



# ALABAMA MEDICAID AGENCY REQUEST FOR PROPOSALS

<b>RFP Number: 2017-Dental-01</b>	<b>RFP Title: Dental Benefit Program Manager Request for Proposal</b>	
<b>RFP Due Date and Time: August 31, 2017 by 5:00 pm Central Time</b>		<b>Number of Pages: 153</b>
<b>PROCUREMENT INFORMATION</b>		
<b>Project Director: Beth Huckabee</b>		<b>Issue Date: July 26, 2017</b>
<b>E-mail Address:</b> <a href="mailto:DBMRFP@medicaid.alabama.gov">DBMRFP@medicaid.alabama.gov</a> <b>Website:</b> <a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a>		<b>Issuing Division: Medical Services Division</b>
<b>INSTRUCTIONS TO CONTRACTORS</b>		
<b>Return Proposal to:</b>  Alabama Medicaid Agency Lurleen B. Wallace Building 501 Dexter Avenue PO Box 5624 Montgomery, AL 36103-5624		<b>Mark Face of Envelope/Package:</b> <b>RFP Number: 2017-Dental-01</b> <b>RFP Due Date: August 31, 2017 by 5:00 pm Central Time</b> <b>Price from Appendix C:</b>
<b>CONTRACTOR INFORMATION</b> <i>(Contractor must complete the following and return with RFP response)</i>		
<b>Contractor Name/Address:</b>	<b>Authorized Contractor Signatory: (Please print name and sign in ink)</b>	
<b>Contractor Phone Number:</b>	<b>Contractor FAX Number:</b>	
<b>Contractor Federal I.D. Number:</b>	<b>Contractor E-mail Address:</b>	

## Section A. RFP Checklist

1. \_\_\_\_ **Read the *entire* document.** Note critical items such as: mandatory requirements; supplies/services required; submittal dates; number of copies required for submittal; licensing requirements; contract requirements (i.e., contract performance security, insurance requirements, performance and/or reporting requirements, etc.).
2. \_\_\_\_ **Note the project director's name, address, phone numbers and e-mail address.** This is the only person you are allowed to communicate with regarding the RFP and is an excellent source of information for any questions you may have.
3. \_\_\_\_ **Take advantage of the "question and answer" period.** Submit your questions to the project director by the due date(s) listed in the Schedule of Events and view the answers as posted on the WEB. All addenda issued for an RFP are posted on the State's website and will include all questions asked and answered concerning the RFP.
4. \_\_\_\_ **Use the forms provided,** i.e., cover page, disclosure statement, etc.
5. \_\_\_\_ **Check the State's website for RFP addenda.** It is the Contractor's responsibility to check the State's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) for any addenda issued for this RFP, no further notification will be provided. Contractors 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 Contractor'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 Contractor's Response.**

## Section B. Schedule of Events

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

<b>EVENT</b>	<b>DATE</b>
RFP Issued	7/26/2017
Round 1 Questions Due by 5 pm CT	7/31/2017
Posting of Round 1 Questions and Answers	8/8/2017
Mandatory Contractor Conference (Pre-registration required. Complete registration form (Appendix H) and return via email to the Project Director by 5 pm CT on August 7, 2017.	8/9/2017
Posting of Mandatory Contractor's Conference Questions and Answers	8/15/2017
Round 2 Questions Due by 5 pm CT	8/18/2017
Posting of Round 2 Questions and Answers	8/24/2017
Proposals Due by 5 pm CT	8/31/2017
Evaluation Period	9/12/2017 – 9/22/2017
Contract Award Notification	TBD
**Contract Review Committee	12/7/2017
Official Contract Award	1/1/2018**

\*\*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 "Contractor 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

<b>Section A. RFP Checklist</b>	<b>2</b>
<b>Section B. Schedule of Events</b>	<b>3</b>
<b>I. Introduction</b>	<b>8</b>
A. Background	8
B. Purpose	9
<b>II. Scope of Work</b>	<b>9</b>
A. General DBM Requirements	9
B. General Program Requirements	10
C. Operation Requirements	14
D. Enrollee Services	27
E. Key Personnel	42
F. Reporting	45
G. Technology Requirements	52
H. Contractor Payments	59
I. Medicaid Responsibilities	60
J. Sanctions	62
K. Fraud and Abuse	65
L. Grievances and Appeals	73
M. Quality Assessment and Performance	89
N. Utilization Management	97
<b>III. Pricing</b>	<b>107</b>
<b>IV. General Medicaid Information</b>	<b>107</b>
<b>V. General</b>	<b>108</b>
<b>VI. Corporate Background and References</b>	<b>109</b>
<b>VII. Submission Requirements</b>	<b>111</b>
A. Authority	111
B. Single Point of Contact	111
C. RFP Documentation	111
D. Questions Regarding the RFP	111
E. Mandatory Contractor Conference	112

F.	Acceptance of Standard Terms and Conditions _____	112
G.	Adherence to Specifications and Requirements _____	112
H.	Order of Precedence _____	112
I.	Contractor’s Signature _____	112
J.	Offer in Effect for 365 Days _____	113
K.	Medicaid Not Responsible for Preparation Costs _____	113
L.	Medicaid’s Rights Reserved _____	113
M.	Price _____	113
N.	Submission of Proposals _____	113
O.	Copies Required _____	114
P.	Late Proposals _____	114
Q.	Proposal Format _____	114
R.	Proposal Withdrawal _____	114
S.	Proposal Amendment _____	115
T.	Proposal Errors _____	115
U.	Proposal Clarifications _____	115
V.	Disclosure of Proposal Contents _____	115
VIII.	Evaluation and Selection Process _____	115
A.	Initial Classification of Proposals as Responsive or Non-responsive _____	115
B.	Determination of Responsibility _____	116
C.	Opportunity for Additional Information _____	116
D.	Evaluation Committee _____	116
E.	Scoring _____	116
F.	Determination of Successful Proposal _____	116
IX.	General Terms and Conditions _____	117
A.	General _____	117
B.	Compliance with State and Federal Regulations _____	117
C.	Term of Contract _____	117
D.	Contract Amendments _____	118
E.	Confidentiality _____	118
F.	Security and Release of Information _____	118
G.	Federal Nondisclosure Requirements _____	119

<b>H.</b>	<b>Contract a Public Record</b>	<b>119</b>
<b>I.</b>	<b>Termination for Bankruptcy</b>	<b>119</b>
<b>J.</b>	<b>Termination for Default</b>	<b>119</b>
<b>K.</b>	<b>Termination for Unavailability of Funds</b>	<b>120</b>
<b>L.</b>	<b>Proration of Funds</b>	<b>120</b>
<b>M.</b>	<b>Termination for Convenience</b>	<b>120</b>
<b>N.</b>	<b>Force Majeure</b>	<b>120</b>
<b>O.</b>	<b>Nondiscriminatory Compliance</b>	<b>120</b>
<b>P.</b>	<b>Conflict of Interest</b>	<b>120</b>
<b>Q.</b>	<b>Open Trade</b>	<b>121</b>
<b>R.</b>	<b>Small and Minority Business Enterprise Utilization</b>	<b>121</b>
<b>S.</b>	<b>Worker’s Compensation</b>	<b>121</b>
<b>T.</b>	<b>Employment of State Staff</b>	<b>121</b>
<b>U.</b>	<b>Immigration Compliance</b>	<b>121</b>
<b>V.</b>	<b>Share of Contract</b>	<b>122</b>
<b>W.</b>	<b>Waivers</b>	<b>122</b>
<b>X.</b>	<b>Warranties Against Broker’s Fees</b>	<b>122</b>
<b>Y.</b>	<b>Novation</b>	<b>122</b>
<b>Z.</b>	<b>Employment Basis</b>	<b>122</b>
<b>AA.</b>	<b>Disputes and Litigation</b>	<b>122</b>
<b>BB.</b>	<b>Records Retention and Storage</b>	<b>123</b>
<b>CC.</b>	<b>Inspection of Records</b>	<b>123</b>
<b>DD.</b>	<b>Use of Federal Cost Principles</b>	<b>123</b>
<b>EE.</b>	<b>Payment</b>	<b>124</b>
<b>FF.</b>	<b>Notice to Parties</b>	<b>124</b>
<b>GG.</b>	<b>Disclosure Statement</b>	<b>124</b>
<b>HH.</b>	<b>Debarment</b>	<b>124</b>
<b>II.</b>	<b>Not to Constitute a Debt of the State</b>	<b>124</b>
<b>JJ.</b>	<b>Qualification to do Business in Alabama</b>	<b>124</b>
<b>KK.</b>	<b>Choice of Law</b>	<b>124</b>
<b>LL.</b>	<b>Alabama interChange Interface Standards</b>	<b>125</b>
<b>Appendix A:</b>	<b>Proposal Compliance Checklist</b>	<b>126</b>

<b>Appendix B: Contract and Attachments</b>	<b>127</b>
<b>Appendix C: Pricing Form</b>	<b>142</b>
<b>Appendix D: Year One DBM Quality Measures Approved by Alabama Medicaid Agency</b>	<b>143</b>
<b>Appendix E: Quality Withhold Program: CY 2019 Incentive Measures</b>	<b>145</b>
<b>Appendix F: Performance Improvement Projects</b>	<b>146</b>
<b>Appendix G: Scope of Work (Scored Items)</b>	<b>148</b>
<b>Appendix H: Mandatory Contractor Conference Notification</b>	<b>153</b>

# I. Introduction

## A. Background

The Alabama Medicaid Agency, hereinafter called Medicaid, an Agency of the State of Alabama, is executing a system transformation that includes the establishment of a managed care system, comprised of Regional Care Organizations (RCOs) in five geographic regions throughout the state that will deliver health care to two-thirds of the state's Medicaid recipients. These newly created entities will contract with providers, assume risk, and be paid on a capitated basis to provide the full range of Medicaid services for enrollees. The transformation is scheduled to be phased in beginning October 2017. Intended outcomes of the transformation include addressing fragmentation in the state's Medicaid delivery system, improvement of beneficiary outcomes, supporting quality of care and improved access to healthcare providers. Medicaid is also in the process of transforming its long-term care system to establish a managed care system. It is expected that no more than two Integrated Care Networks (ICN) will operate state-wide. The ICN is expected to be implemented by October 1, 2018.

During this transition, Medicaid is soliciting proposals for a Dental Benefits Manager (DBM) that will provide a risk-bearing, Prepaid Ambulatory Health Plan (PAHP) healthcare delivery system responsible for implementing and executing specified Medicaid dental benefits and services for eligible Alabama Medicaid enrollees as specified in Section B of this RFP. The term "Contract" used hereinafter refers to any contracted relationship between Medicaid and a Contractor to perform the requirements mentioned in this RFP.

The Alabama Medicaid Dental Program currently pays for routine dental care for children under the age of 21 as long as the child is eligible for full Medicaid. Most children are no longer eligible for routine dental care after their 19<sup>th</sup> birthday unless they are eligible under another eligibility category. Dental services are required to be provided by licensed dentist enrolled as Medicaid dental providers. Adults age 21 and older are not eligible for dental coverage through Medicaid.

Routine procedures involving the teeth covered by Medicaid include:

- A dental checkup every six months
- A dental cleaning every six months
- Crowns and buildups
- Extractions
- Fillings
- Fluoride treatments
- Space maintainers
- Periodontal scaling and root planning
- Sealants
- Root Canals
- X-rays

Medicaid does not cover the following services:

- Routine orthodontic care, e.g., braces
- Routine partials, dentures or bridgework
- All-porcelain crowns
- Periodontal or gum surgery

Dental benefits are not provided for:

- Any female covered only for family planning services under the Plan First Program.



- Any recipient with partial Medicaid coverage

In 2016, Medicaid had 713,587 eligibles under the age of 21 that were enrolled at least one month of the fiscal year with full coverage, of which 328,858 received dental services under this program. The monthly average number of unduplicated eligibles was 580,750. Historical PMPM cost for Fee-for-service dental services is \$13.50-\$14.00.

## **B. Purpose**

This RFP will provide Medicaid with a DBM, hereinafter called Contractor, which will identify savings for Medicaid while ensuring and improving the quality of care, including, but not limited to the following:

1. Improved coordination of care;
2. Better dental health outcomes;
3. Increased quality of dental care;
4. Improved access to routine and essential specialty dental services;
5. Outreach and education to promote dental health;
6. Increased personal responsibility and self-management;
7. A more financially sustainable system; and
8. Net savings to Medicaid compared to the existing Alabama Medicaid Dental Program.

## **II. Scope of Work**

**AS PART OF THE PROPOSAL, CONTRACTORS MUST ACKNOWLEDGE AND COMPLY WITH ALL REQUIREMENTS LISTED IN THE RFP.**

**AS PART OF THE PROPOSAL, CONTRACTORS MUST PROVIDE DETAILED DESCRIPTIONS OF ALL REQUIREMENTS LISTED IN APPENDIX G – SCOPE OF WORK (SCORED ITEMS).**

### **A. General DBM Requirements**

- A.1 Meet federal definition of a PAHP, as defined in 42 CFR §438.2;
- A.2 Meet solvency standards as specified in 42 CFR §438.116;
- A.3 Develop a provider network with the capacity to enroll a minimum of 700,000 Medicaid members into the network;
- A.4 Comply with an approved 1915(b) waiver that governs this PAHP;
- A.5 Successfully complete the Medicaid's Readiness Review prior to the start of operations;
- A.6 Maintain normal business hours of 8:00 a.m. to 5:00 p.m. CT Monday through Friday;
- A.7 Comply with all current state and federal statutes, regulations, and administrative procedures that are or become effective during the term of this Contract. Federal

regulations governing contracts with PAHPs are specified in 42 CFR Part §438 and will govern this Contract. Medicaid is not precluded from implementing any changes in state or federal statutes, rules or administrative procedures that become effective during the term of this Contract and will implement such changes;

- A.8 Have at least five (5) years of experience providing dental services to state Medicaid programs as a PAHP or dental managed care company;
- A.9 Must coordinate and cooperate with the Alabama Medicaid Regional Care Organizations as applicable to ensure coordination of care and services for enrollees.
- A.10 Must submit a written statement stating the Contractor acknowledges and will comply with the requirements set forth in the entire RFP. See also Appendix G.

## **B. General Program Requirements**

### **B.1 Populations**

#### **B.1.1 Mandatory Population**

Serve Medicaid recipients under the age of 21 who are also eligible for full Medicaid.

#### **B.1.2 Excluded Population**

Populations excluded from coverage under this RFP are:

- B.1.2.1 Recipients certified for full Medicaid coverage through Alabama Department of Human Resources;
- B.1.2.2 Recipients certified for full Medicaid coverage through Alabama Department of Youth Services;
- B.1.2.3 Eligibles 21 years of age and over;
- B.1.2.4 Tribal group(s) not opting for coverage under the DBM program;
- B.1.2.5 Eligibles that have Medicare as primary payee and Medicaid as secondary payee (dual eligibles); and
- B.1.2.6 Pregnant women under 21 with full Medicaid coverage.

### **B.2 Primary Dental Provider**

- B.2.1 The Contractor must offer each enrollee a choice of primary dental providers (PDPs). Members who do not make a choice within twenty (20) calendar days from the date of enrollment, must be auto-assigned a PDP.
- B.2.2 When making PDP assignments, the Contractor must take into consideration the enrollee's last PDP (if the PDP is known and available in the Contractor's

network), closest PDP to the enrollee's address, keeping children/adolescents within the same family together, and age.

B.2.3 The Contractor must permit enrollees to request to change PDPs at any time. If the enrollee request is not received by the Contractor's established monthly cut-off date for system processing, the PDP change will be effective the first (1st) day of the next month.

B.2.4 The Contractor must assign all enrollees who are reinstated after a temporary loss of eligibility to the PDP who was treating them prior to loss of eligibility, unless the enrollee specifically requests another PDP, the PDP no longer participates with the Contractor or is at capacity, or the enrollee has changed geographic areas.

### B.3 Core Dental Benefits and Services

The Contractor must provide to members, at a minimum, the dental services outlined in the Alabama Administrative Code, the Alabama State Plan, and the Alabama Provider Billing Manual, which include but are not limited to the following services:

B.3.1 Diagnostic Services which include oral examinations, radiographs and oral/facial images, and diagnostic casts;

B.3.2 Preventive Services which include prophylaxis, topical fluoride treatments, sealants, fixed space maintainers and re-cementation of space maintainers;

B.3.3 Restorative Services which include amalgam restorations, composite restorations, stainless steel crowns; prefabricated resin crowns; pins, core build-ups, pre-fabricated posts and cores, fillings, resin-based composite restorations, and other restorative procedures;

B.3.4 Endodontic Services which include pulp capping, pulpotomy, endodontic therapy on primary and permanent teeth (including treatment plan, clinical procedures and follow-up care), and apexification;

B.3.5 Periodontal Services which include, periodontal scaling and root planning, full mouth debridement, and periodontal maintenance procedures;

B.3.6 Prosthodontics services which includes partial dentures, removable partial denture; pontic, and retainer crown;

B.3.7 Oral and Maxillofacial Surgery services which include non-surgical extractions, surgical extractions, coronal remnants extractions, alveoloplasty, surgical incision, removal of tumors, cysts, and neoplasms; treatment of fractures, reduction of dislocation; and other specified repair procedures;

B.3.8 All full benefit eligible Medicaid Enrollees under age twenty-one (21) may receive EPSDT benefit/services in accordance with Sections 1905(a) and 1905(r) of the Social Security Act. Included are services identified as a result of a comprehensive screening visit or an inter-periodic screening, regardless of

whether or not they are ordinarily covered for all other Enrollees. Additionally, all services the Contractor is responsible for under the Alabama Medicaid program which are necessary to correct or ameliorate a physical or mental illness or condition are included. Claims for normally non-covered services that are provided as a result of an EPSDT service that are not specified as Covered Services under this RFP must be paid FFS and not included in the capitation rate.

B.3.8.1 Services exempted from this contract are:

B.3.8.1.1 Orthodontia services provided by Alabama Department of Rehabilitation (Children's Rehabilitation Service);

B.3.8.1.2 Dental services to recipients 21 years and older;

B.3.8.1.3 Hospital/outpatient facility fee and CPT anesthesia codes when dental services are performed in a hospital/outpatient setting (place of service 22);

B.3.8.1.4 Services covered by the Alabama Medicaid Regional Care Organizations; and

B.3.8.1.5 Services performed that are non-covered but are determined medically necessary by Medicaid as a result of an EPSDT screening.

If new dental services are added to the Medicaid Program, or if services are expanded, eliminated, or otherwise changed, Medicaid will make every effort to give the Contractor sixty (60) days advance notice of the change. However, the Contractor must add, delete, or change any service as may be deemed necessary by Medicaid within the timeframe required by Medicaid if mandated by federal or state legislation, federal or state regulations, or court order.

- o Providers must verify eligibility of these patients at every visit.

#### B.4 Expanded Services

B.4.1 As permitted under 42 CFR §438.3(e), the Contractor may offer expanded services and benefits to enrollees in addition to those core dental benefits and services specified in this RFP.

B.4.2 These expanded services may include dental care services which are currently non-covered services by the Medicaid State Plan and/or which are in excess of the amount, duration, and scope in the Medicaid State Plan.

B.4.3 These services/benefits must be specifically defined by the Contractor in regard to amount, duration and scope. Medicaid will not provide any additional reimbursement for these services/benefits. The Contractor must not seek reimbursement for these services from the enrollees. The expanded services offered by the Contractor will not be taken into consideration when setting the capitation rates.

B.4.4 The Contractor must provide Medicaid a description of the expanded services/benefits to be offered by the Contractor for approval during the Readiness Assessment Review. Additions or modifications to expanded services/benefits made during the contract period must be submitted to Medicaid, for approval.

## B.5 Emergency Services

B.5.1 The Contractor must provide emergency dental services in an office setting to eligible members for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structures, jaws, and tissue of the oral cavity. The Contractor:

- B.5.1.1 Must not require prior authorization for emergency dental services and care;
- B.5.1.2 Must not indicate that emergencies are covered only if care is secured within a certain period of time;
- B.5.1.3 Must not use terms such as “life threatening” or “bona fide” to qualify the kind of emergency that is covered;
- B.5.1.4 Must not deny payment based on the member’s failure to notify the Contractor in advance or within a certain period of time after the care is given;
- B.5.1.5 Must cover Emergency Services regardless of whether the Provider that furnishes the services is in the Contractor’s Provider Network;
- B.5.1.6 Must pay Non-Participating Providers for Emergency Services no more than the amount that would have been paid if the service had been provided under the Medicaid Fee-for-Service program;
- B.5.1.7 Must not deny payment for treatment obtained when an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR § 438.114(a) of the definition of Emergency Medical Condition;
- B.5.1.8 Must not deny payment for treatment obtained when a representative of the Contractor instructs the Enrollee to seek Emergency Services;
- B.5.1.9 Must not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

## B.6 Prohibited Services:

The Contractor is prohibited from providing:

- B.6.1.1 Experimental procedures
- B.6.1.2 Elective cosmetic surgery or services

## C. Operation Requirements

### C.1 Third Party Liability

- C.1.1 The Contractor must comply with Section 1902(a)(25) of the Social Security Act, 42 USC § 1396a(a)(25) and any third party liability (TPL) procedures implemented by Medicaid. Medicaid will identify TPL insurance coverage and submit this information monthly and provide daily updates to the Contractor's third party administrator (TPA). Under this RFP, TPL recovery responsibilities must be retained by Medicaid.
- C.1.2 The Contractor must not deny or delay approval of otherwise covered treatment or services based upon TPL considerations. The Contractor may neither unreasonably delay payment nor deny payment of Claims unless the probable existence of TPL is established at the time the Claim is adjudicated.

### C.2 Cost Avoidance Activities

- C.2.1 The Contractor must have primary responsibility for cost avoidance through the coordination of benefits (COB) relative to Federal and private health insurance-type resources including, but not limited to, private health insurance, ERISA plans and workers compensation. Except as provided in Section 1902(a)(25) of the Social Security Act, the Contractor must attempt to legally avoid initial payment of Claims, whenever possible, where Federal or private health insurance-type resources are available. All payments that are cost avoided by the Contractor must be reported to Medicaid via encounter data submissions. The use of the appropriate HIPAA 837 Loop(s) for Medicare and other insurance paid (OIP) must indicate that TPL has been pursued and the amount which has been cost-avoided.

### C.3 Mandatory Pay and Chase

- C.3.1 The Contractor must comply with state and federal mandatory "pay and chase" requirements. Section 1902(a)(25)(E) and (F) of the Social Security Act require states to pay and later seek reimbursement from liable third parties: (1) for Prenatal and preventive pediatric care, and (2) in the context of a state child support enforcement action. The Contractor must allow for the payment of mandatory pay and chase services regardless of the existence of other insurance. Medicaid will retain the responsibility to seek reimbursement for these services from the other insurance.

### C.4 Copayments

- C.4.1 Any cost sharing imposed on Medicaid members must be in accordance with 42 CFR §§447.50 through 447.57 and cannot exceed cost sharing amounts in the Medicaid State Plan. Alabama currently has no cost sharing requirements for any

of Contractor's core dental benefits and services. Medicaid reserves the right to amend cost sharing requirements.

#### C.5 Provider Network

- C.5.1 In all agreements with Providers, the Contractor must comply with the requirements specified in 42 CFR § 438.214.
- C.5.2 The Contractor must ensure that all Providers are eligible for participation in the Medicaid program. If a Provider was involuntarily terminated from the Medicaid program, other than for purposes of inactivity, that Provider is not considered an eligible Medicaid Provider.
- C.5.3 The Contractor must not employ or contract with Providers excluded from participation in any Federal and/or State health care programs under either Sections 1128 or 1128A of the Social Security Act or any other exclusion authority. In accordance with this RFP, the Contractor must verify at the initial agreement and on a monthly basis that all Participating Providers are not excluded from participation in any Federal and/or State health care programs.
- C.5.4 No Provider agreement which the Contractor enters into with respect to performance under this Contract must in any way relieve the Contractor of any responsibility for the provision of services and duties under this RFP. The Contractor must assure that all services and tasks related to the Provider agreements are performed in accordance with the terms of this Contract. The Contractor must identify in its Provider agreements any aspect of service that may be subcontracted by the Provider.
- C.5.5 The Contractor and its Participating Providers must establish and implement procedures consistent with confidentiality requirements in accordance with this RFP.
- C.5.6 All Provider agreements and amendments must use the template provided by Medicaid and be approved in writing during the Contractor's readiness assessment period or thereafter. Provider agreements do not need to be submitted to Medicaid for review in advance and/or written approval unless the agreement is specifically requested by Medicaid. All Provider agreements and amendments that deviate from the approved template must be submitted to Medicaid for review in advance for written approval with the provision(s) that deviate from the approved template in a format requested by Medicaid.
- C.5.7 If the Contractor declines to include an individual or group of Providers in its Provider Network, the Contractor must give the affected Providers written notice of the reason for its decision within 14 business days.
- C.5.8 The Contractor must provide Medicaid notification when the Contractor receives information about a change in a Participating Provider's circumstances that may affect the Provider's eligibility to participate in the DBM Program, including the termination of the Provider agreement with the Contractor.

- C.5.9 All Participating Providers must be screened by and enrolled with Medicaid for participation in the Medicaid program. Subject to Section II.C.9 of this RFP, the Contractor may execute Provider agreements with potential Providers pending the outcome of screening enrollment, and revalidation, of up to one hundred twenty (120) calendar days.

## C.6 Network Adequacy

The Contractor must provide assurances of their capability to meet and maintain the Network Adequacy standards within the RFP response. Letters of Intent (LOIs) and provider contracts will not be submitted with the RFP response. The selected Contractor will be required to submit Letters of Intent and contracts with providers during the period immediately following the announcement of the selected Contractor. The selected Contractor will be required to submit LOIs of their proposed network to Medicaid for its evaluation of its Network Adequacy within 30 days of receiving the intent to award.

- C.6.1 The Contractor must maintain a network of appropriate Participating Providers that:
- C.6.1.1 Considers anticipated Medicaid enrollment in its service area in accordance with the State's standards for access to care for all Enrollees, including those with limited English proficiency or physical or mental disabilities;
  - C.6.1.2 Considers expected utilization of services, taking into account the characteristics and oral health care needs of specific Enrollees enrolled with the Contractor;
  - C.6.1.3 Considers numbers and types of Providers required to furnish Covered Services;
  - C.6.1.4 Considers number of network Providers who are not accepting new Enrollees;
  - C.6.1.5 Considers geographic location of Providers and Enrollees;
  - C.6.1.6 Is supported by written Provider agreements;
  - C.6.1.7 Is sufficient to provide eligible Indian Enrollees timely access to Covered Services under this Contract from an Indian Health Care Provider (IHCP);
  - C.6.1.8 Is sufficient to provide the delivery of services in a culturally competent manner to all Enrollees in accordance with 42 CFR § 438.206(c)(2); and
  - C.6.1.9 Meets the requirements of 42 CFR § 438.68 and 42 CFR § 438.206, Alabama Medicaid Administrative Code and other applicable laws



and regulations.

