real change is the result of changes in the fundamental processes of healthcare delivery and is most valuable when it offers demonstrable sustained improvements. In contrast, a spurious "one-time" improvement can result from unplanned accidental occurrences or random chance. The PCCM-e must demonstrate whether the interventions and improvement strategies implemented are likely to achieve sustained improvement.

Performance Withholds

Performance Withholds. The monthly PMPM payment will be subject to a withhold amount. The withhold shall be 10 percent (10%) of the QIP portion of the payment. The withhold will be retained by the Agency until the period for determination of return of the withhold to the PCCM-e. The withholds are described in the table below.

Performance Standard 1	**Amount of Performance Withhold at Risk**
Percent of QIP Funds expended directly to beneficiaries	60%
Standard Required to Receive Incentive Payment	
80% of the QIP funds must be used in direct correlation to the recipients. An example includes recipient incentives or payments made to third party vendors that are actively involved it the QIP. If the 80% spend is demonstrated, it is the Agency's intention to release the funds. The PCCM-e shall supply information and data demonstrating to the Agency that QIP funds were expended for the direct benefit of Medicaid recipients as outlined in the proposed QIP. For example, reporting the cost associated with recipient incentives or payments made to third party vendors that are actively involved it the QIP.	

Performance Standard 2	**Amount of Performance Withhold at Risk**
Completion of PCCM-e proposed QIPs	20%
Standard Required to Receive Incentive Payment	
The Agency will consider a QIP to be completed when the objectives and steps the PCCM-e submits as part of their QIP Proposal are met. The PCCM-e must complete all proposed QIPs to be eligible for earning the withhold. For circumstances that prevent completion of all proposed QIPs that are outside of the PCCM-e control, the Agency will have sole discretion whether to determine if the QIP is complete	

Performance Standard 3	**Amount of Performance Withhold at Risk**
Completion of Proposed QIP Outcomes	20%
Standard Required to Receive Incentive Payment	
The PCCM-e shall meet all outcomes proposed in its QIP proposal. The Agency at its discretion will determine if outcomes are appropriately met based on the outcome measures as submitted by the PCCM-e and approved by the Agency.	

Quality Collaborative
The PCCM-e must participate in the Agency-led PCCM-e Quality Collaborative ("Collaborative") that is minimally composed of the Agency, the PCCM-e from each region, and other state agency representative(s) when appropriate.

The Collaborative will meet quarterly, at a minimum, to develop and refine:

- Program measures;
- Utilization and management reports;
- Innovative healthcare and utilization management strategies;
- Quality improvement goals and measures;
- QIP Progress and Evaluation; and
- Opportunity for shared program operations and support.

Appendix M: Quality Incentive Payment Methodology

Overview

Ensuring quality outcomes for Medicaid recipients is one of the primary goals of the ACHN program. Quality efforts should reflect a partnership between the PCCM-e, the providers, and the Agency. To promote quality improvement within the ACHN program, the Agency has implemented a Quality Incentive Payment Program. The PCCM-e will have the opportunity to earn incentives based upon the achievement towards Agency determined benchmarks for each of the identified quality measures. If the PCCM-e achieves the annual benchmarks, it may be eligible to earn an incentive payment up to 15% of the total revenues received in the quality metrics evaluation year. Table 1 provides details related to the incentive payments.

Key Features

- The Agency will select incentive measures to assess the PCCM-e's quality performance. Each of the measures will be appropriately weighted (with consideration of population affected, relative significance of the measure, and opportunity for improvement, among other considerations) when assessing the PCCM-e's performance. If any measure has any sub-components, the total of the sub- components will equal any one incentive measure. The measures are listed in the PCCM-e Quality Measures document.
- The Agency reserves the right to determine the PCCM-e to be ineligible to participate in the Quality Incentive Payment Program if there is a failure to submit the required performance reports to facilitate a related measure calculation, or the PCCM-e is in a sanctioned status that the Agency determines would disqualify the PCCM-e from obtaining the Payment.
- Starting in Fiscal Year 2026, the Agency will distribute earned incentive funds based on the PCCM-e's performance for the quality incentive measures of the previous calendar year. For the first year of implementation, if the PCCM-e is operational for a minimum of 10 months or more, the PCCM-e's performance will be evaluated on the full calendar year's outcomes.

