Alabama Medicaid Agency

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ACHN Provider eBook 2022

Forward

The fortunate and most fortunate are those that are well informed. This is an attempt to improve communication between Alabama Medicaid and the Medicaid providers.

As a practicing physician in Alabama for a few decades, and being involved in improving healthcare to our citizens, I share the frustration at times of the lack of information to facilitate our task to better care for our patients. Individually, we may not do as much, but collectively, we can move the mountains. Yes, I believe that together we can improve the health statistics like infant mortality, childhood obesity, substance dependence, access to healthcare, and improved quality of care while containing the costs.

The Alabama Medicaid Agency is working hard to innovate ways just to accomplish those that I just mentioned, through the Alabama Coordinated Health Network (ACHN).

In this eBook, I have outlined some information I feel is important for all of us who are involved in providing healthcare to our citizens through Alabama Medicaid. Most of the information is taken directly from Alabama Medicaid and their various presentations. Being an eBook, we have the advantage to access the current and changing information through the various links. I hope it serves its purpose.

I want to thank Amelia Hreha, Quality Program Manager at North Alabama Community Care (NACC) who helped me greatly to prepare this. Additionally I would like to thank Dana Garrard Stout, NACC Executive Director; Laura Thompson, NACC Quality Director; Drew Nelson, Alabama Medicaid Agency Director of Networks and Quality Assurance; and Sylisa Lee-Jackson, Alabama Medicaid Agency Health Systems Manager, for their valuable input and with this project.

N. Rao Thotakura, M.D.

TABLE OF CONTENTS

TABLE OF CONTENTS (CONTINUED)

Introduction

Alabama Medicaid Agency (AMA) Overview

Medicaid began in Alabama on January 1, 1970. For over 50 years, millions of Alabamians have received medical services through Medicaid. Medicaid primarily covers low income children, disabled adults, nursing home residents and low-income people who also have Medicare.

Alabama Coordinated Health Network (ACHN) Brief Overview

Alabama Coordinated Health Networks (ACHN) was implemented in October 2019 as an innovative plan to transform health care provided to Medicaid recipients in Alabama. The goal of the ACHN program is to transform the Medicaid delivery system in to a more flexible and cost-efficient effort. This effort was built off the AMA's former case management program structure and effectively linked Eligible Individuals (EIs), Providers, and community resources in each of seven defined regions to improve health outcomes for Medicaid recipients. Care coordination within the ACHN is a single program that allows AMA and Providers a more effective platform for service delivery and improved outcomes.

> *"Alabama Coordinated Health Networks (ACHN) is an innovative plan to transform health care provided to Medicaid recipients in Alabama."*

Governing Boards and Consumer Advisory Committees

Governing Boards

Each ACHN has its own governing board. The board composition is intended to reflect several key components of the health care system and reflect the impact various provider groups have on the populations included in the ACHN. Each board must be comprised of the following six requirements:

- 50% of the board must be primary care physicians (including at least one OB/GYN) who practice in the region and participate with the ACHN. Up to two of these primary care physicians can be employed by a hospital.
- In-region Hospitals (2 slots)
- Community Mental Health Center Representative (1 slot)
- Substance Abuse Treatment Facility Representative (1 slot)

- Consumer Representative (e.g. Recipient, Parent of Recipient or Advocacy Organization Representative) (1 slot)

- Federally Qualified Health Center (FQHC) Representative (1 slot)

Consumer Advisory Committee

Each ACHN has a Consumer Advisory Committee that brings the recipients' input to the policy table and recognizes the importance of their opinions. The ACHNs are responsible for engaging their CAC to advise the ACHN on ways it can be more efficient in providing quality care to its enrollees, in addition to other functions and duties assigned by the organization and approved by AMA.

Each CAC must meet the following requirements:

- Must have at least six members

- At least 20% of the committee must be compromised of Medicaid recipients or parent/care takers of the EIs enrolled in the ACHN.

- Members must reflect the racial, gender, geographic, urban/rural, and economic diversity of the State.

- The CAC must also include members who are representatives of patient or low-income advocacy organizations and only include persons who live in the Region the ACHN plans to serve.

- Governing boards are required to hear from CACs at each governing board meeting.

ACHN Regions and Organizations

There are seven regions in the ACHN each with its own organization for Care Coordination:

- Alabama Care Network Mid-State
- Alabama Care Network Southeast
- Gulf Coast Total Care
- My Care Alabama Central
- My Care Alabama East
- My Care Alabama Northwest
- North Alabama Community Care

ACHN Regions Map

ACHN Regions
- Alabama Care Network Mid-State
- Alabama Care Network Southeast
- Gulf Coast Total Care
- My Care Alabama Central
- My Care Alabama East
- My Care Alabama Northwest
- North Alabama Community Care

Organization Listed by County:

County	Organization
Autauga	My Care Alabama Central
Baldwin	Gulf Coast Total Care
Barbour	Alabama Care Network Southeast
Bibb	My Care Alabama Northwest
Blount	My Care Alabama East
Bullock	Alabama Care Network Southeast
Butler	My Care Alabama Central
Calhoun	My Care Alabama East
Chambers	Alabama Care Network Southeast
Cherokee	My Care Alabama East
Chilton	My Care Alabama Central
Choctaw	Gulf Coast Total Care
Clarke	Gulf Coast Total Care
Clay	My Care Alabama East
Cleburne	My Care Alabama East
Coffee	Alabama Care Network Southeast
Colbert	My Care Alabama Northwest
Conecuh	Gulf Coast Total Care
Coosa	My Care Alabama East
Covington	Alabama Care Network Southeast
Crenshaw	My Care Alabama Central
Cullman	North Alabama Community Care
Dale	Alabama Care Network Southeast
Dallas	My Care Alabama Central
De Kalb	My Care Alabama East
Elmore	My Care Alabama Central
Escambia	Gulf Coast Total Care
Etowah	My Care Alabama East
Fayette	My Care Alabama Northwest
Franklin	My Care Alabama Northwest
Geneva	Alabama Care Network Southeast
Greene	My Care Alabama Northwest
Hale	My Care Alabama Northwest
Henry	Alabama Care Network Southeast
Houston	Alabama Care Network Southeast
Jackson	North Alabama Community Care
Jefferson	Alabama Care Network Mid-State
Lamar	My Care Alabama Northwest
Lauderdale	My Care Alabama Northwest
Lawrence	My Care Alabama Northwest
Lee	Alabama Care Network Southeast
Limestone	North Alabama Community Care
Lowndes	My Care Alabama Central
Macon	Alabama Care Network Southeast
Madison	North Alabama Community Care
Marengo	My Care Alabama Central
Marion	My Care Alabama Northwest
Marshall	North Alabama Community Care
Mobile	Gulf Coast Total Care
Monroe	Gulf Coast Total Care
Montgomery	My Care Alabama Central
Morgan	North Alabama Community Care
Perry	My Care Alabama Central
Pickens	My Care Alabama Northwest
Pike	Alabama Care Network Southeast
Randolph	My Care Alabama East
Russell	Alabama Care Network Southeast
St. Clair	My Care Alabama East
Shelby	Alabama Care Network Mid-State
Sumter	My Care Alabama Northwest
Talladega	My Care Alabama East
Tallapoosa	My Care Alabama East
Tuscaloosa	My Care Alabama Northwest
Walker	My Care Alabama Northwest
Washington	Gulf Coast Total Care
Wilcox	My Care Alabama Central
Winston	My Care Alabama Northwest

ACHN Contact Information

- Alabama Care Network Mid-State
  - Phone: (833) 296-5245
  - Fax: (205) 449-9759
  - Email: acnmidstate@uabmc.edu
  - Website: alabamacarenetwork.com/mid-state

- Alabama Care Network Southeast
  - Phone: (833) 296-5246
  - Fax: (334) 466-4609
  - Email: acnsoutheast@uabmc.edu
  - Website: alabamacarenetwork.com/southeast

- Gulf Coast Total Care
  - Phone: (833) 296-5247
  - Fax: (251) 930-6984
  - Email: gctc@uabmc.edu
  - Website: gulfcoasttotalcare.com

- My Care Alabama Central
  - Phone: (855) 288-8361
  - Fax: (205) 402-9217
  - Email: infocentral@mycarealabama.org
  - Website: mycarealabama.org/mycare-alabama-central

- My Care Alabama East
  - Phone: (855) 288-8366
  - Fax: (205) 402-9222
  - Email: infoeast@mycarealabama.org
  - Website: mycarealabama.org/mycare-alabama-east

- My Care Alabama Northwest
  - Phone: (855) 200-9470
  - eFax: (205) 402-9243
  - infoNW@mycarealabama.org
  - Website: mycarealabama.org/mycare-alabama-northwest

- North Alabama Community Care
  - Phone: (855) 640-8827
  - Fax: (256) 382-2715
  - Email: info@northalcc.org
  - Website: northalcc.org

ACHN Care Coordination Services

Please note that this list is not exhaustive, but rather provides examples of how a referral to an ACHN can benefit recipients. Please contact your ACHN for questions regarding services.

PCP and DCHP Groups will partner with licensed social workers and nurses from the ACHN who will provide Care Coordination services. Care Coordination referrals may be requested by providers, recipients, or community sources. Recipients have the same Medicaid benefits now that they had under the Patient 1st, Plan First, and maternity programs. Recipients with abnormal lead levels, newborn metabolic screenings, and newborn hearing screenings will continue to receive Care Coordination from the Alabama Department of Public Health.

The ACHN care coordinators can, among other things:

- Find a doctor or OB/GYN
- Find a doctor to perform tubal ligation or vasectomy (21 years of age or older)
- Make appointments and provide appointment reminders
- Help recipients seek care in the most appropriate setting (e.g., provider's office versus emergency room)
- Facilitate communication between the patient and care providers
- Avoid hospital stays or Emergency Room visits when possible
- Work with doctors and care team after leaving the hospital
- Provide services in a setting of the recipient's choice, including provider offices, hospitals, ACHN entity office, public location, or in the recipient's home
- Perform a screening and assessment of the recipient's needs
- Help manage complex or non-compliant patients
- Provide education on, answer questions about, and address problems regarding illnesses, pregnancy/maternity care, family planning, and smoking cessation
- Manage medications and assist with choosing a birth control method
- Assist recipients in obtaining transportation or applying for Medicaid
- Help recipients locate needed community services
- Solve problems to improve the quality of life

Provider Participation Requirements

Participation Requirements

Primary Care Providers (PCP) and Groups

For specific information on agreements, please see PARTICIPATION AGREEMENTS section.

Three agreements must be signed to participate:

1. Alabama Medicaid Provider Agreement (Initial Medicaid enrollment to obtain your Medicaid Provider ID number)
2. Alabama Medicaid Primary Care Physician Group Agreement
3. ACHN entity and PCP Group Agreement
   - NOTE: Only one ACHN/PCP Group Agreement is needed. You may participate with any ACHN in any region. You are not contractually obligated to work exclusively with the ACHN you have an agreement with.

To receive payment for services, Physician groups must meet the following criteria for participation:

- Actively work with the ACHN entity to review recipient care plans
- Participate as needed in ACHN Multi-Disciplinary Care Team (MCT)
- Participate in ACHN initiatives centered around quality measures
- Participate in at least two quarterly Medical Management Meetings and one webinar/ facilitation exercise with the regional ACHN medical director over a 12-month period
  - NPs and PAs may attend for PCP
- Review data provided by the ACHN to help achieve regional and state Medicaid goals
- NOTE: Alternate payment methodologies are used for these providers:
  - FQHCs and Rural Health Clinics
  - Physicians who are part of the medical faculty as determined by a state university

Delivering Health Care Professionals (DHCP) and Groups

For specific information on agreements, please see PARTICIPATION AGREEMENTS section.