- C.6.2 The Contractor may contract with any willing provider to provide Covered Services in the Region if the Provider is willing to accept the payments and terms offered comparable Providers. All Providers must meet licensing requirements set by law, must have a Medicaid provider number, and must not otherwise be disqualified from participating in Medicare or Medicaid.
- C.6.3 Access and Availability. The Contractor must meet, and require its Participating Providers to meet, the following standards for timely access to care and services, taking into consideration the urgency of the need for such services:
  - C.6.3.1 The Contractor must require its Participating Providers to offer hours of operation that are no less than the hours of operation offered to commercial enrollees or hours of operation that are comparable to Medicaid Fee-for-Service, if the Provider serves only Medicaid Recipients.
  - C.6.3.2 Appointment Availability – For Dental Care
    - C.6.3.2.1 Urgent Care: Within twenty-four (24) hours of presentation or request
    - C.6.3.2.2 Routine Dental Care – PDP: Within thirty (30) calendar days of presentation or notification excluding legal holidays
    - C.6.3.2.3 Routine Dental Care – Core Specialist: Within forty-five (45) calendar days of presentation or notification excluding legal holidays
  - C.6.3.3 Office Wait Times
    - C.6.3.3.1 Walk-In: Within two (2) hours, or schedule an appointment within the standards of appointment availability
    - C.6.3.3.2 Previously Scheduled Appointment: Within one hour of appointment
  - C.6.3.4 Access for Enrollees with Disabilities
    - C.6.3.4.1 The Contractor must, and must require its Providers or Subcontractors, to comply with the requirements of the Americans with Disabilities Act (ADA). In providing oral health care benefits, the Contractor must not directly or indirectly, through contractual, licensing or other arrangements, discriminate against Enrollees who are qualified disabled individuals covered by the provisions of the ADA.

- C.6.4 The Contractor must develop, implement and maintain policies and procedures and monitoring protocols for Medicaid's approval to:
  - C.6.4.1 Meet and require its Participating Providers to comply with the timely access to care and services requirements under this Contract;
  - C.6.4.2 Monitor Participating Providers regularly to determine compliance with this Contract; and
  - C.6.4.3 Take corrective action if there is a failure to comply with this Contract.

## C.7 Required Providers

- C.7.1 The Contractor must develop, implement and maintain policies and procedures and monitoring protocols for Medicaid's approval to enroll:
  - C.7.1.1 Primary Dental Providers:
    - C.7.1.1.1 Dentist
    - C.7.1.1.2 Pediatric Dentist
    - C.7.1.1.3 Federally Qualified Health Center (FQHC)
    - C.7.1.1.4 Rural Health Clinic (RHC)
- C.7.2 Core Specialists:
  - C.7.2.1 Maxillofacial or Oral Surgeon
- C.7.3 Non-Core Specialists: those Providers not listed in Section II.C.9.2 of this Contract, in adequate numbers needed to appropriately service the Contractor's Enrollees and provide care delivery for all of the services and benefits covered under this Contract.

## C.8 Geographic Access Standards

- C.8.1 The Contractor must comply with geographic access standards set by Medicaid and described in this RFP.
- C.8.2 The Contractor must maintain a Provider Network that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Enrollees in the Region. The minimum network criteria are as follows (next page):

Provider Type	Minimum Number	Distance	Minimum Utilization
Primary Dental Providers (PDPs)	1.5 per 1,000 Enrollees, with a minimum of two	50 mile radius from each Enrollee's residence, with a minimum of two	120 Medicaid encounters per year
Core Specialists (for each of the types identified in Subsection C.7.2 of this RFP)	0.2 per 1,000 Enrollees	100 mile radius from each Enrollee's residence	Minimum of 1 Medicaid encounter per year

C.8.3 If the Contractor is unable to enroll a sufficient number of Providers located within an area to meet the geographic access standards, or is unable to enroll a sufficient number of Providers within a Provider type or specialty, the Contractor may request an exception from the geographic access requirements. Medicaid has the sole discretion to allow for any exception to the geographic access requirements and may request any supporting information from Contractor.

C.8.4 If the Contractor cannot demonstrate sufficient Provider capacity through its geographic access reporting and other network reporting, Medicaid may impose corrective actions to assure Enrollees have appropriate access to services.

C.8.5 Medicaid, in its sole discretion, may grant the Contractor an exception of any Provider-specific network standard.

C.8.5.1 The Contractor may request for an exception to a Provider-specific network standard which must be in writing and include, at a minimum:

C.8.5.1.1 Description of the current Provider-specific network standard;

C.8.5.1.2 The exception the Contractor is requesting;

C.8.5.1.3 Steps taken by the Contractor to comply with requirement before requesting the exception;

C.8.5.1.4 Description of the Contractor's plan to become compliant with the Provider-specific network standard by the expiration of the exception, if granted; and

C.8.5.1.5 Description of the Contractor's plan to adequately provide Covered Services if exception is granted.

- C.8.6 In addition to the information provided by the Contractor and other relevant factors, Medicaid shall, at a minimum, take into consideration the number of Providers in the specialty practicing in the Contractor's Region in evaluating a request from an exception from a Provider-specific network standard.
- C.8.7 If Medicaid grants an exception, the Contractor must submit quarterly reports to Medicaid detailing Enrollee access to the Provider type subject to the exception.
- C.8.8 Any exception issued in accordance with this subsection will expire after one year, which may be renewed upon the Contractor's request and in Medicaid's sole discretion.
- C.8.9 An exception may be revoked earlier if Medicaid determines, in its sole discretion, that the continuance of the exception is to the detriment of the Enrollees or the circumstances at the time the exception was granted materially change.

#### C.9 Out-of-Network Services

- C.9.1 If the Contractor's Provider Network is unable to provide Covered Services to a particular Enrollee, the Contractor must adequately and timely cover these services out-of-network for the Enrollee, for as long as the Contractor is unable to provide them through its existing Provider Network.
- C.9.2 The Contractor must coordinate with non-Participating Providers with respect to payment. The Contractor must ensure that the cost to the Enrollee is no greater than it would be if the services were furnished within the Provider Network.
- C.9.3 The Contractor must allow Indian Enrollees to obtain Covered Services from Out of Network IHCPs from whom the Enrollee is otherwise eligible to receive such services.

#### C.10 Provider Network Reporting and Monitoring

- C.10.1 The Contractor must submit documentation to Medicaid, in a format specified by Medicaid, to demonstrate that it complies with the following requirements:
  - C.10.1.1 Offers an appropriate range of preventive, and specialty services that is adequate for the anticipated number of Enrollees for the Region; and
  - C.10.1.2 Maintains a network of Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees in the Region.
- C.10.2 The Contractor must submit the documentation as specified by Medicaid, but no less frequently than the following:
  - C.10.2.1 At the time it enters into this Contract;

- C.10.2.2 On an annual basis; and
- C.10.2.3 At any time there has been a significant change in the Contractor's operations that would affect the adequacy of capacity and services, including:
  - C.10.2.3.1 Changes in the Contractor's services, benefits, geographic service area, composition of or payments to its Provider Network; or
  - C.10.2.3.2 Enrollment of a new population in the Contractor.

#### C.11 Out-of-State Providers

C.11.1 Dental care and services provided outside the State of Alabama for Enrollees are Covered Services if and only if such services are covered when rendered in-state and are Medically Necessary. Out-of-State Providers must follow the enrollment procedures of Medicaid. Providers bordering Alabama, within thirty (30) miles of the Alabama state line, may be included within the Contractor's Provider Network. All other out-of-State Providers should be enrolled only for the treatment of emergent care or for services not otherwise available in-State. The Contractor is not obligated to pay Out-of-State Providers any more than the amount that would have been paid if the service had been provided under the Medicaid Fee-For-Service Program. Medicaid shall not be responsible for any amounts due or paid in excess of amounts that would have been paid under the Medicaid Fee-For-Service Program.

#### C.12 Provider Terminations or Losses

C.12.1 If the Contractor experiences a material change to its Provider Network or is affected by other factors which have, in the sole discretion of Medicaid, a significant impact on access in the Network and which may result in transferring a substantial number of Enrollees to other Participating Providers in the Contractor's Provider Network, the Contractor must provide Medicaid with a written work plan acceptable to Medicaid to ensure continuity and coordination of care for the Enrollees at least sixty (60) calendar days prior to the date of such action. Medicaid may also request additional information regarding the Participating Provider terminations or losses, including but not limited to a summary of the issue(s) or reason(s) for the termination or loss and information on negotiation(s) or outreach between the Contractor and Participating Provider.

C.12.1.1 For the purposes of this subsection, the following changes are considered to have a significant impact on access in the Region:

C.12.1.1.1 A loss of PDPs that affects compliance with PDP geographic access standards;

C.12.1.1.2 A loss of all Participating Providers in a specific specialty where another Participating Provider in that specialty is not available within the geographic access

standards;

C.12.1.1.3 Other adverse changes to the composition of the network, which impair or deny the Enrollee's adequate access to care.

C.12.1.2 If the Contractor must terminate a Participating Provider due to circumstances that would compromise Enrollee care, the required notice to Medicaid may be shortened with the prior written approval of Medicaid.

C.12.1.3 If a Participating Provider terminates its Participating Provider agreement with the Contractor or if the Contractor is affected by circumstances beyond the Contractor's control and the Contractor cannot reasonably provide the required sixty (60) calendar days' notice, the required notice to Medicaid may be shortened with the prior written approval of Medicaid.

C.12.1.3.1 Unless a Participating Provider is being terminated for cause, the Contractor must allow an Enrollee to continue, and must continue to pay the Provider for, ongoing care with the Participating Provider for up to sixty (60) calendar days from the date the Enrollee is notified by the Contractor of the termination or pending termination of the Participating Provider, or for up to sixty (60) calendar days from the date of Participating Provider termination, whichever is greater. An Enrollee is considered to be receiving ongoing care from a Participating Provider if an Enrollee was treated two (2) or more times during the previous twelve (12) months by the Participating Provider for a condition that requires follow-up care or additional treatment or the services have been prior authorized

C.12.2 The Contractor must give written notice of termination of a contracted Provider, within fifteen (15) calendar days after receipt or issuance of the termination notice, to each Enrollee who received his or her primary dental care from, or was seen on a regular basis by, the terminated Provider. Affected Enrollees include all Enrollees in a PDP's panel and all Enrollees who have been receiving ongoing care from the terminated Provider.

## C.13 Credentialing

C.13.1 Medicaid or its designee is responsible for credentialing and re-credentialing Medicaid Providers. Medicaid or its designee will provide to the Contractor a monthly file that includes Providers that are fully credentialed by Medicaid and changes to Provider credentialing status. The Contractor is responsible for verifying that all Participating Providers are fully credentialed by Medicaid or its designee prior to any Participating Provider delivering any Covered Services to Enrollees.

C.13.2 The Contractor must develop, implement and maintain written policies and procedures for selection and retention of Providers following Medicaid's policy for credentialing and re-credentialing found in the Alabama Medicaid Administrative Code and the Alabama Medicaid Provider Manual.

C.14 Provider Non-Discrimination

C.14.1 In accordance with 42 CFR § 438.12 and § 438.214, the Contractor may not discriminate with respect to the participation, reimbursement or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable Alabama law solely on the basis of that license or certification.

C.14.2 The Contractor's Provider selection and retention policies and procedures must not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

C.14.3 The Contractor is not precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees, as long as they are approved according to Section II.M.7 of the RFP.

C.15 PDP Panel Size

C.15.1 The Contractor must provide Medicaid with reports on PDP panel size in accordance with the Reporting Manual.

C.16 Payment

C.16.1 The minimum Fee-for-Service reimbursement rates that a Contractor must pay providers for applicable Medicaid services provided to an Enrollee must be the prevailing Medicaid Fee-for-Service payment schedule, unless otherwise jointly agreed to by a Provider and a Contractor through a Provider agreement or mandated by Federal law.

C.16.1.1 Fee-for-Service Payments to FQHCs. The Contractor must negotiate and pay FQHCs at rates no less than what the Contractor pays to other Participating Providers who provide comparable services in the Contractor's Provider Network.

C.16.1.2 Payments to IHCP. In accordance with 42 CFR § 438.14(c), the Contractor must pay IHCP, whether participating in the Provider Network or not, for covered managed care services provided to Indian Enrollees who are eligible to receive services from the IHCP either its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Fee-for-Service methodology.

C.16.1.2.1 An IHCP enrolled in Medicaid as a FQHC but not

as the Contractor's Participating Provider must be paid an amount equal to the amount the Contractor pays to Contractor's FQHC Participating Provider that is not an IHCP, including any supplemental payment from the State to account for difference between amount the Contractor pays and what the IHCP FQHC would have received under FFS.

C.16.2 If the Contractor enters into a capitated arrangement with a participating provider, the Contractor must impose the same detailed encounter data reporting requirements as for those Providers paid by the Contractor on a fee-for-Service basis.

C.16.3 Claims Payment Standards. The Contractor must ensure that Claims are processed and payment systems comply with the Federal requirements set forth in 42 USC § 1396a(a)(37)(A), 42 CFR § 447.45 and 42 CFR § 447.46; and in accordance with Alabama laws and regulations, as applicable. The Contractor must be subject to damages pursuant to such laws and regulations and Sanctions for failure to comply with such Claims payment standards.

C.16.3.1 The Contractor is subject to Sanctions if it does not process (pay or deny) Claims within the following timeframes:

C.16.3.1.1 The Contractor must pay 90 percent (90%) of all Clean Claims from Providers for Covered Services within thirty (30) calendar days following receipt; and

C.16.3.1.2 The Contractor must pay 99 percent (99%) of all Clean Claims from Providers for Covered Services within ninety (90) calendar days following receipt.

C.16.3.2 Claims submitted by Providers under investigation for fraud, waste and/or Abuse are not subject to these timeframes.

C.16.4 The Contractor must require Providers to submit Claims through electronic data interchange (EDI) that allows for automated processing and adjudication of Claims. The Contractor must pay Providers via an electronic funds transfer (EFT) payment process. The Contractor must ensure that the date of receipt is the date the Contractor receives the Claim, as indicated by its date stamp on the Claim, and that the date of payment is the date of the check or other form of payment.

C.16.5 In accordance with § 27-1-17.1(b) of the Alabama Code, "If a covered health care provider requests payment under a health insurance plan from a health insurer or its contracted vendor or a regional care organization be made using Automated Clearing HOUSE electronic funds transfer, that request must be honored. Furthermore, such a request may not be used to delay or reject a transaction, or attempt to adversely affect the covered health care provider."



## C.17 Provider Services Telephone Line

C.17.1 The Contractor must operate a toll-free telephone line for Provider inquiries from 8 a.m. to 5 p.m. Central time Monday through Friday, except for Medicaid-approved holidays. The Provider services telephone line must be staffed with personnel who are knowledgeable about the Contractor's program, Covered Services and services covered outside of the RFP.

C.17.2 The Contractor must ensure that, after regular business hours, the Provider services telephone line is answered by an automated system with the capability to provide callers with operating hours and instructions on how to verify enrollment for an Enrollee with an urgent condition or an Emergency Medical Condition. The Contractor must have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for an Enrollee with an urgent condition or an Emergency Medical Condition, provided, however, that the Contractor and its Providers must not require such verification prior to providing Emergency Services.

C.17.3 The Contractor must ensure that the Provider services telephone line meets the following minimum performance requirements:

C.17.3.1 A two (2) minute or less average hold time once the call is in the queue, prior to the call connecting to a representative;

C.17.3.2 A ten percent (10%) or less abandonment rate after fifteen (15) seconds; and

C.17.3.3 An answer rate of ninety percent (90%) or greater.

C.17.4 The Contractor must conduct ongoing call quality assurance to ensure these minimum performance requirements are met. The Contractor must monitor its performance regarding the Provider services telephone line performance requirements and submit performance reports summarizing call center performance as indicated in Section II.F of this RFP and the Reporting Manual. If Medicaid determines that it is necessary to conduct onsite monitoring of the Contractor's Provider services functions, the Contractor is responsible for all reasonable costs incurred by Medicaid or its authorized designee(s) relating to such monitoring.

C.17.5 Failure to meet requirements for the Provider services telephone line may result in Sanctions.

## C.18 Provider Manual

C.18.1 The Contractor must create a Provider Manual for its Participating Providers which must be approved by Medicaid prior to use and updating and which must be binding upon the Participating Providers and the Contractor. The manual and any amendments thereto must serve as a source of information to Providers regarding Covered Services, policies and procedures, Federal and State statutes, and regulations, telephone access and special requirements to ensure all Contract

requirements are being met. At a minimum, the Provider Manual must be consistent with the then-current Alabama Medicaid Provider Manual as applicable.

C.18.2 The Contractor must make the Provider Manual available on its website.

C.18.3 The Contractor must communicate to its Participating Providers changes to the Provider Manual. Such changes must be communicated no later than thirty (30) calendar days of effective date of change and can be electronically transmitted. All changes to the Provider Manual must be sent to Medicaid for approval prior to publication or dissemination.

#### C.19 Provider Training

C.19.1 The Contractor must provide training to all Participating Providers and their staff regarding the DBM Program and special needs of Enrollees within thirty (30) calendar days of a Provider joining the Contractor's Provider Network.

C.19.2 The Contractor must provide ongoing training to its Provider Network as deemed necessary by the Contractor or Medicaid.

C.19.3 All Provider training materials must be submitted to Medicaid for approval prior to use and upon updating.

#### C.20 Provider Incentive Plans

C.20.1 If the Contractor elects to offer Provider Incentive Plans, the Contractor must submit the Provider Incentive Plan to Medicaid in advance for review and/or written approval prior to implementation.

C.20.2 The Contractor's Provider Incentive Plan must be in compliance with requirements set forth in 42 CFR § 422.208 and § 422.210:

C.20.2.1 The Contractor may not make payment directly or indirectly under a Provider Incentive Plan to a Provider as an inducement to reduce or limit Medically Necessary services furnished to an Enrollee.

C.20.2.2 The Contractor must report whether services not furnished by Provider are covered by incentive plan. No further disclosure is required if Provider Incentive Plan does not cover services not furnished by Provider.

C.20.2.3 The Contractor must report what types of incentive arrangement (e.g. withhold, bonus, capitation) will be used by the Contractor.

C.20.2.4 The Contractor must report the percent of withhold or bonus (if applicable).

C.20.2.5 The Contractor must report panel size, and if Enrollees are pooled, the approved method used to pool the Enrollees.

- C.20.2.6 Upon request, the Contractor must provide Medicaid proof the Provider has adequate stop-loss insurance coverage, including amount and type of stop-loss insurance protection to individual Providers and conduct annual Enrollee surveys of Enrollee satisfaction.
- C.20.2.7 The Contractor must provide information on its Provider Incentive Plan to any Medicaid Recipient upon request (this includes the right to adequate and timely information on a Physician Incentive Plan).
- C.20.2.8 The Contractor must disclose to Medicaid and, upon request, disclose to Enrollees, results of conducted Enrollee survey.
- C.20.2.9 The Contractor must disclose to Medicaid results of any conducted Provider survey.

C.20.3 Failure to comply with the requirements for Provider Incentive Plans may result in sanctions.

## **D. Enrollee Services**

### **D.1 Eligibility**

- D.1.1 Medicaid is responsible for administering the Medicaid program including determining eligibility for Medicaid benefits and determining whether Medicaid recipients are mandated to enroll in the DBM Program. Section II.A of this RFP illustrates the populations eligible for participation in the DBM Program.
- D.1.2 The Contractor must not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll with the Contractor. This includes but is not limited to, termination of enrollment or refusal to reenroll a recipient except as permitted under this RFP, or any practice that would reasonably be expected to discourage enrollment or reenrollment by recipients whose medical condition or history indicates probable need for substantial future medical services. Violation of this requirement may result in Sanctions.
- D.1.3 The Contractor must not discriminate against individuals eligible to enroll with the Contractor on the basis of any protected category listed in 42 CFR § 438.3(d) and must not use any policy or practice that has the effect of discriminating on the basis of any protected category listed in 42 CFR § 438.3(d).

### **D.2 Enrollment**

#### **D.2.1 General**

- D.2.1.1 Medicaid is responsible for developing an enrollment process consistent with the requirements of 42 CFR §§ 438.50(d), 438.52, 438.54 and all other applicable laws and regulations. In accordance with this section, Medicaid will enroll individuals with the Contractor based on Medicaid's enrollment and reenrollment

requirements and based on the populations eligible for participation in the DBM Program as illustrated in Section II.B.1 of this RFP. The Contractor must accept all individuals assigned to the Contractor by Medicaid in the order in which they are assigned without restriction up to the limits described in Section II.B.1 of this RFP.

- D.2.1.2 Prior period coverage. Prior period coverage refers to the timeframe from the effective date of Medicaid eligibility to the day the Enrollee is enrolled with the Contractor. With the exception of newborns born to mothers eligible for DBM assignment, Medicaid shall provide prior period coverage for the period of time prior to the Enrollee's enrollment with the Contractor.
- D.2.1.3 Effective date of enrollment. Enrollment with the Contractor, whether chosen by the Enrollee or the Enrollee is auto-assigned, will be effective at 12:00 a.m. Central time on the first (1st) calendar day of the next month for those Enrollees who choose or are auto-assigned to the Contractor on or before the twenty-eighth (28th) calendar day of the month. For those Enrollees who choose or are auto-assigned to the Contractor after the twenty-eighth (28th) calendar day of the month, enrollment with a Contractor will be effective at 12:00 a.m. Central time on the first (1st) calendar day of the second (2nd) month after choice or auto-assignment. Medicaid reserves the right to modify the cut-off date if the 28th calendar day falls on a weekend or holiday.
- D.2.1.4 Lock-in period. Once enrolled with the DBM, Enrollees may not disenroll with the DBM except for cause, described in Section II.D.2.4.8 of this RFP.
- D.2.1.5 Temporary loss of eligibility. The DBM will automatically reenroll an Enrollee with the PDP with which he or she was most recently enrolled if the Enrollee has a temporary loss of eligibility during the lock-in period. In this instance the lock-in period will continue as though there had been no break in eligibility, keeping the original twelve (12) month period.

## D.2.2 Medicaid Management Information System (MMIS) Reporting

- D.2.2.1 Medicaid will provide the Contractor with the following reports, from the Alabama MMIS, for the Contractor to verify Enrollee eligibility and enrollment:
  - D.2.2.1.1 Monthly File. Medicaid or its designee will provide an American National Standards Institute (ANSI) X12 834 standard transaction monthly Enrollee file to the Contractor in accordance with Medicaid's submission schedule. The file will contain the eligibility period and other Enrollee demographic information. It will contain only the most current record for each Enrollee. The

Contractor must reconcile this Enrollee file with the Capitation Payment it receives from Medicaid and notify Medicaid of any discrepancies found within the data on the file within thirty (30) calendar days of receipt.

D.2.2.1.2 Daily File. Medicaid or its designee will provide to the Contractor an 834 daily Enrollee file that contains record(s) for each Enrollee where data for that Enrollee (contained in the 834 file layout) has changed that day. The file will contain add, termination and change records. The file will contain demographic changes, eligibility changes, enrollment changes and third party liability (TPL) information. The Contractor must process this file within three (3) business days of receipt and notify Medicaid of any discrepancies with the Contractor's internal membership information within thirty (30) calendar days of receipt.

D.2.2.2 Alerts. The Contractor must report to Medicaid on a weekly alert file:

D.2.2.2.1 Death

D.2.2.2.2 Changes in Enrollee mailing addresses

D.2.2.3 To facilitate the Enrollee choice period, the Contractor must share the following information with Medicaid's designated enrollment broker:

D.2.2.3.1 Annually and upon request:

D.2.2.3.1.1 Benefits covered

D.2.2.3.1.2 Cost Sharing, if any

D.2.2.3.1.3 Benefits available under the Alabama Medicaid State Plan but not covered under this RFP, including how and where the Enrollee may obtain those benefits, any Cost Sharing and how transportation is provided

D.2.2.3.1.4 Counseling and referral services not covered under this RFP because of moral or religious objections

D.2.2.3.2 Monthly and upon request:

D.2.2.3.2.1 Names, locations, telephone numbers of, and non-English language spoken by current Participating Providers

D.2.2.3.2.2 Identification of Providers, including PMPs, Specialists and hospitals that are not accepting new Enrollees

### D.2.3 Selection and Assignment of Primary Dental Provider

D.2.3.1 The Contractor must ensure each Enrollee has the freedom to choose a PDP in the Contractor's Provider Network within distance standards set forth in this Contract.

D.2.3.1.1 Within fifteen (15) calendar days of enrollment, the Contractor must send the Enrollee a letter encouraging the Enrollee to call the Contractor's Enrollee services department to select a PDP and informing the Enrollee if he or she does not select a PDP one will be selected for the Enrollee.

D.2.3.1.1.1 At the Contractor's option, the letter may also inform the Enrollee of the PDP that the Contractor will assign to the Enrollee if the Enrollee does not select a PDP within thirty (30) calendar days of enrollment. Such letter must include the name, location and office telephone number of the PDP that will be assigned if the Enrollee does not make an alternate PDP selection. Such letter must also inform the Enrollee that he or she may select a different PDP if the Enrollee is dissatisfied with the assignment.

D.2.3.1.2 If an Enrollee does not select a PDP within thirty (30) calendar days of enrollment and if the Contractor does not inform the Enrollee of the PDP assignment in advance in accordance with Section II.D.2.3 of this RFP, the Contractor must make the assignment and notify the Enrollee in writing of his or her PDP's name, location and office telephone number, while providing the Enrollee with an opportunity to select a different PDP if the Enrollee is dissatisfied with the assignment.

D.2.3.1.3 When a Contractor assigns a PDP, it must take into consideration the following:

D.2.3.1.3.1 Enrollee's geographic location;

D.2.3.1.3.2 Enrollee's previous PDP, if known;

D.2.3.1.3.3 Other family members' PDPs, if known;

- D.2.3.1.3.4 Special Health Care Needs, including pregnancy, if known; and
        - D.2.3.1.3.5 Special language and cultural considerations, gathered by the Contractor at the time of enrollment.
  - D.2.3.2 The Contractor must allow each Enrollee to change PDPs at any time, for any reason. The request can be made in person, in writing or by telephone. The Contractor must document each request and must process PDP changes within thirty (30) calendar days of the request. If the Contractor believes an Enrollee is abusing his or her right to change PDPs, the Contractor may request prior approval from Medicaid to limit PDP changes for a particular Enrollee.
  - D.2.3.3 Prior to the fifteenth (15th) day of each month, the Contractor must submit a listing of its Enrollees' PDP assignment to Medicaid's Fiscal Agent.
  - D.2.3.4 The Contractor must allow any Indian Enrollee who is eligible to receive services from an Indian Health Care Provider (IHCP), to elect that IHCP as his or her PDP, if that IHCP participates in Contractor's provider network as a PDP and has capacity to provide the services.
  - D.2.3.5 The Contractor is allowed to change an Enrollee's PDP assignment to another PDP within the Contractor's provider network in the following circumstances:
    - D.2.3.5.1 An Enrollee's PDP ceases to be a participating provider;
    - D.2.3.5.2 An Enrollee's behavior toward the PDP is such that it is not feasible to safely or prudently provide medical care, and the PDP has made reasonable efforts to accommodate the Enrollee;
    - D.2.3.5.3 An Enrollee has initiated legal action against the PDP;
    - D.2.3.5.4 The PDP's license to practice medicine or his or her agreement with the Contractor is suspended for any reason;
    - D.2.3.5.5 The Enrollee requires specialized care for an acute or chronic condition and the Enrollee and Contractor agree that reassignment to a different PDP is in the Enrollee's interest; or
    - D.2.3.5.6 The Enrollee's place of residence has changed such that he or she has moved beyond the PDP geographic access standard.
-

D.2.3.6 The Contractor must give written notice of termination of a PDP, within fifteen (15) calendar days after receipt of the termination notice from the PDP or issuance of the termination notice to the PDP, to each Enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated PDP. In such instances, the Contractor must allow the affected Enrollee to select a PDP or shall make an assignment within fifteen (15) calendar days of the termination notification date. At its option, the Contractor may assign a new PDP and inform the Enrollee of the assignment in the notice of termination along with the Enrollee's right to change PDPs if dissatisfied with the PDP assignment. Disenrollment requirements for all other participating providers are set for in Section II.D.2.4 of this RFP.

#### D.2.4 Disenrollment

D.2.4.1 Medicaid or its designee will process all Enrollee disenrollments consistent with 42 CFR § 438.56. This includes disenrollment due to loss of Enrollee eligibility and all disenrollment requests from Enrollees and Contractor.

