ALABAMA MEDICAID AGENCY

REQUEST FOR PROPOSALS

RFP Number: 2015-HH_RegionC-01	**RFP Title: Health Homes**
RFP Due Date and Time: See schedule of events	**Number of Pages: 69 (Including Guidelines)**

PROCUREMENT INFORMATION

Project Director: Carolyn Miller	**Issue Date: 12/29/2014**
Phone: (334) 353-5539 **E-mail Address:** **Carolyn.Miller@medicaid.alabama.gov** **Website: http://www.medicaid.alabama.gov**	**Issuing Division: Managed Care**

INSTRUCTIONS TO ENTITY

Return Proposal to: **Carolyn Miller** **Alabama Medicaid Agency** **Lurleen B. Wallace Building** **501 Dexter Avenue** **PO Box 5624** **Montgomery, AL 36103-5624**	**Mark Face of Envelope/Package:** **RFP Number:** 2015-HH_RegionC-01 **Firm and Fixed Price** Established monthly care management fee for the recipients participating in the Entity's network. The established Per Member Per Month fee is $9.50 for Health Home Patient 1st Clients.

ENTITY INFORMATION

(Entity must complete the following and return with RFP response)

Entity Name/Address:	Authorized Entity Signatory: (Please print name and sign in ink)
Entity Phone Number:	Entity FAX Number:
Entity Federal I.D. Number:	Entity 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 Entity'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. Entity 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 Entity'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 Entity'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 Entity 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	December 29, 2014
Answers to Questions Posted As Available	01/13/2015-01/20/2015
Mandatory Vendor Conference	Week of January 12, 2015
Last day to Submit Questions (by 5 pm CST)	January 20, 2015
Final Posting of Questions and Answers	January 23, 2015
Proposals Due by 5 pm CST	Proposals due by January 29, 2015
Evaluation Period	1/30/2015 – 02/06/2015
Contract Award Notification	February 11, 2015
** Contract Review Committee	March 5, 2015
Readiness Assessment Period	March 15 – 31, 2015
Official Contract Award/Begin Work	April 1, 2015

* *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 “Entity 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

Section A. RFP Checklist 2

Section B. Schedule of Events 3

I. Introduction 6

II. Scope of Work 7

III. Pricing 27

IV. General Medicaid Information 27

V. General 28

VI. Corporate Background and References 29

VII. Submission Requirements 29

A. Authority 29
B. Single Point of Contact 30
C. RFP Documentation 30
D. Questions Regarding the RFP 30
E. Acceptance of Standard Terms and Conditions 30
F. Adherence to Specifications and Requirements 30
G. Order of Precedence 30
H. Entity's Signature 31
I. Offer in Effect for 90 Days 31
J. State Not Responsible for Preparation Costs 31
K. State's Rights Reserved 31
L. Price 31
M. Submission of Proposals 31
N. Copies Required 31
O. Late Proposals 31

VIII. Evaluation and Selection Process 32

A. Initial Classification of Proposals as Responsive or Non-responsive 32
B. Determination of Responsibility 33
C. Opportunity for Additional Information 32
D. Evaluation Committee 32
E. Scoring 32

IX. Readiness Assessment 33

X. General Terms and Conditions 33

A. General 33
B. Compliance with State and Federal Regulations 33
C. Term of Contract 33
D. Contract Amendments 34
E. Confidentiality 34
F. Security and Release of Information 34
G. Federal Nondisclosure Requirements 34
H. Contract a Public Record 35
I. Termination for Bankruptcy 35
J. Termination for Default 35
K. Termination for Unavailability of Funds 35
L. Termination for Convenience 35
M. Force Majeure 36
N. Nondiscriminatory Compliance 36
O. Small and Minority Business Enterprise Utilization 36
P. Worker's Compensation 36
Q. Employment of State Staff 36
R. Immigration Compliance 36
S. Share of Contract 37
T. Waivers 37
U. Warranties Against Broker's Fees 37
W. Employment Basis 37
X. Disputes and Litigation 37
Y. Records Retention and Storage 37
Z. Inspection of Records 38
AA. Use of Federal Cost Principles 38
BB. Payment 38
CC. Notice to Parties 38
DD. Disclosure Statement 38
EE. Debarment 39
FF. Not to Constitute a Debt of the State 39
GG. Qualification to do Business in Alabama 39
HH. Choice of Law 39
II. Alabama interchange Interface Standards 39

Exhibit A. Definitions 40
Exhibit B. Training Requirements for Care Coordination 42
Exhibit C. Health Home Key Staff Positions 43
Exhibit D. Quarterly Reporting Requirements 47
Exhibit E. Annual Reporting Requirements 47
Exhibit F. Quarterly Income Statement 48
Exhibit G. Annual Budget Report 49
Exhibit H. Contact Requirement Schedule 51
Exhibit I. Care Plan Requirements List 53
Exhibit J. Proposal Compliance Checklist 55
Exhibit K. Contracts and Attachments 56

I. Introduction

A. Alabama operates a statewide Primary Care Case Management (PCCM) managed care program for the state's Medicaid citizens. The Patient 1st Program has been operational since January 1, 1997. The overarching goal of Patient 1st is to provide Alabama Medicaid recipients a medical home. Within the Patient 1st Program, patients are assigned to a primary medical provider (PMP). The PMP is responsible for providing directly or through referral, necessary medical care. PMPs are paid a varying case management fee depending on how they choose to meet contract requirements. Alabama's physician report card, the Profiler, helps the PMP understand the medical and cost utilization of his/her panel as compared to his/her peers. The Profiler illustrates the performance measures that will enable the PMP to share in program savings.

B. Beginning in August 2011, Alabama implemented an enhanced PCCM program, building upon the existing infrastructure by establishing regional networks within local systems of care designed to achieve long-term quality, cost, access, and utilization objectives in the management of care for Medicaid recipients. As part of the Affordable Care Act Section 2703 – Health Homes for Individuals with Chronic Conditions, the Alabama Medicaid Agency (Agency) Patient Care Networks of Alabama (PCNA) programs were established, focusing on the Health Home eligible recipients in Patient 1st. This population includes Patient 1st recipients with asthma, diabetes, cancer, COPD, HIV, mental health conditions, substance use disorders, transplants, sickle cell and heart disease. An additional diagnosis of Hepatitis C is being added with this RFP.

C. The Agency is expanding the Health Home program statewide in 2015 to increase access for case management for health home recipients to all areas of Alabama. Currently, there are PCNAs in four geographical locations. Five regions will be established as follows:

1. Region A, which includes the following counties: Colbert, Cullman, Franklin, Jackson, Lauderdale, Lawrence, Limestone, Madison, Marshall, and Morgan.

2. Region B, which includes the following counties: Blount, Calhoun, Cherokee, Chilton, Cherokee, Coosa, Cleburne, DeKalb, Etowah, Jefferson, Randolph, Shelby, St. Clair, Talladega, Tallapoosa, and Walker.

3. Region C, which includes the following counties: Bibb, Choctaw, Fayette, Greene, Hale, Lamar, Marengo, Marion, Perry, Pickens, Sumter, Tuscaloosa, and Winston.

4. Region D, which includes the following counties: Autauga, Barbour, Bullock, Butler, Chambers, Coffee, Covington, Crenshaw, Dale, Dallas, Elmore, Geneva, Henry, Houston, Lee, Lowndes, Macon, Montgomery, Pike, Russell, and Wilcox.

5. Region E, which includes the following counties: Baldwin, Conecuh, Clarke, Escambia, Mobile, Monroe, and Washington.

Pursuant to Section 22-6-162 of the Alabama Code, the Agency may contract for these case management services with an organization that has been granted by the Agency a probationary regional care organization certification. If the Agency has contracted with such an organization, and that organization on or before October 1, 2016, has failed to gain full

regional care organization certification or has had its probationary certification terminated, then that organization shall refund half the payments made by the Agency to the organization for case management services, paid over the previous 12 months. By including §22-6-162 in Act 2013-261, the Legislature recognized the special benefit derived by the Agency from entering into contracts with probationary regional care organizations for case management services. However, certification as a probationary regional care organization alone does not guarantee that an Entity will be awarded a contract for case management services under this RFP. The Entity(s) whose proposal(s) is determined to be in the best interest of the State will be recommended as the successful Entity(s) as specified in this RFP.

II. Scope of Work

A. The Entity's proposal must present a plan demonstrating its ability to meet the following requirements:

1. Achieve the Primary Purposes of Health Homes:

a. Coordinate PMPs in the Region and ensure that best practices are being followed in relation to the management of chronic conditions. This coordination effort must support an effective and efficient health system that minimizes duplication and cost, and improve health outcomes for the Health Home population.

b. Provide care management for Health Home recipients who are unstable to improve the management of chronic disease or other populations as identified by AMA

c. Facilitate care between PMPs and the 310 Board Certified Community Mental Health Centers (CMHCs), substance abuse (SA), or other behavioral health providers for Health Home recipients.

2. Work with PMPs to review claims data on all Health Home recipients each month.

3. Identify designated individuals who must serve the following functions within the Health Home:

a. Executive Director to serve as primary administrative liaison between the Entity and the Agency.

b. Medical Director who is a PMP responsible for maintaining contact with local providers and representing the Entity at the select program-wide meetings.

c. Quality Care Manager to work with health care practices and community providers in the implementation of quality initiatives targeting the Health Home population.

d. Care Coordination Supervisor to oversee the Care Coordination program, including all Care Coordinators, program policies, documentation and records

e. Network Pharmacist to coordinate and manage education of community pharmacists, PMPs, Health Home staff, and Health Home recipients regarding medication management.

f. Care Coordinators to support care coordination of recipients that are at highest risk and cost in management of their chronic conditions.

g. Community Health Workers to ensure that recipients have access to all Health Home services and act as a liaison with various government agencies and programs, PMPs, public

entities, county entities, and community resources.

h. Transitional Care Nurses to assist recipients with transitioning to a community setting or change in level of care.

i. Behavioral Health Nurses to support the integration of behavioral health services, including both mental health and substance abuse, and medical services for the Entity's recipients.

j. Pharmacists to implement a pharmacy program that will coordinate pharmacy activities for Health Home recipients.

4. Satisfy all requirements in the Health Home Guidelines as detailed in Section B below.

5. Include a statement agreeing to perform the duties specified in this proposal request based on an established monthly care management fee for the recipients participating in the Entity's network. The number of recipients is determined monthly based upon Health Home Recipients on the Patient 1st PMP panel for each PMP agreeing to participate in the Health Home. The established PMPM reimbursement is $9.50 for each Health Home Recipient.

B. **Health Home Guidelines**

1. Organization

   a. Entity must be incorporated as a nonprofit corporation under Alabama law and possess a probationary regional care organization certificate granted Medicaid.

   b. Key staff positions include the Health Home Executive Director, Medical Director, Quality Care Manager, Clinical Pharmacist, and Care Management Supervisor. Within fifteen (15) days, any changes to the Entity's key staff positions and/or waiver of specific staff credentials must be submitted in writing for approval by AMA prior to hiring or designation of the individual to the position.

   c. The Entity must also have in place the organization, management and administrative systems necessary to fulfill all requirements of this RFP and to comply with any other applicable State and Federal laws and regulations. The Entity must demonstrate to the Agency's satisfaction, via submission of a staffing plan and resumes, that it has the necessary staffing, by function and qualifications, to fulfill its obligations under this RFP.

   d. The Entity must maintain all necessary business licenses, registrations and professional certifications to be able to do business in Alabama.