Two agreements must be signed to participate:

1. Alabama Medicaid Provider Agreement (Initial Medicaid enrollment to obtain your Medicaid Provider ID number)
2. ACHN entity and DHCP Group Agreement
   - NOTE: Only one ACHN/DHCP Group Agreement is needed. You may participate with any ACHN in any region. You are not contractually obligated to work exclusively with the ACHN you have an agreement with.

To receive payment for services, DHCP groups must meet the following criteria for participation:

- Participate in the development of the care plan with the ACHN
- Participate in the DHCP selection and referral process
- Provide data, as needed, to the ACHN

Provider Participation Agreements

Participation Agreements

Primary Care Providers (PCP) and Groups

All three agreements listed below are required to participate and receive payment for services within the ACHN.

1. To become a Medicaid Provider, you must first **apply with the Alabama Medicaid Agency and receive your Provider Medicaid ID number**. You can apply online via the Electronic Provider Enrollment Application Portal. Instructions, information, and access to the Electronic Provider Enrollment Application Portal is located on the Alabama Medicaid Agency's website:

    **https://medicaid.alabama.gov/
    content/10.0_Contact/10.3_Provider_Contacts/10.3.4_Provider_Enrollment.aspx**

2. To become a PCP within the ACHN you must fill out the **Alabama Medicaid Primary Care Physician Group Enrollment Agreement.** The Agreement is located on the Alabama Medicaid Agency's website:

    **https://medicaid.alabama.gov/
    content/5.0_managed_care/5.1_ACHN/5.1.3_ACHN_Providers.aspx**

3. To contract with a specific ACHN you must sign an **ACHN Entity and Provider Group Agreement.** Only one ACHN/PCP Group Agreement is needed. You may participate with any ACHN in any region. You are not contractually obligated to work exclusively with the ACHN you have an agreement with.

    Contact an ACHN to begin this process of enrollment. *See ACHN Regions and Organizations and ACHN Contact Information sections.*

Delivering Health Care Professionals (DHCP) and Groups

Both agreements listed below are required to participate and receive payment for services within the ACHN.

1. To become a Medicaid Provider, you must first **apply with the Alabama Medicaid Agency and receive your Provider Medicaid ID number**. You can apply online via the Electronic Provider Enrollment Application Portal. Instructions, information, and access to the Electronic Provider Enrollment Application Portal is located on the Alabama Medicaid Agency's website:

    **https://medicaid.alabama.gov/
    content/10.0_Contact/10.3_Provider_Contacts/10.3.4_Provider_Enrollment.aspx**

3. To contract with a specific ACHN you must sign an **ACHN Entity and Provider Group Agreement.** Only one ACHN/DHCP Group Agreement is needed. You may participate with any ACHN in any region. You are not contractually obligated to work exclusively with the ACHN you have an agreement with.

    Contact an ACHN to begin this process of enrollment. *See ACHN Regions and Organizations and ACHN Contact Information sections.*

16

Medicaid Recipient Eligibility & Covered Services

Recipient Eligibility

Medicaid-eligible persons are referred to as "Eligible Individuals" in the Alabama Medicaid Program.

A person may be eligible for services if the following conditions are met:

- The applicant must be eligible for medical assistance for the <u>date the service is provided</u>. Services cannot be paid under the Medicaid program if they are provided before the effective date of his or her eligibility, or after the effective date of his or her termination of eligibility. Having an application in process for Medicaid eligibility is not a guarantee eligibility.
- The service must be a benefit covered by Medicaid, determined medically necessary (exceptions are preventive family planning and EPSDT screenings) by the Medicaid program, and performed by an approved provider of the service.
- Applicants may be awarded retroactive eligibility to cover a time period prior to the application and award for eligibility. When applicants are awarded eligibility, they receive an award notice that includes the effective dates of coverage. The notice indicates whether retroactive eligibility has been awarded. Providers may contact the Gainwell Provider Assistance Center at 1 (800) 688-7989 to verify retroactive eligibility dates. Providers should not assume future eligibility based on current eligibility.

The Agency is responsible for recipient enrollment in Managed Care programs. ACHN is mandatory for most Medicaid recipients. Medicaid recipients that must participate in Alabama Coordinated Health Network (ACHN) Primary Care Physician (PCP) and Delivering Health Care Professional (DHCP) the ACHN are those for whom eligibility has been determined as listed below.

Eligibility categories include but are not limited to:

- Plan First recipients (women ages 19-55 and men 21 and older),
- Maternity Care recipients;
- Blind/Disabled children and adults;
- Aged and related populations;
- Children under age 19;
- Parents or other caretaker relatives (POCR);
- Foster children;
- Former Foster Care;
- Breast and Cervical Cancer; and
- American Indians (note: may opt-out at any time).

Excluded categories include but are not limited to:

- Medicaid Dual Eligibles (covered by Medicare & Medicaid);
- Long-term institutional care;
- Home and Community-Based Services Waiver;
- Children in the custody of the Department of Youth Services;
- Inmates and people living in Institutions for Mental Diseases (IMDs);
- Aged, blind or disabled individuals receiving only optional state supplements;
- Individuals participating in the Program of All-Inclusive Care for the Elderly (PACE);
- Individuals utilizing hospice services;
- Individuals receiving Refugee Medical Assistance;

Recipient Eligibility (continued)

- Individuals with other commercial managed care insurance or participating in the Health Insurance Premium Payment (HIPP) program; and
- Individuals with limited or no Medicaid coverage (e.g., some non-citizens only eligible for emergency services, or individuals receiving short-term hospital presumptive eligibility).

Confirming Eligibility

Providers who do not verify a recipient's eligibility prior to providing service risk a denial of reimbursement for those services. Whenever possible, providers should verify eligibility prior to providing service. To verify eligibility, providers should perform the following:

If the claim denies for ineligibility, the provider may contact the Gainwell Provider Assistance Center to review the eligibility verification receipt and discuss the reasons the claim denied.

Step 1:   Request to see the recipient's plastic card, or a copy of the eligibility notification letter.

Step 2:   Ask to see a driver's license or other picture identification for adult recipients.

Step 3:   Perform eligibility verification using one of the methods described under Identification in this section.

Step 4:   Review the entire eligibility response, as applicable, to ensure the recipient is eligible for the service(s) in question. Please note that the eligibility response provides lock-in, third party, managed care and dental information. You need all the available information to determine whether the recipient is eligible for Medicaid.

Step 5:   Maintain a paper copy of the eligibility response in the patient's file to reference, should the claim deny for eligibility.

Providers may use various resources to verify recipient eligibility:

- Provider Electronic Solutions software
- Software developed by the provider's billing service, using specifications provided by Gainwell
- Automated Voice Response System (AVRS) at 1 (800) 727-7848
- Contacting the Gainwell Provider Assistance Center at 1 (800) 688-7989
- Web Portal https://www.medicaid.alabamaservices.org/ALPortal

Identification

Recipient ID Number (RID)

Eligible individuals are issued a unique, 13-digit Recipient ID number (RID) that is used to verify eligibility, submit requests for prior authorization, and submit claims. Please note, that while eligible individuals should only be issued only one RID, there are instances where multiple RIDs may be issued for the same eligible individual. When verifying eligibility, the RID entered and the 'Current ID and check digit' value returned by the system for the recipient may differ. Medicaid links all RIDs for a recipient and returns the most current RID as part of the eligibility verification process. Either the original RID or the current RID may be used to submit the claim or verify eligibility. If the recipient has multiple RID's that are not linked, contact the Gainwell Provider Assistance Center at 1 (800) 688-7989 to verify the correct RID for claims submission.

Recipient Eligibility (continued)

Plastic Identification Cards

Most, but not all, Alabama Medicaid recipients have permanent plastic Medicaid cards. These cards are white, blue, and green and resemble a credit card. Each card is embossed on the front (with raised lettering and a hologram in the upper right corner) with the following:

- Recipient Identification (RID) number
- Name
- Date of birth
- Sex
- Two-digit card number

Providers should check the two-digit card number against the card number returned as part of the eligibility verification response. The first card issued has a number of '00'; the second, '01'; and so on. If the numbers do not match (for instance, if the plastic card number is '00' but the eligibility response returns a card number of '01') please notify the recipient they are using an old card and ask to see photo identification.

Proof of Eligibility

Providers are responsible for verifying the identity of an eligible individual before accepting proof of eligibility. Photo identification, such as a driver's license, should be requested from adult recipients, especially those without one of the eligibility notifications listed above. If the eligible individual does not have a photo ID, providers should verify that the date of birth and sex seem appropriate for the eligible individual requesting service.

Providers should verify eligibility by requesting one of the following forms of identification from the eligible individual:

- Plastic Alabama Medicaid Program identification card
- Notification letter for unborn or newborn child
- Notification letter for an eligible individual without a social security number
- Notification letter (or system print) for an eligible individual with retroactive eligibility
- Eligibility notification (in the form of a report) for nursing home residents.

If at any time you suspect that the person requesting or receiving service is not the person to whom the card belongs, it should be reported to the Medicaid Fraud Hotline at the Alabama Medicaid Agency. Call toll-free 1-866-452-4930 and select the fraud option.

Covered Services

The agency covers the following services for Medicaid recipients. This list includes, but is not limited to:

- **Transportation:**
    - **Ambulance Services**: Covered only when medically necessary. (Medical necessity is determined by a set of guidelines and is related to the condition of the patient at the time of transport.) Medicaid will not pay for an ambulance service if another means of transportation can be used without harming the health of the patient.
    - **Non-Emergency Services** -The **Medicaid Non-Emergency Transportation Program** is set up to help cover the cost of transportation to and from medically necessary appointments if Medicaid recipients have no other way to get to their appointments without obvious hardship. Medicaid issues payments for these medically necessary appointments. These rides must be approved by Medicaid ahead of time before payment is made.
- **Dental Services** for recipients under 21 years of age. Most children are no longer eligible after turning 19 unless they are eligible for another category.
- **Doctor Services**: Medicaid pays for 14 doctor visits per calendar year. Additional visits are available for children through the EPSDT program. These include visits to the doctor's office, emergency room, and health care clinics. Medicaid also pays for 16 days of doctor's care when the recipient is in a hospital.
- **Eye Care Services**: Medicaid pays for eye exams and eyeglasses once every three calendar years for recipients 21 years of age or older. Medicaid pays for eye exams once a year for children, or more if medically necessary. Contact lenses may be provided only under certain conditions and when approved ahead of time.
- **Family Planning Services:** Family planning services are available to women of childbearing age and men of any age. Birth control methods covered by Medicaid include birth control pills, IUDs, diaphragms, shots, and implants. Medicaid pays for women, age 21 and older, to have their tubes tied and for vasectomies for men, age 21 year and older. Consent forms must be signed at least 30 days before surgery. Family planning services do not count against regular doctor's office visits.
- **Preventive Health Education Services:** Medicaid pays for classes on preparing for childbirth and preventing teenage pregnancy. Hospitals, county health departments, and other groups offer these classes.
- **Hearing Services** (for recipients under 21 years of age): Medicaid pays for one hearing screening every calendar year beginning at 5 years of age and for hearing aids. Additional covered services may be available if medically necessary.
- **Home Health Services**: Medicaid provides for certain medical services in the home if the recipient has an illness, disability, or injury that keeps them from leaving home without special equipment or the help of another person. Services can be part-time or off and on during a certain period of time. (These services may keep the recipient from needing hospital or nursing home care.) Certain medical supplies, equipment, and appliances which can be used in the home are also covered with some limits.
- **Hospice Services**: Medicaid pays for hospice care for terminally ill persons. There is no limit on hospice days. Covered hospice services include nursing facility care, medical social services, doctors' services, short-term inpatient hospital care, medical appliances and supplies, medicines, home health aide and homemaker services, therapies, counseling services, and nursing home room and board.
- **Hospital Services**: Medicaid covers inpatient care and outpatient services:
    - **Inpatient Hospital Care** - Medicaid inpatient days are unlimited as long as hospital care is medically necessary. Coverage is for a semiprivate room (2 or more beds in

Covered Services (continued)