D.2.4.2 Disenrollment due to loss of Enrollee eligibility for the DBM Program includes:

D.2.4.2.1 Enrollee loses Medicaid eligibility

D.2.4.2.2 Enrollee's eligibility category changes to a category ineligible for the DBM Program (e.g., Enrollee becomes dually eligible for Medicare and Medicaid)

D.2.4.2.3 Enrollee otherwise becomes ineligible to participate in the DBM Program

D.2.4.2.4 Enrollee has become incarcerated

D.2.4.2.5 Enrollee has died

D.2.4.3 When disenrollment is necessary because an Enrollee loses Medicaid eligibility or loses eligibility for the DBM Program, disenrollment shall be effective at 11:59 p.m. Central time on the last calendar day of the month in which loss of eligibility occurs

D.2.4.4 An Enrollee may request disenrollment upon automatic reenrollment under 42 CFR § 438.56(g), if the temporary loss of eligibility has caused the Enrollee to miss the annual open enrollment period.

D.2.4.5 An Enrollee may disenroll for cause at any time. The following constitute cause for disenrollment:

D.2.4.5.1 The Contractor does not, because of moral or religious



objections, cover the service the Enrollee seeks;

D.2.4.5.2 The Enrollee needs related services to be performed at the same time, not all related services are available within the Provider Network, and the Enrollee's PDP or another Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk; or

D.2.4.5.3 Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the Contract or lack of access to Providers experienced in dealing with the Enrollee's health care needs.

D.2.4.6 An Enrollee may disenroll without cause if Medicaid imposes Sanctions on the Contractor, pursuant to Section II.O of this RFP.

D.2.4.7 Enrollee requests for disenrollment may be submitted to Medicaid in a written format. The Contractor must provide assistance to Enrollees seeking to disenroll by providing information to Enrollees about how to contact Medicaid or its designee to request disenrollment. The Enrollee's written request to disenroll must expressly state the reason for the disenrollment.

D.2.4.7.1 Medicaid will take action to approve or disapprove of the Enrollee's request based on the following:

D.2.4.7.1.1 Reasons cited in the Enrollee's request for disenrollment;

D.2.4.7.1.2 Information provided by the Contractor at Medicaid's request; and

D.2.4.7.1.3 Any of the reasons specified in this RFP.

D.2.4.7.2 Medicaid may require the Enrollee to file a Grievance with the Contractor before making a determination on the Enrollee's disenrollment request. The Contractor's Grievance decision must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in Section II.L of this RFP.

D.2.4.7.3 The effective date of an approved disenrollment must be no later than the first business day of the second month following the month in which the Enrollee requests disenrollment. If Medicaid fails to make a determination within the specified timeframe, the disenrollment request shall be considered approved.

D.2.4.7.4 Medicaid shall issue a written determination on the Enrollee's request to disenroll to the Enrollee and the Contractor. If Medicaid determines that there is not good cause for disenrollment, the written determination shall notify the Enrollee of the right to request a State Fair Hearing in accordance with Alabama Administrative Code Rule 560-X-3.

D.2.4.8 Disenrollment Initiated by the Contractor:

D.2.4.8.1 The Contractor must notify Medicaid upon identification of an Enrollee who it knows or believes meets the criteria for disenrollment pursuant to this section.

D.2.4.8.2 The Contractor may request disenrollment of an Enrollee if the Enrollee's utilization of services is fraudulent or abusive or if the Enrollee is disruptive, unruly, threatening or uncooperative to the extent that Enrollee's continued enrollment with the Contractor seriously impairs the Contractor's ability to cover or provide services to the Enrollee or other Enrollees, and the Enrollee's behavior is not caused by a physical or behavioral health condition or other special needs as provided in Section II.D.2.4.8.3 of this RFP.

D.2.4.8.3 The Contractor must not request disenrollment of an Enrollee because of Enrollee's:

D.2.4.8.3.1 Changed health status;

D.2.4.8.3.2 Missed appointments;

D.2.4.8.3.3 Utilization of dental services;

D.2.4.8.3.4 Diminished mental capacity;

D.2.4.8.3.5 Pre-existing medical condition;

D.2.4.8.3.6 Uncooperative or disruptive behavior resulting from the Enrollee's special needs, except when the Enrollee's continued enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular Enrollee or other Enrollees;

D.2.4.8.3.7 Lack of compliance with the treating dentist's plan of care; or

D.2.4.8.3.8 Identification in any protected category

listed in 42 CFR § 438.3(d)(4).

D.2.4.8.4 The Contractor must not request disenrollment because of the Enrollee's attempt to exercise his or her rights under the Grievance and Appeal system, in accordance with Section II.L.3.7 of this RFP.

D.2.4.8.5 The request of one PDP to have an Enrollee assigned to a different Provider must not be sufficient cause for the Contractor to request that the Enrollee be disenrolled from the Contractor. Rather, the Contractor must utilize its PDP assignment process to assign the Enrollee to a different and available PDP.

D.2.4.9 Enrollees must be provided written notice of their disenrollment rights at least sixty (60) calendar days before the start of each enrollment period.

#### D.2.5 Enrollee Services Telephone Line

D.2.5.1 The Contractor must operate a toll-free Enrollee services telephone line which must be fully staffed on business days between 8:00 a.m. and 7:00 p.m. Central time. The Contractor must ensure that the telephone line staff is trained to respond to Enrollee questions for all areas of the DBM Program, including but not limited to, Covered Services and the provider network.

D.2.5.2 The Contractor must develop, implement and maintain policies and procedures, which must be submitted to Medicaid for prior written approval, for operating the toll-free Enrollee services telephone line, or equivalent, that include, but are not limited to, staffing, hours of operation, call response and hold times, abandonment rate, transfer protocols and monitoring.

D.2.5.3 The Contractor must develop, implement and monitor performance standards for the toll-free Enrollee services telephone line. Such standards and monitoring activities must be submitted to Medicaid for approval. At a minimum, the standards must require:

D.2.5.3.1 A two (2) minute or less average hold time once the call is in the queue, prior to the call connecting to a representative

D.2.5.3.2 A ten percent (10%) or less abandonment rate after fifteen (15) seconds

D.2.5.3.3 An answer rate of ninety percent (90%) or greater

D.2.5.4 The Contractor must conduct ongoing call quality assurance to ensure these minimum performance standards are met. The

Contractor must monitor its performance regarding the Enrollee services telephone line performance requirements and submit performance reports summarizing call center performance. If Medicaid determines in its sole discretion that it is necessary to conduct onsite monitoring of the Contractor's Enrollee services telephone line functions, the Contractor will be responsible for all reasonable costs incurred by Medicaid or its authorized designee(s) relating to such monitoring.

D.2.5.5 The toll-free Enrollee services telephone line must have the capability to handle calls from any language for non-English speaking Enrollees, as well as Enrollees with communications impairment, including the use of translators, auxiliary aids such as the telecommunications relay service (TRS), and text telephone (TTY)/telecommunication device for the deaf (TDD) lines.

D.2.5.6 The Contractor must have an automated system available every business day between the hours of 7:00 p.m. and 8:00 a.m. Central time and during weekends and legal holidays. The automated system must include a voice mailbox for callers to leave messages. Contractor must ensure that the voice mailbox has adequate capacity to receive the reasonably anticipated maximum volume of messages. Contractor must return messages on the next business day. This automated system must provide callers with operating instructions on what to do in case of an emergency which must include, at a minimum, the following information in accordance with 42 CFR § 438.10(g)(2)(v):

D.2.5.6.1 What Constitutes an emergency dental condition and emergency services

D.2.5.6.2 The fact that prior authorization is not required for emergency services

D.2.5.6.3 The fact that the Enrollee has a right to use any hospital or other setting for emergency care.

D.2.5.7 Noncompliance with requirements for the Enrollee services telephone line may result in sanctions.

#### D.2.6 Information Requirements

D.2.6.1 The Contractor must develop, implement and maintain policies, procedures and forms designed to clearly and thoroughly explain, in a manner and format that may be easily understood and is readily accessible, the process to enroll and disenroll with Contractor the rights and responsibilities of Enrollees, the Grievance and Appeal System and to help Enrollees and potential Enrollees understand the requirements and benefits of the Contractor's program. The terms "readily accessible" and "limited English proficient" or "LEP" must

have the meanings set forth in 42 CFR § 438.10(a). In addition, the Contractor must notify Enrollees that the right to free and timely language assistance services applies to translated documents and oral interpretation.

- D.2.6.2 The Prevalent Non-English Languages shall be defined as, at a minimum, the top fifteen (15) languages spoken in the State by individuals with LEP.
- D.2.6.3 The Contractor must provide information to potential Enrollees and Enrollees in accordance with 42 CFR § 438.10, Alabama Medicaid Administrative Code, Section 1557 of the Affordable Care Act, and any other applicable laws, which are incorporated herein by reference.
- D.2.6.4 The Contractor must inform potential Enrollees and Enrollees that interpretation service is available for any language and written translation is available in each prevalent Non-English Language. The Contractor must provide, free of charge, interpreters for potential Enrollees and Enrollees whose primary language is any non-English language, not just those non-English languages spoken by five percent (5%) or more of the total covered population of the state. The Contractor must also provide auxiliary aids free of charge to Enrollees with disabilities.
  - D.2.6.4.1 The Contractor must, at the time of enrollment, request Enrollees to inform the Contractor of primary non-English language and any language assistance requirements.
- D.2.6.5 The Contractor must make all written material referenced in this Contract and including at a minimum, provider directories, Enrollee handbooks, Appeal and Grievance Notices and Denial and Termination Notices available to potential Enrollees and Enrollees in a font size no smaller than twelve (12) point and in an easily understandable language that meets the requirements of this section, in English, and all other Prevalent Non-English Languages. Auxiliary aids and services must be made available at no cost to Enrollee upon his or her request, including toll free numbers, TTY/TDY and American Sign Language. Tag lines and large print (no smaller than eighteen (18) point font) must be used by Contractor in connection with such written materials in accordance with 42 CFR § 438.10(d)(3)-(6) and 45 CFR § 92.8.
- D.2.6.6 Upon request by and at no charge to Enrollees, the Contractor must make all written material available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The Contractor must inform potential Enrollees and

Enrollees that written information is available in alternative formats and how to access these formats.

- D.2.6.7 The Contractor must use specific dental managed care terminology required in this RFP and as set forth in 42 CFR § 438.10(c)(4)(i), as well as model Enrollee handbooks and Enrollee notices.
- D.2.6.8 The Contractor must give each Enrollee notice of any significant change, as determined by the State, in the written material and the information required by this subsection and by 42 CFR § 438.10, at least thirty (30) calendar days before the intended effective date of the change.
- D.2.6.9 The Contractor may not directly market to individual Medicaid recipients or potential Enrollees, except as specified in this section, and must adhere to the requirements specified by 42 CFR §§ 438.10 and 438.104. The Contractor is prohibited from door-to-door, telephone, email, texting or other cold-call marketing or engaging in marketing activities that could mislead, confuse or defraud Medicaid Recipients, Enrollees or Potential Enrollees. Marketing materials must receive Medicaid approval prior to use and cannot contain any assertion or statement whether written or oral that:
  - D.2.6.9.1 Potential Enrollees must enroll with the Contractor in order to obtain benefits or in order not to lose benefits; or
  - D.2.6.9.2 Contractor is endorsed by CMS, the Federal or State government or similar entity
- D.2.6.10 When distributing approved marketing materials, the Contractor must distribute the materials throughout the entire state.
- D.2.6.11 The Contractor's marketing activities and materials must not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
- D.2.6.12 The Contractor may only conduct marketing activities in health care settings in common areas, such as cafeterias, recreational rooms or conference rooms. The Contractor may not conduct marketing activities in areas where Enrollees primarily receive health care services, or wait to receive health care services. Areas where the Contractor is prohibited from conducting marketing activities include, but are not limited to, the following:
  - D.2.6.12.1 Waiting rooms;
  - D.2.6.12.2 Exam rooms;
  - D.2.6.12.3 Hospital patient rooms;

D.2.6.13 Sanctions in accordance with Section II.O of this RFP may be imposed if information to Enrollees, Potential Enrollees or Providers is misrepresented or falsified.

#### D.2.7 Medicaid Review and Approval of Materials

D.2.7.1 The Contractor must not change or distribute any materials, including content for the Enrollee portal of the Contractor website, to Enrollees or potential Enrollees without receiving prior written approval from Medicaid.

D.2.7.2 Whenever possible, the Contractor must submit to Medicaid for approval all material intended to be provided to Enrollees at least forty-five (45) calendar days prior to intended use. For urgent communications, Medicaid may provide an expedited review process.

D.2.7.3 Medicaid shall have thirty (30) calendar days to review and/or approve, reject or request revision of materials from the Contractor. Medicaid shall approve, reject or request revision of materials from the Contractor in writing.

D.2.7.4 Medicaid may impose sanctions for distributing information to an Enrollee, potential Enrollee, or provider that contain false or materially misleading information or for distribution, either directly or indirectly through any agent or Subcontractor, of unapproved marketing materials.

#### D.2.8 Enrollee Identification Card

D.2.8.1 The Contractor must issue and mail to a new Enrollee an Enrollee identification card within fifteen (15) calendar days of notification of the Enrollee's enrollment with the Contractor. The Contractor agrees to implement an alternative method by which Enrollees may identify themselves as Enrollees prior to receiving the Enrollee identification card.

D.2.8.2 The Enrollee identification card shall contain at minimum the following elements:

D.2.8.2.1 Enrollee name;

D.2.8.2.2 Contractor identification number, if applicable; and

D.2.8.2.3 Contractor's toll-free Enrollee services telephone line phone number.

D.2.8.3 Failure to meet these requirements for Enrollee identification card may result in sanctions.

## D.2.9 Enrollee Handbook

- D.2.9.1 The Contractor must provide each Enrollee an Enrollee handbook, within a reasonable time not to exceed fifteen (15) calendar days after receiving notice of enrollment, which includes a summary of benefits and coverages available to the Enrollee.
- D.2.9.2 The Enrollee handbook must include information that enables the Enrollee to understand how to effectively use the DBM Program including at a minimum the information set forth in 42 CFR § 438.10(g)(2).
- D.2.9.3 Information required by this section to be provided by the Contractor must be considered to have been properly provided if Contractor:
  - D.2.9.3.1 Mails a printed copy to Enrollee's mailing address or
  - D.2.9.3.2 Provides the information by email after obtaining Enrollee's written consent to do so.
- D.2.9.4 At least once per year, the Contractor must provide notice to its Enrollees that the Enrollee handbook is available upon request.
- D.2.9.5 The Contractor must use the checklist of requirements provided by Medicaid to develop its Enrollee handbook.
- D.2.9.6 All changes to the Enrollee handbook must be sent to Medicaid at least forty-five (45) calendar days prior to intended publication or dissemination to Enrollees. The Contractor must communicate to its Enrollees significant changes as defined by Medicaid to the Enrollee handbook. Such changes must be communicated to Enrollees no later than thirty (30) calendar days before the intended effective change and can be electronically transmitted.
- D.2.9.7 Noncompliance with Enrollee handbook requirements may result in sanctions.

## D.2.10 Participating Provider Directory

- D.2.10.1 The Contractor must make available in paper form, upon request, and electronic form, the following information about its participating providers:
  - D.2.10.1.1 The provider's name as well as any group affiliation;
  - D.2.10.1.2 The provider's street address;
  - D.2.10.1.3 The provider's telephone numbers;
  - D.2.10.1.4 The provider's website URL as appropriate;



- D.2.10.1.5 The provider's specialty, as appropriate;
- D.2.10.1.6 Whether the provider will accept new Enrollees;
- D.2.10.1.7 The provider's cultural and linguistic capabilities as set forth in 42 CFR § 438.10(h)(1)(vii);
- D.2.10.1.8 Whether the providers office has accommodations for people with physical disabilities, including offices, exam rooms and equipment; and
- D.2.10.1.9 The participating provider directory must include the information required in Section II.C.18 of this RFP of each of the following provider types listed in Section II.C.7 of this RFP.
- D.2.10.1.10 The Contractor must submit a monthly update of the provider directory and all provider files to Medicaid's Fiscal Agent.
- D.2.10.2 Information included in a paper participating provider directory must be updated at least monthly and electronic participating provider directories must be updated no later than thirty (30) calendar days after the Contractor receives updated Provider information.
- D.2.10.3 Participating provider directories must be made available on the Contractor's website as a portable document format (PDF) or in any other machine readable file and format approved by Medicaid.
- D.2.10.4 The Contractor must provide new Enrollees the most current complete listing of participating providers, including updates to such listing. If more than one new Enrollee resides at the same address, the Contractor may provide one listing per household and provide additional copies upon request.
- D.2.10.5 The Contractor must notify Enrollees of updates to its participating provider directory in writing at least annually by one of the following methods:
  - D.2.10.5.1 Hardcopy updates;
  - D.2.10.5.2 Hardcopy new complete directories; or
  - D.2.10.5.3 Provide written notification that a new complete directory is available and will be provided upon request either in hardcopy or electronically if the Contractor has the capability of providing such data in an electronic format and the data is requested in that format by an Enrollee.

- D.2.10.6 The foregoing information contained in the participating provider directory must be made available on the Contractor's website. Such information must be updated on a regular basis, but no less frequently than once every week.
- D.2.10.7 Failure to meet requirements for the participating provider directory may result in sanctions.

#### D.2.11 Enrollee Incentives

- D.2.11.1 The Contractor may provide an incentive program to its Enrollees based on health/educational activities or for compliance with health related recommendations, including, but not limited to:
  - D.2.11.1.1 Complete periodic dental exams and cleanings
  - D.2.11.1.2 Sealants placed on covered teeth
- D.2.11.2 The incentive program may include, but is not limited to:
  - D.2.11.2.1 Health related gift items
  - D.2.11.2.2 Gift certificates in exchange for merchandise
- D.2.11.3 Cash or redeemable coupons with a cash value are prohibited.
- D.2.11.4 The Contractor's incentive program, including related material for Enrollee use, must be proposed in writing and prior approved by Medicaid.
- D.2.11.5 The aggregate value of health-related gifts to an Enrollee must not exceed \$75 per Enrollee per calendar year.

### E. Key Personnel

E.1 The Contractor must have the ability to implement a developed organizational, operational, managerial and administrative system capable of fulfilling all contract requirements. The Contractor must be staffed by qualified individuals in numbers appropriate to the sustainability and feasibility of this Contract. As such, the Contractor must employ sufficient staff and utilize appropriate resources as detailed in the following:

#### E.1.1 Project Manager

- E.1.1.1 The Project Manager must have the authority to make all day-to-day management decisions for the Contractor. The Project Manager must have the authority to establish, implement and maintain employment and administrative policies and procedures for all functions and day-to-day operations of the Contractor, including the hiring and firing of employees and any other such responsibilities as authorized. The

Project Manager must maintain a full-time office in the State.

E.1.1.2 The Project Manager must be authorized and empowered to represent the Contractor regarding all matters pertaining to the Contract prior to such representation. The Project Manager must act as liaison between the Contractor and Medicaid and must have responsibilities that include, but are not limited to:

E.1.1.2.1 Ensuring the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

E.1.1.2.2 Receiving and responding to all inquiries and requests made by Medicaid related to the Contract, in the timeframes and formats specified by Medicaid. Where practicable, Medicaid will consult with the Contractor to establish timeframes and formats reasonably acceptable to the Parties;

E.1.1.2.3 Attending and participating in regular meetings or conference calls with Medicaid;

E.1.1.2.4 Making best efforts to promptly resolve any issues identified either by the Contractor or Medicaid that may arise and are related to the Contract;

E.1.1.2.5 Meeting with Medicaid representative(s) on a periodic or as needed basis to review the Contractor's performance and resolve issues;

E.1.1.2.6 Meeting with Medicaid at the time and place requested by Medicaid, if Medicaid determines that the Contractor is not in compliance with the requirements of the Contract.

#### E.1.2 Dental Director

E.1.2.1 The Contractor must have a qualified individual to serve as the Dental Director for the Contractor.

E.1.2.2 The Dental Director must be currently licensed in Alabama as a Doctor of Dentistry ("dentist,") with no restrictions or other licensure limitations. The Dental Director must comply with applicable federal and state statutes and regulations.

E.1.2.3 The Dental Director must be available during normal business hours for Utilization Review decisions, and must be authorized and empowered to represent the Dental Contractor regarding clinical issues, Utilization Review and quality of care inquiries.

E.1.2.3.1 The Dental Director is the only one authorized to deny prior authorizations.

#### E.1.3 Enrollee & Provider Services Manager

E.1.3.1 This employee must be available to serve the recipients and the providers with any need including enrollment, claims filing, education and outreach, etc.

#### E.1.4 Business Process Manager

E.1.4.1 This employee must be available to oversee claims adjudication, prior authorization process, information transferred between Medicaid and the Contractor, trained and experienced in data processing, data reporting and Claims resolution to ensure that the computer system reports that the Contractor provides to Medicaid and its designee are accurate; coordinator must have a good working knowledge of the Contractor's entire program and operation, as well as the technical expertise to answer questions related to the operation of the system.

E.1.4.2 This employee must be available to oversee claims adjudication, prior authorization process, information transferred between Medicaid and the Contractor, trained and experienced in data processing, data reporting and Claims resolution to ensure that the computer system reports that the Contractor provides to Medicaid and its designee are accurate; coordinator must have a good working knowledge of the Contractor's entire program and operation, as well as the technical expertise to answer questions related to the operation of the system.

#### E.1.5 Compliance and Grievance Manager

E.1.5.1 The Compliance Officer is responsible for ensuring that the Contractor and its Subcontractors are in compliance with the Contract, all applicable Federal and State laws and regulations, that adequate policies, procedures, internal controls and audits are developed, implemented and maintained, and that effective lines of communication exist between the Compliance Officer and the Contractor's staff as well as between the Compliance Officer and Medicaid's staff. The Compliance Officer must be qualified by training and experience to oversee the Contractor's Compliance Plan and to oversee Program Integrity and fraud, waste and/or Abuse programs. The Contractor must have and maintain a system for training and education for the Compliance Officer, the Contractor's senior management, and the Contractor's employees for the Federal and State standards and requirements under this Contract. The Compliance Officer should not be employed by any entity with a direct or indirect ownership interest in the Contractor or a risk-bearing participant of the Contractor.

## E.1.6 Quality Assurance Manager

E.1.6.1 The Quality Assurance Manager is responsible for managing and implementing the quality management and quality improvement programs for the Contractor as required in this RFP. Oversees quality assurance and compliance functions to ensure programs and services are implemented at the highest standards so Enrollees receive the highest level of care. Responsible for monitoring and updating policies and procedures to include regulatory changes. Provides input to strategic decisions that affect the functional area of responsibility.

## E.1.7 Other Key Personnel

E.1.7.1 Contractor must maintain sufficient staffing levels to meet program requirements and maintain the capability to ensure services outlined in this RFP and the Contract will be performed. Contractor must designate key management and technical personnel who will be assigned to the Contract. Contractor must, upon request, provide Medicaid with a resume of any members of its staff assigned to or proposed to be assigned to any aspect of the performance of the services outlined in this RFP. Medicaid shall have the absolute right to approve or disapprove the Contractor's Project Manager, Dental Director, Business Process Manager, Quality Assurance Manager, and Compliance and Grievance Manager or to approve or disapprove any proposed changes in this personnel, or to require the remove or reassignment of any personnel found by Medicaid to be unwilling or unable to perform under the terms of the RFP or Contract.

## F. Reporting

### F.1 General Requirements

- F.1.1 The Contractor must comply with all the reporting requirements established by this RFP as per 42 CFR 438.242(a) and (b), the Contractor must maintain a health information system that collects, analyzes, integrates and reports data that complies with Medicaid and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization and grievances and appeals. The Contractor must collect data on member and provider characteristics and on services furnished to members.
- F.1.2 In the event that there are no instances in the above section to report, the Contractor must submit a report stating such.
- F.1.3 As required by 42 CFR 438.604(a) and (b), and 42 CFR 438.606, the Contractor must certify all submitted data, documents and reports. The data that must be certified include, but are not limited to, financial reports, encounter data, and other information as specified within this RFP. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data.

F.1.4 The Contractor must submit the certification concurrently with the certified data and documents. Medicaid will identify specific data that requires certification.

F.1.5 The data must be certified by one of the following:

F.1.5.1 Contractor's Project Manager; or

F.1.5.2 An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

## F.2 Ad Hoc Reports

F.2.1 The Contractor must prepare and submit any other reports as required and requested by Medicaid, any of Medicaid designees, and/or CMS, that is related to the Contractor's duties and obligations under this RFP. Information considered to be of a proprietary nature must be clearly identified as such by the Contractor at the time of submission. Medicaid will make every effort to provide a sixty (60) day notice of the need for submission to give the Contractor adequate time to prepare the reports. However, there may be occasions the Contractor will be required to produce reports in a shorter timeframe.

## F.3 Ownership Disclosure

F.3.1 Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR 455.100-455.104). Form CMS 1513, Ownership and Control Interest Statement, must be submitted to Medicaid with the proposal; and then resubmitted prior to implementation for each Contract period or when any change in the Contractor's management, ownership or control occurs. The Contractor must report any changes in ownership and disclosure information to Medicaid within thirty (30) calendar days prior to the effective date of the change.

### F.3.2 Information Related to Business Transactions

F.3.2.1 The Contractor must furnish to Medicaid or to HHS, information related to significant business transactions as set forth in 42 CFR 455.105. Failure to comply with this requirement may result in termination of this RFP.

F.3.2.2 The Contractor must submit, within thirty-five (35) days of a request made by Medicaid, full and complete information about:

F.3.2.2.1 The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than \$10,000 during the twelve (12) month period ending on the date of this request.

F.3.2.2.2 Any significant business transactions between the Contractor and any wholly owned supplier or between

the Contractor and any subcontractor, during the five (5) year period ending on the date of this request.

F.3.2.3 For the purpose of this RFP, “significant business transactions” means any business transaction or series of transactions during any state fiscal year that exceed the \$25,000 or five (five percent) percent of the Contractor’s total operating expenses, whichever is greater.

F.3.3 Report of Transactions with Parties in Interest

F.3.3.1 The Contractor must report to Medicaid all “transactions” with a “party of interest” as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B), as required by Section 1903(m)(4)(A) of the Social Security Act. Federally qualified plans are exempt from this requirement.

F.3.3.2 Definition of Party in Interest – As defined in 1318(b) of the Public Health Service Act, a party in interest is:

F.3.3.2.1 Any director, officer, partner, or employee responsible for management or administration of a Contractor; any person who is directly or indirectly the beneficial owner of more than five percent of the equity of the Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent of the Contractor; or, in the case of a Contractor organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

F.3.3.2.2 Any organization in which a person described in subsection “1” is director, officer, or partner; has directly or indirectly a beneficial interest of more than five percent of the equity of the Contractor; or has a mortgage, deed of trust, note, or other interest valuing more than five percent of the assets of the Contractor;

F.3.3.2.3 Any person directly or indirectly controlling, controlled by, or under common control with a Contractor; or

F.3.3.2.4 Any spouse, child, or parent of an individual described in subsections 1, 2, or 3.

F.3.4 Types of Transactions Which Must Be Disclosed – Business transactions which must be disclosed include:

F.3.4.1 Any sale, exchange, or lease of any property between the Contractor and a party in interest;

F.3.4.2 Any lending of money or other extension of credit between the

Contractor and the party in interest; and

F.3.4.3 Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and the party in interest. This does not include salaries paid to employees for services in the normal course of their employment.

F.3.5 The information that must be disclosed in the transactions listed in Section II.F.3.4 above between a Contractor and a party in interest include:

F.3.5.1 The name of the party in interest for each transaction;

F.3.5.2 A description of each transaction and the quantity or units involved;

F.3.5.3 The accrued dollar value of each transaction during the fiscal year; and

F.3.5.4 Justification of the reasonableness of each transaction.