2. Financial

   a. The Entity must prepare and submit an annual budget to the Alabama Medicaid Managed Care Division for approval at least thirty (30) days prior to the start of each state fiscal year that specifies how the enhanced care management fees paid under this program will be spent to develop and maintain Health Home activities.

   b. The fiscal year for the Health Homes must be the same as of the State of Alabama, October 1 through September 30.

   c. The Entity must provide, at a minimum, the expenses and revenues specified in the budget forms. Refer to Exhibits F and G.

   d. The Entity must obtain written approval from the Alabama Medicaid's Managed Care Division prior to revising any budget line-item more than ten (10) percent.

   e. The Entity must maintain accurate records of expenditures in accordance with federal financial reporting and governmental accounting standards as defined by Generally Accepted Accounting Principles (GAAP).

f. The Entity must annually have an audit performed by an independent certified public accountant that encompasses both financial and compliance components. The audit will either be a Single Audit or a Program-Specific Audit.

g. The Entity must carry over no more than two months operating expenses at the close of the state fiscal year and must obtain the prior written approval of the Agency to use said funds for any purpose other than those Health Home Program's Pre-Approved Reserve Fund uses listed below:

    i. Heighten efforts to manage the Health Home population through increased care management, education, and clinical monitoring.

    ii. Pharmacist for additional support in medication reconciliation.

    iii. Improved regional availability of regional services such as dietician services, health screenings, and origination fees for telemedicine. Other initiatives will be considered by the agency on request.

    iv. Supporting the development of medical homes and interdisciplinary work among Participating PMPs.

    v. Integration initiatives: particularly those focusing on the behavioral health and primary care.

    vi. Activities outside of this list require the authorization of Medicaid.

h. The Entity must submit by September 1 of each fiscal year a proposed budget for residual/excess funds for Agency approval. Any approved residual/excess funds must be expended within 60 days of the end of the fiscal year.

i. If, on or before October 1, 2016, the Entity has failed to gain full regional care organization certification or has had its probationary certification terminated, the Entity shall, pursuant to Code of Alabama (1975) § 22-6-162, refund an amount equal to half the payments made by the Agency to the Entity for Health Homes services during the twelve (12) months preceding October 1, 2016 or, if sooner, during the 12 months preceding the date of termination of probationary certification. The Entity shall pay such amount in full to the Agency not later than October 31, 2016 or, if sooner, 30 days after the date of termination of probationary certification.

j. In order to assure full performance of all obligations imposed on an Entity contracting with the State of Alabama, the Entity must provide a performance guarantee in an amount equal to fifty percent (50%) of the aggregate amount of the payments projected to be made by the Agency to the Entity for Health Home services during the first twelve (12) months of the contract, as estimated by the Agency in its discretion. The performance guarantee must be submitted by Entity 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.

    i. The form of performance guarantee must be one of the following:

1. Cashier's check (personal or company checks are not acceptable)
2. Other type of bank certified check
3. Money order
4. An irrevocable letter of credit
5. Surety bond issued by a company authorized to do business within the State of Alabama

ii. Failure to perform satisfactorily shall cause the performance guarantee to become due and payable to the State of Alabama. For the avoidance of doubt and without limitation, the Entity's failure to timely pay a refund due the Agency pursuant to Code of Alabama (1975) § 22-6-162 and paragraph i. of this Section 2 shall cause the performance guarantee to become due and payable to the State of Alabama. The Agency's Chief Financial Officer shall be custodian of the performance guarantee. The performance guarantee must be extended in the event the Agency exercises its option to extend this contract.

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

l. The Entity must 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.

m. The Entity must 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.

n. The Entity must 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 the Entity 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 must be retained until resolution.

o. The Entity agrees that representatives of the Comptroller General, Health and Human Services (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 the Entity's books and records pertaining to contract performance and costs thereof. The Entity must cooperate fully with requests from any of the agencies listed above and must furnish free of charge copies of all requested records. The Entity may require that a receipt be given for any original record removed from the Entity's premises.

p. Establish contracts with PMPs that assure a commitment to care manage clinical care pursuant to the Health Home Program. Copies of signed provider contracts must be sent to the Alabama Medicaid Managed Care Division by the 15th of the month to enroll the provider in the Health Home effective for the following month and qualify the PMP for monthly enhanced care management fee.

q. Medicaid will pay a care management fee to the Entity in the first check-write of each month for each recipient in the Entity's network during the current month based on PMP assignments made by the 20th day of the previous month.

r. Subcontracts for services with a value over $10,000 per year must be prior approved in writing by the Agency.

3. Administrative

a. Employ a **Health Home** Executive Director to serve as primary administrative liaison between the Entity and Alabama Medicaid Managed Care Division. For additional information on the requirements for this position, refer to Exhibit C – Key Health Home Staff Positions.

b. The Entity must develop and implement a process to document and address grievances and complaints.

c. Reporting requirements:

i. Quarterly reports must be submitted to Alabama Medicaid Managed Care Division by the 15th of the month following the end of the quarter on the standardized Medicaid form See Exhibit D for quarterly Reporting Requirements.

ii. Annual reports must be submitted based on the state fiscal year by the end of the quarter following the end of the fiscal year. The reports should be in the format prescribed by the Alabama Medicaid Managed Care Division. See Exhibit E for requirements.

d. Health Information Technology -

i. The Entity must use information technology systems and processes to integrate and share the following data elements, at a minimum, to create a single, centralized, comprehensive record for each Health Home Recipient:

1. Demographic data

2. Enrollment data

3. Care Coordination data, including assessment results, the care plan, case notes, Care Coordinator assignment

4. Claims and pharmacy data

5. Authorization and referrals

ii. This system must be linked to other databases, systems, and the centralized patient record that the Entity uses to maintain information about the Health Home recipient. The system must integrate the recipient information in a meaningful way to facilitate care coordination needs. The system must have the capability to share care coordination information with the Health Home Recipient and any member of the care team, as appropriate.

iii. The Entity must ensure that the centralized patient record is current and accessible twenty-four (24) hours a day, seven (7) days a week in its entirety to the care team or other authorized personnel in order to facilitate care coordination needs, respond to urgent/emergent needs, and to ensure effective, safe service delivery

e. Education and Outreach Materials

i. The Entity must develop and implement effective recipient education and outreach programs which support health outcome initiatives.

ii. The Entity must provide Medicaid with all planned health education activities and targeted implementation dates on the annual report. Refer to Exhibit E – Annual Reporting Requirements. The Entity must receive express written approval from Medicaid prior to distribution of any and all educational materials regardless of source.

iii. The Entity must submit to Medicaid for approval all material intended to be provided to recipients at least forty-five (45) calendar days prior to intended use.

iv. The Agency shall have thirty (30) calendar days to review and approve, reject or request revision from the Entity.

f. Health Home Services Telephone Line

i. The Entity must operate a toll-free telephone line for Health Home inquiries from 8 a.m. to 5 p.m. local time for the region, Monday through Friday, except for

Agency-approved holidays. The Health Home Services telephone line must be staffed with personnel who are knowledgeable about the Entity's program and covered services.

ii. The Entity must operate a toll-free Recipient services telephone line which must be fully staffed on business days between 8:00 a.m. and 7:00 p.m. local time. The Entity must ensure that the telephone line staff is trained to respond to recipient questions for all areas of the Health Home Program, including but not limited to covered services and provider network.

g. Staff Training – Administrative Requirements

i. The Entity must conduct professional training sessions as specified in Exhibit B of this RFP. The Entity must provide to Medicaid for prior review and/or approval an Annual Training Plan as well as a training evaluation summary.

h. Community Resource Guide

i. The Entity 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). The community resource guide must be kept up-to-date and made available to the Entity's care coordination staff that has contact with recipients. Upon request, the community resource guide must be made available to recipients.

4. Health Home Services

a. Criteria for Health Home Services

i. Recipients must have two chronic conditions, one chronic condition and the risk of developing another, a serious mental health condition with at least one of the following diagnoses:

1. Mental Health Condition

2. Substance Use Disorder

3. Asthma

4. Diabetes

5. Heart Disease

6. BMI over 25

7. Transplants with a look back of Medicaid claims for five (5) years

8. Cardiovascular Disease

9. Chronic Obstructive Pulmonary Disease

10. Cancer

11. HIV with a look back of Medicaid claims data 18 months but the basis for identification medications

12. Sickle Cell Anemia

13. Hepatitis C Virus

b. Transitional Care Program

i. The Entity must develop a Transitional Care Program to support recipients in the Target Population when discharged from an inpatient or residential setting to include, but not be limited to:

1. Collaborating with hospital discharge planners and behavioral health staff in preparation for the recipients return to the community;

2. Ensuring appropriate home based support and services are available;

3. Implementing medication reconciliation in concert with the PMP and Network Pharmacist to assure continuation of needed therapy following inpatient discharge;

4. Developing a care clan when there is a need for complex for high or medium risk care management;

5. Ensuring appropriate follow-up appointments are made with the PMP and / or specialists;

6. Promoting the ability and confidence in self-management of chronic illnesses in the Target population; and

7. Providing care coordination until all goals are met or recipients elect not to receive services.

ii. Transition of Care Policies and Procedures. The Entity must, initially, and as revised, submit to the Agency for review and prior approval, transition of care policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to a recipient's care.

iii. Transition of Care Team. The Entity must have an interdisciplinary Transition of Care Team to design and implement the transition of care plan and provide oversight and management of all transition of care processes. The Transition of Care Team may be part of the Multidisciplinary Care Team (MCT) as described in the Care Coordination Section (II.B.4.c.vii). The Transition of Care Team must consist of Transitional Care Nurses in addition to any staff necessary to support recipients in their transition to a new care setting. Specific requirements for Transitional Care Nurses are detailed in Exhibit 2 Health Home Key Staff Positions.

iv. Transition of Care Process. The Transitional Care Nurses/ Team must establish processes to assist patients in their transition from a facility to the community setting to include, but not be limited to the following:

1. Review recipient census at inpatient or residential settings to identify Health Home recipients needing support at discharge – minimum once per week;

2. Consult with discharge planners regarding the needs of Health Home Recipients – minimum once per week;

3. Educate recipients regarding the services provided by the Health Homes;

4. Complete assessments of patients requiring heavy or medium Care Coordination within 10 business days of patient interviews. All assessments must be face to face with the recipient;

5. Following discharge from inpatient and residential settings, Transitional Care Nurses/ Team must complete medication reconciliation, education with Health Home recipients regarding medical management, and provide referrals to needed resources within ten (10) calendar days of discharge;

6. Assist with environmental adaptations, equipment, and technology the Health Home Recipient needs for a successful care setting transition;

7. Consult with Health Home staff and other members of the multidisciplinary team to address patient needs and develop a care plan as needed;

8. Transfer / Refer to Care Coordinator for care coordination as needed; and

9. Ensuring proper transition and coordination with Alabama Department of Mental Health, the Agency and with 310 Board Certified CMHCs when recipients are moving to or from a mental health commitment.

c. **Care Coordination Program**

i. Purpose: The Entity must establish processes to support care coordination of Health Home recipients that are at highest risk and cost, to include, but not be limited to the following:

1. Develop and implement patient centered holistic plans of care;

2. Improve health literacy, health outcomes and self-management;

3. Improve utilization of information technology resources by recipients and PMPs in the Health Home as available;

4. Promote effective use of the healthcare system and community resources;

5. Reduce the potential for risks of catastrophic or severe illness;

6. Prevent disease exacerbations and complications;

7. Reduce inappropriate utilization and costs associated with Emergency Departments and hospital inpatient services;

8. Work to identify additional key resources and incorporate these into the strategies implemented such as partnerships with the Alabama Department of Public Health, Alabama Department of Mental Health, and Children's Rehabilitation Services.