- a room). If a private room is requested, the recipient must pay the difference in the cost.
  - **Outpatient Care** - Medicaid pays for emergency and non-emergency outpatient hospital visits when medically necessary. There are no limits on outpatient hospital visits for lab work, X-ray services, radiation treatment, or chemotherapy. Medicaid pays for 3 outpatient surgical procedures per calendar year if the surgeries are done in a place called an **Ambulatory Surgical Center.**
  - **Psychiatric Hospital Services** - Medicaid pays for medically necessary services in a psychiatric hospital for children under 21 years of age and adults over age 65.
- **Laboratory and X-Ray Services**: Medicaid pays for laboratory and X-ray services when these are medically necessary.
- **Maternity Services:** Medicaid pays for prenatal (before the baby is born) care, delivery and postpartum (after the baby is born) care. Medicaid also pays for prenatal vitamins.
- **Mental Health Services**: Medicaid pays for treatment of people diagnosed with mental illness or substance abuse. The treatment is provided through licensed psychologists or community mental health centers for eligible children and adults, and through the Department of Human Resources (DHR) and the Department of Youth Services (DYS) for children under 21 years of age being served by DHR and DYS. The services received from a community mental health center do not count against regular doctor's office visits or other Medicaid covered services.
- **Nurse Midwife Services**: Medicaid covers nurse midwife services for maternity care, delivery, routine gynecology services, and family planning services.
- **Nursing Home Care Services**: Medicaid pays for nursing home room and board and medicines prescribed by a doctor. In certain hospitals, nursing home care services are provided to Medicaid patients who are waiting to go into a nursing home, if they meet the guidelines for nursing home care. This is called Post Hospital Extended Care (PEC). Medicaid also pays for long term care for people who are intellectually disabled.
- **Out-of-State Services**: Covered Medicaid services in Alabama may be covered out-of-state if the conditions below are met.
  - It would be hazardous to have the recipient travel back to Alabama for treatment.
  - The medical services needed are more readily available in the other state.
  - An out-of-state medical provider has a contract with Medicaid in Alabama.
  - The medical provider must agree to enroll as a provider with the Alabama Medicaid Agency. Some services must be approved before the service can be given by an out-of-state provider.
- **Prescription Drugs:** Medicaid pays for most medicines ordered by the doctor. There are some drugs that must be approved by Medicaid ahead of time. For some recipients, Medicaid limits the number of brand name drugs each month. Your doctor or pharmacist can tell you which drugs are paid for by Medicaid.
- **Renal Dialysis Services**: Medicaid pays for 156 outpatient dialysis treatments each year for recipients with kidney failure. Medicaid also pays for certain drugs and supplies.
- **Transplant Services**: Medicaid pays for some organ transplants. If a transplant is needed, the recipient's doctor will work directly with Medicaid to arrange for the transplant.

Services Not Covered:

- Cosmetic surgery or procedures
- Dental services for recipients age 21 and older
- Dental services for women who are eligible for family planning services only
- Dental services, such as routine orthodontic care (braces), routine partials, dentures or bridgework, gold caps or crowns, or periodontal or gum surgery

Covered Services (continued)

Services Not Covered (continued):

- Hearing services for recipients age 21 and older
- Hospital meal trays or cots for guests
- TV rentals and VCRs in hospital rooms
- Infertility services or treatment
- Recreational therapy or experimental treatments, supplies, equipment ordrugs
- Respiratory therapy, speech therapy, and occupational therapy for recipients age 21 and older
- Services or treatment if a person is not eligible for Medicaid
- Sitter services
- Any service not covered under the State Plan for Medical Assistance

Primary Care Providers (PCP)

PRIMARY CARE PROVIDERS (PCP)

Provider Selection and Referral Requirements

Please note, referral requirements may change at any time. Notices are sent via Provider ALERT. While we strive to have the most up-to-date information in this manual, it is recommended that you refer to the Provider Billing Manual.

PCP Referrals are not required for reimbursement for Medicaid services. However, some services and some DME require an EPSDT referral. For EPSDT referred services, refer to Appendix A of the Provider Billing Manual. Lock-in referrals are still required for reimbursements.

Reimbursements and Payments

Detailed information regarding filing claims and receiving reimbursements, see the Provider Billing Manual Chapters 5 and 6.

Remittance Advice (RA) Report and Payment

Detailed information regarding the contents of the RA Report can be found in the Provider Billing Manual in Chapter 6, Section 1.

Detailed information regarding the reimbursement schedule can be found in the Provider Billing Manual in Chapter 6, section 2.

Detailed information regarding late or missing EFT payments can be found in the Provider Billing Manual in Chapter 6, section 3.

The RA indicates claims that have been paid or denied, and lists claims that are currently in process (suspended claims). Providers are urged to examine each RA carefully. Claims listed as "claims in process" are being processed and will appear on one of the next two RAs as paid, denied, or still in process. A provider can receive an electronic copy of the RA or download a copy. The electronic copy is the 835 Health Care Claim Payment/Advice. Providers wishing to receive the 835 must be assigned a 'submitter ID" and an indicator must be set in the system to generate the electronic report. The Electronic Remittance Advice Agreement Form is available on the Alabama Medicaid website.

Any claim that does not appear on an RA within forty-five working days from the time of submission should be resubmitted immediately. Providers are required to maintain a copy of each claim submitted to be used for comparison if there are questions concerning the disposition of claims. A provider who wishes to question a paid or denied claim should do so by calling the Gainwell Provider Assistance Center at 1(800) 688-7989. To request an adjustment of a previously paid claim, refer to Section 5.10 of the Provider Billing Manual.

Claims that have been accepted for processing are processed on a daily basis. EFT is the required method to deposit funds for claims for payment. All payee providers (individuals not within a group, groups and facilities) must also be enrolled in EFT. These funds can be credited to either checking or savings accounts, directly into a provider's bank account, provided the bank selected accepts Automated Clearing House (ACH) transactions. Payment for these claims is based on the twice a month Alabama Medicaid checkwrite schedule. Information regarding checkwrite schedules is listed in the bimonthly publication of the Alabama Medicaid Provider Bulletin and can also be obtained on the Alabama Medicaid website.

PRIMARY CARE PROVIDERS (PCP)

Patient Attribution

Attribution is the process that will be used to associate a Medicaid recipient to the PCP Group that provides primary care to that recipient. Under the ACHN Program, Medicaid recipients will be attributed to PCP Groups based on historical claims data utilization. PCPs are encouraged to continue seeing patients, as medically necessary, on a consistent basis to increase the likelihood of attribution. Attribution is a critical factor in determining distribution of bonus payments among eligible providers. Attribution will replace panel assignments. Under ACHN, the Patient 1st program ceases to exist and capitation payments will no longer be paid. A smaller number of attributed members compared to members in the previous panel does not necessarily equate to a reduced payment.

- Recipients will not be assigned to individual PCPs, but will be attributed at PCP group level.
- Recipients will be attributed to PCP group based on where they received services.
- Score will be calculated for each recipient/provider combination.
- The provider with the highest score for the recipient will be attributed that recipient.
- More recent claims and preventive visits will receive higher values in this calculation.
- Recipients will only be attributed to one PCP group per quarter.
- Attribution will be updated quarterly.

Quality Improvement

The Quality Improvement Program includes the establishment of a managed care system, combining Family Planning, Patient 1st, Health Home, and Maternity Care functions into single, region specific Primary Care Case Management Entities (PCCM-E). AMA is contracting with ACHNs, which will be responsible for managing the quality of Medicaid services and related care coordination to foster and encourage innovation, improvement, and clinical transformation at the care delivery level. Each Each ACHN organization has their own Improvement Plan and interventions to address the following quality improvement initiatives:

- Childhood Obesity
- Infant Mortality
- Substance Use Disorder

Through the ACHN Program, AMA aims to accomplish the following objectives:

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

In offering incentives through a new payment model and by addressing these challenges, the total cost of care, improved health outcomes, and reduced avoidable hospital care can be more effectively managed. ACHN Program utilizes a value-based purchasing (VBP) strategy that aligns incentives for the State, ACHN, providers and enrollees to achieve the Program's overarching program objectives. Providers are encouraged to implement electronic health record technology and utilize the Agency's current Health Information Exchange (HIE), referred to as OneHealthRecord®. The ACHN Networks are also responsible for creating their own health information management system (HIMS) to track and monitor patient progress.

PRIMARY CARE PROVIDERS (PCP)

Childhood Obesity

Alabamians identified nutrition and physical activity as the fourth greatest current health concern in Alabama. Obesity is a serious health concern for children and adolescents. Results from a National Health and Nutrition Examination Survey using measured heights and weights indicate that an estimated 17% of children and adolescents ages two through 19 years are obese. Obese children and adolescents are at risk for health problems during their youth and as adults. For example, during their youth, obese children and adolescents are more likely to have risk factors associated with cardiovascular disease, such as high blood pressure, high cholesterol, and Type 2 diabetes, than are other children and adolescents.

Alabama has a high rate of obesity and a low level of physical activity. In addition, Alabamians do not have a healthy diet and eat relatively few fruits and vegetables. A third of Alabama's population is obese and usually ranks in the top five states in the nation in obesity. This is partly due to the low levels of physical activity. In 2011, only 15.0 percent of the population met the physical activity guidelines. Almost half of Alabamians did not consume even a single fruit or glass of fruit juice daily. Also, over a quarter of the population consumed vegetables less than once per day. The result of this is a very unhealthy population with high rates of heart disease, stroke, and diabetes. In addition, many cancers are related to the poor diet and lack of exercise.

Infant Mortality

Alabamians identified poor pregnancy outcomes as the third greatest current health concern in Alabama. In 2011, Alabama had the second highest infant mortality rate in the nation and was one of only two states with a rate above 8 per 1,000 live births. The Alabama rate for 2011-2013 was 39 percent higher than the national rate from 2010-2012. In addition, the disparity in the survival of African American and Caucasian infants is striking. African American babies died at twice the rate of Caucasian babies. Infants born in rural counties had a survival advantage over their urban counterparts. Babies of teen mothers were more likely to die than those born to older mothers. There are also social class differences. Babies born to less educated mothers and those with Medicaid insurance coverage died at a higher rate than those born to more educated mothers and those with private insurance coverage.

Low birth weight is the factor most associated with infant mortality. Infants born at low birth weight are 20 times more likely to die as those born at normal birth weight and two-thirds of infant deaths are low birth weight. Babies born in Alabama are 25 percent more likely to be low birth weight than babies born in the United States. Very young and old mothers are more prone to bear low birth weight babies. In addition, African American babies are over 80 percent more likely to be born at low birth weight than Caucasian babies.

A major public health goal is for all females to receive adequate prenatal care. However, the percent of mothers receiving adequate prenatal care declined from 78.4 percent in 2002-2003 to 75.2 percent in 2012-2013. Younger mothers are more likely to receive inadequate prenatal care. In addition, African American mothers and those with Medicaid insurance coverage are more likely to receive inadequate prenatal care. Rural mothers are also slightly more likely to receive inadequate prenatal care.

Poor pregnancy outcomes can be biological or social, with many factors affecting the length of the pregnancy or the survival of the infant. Many of these factors also affect the time the mother begins prenatal care and the number of visits she receives.

PRIMARY CARE PROVIDERS (PCP)

Governor Kay Ivey convened the Children's Cabinet in December 2017 to address the problem of infant mortality in Alabama. A subcommittee was created to develop an action plan. This subcommittee is comprised of leaders from the following agencies:

- Alabama Department of Early Childhood Education
- Alabama Department of Human Resources
- Alabama Department of Mental Health
- Alabama Department of Public Health
- Alabama Medicaid Agency
- Alabama Office of Minority Affairs

The Alabama Legislature appropriated $1 million for the State of Alabama Infant Mortality Reduction Plan.