F.3.6 Medicaid may require that the information on business transactions be accompanied by a consolidated financial statement for the Contractor and the party in interest.

F.3.7 If the Contractor has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the Contractor's business transactions must be reported.

F.3.8 If the contract is renewed or extended, the Contractor must disclose information on business transactions which occurred during the prior contract period.

#### F.4 Encounter Data

F.4.1 The Contractor must comply with the required format provided by Medicaid. Encounter data includes claims paid by the Contractor for services delivered to members through the Contractor during a specified reporting period. Medicaid collects and uses this data for many reasons such as: federal reporting, rate setting, service verification, managed care quality improvement program, utilization patterns, access to care, and research studies.

F.4.2 Medicaid may change the Encounter Data Transaction requirements with thirty (30) calendar days' written notice to the Contractor. The Contractor must, upon notice from Medicaid, provide notice of changes to subcontractors

#### F.5 Information on Persons Convicted of Crimes

F.5.1 The Contractor must furnish Medicaid information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR 455.106. Failure to



comply with this requirement may lead to termination of this Contract.

#### F.6 Errors

F.6.1 The Contractor agrees to prepare complete and accurate reports for submission to Medicaid. If after preparation and submission, a Contractor error is discovered either by the Contractor or Medicaid, the Contractor must correct the error(s) and submit accurate reports as follows:

F.6.1.1 For encounters - In accordance with the timeframes specified in the Sanctions Section of this RFP.

F.6.1.2 For all reports – Fifteen (15) calendar days from the date of discovery by the Contractor or date of written notification by Medicaid (whichever is earlier). Medicaid may at its discretion extend the due date if an acceptable corrective action plan has been submitted and the Contractor can demonstrate to Medicaid’s satisfaction that the problem cannot be corrected within fifteen (15) calendar days.

F.6.2 Failure of the Contractor to respond within the above specified timeframes may result in a loss of any money due the Contractor and the assessment of monetary penalties as provided in Sanctions Section of this RFP.

#### F.7 Report Submission Timeframes

F.7.1 The Contractor must ensure that all required reports or files, as stated in this RFP, are submitted to Medicaid in a timely manner for review and approval. The Contractor’s failure to submit the reports or files as specified may result in the assessment of monetary penalties, as stated in the Sanctions Section of this RFP.

F.7.2 Unless otherwise specified, deadlines for submitting files and reports are as follows:

F.7.2.1 Daily reports and files must be submitted within one (1) business day following the due date;

F.7.2.2 Weekly reports and files must be submitted on the Wednesday following the reporting week;

F.7.2.3 Monthly reports and files must be submitted within fifteen (15) calendar days of the end of each month;

F.7.2.4 Quarterly reports and files must be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date;

F.7.2.5 Annual reports and files must be submitted on January 31 for the prior calendar year; and

F.7.2.6 Ad Hoc reports must be submitted within three (3) business days from the agreed upon date of delivery.

## F.8 Transition and Turnover Plan

### F.8.1 Introduction

F.8.1.1 Turnover is defined as those activities that the Contractor is required to perform upon termination of the Contract in situations in which the Contractor must transition contract operations to Medicaid or a third party. The turnover requirements in this section are applicable upon any termination of the Contract.

### F.8.2 General Turnover Requirements

F.8.2.1 In the event the Contract is terminated for any reason, the Contractor must:

F.8.2.1.1 Comply with all terms and conditions stipulated in the RFP, including continuation of core dental benefits and services under the RFP, until the termination effective date;

F.8.2.1.2 Promptly supply all information necessary for the reimbursement of any outstanding claims; and

F.8.2.1.3 Comply with direction provided by Medicaid to assist in the orderly transition of equipment, services, software, leases, etc. to Medicaid or a third party designated by Medicaid.

## F.9 Turnover Plan

F.9.1 As a part of the Readiness Review, the Contractor must submit a Turnover Plan. The Plan must address the turnover of records and information maintained by the Contractor relative to core dental benefits and services provided to Medicaid members for the timeframe specified by Medicaid. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by Medicaid.

F.9.2 The Turnover Plan must address the possible turnover of the records and information maintained to either Medicaid or a third party designated by Medicaid. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by Medicaid.

F.9.3 As part of the Turnover Plan, the Contractor must provide Medicaid with copies of all relevant member and core dental benefits and services data, documentation, or other pertinent information necessary, as determined by Medicaid, for

Medicaid or a subsequent Contractor to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation. The Plan must describe the Contractor's approach and schedule for transfer of all data and operational support information, as applicable. The information must be supplied in media and format specified by Medicaid and according to the schedule approved by Medicaid.

#### F.10 Transfer of Data

- F.10.1 The Contractor must transfer all data regarding the provision of member core dental benefits and services to Medicaid or a third party, at the sole discretion of Medicaid and as directed by Medicaid. All transferred data must be compliant with HIPAA.
- F.10.2 All relevant data must be received and verified by Medicaid or the subsequent Contractor. If Medicaid determines that not all of the data regarding the provision of member core dental benefits and services to members was transferred to Medicaid or the subsequent Contractor, as required, or the data is not HIPAA compliant, Medicaid reserves the right to hire an independent contractor to assist Medicaid in obtaining and transferring all the required data and to ensure that all the data are HIPAA compliant. The reasonable cost of providing these services must be the responsibility of the Contractor.

#### F.11 Post-Turnover Services

- F.11.1 Thirty (30) days following turnover of operations, the Contractor must provide Medicaid with a Turnover Results report documenting the completion and results of each step of the Turnover Plan. Turnover will not be considered complete until this document is approved by Medicaid.
- F.11.2 If the Contractor does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for Medicaid or the subsequent Contractor to assume the operational activities successfully, the Contractor agrees to reimburse Medicaid for all reasonable costs, including, but not limited to, transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records.
- F.11.3 The Contractor must pay any and all additional costs incurred by Medicaid that are the result of the Contractor's failure to provide the requested records, data or documentation within the time frames agreed to in the Turnover Plan.
- F.11.4 The Contractor must maintain all files and records related to members and providers for five years after the date of final payment under the Contract or until the resolution of all litigation, claims, financial management review or audit pertaining to the Contract, whichever is longer. The Contractor agrees to repay any valid, undisputed audit exceptions taken by Medicaid in any audit of the Contract.

## G. Technology Requirements

### G.1 General Requirements

- G.1.1 The Contractor's solution must provide the functional capabilities as described in this RFP including collecting, analyzing, integrating, and reporting data. The various components of the system must, as determined by Medicaid, be sufficiently integrated to effectively and efficiently meet the requirements of this RFP, must comply with Section 6504(a) of the Affordable Care Act, and must be adaptable to allow for future modification.
- G.1.2 The Contractor agrees to comply with future changes in Federal and State law, Federal and State regulations and Medicaid requirements and procedures.
- G.1.3 The solution must maintain all Claims payment standards in accordance with this RFP and must be capable of processing changes daily to support proper Claims processing systems.

### G.2 Data Collection

- G.2.1 The solution must collect data on:
  - G.2.1.1 Enrollee eligibility files;
  - G.2.1.2 Prior Authorization approvals;
  - G.2.1.3 Utilization of services;
  - G.2.1.4 Denials, Grievances and Appeals;
  - G.2.1.5 Enrollee characteristics (including race, primary language, gender and disability).
- G.2.2 Evaluation of these data should be a part of regular Contractor operations and both the data and the evaluation process are subject to Medicaid's review and/or evaluation. The Contractor must be able to receive, update and maintain the Enrollee eligibility files as provided by Medicaid and described in Section II.G.2 of this RFP.

- G.3 The Contractor must develop, implement and maintain adequate policies in regard to the timely transfer of Enrollee Dental Records to ensure continuity of care when Enrollees are treated by more than one dental Provider.

### G.4 Encounter Capture and Reporting

- G.4.1 The solution must capture and document all service-level Encounters between dental Providers and Enrollees, whether provided through a Fee-for-Service arrangement or through a capitated arrangement.
- G.4.2 The Contractor must submit Encounter data for all services rendered to Enrollees

under this RFP, including Encounters where the Contractor determined no liability exists. The Contractor must submit Encounter data for all services rendered to Enrollees under this RFP even if the Contractor did not make any payment for a Claim, including Claims for services to Enrollees furnished under a Provider agreement or provided under Subcontract, capitation, or special arrangement with another facility or program.

- G.4.3 The Contractor must submit Encounter records at least monthly and within sixty (60) calendar days following the end of the month in which the Contractor paid the Claims for services. The Contractor must submit all Enrollee Encounter data that Medicaid is required to report to CMS under 42 CFR § 438.818.
- G.4.4 The Encounter records must be Enrollee and Provider specific, listing all required data elements for each service provided. If Encounter records are not of an acceptable quality, are incomplete, or are not submitted timely, the Contractor will not be considered in compliance with this RFP requirement unless and until acceptable data are submitted.
- G.4.5 Medicaid shall notify the Contractor, in writing, of the start date for submission of Encounters through its Fiscal Agent. Once the Contractor is notified by Medicaid of the date for initiating Encounter submissions (submission start date), the Contractor must submit its schedule for transmitting Encounter data for all services collected for Claims beginning at the start date of the Contract, and up to the submission start date. The Contractor must submit this schedule to Medicaid for approval within ten (10) business days after the date of Medicaid's notice to begin submitting Encounters.
- G.4.6 The Contractor must submit Encounter data in compliance with Medicaid's then current Fee-for-Service billing rules.
- G.4.7 The Contractor must provide complete and accurate Encounter data to Medicaid. The Contractor must implement review procedures to validate Encounter data submitted by Providers for completeness, logic, and consistency.
  - G.4.7.1 Completeness of Data - Medicaid will use Encounter data completeness benchmarks to identify areas where Encounters are potentially underreported. These benchmarks will reflect the minimum acceptable number of Covered Services reported in the service month, per one thousand Enrollees. The benchmarks may be revised as necessary to ensure that they are reasonable and accurately reflect minimum reporting expectations.
    - G.4.7.1.1 If the Contractor falls below completeness benchmarks for any managed care category of service/Encounter group combination, Medicaid will notify the Contractor that reporting deficiencies may have occurred for a specified service month. Medicaid may require documentation regarding the potential deficiency and/or a corrective action plan (CAP) from the Contractor. The Contractor will be notified each reporting month of the

number of services reported by category of service, per one thousand Enrollees for each of the proceeding twenty-four (24) months.

G.4.7.1.2 If the Contractor fails to meet a category of service/Encounter group monthly benchmark without providing an acceptable explanation as determined by Medicaid, the Contractor will be subject to a withhold of a portion of the Capitation Payment. Such withholding will be applied regardless of the Contractor's submission or intended submission of a CAP.

G.4.7.1.3 Medicaid will examine each service month against the Encounter data completeness benchmarks after six (6) months.

G.4.7.2 Accuracy of Data - For the first six (6) months of the Contract, the accuracy standard will be ninety-five percent (95%) of the records in the Contractor's Encounter batch submission must pass X12 EDI compliance edits and the Alabama MMIS threshold and repairable compliance edits. After the first six (6) months of the Contract, ninety-eight percent (98%) of the records in the Contractor's Encounter batch submission must pass X12 EDI compliance edits and the Alabama Medicaid MMIS threshold and repairable compliance edits. The X12 EDI compliance edits are established through Strategic National Implementation Process (SNIP) levels one through four (4). MMIS threshold and repairable edits that report exceptions are set forth in the Companion Guide.

G.4.7.3 Encounter data submission accuracy and completeness is also measured by, but not limited to:

G.4.7.3.1 An Encounter Acceptance Rate of ninety-eight percent (98%) (excluding Contractor-denied Encounters, duplicate Encounters, and other non-correctable denied Encounters determined at the sole discretion of Medicaid, and other Encounters at the request of the Contractor and approved by Medicaid) for each HIPAA transaction type, of each month;

G.4.7.3.2 A duplicate Encounter resubmission rate not greater than two percent (2%) each month;

G.4.7.3.3 The achievement of completeness benchmarks for specified categories of service, as set forth in the Vendor Companion Guide.

G.4.7.4 If the Contractor fails to meet a category of service/Encounter group monthly benchmark, as set forth in the Companion Guide, without providing an acceptable explanation as determined by Medicaid, the

Contractor will be subject to corrective action including Sanctions. If the Contractor is unable to satisfactorily demonstrate that Encounter data are complete, Medicaid may conduct reviews of Dental Records, or utilize other means to evaluate reporting compliance. Sanctions may be applied regardless of the Contractor's submission or intended submission of a CAP.

G.4.7.4.1 The amount of the Sanction imposed in accordance with the above subsection will be calculated based on the total capitation payments made to the Contractor during the previous reporting month.

G.4.7.4.2 The Sanction amount for failing to achieve a monthly benchmark must be dependent on the ratio of approved Encounters to the benchmark for that category of service/Encounter group combination as presented in the table below.

G.4.7.4.2.1 Sanction Calculation by

Encounters to Benchmark Ratio

<b>Ratio of Approved Encounters to Benchmark</b>	<b>Sanction Calculation</b>
98% accurate and complete	No Sanction
For every percentage point under 98%	0.25% of Capitation Payment

G.4.7.4.3 The Contractor will be informed each reporting month of the number of approved Encounters processed during the previous month, and the associated approved Encounter rate.

G.4.7.4.4 If after ninety (90) calendar days from the date of notification, the Contractor's approved Encounter rate is less than the rate defined in the table above, Medicaid will withhold an amount equal to one-quarter percent (.25%) of the total capitation payment to the Contractor for the service period equal to the reporting month.

G.4.7.4.5 If the Contractor submits incomplete or inaccurate Encounter data, it may be subject to Sanctions in accordance with Section II.O of this RFP.

- G.4.7.5 The approved Encounter rate will be recalculated monthly and the withheld amount may be released to the Contractor once the approved Encounter records have been corrected and resubmitted such that the approved rates falls below the stated approved rate. The release of any withheld amount for approved Encounter records is subject to offset for withholding of payments for Encounter data completeness.
- G.4.7.6 If after twelve (12) months from the date of notice in the initial reporting month, the Contractor fails to correct denied Encounters for the processing month to reflect an approved rate less than the stated approved rate above, the withheld funds will be considered damages and will not be released to the Contractor. At the sole discretion of Medicaid, the Contractor may be subject to additional damages and/or Sanctions, if denied Encounter records are excessive for any month.
- G.4.7.7 The amount withheld from a Contractor for excessive denied Encounter records and failure to achieve a required completeness benchmark will not exceed a total of two percent (2%) of the capitation paid for the reporting month. This limit will be applied after the calculation of the total amount to be withheld, if any, for excessive denied Encounter records and/or failure to achieve a required completeness benchmark.

#### G.4.8 Remittance Advice

- G.4.8.1 Remittance Advice File - Medicaid's fiscal agent shall produce a HIPAA compliant Claims status report, 277CA Claims Acknowledgement, which itemizes all processed Encounter records. The Contractor must be responsible for accepting and processing this Claims Status report, in accordance with the Vendor Companion Guide. This must include the disposition (approved or denied) for each Encounter record, along with the error(s) for every denied Encounter record.
  - G.4.8.2 Reconciliation - The Contractor must be responsible for matching the Encounter records on the Claims Status report against the Contractor's data file(s). The Contractor must correct any denied Encounter records and any other discrepancies noted on the file. Corrections must be resubmitted within ninety (90) calendar days of Contractor receipt of the claims status report. All corrections to denied Encounter data, as reported, must be resubmitted.
- G.4.9 The Contractor must submit an Encounter data certification and validation report form as found in an Exhibit of this RFP with each Encounter data submission, as required by 42 CFR § 438.604.



G.4.10 The Contractor must convert all information that enters its Claims systems via hard copy paper Claims or other proprietary formats to Encounter data to be submitted in the appropriate HIPAA compliant format.

#### G.5 Electronic File Exchange

G.5.1 The solution must support receiving electronic Capitation Payment/remittance advice through the receipt of 835 and 820 files.

G.5.2 When transmitting files to Medicaid, the fiscal agent or other entities involved in providing services to Enrollees, the Contractor must have a Secure File Transfer Protocol (SFTP) and Electronic Data Interchange (EDI) compatible with Medicaid, the fiscal agent and with others designated by Medicaid.

#### G.6 Accuracy

G.6.1 The Contractor must ensure that data received from Providers is correct and complete by verifying the accuracy and timeliness of reported data and screening the data for completeness, logic, and consistency, and collecting service information in standardized formats to the extent feasible and appropriate.

G.6.2 For all Encounter data submitted after the submission start date, if Medicaid or its fiscal agent notifies the Contractor of Encounters that do not comply with X12 Electronic Data Interchange (EDI) compliance edits or other Medicaid threshold and repairable compliance edits, the Contractor must correct all such Encounters within sixty (60) calendar days after such notice.

G.6.3 The Contractor must ensure that its Subcontractors, if any, meet the same technical requirements as defined in this section. Medicaid will hold the Contractor responsible and may impose Sanctions for any errors, noncompliance or fraud, waste and/or Abuse, even if such issues originate from a Subcontractor.

#### G.7 HIPAA Standards and Code Sets

G.7.1 The Contractor must satisfy all Health Insurance Portability and Accountability Act (HIPAA) requirements with respect to Protected Health Information (PHI).

G.7.2 Regardless of whether the Contractor is considered a covered entity under HIPAA, the Contractor shall use the HIPAA Transaction and Code Sets, specifically the ANSI X12N 837D Transaction format as described in the Vendor Companion Guide, as the exclusive format for the electronic communication of health care Claims and Encounter record submitted, regardless of date of service. The Contractor paid and allowed amounts must be provided for non-capitated Participating Providers.

#### G.8 Network and Back-up Capabilities

- G.8.1 The Contractor must maintain full and complete back-up copies of data and software in accordance with the following timelines: weekly back-ups, daily back-ups sufficient to cover eight (8) days, incremental daily back-ups sufficient to cover eight (8) days with the oldest incremental back-up archiving off on the ninth day in the cycle. Back-ups must be adequate and secure for all computer software and operating programs, databases, files, systems, operations and user document (in electronic and non-electronic form) including eligibility verification, enrollment/eligibility update processing, and prior authorization processing and claims processing. All back-ups must be sufficient to support the immediate restoration and recovery of lost or corrupted data or software.
- G.8.2 The Contractor must maintain a back-up log to verify the back-ups were successfully run, and a back-up status report shall be provided to Medicaid upon request.
- G.8.3 The Contractor must store its back-up data in an off-site location approved by Medicaid. Upon the expiration of the Contract term or the termination date, all Medicaid related data must be returned to Medicaid. After Medicaid's verification of the returned data, the Contractor must remove/delete and sanitize all Medicaid data from all Contractor storage devices and media in accordance with the National Institute of Standards and Technology (NIST) Special Publication 800-88 Guidelines for Media Sanitization Revision 1 or the most current revision and submit an attestation of those actions to Medicaid. The Contractor's obligation to remove/delete and sanitize Medicaid data from all Contractor storage devices and media must survive the expiration or termination of this RFP. The Contractor may retain data obtained from Medicaid only if Medicaid determines, in its sole discretion, that the data to be retained by the Contractor is necessary for the Contractor's management and administration or to perform its legal responsibilities. The duration and terms of such retention will be determined by Medicaid at the time Medicaid approves the Contractor's request to retain data.

## G.9 Information Security and Access Management

- G.9.1 The Contractor must operate in accordance with the policies and regulations set forth by the State of Alabama Office of Information Technology. This will ensure the system is protected by firewalls, antivirus protection, secure ID authentication and access logging. The Contractor is responsible for maintaining the systems and applying all patches and updates to keep the system up-to-date.
- G.9.2 The Contractor must provide for physical and electronic security of all PHI generated or acquired by the Contractor in implementation of the Contract, in compliance with HIPAA. The Contractor must provide an information security plan for review and approval by Medicaid. The Contractor must make any changes to the information security plan requested by Medicaid and resubmit the plan within 5 business days of the request.

G.9.3 To the extent any of the Contractor's employees or subcontractors are required to provide services on site at any State facility, the Contractor may be required to provide and complete all necessary paperwork for security access to sign on at the State's site. This may include conduct and provision to the State of State and Federal criminal background checks, including fingerprinting, for each individual performing services on site at a State facility. These checks may be performed by a public or private entity, and, if required, must be provided prior to the employee's providing on-site services. Medicaid reserves the right to refuse to allow any individual employee to work on State premises, based upon information provided in a background check. At all times, at any facility, the Contractor's personnel shall ensure cooperation with State site requirements.

#### G.10 Disaster Recovery

G.10.1 The Contractor must execute all activities needed to recover and restore operation of information systems, data and software at an existing or alternate location under emergency conditions within seventy-two (72) hours of the identification or a declaration of a disaster. The Contractor must maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups, and disaster recovery.

### H. Contractor Payments

H.1 The Contractor is due monthly capitation payments for each Enrollee from the first month the Contractor is authorized to provide covered services under this RFP to the effective date of disenrollment or termination of this Contract, whichever occurs first.

H.2 The first total capitation payment due to the Contractor will be paid in two (2) installments. Payment of the first installment of twenty-five percent (25%) of the total capitation payment for such month will be made within the first eight (8) business days of such month. Payment of the second (2nd) installment of seventy-five percent (75%) of the total capitation payment for such month will be deferred and paid, subject to any withholds of this RFP, at the end of the Contract term, including any extensions. Beginning with the second (2nd) total capitation payment, the Contractor will be paid the full amount of each total capitation payment within the first eight (8) business days of each month.

H.3 If and each time the Contractor's monthly capitation payment increases, or decreases by more than fifteen percent (15%) in the aggregate, Medicaid will have the right to recalculate the deferred installment in accordance with Section II.I.3 of this RFP. In such event, the recalculated deferred installment shall be seventy-five percent (75%) of the then current total capitation payment and Medicaid will reduce, or increase the next month's total capitation payment by an amount equal to the increase, or decrease in the deferred installment.

H.4 The Contractor shall receive a full month's capitation payment for the month in which an Enrollee's disenrollment occurs.

- H.5 The Parties acknowledge and accept that Medicaid has a right to recover capitation payments paid to the Contractor for enrollees listed on the monthly roster who are later determined ineligible for enrollment. In any event, Medicaid may only recover payments made for enrollees listed on a roster if it is determined by Medicaid that the Contractor was not at risk for provision of Covered Services for any portion of the payment period. Upon erroneous payment identified by the Contractor or Medicaid, reconciliation must be made by adjusting Contractor's future monthly capitation payment.
- H.6 In accordance with 42 CFR § 457.1201(o), the Contractor must include an attestation to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury.
- H.7 Contractor agrees to accept payment in full and must not seek additional payment from a member for any unpaid costs;
- H.8 The Contractor must agree to have written policies and procedures for receiving and processing payments and adjustments. Any charges or expenses imposed by financial institutions for transfers or related actions shall be borne by the Contractor;

## **I. Medicaid Responsibilities**

Primary responsibility for administration of the Dental Benefit Program Manager will remain with the Alabama Medicaid Agency. Medicaid agrees to the following responsibilities, as outlined in accordance with the Alabama Administrative Code and 1915 (b) waiver, to facilitate contract performance and outlined deliverables:

### **I.1 Contractor Reimbursement**

- I.1.1 Medicaid shall make monthly capitated payments for each member enrolled with the Contractor. The capitation rate will be developed in accordance with 42 CFR 438.6. The projected capitated payment rate range is contained in Appendix C and are subject to change based upon the implementation date of the program.

### **I.2 Payment Adjustments**

- I.2.1 In the event that an erroneous payment is made to the Contractor, Medicaid shall reconcile the error by adjusting the Contractor's future monthly capitation payment.
- I.2.2 Retrospective adjustments to prior payments may occur when it is determined that a member's aid category was changed. Payment adjustments may only be made when identified within twelve (12) months from the date of the member's aid category change for all services delivered within the twelve (12) month time period. If the member switched from a Contractor eligible aid category to a Contractor excluded aid category, previous capitation payments will be recouped from the Contractor.
- I.2.3 The Contractor must refund payments received from Medicaid for a deceased member effective the month of service after the month of death. Medicaid will recoup the payment as specified in the Systems Companion Guide.

- I.2.4 The entire monthly capitation payment must be paid following the month of birth and month of death. Payments must not be pro-rated to adjust for partial month eligibility as this has been factored into the actuarial rate setting.

### I.3 Rate Adjustments

- I.3.1 Medicaid's actuaries will establish capitation rates, which must be reviewed and approved by CMS as actuarially sound, on a prospective basis by establishing base data, adjusting for retrospective and prospective programmatic changes, trend and non-medical load. Capitation rates shall be certified by Medicaid's actuary in accordance with 42 CFR § 438.4(b)(6), and by accepting the terms of this Contract, the Contractor waives the right to appeal or otherwise challenge such capitation rates on the basis of actuarial soundness. Non-covered services under the Alabama Medicaid program will not be incorporated in the Capitation Payment methodology that results in the capitation rates certified by Medicaid's actuary in accordance with 42 CFR § 438.6(c) and accepted under the terms of this Contract. Medicaid will reevaluate the payment structure as a result of the inclusion or removal of a Medicaid covered dental service (s) and/or inclusion or removal of a Medicaid covered population.

- I.3.2 Any adjusted rates must continue to be actuarially sound as determined by Medicaid's actuarial contractor and will require an amendment to the Contract that is mutually agreed upon by both parties. Any alteration, variation, modification, or waiver of provisions of the contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of Medicaid. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.

#### I.3.3 Medicaid reserves the right to re-negotiate the PMPM rates:

- I.3.3.1 If the rate floor is removed;
- I.3.3.2 If a result of federal or state budget reductions or increases;
- I.3.3.3 If due to the inclusion or removal of a Medicaid covered dental service(s) not incorporated in the monthly capitation rates; or
- I.3.3.4 In order to comply with federal and/or state requirements.

- I.4 The Contractor must acknowledge that capitation rates will be evaluated by Medicaid on an annual basis. Any adjustment to capitation rates during the term of this Contract and in accordance with Section II.H of this RFP, shall be deemed incorporated into this Contract without further action by the Parties, upon approval of such adjustments by Medicaid and the United States Department of Health and Human Services (HHS).

**J. Sanctions**

Medicaid may impose the following intermediate sanctions for non-compliance with the RFP performance standards as set forth in Appendix J. This RFP and its appendices are subject to modifications as maybe required by changes in federal and/or state law or regulations. The Contractor agrees to pay Medicaid the sums set forth below unless waived by Medicaid.

J.1 Medicaid may impose the following intermediate sanctions for noncompliance with Contract performance standard(s). This Contract, its Exhibits, and its Appendices are subject to such modifications as may be required by changes in Federal or State law or regulations.