9. Utilize evidence-based clinical practice guidelines; and

10. Promote the medical home through the education of recipients on its importance.

ii. The Entity must develop, implement, and maintain policies, procedures and protocols related to the daily operations of the Health Home Care Coordination Program for the Agency's review and approval. The Entity must review policies, procedures, and protocols at least annually to conform to changes in the Health Home Care Coordination Program approaches, technologies, and changes in Federal or State law and policy.

iii. The Entity must ensure that staff who are completing care coordination functions are operating within their professional scope of practice, are appropriate for responding to the Recipient's needs, and follow the State's licensure/credentialing requirements as defined in Exhibit C Key Health Home Staff positions of this RFP.

iv. Patient selection process. The Entity must use a process to identify patterns of care that are likely to lead to higher (preventable) costs through data provided by the Agency, admissions to inpatient and residential facilities, and referrals from PMPs or other state agencies. These patterns of care must be mapped to specific interventions that would be expected to improve health outcomes and control costs. This includes but is not limited to:

1. Identify through screening results, utilization review or other mechanisms individuals receiving inadequate care for chronic conditions, including medical, mental health and substance use disorders;

2. Identifying individuals receiving contraindicated medications and patients in need of medication reconciliation;

3. Identifying individuals who use the Emergency Department with conditions that could be treated in primary care settings;

4. Identifying individuals who have been hospitalized with complications of medical conditions and hospitalizations that could have been avoided with proper care management; and

5. Identifying and prioritizing individuals whose medical or behavioral conditions can be positively affected or better controlled by care management in contrast to those whose conditions cannot.

v. Risk Assessments and Stratification. The Entity must use a process to identify and stratify Recipients who are determined to need care coordination services within the Health Home into appropriate categories of risk. The Entity must stratify Recipients into one of the following three (3) levels of health risks:

1. Level 1 – Low Risk

2. Level 2 – Medium/ Moderate Risk

3. Level 3 - High Risk

4. The Entity must use the results of the risk identification strategy to assign an initial risk level as described above to each recipient for the purpose of determining the timeframe and mode by which recipients will receive Care Coordination and assessments as outlined in Exhibit H of this RFP. As the recipient's needs are identified or goals are met, the recipient's risk level may change.

5. Health and psychosocial assessment. Recipients identified in the health risk screening and stratification as medium or high risk must also receive a health and psychosocial assessment conducted by a Care Coordinator or a Transitional Care Nurse. Health and psychosocial assessments must be completed within twenty-one (21) days from initial health risk screening. The needs identified in this health and psychosocial assessment will be the basis for the recipient's care plan.

vi. Care Planning. Recipients stratified as medium or high risk must receive a recipient care plan. Care plans must be patient/ caregiver-centered and with a team approach, including not only the Entity's staff, but also PMPs and community agencies as appropriate, such as behavioral health entities, Alabama Department of Public Health, family resource centers, etc. The care plan Requirements Checklist is set forth in Exhibit I of this RFP.

vii. Multidisciplinary Care Team

1. The Entity is required to assign a Care Coordinator to establish and coordinate a Multidisciplinary Care Team (MCT) for Health Home recipients meeting the medium and high level of risk as stipulated in this Section. The MCT is comprised of health care professionals including but not limited to Physicians and other professionals, such as Transitional Care Nurses, Community Health Workers, Pharmacists, Behavioral Health professionals or any professionals deemed appropriate. The Recipient's PMP must be an integral participant of the team.

2. The MCT must meet virtually, be free standing or be based at a hospital, community health center, DMH certified and contracted 310 Board Provider, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate and as approved by Medicaid.

3. All medium and high risk Recipients must have access to and direct the development of a MCT. The MCT must be person-centered, built on the Recipient's specific preferences and needs and with his or her input, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity. MCTs must:

    a. Be coordinated by a Care Coordinator who is accountable for coordination of all benefits and services the Recipient may need;

    b. Support PMPs in medical homes and assist in assuring integration of services;

    c. Assure appropriate and efficient care transitions, including, but not limited to, discharge planning;

    d. Assess the physical, social and behavioral risks and needs of each Recipient;

    e. Provide medication management;

    f. Provide Recipient health education on complex clinical conditions and wellness programs;

    g. Assure integration of primary, specialty, behavioral health, long term services and support (LTSS), and referrals to community-based resources, as appropriate;

    h. Maintain frequent contact with the recipient through various methods, including, but not limited to, face-to-face visits, email and telephone options, as appropriate to the Recipient's needs and risk-level; and

    i. Assist in development, implementation and monitoring of the care plan.

viii. Care Coordination Contact Schedule: The Entity must establish a contact schedule that is based on the Recipient's needs and interventions as agreed upon in the care plan. The schedule may fluctuate to meet the needs of the Recipient and to reflect changes to the care plan. At a minimum, the Entity must adhere to the following contact requirement schedule as specified in Exhibit H for each stratification level.

d. Medication Reconciliation Review Process

i. Medication Reconciliation Review is the process of gathering, organizing and sharing drug use information from multiple sources, including recipient, medical chart, prescription fill history, and discharge instructions, with PMPs in order to

identify and resolve urgent and emergent drug-drug duplications, interactions, possible adverse events, poor adherence or other suboptimal drug-taking behaviors.

ii. The Entity must have Network and Clinical Pharmacists on staff to support the Medication Reconciliation Review Process. Requirements for Network and Clinical Pharmacists are detailed in Exhibit C Health Home Key Staff of this RFP.

iii. Medication Reconciliation must be completed for all recipients stratified as medium or high risk including medium and high risk Health Home recipients as identified in Section II.B.4.C.v and including all Transitional Care Recipients.

iv. Completion of a Medication List must be performed by a Transitional Care Nurse, Behavioral Health Nurse, Care Coordinator, pharmacist, or other personnel with adequate skill and competency such as Community Health Worker (CHW)

v. The Medication List must include, but is not limited to:

1. Discharge instruction from hospital/ facility;
2. PMP chart or electronic health record (EHR);
3. Fill history (Pharmacy Home/ Entity's care management database);
4. Information from EHR;
5. Information from Health Home Participating PMP;
6. Information from any pharmacy on medication the recipient has used within the last year; and
7. Over-the-counter/ non-legend drugs, dietary/ herbal supplements, etc. Information may need to be obtained through Medication Reconciliation.

vi. The Medication List must be reviewed by a Clinical Pharmacist for Medication Reconciliation Review. Contraindications must be reviewed by a Clinical Pharmacist. The Clinical Pharmacist must be available for consultation with Health Home staff.

vii. The Medication List must be used during the Health Home Recipient interview of the Health and Psychosocial Assessment to enhance drug use information gathering. The caregiver or family may be present at the interview which may take place in the home, clinic, pharmacy, or via telephone. Medication List should also include discharge instructions, PMP chart, prescription fill history and patient report, as appropriate.

viii. The Medication List must be used during the recipient interview of the Health and Psychosocial Assessment to enhance drug use information gathering, which should also include chart, prescription fill history and patient report, as appropriate. The caregiver or family may be present at the interview. At a

minimum, the process must identify duplications and/ or discrepancies between the Medication Lists and other sources (e.g. fill history, patient interview, PMP chart) arising from uncoordinated care or patient non-adherence.

e. Behavioral Health Program

i. Purpose: The Entity must implement a program approved by the Agency to integrate behavioral health services, including both mental health and substance abuse, and medical services for recipients.

ii. The Entity must have Behavioral Health Nurses on staff to support the Behavioral Health Program. Requirements for Behavioral Health Nurses are detailed in Exhibit C - Health Home Key Staff of this RFP.

iii. Responsibilities of the Behavioral Health Nurse include:

1. Educate Health Home Program recipients regarding services provided through the Health Home and assist in enrollment.

2. Link Health Home Program recipients to appropriate services to integrate behavioral health and medical care.

3. Provide consultation to the MCT regarding behavioral health issues or topics and resources in the area.

iv. The Entity must provide the following behavioral and physical health integration elements in training and evaluation of Participating PMPs and Health Home program staff:

1. Joint sponsorship of trainings with community stakeholders

2. Development and sharing of resources and tools to support Participating PMPs

3. Prevention of substance use issues

e. Documentation

i. All services to patients, including assessments, interventions, care plans, follow up, monitoring, collateral meetings, and collaboration with staff must be documented in the electronic data system implemented by the Entity pursuant to Section II.B.3.d of this RFP.

ii. All documentation must be completed within 10 working days.

f. Quality Improvement/ Medical Management

i. The Entity must employ or contract with a Medical Director who may be part time or full time. Refer to Exhibit C for staff requirements.

ii. The Medical Director's primary responsibilities include:

1. Maintaining contact with local PMPs;

2. Representing the Entity in person at local and state meetings or conferences;

3. Addressing local issues at the community level; and

4. Leading quarterly medical management meetings in the region.

iii. The Entity must employ or contract with a Quality Care Manager who must work with practices and community PMPs in the implementation of the chronic care program. Refer to Exhibit C for staff requirements.

1. The primary responsibilities the Quality Care Manager include:

a. Support the care management of those in the region that are at the highest risk and cost along with other areas of focus as chosen by the Health Home;

b. Work with existing case managers to meet Health Home goals (listed in II. A. Scope of Work – Primary Purposes of Health Homes) or initiatives as defined by the Entity or the Agency;

c. Assist the Medical Management Committee by providing data and assistance in implementing health initiatives;

d. Ensure quality of services provided in accordance with state and federal regulations; and

e. Review and report data and information to the Medical Director, Medical Management Committee, and the Probationary Regional Care Organization related to Quality Measures adopted by the Agency.

iv. The Entity must provide population health management ("Medical Management") by:

1. Systematic data analysis to target recipients and PMPs for outreach, education, and intervention;

2. Monitoring system access to care, services, and treatment including linkage to a medical home;

3. Monitoring and building PMP capacity;

4. Monitoring quality and effectiveness of interventions to the population;

5. Supporting the medical home through education and outreach to recipients and PMPs within 30 days of enrollment;

6. Facilitating quality improvement activities that educate, support, and monitor PMPs regarding evidence based care for best practice; and

7. Implement clinical management initiatives identified as priorities by the Agency.

v. The Entity must establish a Medical Management Committee which meets the following requirements:

1. Chaired by the Medical Director; and

2. Composed of Health Home PMPs who:

a. Contract with Medicaid to provide services;

b. Meet at least every three months with the Medical Management Committee;

c. Implement and supervise program initiatives centered around Quality Measures; and

d. Review utilization data with PMPs as needed to help achieve Health Home goals.

vi. The Entity must collaborate with the Agency to facilitate PMP participation in periodic external chart reviews to monitor the effectiveness of quality improvement initiatives. These quality measures include:

1. Improved health outcomes for adults with diabetes;

2. Improved health through the reduction of Adult BMI;

3. Improved treatment of individuals identified as having clinical depression using a standardized too;

4. Improved coordination of care for individuals with asthma;

5. Improved care coordination through timely transmission of transition records;

6. Improved preventive care for children receiving health home services; and

7. Improved health outcomes of individuals with chronic illnesses through reduction in hospital re-admission rates and ambulatory care sensitive condition admissions.