Substance Use Disorder

Alabamians identified mental health and substance abuse as the second greatest current health concern in Alabama. Mental health care and substance abuse are major problems in Alabama. State government spends a large part of its budget for corrections incarcerating substance abusers. In addition, Alabama has a serious shortage of mental health providers, especially in rural areas.

Suicide and drug related mortality have increased in recent years, with suicide ranking as the eleventh leading cause of death in 2013. Poor mental health affects thousands of Alabamians and many illnesses go undiagnosed and untreated because of a shortage of providers. In addition, thousands more are in prison because of substance abuse. Mental health problems affect the rich and poor, African American and Caucasian, urban and rural residents, and place a heavy burden on the economy and society.

Substance abuse can lead to imprisonment, loss of employment, divorce, child and spouse abuse, disability, or even death. In 2013, 95,299 (8.3%) Medicaid recipients had been diagnosed with substance abuse. The problem is similar for rural residents (8.7 %) compared to urban residents (8.1%). Alabama's Medicaid substance abuse is occurring at a rate of 8.3% of the Medicaid population. The highest in public health area saw 11.7 % and the lowest saw 6.5%.

During the years 2011-2013, a total of 1,789 citizens from Alabama died from drug-related mortality. This is a rate of 12.7 per 100,000 population, which is slightly smaller than the overall rate for the United States as a whole, or 13.9 per 100,000. Alabama's drug-related mortality is very similar for rural and urban counties (12.8 and 12.6 per 100,000, respectively). In Alabama, drug-related mortality is:

- Highest for adults aged 25-54.
- Approximately 50 percent higher for males than for females.
- Almost four times higher for Caucasians than for African Americans.
- Extremely low in the Hispanic population

PRIMARY CARE PROVIDERS (PCP)

Quality Incentives

Quality assurance activities and program monitoring efforts will look at all facets of the program including measuring the PCP against established program goals, determining contract compliance, and focusing on program outcomes - all of which involve both administrative and performance measures.

ACHN Bonus Payment Pool

Quarterly bonus payments will be made on the second checkwrite of the first month of the quarter. Medicaid will set aside funds from the annual bonus payment pool. If funds are recouped from a PCP group, the recouped amount will be added to the reserve funds. During the last quarter of the fiscal year, the Agency will distribute any remaining reserve funds to actively participating ACHN PCP groups. Providers that are eligible for BUMP payments will still be able to receive BUMP rates if they choose not to participate with the ACHN but will not be eligible for Participation Rates or Bonus Payments.

PCP Group Bonus Payments Eligibility Requirements:

- Enters into a Participation Agreement with an ACHN
- Actively participates with an ACHN
- Meets the criteria established by the Agency for quality
- Meets the criteria established by the Agency for cost effectiveness
- Achieves (or working towards) Patient Centered Medical Home (PCMH) Recognition

Bonus Payments for Quality, Cost Effectiveness, and PCMH Recognition

This is a Bonus pool in the amount of $15 million annually to fund three (3) Bonus payments for eligible Participating PCP Groups. The Bonus Payment pool is allotted as follows:

- 50% for Quality
- 45% for Cost Effectiveness
- 5% for Patient-Centered Medical Home (PCMH) Recognition

PCP Quality Measures

Quality Measure Benchmarks can be found on the Agency's website under ACHN Provider Quality Measures.

- Well-child visits for children, ages 3-6
- Adolescent well care visits
- Immunization status–Child
- Immunization status–Adolescent
- Antidepressant medication management
- HbA1c test for diabetic patients
- Follow-up after ER visit for alcohol or other drugs
- Chlamydia Screening in Women

PRIMARY CARE PROVIDERS (PCP)

Quality Bonus Payments

- Between October 2019–July 2021, all practice groups automatically received a Quality Bonus Payment that was based solely on the number of attributed patients
- Beginning October 2021, the Group must achieve annual Bonus benchmarks determined by the Medicaid Agency
- Benchmarks are statewide, updated annually, and will be posted to the Agency's website

Cost Effectiveness Bonus Payments

*Please see **MARA Scoring** section for detailed information regarding the Cost Effectiveness Bonus Payment calculations. An **ACHN Provider Cost Effectiveness Bonus Explanation and FAQ** is available on the Alabama Medicaid website under the **ACHN Providers** section.*

Between October 2019–October 2020, ACHN participating PCP groups will receive a Cost Effectiveness Bonus Payment based on the number of Medicaid recipients attributed to the PCP group for the prior quarterly period. Beginning January 2021, PCP Groups will be eligible for a Bonus payment if the PCP group meets or exceeds the Cost Effectiveness criteria. The Agency uses a MARA Scoring system for calculating the Cost Effectiveness Bonus.

The Cost Effectiveness calculation includes a PMPM calculation for the ACHN population. The Cost Effectiveness calculation excludes the most recent three (3) months of data, hospital access payments, entity case management costs, other Bonus Payments in the waiver, and drug rebates.

Patient Centered Medical Home (PCMH) Recognition Bonus Payments

Please see PCMH section for detailed information regarding the Patient Centered Medical Home (PCMH) Recognition Bonus Payments.

Calculations for the PCMH Recognition Bonus Payments are based on attributed members. The eligible and actively participating provider must establish his or her PCHM status with Medicaid in order to receive this Bonus payment.

Active Participation VS. Bump Rates

Procedure	Procedure Description	BUMP Rate	ACHN Participation Rate	Amount Increase
99201	OFFICE/OUTPATIENT VISIT NEW	$40.04	$42.00	$1.96
99202	OFFICE/OUTPATIENT VISIT NEW	$69.27	$73.00	$3.73
99203	OFFICE/OUTPATIENT VISIT NEW	$100.52	$107.00	$6.48
99204	OFFICE/OUTPATIENT VISIT NEW	$155.25	$166.00	$10.75
99205	OFFICE/OUTPATIENT VISIT NEW	$194.18	$210.00	$15.82
99211	OFFICE/OUTPATIENT VISIT EST	$18.46	$19.00	$0.54
99212	OFFICE/OUTPATIENT VISIT EST	$40.36	$41.00	$0.64
99213	OFFICE/OUTPATIENT VISIT EST	$68.17	$72.00	$3.83
99214	OFFICE/OUTPATIENT VISIT EST	$100.91	$108.00	$7.09
99215	OFFICE/OUTPATIENT VISIT EST	$135.59	$146.00	$10.41
99241	OFFICE CONSULTATION	$45.45	$46.00	$0.55
99242	OFFICE CONSULTATION	$85.87	$88.00	$2.13
99243	OFFICE CONSULTATION	$117.58	$122.00	$4.42
99244	OFFICE CONSULTATION	$175.38	$184.00	$8.62
99245	OFFICE CONSULTATION	$214.62	$226.00	$11.38

PRIMARY CARE PROVIDERS (PCP)

Quality Measure and Cost Effectiveness Scorecards

Accessing your scorecards

Scorecards can be accessed on the Agency's Provider Web Portal:

www.medicaid.alabamaservices.org/ALPortal

1. To access the login panel, click **Account,** click **Secure Site,** and then log into your account.
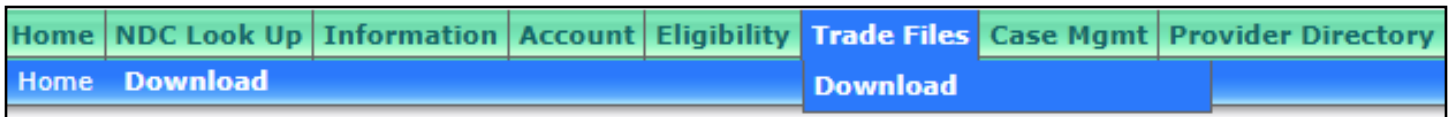
Welcome to the Alabama Medicaid Interactive web site!

Quick Links
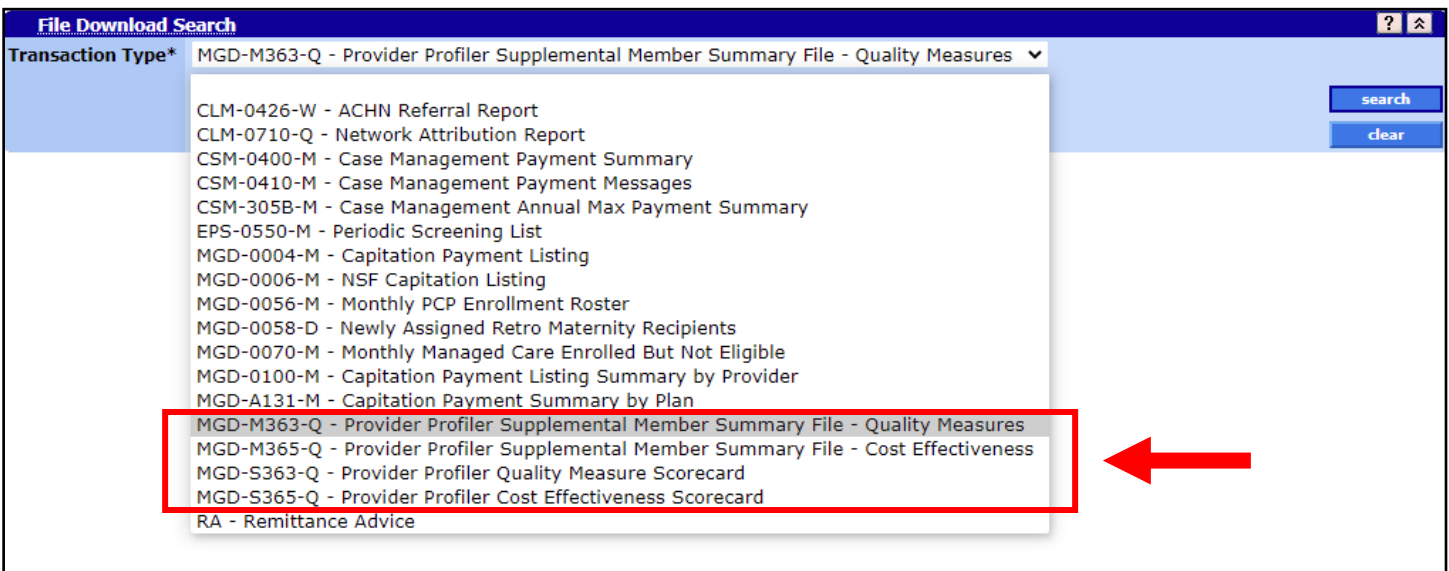
- **Provider Enrollment Portal**
- **My Medicaid**
- **NDC Look Up**

- This site is intended for providers, clerks, and trading partners.
- The secure site gives providers, clerks and billing agents the opportunity to view Claim and Prior Authorization status as well as Eligibility Verification inquiries and to upload and download standard X12 and NCPDP transactions.
- To proceed with logging into the secure site, go to **Account >> Secure Site.**

2. Click on **Trade Files** tab and then **Download**

Home	NDC Look Up	Information	Account	Eligibility	Trade Files	Case Mgmt	Provider Directory
Home	Download				Download		

3. Select the report from the **Transaction Type** dropdown menu

File Download Search

Transaction Type* MGD-M363-Q - Provider Profiler Supplemental Member Summary File - Quality Measures

search

clear

CLM-0426-W - ACHN Referral Report
CLM-0710-Q - Network Attribution Report
CSM-0400-M - Case Management Payment Summary
CSM-0410-M - Case Management Payment Messages
CSM-305B-M - Case Management Annual Max Payment Summary
EPS-0550-M - Periodic Screening List
MGD-0004-M - Capitation Payment Listing
MGD-0006-M - NSF Capitation Listing
MGD-0056-M - Monthly PCP Enrollment Roster
MGD-0058-D - Newly Assigned Retro Maternity Recipients
MGD-0070-M - Monthly Managed Care Enrolled But Not Eligible
MGD-0100-M - Capitation Payment Listing Summary by Provider
MGD-A131-M - Capitation Payment Summary by Plan
MGD-M363-Q - Provider Profiler Supplemental Member Summary File - Quality Measures
MGD-M365-Q - Provider Profiler Supplemental Member Summary File - Cost Effectiveness
MGD-S363-Q - Provider Profiler Quality Measure Scorecard
MGD-S365-Q - Provider Profiler Cost Effectiveness Scorecard
RA - Remittance Advice