<b>Contract Section</b>	<b>Performance Standard</b>	<b>Intermediate Sanction</b>
II.D.2.5 - Enrollee Services Telephone Line/Call Center	<ul style="list-style-type: none"> <li>Noncompliance with Enrollee services telephone line requirements.</li> </ul>	<ul style="list-style-type: none"> <li>Up to \$100 for each hour or portion thereof that toll-free lines are not operational</li> <li>Up to \$100 for each percentage point for each standard that the Contractor fails to meet the requirements for a monthly reporting period</li> <li>Up to \$100 may be assessed for each thirty (30) second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time</li> </ul>
II.D.2.6 - Information Requirements	<ul style="list-style-type: none"> <li>Misrepresents or falsifies information to Enrollees, potential Enrollees or Providers.</li> </ul>	<ul style="list-style-type: none"> <li>Up to \$25,000 for each determination</li> </ul>
II.D.2.7 - Medicaid Review and Approval	<ul style="list-style-type: none"> <li>Distribution of unapproved marketing material or those that contain false or materially misleading information.</li> </ul>	<ul style="list-style-type: none"> <li>Up to \$25,000 for each determination</li> </ul>
II.D. – Enrollee Services D.2.8, II.D.2.9, II.2.10	<ul style="list-style-type: none"> <li>Failure to provide Enrollee ID card, Enrollee handbook and provider directory to Enrollees as specified in this Contract.</li> </ul>	<ul style="list-style-type: none"> <li>\$250 for each day after timeframe by which Enrollee was to receive documents. Limit of \$10,000 per month</li> </ul>

<b>Contract Section</b>	<b>Performance Standard</b>	<b>Intermediate Sanction</b>
II.C.16.3- Claims Payment Standards	<ul style="list-style-type: none"> <li>• Untimely payments to Providers.</li> </ul>	<ul style="list-style-type: none"> <li>• Up to \$5,000 for the first quarter that Claims performance percentages by claim type, fall below the performance standards</li> <li>• Up to \$25,000 per quarter for each additional quarter that the claims performance percentages by claim type, fall below the performance standards</li> </ul>
II.C.17 - Provider Services Telephone Line	<ul style="list-style-type: none"> <li>• Noncompliance with Provider services telephone line requirements.</li> </ul>	<ul style="list-style-type: none"> <li>• Up to \$100 for each hour or portion thereof that appropriately staffed toll-free lines are not operational</li> <li>• Up to \$100 for each percentage point for each standard that the Contractor fails to meet the requirements for a monthly reporting period</li> <li>• Up to \$100 may be assessed for each thirty (30) second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time</li> </ul>
II.C.20 – Provider Incentive Plans	<ul style="list-style-type: none"> <li>• Fails to comply with requirements for Provider Incentive Plans</li> </ul>	<ul style="list-style-type: none"> <li>• Up to \$25,000 for each determination</li> </ul>
<ul style="list-style-type: none"> <li>• II.M.5</li> </ul>	<ul style="list-style-type: none"> <li>• Failure to submit or submission of incomplete or untimely reporting of annual, EQRO audited quality measure data that reflects performance for the previous calendar year (e.g., measurement year).</li> <li>• Failure to produce or report rates for all DBM Quality Measures in accordance with Medicaid specifications.</li> </ul>	<ul style="list-style-type: none"> <li>• Up to 2.5% of total capitation payment per year</li> <li>• Contractor would be ineligible to participate in the DBM quality withhold program funds distribution</li> <li>• Contractor would be ineligible to participate in the Quality Improvement Project (QIP)</li> </ul>

<b>Contract Section</b>	<b>Performance Standard</b>	<b>Intermediate Sanction</b>
II.L.3 - Policies and Procedures for Grievance and Appeal System	<ul style="list-style-type: none"> <li>• Untimely resolution of Enrollee Appeals.</li> </ul>	<ul style="list-style-type: none"> <li>• \$250 per day for each appeal not timely resolved</li> </ul>
II.G.4.7.4.2 -Sanction Calculation by Encounters to Benchmark Ratio	<ul style="list-style-type: none"> <li>• Approved Encounters less than 98%.</li> </ul>	<ul style="list-style-type: none"> <li>• 0.25% of capitation per month for each percentage point below ninety-eight percent (98%), subject to any limitations otherwise set forth in the Contract</li> </ul>
II.F.1 - Reporting	<ul style="list-style-type: none"> <li>• Misrepresents or falsifies information furnished to the Medicaid or CMS.</li> </ul>	<ul style="list-style-type: none"> <li>• Up to \$100,000 for each determination</li> </ul>
II.F.1.3- Reporting	<ul style="list-style-type: none"> <li>• Untimely or inaccurate report submission.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Untimely Report:</i> \$250 for each day after the due date until report is delivered. The assessment may be increased to \$500 per day if the report is not delivered within thirty (30) calendar days of the original due date.</li> <li>• <i>Inaccurate Report:</i> If after fifteen (15) calendar days of notification of inaccurate report data the Contractor does not provide a corrected report, an assessment of \$250 per day will be imposed until the corrected report is provided. The assessment may be increased to \$500 per day if the report is not delivered within thirty (30) calendar days of receipt of notification of incorrect data.</li> </ul>
II.E – Key Personnel	<ul style="list-style-type: none"> <li>• Failure to maintain necessary adequate staffing levels to perform the requirements of the RFP.</li> </ul>	<ul style="list-style-type: none"> <li>• \$1,000 per instance</li> </ul>
II.G – Technology Requirements	<ul style="list-style-type: none"> <li>• Failure to meet technical requirements specified in the RFP.</li> </ul>	<ul style="list-style-type: none"> <li>• \$100 per day the requirement is unmet</li> </ul>
IX.E - General Terms and Conditions	<ul style="list-style-type: none"> <li>• Failure to safeguard confidential information of providers, recipients or the Medicaid program</li> </ul>	<ul style="list-style-type: none"> <li>• \$10,000 per instance plus any penalties incurred by Medicaid for said sanction</li> </ul>



- J.2 In addition to the above, in accordance with 42 CFR § 438.730 Medicaid may deny payments to the Contractor as a Sanction if Medicaid determines that the Contractor acts or fails to act as specified in 42 CFR § 438.700(b)(1) through (b)(6).
- J.3 Contractor will receive written notice from Medicaid upon a finding of failure to comply with contract requirements, which contains a description of the events that resulted in such a finding. Contractor will be allowed to submit rebuttal information or testimony in opposition to such findings. Medicaid will make a final decision regarding sanctions.

## **K. Fraud and Abuse**

### **K.1 General Requirements**

- K.1.1 The Contractor must comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs.
- K.1.2 The Contractor must meet with Medicaid and the Attorney General's Medicaid Fraud Control Unit (MFCU), periodically, at Medicaid's request, to discuss fraud, abuse, neglect and overpayment issues. For purposes of this section, the Contractor's compliance officer must be the point of contact for the Contractor.
- K.1.3 The Contractor must cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours any state or federal agency, and/or their designee(s), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules for as often as they may deem necessary during the Contract period and for a period of six (6) years from the expiration date of the Contract (including any extensions to the Contract).
- K.1.4 The Contractor and its subcontractors must make all program and financial records and service delivery sites open to the representative or any designees of the above. Each federal and state agency must have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with Contractor clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but must last as long as records are retained. The Contractor must provide originals and/or copies (at no charge) of all records and information requested. Requests for information must be compiled in the form and the language requested.
- K.1.5 Contractor's employees and its contractors and their employees must cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.

- K.1.6 The Contractor must provide access to Medicaid and/or its designee to all information related to grievances and appeals filed by its members. Medicaid shall monitor enrollment and termination practices and ensure proper implementation of the Contractor's grievance procedures, in compliance with 42 CFR § 438.228.
- K.1.7 The Contractor must certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The Contractor must not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the Contract, and Medicaid policy.
- K.1.8 The Contractor must report to Medicaid, within three (3) business days, when it is discovered that any Contractor employees, network provider, subcontractor, or subcontractor's employees have been excluded, suspended, or debarred from any state or federal healthcare benefit program.

## K.2 Fraud and Abuse Compliance Plan

- K.2.1 In accordance with 42 CFR §438.608(a), the Contractor must have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.
- K.2.2 In accordance with 42 CFR §438.608(a)(1), the Contractor must designate a compliance officer and compliance committee that have the responsibility and authority for carrying out the provisions of the compliance program. These individuals must be accountable to the Contractor's board of directors and must be directly answerable to the Project Manager or to the board of directors and senior management. The Contractor must have an adequately staffed Medicaid compliance office with oversight by the compliance officer.
- K.2.3 The Contractor must submit the Fraud and Abuse Compliance Plan within thirty (30) calendar days from the date the Contract is signed with the Contractor, but no later than thirty (30) calendar days prior to the Readiness Review. The Contractor must submit updates or modifications to Medicaid for approval at least thirty (30) calendar days in advance of making them effective. Medicaid, at its sole discretion, may require that the Contractor modify its compliance plan. The Contractor compliance program must incorporate the policy and procedures to be specified by Medicaid and must incorporate the following:
  - K.2.3.1 Written policies, procedures, and standards of conduct that articulate Contractor's commitment to comply with all applicable federal and state standards;
  - K.2.3.2 Effective lines of communication between the compliance officer and the Contractor's employees, providers and contractors enforced through well-publicized disciplinary guidelines;

- K.2.3.3 Procedures for ongoing monitoring and auditing of Contractor systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;
- K.2.3.4 Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the compliance officer, to receive them. Several independent reporting paths must be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;
- K.2.3.5 Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR Part 438.608;
- K.2.3.6 Protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the Contractor. The Contractor must ensure that the identity of individuals reporting violations of the compliance plan shall be held in confidence to the utmost extent possible. Anyone who believes that he or she has been retaliated against may report this violation to the Alabama Medicaid Program Integrity Division and/or the U.S. Office of Inspector General;
- K.2.3.7 Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR Part 438.608(a)(1);
- K.2.3.8 Well-publicized disciplinary procedures that must apply to employees who violate the Contractor's compliance program;
- K.2.3.9 Effective training and education for the compliance officer, managers, employees, providers and members to ensure that they know and understand the provisions of Contractor's compliance plan;
- K.2.3.10 Procedures for timely consistent exchange of information and collaboration with the Alabama Medicaid Program Integrity Division; and
- K.2.3.11 Provisions that comply with 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Medicaid, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the State of Alabama or its Departments.

### K.3 Prohibited Affiliations

K.3.1 In accordance with 42 CFR § 438.610 and 42 CFR § 457.935, the Contractor must not knowingly have a relationship of the type described in this section with the following:

K.3.1.1 An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation or from participating in non- procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

K.3.1.2 An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR § 2.101, of a person described in this section.

K.3.1.3 The Contractor must not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under Sections 1128 or 1128A of the Social Security Act.

K.3.1.4 The relationships described in this section are as follows:

K.3.1.4.1 A director, officer or partner of the Contractor;

K.3.1.4.2 A Subcontractor;

K.3.1.4.3 A person with beneficial ownership of five percent (5%) or more of the Contractor's equity.

K.3.1.4.4 A Participating Provider or person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Contract.

K.3.2 If Medicaid learns that Contractor has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in Federal healthcare programs, Medicaid:

K.3.2.1 Must notify the Secretary of HHS of the noncompliance;

K.3.2.2 May continue an existing agreement with the Contractor unless the Secretary of HHS directs otherwise; and

K.3.2.3 May not renew or extend the existing Contract with the Contractor unless the Secretary of HHS provides to Medicaid and to Congress a written statement describing compelling reasons that exist for renewing or extending the Contract despite the prohibited affiliations.

- K.3.2.4 Nothing in this section must be construed to limit or otherwise affect any remedies available to the United States under Sections 1128, 1128A, or 1128B of the Social Security Act.
- K.3.3 The Contractor must disclose to CMS and Medicaid, and to Enrollees upon reasonable request, information on ownership and control, business transactions and persons convicted of crimes in accordance with 42 CFR Part 455, Subpart B. The Contractor must obtain federally required disclosures from all Participating Providers and applicants in accordance with 42 CFR § 455 Subpart B and 42 CFR § 1002.3, and as specified by Medicaid including but not limited to obtaining such information through Provider enrollment forms.
- K.3.4 The Contractor must notify Medicaid within three (3) business days of the time it receives notice that action is being taken against the Contractor or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the Contractor or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.
- K.3.5 The Contractor must disclose to Medicaid, any persons or corporations with an ownership or control interest in the Contractor that:
  - K.3.5.1 Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's equity
  - K.3.5.2 Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least five percent (5%) of the value of the Contractor's assets
  - K.3.5.3 Is an officer or director of a Contractor organized as a corporation
  - K.3.5.4 Is a partner in a Contractor organized as a partnership
- K.3.6 In accordance with 42 CFR § 455.104(b), the Contractor must disclose the following to Medicaid:
  - K.3.6.1 The name and address of any individual or corporation with an ownership or control interest in Contractor. The address for corporate entities must include an applicable primary business address, every business location, and P.O. Box address;
  - K.3.6.2 Date of birth and Social Security Number (in the case of an individual);
  - K.3.6.3 Other tax identification number (in the case of a corporation) with an ownership or control interest in Contractor or in any Subcontractor in which Contractor has a five percent (5%) or more interest;

- K.3.6.4 Whether the individual or corporation with an ownership or control interest in Contractor is related to another person with ownership or control interest in Contractor as a spouse, parent, child, or sibling; or whether the individual or corporation with an ownership or control interest in any Subcontractor in which Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling;
  - K.3.6.5 The name of any other disclosing entity (or Medicaid's Fiscal Agent or other managed care entity) in which an owner of Contractor has an ownership or control interest; and
  - K.3.6.6 The name, address, date of birth, and Social Security Number of any managing employee of Contractor.
- K.3.7 In accordance with 42 CFR § 455.104(c), disclosures from Contractor are due at any of the following times:
- K.3.7.1 Upon the Contractor submitting a proposal in accordance with Medicaid's procurement process;
  - K.3.7.2 Upon execution, renewal, or extension of a Contract with Medicaid; or
  - K.3.7.3 Within thirty-five (35) calendar days after any change in ownership of the Contractor.
- K.3.8 In accordance with 42 CFR § 455.104(d), all disclosures must be provided to Medicaid.
- K.3.9 In accordance with 42 CFR § 455.104(e), Federal financial participation (FFP) is not available in any amounts made to a Contractor that fails to disclose ownership or control information as required by said section. FFP is also not available for any amounts paid to the Contractor that could be excluded from participation in Medicare or Medicaid for any of the following reasons:
- K.3.9.1 The Contractor is controlled by a sanctioned individual;
  - K.3.9.2 The Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in Section 1128(b)(8)(B) of the Social Security Act; or
  - K.3.9.3 The Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

K.3.9.3.1 Any individual or entity excluded from participation in Federal health care programs; or

K.3.9.3.2 Any entity that would provide those services through an excluded individual or entity.

K.3.10 The Contractor must maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to Medicaid in accordance with this Contract and relevant Federal and State laws and regulations. In addition, the Contractor must comply with all reporting and disclosure requirements of 42 USC § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act. The Contractor must also comply with all reporting and disclosure requirements set forth in any federal or state statute or regulation. See the Exhibits of this RFP.

#### K.4 Reporting

K.4.1 In accordance with 42 CFR § 455.1(a)(1) and §455.17, the Contractor must be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the State Office and Alabama Attorney General Medicaid Fraud Control Unit (MFCU) and Medicaid within five (5) business days of discovery, taking prompt corrective actions and cooperating with Medicaid in its investigation of the matter(s). Additionally, the Contractor must notify Medicaid within three (3) business days of the time it receives notice that action is being taken against the Contractor or Contractor employee, network providers contractor or contractor employee or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the Contractor or a Medicaid contractor or CHIP program, or any program listed in Executive Order 12549.

K.4.2 The Contractor, through its compliance officer, must report all activities on a quarterly basis to Medicaid. If fraud, abuse, waste, neglect or overpayment issues are suspected, the Contractor compliance officer must report it to Medicaid immediately upon discovery. Reporting must include, but are not limited to:

K.4.2.1 Number of complaints of fraud, abuse, waste, neglect and overpayments made to the Contractor that warrant preliminary investigation;

K.4.2.2 Number of complaints reported to the Compliance Officer; and

K.4.2.3 For each complaint that warrants investigation, the Contractor must provide Medicaid, at a minimum, the following:

K.4.2.3.1 Name and ID number of provider and member involved if available;

K.4.2.3.2 Source of complaint;

- K.4.2.3.3 Type of provider;
- K.4.2.3.4 Nature of complaint;
- K.4.2.3.5 Approximate dollars involved if applicable; and
- K.4.2.3.6 Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.

## K.5 Dental Records

K.5.1 The Contractor must have a method to verify that services for which reimbursement was made, was provided to members. The Contractor must have policies and procedures to maintain, or require Contractor providers and contractors to maintain, an individual dental record for each member. The Contractor must ensure the dental record is:

- K.5.1.1 Accurate and legible;
- K.5.1.2 Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and
- K.5.1.3 Readily available for review and provides dental and other clinical data required for Quality and Utilization Management review.

K.5.2 In addition to any state regulatory requirements, the Contractor must ensure the dental record includes, minimally, the following:

- K.5.2.1 Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);
- K.5.2.2 Primary language spoken by the member and any translation needs of the member;
- K.5.2.3 Services provided through the Contractor, date of service, service site, and name of service provider;
- K.5.2.4 Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the Contractor;
- K.5.2.5 Referrals including follow-up and outcome of referrals;
- K.5.2.6 Documentation of emergency and/or after-hours encounters and follow-up;
- K.5.2.7 Signed and dated consent forms (as applicable);



- K.5.2.8 Documentation of advance directives, as appropriate; and
- K.5.2.9 Documentation of each visit, which must include:
  - K.5.2.9.1 Date and begin and end times of service;
  - K.5.2.9.2 Chief complaint or purpose of the visit;
  - K.5.2.9.3 Diagnoses or dental impression;
  - K.5.2.9.4 Objective findings;
  - K.5.2.9.5 Patient assessment findings;
  - K.5.2.9.6 Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG);
  - K.5.2.9.7 Medications prescribed;
  - K.5.2.9.8 Health education provided;
  - K.5.2.9.9 Name and credentials of the provider rendering services (e.g. DDS) and the signature or initials of the provider; and
  - K.5.2.9.10 Initials of providers must be identified with correlating signatures.
- K.5.3 The Contractor must provide one (1) free copy per calendar year of any part of member's record upon member's request.
- K.5.4 All documentation and/or records maintained by the Contractor or any and all of its network providers must be maintained for at least six (6) years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

## **L. Grievances and Appeals**

### **L.1 General**

- L.1.1 In accordance with 42 CFR § 438 Subpart F, the Contractor must establish and maintain a Grievance and Appeal system under which Enrollees, or Providers acting on their behalf, may file Grievances and Appeal Adverse Benefit Determinations. The Grievance and Appeals system must include a Grievance process, an Appeals process and access to the State's Fair Hearing System, as well as processes to collect and track information about the Grievance and Appeal System appropriately.

L.1.2 In the event of any conflict or discrepancy between the provisions of this section and the hearing rules set forth in Alabama Medicaid Administrative Code Rules 560-X-3-.01 through 560-X-3-.07, this section shall control and the conflicting provisions of the other stated rules shall not apply.

L.1.3 An Aggrieved Party may request a Fair Hearing by filing a written request with the Medicaid Administrative Hearings Office within 60 calendar days of the date of the reconsideration denial notice by the selected Contractor. The selected Contractor's consulting and other appropriate personnel who were involved in the denial must be available at Medicaid's request Monday through Friday, from 8:00 am to 5:00 pm, to provide justification for the denial and participate in any Fair Hearings as scheduled by Medicaid.

## L.2 Definitions

L.2.1 For the purposes of this section only, the following terms have the following meanings when capitalized:

- Enrollee - a Medicaid Recipient currently enrolled with a Contractor. When used in this section, the term Enrollee also includes a Provider or any other person authorized by the Enrollee in writing on Medicaid's approved form to act on behalf of an Enrollee in accordance with Alabama Medicaid Administrative Code Rules 560-X-26-.01 through 560-X-26-.03, or a person authorized by court order to act on behalf of an Enrollee (with the exception that Providers cannot request a continuation of benefits).
- Grievance - an expression of dissatisfaction by an Enrollee about any matter other than an Adverse Benefit Determination as defined in this section. Grievances may include, but are not limited to, the quality of care or Covered Services provided, and aspects of interpersonal relationships such as rudeness or failure to respect the Enrollee's rights regardless of whether remedial action is requested. Grievances also include an Enrollee's right to dispute an extension of time proposed by the Contractor to make a Prior Authorization decision.

### L.2.1.1 Adverse Benefit Determination:

L.2.1.1.1 Denial or limited authorization of a requested service, including the determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service;

L.2.1.1.2 Reduction, suspension, or termination of a previously authorized Covered Service;

L.2.1.1.3 Denial, in whole or in part, of payment for a Covered Service;

- L.2.1.1.4 Failure to cover or provide Covered Services in a timely manner, as specified in Section II.C.6.3;
- L.2.1.1.5 Failure of the Contractor to process and resolve Grievances, Appeals or Expedited Appeals within the required timeframes herein; or
- L.2.1.1.6 For an Enrollee that resides in a rural area, as determined by CMS, the denial of an Enrollee's request to obtain Covered Services outside the Provider Network in accordance with 42 CFR § 438.52(b)(2)(ii):
  - L.2.1.1.6.1 From any other Provider (in terms of training, experience, and specialization) not available within the Provider Network.
  - L.2.1.1.6.2 From a non-Network Provider who is the main source of a service to the Enrollee, as long as that Provider is given the same opportunity to become a Participating Provider as other similar Providers. If the Provider does not choose to join the Provider Network or does not meet the qualifications, the Enrollee is given a choice of Participating Providers and is transitioned to a Participating Provider within sixty (60) calendar days.
  - L.2.1.1.6.3 Because the Contractor or the only Provider available does not cover or provide the Covered Service due to moral or religious objections.
  - L.2.1.1.6.4 Because the Enrollee's Provider determines that the Enrollee needs related Covered Services that would subject the Enrollee to unnecessary risk if received separately and not all related services are available within the Provider Network.
  - L.2.1.1.6.5 Medicaid determines that other circumstances warrant out-of-network treatment.
- L.2.1.1.7 The denial of an Enrollee's request to dispute a financial liability, including Cost Sharing.

L.2.1.2 Date of Appeal

L.2.1.2.1 For requests of an Appeal or State Fair Hearing where a written request is required, the date the Contractor or Medicaid receives a written request for an Appeal or State Fair Hearing.

L.2.1.2.2 For oral requests that are not required to be confirmed in writing (including but not limited to requests for expedited resolution under Section II.D.2.7.2), it must be the date the Contractor receives written confirmation of the request for an Appeal.

L.2.1.3 State Fair Hearing - the process described in 42 CFR part 431, Subpart E and Alabama Medicaid Administrative Code Rule 560-X-3-.01 through .07.

### L.3 Policies and Procedures for Grievance and Appeal System

L.3.1 The Contractor must develop, implement and maintain written policies and procedures approved by Medicaid that clearly and fully explain an Enrollee's right to file Grievances, Appeals, and request State Fair Hearings, as well as forms approved by Medicaid for doing so. Any material changes to such policies and procedures must be approved by Medicaid and copies provided to the Enrollees and Participating Providers in writing at least thirty (30) calendar days prior to implementation. Unless material changes are submitted for Medicaid review and/or approval, the Contractor must submit an annual attestation certifying there have been no material changes.

L.3.2 All policies, procedures, forms, and notices required herein must meet the requirements of Section II.L.1 of this RFP, 42 CFR § 438.10, and other applicable laws and regulations. The rights of an Enrollee and other information required under the Grievance and Appeal system must be fully set forth in the Provider Manual and Enrollee Handbook and must be posted on the Contractor's website. The Enrollee Handbook and other required information must be provided to the Enrollee within sixty (60) calendar days of enrollment. In accordance with 42 CFR § 438.414, such documents, and the information specified in 42 CFR § 438.10(g)(2)(xi), must also be provided to Providers and Subcontractors when their respective contracts are entered into.

L.3.3 The Contractor must cooperate with the Enrollee and provide reasonable assistance as needed to explain and complete forms and take other procedural steps related to the filing of Grievances, Appeals, and requests for State Fair Hearings, including but not limited to, providing free auxiliary aids and interpreter services upon request. The Contractor must also, if requested by the Enrollee, provide reasonable assistance to help the Enrollee understand the decision rendered.

L.3.4 The Contractor must maintain a toll free number with TTY/TTD and interpreter capability for Enrollees. The toll free number must be available during normal business hours.

- L.3.5 The Contractor's process for handling Grievances and Appeals must require that the Contractor:
  - L.3.5.1 Timely acknowledge, in writing, receipt of each Grievance and Appeal and state the date, time, and process by which the Grievance or Appeal is to be heard and decided.
  - L.3.5.2 Ensure that individuals making decisions in connection with any Grievance or Appeal are individuals:
    - L.3.5.2.1 Who were neither involved in any previous level of review or decision-making regarding the matters at issue nor a subordinate of such individual.
    - L.3.5.2.2 Who, if deciding any of the following, are individuals with appropriate clinical expertise, as determined by Medicaid, in treating the Enrollee's condition or disease:
      - L.3.5.2.2.1 The Grievance or Appeal involves clinical issues
      - L.3.5.2.2.2 The Appeal is of a denial of a Prior Authorization based on lack of Medical Necessity, or
      - L.3.5.2.2.3 A Grievance is received regarding denial of a request for an expedited appeal.
    - L.3.5.2.3 Who must take into account all comments, documents, records, and other information submitted by the Enrollee, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
  - L.3.5.3 Provide that oral Appeal requests of an Adverse Benefit Determination are treated as Appeals and must be confirmed in writing in accordance with the timeframes established herein, unless the Enrollee requests expedited resolution.
  - L.3.5.4 Provide that all Appeal requests required to be filed in writing must be signed by the requesting party. For purposes of the signature requirement, the Contractor must accept handwritten signatures, as well as electronic or digital signatures, in accordance with Alabama Medicaid Administrative Code Rule 560-X-1-.18.
  - L.3.5.5 Provide the Enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

- L.3.5.6 Provide the Enrollee a copy of the Enrollee's file, Medical Records, other documents and records, and any new or additional evidence considered, relied upon or generated by the Contractor in connection with the Appeal of an Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the Appeal resolution timeframe established herein.
- L.3.5.7 Include as parties to the Appeal, the Enrollee and his or her representative or the legal representative of a deceased Enrollee's estate.
- L.3.6 The Contractor must advise Enrollee of the right to request benefits as set forth in Section II.L.3.2 of this RFP, 42 CFR § 438.420, and any other applicable laws and regulations while the Appeal or State Fair Hearing is pending and that the Enrollee may in such case, if consistent with Medicaid policy, be held liable for the cost of those benefits if the Appeal or State Fair Hearing is not decided in favor of Enrollee.
- L.3.7 The Contractor must not discourage any Enrollee from using any aspect of the Grievance and Appeal System set forth in this section nor encourage the withdrawal of a Grievance, Appeal, State Fair Hearing request or request for an expedited resolution filed pursuant to this section. The Contractor must not use any such filing or resolution thereof as a reason to retaliate against the Enrollee or Provider or as a basis to seek disenrollment of the Enrollee or his/her Provider.
- L.3.8 Consistent with rules promulgated by Medicaid and otherwise required by law, the Enrollee's right to confidentiality must be maintained as much as practical through each step of the Grievance and Appeal system taking into consideration the need for disclosure of medical information and any other information necessary to resolve the Enrollee's Grievance, Appeal or State Fair Hearing, to determine payments or benefits that may be due and/or to evaluate quality of care by the Contractor or the effectiveness of the Grievance and Appeal system established by the Contractor. Contractor must use and/or disclose the minimum Enrollee Medical Records and other confidential information necessary for the purpose of adjudicating Grievances and Appeals, and must protect the confidentiality of such information consistent with the requirements of HIPAA, including regulations at 45 CFR Parts 160 and 164.
- L.3.9 The failure on the part of a Contractor to timely resolve or act on an Enrollee's Appeal as required by this section may result in sanctions.
  - L.3.9.1 Should Medicaid reasonably conclude from the information provided that the Contractor has not established, maintained and enforced a Grievance and Appeal system that satisfies the provisions of this section and applicable laws and regulations, Medicaid shall require the Contractor to immediately take appropriate corrective action. Failure to take appropriate corrective action after a reasonable opportunity to correct the deficiency can lead to action brought by Medicaid against the Contractor, including, but not limited to, Sanctions in accordance with Section II.O of this RFP.