8. Other metrics determined by the Agency.

vii. In order for the Entity to report quality metrics for the entire Medicaid region, the Agency may provide data to the Entity for all Patient 1st Medicaid recipients in the region regardless of chronic condition with the expectation that the Entity will restrict the data of Patient 1st Medicaid recipients not meeting the chronic care criteria. The Entity must provide care coordination services for those meeting the definitions of chronic conditions and may provide additional services to other Patient 1st Medicaid recipients in the region.

viii. The Entity must educate new PMPs within 30 days of enrollment about the Health Home Program priority initiatives through orientation, training, and technical assistance.

ix. The Medical Director and Executive director of the Entity must meet in person, quarterly, at a minimum, with Medicaid and other Health Home Programs to develop and refine:

1. Program measures;
2. Utilization and management reports;
3. Innovative health care and utilization management strategies;
4. Quality improvement goals and measures; or
5. Opportunity for shared program operations and support.

g. Participating Primary Medical Providers

i. The Entity may contract with Primary Medical Providers (PMPs) who:

1. Contract with the Agency to provide services;
2. Comply with the requirements specified in *42 CFR § 438.214*; and
3. Agree to participate in quarterly medical management meetings

ii. The Entity must ensure that all interested PMPs are eligible for participation in the Health Home Program. If a PMP was involuntarily terminated from the Health Home Program, other than for purposes of inactivity that PMP is not considered an eligible Medicaid Provider.

iii. The Entity may not employ or contract with PMPs excluded from participation in any Federal and/ or State health care programs under either *Section 1128* or *Section 1128A* of the Social Security Act or any other exclusion authority. The Entity must verify at the initial provider agreement and/ or contract and on a monthly basis that PMPs are not

excluded from participation in the Medicaid program.

iv. No PMP contract which the Entity enters into with respect to performance under this RFP must in any way relieve the Entity of any responsibility for the provision of services and duties under this RFP. The Entity must ensure that all services and tasks related to the Provider contract are performed in accordance with the terms of this RFP.

v. All Provider contracts and amendments executed by the Entity must be in writing, signed and dated by the Entity and the PMP.

h. Partnering with Outside Entities

i. The Entity must create an infrastructure to manage and support the Target Populations by partnering with community resources to:

1. Establish an ongoing process with community providers and agencies to coordinate the planning and provision of care management and support services for the target population.

2. Support behavioral health and medical integration by managing individuals with co-morbidities.

ii. The Entity must develop a working relationship with the local Department of Public Health offices to coordinate case management of recipients and connect Health Home recipients with other ADPH resources by:

1. Bi-directional referring of patients to needed services. The Entity will receive referrals from ADPH to address psychosocial and medical issues related to chronic conditions; while ADPH may address public health related issues including, but not limited to high lead levels, newborn screenings to include hearing and metabolic conditions, family planning and interconceptual care; and

2. Sharing medical and behavioral health information upon approval of patient.

iii. The Entity must schedule trainings and in-services between agencies to increase knowledge and understanding of programs and resources. Develop a working relationship with 310 Board Certified CMHCs and behavioral health facilities to coordinate the case management of Health Home recipients and other services that could be provided by:

1. Coordinating joint staff meetings for Health Home recipients as needed;

2. Collaborating in discharge planning at behavioral health facilities;

3. Bi-directional referring of patients to needed services;

4. Co-locating Health Home staff at the 310 Board Certified CMHCs when possible;

5. Sharing medical and behavioral health information upon approval of patient; or

6. Scheduling trainings and in-services between agencies to increase knowledge and understanding of programs and resources.

iv. The Entity must develop a working relationship with SA Providers to coordinate the case management of Health Home recipients and other services that could be provided by:

1. Coordinating ongoing joint staff meetings for Health Home recipients;

2. Collaborating in discharge planning at behavioral health facilities;

3. Bi-directional referring of patients to needed services;

4. Co-locating Health Home staff at the 310 Board Certified CMHCs when possible;

5. Sharing medical and behavioral health information upon approval of patient;

6. Scheduling trainings and in-services between agencies to increase knowledge and understanding of programs and resources.

i. **Confidentiality of Data and Recipient Information**

i. The Entity must ensure that all Protected Health Information (PHI) data is maintained in accordance with state and national standards.

ii. The Entity must ensure that all staff is trained in the proper protection of PHI.

III. **Penalties**

1. The purpose of a liquidated damage is to ensure adherence to the performance requirements in the Scope of Work. In the event the Entity fails to meet the contract requirements or perform the work described in the Health Home Guidelines or the RFP, Entity agrees to pay Alabama Medicaid the sums set forth below as liquidated damages unless these damages are waived by Alabama Medicaid. No punitive intention is inherent in the assessment of liquidated damages.

2. Failure to submit quarterly list of complaints and grievances with resolutions pursuant by the 15th of the month following the end of the quarter - $1000 per day.

3. Failure to submit quarterly report of Network/Clinical Pharmacist activities to include participation in meetings, educational activities, summary of clinical management initiatives, management of drug costs and activities that support the medical home concept and safe, effective, appropriate and economical use of medications by the 15th of the following month - $1000 per day.

4. Failure to submit quarterly summary of clinical management/quality initiatives and benchmarks and summary of findings in external chart reviews by then15th of the following month -$ 1000

per day.

5. Failure to submit quarterly summary of medical management meetings including summary of PMP reports and outcomes by the 15th of the following month - $1000 per day.

    i. Failure of the Entity to comply with requirements of the Health Home Guidelines will require a Plan of Correction. The Entity shall have 10 working days to submit a written Plan of Correction. The Agency will review the plan and determine if it cures the non-compliance. If noncompliance is not rectified, or if the Plan of Correction is not adequate, then the Agency will assess a penalty. Penalties are not to exceed the daily pro rata payment from the Agency for each day in non-compliance. Failure to meet performance requirements after additional reviews will require specific actions to be taken by the Agency which may include identification of additional staff, identification of specific staff failing to meet performance requirements, and termination of staff for failure to perform.

6. Failure to submit annual budget - $1000 per day

    i. Failure to submit annual audited financial statements or the equivalent for a public institution along with an actual versus budgeted year end reconciliation - $1000 per day

7. Failure to perform any other tasks as described in the RFP -$5,000 per instance

8. Written notification of each failure to meet contractual requirements shall be given to the Entity. The imposition of damages pursuant to this section is not in lieu of any other remedy available to the Agency. The Agency shall withhold from Entity reimbursements the amounts necessary to satisfy any damages imposed. Entity shall be allowed to submit rebuttal information or testimony in opposition to such findings. The Agency shall make a final decision regarding implementation of liquidated damages.

IIV. Pricing

Entity's response must include a statement agreeing to perform the duties specified in this proposal request based on an established monthly care management fee for the recipients participating in the Entity's network. The number of recipients is determined monthly based upon the Health Home Recipients on the Patient 1st PMP panel for each PMP agreeing to participate in the Health Home. The established PMPM reimbursement is $9.50 for each Health Home Patient 1st client.

The established price can be changed upon mutual agreement of the parties if deemed necessary by the Agency.

V. General Medicaid Information

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 health care services rendered to low income individuals through a partnership with health care providers and other health care insurers both public and private.

Medicaid's central office is located at 501 Dexter Avenue in Montgomery, Alabama. Central office personnel are responsible for data processing, program management, financial management, program integrity, general support services, professional services, and recipient eligibility services. For certain recipient categories, eligibility determination is made by Agency personnel located in ten (10) district offices throughout the state and by one hundred eighty (180) out-stationed workers in designated hospitals, health departments and clinics. Medicaid eligibility is also determined through established policies by the Alabama Department of Human Resources and the Social Security Administration. In FY 2013, there were 1,095,266 Alabama citizens eligible for Medicaid benefits through a variety of programs.

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

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

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

VI. General

This document outlines the qualifications which must be met in order for an Entity to serve as the Entity. It is imperative that potential Entities describe, **in detail,** how they intend to approach the Scope of Work specified in Section II of the RFP. 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 Entity must provide an explanation in the proposal that demonstrates the Entity's working knowledge of program/policy requirements as described, herein, including but not limited to 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 RFP Addenda, the Alabama Administrative Code/Agency Provider Manual/Medicaid's written response to prospective Entity questions and how staff will be trained on program/policy requirements.

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

VII. Corporate Background

Entities submitting proposals must:

a. Provide evidence that the Entity possesses the qualifications for staffing as required in this RFP.

b. Have all necessary business licenses, registrations and professional certifications at the time of contracting to be able to do business in Alabama. Alabama law provides that a foreign corporation (an out-of-state company/firm) may not transact business in the state of Alabama until it obtains a Certificate of Authority from the Secretary of State, Section 10-2B-15.01, et seq., Code of Alabama 1975. To obtain forms for a Certificate of Authority, contact the Secretary of State, Corporations Division, (334) 242-5324, www.sos.state.al.us. The Certificate of Authority or a letter/form showing application has been made for a Certificate of Authority must be submitted with the proposal.

c. Provide documentation that the Entity is operating as a nonprofit corporation under Alabama law. The Entity must provide with its proposal a copy of its Nonprofit Articles of Incorporation or Certificate of Formation and Bylaws.

d. Document the resources and capability for completing the work necessary to implement by April 1, 2015. The proposal must include a chart outlining the proposed tasks needed to complete the implementation by April 1, 2015.

e. Comply with Code of Alabama (1975), § 31-13-9 which provides that as a condition for the award of any contract, grant, or incentive by the state, any political subdivision thereof, or any state- funded entity to a business entity or employer that employs one or more employees, the business entity or employer will not knowingly employ, hire for employment, or continue to employ an unauthorized alien. Business Entity must also attach an affidavit form and documentation establishing that Business Entity is enrolled in the E-Verify Program. Business Entity must further agree that, should it employ or contract with any subcontractor(s) in connection with the performance of the services pursuant to this contract, that the Business Entity will secure from such subcontractor(s) verification of compliance with Code of Alabama (1975) § 31-13-9 in an affidavit and further obtain documentation that subcontractor is enrolled in the E-Verify program prior to performing any work on the project. Business Entity shall maintain the subcontractor documentation that shall be available upon request by the Agency.

f. Provide evidence that Entity has been granted probationary regional care organization certification by the Agency as prescribed by Code of Alabama (1975) § 22-6-162.

VIII. Submission Requirements

A. Authority

This RFP is issued under the authority of Section 41-16-72 of the Alabama Code, Section 22-6-162 of the Alabama Code, and 45 CFR 74.40 through 74.48. The RFP process is a procurement option allowing the award to be based on stated evaluation criteria. The RFP states the relative importance of all evaluation criteria. No other evaluation criteria, other than as outlined in the RFP, will be used.