PRIMARY CARE PROVIDERS (PCP)

Quality Measure Scorecard (MGD-S362-Q & MGD-M362-Q Reports)

The **Provider Profiler Quality Measure Scorecard Report (MGD-S362-Q)** is the summary level report that illustrates your current scoring.

```
Report   : MGD-S362-Q                    ALABAMA MEDICAID AGENCY                  Run Date: 01/21/2020
Process  : MGDS362Q              MEDICAID MANAGEMENT INFORMATION SYSTEM           Run Time:   09:17:15
Location: MGDS362Q              PROVIDER PROFILER QUALITY MEASURE SCORECARD                Page:      1
                                  REPORT PERIOD: 01/01/2020 - 03/31/2020

PROVIDER (NPI:MCD:NAME): 009999999        : 999999900        : ABC PROVIDERS PC

The ACTUAL bonus payments for this quarter are based solely on provider attribution.  The CALCULATED Provider Quality
bonus payments begin in July 2021. The ESTIMATED bonus payment shown in the scorecard below is projected based on
Quality Measures for this quarter and are shared for illustrative purposes only.  This dashboard is designed to provide
guidance for attainment of future bonus calculations.  Quality Measure scores are based on attributed recipients for
this quarter and calculated using calendar year 2018 as the measurement period.

Total Number of Attributed ACHN Members:                      497,211
Attributed Members in Groups Meeting Quality Score Minimum:   287,046
Members Attributed to PCP Group in Quarter:                       769
Quarterly Bonus Amount:                                     $5,249.59

PCP QUALITY BONUS PAYMENT SCORECARD

                        Measure   Numerator  Denominator   Quality    Baseline   Benchmark   Improvement   Meets
                                                            Score                              Needed       Target
    PEDIATRIC MEASURES  W34-CH       51          65         78.5%      61.1%      66.7%        -11.8%        Yes
                        AWC-CH       21          31         67.7%      43.0%      45.0%        -22.7%        Yes
                        CIS-CH       12          25         48.0%      70.5%      74.0%         26.0%        No
                        IMA-CH        2           6         33.3%      20.4%      24.6%         -8.7%        Yes
    ADULT MEASURES      AMM-AD        0           0          0.0%      29.6%      37.1%          0.0%        N/A
                        HA1C-AD       0           0          0.0%      73.4%      83.3%          0.0%        N/A
                        FUA-AD        0           0          0.0%      11.4%      12.4%          0.0%        N/A
                        CHL-AD        0           0          0.0%       9.7%      54.3%          0.0%        N/A

Provider Quality Measures Legend
    W34-CH    Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
    AWC-CH    Adolescent Well Care Visits
    CIS-CH    Childhood Immunization Status (Combo 3)
    IMA-CH    Immunization for Adolescents (Combo 2)
    AMM-AD    Antidepressant Medication Management - Continuation Phase (6 months)
    HA1C-AD   Comprehensive Diabetes Care: Hemoglobin A1C (HbA1C) Testing
    FUA-AD    Follow-Up after Emergency Department Visit for Alcohol or other drug abuse or Dependence (30 Days)
    CHL-AD    Chlamydia Screening in Women Ages 21 - 24

QUALITY BONUS PAYMENT CALCULATION METHODOLOGY STEPS
        $1,875,000    Quarterly Quality Bonus Payment Pool
              50%     Minimum Quality Metric for Bonus (a)
              769     Members Attributed (b)
            0.15%.    Distribution of Attributed Members (c)
           75.00%     Quality Score (d)
            0.27%     Distribution of Attributed Members for Groups Meeting Quality Metric Minimum (e)
            0.27%     Bonus Distribution Rate before normalization (f)
            0.28%     Normalized Bonus Distribution Rate (g)
        $5,249.59     Quality Bonus Distribution (h)

Methodology:
    (a) - Represents the minimum ratio of applicable quality metrics met
    (b) - Represents the members attributed to the PCP group in the quarter
    (c) - Represents the distribution of members in each PCP Group compared to the total ACHN attributed members
    (d) - Represents members attributed to PCP Group in the quarter who met the minimum quality metric
    (e) - Represents the distribution of members in each PCP Group who met the minimum quality metric
    (f) - Bonus Distribution by PCP group before normalization
          (calculated by multiplying the Quality Score and member distribution in groups meeting minimum quality metric)
    (g) - Bonus Distribution by PCP group after normalization
          (calculated by dividing the bonus distribution rate for each PCP group  by the sum of total rates for qualifying groups)
    (h) - Bonus Distribution is calculated by multiplying the normalized bonus distribution rate and the quarterly bonus amount.

                              ** End of Report **
```

PRIMARY CARE PROVIDERS (PCP)

The **Provider Profiler Supplemental Member Summary File (MGD-M362-Q)** is a report that shows how each individual EI affects your score.

```
Report   : MGD-M362-Q                      ALABAMA MEDICAID AGENCY                            Run Date: 01/21/2020
Process  : MGDM362Q                    MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   08:55:00
Location: MGDM362Q        PROVIDER PROFILER SUPPLEMENTAL MEMBER SUMMARY FILE - QUALITY MEASURES          Page:        1
                                 REPORT PERIOD: 01/01/2020 - 03/31/2020

   PROVIDER (NPI:MCD:NAME): 9999999999      : 999999999       : XYZ MEDICAL ASSOCIATES PC

     MEMBERS ATTRIBUTED IN QUARTER:              23

     MEDICAID ID    BIRTH DATE   W34-CH      AWC-CH      CIS-CH      IMA-CH      AMM-AD      HA1C-AD     FUA-AD      CHL-AD
                                 N    D      N    D      N    D      N    D      N    D      N    D      N    D      N    D
   000000000001    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      1    1      0    0      0    0
   000000000002    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      0    0      0    0      0    0
   000000000003    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    1      1    1      0    0      0    0
   000000000004    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      0    0      0    0      0    0
   000000000005    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      0    0      0    0      0    0
   000000000006    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      1    1      0    0      0    0
   000000000007    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      1    1      0    0      0    0
   000000000009    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    1      1    1      0    0      0    0
   000000000010    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      1    1      0    0      0    0
   000000000011    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      0    0      0    0      0    0
   000000000012    XX/XX/XXXX    0    0      1    1      0    0      0    0      0    0      0    0      0    0      0    0
   000000000013    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    1      1    1      0    0      0    0
   000000000014    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      0    0      0    0      0    0
   000000000015    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      0    0      0    0      0    0
   000000000016    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      1    1      0    0      0    0
   000000000017    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      1    1      0    0      0    0
   000000000018    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      0    0      0    0      0    0
   000000000019    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      0    0      0    0      0    0
   000000000020    XX/XX/XXXX    0    0      0    1      0    0      0    0      0    0      0    0      0    0      0    0
   000000000021    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      0    0      0    0      0    0
   000000000022    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      0    0      0    0      0    0
   000000000023    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      0    0      0    0      0    0
   000000000024    XX/XX/XXXX    0    0      0    0      0    0      0    0      0    0      0    0      0    0      0    0

   TOTALS    Measure      NUMERATOR    DENOMINATOR         Measure      NUMERATOR    DENOMINATOR
             W34-CH           0             0              AMM-CH           0             3
             AWC-CH           1             2              HAC-CH           9             9
             CIS-CH           0             0              FUA-CH           0             0
             IMA-CH           0             0              CHL-CH           0             0

   In the column headings, N=NUMERATOR,  D=DENOMINATOR.
   Value '1' in the numerator and/or denominator indicates that the recipient met the criteria for the specific Quality Measure.
   Value '0' in the numerator and/or denominator indicates that the recipient did not meet the criteria for the Quality Measure.
   Values above '1' in the numerator and/or denominator is applicable only to FUA-AD measure,
   which indicates a count of follow-up visits (e.g. a value of '3' equals '3' visits).

   Provider Quality Measures Legend:
     W34-CH    Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
     AWC-CH    Adolescent Well Care Visits
     CIS-CH    Childhood Immunization Status (Combo 3)
     IMA-CH    Immunization for Adolescents (Combo 2)
     AMM-AD    Antidepressant Medication Management - Continuation Phase (6 months)
     HA1C-AD   Comprehensive Diabetes Care: Hemoglobin A1C (HbA1C) Testing
     FUA-AD    Follow-Up after Emergency Department Visit for Alcohol or other drug abuse or Dependence (30 Days)
     CHL-AD    Chlamydia Screening in Women Ages 21 - 24

                                      ** End of Report **
```

PRIMARY CARE PROVIDERS (PCP)

Cost Effectiveness Scorecard

The **Provider Profiler Cost Effectiveness Scorecard Report (MGD-S364-Q)** is the summary level report that illustrates your current scoring.

```
Report  : MGD-S364-Q              ALABAMA MEDICAID AGENCY              Run Date: 01/21/2020
Process : MGDS364Q          MEDICAID MANAGEMENT INFORMATION SYSTEM     Run Time:   08:33:03
Location: MGDS364Q          PROVIDER PROFILER COST EFFECTIVENESS SCORECARD      Page:       1
                               REPORT PERIOD: 01/01/2020 - 03/31/2020

PROVIDER (NPI:MCD:NAME): 0099999999     : 999999900     : ABC PROVIDERS PC

The ACTUAL bonus payments for this quarter are based solely on provider attribution.  The CALCULATED Provider Cost Effectiveness
bonus payments begin in January 2021.  The ESTIMATED bonus payment shown in the scorecard below is projected based on
Cost Effectiveness Measures for this quarter and are shared for illustrative purposes only.  This dashboard is designed to provide
guidance for attainment of future bonus calculations.  Cost Effectiveness scores are based on attributed recipients for this quart
and calculated using claims data from 10/01/2018 to 09/30/2019 as the measurement period.

    TOTAL NUMBER OF ATTRIBUTED ACHN MEMBERS:                           497,211
    ATTRIBUTED MEMBERS IN GROUPS AT OR BELOW MEDIAN THRESHHOLD:        180,048
    MEMBERS ATTRIBUTED TO PCP GROUP IN QUARTER:                           769
    COST EFFECTIVENESS BONUS:                                        $7,207.45

    PCP Cost Effectiveness Bonus Payment Scorecard - Cost Effectiveness Metrics

    Service Type              PMPM       State-wide PMPM
    Inpatient                 $24                $70        Practice Risk Score              1.56
    Outpatient                $2                 $15        Expected PMPM                    $448
    Mental Health             $13                $12        Cost Effectiveness Score         0.37
    Pharmacy                  $31                $81        Median Threshold                 0.58
    Physician                 $44                $51        Below Median                      Yes
    Other                     $50                $55
    TOTAL                     $166               $287

    COST EFFECTIVENESS BONUS PAYMENT CALCULATION METHODOLOGY STEPS
        $1,687,500    Quarterly Cost Effectiveness Bonus Payment
             0.58     Median Threshold (a)
              769     Members Attributed (b)
            0.15%     Distribution of Attributed Members (c)
            0.43%     Distribution of Attributed Members for Groups below Median Threshold (d)
             0.37     Cost Effectiveness Score (e )
            0.43%     Bonus Distribution Rate (f)
        $7,207.45     Cost Effectiveness Bonus Distribution (g)

        Methodology:
    (a) - Represents the state-wide median Cost Effectiveness Score threshold
    (b) - Represents the members attributed to the PCP group in the quarter
    (c) - Represents the distribution of members in each PCP Group compared to the total ACHN attributed members
    (d) - Represents the distribution of members in PCP Group compared to those at or below median threshold
    (e) - Represents the practice Cost Effectiveness Score (Actual PMPM divided by Expected PMPM);
          Expected PMPM calculated multiplying State-wide PMPM and Practice Risk Score
    (f) - Bonus Distribution Rate: Represents the distribution of members in each PCP Group who are at or below Median Threshold
    (g) - Cost Effectiveness Bonus Distribution (calculated by multiplying the bonus distribution rate and Quarterly Incentive)


                              ** End of Report **
```