Methodology

Setting Final Rate and Annual Improvement Targets. In an effort to provide the PCCM-e opportunities to improve the quality of healthcare within the state, the Agency has identified quality incentive metrics and the expected annual targets to be met. The Agency will calculate regional baseline rates using Calendar Year 2018 - 2022 data in most cases and communicate the rationale for the exceptions. (For example, the covid pandemic significantly influenced some rate trends, and the Agency took this into account). The Agency will determine a final rate and annual improvement targets for each measure as follows:

- Final Rate Target: The Agency will establish regional and state baselines through comparison to national benchmarks where they exist, using multiple sources like NCQA Quality Compass, Mathematica analyses reports of CMS Core Set Measure Reporting, etc. The Agency will also consider existing trends when selecting an appropriate final rate target that reflects an achievable and meaningful level of quality improvement for the measure.
- Annual Improvement Target: Annual improvement targets for each PCCM-e and each measure will typically be based on a linear improvement in each measure from the regional baseline to the final rate target. Each PCCM-e is projected to meet or exceed the final rate target by the end of FY29.

Calculating the Quality Incentive Score. Each of the incentive measures will be assigned a point value by the Agency for a maximum quality incentive score of one hundred (100) points. As described above, for each measure, the Agency will set a Final Rate Target and an Annual Improvement Target. If the PCCM-e meets the final rate target, the PCCM-e will earn the assigned points for the measure. If the PCCM-e fails to meet the final rate target, yet achieves the annual improvement target, the PCCM-e will still earn the assigned points for the measure. If the PCCM-e fails to meet either target, it will receive zero points for the measure.

Composite Measures. Composite measures are measures that consist of two (2) or more components (i.e., sub-measures). For example, the Contraceptive Care measure (CCW-AD/CH) is one incentive measure that consists of two components: 1) Provision of most or moderately effective birth control, 2) Provision of long-acting reversable contraceptives. The Agency will divide composite measures into equally weighted components. If a PCCM-e meets one of the two components of a composite quality measure, the PCCM-e will have earned one-half of the assigned points for that measure.

The Agency will sum the points from all incentive measures to calculate a total Quality Incentive Payment score for the PCCM-e. The Agency will distribute the earned withhold funds as outlined in Table 1 below:

Table 1: Quality Incentive Payment Methodology

Quality Incentive Payment Methodology	
Total Quality Incentive Program Score	Percentage of Incentive Earned
Less than 20 points	0 %
Between 20 points and 30 points	25%
Between 31 points and 50 points	50%
Between 51 points and less than 80 points	75%
80 or more points	100%

Ongoing Monitoring and Performance Improvement Activities. At the end of each Fiscal Year, the PCCM-e must meet with the Agency to review the quality measures and share best practices. Additionally, the Agency will meet at least quarterly with each PCCM-e to review preliminary data, review measure specifications, plan for data gathering, and share early successes and challenges.

Appendix N: Quality Measures

(Effective 10/1/24)

Subject to Change

#	Measure Abbreviation	Network Measure Name	Points
1	BCS-AD	Breast Cancer Screening	10
2a	CCW-AD1	Contraceptive Care (Most effective or moderately effective method of contraception)	5
2b	CCW-AD2	Contraceptive Care (Long-acting reversible method of contraception LARC)	5
3a	CCW-CH1	Contraceptive Care (Most effective or moderately effective method of contraception)	5
3b	CCW-CH2	Contraceptive Care (Long-acting reversible method of contraception LARC)	5
4	DEV-CH	Developmental Screening in the First Three Years of Life	10
5	FUH-AD	Follow-Up after Hospitalization for Mental Illness	5
6	FUM-AD	Follow-Up After Emergency Department Visit for Mental Illness	5
7a	IET-AD	Initiation & Engagement of Alcohol and other Drug Abuse or Dependence Treatment (Initiation)	5
7b	IET-AD	Initiation & Engagement of Alcohol and other Drug Abuse or Dependence Treatment (Engagement)	5
8	LBW-CH	Live Births Weighing Less than 2,500 Grams	5
9	OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder	10
10	PPC-CH	Prenatal and Postpartum Care: Timeliness of Prenatal Care	5
11a	W30-CH1	Well-Child Visits in the First 30 months of Life (1st 15 months)	5
11b	W30-CH2	Well-Child Visits in the First 30 months of Life (15 months - 30 months)	5
12	WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI)	10

Appendix O: Contingency and Continuity Requirements

Contingency and Continuity Planning

Continuity Planning

Continuity planning and execution shall encompass all activities, processes and resources necessary for the Contractor to continue to provide mission-critical business functions and processes during a disaster. Continuity planning shall be coordinated with information system contingency planning to ensure alignment. Continuity planning shall address processes for restoring critical business functions at an existing or alternate location. Continuity activities shall include coordination with the Agency and its designees to ensure continuous eligibility, enrollment and delivery of services.