In accordance with 45 CFR 74.43, the State encourages free and open competition among Entities. 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 an Entity(s) 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. **Entities 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 an Entity from further consideration. Contact information for the single point of contact is as follows:

Project Director:	**Carolyn Miller**
Address:	**Alabama Medicaid Agency** **Lurleen B. Wallace Bldg.** **501 Dexter Avenue** **PO Box 5624** **Montgomery, Alabama 36103-5624**
Telephone Number:	**334-353-5539**
Fax Number:	**334-353-7632**
E-Mail Address:	**Carolyn.Miller@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

Entities 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

Entity must submit a statement stating that the Entity 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

Entity must submit a statement stating that the Entity 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, ambiguities, conflicts or contradictions between language contained in the RFP and an Entity'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 Entity's proposal.

H. Entity's Signature

The proposal must be accompanied by the RFP Cover Sheet signed in ink by an individual authorized to legally bind the Entity. The Entity'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 Entity 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 Entity 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 Entity. The State is not liable for any expense incurred by the Entity in the preparation and presentation of their proposal or any other costs incurred by the Entity 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 Entity whose proposal is within the competitive range with respect to technical plan and cost;
- Adopt to its use all, or any part, of an Entity'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;
- Award a contract to one or more successful Entities.

L. Price

Entity must respond to this RFP by utilizing the RFP Cover Sheet to accept the established PMPM monthly care management fee for the recipients participating in the Entity's Health Home program in order to complete the Scope of Work.

M. Submission of Proposals

Proposals must be sealed and labeled on the outside of the package to clearly indicate that they are in response to 2015-HH_RegionC-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 Entity to ensure receipt of the Proposal by the deadline specified in the Schedule of Events.

N. Copies Required

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

O. Late Proposals

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

IX. Evaluation and Selection Process

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

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

Proposals failing to demonstrate that the Entity meets the mandatory requirements 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 an Entity has met the standards of responsibility. In determining responsibility, the Project Director may consider factors such as, but not limited to, the entity'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.

C. Opportunity for Additional Information

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

D. Evaluation Committee

An Evaluation Committee appointed by the Project Director will read the proposals, may conduct corporate and personal reference checks, will score the proposals, and will make a written recommendation to the Commissioner of the Agency. The Agency may change the size or composition of the Evaluation 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
Staffing Qualifications and Experience	20
Demonstration of plan for implementing the following:	
Financial/ Administrative Structure	15
Coordination of Care	20
Medical Management	15
Demonstration of local PMP's commitment to the Health Home.	30
Total	**100**

F. Determination of Successful Proposal(s)

Certification as a probationary regional care organization alone does not guarantee that an Entity will be awarded a contract for case management services under this RFP. The Entity(s) whose proposal(s) is determined to be in the best interest of the State will be recommended as the successful Entity(s). The Project Director will forward this/those Entity(s)'s proposal(s) through the supervisory chain to the Commissioner, with documentation to justify the Committee's recommendation(s).

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

X. Readiness Assessment

All Entity(s) who are awarded a contract under this RFP must satisfactorily, as determined by the Agency, complete a readiness assessment review before commencing any work under the terms of this RFP/contract.

XI. General Terms and Conditions

A. General

This RFP and the Entity'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. The Entity'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 RFP Addenda
    - The Medicaid Administrative Code/Agency Provider Manual/Medicaid's written response to prospective Entity questions

B. Compliance with State and Federal Regulations

The Entity shall perform all services under the contract in accordance with applicable federal and state statutes and regulations. Medicaid retains full operational and administrative authority and responsibility over the Alabama Medicaid Program in accordance with the requirements of the federal and state statutes and regulations as the same may be amended from time to time. Without limiting the foregoing, to the extent they apply to the contract, the provisions contained in Appendix A, Code of Federal Regulations, Title 45, Part 74 are incorporated herein.

C. Term of Contract

The initial contract term shall be effective April 1, 2015, through September 30, 2016. Alabama Medicaid shall have three, one-year options for extending this contract if approved by the Legislative Contract Review Oversight Committee. At the end of the contract period Alabama Medicaid may at its discretion, exercise the extension option and allow the period of performance to be extended at the rate indicated on the RFP Cover Sheet. The Entity will provide a statement agreeing to perform the duties specified in this proposal request based on an established monthly care management fee for the recipients participating in the Entity's network for each year of the contract, including any extensions. The number

of recipients is determined monthly based upon the Health Home Recipients on the Patients 1st PMP panel for each PMP agreeing to participate in the Health Home. The established PMPM reimbursement is $9.50 for each Health Home Patient 1st client.

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

D. Contract Amendments

No alteration, modification, amendment or variation of the terms of the contract shall be valid unless made in writing and duly signed and executed by the parties thereto. Every such alteration, modification, amendment or variation 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 all state and federal laws and regulations applicable to the Alabama Medicaid Program, as they may be amended. In the event of any substantial change in such Plan, laws, or regulations, that materially affects the operation of the Alabama Medicaid Program or the costs of administering such Program, either party, after written notice and before performance of any related work, may apply in writing to the other for an equitable adjustment in compensation caused by such substantial change.

E. Confidentiality

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

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

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

Pursuant to requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191), the successful Entity must sign and comply with the terms of a Business Associate agreement with the Agency Exhibit K Attachment A.

F. Security and Release of Information

The Entity 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. The Entity 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. The Entity shall not be entitled to use of Alabama Medicaid Program data in its other business dealings. All requests for program data shall be referred to Medicaid for response by the Commissioner only.

G. Federal Nondisclosure Requirements

Each officer or employee of any person to whom Social Security information is or may be disclosed shall be notified in writing by such person that Social Security information disclosed to such officer or employee can be only used for authorized purposes and to that extent and any other unauthorized use herein constitutes a felony punishable upon conviction by a fine of as much as $5,000 or imprisonment for as long as five years, or both, together with the cost of

prosecution. Such person shall also notify each such officer or employee that any such unauthorized further disclosure of Social Security information may also result in an award of civil damages against the officer or employee in an amount not less than $1,000 with respect to each instance of unauthorized disclosure. These penalties are prescribed by IRC Sections 7213 and 7431 and set forth at 26 CFR 301.6103(n).

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

H. Contract a Public Record

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

I. Termination for Bankruptcy

The filing of a petition for voluntary or involuntary bankruptcy of a company or corporate reorganization pursuant to the Bankruptcy Act shall, at the option of Medicaid, constitute default by Entity effective the date of such filing. The Entity 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 the Entity in writing that performance under the contract is terminated and proceed to seek appropriate relief from the Entity.

J. Termination for Default

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

K. Termination for Unavailability of Funds

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

L. 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 Entity by certified or registered mail, return receipt requested. The termination shall be effective as of the date specified in the notice. In such event, the Entity will be entitled only to payment for all work satisfactorily completed. The Entity will not be entitled to payment for uncompleted work, or for anticipated profit, unabsorbed overhead, or any other costs.

M. Force Majeure

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

N. Nondiscriminatory Compliance

The Entity 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.

O. Small and Minority Business Enterprise Utilization

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

P. Worker's Compensation

The Entity 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.

Q. Employment of State Staff

The Entity 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 two (2) years pursuant to the Alabama Code of Ethics, §36-25-1 et seq., Code of Alabama 1975.

R. Immigration Compliance

The Entity will not knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama. The Entity 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. The Entity will document that the Entity 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 Entity 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. The Entity 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 Entity will secure from such subcontractor(s) documentation that subcontractor is enrolled in the E-Verify program prior to performing any work on the project. The subcontractor shall verify every employee that is required to be verified according to the applicable federal rules and regulations. This subsection shall only apply to subcontractors performing work on a project subject to the provisions of this section and not to collateral persons or business entities hired by the subcontractor. The Entity shall maintain the subcontractor documentation that shall be available upon request by the 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.

S. Share of Contract

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

T. 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.

U. Warranties Against Broker's Fees

The Entity 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.

V. Novation

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

W. Employment Basis

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

X. Disputes and Litigation

Except in those cases where the proposal response exceeds the requirements of the RFP, any conflict between the response of the Entity 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 Entity'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 Entity must proceed diligently with the performance of the contract in accordance with the disputed decision.

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

Any litigation brought by Medicaid or the Entity 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.

Y. Records Retention and Storage

The Entity 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 the Entity 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.

Z. Inspection of Records

The Entity 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 Entity's books and records pertaining to contract performance and costs thereof. The Entity shall cooperate fully with requests from any of the agencies listed above and shall furnish free of charge copies of all requested records. The Entity may require that a receipt be given for any original record removed from the Entity's premises.

AA. Use of Federal Cost Principles

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

BB. Payment

Medicaid will pay the established care management fee to the Entity in the first check-write of each month for each recipient in the Entity's network during the current month based on PMP assignments made by the 20th day of the previous month. Payments are dependent upon successful completion and delivery of scope of work as described in Section II and reporting requirements including the following:

- Quarterly list of complaints and grievances with resolutions due on the 15th of the month following the end of the quarter
- Monthly report of Performance of Care Management System including the number of cases handled per case manager and the performance of duties as described in Section II
- Annual Budget as described in Section II.B.2. of the RFP
- Annual audited financial statements or the equivalent for a public institution along with an actual versus budgeted year end reconciliation
- Quarterly Report of Network/Clinical Pharmacist activities to include participation in meetings, educational activities, summary of clinical management initiatives, management of drug costs and activities that support the medical home concept and safe, effective, appropriate and economical use of medications.
- Quarterly summary of clinical management/quality initiatives and benchmarks and summary of findings in external chart reviews
- Quarterly summary of medical management meetings including summary of PMP reports and outcomes

CC. Notice to Parties

Any notice to Medicaid under the contract shall be sufficient when mailed to the Project Director. Any notice to the Entity shall be sufficient when mailed to the Entity 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.

DD. Disclosure Statement

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

EE. Debarment

The Entity 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.

FF. 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 Entity'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.

GG. Qualification to do Business in Alabama

Should a foreign corporation be selected to provide professional services in accordance with this RFP, it must be qualified to transact business in the State of Alabama and possess a Certificate of Authority issued by the Secretary of State at the time a professional services contract is executed. To obtain forms for a Certificate of Authority, contact the Secretary of State, Corporations Division, (334) 242-5324, www.sos.state.al.us. The Certificate of Authority or a letter/form showing application has been made for a Certificate of Authority must be submitted with the proposal.

HH. 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 law 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.

II. Alabama interChange Interface Standards

The Entity hereby certifies that any exchange of MMIS data with the Agency's fiscal agent will be accomplished by following the Alabama interChange Interface Standards Document, which is contained in the RFP library.

JJ. Inconsistencies

All information contained in this RFP and any amendments reflect the best and most accurate information available to Medicaid at the time of RFP preparation. No inaccuracies in such data shall constitute a basis for change of the payments to the Entity or a basis for legal recovery of damages, actual, consequential or punitive, except to the extent those inaccuracies are the result of intentional misrepresentation by Medicaid.

DEFINITIONS

The following terms have the meaning stated for the purposes of this contract.