PRIMARY CARE PROVIDERS (PCP)

The **Provider Profiler Supplemental Member Summary File - Cost Effectiveness Report (MGD-M364-Q)** shows how each individual EI affects your score.

```
Report  : MGD-M364-Q                    ALABAMA MEDICAID AGENCY                           Run Date: 01/21/2020
Process : MGDM364Q                 MEDICAID MANAGEMENT INFORMATION SYSTEM                  Run Time:   08:33:11
Location: MGDM364Q         PROVIDER PROFILER SUPPLEMENTAL MEMBER SUMMARY - COST EFFECTIVENESS    Page:        1
                                REPORT PERIOD: 01/01/2020 - 03/31/2020

PROVIDER (NPI:MCD:NAME): 9999999999     : 999999999        : XYZ MEDICAL ASSOCIATES PC

  MEMBERS ATTRIBUTED IN QUARTER:              23

  MEDICAID  ID    BIRTH DATE   INPATIENT  OUTPATIENT    MENTAL    PHARMACY   PHYSICIAN    OTHER      TOTAL     TOT    PMPM
                                COSTS       COSTS      HEALTH      COSTS      COSTS      COSTS      COSTS      MBR
                                                       COSTS                                                  MTHS
000000000001    XX/XX/XXXX          0           0          0         960         64         59      1,083      12      90
000000000002    XX/XX/XXXX      4,341          15          0         457      1,017        386      6,218      12     518
000000000003    XX/XX/XXXX          0         372          0       2,818      1,428        810      5,429      12     452
000000000004    XX/XX/XXXX          0         459          0         115        838        975      2,389      12     199
000000000005    XX/XX/XXXX          0         737          0       8,080      2,212        950     11,981      12     998
000000000006    XX/XX/XXXX          0           0          0         944         42        117      1,104      12      92
000000000007    XX/XX/XXXX          0         252          0       5,383      1,679        356      7,671      12     639
000000000009    XX/XX/XXXX          0           0          0       2,229        422        160      2,811      12     234
000000000010    XX/XX/XXXX      7,815         951          0       1,814      5,572      3,630     19,783      12   1,648
000000000011    XX/XX/XXXX          0         982          0       1,091      2,187        112      4,373      12     364
000000000012    XX/XX/XXXX          0         196          0           0         22         65        285      12      23
000000000013    XX/XX/XXXX          0         376          0          51        767      1,970      3,166      12     263
000000000014    XX/XX/XXXX          0           0          0         298        199        101        599      12      49
000000000015    XX/XX/XXXX      4,291         456        294       6,172      2,814      1,427     15,458      12   1,288
000000000016    XX/XX/XXXX          0           0          0       6,647        139         87      6,873      12     572
000000000017    XX/XX/XXXX          0           0          0         266        192        121        581      12      48
000000000018    XX/XX/XXXX          0         251        914      25,265        745         48     27,224      12   2,268
000000000019    XX/XX/XXXX          0         272          0         497        125        252      1,148      12      95
000000000020    XX/XX/XXXX          0           0          0      62,190        407        224     62,823      12   5,235
000000000021    XX/XX/XXXX      2,156       1,781          0         617      5,390      2,278     12,225      12   1,018
000000000022    XX/XX/XXXX     12,156         864          0         597      1,130        258     15,007      12   1,250
000000000023    XX/XX/XXXX          0         944          0       1,033      1,902      1,505      5,385      12     448
000000000024    XX/XX/XXXX          0         175          0          47      1,072        357      1,652      10     165

TOTALS                         30,761       9,089      1,209     127,582     30,377     16,257    215,277     274     785

                               ** End of Report **
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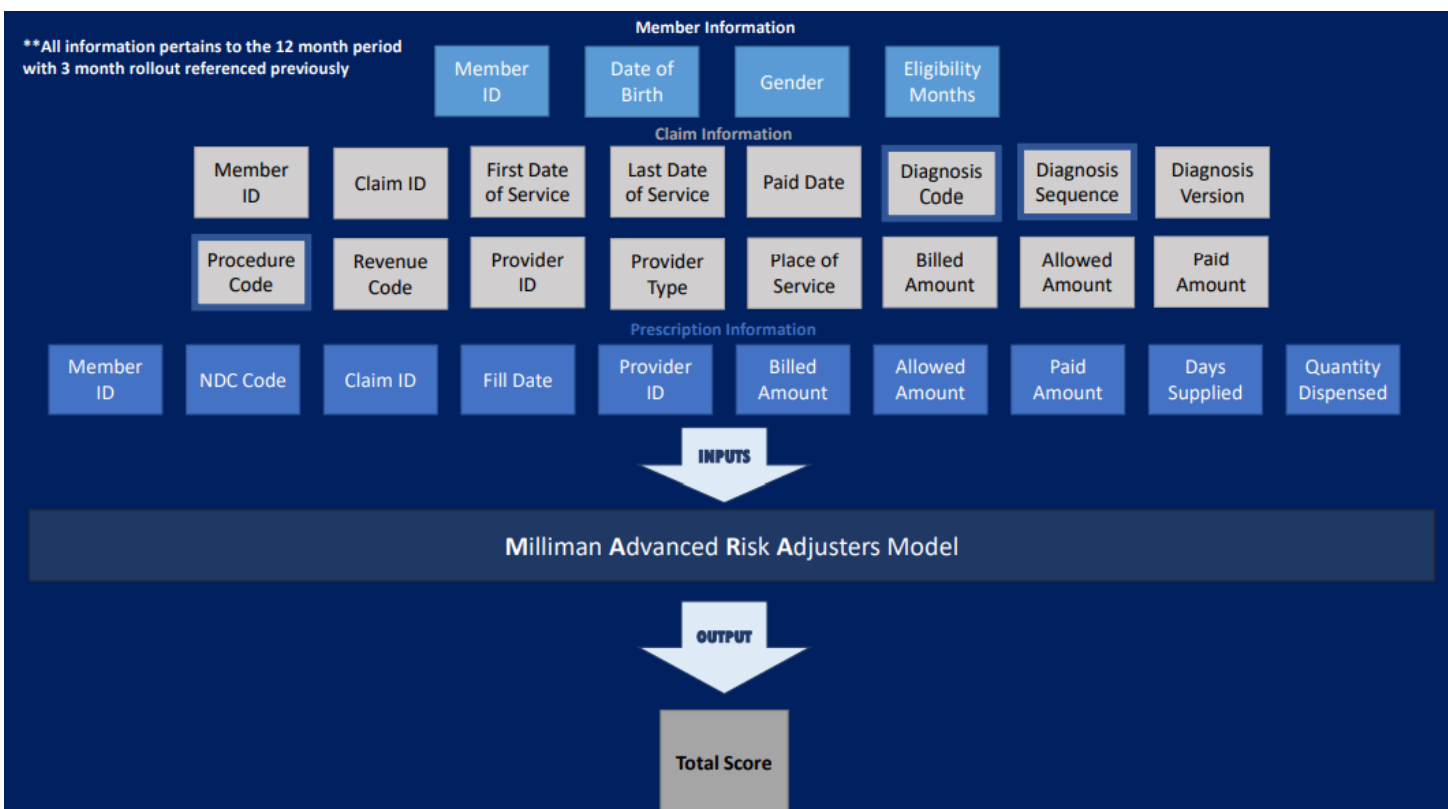# PRIMARY CARE PROVIDERS (PCP)

MARA Scoring

The Alabama Medicaid Agency utilizes Milliman Advanced Risk Adjusters (MARA) software to assess the cost risks of the ACHN population and apply a customized algorithm to calculate a Cost Effectiveness score for each participating PCP group. These scores are standardized metrics used to evaluate a member's previous health experience and/or to predict health outcomes.

The Agency utilizes multiple risk scores for ACHN Processes.

- Prospective Risk Scores – which predicts future risk given the past year's claims experience, used for Care Coordination.
- Concurrent Risk Scores – provides a singular, standardized, expected risk score given the past year's claim experience, used for Cost Effectiveness Bonus Calculations.

The MARA Scoring system for calculating the Cost Effectiveness Bonus includes:

- Compares a 12-month per member per month (PMPM) to a risk-adjusted expected PMPM based on the costs of similar PCP groups that treat Medicaid recipients
- Groups ranked by an efficiency score that is derived from actual PMPM versus the expected PMPM
- Bonus payment is paid for PCP groups at or below the median efficiency score (i.e., more efficient)
- Calculation occurs three months after the previous twelve (12) month's performance has been derived. For example, the quarterly payments made in January 2021 will be based on the actual Cost Effectiveness calculated for the period between October 1, 2019, and September 30, 2020, to allow for three months of claims payment completion

PRIMARY CARE PROVIDERS (PCP)

Patient Centered Medical Home (PCMH) Recognition Bonus Payments

The purpose of the PCMH Recognition Bonus payment is to incentivize providers to attain PCMH recognition ensuring Medicaid recipients are receiving care through a nationally recognized medical home model. PCMH achievement or progress toward PCMH achievement will be required from all PCP Groups that would like to receive the 5% bonus payment for PCMH recognition.

PCP groups can obtain PCMH recognition or certification through nationally recognized entities such as National Committee for Quality Assurance (NCQA), the Compliance Team, or the Joint Commission among others. The PCP group's certification of achievement and/or supporting documentation (proof) as adequate progress towards achievement must be in an active status on the last day in September of the (current) fiscal year in order to receive approval for the next fiscal year. A screen print of this progress must be attached to the attestation form and can be obtained from the nationally recognized entity. All PCP groups will be required to submit the PCMH Attestation Form annually to become PCMH recognized. The PCMH Recognition bonus payment attestation and proof of achievement (or progress towards achievement) are due to Medicaid annually, no later than October 1, by 5:00 P.M. (CST).

PCMH Recognition (adequate progress) towards achievement is defined as follows:

A. National Committee for Quality Assurance (NCQA) - PCP groups must have completed at least one (1) check-in and met one (1) or more Cores within the qualifying timeline for the upcoming fiscal year. Core met proof of supporting documentation must show continued progress until full PCMH Recognition has been obtained. Providers can send a screen print of the 'transforming' page in their dashboard from the NCQA website.
B. The Compliance Team - PCP groups must provide proof that progress has been made on their Quarterly PCMH Quality Reporting. Progress is defined as improvement in numbers as the months proceed. A blank PCMH Quality Reporting is unacceptable. The PCP group must have completed at least one (1) quarter with said entity and show continued progress towards PCMH Recognition accreditation.
C. The Joint Commission - PCP groups must provide proof that they have reached the 'Prepare for Survey' stage and/or beyond of the PCMH process. Additionally, at least 1 (one) of the tools within 'Prepare for Survey' must have been utilized or accessed to demonstrate progress.

Send the completed PCMH Attestation Form and its supporting documentation in one of the following ways:

By mail: Alabama Medicaid Agency Network Provider Assistance Unit
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

By fax: (334)353-3856

By e-mail: Patricia Toston and Jessica Brooks:
Patricia.Toston@medicaid.alabama.gov
Jessica.Brooks@medicaid.alabama.gov

PRIMARY CARE PROVIDERS (PCP)

Medical Management Meetings

Please note that due to Covid, the Agency has allowed all Medical Management Meetings be attended via webinar. This allowance is <u>temporary</u> and the original in-person requirements will resume at a date to be determined. Updates regarding this policy will be posted on the Agency's website under <u>ACHN Alerts</u>.

Each ACHN will hold Medical Management Meetings with the purpose to foster the primary professional development and networking opportunities for the ACHN and the primary care providers (as well as other agencies and/or providers who may have roles, responsibilities, and interests related to the Entity). It is a platform to address challenges and develop successful strategies for meeting ACHN and Agency goals.

PCP active participation requires attendance over a 12-month period to at least two quarterly medical management meetings and one webinar/facilitation exercise with the ACHN's medical director One PCP or nurse practitioner/physician assistant from the group may attend to meet attendance requirements. The 12-month period starts October 1st and ends on the following September 30th.

If a PCP stops actively participating or terminates their agreement with the ACHN they signed the original agreement with, then the PCP Group must sign another agreement to actively participate with a different ACHN to continue receiving Participation Rates and Bonus payments. In the absence of these agreements, PCP Groups will not be eligible to receive enhanced Participation Rates or Bonus Payments for Quality, Cost Effectiveness, and Patient Centered Medical Home (PCMH) recognition. If a provider chooses not to engage in active participation, they will receive regular fee-for-service rates and, if eligible, current BUMP rates.

Each ACHN will post and send notice regarding the upcoming quarter's Medical Management Meeting dates and times. It is the responsibility of the PCP to ensure attendance to meet the active participation requirements.

Alabama Medicaid Agency Required Forms

PCP forms provided by the Alabama Medicaid Agency can be located on their website:

https://medicaid.alabama.gov/
content/9.0_Resources/9.4_Forms_Library/9.4.19_ACHN_PCP_Forms.aspx

Delivering Health Care Professionals (DHCP)

DELIVERING HEALTH CARE PROVIDERS (DHCP)

Covered Services

All services provided by the DHCP will be billed fee for service.

Antepartum Care

Antepartum care includes the following usual prenatal services:

- Initial visit at the time pregnancy is diagnosed
- Initial and subsequent histories
- Maternity counseling
- Risk assessments
- Physical exams
- Recording of weight
- Blood pressure recordings
- Fetal heart tones
- Lab work appropriate to the level of care including hematocrit and chemical urinalysis

Delivery

Please refer to the Provider Billing Manual in Chapter 28 for charges that are billable fee-for-service by physicians.

Delivery includes vaginal delivery, with or without episiotomy, with or without forceps or cesarean section delivery. More than one fee may not be billed for a multiple birth delivery. Delivery includes, but is not limited to, professional services, such as physician's services and anesthesiology. Any non-routine newborn care must be billed under the baby's Medicaid number.

Hospitalization

Hospitalization includes delivery as well as any pregnancy-related hospitalizations that occur in the antepartum period or postpartum period. Hospitalization includes all charges that are normally submitted on the uniform billing claim form (UB-04), which includes but is not limited to the following:

- Labor
- Delivery or operating room
- Room and board including well baby nursery days
- Drugs, supplies, and lab/radiology services obtained during
- Hospitalization
- Physician sterilization charges may be billed fee-for-service
- The assistant surgeon fees for cesarean (C-section) deliveries are to be billed fee for service
- Anesthesia services include anesthesia services performed by an anesthesiologist or the delivering physician that are not medically contraindicated.