General Responsibilities

In any readiness assessments or ongoing monitoring required by this contract, the Vendor/Contractor shall develop and submit contingency and continuity planning documents acceptable to the Agency. In addition, the Vendor/Contractor shall ensure on–going maintenance and execution of the Agency accepted contingency and continuity plans. The Vendor's/Contractor's contingency and continuity planning responsibilities include, but are not limited to:

- Notifying the Agency of any disruptions in normal business operations that affects the access and use of the Vendor's/Contractor's HIMS by a recipient, provider, or the Agency for any duration longer than one hour with a plan for resuming normal operations.

- Ensuring users continue to receive services with minimal interruption.

- Ensuring data is safeguarded and accessible in the same manner that complies with federal security guidelines as (described by, laid out in, required by) FISMA, OMB A- 130, FIPS 200, and NIST 800-53 and requirements from Agency IT.

- Training Contractor staff and appropriate subcontractors on the requirements of the information system contingency and continuity plans.

- Developing plans for system problem resolution that do not rise to the level of Disaster. The plans shall include notification of the Agency immediately upon identification of network hardware or software failures and sub–standard performance that affects the access and use of the system for any duration longer than six hours and triage with the Agency to determine the severity level or deficiencies or defects and determine timelines for fixes.

Information Systems Contingency Planning and Execution

The Vendor shall develop information systems contingency planning in accordance with 45 C.F.R. § 164.308(a)(7). Contingency plans shall include: (i) data backup plans, (ii) Disaster recovery plans, and (iii) emergency mode of operation plans. Application and data criticality analysis and testing and revisions procedures shall also be addressed within the required contingency plans. The Contactor shall execute all activities needed to recover and restore operation of information systems, data and software at an existing or alternate location under emergency conditions within six (6) hours of the identification or a declaration of a Disaster. The Contractor shall maintain

appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back–ups, and disaster recovery.

Back–Up Requirements

The Contractor shall maintain full and complete back-up copies of data and software in accordance with the following timelines: weekly back-ups, daily back-ups sufficient to cover eight days, incremental daily back-ups sufficient to cover eight days with the oldest incremental back-up archiving off on the ninth day in the cycle. Back-ups must be adequate and secure for all computer software and operating programs, databases, files, systems, operations and user document (in electronic and non-electronic form). All back-ups must be sufficient to support the immediate restoration and recovery of lost or corrupted data or software. The Contractor shall maintain a back–up log to verify the backups were successfully run, and a back–up status report shall be provided to the Agency upon request. The Contractor shall store its back-up data in an off-site location in compliance with Federal Information Security requirements/guidelines and approved by the Agency.

Upon the expiration of the Contract term or the termination date, all the Agency related data shall be returned to the Agency. After the Agency's verification of the returned data, the Contractor shall remove/delete and sanitize all Medicaid data from all Vendor storage devices and media in accordance with the NIST Special Publication 800-88 Guidelines for Media Sanitization Revision 1 or the most current revision and submit an attestation of those actions to the Agency. The Contractor's obligation to remove/delete and sanitize Medicaid data from all Contractor storage devices and media shall survive the expiration or termination of this Contract. The Contractor may retain data obtained from the Agency only if the Agency determines, in its sole discretion, that the data to be retained by the Contractor is necessary for the Contractor's management and administration or to perform its legal responsibilities. The duration and terms of such retention will be determined by the Agency at the time the Agency approves the Contractor's request to retain data.

Noncompliance with Disaster Recovery Requirements

The Contractor is responsible for executing all activities needed to recover and restore operation of information systems, data and software at an existing or alternate location under emergency conditions within six hours of identification or a declaration of a disaster for the recovery time objective (RTO) and six hours for recovery point objective (RPO). Noncompliance with requirements for contingency and continuity planning may result in sanctions. In addition, if the Contractor's failure to restore operations requires the Agency to transfer users to another vendor, to assign operational responsibilities to another vendor or the Agency is required to assume the operational responsibilities, the Agency will require the Contractor to pay any difference between the payments that would have been paid to the Contractor and the payments and/or other payments being paid to the replacement vendor. In addition, the Contractor shall pay any costs the Agency incurs associated with the Contractor's failure to restore operations following a disaster, including but not limited to costs to accomplish the transfer of users or reassignment of operational duties.

Appendix P: Top 15 Prevalent Non-English Languages Spoken in Alabama

Top 15 Prevalent Non-English Languages Spoken in Alabama

Prevalent Non-English Languages is defined as, at a minimum, the top 15 languages spoken in the state by individuals with LEP. The following languages are defined as Prevalent Non-English Languages:

1. Spanish or Spanish Creole
2. Korean
3. Chinese
4. Vietnamese
5. Arabic
6. German
7. French
8. Gujarati
9. Tagalog
10. Hindi
11. Laotian
12. Russian
13. Portuguese
14. Turkish
15. Japanese