#### L.4 Grievance Process

- L.4.1 An Enrollee may submit a Grievance orally or in writing at any time. A Grievance may only be filed with the Contractor as the first step in the grievance process.
- L.4.2 The Contractor must acknowledge receipt of the Grievance within five (5) business days, consider each Enrollee Grievance and, provide notice of the resolution of the Grievance as expeditiously as the Enrollee's health condition requires but no more than thirty (30) calendar days from receipt of the Grievance.
- L.4.3 The Grievance process must be conducted in accordance with the policies and procedures established in Section II.L of this RFP including the selection of an individual to review the Grievance.
- L.4.4 The response to the Grievance by the Contractor must be in writing in a format and language that at a minimum, meets the requirements of 42 CFR § 438.10, and fully explains the decision and reasons for each part of the Grievance presented.
- L.4.5 Enrollees have no right to Appeal an unsatisfactory resolution of a Grievance, provided however, the failure on the part of the Contractor to act on a Grievance as required by this section shall constitute an Adverse Benefit Determination which is subject to Appeal in accordance with the requirements established herein.

#### L.5 Adverse Benefit Determination

- L.5.1 Notice of Adverse Benefit Determination - In the event the Contractor makes an Adverse Benefit Determination regarding an Enrollee, a timely and adequate written notice of Adverse Benefit Determination must be mailed to the Enrollee as expeditiously as possible. The notice of Adverse Benefit Determination must be sent by mail to the Enrollee's last known address and may also be communicated to the Enrollee by email or facsimile transmission. Medicaid expects the notice to be mailed on the same day as dated. All notices of Adverse Benefit Determinations must at a minimum, clearly and thoroughly explain in accordance with 42 CFR § 438.10, on forms approved by Medicaid, the following:
  - L.5.1.1 The Adverse Benefit Determination the Contractor has taken or proposes to take and when.
    - L.5.1.1.1 The reasons for the Adverse Benefit Determination, including the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination. Such information includes Medical Necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

- L.5.1.2 The Enrollee's right to Appeal to the Contractor's Dental Director to challenge the Adverse Benefit Determination under the provisions of this RFP, 42 CFR Part 438, Subpart F, including but not limited to, information on exhausting the Contractor's one level of appeal set forth herein, and the right to seek a State Fair Hearing.
  - L.5.1.3 The procedures an Enrollee must follow to exercise his or her right to Appeal to the Contractor's Dental Director and seek a State Fair Hearing.
  - L.5.1.4 The circumstances under which an Appeal or State Fair Hearing can be expedited in accordance with Section D.2.7.2 of this RFP and how to request it.
  - L.5.1.5 The procedures an Enrollee must follow to request and receive a continuation of benefits pending resolution of the Appeal and State Fair Hearing and the circumstances under which the Enrollee may later be required to pay for the Covered Services continued, consistent with State policy.
- L.5.2 Timing of notices of Adverse Benefit Determinations. The Contractor must mail the notice within the following timeframes:
- L.5.2.1 Advance Notice - For termination, suspension, or reduction of previously authorized covered services the notice must be sent at least ten (10) calendar days prior to the effective date of the Adverse Benefit Determination.
  - L.5.2.2 Exceptions from Advance Notice - The Contractor must send the notice not later than the date of Adverse Benefit Determination in the following circumstances:
    - L.5.2.2.1 In the death of the Enrollee;
    - L.5.2.2.2 A signed written Enrollee statement requesting Covered Service termination or giving information requiring termination or reduction of Covered Services and where he or she indicates an understanding that this must be the result of supplying that information);
    - L.5.2.2.3 The Enrollee's admission to an institution where he or she is ineligible for further Covered Services;
    - L.5.2.2.4 The Enrollee's address is unknown and mail directed to him or her has no forwarding address;
    - L.5.2.2.5 The Enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;



- L.5.2.2.6 The Enrollee's dentist prescribes a change in the level of oral health care;
- L.5.2.2.7 The notice involves an adverse determination with regard to preadmission screening requirements; or
- L.5.2.2.8 The transfer or discharge from a facility will occur in an expedited fashion as described in 42 CFR § 438.15.
- L.5.2.2.9 The period of advanced notice may be shortened to five (5) calendar days before the date of action if probable Enrollee fraud has been verified.
- L.5.2.2.10 For denial of payments, the notice must be sent at the time of any Adverse Benefit Determination affecting the claim.
- L.5.2.2.11 For standard Prior Authorization decisions that deny or limit Covered Services, as expeditiously as the Enrollee's condition requires that may not exceed fourteen (14) calendar days following receipt of the request for Covered Service with a possible extension of fourteen (14) calendar days if:
  - L.5.2.2.11.1 The Enrollee or Provider requests extension; or
  - L.5.2.2.11.2 The Contractor justifies to Medicaid a need for additional information and how the extension is in the Enrollee's best interest.
  - L.5.2.2.11.3 If the Contractor meets the required criteria for extending the timeframe for standard Covered Service Prior Authorization decisions consistent with Section II.L.5 of this RFP, it must:
    - L.5.2.2.11.3.1 Provide written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with the decision; and;

L.5.2.2.11.3.2 Issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

L.5.2.2.11.4 Covered Service Prior Authorization decisions not reached within the timeframes specified herein and/or as required under 42 CFR § 438.210(d) constitutes a denial and thus an Adverse Benefit Determination on the date the timeframes expire.

L.5.2.2.11.5 For expedited Covered Service Prior Authorization decisions in which a Provider indicates and/or the Contractor determines that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited Prior Authorization decision and provide notice as expeditiously as the Enrollee's health conditions requires and no later than seventy-two (72) hours after receipt of the request for service.

L.5.2.2.11.5.1 The Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the enrollee request an extension or of the Contractor justifies to Medicaid a need for additional information and how the extension is in the best interest of the Enrollee.

## L.6 Appeal and State Fair Hearing Process

### L.6.1 Appeal to Dental Director

- L.6.1.1 The Enrollee may within sixty (60) calendar days of receipt of notice of an Adverse Benefit Determination file an Appeal orally or in writing with the Dental Director of the Contractor. An oral notice of Appeal must be confirmed in writing within three (3) calendar days, unless the Enrollee requests an expedited appeal.
- L.6.1.2 The parties to an Appeal must include the Enrollee and his or her representative or the legal representative of a deceased Enrollee's estate.
- L.6.1.3 If the Contractor fails to adhere to the notice and timing requirements for Appeals required hereunder, the Enrollee must be deemed to have exhausted the Contractor's internal Appeal process and may then initiate the process for a State Fair Hearing.
- L.6.1.4 The Dental Director must send the Enrollee notice of receipt of the Appeal within three (3) calendar days from the Date of Appeal. The acknowledgment must state when the Enrollee's Appeal will be heard which, except as otherwise provided in this section, must be no later than twenty (20) calendar days from the Date of Appeal.
- L.6.1.5 The Contractor must provide the Dental Director all relevant parts of the Enrollee's case file and Medical Records and all other information submitted by the Enrollee.
- L.6.1.6 Within five (5) calendar days of the Date of Appeal, the Enrollee must submit to the Dental Director all written materials the Enrollee would like to be considered.
- L.6.1.7 The Dental Director must conduct the Appeal in accordance with the Contractor's policies and procedures that meet the requirements of Section II.L.5 of this RFP.
- L.6.1.8 The rules of evidence shall not apply.
- L.6.1.9 The Dental Director must resolve each Appeal and provide the Enrollee notice of the decision, as expeditiously as the Enrollee's health condition requires which in any event must be no more than thirty (30) calendar days from the Date of Appeal. The Dental Director's decision must be binding on the Contractor.
- L.6.1.10 Content and Notice of Appeal Resolution -The written notice must be in a format and language that, at a minimum, meets the requirements of 42 CFR § 438.10. Medicaid expects the notice to be mailed on the same day as dated. The notice must include the following:
  - L.6.1.10.1 The results of the decision including, reasonable detail regarding the basis of the decision and the date it was completed.

L.6.1.10.2 For Appeals not resolved wholly in the favor of the Enrollee:

L.6.1.10.2.1 The right and process to request a State Fair Hearing; and,

L.6.1.10.2.2 The right to request and receive a continuation of benefits while the State Fair Hearing is pending, and how to make the request.

L.6.1.10.2.3 That the Enrollee, consistent with State policy, be held liable for the cost of those benefits if the State Fair Hearing decision upholds the Contractor's Adverse Benefit Determination.

L.6.1.11 Extension of Timeframes

L.6.1.11.1 The Contractor may extend the Appeal timeframe up to fourteen (14) calendar days if:

L.6.1.11.1.1 The Enrollee requests the extension; or

L.6.1.11.1.2 The Contractor demonstrates (to the satisfaction of Medicaid upon the extension request) that there is need for additional information and how the delay is in the Enrollee's interest.

L.6.1.11.2 In the event the Contractor extends the timeframe not at the request of the Enrollee, the Contractor must complete all of the following:

L.6.1.11.2.1 Make reasonable efforts to provide the Enrollee prompt oral notice of the delay.

L.6.1.11.2.2 Within two (2) calendar days provide the Enrollee written notice of the reason(s) for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with the decision.

L.6.1.11.2.3 Resolve the Appeal as the Enrollee's health condition requires and no later than the date the extension expires.

## L.6.2 State Fair Hearing

- L.6.2.1 Should the Enrollee receive notice that the Adverse Benefit Determination has been upheld by the Dental Director, the Enrollee may request a State Fair Hearing within one hundred twenty (120) calendar days from the Contractor's notice of Appeal resolution. In the event an Enrollee files a State Fair Hearing request with the Contractor instead of Medicaid, the Contractor must forward such request to Medicaid within two (2) business days of receipt.
- L.6.2.2 Medicaid shall, within ten (10) calendar days from the Date of Appeal provide the Enrollee written notice of such receipt and of the date and time the State Fair Hearing has been scheduled by Medicaid. The State Fair Hearing must take place no later than twenty (20) calendar days from the Date of Appeal. Hearings may be continued for up to fourteen (14) calendar days at the request of the Enrollee, or for good cause shown, at the request of the Contractor.
- L.6.2.3 Medicaid shall request the following information from the Contractor which must be provided within seven (7) calendar days from the Date of Appeal of the State Fair Hearing request:
  - L.6.2.3.1 A copy of the relevant parts of the Enrollee's case file and Medical Records;
  - L.6.2.3.2 All documents considered by or presented to the Dental Director and the decision rendered.
- L.6.2.4 The Enrollee must be entitled to review all such information before and during the State Fair Hearing and are entitled to a copy of such information upon request.
- L.6.2.5 The Enrollee must be afforded a full evidentiary hearing in the Region in which the Enrollee resides.
- L.6.2.6 The parties to the State Fair Hearing must be the Contractor and the Enrollee and his or her representative or the representative of a deceased Enrollee's estate. The Enrollee may represent himself/herself before Medicaid or have someone else appear on the Enrollee's behalf in person, or in writing at the election of the Enrollee in accordance with applicable state and federal rules and regulations for appointing authorized representatives and be provided a reasonable opportunity to present evidence and testimony including the opportunity to cross-examine adverse witnesses and make legal and factual arguments.
- L.6.2.7 A record must be made of the hearing and the Contractor must be responsible for the cost.

L.6.2.8 Medicaid will issue a written decision within ninety (90) calendar days of the Date of Appeal to Medicaid stating with specificity the basis for the decision which shall be binding upon the Contractor.

#### L.6.3 Appeal to Circuit Court

L.6.3.1 If the Enrollee is dissatisfied with the decision rendered by Medicaid, the Enrollee may file an appeal to the circuit court in the county in which the Enrollee resides, or the county in which the Provider provides the services at issue to the Enrollee. The Enrollee must file the appeal in circuit court by no later than thirty (30) calendar days after receipt of the decision rendered in connection with the State Fair Hearing by Medicaid.

#### L.7 Expedited Appeals Process

L.7.1 Notwithstanding anything herein to the contrary, an Enrollee must have the right to request an expedited Appeal to the Contractor that would not follow the standard time for Appeals otherwise set forth in this section, if the Enrollee's Provider indicates or the Contractor determines that following the standard time for Appeal could seriously jeopardize the Enrollee's life, mental or physical health or the ability to attain, maintain or regain maximum function.

L.7.2 The Enrollee or Provider may file an expedited Appeal request either orally or writing. No additional Enrollee follow-up is required.

L.7.3 The Contractor must make a decision on the expedited appeal request no later than seventy-two (72) hours after receipt of the request for an expedited appeal.

L.7.4 If the decision is made to deny an expedited appeal, the Enrollee must be advised of the denial within forty-eight (48) hours of the request after which the standard review and Appeals process outlined in this section shall apply.

L.7.5 The Contractor must inform Enrollee of the limited time to exercise his or her rights in person and in writing, to present evidence and testimony and make legal and factual arguments sufficiently in advance of the Appeal resolution timeframe established herein.

L.7.6 The Contractor may extend the expedited Appeal process up to fourteen (14) calendar days if:

L.7.6.1 The Enrollee requests the extension; or

L.7.6.2 The Contractor demonstrates (to the satisfaction of Medicaid upon the extension request) that there is need for additional information and how the delay is in the Enrollee's interest.

L.7.7 In the event the Contractor extends the timeframe not at the request of the Enrollee, the Contractor must complete all of the following:

- L.7.7.1 Make reasonable efforts to give the Enrollee oral notice of the delay
- L.7.7.2 Within two (2) calendar days provide the Enrollee written notice of the reason(s) for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with the decision.
- L.7.7.3 Resolve the Appeal as the Enrollee's health condition requires and no later than the date the extension expires.
- L.7.7.4 The Contractor must ensure that punitive action is not taken against an Enrollee or his/her Provider who either requests an expedited resolution or supports an Enrollee's Appeal.

## L.8 Continuation of Benefits

- L.8.1 During the Appeal or State Fair Hearing provided for herein, the Contractor must continue the Enrollee's benefits if all the following conditions are met:
  - L.8.1.1 The Enrollee files a request for a continuation of benefits on or before the later of the following:
    - L.8.1.1.1 Within ten (10) calendar days of the Contractor mailing the notice of Adverse Benefit Determination, or within ten (10) calendar days of the Contractor mailing notice that the Adverse Benefit Determination was upheld on Appeal in favor of the Contractor.
    - L.8.1.1.2 The intended effective date of the Contractor's proposed Adverse Benefit Determination
  - L.8.1.2 The Enrollee files the notice of Appeal or request for State Fair Hearing timely in accordance with the timeframe established herein and all of the following are present:
    - L.8.1.2.1 The Appeal or State Fair Hearing request involves the termination, suspension, or reduction of a previously authorized Covered Services;
    - L.8.1.2.2 The Covered Services were ordered by an authorized Provider;
    - L.8.1.2.3 The original period covered by the original authorization has not expired; and
    - L.8.1.2.4 The Enrollee timely files for a continuation of benefits.
- L.8.2 If, at the Enrollee's request, the Contractor continues or reinstates the Enrollee's benefits while the Appeal or request for State Fair Hearing is pending, the benefits must be continued until one of the following occurs:

- L.8.2.1 The Enrollee withdraws the Appeal or request for State Fair Hearing in writing.
- L.8.2.2 The Enrollee fails to request a State Fair Hearing and continuation of benefits within the ten (10) calendar days from the Contractor's Notice of Decision
- L.8.2.3 Medicaid issues a State Fair Hearing decision adverse to the Enrollee.

L.8.3 If the final resolution of the Appeal or State Fair Hearing request is adverse to the Enrollee (i.e. upholds the Contractor's Adverse Benefit Determination) the Contractor may, consistent with the Medicaid's policy on recoveries under 42 CFR § 431.230(b), recover from the Enrollee the cost of the services furnished to the Enrollee while the Appeal and State Fair Hearing request is pending, to the extent that they were furnished solely because of the requirements of this section.

L.8.4 If Covered Services were not furnished to the Enrollee while the Appeal or request for a State Fair Hearing is pending and the decision to deny, limit, or delay services is reversed, the Contractor must authorize or provide the disputed Covered Services promptly, and as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date the Contractor received notice reversing the decision.

L.8.5 The Contractor must pay for disputed Covered Services, in accordance with Medicaid policy and regulations, if the decision to deny Prior Authorization of Covered Services is reversed and the Enrollee received the disputed Covered Services while the Appeal or State Fair Hearing was pending.

## L.9 Documentation

L.9.1 The Contractor must maintain records of Grievances and Appeals, as well as all decisions rendered in response, for at least ten (10) years.

L.9.2 The Contractor must review the records of Grievances and Appeals for completeness and accuracy regularly, but at least quarterly, and monitor the outcomes of such Grievances and Appeals for updates and as part of its quality assurance responsibility and ongoing monitoring procedures.

L.9.3 The Contractor's records of Grievances and Appeals must set forth at a minimum:

L.9.3.1 Each Enrollee's name for whom the Grievance or Appeal was filed;

L.9.3.2 The date each Grievance and/or Appeal was received;

L.9.3.3 A general description of the reason for each Grievance and Appeal;

L.9.3.4 The Enrollee's Provider for the Covered Service at issue, if any;



- L.9.3.5 Whether continuation of benefits were requested and provided in each instance;
  - L.9.3.6 The date of each review or, if applicable, review meeting;
  - L.9.3.7 The outcome of each Grievance or Appeal;
  - L.9.3.8 The date of decision by the Contractor;
  - L.9.3.9 The dates responses to the Grievance or Appeal were provided to the Enrollee; and
  - L.9.3.10 The total number of Grievances and Appeals.
- L.9.4 The Contractor must file a report at least annually with Medicaid that fairly and accurately summarizes the information required to be set forth on Grievances and Appeals.
- L.9.5 The records required in this subsection must be accurately maintained in a manner accessible to Medicaid and CMS. Medicaid and CMS upon request must be entitled to review all documents in the possession of the Contractor related to such Grievances and Appeals as a means of monitoring quality of care and the effectiveness of the policies and procedures of the Contractor in responding to Enrollee Grievances and Appeals.

## **M. Quality Assessment and Performance**

### **M.1 General**

- M.1.1 In accordance with 42 CFR § 438 Subparts D and E, the Contractor must have an ongoing Quality Assessment and Performance Improvement Program that executes a Quality Improvement Plan to systematically monitor and evaluate the quality and appropriateness of care and services rendered to Enrollees and promote and improve quality of care and quality patient outcomes for its Enrollees.
- M.1.2 The Contractor must develop, implement and maintain written policies and procedures which address components of effective oral health care management including but not limited to anticipation, identification, monitoring, measurement and evaluation of Enrollee's health care needs, and effective action to promote quality of care.
- M.1.3 The Contractor must develop and implement improvements in processes that enhance clinical efficiency, provide effective utilization, provide care coordination and focus on improved outcomes management.
- M.1.4 Any quality-related concerns that are identified by Medicaid, but are not included in a Performance Improvement Project (PIP) as set forth in Appendix F an Exhibit of this RFP must be addressed and resolved by the Contractor within timeframes specified by Medicaid.

- M.1.5 The Contractor must demonstrate in its care management specific interventions to better manage the care of and promote healthier Enrollee outcomes, including Enrollee incentives if any. See Section D.2.11 of this RFP for requirements related to use of Enrollee incentives.
- M.1.6 The Contractor must implement any performance measures and PIPs identified by CMS and required by Medicaid in accordance with 42 CFR §438.330(c)-(d).
- M.1.7 The Contractor must provide Medicaid any requested data for use in a managed care quality rating system implemented in accordance with 42 CFR § 438.334.
- M.1.8 The Contractor is not required to be a NCQA Accredited Health Plan, but if it is, the annual Accreditation report must be submitted to Medicaid for review.

## M.2 Quality Improvement Plan

M.2.1 The Contractor must develop and submit a written Quality Improvement Plan (herein “Improvement Plan”) to Medicaid within thirty (30) calendar days from execution of the RFP, and resubmit it to Medicaid annually by the start of the contract year of each year for written approval.

M.2.2 The Contractor must annually:

- M.2.2.1 Measure and report to Medicaid on its performance, using the standard measures required by Medicaid;
- M.2.2.2 Submit data, specified by Medicaid, which enables Medicaid to calculate the Contractor’s performance using the standard measures identified by Medicaid; or
- M.2.2.3 Perform a combination of the activities described in this subsection of this RFP.

M.2.3 The Improvement Plan must:

- M.2.3.1 Include processes for the investigation and resolution of individual performance or quality of care issues whether identified by the Contractor or Medicaid that:
  - M.2.3.1.1 Allow for the tracking and trending of issues on an aggregate basis pertaining to problematic patterns of care;

- M.2.3.1.2 Allow for annual submission and implementation of no fewer than two (2) PIPs in accordance with 42 CFR §438.330(d). Each PIP must be completed within timeframes established by Medicaid to allow information on the success of PIPs to be available to Medicaid for its ongoing review of the Contractor's Quality Assessment and Performance Improvement Program;
- M.2.3.1.3 Collect and submit performance measurement data in accordance with 42 CFR §438.330(c);
- M.2.3.1.4 Implement mechanisms to detect both underutilization and overutilization of services; and
- M.2.3.1.5 Implement mechanisms to assess the quality and appropriateness of care furnished to Enrollees with Special Health Care Needs.

M.2.4 Define how the Contractor is to use any of the programs or activities found in this RFP or Exhibits to develop its PIPs. Appendix F of this RFP sets forth PIP requirements.

M.2.5 Detail the Contractor's Enrollee incentive plans including but not limited to disclosure of incentive structure, value and methodology. The Contractor must be allowed to offer Enrollee incentive plans to encourage healthy behavior if such plans are in accordance with all applicable Federal and State laws, rules and regulations. See Section II.D.2.11 of this RFP for requirements related to use of Enrollee incentives.

M.2.6 Allow for input from both Medicaid and the Contractor.

### M.3 Practice Guidelines

M.3.1 The Contractor must adopt Practice Guidelines as set forth in this section.

M.3.2 The Contractor's adopted Practice Guidelines must be developed in consultation with the Contractor's Participating Providers and be reviewed and updated periodically, as appropriate.

M.3.3 The Contractor must develop Practice Guidelines based on the health needs of the Enrollee and opportunities for improvement identified as part of the Contractor's Quality Improvement Plan.

M.3.4 The Contractor must make Practice Guidelines available to all affected Providers, through the Provider Portal and other appropriate forums. The Contractor must also make Practice Guidelines available to Enrollees and Potential Enrollees upon request.

M.3.5 In accordance with 42 CFR § 438.236(d), the Contractor's decisions regarding utilization management, Enrollee education, coverage of services and other areas to which the guidelines apply must be consistent with the Contractor's Practice Guidelines.

#### M.4 External Quality Reviews

M.4.1 The Contractor must comply with applicable provisions of 42 CFR § 438 Subpart E.

M.4.2 On at least an annual basis, the Contractor must cooperate fully with any and all independent assessments as authorized by Medicaid and/or conducted by Medicaid's contracted External Quality Review Organization (EQRO) or other designee to assess the Contractor's performance including quality outcomes, timeliness of, and access to Covered Services.

M.4.3 Contractor must provide to the EQRO all information the EQRO deems to be necessary in performing its review of the Contractor.

M.4.4 Independent assessments must include, but not be limited to, validation of Contractor-submitted quality measure rates via an EQRO – or other designee – conducted audit, any independent evaluation required by Federal or State statute or regulation, and any other independent evaluation required by Medicaid.

#### M.5 Quality Measurement and Reporting

M.5.1 The Contractor must submit annual, quality measure data audited by Medicaid-contracted EQRO that reflects performance for the previous calendar year to Medicaid according to submission requirements defined in the Reporting Manual.

M.5.2 The Contractor must produce and report rates for all DBM Quality Measures in accordance with Medicaid specifications, including but not limited to, Dental Quality Alliance (DQA), National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS®), Agency for Healthcare Research and Quality (AHRQ) and EQRO-developed specifications. The reported rates must clearly identify the numerator and denominator used to calculate each rate. The Contractor must collect data from administrative systems, Medical Records, electronic records or through approved processes such as those utilizing a health information exchange (HIE), and provide this data with supporting documentation, as requested by Medicaid, for each measure.

M.5.3 The Contractor must comply with all measurement and reporting requirements in an Exhibit and Section II.F of this RFP. Contractor's failure to provide complete reports, certifications, or other information required of this Section II.F and an Exhibit of this RFP within the timeframes established by Medicaid must be considered deficient and will be subject to Sanctions.

M.5.3.1 Reports and certifications must be deemed incomplete when they do not contain all data required by Medicaid or when they contain inaccurate data.

## M.6 Quality Withhold Program

M.6.1 The Contractor must participate in Medicaid's Quality Withhold Program. Beginning on January 1, 2019, the Contractor will be subject to a one percent (1.0%) withhold of its total capitation payment to fund a quality withhold payment pool. In accordance with 42 CFR § 438.6(b)(6), the Quality Withhold Program must:

M.6.1.1 Be for a fixed period of time and performance will be measured during the rating period under the Contract in which the withhold arrangement is applied;

M.6.1.2 Not be renewed automatically;

M.6.1.3 Be made available to both public and private contractors under the same terms of performance;

M.6.1.4 Not condition Contractor participation in the Quality Withhold Program on the Contractor's entering into or adhering to intergovernmental transfer agreements; and

M.6.1.5 Be necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in Medicaid's quality strategy.

M.6.2 Additional details on the Quality Withhold Program are set forth in an Exhibit of this RFP.

## M.7 Provider Standards Committee

M.7.1 As required by and referenced in this RFP, the Contractor must have a Provider Standards Committee which must review and develop Provider Quality Measures. These Provider Quality Measures must be the performance standards and quality measures required of a Participating Provider by the Contractor.

M.7.2 The performance standards reviewed and developed by a provider standards committee must include, but not be limited to, provider performance benchmarks relating to the efficiency and management of care provided to Medicaid beneficiaries. Performance standards must not include office hours, terms of reimbursement or the application of such standards in a contract between the Contractor and a provider. The quality measures reviewed and developed by a provider standards committee must include, but not be limited to, numeric quantification of results or outcomes of high-quality care experienced by Medicaid beneficiaries.

- M.7.3 The Contractor must promptly publish and distribute to its providers and Medicaid all performance standards and quality measures developed by the provider standards committee.
- M.7.4 The performance standards and quality measures must be subject to the approval of the Medicaid Quality Assurance Committee established in Section 22-6-154 of the Alabama Code.
- M.7.4.1 If the Contractor or a provider is dissatisfied with any performance standard or quality measure developed or approved by the provider standards committee, the Contractor or provider who is dissatisfied may within 30 calendar days of publication of the performance standard or quality measure make a written request for review of the performance standard or quality measure to the Medicaid Quality Assurance Committee.
- M.7.4.2 Upon receipt of the request for review, the Medicaid Quality Assurance Committee shall request any information and documents to review the performance standard or quality measure at issue and the Contractor or the provider shall have 10 business days to provide the Medicaid Quality Assurance Committee with the requested information and documents and any additional supporting information and documents that the Contractor or provider wishes to present to the Medicaid Quality Assurance Committee. In addition, the chairperson of the provider standards committee shall have 10 business days to provide the Medicaid Quality Assurance Committee with requested information and documents concerning the basis, supporting studies and rationale for the performance standard or quality measure.
- M.7.4.3 The Medicaid Quality Assurance Committee shall either approve or disapprove the performance standard or quality measure at issue and shall promptly notify the Contractor, the provider and the provider standards committee of its determination. Upon request by the Medicaid Quality Assurance Committee, the provider standards committee must review any such approved performance standard or quality measure within six months after such approval and the provider standards committee must provide the Medicaid Quality Assurance Committee a written report detailing the efficacy of said performance standard or quality measure. The Medicaid Quality Assurance Committee may withdraw its approval of the performance standard or quality measure based upon the findings of the provider standards committee's report.
- M.7.4.4 No member of the Medicaid Quality Assurance Committee who also served on the provider standards committee which developed the performance standard or quality measure at issue must vote or participate in the Medicaid Quality Assurance Committee's review of that performance standard or quality measure.