- DHCPs must perform medically necessary ultrasounds and submit fee for service claims to Gainwell for payment. The details regarding ultrasounds are found in the Provider Billing Manual Chapter 28
- All outpatient hospital services associated with a pregnancy related condition are to be billed

as fee for service by the Provider of service utilizing the most appropriate CPT code. A pregnancy diagnosis code, primary or secondary, must be used when billing maternity care services

Postpartum Care

Postpartum care includes office visits, home visits, and in-hospital visits following delivery for routine care through the end of the month of the 60-day postpartum period. The postpartum exam should be accomplished 21 to 56 days after delivery.

Other Billable Services

Services provided outside the scope of the global fee that may be billed separately are listed below:

Drugs	Family planning or general drugs (for example, oral contraceptives or iron pills) prescribed by a provider with a written prescription to be filled later may be billed on a fee-for-service basis. In addition, women on Plan First have the option of obtaining oral contraceptives, the contraceptive ring, or the contraceptive patch, with a prescription from a private provider, at a Medicaid-enrolled community/outpatient pharmacy. Injections administered by the physician or outpatient facility can be billed on a fee-for-service basis (for example, Rhogam or Iron). Smoking cessation products for pregnant women will be covered after prior authorization through the Pharmacy Administrative Services contractor. Refer to Appendix Q Tobacco Cessation for additional information. The recipient must be enrolled and receiving counseling services through the Alabama Department of Public Health Quitline. Approval will be granted up to 3 months at a time.
Lab Services	All lab services except hemoglobin, hematocrit, and chemical urinalysis.
Radiology	All radiology services are outside of the global fee unless performed during an inpatient stay or for ultrasounds and non-stress tests. The professional component for radiology services is a component of the primary contractor global fee and should be billed separately to the primary contractor with the exception of teaching hospitals.
Dental	Dental services are covered for recipients under 21 years of age.
Physician	Physician fees for family planning procedures (for example, sterilization), and genetic counseling. Claims for circumcision, standby and infant resuscitation may be billed
Family Planning Services	Appropriate Family planning services with family planning procedure code or indicator. Eligible recipients will receive family planning services from an ACHN.
Home Visit (99347-FP)	The home visit is a brief evaluation by a medical professional in the home of an established recipient and is for the purpose of providing contraceptive counseling (using the PT+3 teaching method) and administration/issuance of contraceptive supplies. The home visit is for postpartum women during the 60-day postpartum period and usually occurs within 7-14 days after delivery. A home visit is limited to one per 60-day postpartum period and usually occurs within 7-14 days after delivery. A home visit is not a covered service for recipients with Plan First eligibility and can only be provided as a family planning service by Medicaid eligible family planning providers to eligible recipients. To qualify for reimbursement for the home visit:

DELIVERING HEALTH CARE PROVIDERS (DHCP)

Continued Home Visit (99347-FP)	• Medical professionals who are licensed to administer medications such as oral contraceptives or to give injections must provide the home visit. • The home visit must include: brief medical histories: family, medical, contraceptive, and OB/GYN, blood pressure and weight check, contraceptive education and counseling using the PT+3 teaching method assuring that the recipient: • Understands how to use the method selected, • How to manage side effects/adverse reactions, • When/whom to contact in case of adverse reactions, and the importance of follow-up. • Scheduling of a follow-up visit in the clinic if needed • Issuance or prescription of contraceptive supplies as appropriate. The recipient must give her signed consent for this visit.
Extended Family Planning Counseling Visit (99212-FP)	The extended family planning counseling visit is a separate and distinct service consisting of a minimum of 10 face-to-face minutes of extended contraceptive counseling using the PT+3 teaching method. The extended family planning counseling visit is for postpartum women during the 60-day postpartum period and is performed in conjunction with the 6-week postpartum visit in the office/clinic setting. An extended family planning counseling is limited to once during the 60- day post-partum period, and is not available for women who have undergone a sterilization procedure or Plan First eligible recipients on the Plan First Program. The counseling services are those provided above and beyond the routine contraceptive counseling that is included in the postpartum visit. The purpose of this additional counseling time is to take full advantage of the window of opportunity that occurs just after delivery when the physical need for pregnancy delay is at a peak. An Extended Family Planning Counseling Visit is not covered for Plan First recipients and can only be provided as a family planning service by eligible family planning providers to eligible recipients. The following services are required: • Contraceptive counseling and education • STD/HIV risk screening and counseling • Issuance of contraceptive supplies. NOTE: In the event of a premature delivery or miscarriage, the EDC, "Expected Date of Confinement", must be documented on the claim form in block 19 in order to be reimbursed for procedure code 99212-FP. All visits must be documented in the recipient's chart and reflective of the treatment and care provided.
Emergency Services	Outpatient emergency room services (including the physician component) (claims containing a facility fee charge of 99281, 99282, 99283, 99284, or 99285) and associated physician charges (99281-99288) will be reimbursed separately from the global fee. Access to emergency services will not be restricted by the Maternity Care Program.
Transportation	Transportation as allowed under the Alabama Medicaid State Plan may be billed on a fee-for-service basis.

Mental Health	Screening, Brief Intervention, and Referral to Treatment (SBIRT) are services designed to identify individuals who are at risk for development of substance use disorders, assist individuals in implementing strategies to reduce the potential for development of substance use disorders, and refer individuals who have identified needs for substance abuse treatment to specialized substance abuse treatment providers. Note: The intent of SBIRT is referral for Substance Abuse to include alcohol and drug abuse as smoking cessation is covered in the Maternity Care Program under Care Coordination Services. Screening: A full screen, as reimbursable through this benefit, is a structured process used to identify an individual whose current use of alcohol and/or other drugs creates a clearly defined risk for harm in some life dimension. A non-reimbursable pre-screening process must provide documentation of the need for a full screen. The pre-screening process may consist of, as few as, one to two brief questions incorporated into a general health questionnaire; a valid and reliable short screening tool; observations of attending medical personnel; interview and self-report; laboratory results; and/or concerns expressed by significant others. The full screen must be conducted utilizing an authorized, evidence-based screening tool with established reliability and validity in the identification of individuals who are at risk for developing substance use disorders. The tool must also provide enough information to establish an appropriate level of intervention in relation to each individual's identified risk factors. Authorized tools that may be used to conduct the full screen include the following: • Alcohol, Smoking, and Substance Involvement Test (ASSIST) • Drug Abuse Screening Test (DAST) • Alcohol Use Disorders Identification Test (AUDIT) • Car, Relax, Alone, Forget, Family or Friends, Trouble (CRAFFT) Questionnaire • Problem Oriented Screening Instrument for Teenagers (POSIT) • UNCOPE Substance Abuse Screening Additional tools that conform to the criteria specified above may be utilized to provide the full screen. Prior to use, however, each tool not listed above must be reviewed and authorized for use by the Alabama Medicaid Agency. The full screening process includes the provider's evaluation of the results and an explanation of these results to the individual who has been screened. The provider must clearly explain the level of risk associated with the identified alcohol and/or drug use pattern, and describe the corresponding implications within the context the individual's health and other life dimensions. The provider's response to low risk substance use shall be provided during the screening process as according to the identified needs of the individual. This may include, but is not limited to, the dissemination of material that provides information on the risks associated with drinking and drug use, for example:

DELIVERING HEALTH CARE PROVIDERS (DHCP)

Continued Mental Health	• Potential alcohol and drug interactions with medications the individual is taking. • The potential for exacerbation of a health condition with alcohol and drug use. • The potential impact of alcohol or drug use on pregnancy. If the individual has a positive full screen, indicative of a moderate to high risk for a substance use disorder, the provider must be prepared to conduct or obtain brief intervention services during this same visit. BRIEF INTERVENTION A brief intervention is an organized encounter that includes, at a minimum, a provider and an individual who has been identified through a full screening process as being at moderate to high risk for development of a substance use disorder. Through the use of motivational strategies with demonstrated effectiveness, the goals of a brief intervention are to increase the individual's awareness and insight regarding current alcohol and/or drug use; to establish acceptance of a need for change; and to support the individual in development and implementation of a plan for change. The brief intervention may consist of a single brief (15 minutes) session or multiple brief sessions dependent upon the unique needs of each individual. Referrals for specialized substance abuse treatment services are provided in conjunction with brief interventions. During any brief intervention, including the first session, the provider must be prepared to make a direct referral to a specialized substance abuse treatment provider for individuals who are at high risk for severe substance use and related consequences. Referrals must be initiated as soon a need for such is established. SERVICE UNITS/LIMITS • Screening: H0049 • Service Unit: Episode • Limit: One per pregnancy Providers may bill for time that is spent face-to-face administering an authorized screening tool, discussing the screening results, and providing recommendations for further actions. Providers may not bill for the time during which an individual self-administers a screening tool. • Brief Intervention: H0050 • Service Unit: 15 minutes • Limit: 1/day, 2/pregnancy Providers may bill for time that is spent face-to-face implementing strategies to assist individuals with moderate to high risks for development of substance use disorders in behavior modification that supports risk reduction. Allowable strategies include efforts made by the provider to assist the individual in accessing specialty substance abuse treatment services when there is an identified need for such. Restrictions: SBIRT services are not a covered benefit for: • Smoking and tobacco abuse. • Individuals who have been diagnosed with a substance use disorder.