1. **Agency** – Alabama Medicaid Agency
2. **Care Coordination** – Management of care including recruitment, outreach, psychosocial assessment, service planning, assisting the Recipient in arranging for appropriate services, including but not limited to, resolving transportation issues, education, counseling and follow-up and monitoring to ensure services are delivered and continuity of care is maintained.
3. **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** – An unclothed physical examination using quick, simple procedures to sort out apparently well children from those who have a disease, condition or abnormality and to identify those who may need diagnosis, evaluation and/or treatment of their physical or mental problems.
4. **Electronic Health Record (EHR)** – An electronic record of an individual's health-related information that conforms to nationally recognized interoperability standards and that can be created, managed and consulted by authorized clinicians and staff across more than one health care Provider.
5. **Enhanced Case Management Fee** – The fee paid by Medicaid to the Entity per recipient per month, which shall be payment in full for the services described in Section II, Scope of Work, and provided by the Entity. The Entity shall submit to the State annual budget reports and shall be held accountable for appropriate administration of the care management fee.
6. **Enrollee** – A person who has been assigned one or more Medicaid identification numbers and has been certified by the Agency as eligible for Medicaid under the State Plan.
7. **Entity** – An organization certified by Alabama Medicaid as a Probationary Regional Care Organization responding the Health Home RFP.
8. **Health Home** – A care model that includes a team-based approach to providing comprehensive, person-centered care and integrating the physical and mental health needs of recipients. Recipients eligible for participation in a health home include three groups: those with two chronic conditions, those with one chronic condition and risk of a second, and those with one "serious and persistent" mental health condition. The following services are typically provided:
    a. Comprehensive care management
    b. Care Coordination and health promotion
    c. Transitional inpatient to outpatient care
    d. Individual and family support
    e. Referrals to community and social support services
    f. Services linked through health information technology
9. **Health Home Recipient** – A person who has been assigned one or more Medicaid identification numbers, has been certified by the Agency as eligible for medical assistance under the State Plan, and meets the criteria for receiving Health Home services.
10. **Health Information Technology** – The electronic transmission of health related information between organizations according to nationally recognized standards.
11. **HIPAA** – The administrative Simplification Provisions, Sections 261 through 264, of the Federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
12. **Medical Directors** – The Health Home leadership body in which each Health Home is represented by its Medical Director. This body works with Alabama Medicaid in establishing Health Home clinical policy and providing clinical oversight for the Health Home.

13. **Medical Record** – The document that records all of the medical treatment and services provided to the recipient.
14. **Participating Provider** – Person or organization entering into a written agreement with the Health Home to deliver covered services to recipients or a participating member of the Health Home.
15. **Performance Measure** – A consistent measurement of service, practice, and governance of a health care organization. Measurements must produce solid, statistically-based measurement of critical processes that, in turn, must permit the organization to make solid decisions about improvements.
16. **Physician** – Physician shall mean:
    a. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she renders services.
    b. A doctor of dentistry or of dental or oral surgery licensed to practice dentistry or dental or oral surgery by the state in which he or she renders services but only with respect to:
        i. Surgery related to the jaw.
        ii. The reduction of any fracture relating to the jaw or facial bone.
        iii. Surgery within the oral cavity for removal of lesions or the correction of congenital defects.
        iv. Fabrication of a prosthesis for closure of a lesion, or congenital defect such as cleft palate.
17. **Preventive Services** – Services rendered to prevent or delay the onset of disease. Examples of preventive services include: (1) for adults: pap smears; vaccines for the prevention of pneumonia, diphtheria-tetanus, and influenza; mammograms; and (2) for children under 21 years: EPSDT screening and age-appropriate immunizations; urinalysis; lead screening; and hematocrit. The Health Home Program aims to implement targeted disease management activities, including preventive health maintenance.
18. **Primary Medical Provider (PMP)** – A Provider or entity that provides or arranges for PMP coverage for services, consultation or referrals twenty-four (24) hours a day, seven (7) days a week.
19. **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.
20. **Provider Network** – Those Participating Providers affiliated with the Entity who is authorized to provide services to recipients.
21. **Quality Improvement** - The process of continuously finding ways to improve and provide better patient care and services, including assuring that health care services are appropriate, timely, accessible, medically necessary and high quality.
22. **Recipient** – A person who has been assigned one or more Medicaid identification numbers and has been certified by the Agency as eligible for medical assistance under the State Plan. A recipient is also a person receiving services through Health Homes.
23. **Service Area** – The defined geographic area within which the Health Home and the Agency have agreed that the Health Home shall coordinate the provision of Covered Services needed by Target Population through participating providers or referral arrangements.
24. **Target Population** – Group of individuals enrolled, assigned, or otherwise contracted to be managed by the Health Home.

TRAINING REQUIREMENTS FOR CARE COORDINATION

Upon hire and annually thereafter, the Entity must provide training for its Care Coordinators and staff who participate in the MCT on, at a minimum, the following topics:

- Person-centered care planning process
- Cultural and disability competence
- Communication
- Accessibility and accommodations
- Independent living and recovery
- Wellness principles
- Americans with Disabilities Act (ADA) requirements
- Other topics as defined by the Agency

During the implementation phase of the RCO Program, the Entity must provide training on the following topics:

- Federal and State laws and program requirements
- Initial contact and information referral
- Assessment
- Eligibility
- Enrollment
- Risk stratification
- Care planning (goals, objectives, outcomes and service planning)
- Use of person-centered language in all communications
- Due process including grievances and appeals
- Documentation requirements
- Abuse, neglect and exploitation and all other incident reporting
- Medication management
- Risk and safety planning
- Community resources including an explanation of the resources available and training on how to access the services

The Entity must provide mandatory annual training for Care Coordinators on the following topics:

- Cultural competency/ diversity training that is specific to the Region and addresses the culture/ diversity in that Region
- Medication management
- Risk stratification

Risk and safety planning

- Community resources including an explanation of the resources available and training on how to access the services

• Health Insurance Portability and Accountability Act (HIPAA)
• Customer service
• Domestic Violence

The Entity must record written attestations that it has provided all of the required training.

Exhibit C

HEALTH HOME KEY STAFF POSITIONS

Administrative / Medical Management Staff

Executive Director

- A BS or BA degree from an accredited college or university, a minimum of three years of management experience in managed health care, and experience working with low income populations.
- The authority to make all day to day program decisions including hiring, firing, financial and contract agreements within policies, procedures and the budget approved by the board.
- Maintain a full-time office in the Health Home region.

Medical Director

- Primary Care Physician licensed by the State of Alabama and practicing in the Region for which he or she serves as Medical Director.
- Actively involved in all of the Entity's major clinical program components and directly participates in medical management of the Health Home, Quality Improvement, and Utilization Management.

Quality Care Manager

- A BSN and have current license or
- Master's Degree in Social from an accredited School of Social Work and maintain appropriate license

Care Coordination Staff

The Entity must have appropriate Care Coordination staff. Care Coordination is a professional skill that must be supported by the Entity. The skills and functions employed by Care Coordination staff include community orientations, including the ability to locate, augment and develop resources including information on services offered by other agencies.

Care Coordination staff includes Care Coordinators, Community Health Workers and Transitional Care Nurses. The Entity must have a process to ensure that a recipient or caregiver is able to request a change in his or her Care Coordinator or Community Health Worker.

Care Coordination Supervisor

- A Master's degree in Social Work from an accredited school of Social Work and a minimum of a Licensed Graduate Social Worker (LGSW), or a Bachelor's degree in Nursing with appropriate license

Care Coordinators

- Care Coordinators should have the following professional criteria:
    - A Bachelor's or Master's degree in Social Work from an accredited school of Social Work and appropriate license, or a Bachelor's degree in Nursing with appropriate license
    - Experience in Care Coordination or case management in a medical or behavioral health setting
- The Entity must provide a minimum level of Care Coordinators to ensure their presence in the community (e.g., physicians' offices, clinics, hospitals and community-based centers), as well as outreaching to recipients in the home, via phone and/ or in person. These Care Coordinators are to provide non-clinical services, such as educating recipients about the importance of visiting their PMP, assisting them with transportation issues or other social issues affecting their ability to use their Entity benefits.
- The Care Coordinator must provide the recipient with a business card that provides the location and telephone number where the recipient can get in touch with the Care Coordinator should any questions arise. The Care Coordinators must be located in an area which provides adequate recipient access and maintains recipient confidentiality
- Private offices are preferred. Care Coordinators must have telephones for use with recipient contacts.
- Caseloads of Care Coordinators must not exceed the standards on average during the calendar year:
    - Low risk recipients. Recipients identified as Level 1 Low risk are case managed on a limited basis and do not have a caseload
    - Medium risk recipients. Recipients identified as needing supportive Care Coordination services – 1:50
    - High risk recipients. Recipients identified as needing intensive Care Coordination services – 1:50

Community Health Workers

- Community Health Workers must have a minimum of a high school diploma or G.E.D. and a valid driver's license
- The Entity must have Community Health Workers and demonstrate to the Agency that its Community Health Workers are qualified to perform all the functions and responsibilities outlined in this contract
- The Entity must staff a sufficient number of Community Health Workers to initiate a timely response to an recipient's inquiry or needs, including those in the Health Home program

- The purpose of the Community Health Worker is to ensure that recipients have access to all covered services appropriate to the recipient's condition or circumstance and to act as a liaison with various government agencies and programs, PMPs, public entities, county entities and community resources

Transitional Care Nurses

- The Entity must employ Transitional Care Nurses to support Transitional Care Teams. Transitional Care Nurses must be skilled personnel with extensive knowledge and experience transitioning recipients with special health care needs and must meet the following criteria:
    - Possess, at a minimum, a BSN degree
    - Maintain appropriate licensure
    - Preferably reside within the Region of the Entity
    - Have experience in a hospital setting

Behavioral Health Nurses

- The Entity must employ Behavioral Health Nurses to support the Behavioral Health Program, specifically the integration of behavioral health services, including both mental health and substance abuse, and medical services for the Entity's recipients. The Behavioral Health Nurse must meet the following criteria:
    - Possess a minimum of a BSN degree
    - Maintain appropriate licensure
    - Have experience in the behavioral health field

Pharmacy Staff

The Entity must employ personnel to implement a pharmacy program that will coordinate pharmacy activities for Health Home Recipients

Network Pharmacist

- Provide leadership and oversight of the Pharmacy Program for the Health Home, including supervision of Clinical Pharmacists.
- Coordinate and manage education of community pharmacists and PMPs on the Health Home Program and Agency pharmacy initiatives.
- Engage in, and manage staff to implement programs that advance the Medical Home.
- Work with the Entity'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 Health Home and Agency meetings as requested, such as Steering Committee meetings, Medical Management Committee meetings, Alabama Medicaid Pharmacy and Therapeutics (P&T) and Drug Utilization Review (DUR) meetings, and Health Home Director's Meetings.