- M.7.4.5 No performance standard or quality measure reviewed or developed by the Contractor's provider standards committee and/or by the Medicaid Quality Assurance Committee shall be subject to review. The contractual application of these standards and measures shall be subject to review but not the performance standards or quality measures themselves.
- M.7.5 At least 60 percent of the members of the provider standards committee must be dentists or oral surgeons licensed in the State of Alabama who provide care to Medicaid beneficiaries served by the Contractor. The dental practices of the provider members must be consistent with and reflective of the dental services provided Medicaid beneficiaries.
- M.7.6 The Contractor dental director must serve as chairperson of the provider standards committee.
- M.7.7 No more than 50 percent of the members of the provider standards committee must reside in one county of the Medicaid region.
- M.7.8 The members of the provider standards committee must serve two-year terms.
- M.7.9 The provider standards committee must meet at least semi-annually and at other times upon the written request of the chairperson or a majority of the members. Written notice indicating the date, time and place of each meeting must be sent to each member of the provider standards committee not less than 7 calendar days prior to said meeting by the chairperson or any member of the committee; provided, however, that any member of the committee may waive his or her right to such notice and such waiver may be oral, by telephone, or by any such means of communication.
- M.7.10 The members of the provider standards committee may participate in a meeting of the committee by means of telephone conference, videoconference, or similar communications equipment by means of which all persons participating in the meeting may hear each other at the same time. Participation by such means must constitute presence in person at a meeting for all purposes, including the establishment of a quorum.
- M.7.11 Medicaid may adopt and implement performance standards, quality measures and quality matrices in addition to or in conflict with the performance standards and quality measures adopted by a provider standards committee. In the event of any conflict between a performance standard, quality measure or quality matrix adopted by a provider standards committee and a performance standard, quality measure or quality matrix adopted by Medicaid, the performance standard, quality measure or quality matrix adopted by Medicaid must supersede the performance standard, quality measure or quality matrix adopted by the provider standards committee.
- M.7.12 Medicaid shall decide any disagreement concerning whether a specific issue, dispute or matter is to be considered by a provider standards committee under this rule or a contract dispute committee.

## M.8 Performance Monitoring and Improvement Process

- M.8.1 The Contractor must cooperate and participate, as requested by Medicaid, in Medicaid's performance monitoring and improvement process. At a minimum, this must include the following activities: the review of monthly, quarterly and annually-reported quality and Performance Measure data, including DBM Quality Measures as defined in Section II.M.5.2 of this RFP, Provider Quality Measures as defined in Section II.M.7 of this RFP, CMS-required performance standards and other measures as deemed appropriate by Medicaid to manage the Contractor.
- M.8.2 At least quarterly and upon request by Medicaid, the Contractor must attend a meeting with Medicaid to share performance results and to discuss performance successes and challenges to aid Medicaid in determining the effectiveness of Contractor's quality improvement activities.
- M.8.3 At least annually and upon request by Medicaid, the Contractor must attend a meeting with the Medicaid Quality Assurance Committee to be informed of the DBM Quality Measures for the upcoming calendar year.
- M.8.4 At least annually and upon request by Medicaid, the Contractor must facilitate a meeting with Medicaid and the Contractor's Provider Standards Committee to share the Contractor's performance results for the purpose of determining the effectiveness of Provider performance standards and Provider Quality Measures.
- M.8.5 Quality Monitoring by Medicaid - Medicaid shall review, at least annually, the impact and effectiveness of the Contractor's Quality Assessment and Performance Improvement Program. At least sixty (60) calendar days prior to Medicaid's review, the Contractor must provide to Medicaid:
- M.8.5.1 The Contractor's most current written Quality Assessment and Performance Improvement Program description;
  - M.8.5.2 The Contractor's most current annual Quality Improvement Plan;
  - M.8.5.3 The Contractor's most current Quality Improvement Plan evaluation for the previous calendar year;
  - M.8.5.4 Documentation of the Contractor's compliance with standards described by Medicaid's quality strategy; and
  - M.8.5.5 All other information requested by Medicaid to facilitate Medicaid's review of the Contractor's compliance standards defined in Medicaid's quality strategy.
- M.8.6 All documents submitted to Medicaid must provide evidence of a well-defined, organized program designed to improve care as set forth in Section II.M of this RFP, and must be deemed acceptable by Medicaid.



M.8.7 Medicaid's review of the impact and effectiveness of the Contractor's Quality Assessment and Performance Improvement Program must also include:

M.8.7.1 The results of the Contractor's PIPs;

M.8.7.2 The Contractor's compliance with Medicaid's quality strategy; and

M.8.7.3 The Contractor's historical or trend data.

## **N. Utilization Management**

### **N.1 Utilization Requirements**

#### **N.1.1 General Requirements**

N.1.1.1 The Contractor must develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization, which include, at minimum, procedures to evaluate medical necessity and the process used to review and approve the provision of dental services. The Contractor must submit an electronic copy of the UM policies and procedures to Medicaid or written approval within thirty (30) calendar days from the date the Contract is signed by the Contractor, but no later than prior to the Readiness Review, annually thereafter, and prior to any revisions.

N.1.1.2 The UM Program policies and procedures must meet all Utilization Review Accreditation Commission (URAC) standards or equivalent and include medical management criteria and practice guidelines that:

N.1.1.2.1 Are adopted in consultation with a contracting dental care professionals;

N.1.1.2.2 Are objective and based on valid and reliable clinical evidence or a consensus of dental care professionals in the particular field;

N.1.1.2.3 Are considering the needs of the members; and

N.1.1.2.4 Are reviewed annually and updated periodically as appropriate.

N.1.1.3 The policies and procedures must include, but not be limited to:

N.1.1.3.1 The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of dental care services;

- N.1.1.3.2 The data sources and clinical review criteria used in decision making;
  - N.1.1.3.3 The appropriateness of clinical review shall be fully documented;
  - N.1.1.3.4 The process for conducting informal reconsiderations for adverse determinations;
  - N.1.1.3.5 Mechanisms to ensure consistent application of review criteria and compatible decisions;
  - N.1.1.3.6 Data collection processes and analytical methods used in assessing utilization of dental care services; and
  - N.1.1.3.7 Provisions for assuring confidentiality of clinical and proprietary information.
- N.1.1.4 The Contractor must disseminate the practice guidelines to all affected providers and, upon request, to members. The Contractor must take steps to encourage adoption of the guidelines.
- N.1.1.5 The Contractor must identify the source of the dental management criteria used for the review of service authorization requests, including but not limited to:
- N.1.1.5.1 The Contractor must be identified if the criteria were purchased;
  - N.1.1.5.2 The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state dental care provider association or society;
  - N.1.1.5.3 The guideline source must be identified if the criteria are based on national best practice guidelines; and
  - N.1.1.5.4 The individuals who will make medical necessity determinations must be identified if the criteria are based on the dental/medical training, qualifications, and experience of the Contractor's Dental Director or other qualified and trained professionals.
- N.1.1.6 UM Program dental management criteria and practice guidelines must be disseminated to all affected providers, and members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

- N.1.1.7 The Contractor must have written procedures listing the information required from a member or dental care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or healthcare provider when requested. The procedures shall outline the process to be followed in the event the Contractor determines the need for additional information not initially requested.
- N.1.1.8 The Contractor must have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the Contractor may deny authorization of the requested service(s).
- N.1.1.9 The Contractor must have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines
- N.1.1.10 The Contractor must use Medicaid's medical necessity definition as defined in Medicaid's Provider Billing Manual and the Alabama Administrative Code for medical necessity determinations. The Contractor must make medical necessity determinations that are consistent with the Medicaid's definition.
- N.1.1.11 The Contractor must submit written policies and processes for Medicaid approval, within thirty (30) calendar days, but no later than prior to the Readiness Review, of the contract signed by the Contractor on how the core dental benefits and services the Contractor provides ensure:
  - N.1.1.11.1 The prevention, diagnosis, and treatment of health impairments;
  - N.1.1.11.2 The ability to achieve age-appropriate growth and development; and
  - N.1.1.11.3 The ability to attain, maintain, or regain functional capacity.
- N.1.1.12 The Contractor must identify the qualification of staff who will determine medical necessity.
- N.1.1.13 Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.
- N.1.1.14 The Contractor must ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease must determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

- N.1.1.15 The individual(s) making these determinations must not have a history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.
- N.1.1.16 The individual making these determinations must be required to attest that no adverse determination will be made regarding any dental procedure or service outside of the scope of such individual's expertise.
- N.1.1.17 The Contractor must provide a mechanism to reduce inappropriate and duplicative use of healthcare services. Services must be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The Contractor must not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The Contractor may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR 438.210.
- N.1.1.18 The Contractor must ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210.
- N.1.1.19 The Contractor must report fraud and abuse information identified through the UM program to Medicaid's Program Integrity Unit in accordance with 42 CFR 455.1(a)(1).
- N.1.1.20 In accordance with 42 CFR §456.111 and 456.211, the Contractor Utilization Review plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this section. This information must include, at least, the following:
- N.1.1.20.1 Identification of the enrollee;
  - N.1.1.20.2 The name of the enrollee's dentist;
  - N.1.1.20.3 Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;

- N.1.1.20.4 The plan of care required under 42 CFR 456.80 and 456.180;
- N.1.1.20.5 Initial and subsequent continued stay review dates described under 42 CFR 456.128, 456.133; 456.233 and 456.234;
- N.1.1.20.6 Date of operating room reservation, if applicable; and
- N.1.1.20.7 Justification of emergency admission, if applicable.

#### N.1.2 Utilization Management Committee

- N.1.2.1 The UM program must include a Utilization Management (UM) Committee that integrates with other functional units of the Contractor as appropriate and supports the Quality Assessment and Performance Improvement program (QAPI Program) (refer to the Quality Management subsection for details regarding the QAPI Program).
- N.1.2.2 The UM Committee must provide utilization review and monitoring of UM activities of both the Contractor and its providers and is directed by the Contractor's Dental Director. The UM Committee must convene no less than quarterly and shall submit a summary of the meeting minutes to Medicaid with other quarterly reports. UM Committee responsibilities include:
  - N.1.2.2.1 Monitoring providers' requests for rendering healthcare services to its members;
  - N.1.2.2.2 Monitoring the dental appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;
  - N.1.2.2.3 Reviewing the effectiveness of the utilization review process and making changes to the process as needed;
  - N.1.2.2.4 Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;
  - N.1.2.2.5 Monitoring consistent application of "medical necessity" criteria;
  - N.1.2.2.6 Application of clinical practice guidelines;
  - N.1.2.2.7 Monitoring over- and under-utilization;
  - N.1.2.2.8 Review of outliers; and

N.1.2.2.9 Dental Record Reviews.

N.1.2.3 Dental Record Reviews must be conducted to ensure that primary care dentists provide high quality healthcare that is documented according to established standards. The Contractor must establish and distribute to providers standards for Record Reviews that include all dental record documentation requirements addressed in the RFP.

N.1.2.4 The Contractor must maintain a written strategy for conducting dental record reviews, reporting results, and the corrective action process. The strategy must be provided within thirty (30) calendar days from the date the Contract is signed by the Contractor, but no later than prior to the Readiness Review, and annually thereafter. The strategy must include, at a minimum, the following:

N.1.2.4.1 Designated staff to perform this duty;

N.1.2.4.2 The method of case selection;

N.1.2.4.3 The anticipated number of reviews by practice site;

N.1.2.4.4 The tool the Contractor will use to review each site; and

N.1.2.4.5 How the Contractor will link the information compiled during the review to other Contractor functions (e.g. QI, credentialing, peer review, etc.)

N.1.2.5 The Contractor must conduct reviews at all primary dental services providers that have treated more than 100 unduplicated members in a calendar year, including individual offices and large group facilities. The Contractor must review each site at least one (1) time during each five (5) year period.

N.1.2.6 The Contractor must review a reasonable number of records, in a random process, at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target, though additional reviews must be completed for large group practices or when additional data is necessary in specific instances

N.1.2.7 The Contractor must report the results of all record reviews to Medicaid quarterly with an annual summary.

N.1.3 Utilization Management Reports

N.1.3.1 The Contractor must submit reports as specified by Medicaid. Medicaid reserves the right to request additional reports as deemed by Medicaid. Medicaid must make every effort to notify the Contractor of additional required reports no less than 30 calendar days prior to due date of those reports. However, there may be occasions the Contractor will be requested to submit reports in a shorter time frame.

#### N.1.4 Service Authorization

N.1.4.1 Service authorization includes, but is not limited to, prior authorization.

N.1.4.2 The Contractor UM Program policies and procedures must include service authorization policies and procedures consistent with 42 CFR 438.210 and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:

N.1.4.2.1 Written policies and procedures for processing requests for initial and continuing authorizations of services, where a provider does not request a service in a timely manner or refuses a service;

N.1.4.2.2 Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;

N.1.4.2.3 Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a healthcare professional who has appropriate clinical expertise in treating the enrollee's condition or disease;

N.1.4.2.4 Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process must be included in its member manual and incorporated in the grievance procedures;

N.1.4.2.5 The Contractor's service authorization system must provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and

N.1.4.2.6 The Contractor's service authorization system must have capacity to electronically store and report all service authorization requests, decisions made by the Contractor regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.

N.1.4.3 The Contractor must not deny continuation of higher level services for failure to meet medical necessity unless the Contractor can provide the service through an in-network or out-of-network provider for a lower level of care.

#### N.1.5 Timing of Service Authorization Decisions

##### N.1.5.1 Standard Service Authorization

N.1.5.1.1 The Contractor must make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate dental information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations must be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested. The Contractor must maintain documentation system to report to Medicaid on a monthly basis all service authorizations provided in the format specified by Medicaid.

N.1.5.1.2 An extension may be granted for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the Contractor justifies to Medicaid a need for additional information and the extension is in the member's best interest. In no instance must any determination of standard service authorization be made later than (25) calendar days from receipt of the request.

##### N.1.5.2 Expedited Service Authorization

N.1.5.2.1 In the event a provider indicates, or the Contractor determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.



N.1.5.3 Post Authorization

N.1.5.3.1 The Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the Contractor justifies to Medicaid a need for additional information and how the extension is in the member's best interest.

N.1.5.3.2 The Contractor must make retrospective review determinations within thirty (30) calendar days of obtaining the results of any appropriate dental or medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.

N.1.5.3.3 The Contractor must not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.

N.1.5.4 Timing of Notice

N.1.5.4.1 Approval

N.1.5.4.1.1 For service authorization approval for a non-emergency admission, procedure or service, the Contractor must notify the provider of as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and must provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.

N.1.5.4.1.2 For service authorization approval for extended stay or additional services, the Contractor must notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service within one (1) business day of the service authorization approval.

N.1.5.4.2 Adverse Action

N.1.5.4.2.1 The Contractor must notify the member, in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in this RFP. The notice of action to members must be consistent with requirements in 42 CFR §438.10(c) and (d), 42 CFR §438.404(c), and 42 CFR §438.210(b)(c)(d) and in this RFP for member written materials.

N.1.5.4.2.2 The Contractor must notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

#### N.1.5.4.3 Informal Reconsideration

N.1.5.4.3.1 As part of the Contractor appeal procedures, the Contractor must include an Informal Reconsideration process that allows the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

N.1.5.4.3.2 In a case involving an initial determination, the Contractor must provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the dentist or clinical peer making the adverse determination.

N.1.5.4.3.3 The informal reconsideration should occur within one (1) business day of the receipt of the request and should be conducted between the provider rendering the service and the Contractor's dentist authorized to make adverse determinations or a clinical peer designated by the Dental Director if the dentist who made the adverse determination cannot be available within one (1) business day. The informal reconsideration will in no way extend the 30 day required timeframe for a Notice of

## Appeal Resolution.

### N.1.5.4.4 Exceptions to Requirements

- N.1.5.4.4.1 The Contractor must not require service authorization for emergency dental services as described in this section whether provided by an in-network or out-of-network provider.
- N.1.5.4.4.2 The Contractor must not require service authorization or referral for EPSDT dental screening services.
- N.1.5.4.4.3 The Contractor must not require service authorization for the continuation of covered services of a new member transitioning into the Contractor, regardless of whether such services are provided by an in-network or out-of-network provider, however, the Contractor may require prior authorization of services beyond thirty (30) calendar days.

## III. Pricing

Contractors must complete Appendix C and the RFP Coversheet, the first page of this RFP.

## IV. General Medicaid Information

The Alabama Medicaid Agency is responsible for the administration of the Alabama Medicaid Program under a federally approved State Plan for Medical Assistance. Through teamwork, Medicaid 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 Medicaid personnel located in eleven (11) district offices throughout the state and by one hundred forty (140) out-stationed workers in designated hospitals, health departments and clinics. Medicaid eligibility is also determined through established policies by the Alabama Department of Human Resources and the Social Security Administration. In 2015, an average of 1,049,787 Alabama citizens were eligible for Medicaid benefits through a variety of programs.

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

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

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

## V. General

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

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

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

## VI. Corporate Background and References

### Entities submitting proposals and all subcontractors must:

- a. Provide evidence that the Contractor possesses the qualifications required in this RFP.
  - b. Provide a description of the Contractor's organization, including:
    1. Date established.
    2. Ownership (public company, partnership, subsidiary, etc.). Include an organizational chart depicting the Contractor's organization in relation to any parent, subsidiary or related organization.
    3. Number of employees and resources.
    4. Names and resumes of Key Personnel in regards to this contract.
    5. A list of all similar projects the Contractor has completed within the last 5 years.
    6. A detailed breakdown of proposed staffing for this project, including names and education background of all employees that will be assigned to this project as explained in Section II of the RFP.
    7. A list of all Medicaid agencies or other entities for which the Contractor currently performs similar work.
    8. Contractor's acknowledgment that Medicaid will not reimburse the Contractor until: (a) the Project Director has approved the invoice; and (b) Medicaid has received and approved all deliverables covered by the invoice.
    9. Details of any pertinent judgment, criminal conviction, investigation or litigation pending against the Contractor or any of its officers, directors, employees, agents or subcontractors of which the Contractor has knowledge, or a statement that there are none. Medicaid reserves the right to reject a proposal solely on the basis of this information.
  - c. Have all necessary business licenses, registrations and professional certifications at the time of the contracting to be able to do business in Alabama. Alabama law provides that a foreign corporation (a business corporation incorporated under a law other than the law of this state) may not transact business in the state of Alabama until it obtains a Certificate of Authority from the Secretary of State. To obtain forms for a Certificate of Authority, contact the Secretary of State, (334) 242-5324, [www.sos.state.al.us](http://www.sos.state.al.us). The Certificate of Authority or a letter/form showing application has been made for a Certificate of Authority must be submitted with the bid.
  - d. Have proven experience performing DBM work for Medicaid programs and have been in business a minimum of 5 years.
  - e. Furnish three (3) references for projects of similar size and scope, including contact name, title, telephone number, and address. Performance references should also include contract type, size, and duration of services rendered. **You may not use any Alabama Medicaid Agency personnel as a reference.**
  - f. Document the resources and capability for completing the work necessary to implement the DBM. The Contractor proposal must include a chart outlining the proposed tasks needed to complete the implementation by the Readiness Assessment deadline, as well as outline follow-up and routine reporting deliverables and staff needed to complete the proposed tasks.
-

g. Solvency

1. The Contractor must maintain minimum solvency and financial requirements as provided in this subsection at the following levels:
2. Restricted reserves of two hundred fifty thousand dollars (\$250,000) or an amount equal to twenty-five percent (25%) of the Contractor's total actual or projected average monthly expenditures, whichever is greater.
3. Capital or surplus, or any combination thereof, of five hundred thousand dollars (\$500,000).
4. The Contractor must adjust the required restricted reserves within thirty (30) calendar days after the end of each calendar quarter. Adjustments must be based on the average monthly total capitated payment for such preceding quarter.
5. Instead of maintaining the financial reserves as required in g.2 of this subsection, the Contractor may submit to Medicaid a written guaranty in the form of a letter of credit issued by a financial institution, in an amount equal to the financial reserves that would otherwise be required of the Contractor under this Contract, to guarantee the performance of the provisions of this Contract. The letter of credit shall be issued by a financial institution authorized in the State of Alabama and approved by Medicaid. No assets of the Contractor shall be pledged or encumbered in connection with the performance bond.
6. Unless and until the Contractor satisfies its financial reserve requirements with a performance bond, the Contractor shall establish a restricted reserve account with a third party financial institution that is authorized to do business in the State of Alabama and is satisfactory to Medicaid for the purpose of holding the Contractor's restricted reserve funds.
7. Medicaid has the authority to require additional capital and surplus, access and disburse the Contractor's restricted reserves, and impose other obligations on the Contractor if Medicaid determines that the Contractor is in a hazardous financial condition or insolvent.
8. If and when Medicaid determines from any information, report, document or statement made to Medicaid or from any examination conducted by Medicaid that an organization demonstrates a hazardous financial condition or is insolvent, Medicaid may take action.
9. The Contractor shall be responsible for continuation of services to Enrollees during insolvency, for the duration of the period for which payment may be due to Providers, or for fifteen (15) calendar days after termination of the Contract.
10. If Medicaid determines that the Contractor is insolvent, Medicaid shall notify the Contractor's provider network of the Contractor's insolvency.
11. In the event of the Contractor's insolvency, the Contractor shall not hold its Enrollees liable for the Contractor's debts.
12. The Contractor shall provide such financial reports and information as required by Medicaid. The Contractor must promptly provide written notice of any change in the financial condition of the Contractor which could result in a determination by Medicaid of a hazardous financial condition or insolvency, including but not limited to any deficiency in the required restricted reserves or capital and surplus of the Contractor. The notice must describe the circumstances leading or contributing to hazardous financial conditions or insolvency and the Contractor's plan of action for addressing the circumstance. The Contractor recognizes that Medicaid may at any

time take any action or exercise any authority, right or remedy available under this Contract or applicable law in connection with change in financial condition.

Medicaid reserves the right to use any information or additional references deemed necessary to establish the ability of the Contractor to perform the conditions of the contract.

## VII. Submission Requirements

### A. Authority

This RFP is issued under the authority of Section 41-16-72 of the Alabama Code and 45 CFR part 75. The RFP process is a procurement option allowing the award to be based on stated evaluation criteria. The RFP states the relative importance of all evaluation criteria. No other evaluation criteria, other than as outlined in the RFP, will be used.

In accordance with 45 CFR part 75, Medicaid encourages free and open competition among Contractors. Whenever possible, the Medicaid will design specifications, proposal requests, and conditions to accomplish this objective, consistent with the necessity to satisfy Medicaid's need to procure technically sound, cost-effective services and supplies.

### B. Single Point of Contact

From the date this RFP is issued until a Contractor 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. **Contractors or their representatives must not communicate with any Medicaid staff or officials regarding this procurement with the exception of the Project Director.** Any unauthorized contact may disqualify the Contractor from further consideration. Contact information for the single point of contact is as follows:

<i>Project Director:</i>	<b>Beth Huckabee</b>
<i>Address:</i>	<b>Alabama Medicaid Agency Lurleen B. Wallace Bldg. 501 Dexter Avenue PO Box 5624 Montgomery, Alabama 36103-5624</b>
<i>E-Mail Address:</i>	<b><u><a href="mailto:DBMRFP@medicaid.alabama.gov">DBMRFP@medicaid.alabama.gov</a></u></b>

### 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 Medicaid's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

### D. Questions Regarding the RFP

Contractors with questions requiring clarification or interpretation of any section within this RFP must submit questions and receive formal, written replies from Medicaid. Each question must be submitted to

the Project Director via email. Questions and answers will be posted on the Medicaid website as described in the Schedule of Events.

#### **E. Mandatory Contractor Conference**

There will be a mandatory in-person conference of all Contractors interested in submitting a proposal in response to this RFP. The Contractor submitting the Proposal or its representative must register in-person as required at the site of this mandatory conference.

A Proposal submitted by a Contractor which failed to attend the mandatory conference and register as required will be rejected upon receipt.

The mandatory conference will be held at the Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, AL, 2<sup>nd</sup> floor Auditorium at 10:00 AM on Wednesday, August 9, 2017.

Contractors will have the opportunity to ask questions during the conference. The State will not respond to questions during the conference but will post a written response as provided in Section VII.D.

The Contractor must complete Appendix H - Intent to Attend Mandatory Contractor Conference Notification and submit to the Project Director via email.

#### **F. Acceptance of Standard Terms and Conditions**

Contractor must submit a statement stating that the Contractor has an understanding of and will comply with the terms and conditions as set out in this RFP. Additions or exceptions to the standard terms and conditions are not allowed. Any addition or exception to the terms and conditions are considered severed, null and void, and may result in the Contractor's proposal being deemed non-responsive.

#### **G. Adherence to Specifications and Requirements**

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

#### **H. Order of Precedence**

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

#### **I. Contractor's Signature**

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



**J. Offer in Effect for 365 Days**

A proposal may not be modified, withdrawn or canceled by the Contractor for a 365-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 Contractor so agrees in submitting the proposal.

**K. Medicaid 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 Medicaid are entirely the responsibility of the Contractor. Medicaid is not liable for any expense incurred by the Contractor in the preparation and presentation of their proposal or any other costs incurred by the Contractor prior to execution of a contract.

**L. Medicaid's Rights Reserved**

While the Medicaid 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 Medicaid to award and execute a contract. Upon a determination such actions would be in its best interest, Medicaid, 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 Contractor whose proposal is within the competitive range with respect to technical plan and cost;
- Adopt to its use all, or any part, of a Contractor'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 Medicaid and will be posted on the RFP website);
- Not award any contract.

**M. Price**

Contractors must respond to this RFP by utilizing the RFP Cover Sheet to indicate the aggregate bid rate within the rate ranges provided in Appendix C.

**N. Submission of Proposals**

Proposals must be sealed and labeled on the outside of the package to clearly indicate that they are in response to 2017-DBM-01. Proposals must be sent to the attention of the Project Director and received at Medicaid as specified in the Schedule of Events. It is the responsibility of the Contractor to ensure receipt of the Proposal by the deadline specified in the Schedule of Events.

## **O. Copies Required**

Contractors must submit one original Proposal with original signatures in ink, one additional hard copy in binder form, plus two electronic copies of the Proposal on CD/DVD or jump drive clearly labeled with the Contractor name. One electronic copy (Word, Excel, and searchable PDF format) MUST be a complete version of the Contractor's response and the second electronic (searchable PDF format) copy MUST have any information asserted as confidential or proprietary removed. Contractor must identify the original hard copy clearly on the outside of the proposal. The electronic copy of Appendix C Pricing Form must be in Excel in Microsoft Office Suite 2010 or later and included with the hard copy submission.

## **P. Late Proposals**

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

## **Q. Proposal Format**

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

The Contractor must structure its response in the same sequence, using the same labeling and numbering that appears in the RFP section in question. For example, the proposal would have a major section entitled "Scope of Work." Within this section, the Contractor would include their response, addressing each of the numbered sections in sequence, as they appear in the RFP: i.e. B.1.2.1, B.1.2.2, B.1.2.3, and so on. The response to each section must be preceded by the section text of the RFP followed by the Contractor's response.

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

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

## **R. Proposal Withdrawal**

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

## **S. Proposal Amendment**

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

## **T. Proposal Errors**

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

## **U. Proposal Clarifications**

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

## **V. Disclosure of Proposal Contents**

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

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

# **VIII. Evaluation and Selection Process**

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

All proposals will initially be classified as either "responsive" or "non-responsive." Proposals may be found non-responsive at any time during the evaluation process or contract negotiation if any of the

required information is not provided; or the proposal is not within the plans and specifications described and required in the RFP. If a proposal is found to be non-responsive, it will not be considered further.