- Serve as a resource to Health Home PMPs and care managers on general drug information and Agency pharmacy policy issues.
- Educate and 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 on administrative detailing to Health Home PMPs.
- Develop and coordinate e-prescribing efforts.
- Participate in regular status calls with Agency Pharmacy Program staff.
- Meet the following criteria:
    - Holds a current Alabama Pharmacy license in good standing
    - Works within the Health Home region
    - Has at a minimum a B.S. in Pharmacy
    - Possesses good organizational and administrative skills
- Complete the following goals each quarter:
    - Perform five (5) physician educational visits.
    - Perform five (5) pharmacy educational visits.
    - Perform one (1) home visit with Health Home Program recipient.
    - Provide one (1) in-service training on various clinical topics for care managers.
    - Run report on high utilizers. Review the top ten (10) by costs and identify any possible recipients to be referred to the Care Coordinator for enrollment into the Health Home.
    - Perform and submit Medication Reconciliations for Health Home Program recipients within five (5) Business Days after receipt of Medication List.
    - Perform and submit Medication Reconciliations for transitional/ discharge patients within three (3) Business Days after receipt of Medication List.

Clinical Pharmacist

- Pharmacy management programs for those receiving multiple medications
- Coordinate and support pharmacy initiatives, such as dispensing of ninety (90) day supply for maintenance medications, pharmacist vaccine administration, smoking cessation, and other programs as outlined by the Health Home Program.
- Assist Physicians in creating and managing drug regimens of recipients with chronic disease states (e.g., diabetes, asthma, CHF, etc.). This may include, but shall not be limited to, activities such as meeting with recipients, adjusting medication dosages in concert with PMP and PMP peak flow monitoring
- Perform Medication Reconciliation assessments as requested by Health Home PMPs and/ or Care Coordinators to optimize the recipient's drug regimen.
- Educate community pharmacists on the Health Home Program and Agency pharmacy initiatives.
- Serve as a resource to Health Home PMPs and Care Coordinators on general drug information and Agency drug policy issues

- Meet the following criteria:
  - Hold a current Alabama Pharmacist license in good standing
  - Works within the Region
  - Has at a minimum a Pharm.D. degree
  - Formal residency training or equivalent clinical experience (minimum of three (3) calendar years) to work in concert with Health Home leadership

Exhibit D

QUARTERLY REPORTING REQUIREMENTS

RFP Section	Report Title
II.B.3 Financial	Quarterly Budget Update
II.C.2. Administrative – Grievances and Complaints	Complaints and Grievances
II.C.7. Staff Training – Administrative Requirements	Staff Training
II.D.9. Pharmacy Program	Clinical Pharmacy Activities
II.D.11.f. Medical Management Committee	Medical Management Meetings
II.D.11. Quality Improvement and Medical Management	Quality Initiatives and Benchmarks
II.D. 1. Transitional Care Program II.D.13 Partnering with Outside Entities	Outreach Activities to Community Agencies, 310 Board Certified CMHCs, and Medical Facilities

Exhibit E

ANNUAL REPORTING REQUIREMENTS

RFP Section	Report Title
II.B.2.a. Financial - Budget	Annual Budget

II.B.2.f. Annual Audit	Annual audit performed by an independent certified public accountant
II.B.2.g. Financial	Proposed budget for Residual Funds
II.B.3.e Education and Outreach Materials	Planned Health Education Activities and Implementation Dates
II.B.3.g. Staff Training	Annual Training Plan

Exhibit F

Quarterly Income Statement
Health Home:
Quarter:
Date Submitted

	Year To Date			
	Actual	**Budget**	**Variance**	**Annual Budget**
Revenues				
		-	-	-
Total Revenues				
Expenses				
Total Expenses	-	-	-	-
Revenues Over (Under) Expenses	-	-	-	-
Other Income				
	-	-	-	-
	-	-	-	-
Total Grant Income Received				
Other Expense				

	-	-	-	-
Total Grant Funds Expensed	-	-	-	-
Net Other Income	-	-	-	-
	-	-	-	-
Net Income	-	-	-	-

Note:

Exhibit G

ANNUAL BUDGET REPORT

Health Home:

Date Submitted:

	Previous Year	Proposed Annual Budget	**Variance**
Revenues	-	-	
			-
Total Revenues			
Expenses	-	-	
Total Expenses			-
Revenues Over (Under) Expenses			-
Other Income	-	-	
			-
			-
Total Grant Income Received			
Other Expense	-		

Total Grant Funds Expensed			- -
Net Other Income			-
Net Income			- -

Note:

CONTACT REQUIREMENT SCHEDULE

Table D.2-1: Minimum Contact and Requirement Schedule by Recipient Risk Level

Risk Stratification Level	Minimum Contact and Requirement Schedule	
	First six (6) months of enrollment in the risk stratification level (note: visit is an in-person contact)	Month seven (7) until conclusion of the recipient care plan (note: visit is an in-person contact)
High	• Within twenty-one (21) Calendar Days of initial health risk screening and stratification: Health and psychosocial assessment completed • Within twenty-five (25) Calendar Days of health and psychosocial assessment: care plan developed • Per week: At least one documented goal in place with at least one (1) task or more documented and completed • Months 0-1: Two (2) face-to-face visits. Maximum of fifteen (15) Calendar Days between visits • Months 2-3: One (1) visit per month. Maximum of thirty (30) Calendar Days between visits • Months 4-6: Two (2) visits in ninety (90) Calendar Days. Maximum of forty-five (45) Calendar Days between visits • Telephonic contact as needed	• Per week: At least one documented goal in place with at least one (1) task or more documented and completed • One (1) visit every two (2) months. Maximum of sixty (60) Calendar Days between visits • Monthly telephonic contact

Risk Stratification Level	Minimum Contact and Requirement Schedule	
	First six (6) months of enrollment in the risk stratification level (note: visit is an in-person contact)	Month seven (7) until conclusion of the recipient care plan (note: visit is an in-person contact)
Medium	• Within twenty-one (21) Calendar Days of initial health risk screening and stratification: Health and psychosocial assessment completed • Within twenty-five (25) Calendar Days of health and psychosocial assessment: care plan developed • Per month, but less than one (1) per week: At least one documented goal in place with at least one (1) or more documented and completed tasks • Months 0-2: One (1) face-to-face visit • Months 3-6: Two (2) visits. Maximum of sixty (60) Calendar Days between visits • Telephonic contact as needed	• Per month, but less than one (1) per week: At least one documented goal in place with at least one (1) or more documented and completed tasks • One (1) visit every three (3) months. Maximum of ninety (90) Calendar Days between visits • Monthly telephonic contact
Low	• At least one (1) documented task per calendar year, but not more than two (2) per quarter • Months 0-4: One (1) face-to-face visit • Months 5-6: One (1) telephonic contact	• One (1) visit every six (6) months. Maximum of one hundred eighty (180) Calendar Days between visits • Quarterly telephonic contact

Exhibit I

CARE PLAN REQUIREMENTS CHECKLIST

1. All Care Coordination services to recipients must be documented in an electronic data system implemented by the Entity.
2. All documentation must be completed within ten (10) Business Days of the Care Coordination service.
3. The care clan, if applicable, must be reviewed and updated no less than every ninety (90) Calendar Days. care plans must also be updated when there is a change in the recipient's health status or needs, change in diagnosis, change in caregiver status, change in functional status, a significant health care event (e.g., hospital admission or transition between care settings), or as requested by the recipient's caregiver, or his or her PMP.
4. The care plan must apply evidence-based guidelines or best practices when developing and implementing goals and interventions.
5. Recipients determined as Low risk do not require a care plan. However, the Entity is required to maintain stable conditions/ problems and/ or provide population management services, (e.g., resolution of health care access issue or mail materials relevant to the Entity's programs).
6. Completion of the Patient Health Question-2 (PHQ-2) to assess for symptoms of depression for all recipients ages 18 and older.
7. Completion of the Patient Health Question-9 (PHQ-9) if the patient scores a four (4) or higher on the PHQ-2
8. Recipients stratified as medium and high risk require:
    (a) Medication Reconciliation/ Review
    (b) Development of pending tasks
    (c) Completion of a Health and Psychosocial Assessment
9. At a minimum, the recipient care plan for recipients determined as either medium or high risk must include:
    (a) Identified needs
    (b) Goals to address identified needs
    (c) Interventions to achieve goals
    (d) Frequency of follow-up/ monitoring to achieve goals
    (e) Opportunity for recipient participation and an opportunity for input from the PMP, other PMPs, a legal representative, and the recipient's family and caregiver if appropriate during the development, implementation and ongoing assessment of the recipient care plan
    (f) Identification and evaluation of risks associated with the recipient's care
    (g) The Health and Psychosocial Assessment and recipient care plan if applicable must include the following elements:

i. A provision to refer the recipient, if applicable, to a community or social services agency, assist the recipient in contacting the Agency and validate the recipient received the service
ii. A communication plan developed with the recipient, including the method of preferred contact and a contact schedule that is based on the recipient's needs
iii. An aggressive strategy for effective and comprehensive transitions of care between care settings which includes obtaining the discharge/ transition plan, conducting timely follow up with the recipient and his/ her PMPs as appropriate, performing medication reconciliation, and ensuring the timely provision of formal and informal supports
iv. Continuous evaluation of the appropriateness of the recipient's current assignment to the risk stratification level
v. The recipient's personal or cultural preferences, such as types or amounts of services
vi. The recipient's preference of PMPs and any preferred characteristics, such as gender or language
vii. The recipient's living arrangements
viii. Covered services and services covered outside of the Contract to address each identified need, provided that the Entity shall not be required to pay for services covered outside of the Contract
ix. Actions and interventions necessary to achieve the recipient's objectives
x. Follow-up and evaluation
xi. Collaborative approaches to be used
xii. Desired outcome and goals, both clinical and non-clinical
xiii. Status of the recipient's goals
xiv. Barriers or obstacles
xv. Responsible parties
xvi. Standing referrals
xvii. Community resources
xviii. Informal supports
xix. Timeframes for completing actions
xx. Back-up plan arrangements for critical services
xxi. Crisis plans for a recipient with behavioral health conditions

Exhibit J: 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	Article I. 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 a new SMAC program as outlined in the request for proposal regarding each element listed in the scope of work.
☐	10. The response includes (if applicable) a Certificate of Authority or letter/form showing application has been made with the Secretary of State for a Certificate of Authority.

Exhibit K: Contract and Attachments

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

Sample Contract
Attachment A: Business Associate Addendum
Attachment B: Contract Review Report for Submission to Oversight Committee
Attachment C: Immigration Status
Attachment D: Disclosure Statement
Attachment E: Letter Regarding Reporting to Ethics Commission
Attachment F: Instructions for Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion

Attachment G: Beason-Hammon Certificate of Compliance

CONTRACT
BETWEEN
THE ALABAMA MEDICAID AGENCY
AND

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

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

Contractor shall be compensated for performance under this contract in accordance with the provisions of the RFP and the price provided on the RFP Cover Sheet response, in an amount not to exceed _____.

Contractor and the Alabama Medicaid Agency agree that the initial term of the contract is ____to _____.

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

CONTRACTOR

_____
Contractor's name here

_____
Date signed

_____
Printed Name

Tax ID:_____

APPROVED:

_____
Governor, State of Alabama

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

_____
Stephanie McGee Azar
Acting Commissioner

_____
Date signed

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.