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

**B. Determination of Responsibility**

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

**C. Opportunity for Additional Information**

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

**D. Evaluation Committee**

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

**E. Scoring**

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

<b>Evaluation Factor</b>	<b>Highest Possible Score Percentage</b>
Corporate Background	<b>10%</b>
References	<b>10%</b>
Scope of Work	<b>25%</b>
Required Deliverables	<b>5%</b>
Price	<b>50%</b>
<b>Total</b>	<b>100%</b>

**F. Determination of Successful Proposal**

In the event Medicaid chooses to award a contract as a result of this RFP, the Contractor whose proposal is determined to be in the best interest of Medicaid will be recommended as the successful Contractor. The Project Director will forward this Contractor's proposal through the supervisory chain to the Commissioner, with documentation to justify the Committee's recommendation.

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

## **IX. General Terms and Conditions**

### **A. General**

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

The contract shall include the following:

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

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

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

### **C. Term of Contract**

If a contract is awarded as a result of this RFP, the initial contract term shall be for two (2) years effective April 1, 2018, through March 30, 2020. Alabama Medicaid Agency shall have the option of extending the contract for three (3) one-year periods, after review 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 Contractor will provide pricing for each year of the contract, including any extensions.

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

#### **D. Contract Amendments**

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

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

#### **E. Confidentiality**

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

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

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

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

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

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

Alabama Medicaid Program data in its other business dealings without prior written consent of Medicaid. All requests for program data shall be referred to Medicaid for response by the Commissioner only.

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

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

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

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

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

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

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

#### **J. Termination for Default**

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

may, at its option, notify Contractor in writing that performance under the contract is terminated and proceed to seek appropriate relief from Contractor.

**K. Termination for Unavailability of Funds**

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

**L. Proration of Funds**

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

**M. Termination for Convenience**

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

**N. Force Majeure**

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

**O. Nondiscriminatory Compliance**

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

**P. Conflict of Interest**

The parties acknowledge and agree that the Contractor must be free of conflicts of interest in accordance with all federal and state regulations while performing the duties within the contract. The Contractor



agrees that it has no conflict of interest preventing the execution of this Contract, and the Contractor will abide by applicable state and federal regulations.

**Q. Open Trade**

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

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

In accordance with the provisions of 45 CFR Part 75 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.

**S. Worker's Compensation**

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

**T. Employment of State Staff**

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

**U. Immigration Compliance**

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

Pursuant to Ala. Code §31-13-9(k), by signing this contract, the contracting parties affirm, for the duration of the agreement, that they will not violate federal immigration law or knowingly employ, hire

for employment, or continue to employ an unauthorized alien within the State of Alabama. Furthermore, a contracting party found to be in violation of this provision shall be deemed in breach of the agreement and shall be responsible for all damages resulting therefrom.

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

**V. Share of Contract**

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

**W. Waivers**

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

**X. Warranties Against Broker's Fees**

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

**Y. Novation**

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

**Z. Employment Basis**

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

**AA. Disputes and Litigation**

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

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

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

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

**BB. Records Retention and Storage**

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

**CC. Inspection of Records**

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

**DD. Use of Federal Cost Principles**

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

**EE. Payment**

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

**FF. Notice to Parties**

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

**GG. Disclosure Statement**

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

**HH. Debarment**

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

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

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

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

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

**KK. Choice of Law**

The construction, interpretation, and enforcement of this contract shall be governed by the substantive contract law of the State of Alabama without regard to its conflict of laws provisions. In the event any

provision of this contract is unenforceable as a matter of law, the remaining provisions will remain in full force and effect.

**LL. Alabama interChange Interface Standards**

Contractor hereby certifies that any exchange of MMIS data with Medicaid's fiscal agent will be accomplished by following the Alabama interChange Interface Standards Document, which will be posted on the Medicaid website.

## Appendix A: Proposal Compliance Checklist

### ***NOTICE TO CONTRACTOR:***

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.

---

Contractor Name

---

Project Director

---

Review Date

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

<input checked="" type="checkbox"/> IF CORRECT	BASIC PROPOSAL REQUIREMENTS
<input type="checkbox"/>	1. Contractor's original proposal received on time at correct location.
<input type="checkbox"/>	2. Contractor submitted the specified copies of proposal and in electronic format.
<input type="checkbox"/>	3. The Proposal includes a completed and signed RFP Cover Sheet.
<input type="checkbox"/>	4. The Proposal is a complete and independent document, with no references to external documents or resources.
<input type="checkbox"/>	5. Contractor submitted signed acknowledgement of any and all addenda to RFP.
<input type="checkbox"/>	6. The Proposal includes written confirmation that the Contractor understands and shall comply with all of the provisions of the RFP.
<input type="checkbox"/>	7. The Proposal includes required client references (with all identifying information in specified format and order).
<input type="checkbox"/>	8. The Proposal includes a corporate background.
<input type="checkbox"/>	9. The Proposal includes a detailed description of the plan to design, implement, monitor, address special situations related to a new DBM as outlined in the request for proposal regarding each element listed in the scope of work.
<input type="checkbox"/>	10. Contractor must submit a statement stating that the Contractor has an understanding of and will comply with the terms and conditions as set out in this RFP. Additions or exceptions to the standard terms and conditions are not allowed. Any addition or exception to the terms and conditions are considered severed, null and void, and may result in the Contractor's proposal being deemed non-responsive.
<input type="checkbox"/>	11. 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.
<input type="checkbox"/>	12. The response must include an E-Verify Memorandum of Understanding with the Department of Homeland Security.

## **Appendix B: Contract and Attachments**

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

Sample Contract

*Attachment A:* Business Associate Addendum

*Attachment B:* Contract Review Report for Submission to Oversight Committee

*Attachment C:* Immigration Status

*Attachment D:* Disclosure Statement

*Attachment E:* Letter Regarding Reporting to Ethics Commission

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

*Attachment G:* Beason-Hammon Certificate of Compliance

CONTRACT

BETWEEN  
THE ALABAMA MEDICAID AGENCY  
AND

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

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

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

Contractor and the Alabama Medicaid Agency agree that the initial term of the contract is \_\_\_\_ to \_\_\_\_\_.

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

CONTRACTOR

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

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

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

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

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

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

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

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

APPROVED:

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

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



**ALABAMA MEDICAID AGENCY  
BUSINESS ASSOCIATE ADDENDUM**

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

**1. BACKGROUND**

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

---

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

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

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

**2. DEFINITIONS**

**2.1 General Definitions**

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

**2.2 Specific Definitions**

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

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

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

**3. OBLIGATIONS OF BUSINESS ASSOCIATE**

Business Associate agrees to the following:

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

**3.12** Notify the Covered Entity within five (5) business days following the discovery of a breach of unsecured PHI on the part of the Contractor or any of its sub-contractors, and

3.12.1. Provide the Covered Entity the following information:

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

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

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

- 4.1** Use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure would not violate the Subpart E of 45 C.F.R. Part 164 if done by Covered Entity;

- 4.2 Use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- 4.3 Disclose PHI for the proper management and administration of the Business Associate, provided that:
  - 4.3.1. Disclosures are Required By Law; or
  - 4.3.2. Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- 4.4 Use PHI to provide data aggregation services to Covered Entity as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

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

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

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

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

The Covered Entity agrees to the following:

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

## **7. TERM AND TERMINATION**

- 7.1 **Term.** The Term of this Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.
- 7.2 **Termination for Cause.** Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:

- 7.2.1. Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;
- 7.2.2. Immediately terminate this Agreement; or
- 7.2.3. If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

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

- 7.3.1 Except as provided in paragraph (2) of this section or in the Contract, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.
- 7.3.2 In the event that Business Associate determines that the PHI is needed for its own management and administration or to carry out legal responsibilities, and returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall:
  - 7.3.2.a Retain only that PHI which is necessary for business associate to continue its proper management and administration or to carry out its legal responsibilities;
  - 7.3.2.b Return to covered entity or, if agreed to by covered entity, destroy the remaining PHI that the business associate still maintains in any form;
  - 7.3.2.c Continue to use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as business associate retains the PHI;
  - 7.3.2.d Not use or disclose the PHI retained by business associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Section 4, “Permitted Uses and Disclosures” which applied prior to termination; and
  - 7.3.2.e Return to covered entity or, if agreed to by covered entity, destroy the PHI retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

### **7.4 Survival**

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

## **8. GENERAL TERMS AND CONDITIONS**

- 8.1** This Agreement amends and is part of the Contract.

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

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

**ALABAMA MEDICAID AGENCY**

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

Printed Name: Clay Gaddis

Title: Privacy Officer

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

**BUSINESS ASSOCIATE**

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

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

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

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

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

CONTRACT REVIEW REPORT

(Separate review report required for each contract)

Name of State Agency: Alabama Medicaid Agency

Name of Contractor:

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

\* Is Contractor organized as an Alabama Entity in Alabama? YES NO
\* If not, has it qualified with the Alabama Secretary of State to do business in Alabama? YES NO

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

Contract Number:

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

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

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

Date Contract Effective: Date Contract Ends:

Type of Contract: NEW: RENEWAL: AMENDMENT:

If renewal, was it originally Bid? Yes No

If AMENDMENT, Complete A through C:

(A) Original contract total \$
(B) Amended total prior to this amendment \$
(C) Amended total after this amendment \$

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

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

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

If no, please give a brief explanation:

Summary of Contract Services to be Provided:

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

I certify that the above information is correct.

Signature of Agency Head

Signature of Contractor

Printed Name

Printed Name

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

**IMMIGRATION STATUS**

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

---

Signature of Contractor

---

Witness





# State of Alabama Disclosure Statement

(Required by Act 2001-955)

ENTITY COMPLETING FORM

---

ADDRESS

---

CITY, STATE, ZIP NUMBER TELEPHONE 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 RECEIVED	TYPE OF GOODS/SERVICES	AMOUNT

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

Yes     No

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

STATE AGENCY/DEPARTMENT OF GRANT	DATE GRANT AWARDED	AMOUNT

STATE AGENCY

---

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

NAME OF PUBLIC OFFICIAL/EMPLOYEE DEPARTMENT/AGENCY	ADDRESS	STATE

**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.*



KAY IVEY  
Governor

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

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



STEPHANIE MCGEE AZAR  
Commissioner

MEMORANDUM

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

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

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

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

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

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

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

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

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

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

Attachment G

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

# Appendix C: Pricing Form

**Instructions:** As a part of the Contractor’s response, the Contractor must complete Appendix C. An MS Excel document is posted on the Medicaid Website for the Contractors to fill out and submit in accordance with the submission requirements of the RFP. Below is a sample of the Appendix C:

Alabama Medicaid Agency

**Instructions:**

Please complete the colored columns of the table below. The Base Year MMs and PMPM has been provided for you. Once each component is filled in, the final PMPM for each cohort will be calculated at the end of the table. Additional comments can be made on the [Comments] tab. The assumptions provided by the awarded vendor will be considered by the State and it’s actuaries for the development of actual capitation rates.

Please select type of vendor.

**For Profit**

COA	Base Year MMs	Base PMPM <sup>1</sup>	Medical				Non-Medical					Loaded PMPM		
			Trend <sup>2</sup>		Medical Savings <sup>3</sup>		Admin	Care Coord. And Care Mngmnt.	Profit/ R&C	HIPF <sup>4</sup>	Other NML <sup>5</sup>		Combined	
			Annual %	Adjusted PMPM	Savings %	Adjusted PMPM	PMPM	PMPM	% of total	% of total	PMPM		NML %	
Child 0-1	932,241	\$ 0.73		\$ 0.73		\$ 0.73				1.5%	1.0%	\$ -	2.5%	\$ 0.75
Child 2-5	1,527,318	\$ 13.44		\$ 13.44		\$ 13.44				1.5%	1.0%	\$ -	2.5%	\$ 13.79
Child 6-18	4,409,855	\$ 16.66		\$ 16.66		\$ 16.66				1.5%	1.0%	\$ -	2.5%	\$ 17.09
Child 19-20	95,391	\$ 9.82		\$ 9.82		\$ 9.82				1.5%	1.0%	\$ -	2.5%	\$ 10.07
<b>Total</b>	<b>6,962,805</b>	<b>\$ 13.73</b>	<b>0.0%</b>	<b>\$ 13.73</b>	<b>0.0%</b>	<b>\$ 13.73</b>	<b>\$ -</b>	<b>\$ -</b>	<b>1.5%</b>	<b>1.0%</b>	<b>\$ -</b>	<b>2.5%</b>	<b>\$ 14.08</b>	

<sup>1</sup> Represents experience from July 1, 2014 - June 30, 2016 for the services and populations covered as discussed in this RFP. One year of trend was applied to July 1, 2014 - June 30, 2015 data  
<sup>2</sup> Please input annual trend projections. Trend goes from Base Year 2 (July 1, 2015 - June 30, 2016 ) to the contract period (April 1, 2018 - March 31, 2019)  
<sup>3</sup> A cost reduction assumption in the savings column should be input as negative. The rating categories of service by category of aid are provided in the next tab  
<sup>4</sup> The selection of vendor type will calculate HIPF.  
<sup>5</sup> If there are other components needed for non-medical load, calculate combined PMPM for those components. Otherwise no input needed.

## Appendix D: Year One DBM Quality Measures Approved by Alabama Medicaid Agency

**Table D.2-1: Year One DBM Quality Measures**

Measure	Description	Measure Source
1. Total Eligibles Who Received Dental Sealants for 6 – 9 Year Old Children as Elevated Caries Risk	Percentage of enrolled children ages 6 to 9 at elevated risk of dental caries (i.e., “moderate” or “high” risk) who received a sealant on a permanent first molar tooth within the measurement year.	CMS Child Core
2. Total Eligibles Who Received Dental Sealants for 10-14 Year Old Children as Elevated Caries Risk	Percentage of enrolled children ages 10 to 14 at elevated risk of dental caries (i.e., “moderate” or “high” risk) who received a sealant on a permanent first molar tooth within the measurement year.	DQA
3. Total Eligibles Who received Preventive Dental Services (ages 1-20)	Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid for at least 90 continuous days, were eligible for dental services, and who received at least one preventive dental service during the reporting period.	CMS Child Core/DBM Quality Measure
4. Rate of Dental Procedures performed in surgical units	Rate of inpatient claims with dental procedures performed in the hospital. Limit the population to only children younger than 19, with the denominator to be total population.	DBM Quality Measure
5. Oral Evaluation	Percentage of enrolled children under the age of 21 who received a comprehensive or periodic oral evaluation within the reporting year.	DQA
6. Topical Fluoride for Children at Elevated Caries Risk	Percentage of enrolled children aged 1 – 21 years who are at “elevated” risk (i.e., “moderate” or “high”) who received at least 2 topical fluoride applications within the reporting year/	DQA
7. Usual Source of Services	Percentage of all children enrolled in two consecutive years who visited the same practice or clinical entity in both years.	DQA
8. Follow-Up after Emergency Department Visits for Dental Caries in Children	Percentage of ambulatory care sensitive Emergency Department (ED) visits for dental caries among children 0 – 20 years in the reporting period for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit.	DQA

Measure	Description	Measure Source
9. Total Eligibles Receiving Any Dental Services	The unduplicated number of individuals under the age of 21 with at least 90 continuous days of enrollment during the reporting year who received at least one dental service by or under the supervision of a dentist.	CMS 416 EPSDT Report
10. Total Eligibles Receiving Preventive Dental Services	The unduplicated number of individuals under the age of 21 with at least 90 continuous days of enrollment during the reporting year who received at least one preventative dental service by or under the supervision of a dentist.	CMS 416 EPSDT Report
11. Total Eligibles Receiving Dental Treatment Services	The unduplicated number of individuals under the age of 21 with at least 90 continuous days of enrollment during the reporting year who received at least one dental treatment service by or under the supervision of a dentist.	CMS 416 EPSDT Report
12. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	The unduplicated number of individuals with at least 90 continuous days of enrollment during the reporting year in the appropriate age categories of 6-9 and 10-14, who received a sealant on a permanent molar tooth.	CMS 416 EPSDT Report
13. Total Eligibles Receiving Diagnostic Dental Services	The unduplicated number of individuals under the age of 21 with at least 90 continuous days of enrollment during the reporting year who received at least one diagnostic dental service by or under the supervision of a dentist.	CMS 416 EPSDT Report
14. Total Eligibles Receiving any Dental or Oral Health Service	The unduplicated number of individuals under the age of 21 with at least 90 continuous days of enrollment during the reporting year who received either a “dental service” by or under the supervision of a dentist or an “oral health service” by a qualified health care practitioner who is neither a dentist nor providing services under the supervision of a dentist..	CMS 416 EPSDT Report
15. Percentage of enrolled children who are at "elevated" risk (i.e., "moderate" or "high") who received (1, 2, 3, 4 or more) topical fluoride applications as a dental service within the reporting year.	This measure is used to assess the percentage of enrolled children who are at "elevated" risk (i.e., "moderate" or "high") who received (1, 2, 3, 4 or more) topical fluoride applications as a dental service within the reporting year.	NQF/DQA



## Appendix E: Quality Withhold Program: CY 2019 Incentive Measures

**Table E.4.1: CY 2019 Incentive Measures for Quality Withhold Program**

Measure	Description	Measure Source
1. Total Eligibles Who Received Dental Sealants for 6 – 9 Year Old Children as Elevated Caries Risk	Percentage of enrolled children ages 6 to 9 at elevated risk of dental caries (i.e., “moderate” or “high” risk) who received a sealant on a permanent first molar tooth within the measurement year.	CMS Child Core
2. Total Eligibles Who Received Dental Sealants for 10-14 Year Old Children as Elevated Caries Risk	Percentage of enrolled children ages 10 to 14 at elevated risk of dental caries (i.e., “moderate” or “high” risk) who received a sealant on a permanent first molar tooth within the measurement year.	DQA
3. Total Eligibles Who received Preventive Dental Services (ages 1-20)	Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid for at least 90 continuous days, were eligible for dental services, and who received at least one preventive dental service during the reporting period.	CMS Child Core/DBM Quality Measure
4. Oral Evaluation	Percentage of enrolled children under the age of 21 who received a comprehensive or periodic oral evaluation within the reporting year.	DQA
5. Topical Fluoride for Children at Elevated Caries Risk	Percentage of enrolled children aged 1 – 21 years who are at “elevated” risk (i.e., “moderate” or “high”) who received at least 2 topical fluoride applications within the reporting year/	DQA
6. Usual Source of Services*	Percentage of all children enrolled in two consecutive years who visited the same practice or clinical entity in both years.	DQA

**\*Measure will not be utilized until the second year of the Contract (CY2020)**

## Appendix F: Performance Improvement Projects

### Performance Improvement Projects

- AA.1.1. Performance Improvement Projects (PIPs) assess and improve the processes and outcomes of oral health care covered or provided by the Contractor. Annually, the Contractor must submit for Medicaid’s approval, a description of two (2) PIPs. Medicaid reserves the right to require additional PIPs if it identifies deficiencies in DBM performance or if required by CMS per 42 CFR § 438.330(a)(2).
- AA.1.2. The Contractor must report the status and results of each PIP to Medicaid as requested, but not less than once per year.
- AA.1.3. The PIPs must be reviewed and validated by Medicaid’s External Quality Review Organization (EQRO) and contain the following sections in each, as prescribed by CMS<sup>1</sup>:
  - AA.1.3.1. Study topic(s): The PIP should target improvement in either clinical or non-clinical services delivered in the state. Topics selected for study must reflect the Medicaid enrollment in terms of demographic characteristics, prevalence of disease or condition, and the potential consequences of the disease or condition. In addition, CMS, in consultation with Medicaid and other stakeholders, may specify performance measures and topics for PIPs.
  - AA.1.3.2. Study question(s): The study question(s) must be clear, concise, and answerable. The study question(s) identifies the focus of the PIP and sets the framework for data collection, analysis, and interpretation. Potential sources of information to help form the study question include:
    - AA.1.3.2.1. State data relevant to the topic being studied
    - AA.1.3.2.2. Contractor data relevant to the topic being studied
    - AA.1.3.2.3. Relevant clinical literature
  - AA.1.3.3. Study variable(s): A study variable is a measurable characteristic, quality, trait or attribute of a particular individual, object or situation being studied.
  - AA.1.3.4. Representative and generalizable sample: Measurement and improvement efforts must be system-wide. The PIP must clearly identify the “system” or study population, also referred to as the universe. Once the population is identified, the Contractor must determine whether to study data for the entire population or a sample of that population. A representative sample of the identified population is acceptable.

---

<sup>1</sup> Centers for Medicare and Medicaid Services, EQR-Related Activity Protocols, 2012.  
<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>

- AA.1.3.5. Sound sampling methods (if sampling is used): Proper sampling methods are necessary to provide valid and reliable (generalizable) study results. Healthcare Effectiveness Data and Information Set (HEDIS®) measures and HEDIS® sampling methodology are generally considered valid and reliable.
- AA.1.3.6. Reliable data collection: Data collection procedures must ensure that the data used to measure an indicator of performance are valid and reliable. A valid measure is one that measures what it intends to measure, while a reliable measure that provides consistent results is an indication that the data will produce consistent, repeatable or reproducible measurements. Potential sources of data include:
- AA.1.3.6.1. Administrative data (e.g., membership, enrollment, claims, encounters)
  - AA.1.3.6.2. Medical records
  - AA.1.3.6.3. Tracking logs
  - AA.1.3.6.4. Results of any provider interviews
  - AA.1.3.6.5. Results of any Medicaid Enrollee interviews and surveys
- AA.1.3.7. Measurement of performance using objective quality indicators: Real, sustained improvements result from a continuous cycle of measuring and analyzing performance, and developing and implementing system-wide improvements. Actual improvements depend on thorough analysis and implementation of appropriate solutions.
- AA.1.3.8. Implementation of system interventions to achieve improvement in quality: Data analysis begins with examining the performance on the selected clinical or non-clinical indicators, including the collection and calculation of baseline rates and ongoing remeasurement. The examination should be initiated using statistical analysis techniques defined in a data analysis plan.
- AA.1.3.9. Evaluation of the effectiveness of the interventions: It is important to determine if a reported change represents “real” change or is an artifact of a short-term event unrelated to the intervention, or random chance. The Contractor must demonstrate whether the cause for improvement was due to the interventions and improvement strategies implemented.
- AA.1.3.10. Planning and initiation of activities for increasing or sustaining improvement: Real change is the result of changes in the fundamental processes of oral health care delivery and is most valuable when it offers demonstrable sustained improvements. In contrast, a spurious “one-time” improvement can result from unplanned accidental occurrences or random chance. The Contractor must demonstrate whether the interventions and improvement strategies implemented are likely to achieve sustained improvement.

## Appendix G: Scope of Work (Scored Items)

### Alabama Medicaid Agency

### Dental Benefit Program Manager Request for Proposal

**RFP#: 2017-Dental-01**

### Scope of Work (Scored Items)

**Instructions:** Contractors must provide a hard and soft copy narrative response to the Section II. Scope of Work scored items that are listed in the same format provided below. Each response to a narrative question must not exceed two (2) pages. Attached documents, including graphics, flow charts, diagrams, and other descriptive information should only be used to support the information in the narrative response. Attachments not directly referenced in the narrative response will not be reviewed. Attachments, including graphics, charts, and other supplemental information must not exceed 10 pages for all of this document. Pages in excess of the stated page limits (including supplemental pages) will not be reviewed.

<b>Section No.</b>	<b>Provide Descriptions of:</b>
II.A.10	Describe how the Contractor will deliver core dental benefits and services to all assigned members through the contract period with the exception of those services listed in Section B.3;
<b>Response:</b>	
II.A.11	Describe how the Contractor will reduce inappropriate and duplicative use of dental services;
<b>Response:</b>	

<b>Section No.</b>	<b>Provide Descriptions of:</b>
II.A.12	Describe how the Contactor will administer and manage Contractor’s requirements and responsibilities under the contract with Medicaid and any and all Medicaid issued policy manuals and guides. This is also applicable to all subcontractors, employees, agents and anyone acting for or on behalf of the Contractor.
<b>Response:</b>	
II.B.2	Describe will offer each enrollee a choice of primary dental providers (PDPs) that takes into consideration the enrollee's last PDP (if the PDP is known and available in the Contractor's network), closest PDP to the enrollee's ZIP code location, keeping children/adolescents within the same family together, and age.
<b>Response:</b>	
II.B.6	Provide descriptions of the potential expanded services/benefits to be offered by the Contractor for approval.
<b>Response:</b>	
II.C.7	Describe the Contractor’s approach to recruiting providers to complete the Network Adequacy Standards. The approach should include descriptions of the recruitment strategy, retention strategy, and the orientation and training of both current and new providers in the network.
<b>Response:</b>	
II.C.8	Describe how the Contractor will meet the requirements of Section C.8.1.
<b>Response:</b>	

<b>Section No.</b>	<b>Provide Descriptions of:</b>
II.D.7	Describe the welcome information a new enrollee would receive to meet the requirements listed in Section D of the RFP.
<b>Response:</b>	
II.G.10	Provide a description of how the Contractor will ensure timely transfer of Enrollee Dental Records to ensure continuity of care when Enrollees are treated by more than one dental Provider.
<b>Response:</b>	
II.G.10	Provide an action plan to identify and bring resolution to incomplete or inaccurate encounter claims reporting.
<b>Response:</b>	
II.M.1	Provide a description of the Contractor's approach to effective oral health care management including but not limited to anticipation, identification, monitoring, measurement and evaluation of Enrollee's health care needs, and effective action to promote quality of care.
<b>Response:</b>	
II.M.2	Describe the processes for the investigation and resolution of individual performance or quality of care issues used in another state.
<b>Response:</b>	

<b>Section No.</b>	<b>Provide Descriptions of:</b>
II.M.2	Provide a copy of the Contractor's Quality Improvement Plan and Provider Incentive Plan if utilized.
<b>Response:</b>	
II.M.5	Provide a narrative of the Contractor's approach to data collections. Provide sample of quality measure reports, dashboards, or provider profiles/report cards utilized in other states.
<b>Response:</b>	
II.M.7	Describe how the Contractor would encourage participation on a Provider Standards Committee (PSC) which must review and develop the performance standards and quality measures required of a provider by the Contractor
<b>Response:</b>	
II.M.7	Describe the Contractor's approach to the PSC including, but not limited to, encouragement of provider participation, the purpose of the PSC, importance of PSC recommendations, and provider engagement in the Contractor's operation.
<b>Response:</b>	
II.N.1	Describe the Contractor's approach to utilization management, including use of prior authorizations, to encourage proper utilization of services, and the encouragement of evidence based clinical guidelines and quality outcomes.
<b>Response:</b>	

<b>Section No.</b>	<b>Provide Descriptions of:</b>
Appendix F	Describe a Performance Improvement Project the Contractor has conducted in another state with dental managed care. Describe the results of that Performance Improvement Project.
<b>Response:</b>	
Appendix F	Describe at least one Performance Improvement Project the Contractor has identified and implemented changes that have resulted because of the PIP from other states with dental managed care that the Contractor has done. Describe how the operational changes identified due to the results of the PIP were implemented in their day-to-day organizational activities.
<b>Response:</b>	



# Appendix H: Mandatory Contractor Conference Notification

## INTENT TO ATTEND MANDATORY CONTRACTOR CONFERENCE NOTIFICATION

This form acknowledges that \_\_\_\_\_ (company name) intends to attend the Mandatory Contractor Conference for the Dental Benefit Manager RFP. This conference is **mandatory** for all Contractors that will be submitting a response to the RFP. This sheet must be received by 5:00 p.m. on August 7, 2017.

### **NOTE:**

**Contractors who require clarification and/or interpretation of any sections of the RFP are allowed to ask verbal question that must also be submit in writing during the mandatory conference.**

### COMPANY NAME

\_\_\_\_\_

**REPRESENTATIVE'S NAME** (List all attending. Agency must be notified in advance of changes in representation)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### COMPANY ADDRESS

\_\_\_\_\_

\_\_\_\_\_

**Phone:** \_\_\_\_\_

**FAX:** \_\_\_\_\_

**Email:** \_\_\_\_\_

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