_____
General Counsel

ALABAMA MEDICAID AGENCY
BUSINESS ASSOCIATE ADDENDUM

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

1. BACKGROUND

a. Covered Entity and Business Associate are parties to a contract entitled _____ (the "Contract"), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

b. 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 Privacy Rule (as defined below).

c. The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose protected health information to a business associate, and may allow 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

Unless otherwise clearly indicated by the context, the following terms shall have the following meaning in this Agreement:

a. "Breach" shall have the meaning set forth in 45 C.F.R. § 164.402.

b. "Electronic Health Record" shall mean an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

c. "Electronic Protected Health Information" means Protected Health Information that is transmitted by Electronic Media (as defined in the Security and Privacy Rule) or maintained in Electronic Media.

d. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

e. "Individual" shall have the same meaning as the term "individual" in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

f. "Personal Health Record" shall mean an electronic record of identifiable health information on an individual that can be drawn from multiple sources and that is managed, shared and controlled by or primarily for the individual.

g. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

h. “Protected Health Information” (PHI) shall have the same meaning as the term “protected health information” in 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

i. “Required By Law” shall have the same meaning as the term “required by law” in 45 CFR 164.103.

j. “Secretary” shall mean the Secretary of the United States Department of Health and Human Services or his designee.

k. “Security Incident” shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

l. “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 162, and Parts 164, Subparts A and C. The application of Security provisions Sections 164.308; 164.310, 164.312, and 164.316 of title 45, Code of Federal Regulations shall apply to a business associate of a covered entity in the same manner that such sections apply to the covered entity.

m. Unless otherwise defined in this Agreement, capitalized terms used herein shall have the same meaning as those terms have in the Privacy Rule.

n. “Unsecured Protected Health Information” is protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary of Health and Human Services in the guidance issued under section 13402(h)(2) of Public Law 111–5 on the HHS Web site.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

a. Use and Disclosure of PHI. Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as Required By Law.

b. Appropriate Safeguards. Business Associate agrees to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the PHI other than as provided for by this Agreement. The Business Associate agrees to take steps to safeguard, implement and maintain PHI in accordance with the HIPAA Privacy Rule.

c. Mitigation. Business Associate agrees to 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.

d. Report Unauthorized Use or Disclosure. Business Associate agrees to promptly report to Covered Entity any use or disclosure of PHI not provided for by this Agreement of which it becomes aware.

e. Applicability to Business Associate’s Agents. In accordance with 45CFR 164.502(e)(1)(ii) and 164.308(b)(2), Business Associate shall ensure that any subcontractors or agents 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. The Business Associate agrees to have HIPAA-compliant Business Associate Agreements or equivalent contractual agreements with agents to whom the Business Associate discloses Covered Entity PHI.

f. Access. Upon receipt of a written request from Covered Entity, Business Associate agrees to provide Covered Entity, in order to allow Covered Entity to meet its requirements under 45 CFR 164.524,

access to PHI maintained by Business Associate in a Designated Record Set within thirty (30) business days.

g. Amendments to PHI. Business Associate agrees to make any amendment(s) to PHI maintained by Business Associate in a Designated Record Set that Covered Entity directs or agrees to, pursuant to 45 CFR 164.526 at the request of Covered Entity, within thirty (30) calendar days after receiving a written request for amendment from Covered Entity.

h. Availability of Documents. Business Associate agrees to 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 for purposes of the Secretary determining Covered Entity's compliance with the Privacy and Security Rules, within five business days after receipt of written notice.

i. Documentation of PHI Disclosures. Business Associate agrees to keep records of disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

j. Accounting of Disclosures. The Business Associate agrees to provide to Covered Entity, within 30 days of receipt of a written request from Covered Entity, information collected in accordance with the documentation of PHI disclosure of this Agreement, to permit 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 CFR 164.528.

k. The Business Associate shall 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.

l. The Business Associate shall notify the Covered Entity within 5 business days following the discovery of a breach of Protected Health Information (PHI).

m. The Business Associate shall provide the Covered Entity the following information when a breach of unsecured protected health information is discovered:

    1. The number of recipient records involved in the breach.
    2. A description of what happened, including the date of the breach and the date of the discovery of the breach if known.
    3. 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).
    4. Any steps the individuals should take to protect themselves from potential harm resulting from the breach.
    5. 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.
    6. 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.
    7. A proposed media release developed by the Business Associate.

n. The Business Associate shall obtain Covered Entity approval prior to reporting any breach required by 45 CFR Part 164, Subpart D.

o. The Business Associate shall, after receiving Covered Entity approval, provide the necessary notices to the recipient, prominent media outlet, or the Secretary of Health and Human Services (HHS) to report Business Associate breaches as required by 45 CFR Part 164, Subpart D.

p. Covered Entity will coordinate with the Business Associate in the determination of additional specific actions that will be required of the Business Associate for mitigation of the breach.

q. If the Business Associate is a vendor of personal health records, notification of the breach will need to be made with the Federal Trade Commission.

r. The Business Associate shall be responsible for any and all costs associated with the notification and mitigation of a breach that has occurred because of the negligence of the Business Associate.

s. The Business Associate shall pay all fines or penalties imposed by HHS under 45 CFR Part 160 HIPAA Administrative Simplification: Enforcement rule for breaches made by any employee, officer, or agent of the Business Associate.

t. The Business Associate shall be subject to prosecution by the Department of Justice for criminal violations of HIPAA if the Business Associate obtains accesses or discloses individually identifiable health information without authorization, and shall be responsible for any and all costs associated with prosecution.

4. PERMITTED USES AND DISCLOSURES

a. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure would not violate the Subpart E of 45 CFR Part 164 if done by Covered Entity;

b. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that:

   1. disclosures are Required By Law; or

   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.

d. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 42 CFR 164.504(e)(2)(i)(B).

e. Business Associate may not use or disclose PHI if the use or disclosure would violate any term of the Contract.

5. REPORTING IMPROPER USE OR DISCLOSURE

a. The Business Associate shall report to the Covered Entity any use or disclosure of PHI not provided for by this agreement immediately from the time the Business Associate becomes aware of the use or disclosure.

b. The Business Associate shall report to the Covered Entity any Security Incident and/or breach immediately from the time the Business Associate becomes aware of the use or disclosure.

6. OBLIGATIONS OF COVERED ENTITY

a. Covered Entity shall notify the Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 CFR 164.520, to the extent that such limitation may affect Alabama Medicaid's use or disclosure of PHI.

b. Covered Entity shall 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.

c. Covered Entity shall notify the Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

d. Covered Entity shall 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.

e. Covered Entity shall provide Business Associate with only that PHI which is minimally necessary for Business Associate to provide the services.

7. TERM AND TERMINATION

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

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

   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;
   2. Immediately terminate this Agreement; or
   3. If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

c. **Effect of Termination**.

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

    a. Retain only that protected health information which is necessary for business associate to continue its proper management and administration or to carry out its legal responsibilities;
    b. Return to covered entity or, if agreed to by covered entity, destroy the remaining protected health information that the business associate still maintains in any form;
    c. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR 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 protected health information;
    d. Not use or disclose the protected health information retained by business associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out at Section 4, "Permitted Uses and Disclosures" which applied prior to termination; and
    e. Return to covered entity or, if agreed to by covered entity, destroy the protected health information 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.

d. **Survival**

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

8. GENERAL TERMS AND CONDITIONS

a. This Agreement amends and is part of the Contract.

b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.

c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

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

e. 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 Privacy Rule and HIPAA.

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

ALABAMA MEDICAID AGENCY

Signature: _____

Printed Name: Clay Gaddis

Title: Privacy Officer

Date: _____

BUSINESS ASSOCIATE

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Attachment B

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

CONTRACT REVIEW REPORT

(Separate review report required for each contract)

Name of State Agency: Alabama Medicaid Agency

Name of Contractor: _____

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

* Is Contractor organized as an Alabama Entity in Alabama? YES_____NO_____
* If not, has it qualified with the Alabama Secretary of State to do business in Alabama? YES_____ NO_____

Is Act 2001-955 Disclosure Form Included with this Contract? YES __X__ NO _____
Does Contractor have current member of Legislature or family member of Legislator employed? YES_____NO_____
Was a lobbyist/consultant used to secure this contract OR affiliated with this contractor? YES_____ NO_____
If Yes, Give Name: _____

Contract Number: _____

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

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

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

Date Contract Effective: _____ Date Contract Ends: _____

Type of Contract: NEW: _____ RENEWAL: _____ AMENDMENT:_____

If renewal, was it originally Bid? Yes _____ No _____

If AMENDMENT, Complete A through C:

(A) Original contract total $ _____

(B) Amended total prior to this amendment $ _____

(C) Amended total after this amendment $ _____

Was Contract secured through Bid Process? Yes ____ No ____ Was lowest Bid accepted? Yes ___ No____
Was Contract secured through RFP Process? Yes ____ No ___ **Date RFP was awarded** _____
Posted to Statewide RFP Database at http://rfp.alabama.gov/Login.aspx YES _____ No_____
If no, please give a brief explanation:

Summary of Contract Services to be Provided: _____

_____

_____

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

_____

_____

I certify that the above information is correct.

_____ _____
Signature of Agency Head Signature of Contractor

_____ _____
Printed Name Printed Name

Agency Contact: Stephanie Lindsay Phone: (334) 242-5833
Revised: 2/20/2013

Attachment C

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

Attachment D

State of Alabama
Disclosure Statement

(Required by Act 2001-955)

ENTITY COMPLETING FORM

ADDRESS

CITY, STATE, ZIP TELEPHONE NUMBER

(____)_____

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

Alabama Medicaid Agency

ADDRESS

501 Dexter Avenue, Post Office Box 5624 CITY,

STATE, ZIP 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	ADDRESS	STATE DEPARTMENT/AGENCY

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

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

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

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

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

NAME OF PAID CONSULTANT/LOBBYIST	ADDRESS

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

Signature Date

Notary's Signature Date Date Notary Expires

Act 2001-955 requires the disclosure statement to be completed and filed with all proposals, bids, contracts, or grant proposals to the State of Alabama in excess of $5,000.

Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624
www.medicaid.alabama.gov
e-mail: almedicaid@medicaid.alabama.gov

ROBERT BENTLEY
Governor

Telecommunication for the Deaf: 1-800-253-0799
334-242-5000 1-800-362-1504

STEPHANIE MCGEE AZAR
Acting Commissioner

MEMORANDUM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

State of _____)

County of _____)

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

DATE:_____

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

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

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

2. Using the following definitions from Section 3 of the Act, select and initial either (a) or (b), below, to describe the Contractor/Grantee's business structure.
   BUSINESS ENTITY. Any person or group of persons employing one or more persons performing or engaging in any activity, enterprise, profession, or occupation for gain, benefit, advantage, or livelihood, whether for profit or not for profit. "Business entity" shall include, but not be limited to the following:
   a. Self-employed individuals, business entities filing articles of incorporation, partnerships, limited partnerships, limited liability companies, foreign corporations, foreign limited partnerships, foreign limited liability companies authorized to transact business in this state, business trusts, and any business entity that registers with the Secretary of State.
   b. Any business entity that possesses a business license, permit, certificate, approval, registration, charter, or similar form of authorization issued by the state, any business entity that is exempt by law from obtaining such a business license, and any business entity that is operating unlawfully without a business license.

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

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

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

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

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

Certified this _____ day of _____ 20____. _____

Name of Contractor/Grantee/Recipient

By: _____

Its _____

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

WITNESS: _____

_____
Print Name of Witness