Continued Mental Health	• Individuals who have had previous and/or are now receiving treatment for a substance use disorder. Service Documentation: Documentation of services provided shall incorporate the following: • The need for and method of identification of the need for SBIRT as established during a pre-screening process. • Identification of the screening tool used to conduct the full screening process. • The results of the full screening process. • Brief intervention goals unique to each individual. • Summary report of each brief intervention session conducted, including the implementation of established motivational strategies. • Referrals made and outcomes. • Follow-up services provided. Approved Providers: Coverage of Screening, Brief Intervention, and Referral for Treatment (SBIRT) for pregnant women is covered in conjunction with antepartum care provided by physicians, physician employed nurse practitioners, nurse midwives, physician-employed physician assistants and FQHCs. Prior to offering the services health care professionals must complete an online tutorial which can be accessed at http://www.mh.alabama.gov. The Mental Health and Substance Abuse Services Division of the Alabama Department of Mental Health will notify the Medicaid Maternity Care Program of health care professionals' successful completion of the tutorial. Procedure codes H0049 (screening for substance use) and H0050 (brief intervention and referral to treatment) will then be billable for the health care professional who has successfully completed the online tutorial. An ICD-10 code of Z331 must be billed by the provider on the claim form
Referral to Specialists	DHCPs may provide referrals to specialists. Services provided by non-OB specialty physicians (i.e. cardiologists, endocrinologists) for problems complicated or exacerbated by pregnancy can be billed fee-for-service by the provider of service. A general/family practitioner is not considered a specialty provider. A Board Certified Perinatologist is considered a specialty provider and may bill fee-for-service for high risk patients only. Refer to the Chapter 28, Physicians Chapter, for billing information.
Non-Pregnancy Related Care	Services provided that are not pregnancy-related may be billed fee-for-service. A recipient's age, health care requirements, and place of residence may further define his or her eligibility for Medicaid covered services. For this reason, it is very important that the providers verify recipient eligibility and ensure they understand all aspects of the eligibility response. A provider may reference the fee schedules for a list of covered services on the following link: http://medicaid.alabama.gov/content/Gated/7.3G_Fee_Schedules.aspx. The fee schedules are not an all-inclusive list of procedure codes covered by the Agency. Reference Chapter 4, Obtaining Prior Authorization (PA) for PA requirements.

DELIVERING HEALTH CARE PROVIDERS (DHCP)

Tobacco Cessation Face-To-Face Counseling	The Alabama Medicaid Agency covers smoking cessation benefits for Medicaid-eligible pregnant women. Medicaid will reimburse for up to four face- to-face counseling sessions in a 12-month period. The reimbursement period will begin in the prenatal period and continue through the postpartum period (60 days after delivery or pregnancy end). Documentation must support each counseling session. Face-to-face counseling services must be provided: • By or under the supervision of a physician; • By other health care professionals who are legally authorized to furnish such services under State law and within their scope of practice and who is authorized to provide Medicaid coverable services other than tobacco cessation services
Long Acting Reversible Contraception (LARC)	Effective for dates of service June 4, 2019, and thereafter Alabama Medicaid will reimburse the cost of the long acting reversible contraceptive to the facility when provided in the inpatient hospital setting immediately after a delivery or up to the time of the inpatient discharge for postpartum women, or in an outpatient setting immediately after discharge from the inpatient hospital for postpartum women. The insertion of the device/drug implant will be billable to Medicaid by both the physician and hospital for reimbursement. Refer to Chapter 19 Hospital for additional information. For questions regarding hospital billing contact Elizabeth Huckabee, Director, Medical Services Division at Elizabeth.Huckabee@medicaid.alabama.gov. For questions regarding physician billing contact Jean Wackerle, Associate Director, Physicians Program, at (334) 242-2312 or via email Jean.Wackerle@medicaid.alabama.gov

Provider Selection and Referral Requirements

Please note, referral requirements may change at any time. Notices are sent via Alert. While we strive to have the most up-to-date information in this manual, it is recommended that you refer to the Provider Billing Manual.

DHCPs may provide referrals to specialists. Referrals to specialty providers for a pregnant recipient (i.e., Cardiology, Endocrinology, etc.) are paid fee-for-service. All maternity claims must have a DHCP selection referral number from the ACHN to receive payment from Medicaid. Although DHCPs will already have the ACHN NPI number, it is the responsibility of the DHCP to ensure a referral is in medical record and contact has been made with the ACHN. This ensures collaborative communication between the DHCP and the ACHN for quality health outcomes.

Medicaid Recipients that are not assigned to an ACHN on the date of service will not require a DHCP referral from the ACHN for reimbursement.

In emergency circumstances, maternity claims submitted with an emergency indicator (Certified Emergency – Service Authorization Exception Code – 3) will not require a DHCP referral from an ACHN for reimbursement.

Spontaneous abortions do not require a DHCP referral number from the ACHN. However, the DHCP should notify the ACHN when a pregnancy ends due to a spontaneous abortion.

DELIVERING HEALTH CARE PROVIDERS (DHCP)

Care Coordination

The ACHN care coordinator arranges a coordinated system of obstetrical care for pregnant women based on specific guidelines for care coordination services. The care coordination services provided by the ACHN for a maternity recipient are listed below:

- Eligibility assistance
- First Face-to-Face encounter
- Face-to-Face follow-up encounter (two encounters allowed if high risk)
- Inpatient Face-to-Face delivery encounter
- In home Face-to-Face postpartum encounter (for high risk recipients)

Quality Improvement

DHCPs can positively impact quality in the following ways:

- Performing a prenatal visit in the first trimester
- Performing a postpartum visit (21-56 days)
- Participating in quality improvement projects with an ACHN

Reimbursements and Payments

Providers should bill Medicaid claims electronically. Refer to the Provider Billing Manual Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing. When filing a claim on paper, a CMS-1500 claim form is required.

Medicaid will pay $150.00 for each Bonus Payment and the following procedure codes must be submitted on a separate claim:

- **H1000:** Initial Prenatal Visit. Actively participating DHCPs may bill procedure code H1000 if the following criteria is met:
    - The Medicaid recipient has a confirmed pregnancy by a medical professional and/or lab test on or before the date of service and
    - The Medicaid recipient completes a gynecology/obstetrics medical visit within 90 days (12 weeks) of the last menstrual period.
- **G9357:** Postpartum Visit. Actively participating DCHPs may bill procedure code G9357 if the following criteria is met:
    - The Medicaid recipient has delivered (including miscarriages/spontaneous abortions)
    - A paid delivery claim has been processed by the Alabama Medicaid Agency
    - The Medicaid recipient completes a visit with the DHCP between 21 and 56 days of delivery
    - If a provider files procedure code G9357 between 21 and 56 days of delivery and receives a denial, the provider may submit an override request. The override request must be sent to:

DELIVERING HEALTH CARE PROVIDERS (DHCP)

Alabama Medicaid Agency
Managed Care Division
Attention: Linda White
501 Dexter Avenue P.O. Box 5624
Montgomery, AL 36103-5624

Only one (1) initial and/or postpartum DHCP bonus payment will be paid per recipient per pregnancy. Duplicate DHCP bonus payments will not be paid for the same recipient during the same pregnancy. Nurse Practitioners, Physician Assistants, and Nurse Midwives will receive 80% of the physician rate for these Bonus Payments. These Bonus Payments also apply to FQHCs and RHCs. Medicaid recipients that are not enrolled in the ACHN program on the date of service are not eligible for the prenatal nor the postpartum visit bonus payments.

Beginning with dates of service October 1, 2021, DHCPs will be reimbursed the following new rates for the specified procedure codes:

Procedure Code	Description	New Rate (for RURAL area providers)	New Rate (for URBAN area providers)
59400	Obstetrical Care	$2,090	$1,690
59409	Obstetrical Care	$1,640	$1,340
59410	Obstetrical Care	$1,690	$1,390
59510	Cesarean Delivery	$2,090	$1,690
59514	Cesarean Delivery	$1,640	$1,340
59515	Cesarean Delivery	$1,690	$1,390
59610	Vbac Delivery	$2,090	$1,690
59612	Vbac Delivery Only	$1,550	$1,250
59614	Vbac Care After Delivery Only	$1,600	$1,300
59618	Attempted Vbac Delivery	$2,090	$1,690
59620	Attempted Vbac Delivery Only	$1,600	$1,300
59622	Attempted Vbac After Care	$1,600	$1,300

Reimbursement for DHCP bonus payments will also increase. Beginning with dates of service October 1, 2021, DHCPs will be reimbursed for the specified DHCP bonus payments at the following new rates:

Procedure Code	Description	New Rate (for RURAL area providers)	New Rate (for URBAN area providers)
H1000	Prenatal Visit Bonus	$150	$150
G9357	Postpartum Visit Bonus	$150	$150

The prenatal bonus payment may be available to providers who render services to pregnant recipients within 90 days of the last menstrual period. The postpartum bonus payment may be available to providers who render services to recipients between 21-56 days after delivery. The DHCP bonus payment procedure codes must be billed on a separate claim for reimbursement. Physicians will be reimbursed at 100% for the new global rates and DHCP bonus payments. Nurse practitioners, physician assistants, and nurse midwives will be reimbursed 80% of the physician rate for the new global rates and DHCP bonus payments

Family Planning Services

Family Planning Services

ACHN staff will help promote family health, responsible behavior, and healthy mothers and babies. Medicaid wants to help prevent an unintended pregnancy and help Medicaid Recipients plan when they want to have a baby. Social workers and nurses who work for the ACHN will get Medicaid Recipients the help needed.

ACHN social workers and nurses will (if desired) help:

- Find a doctor to tie tubes or perform a procedure to keep a woman from getting pregnant, for recipients aged 21 years of age or older
- Find a doctor to perform a procedure to avoid getting a woman pregnant, for male recipients aged 21 or older
- Make appointments, help keep your appointments, and provide appointment reminders
- Answer questions about family planning; choose a birth control method and give advice about any problems
- Stop smoking and/or stop tobacco use

Body Mass Index (BMI) Requirements

Body Mass Index (BMI) Requirements

Actual incidence of obesity among the Medicaid population is difficult to assess since BMI reporting is so poor among Medicaid providers. Childhood obesity is a serious problem in the United States putting children and adolescents at risk for poor health. Obesity prevalence among children and adolescents is still too high. Childhood obesity is an area of focus for the ACHN program and a Childhood Obesity initiative is one of three Quality Improvement Projects the Networks are required to implement.

- Obese Medicaid recipients ages 18 years or older (identified by a Medicaid claim with a diagnosis of obesity) are significantly more likely to have a chronic condition.
- Obese individuals are 7 to 12 times more likely than those with normal BMI to develop diabetes.
- Obesity increases a person's risk of developing coronary artery disease by 80%, as compared to normal BMI.
- Obese individuals are 64% more likely than people in the normal BMI range to suffer an Ischemic stroke.

Primary Care Physicians (PCPs), nurse practitioners/physician assistants (collaborating with a PCP), PCP groups/ individual PCPs participating with an Alabama Coordinated Health Network (ACHN), Federally Qualified Health Centers, Rural Health Centers, Public Health Departments, Teaching Facilities, and OB/GYNs that bill procedure codes 99201-99205, 99211-99215, and 99241-99245 will be required to include a BMI diagnosis on the claim. The claim will be denied when a BMI diagnosis is not on the claim. A BMI diagnosis will only be required once on an annual basis for claims to pay.

EPSDT procedure codes 99382-99385 and 99392-99395 must also include a BMI diagnosis on the claim annually. The claim will be denied when a BMI diagnosis is not on the claim. Some specialists and nurse practitioners/physician assistants collaborating with these specialists are exempt from the BMI requirement. Refer to Chapter 40 of the Provider Billing Manual for a list of provider specialists that are exempt from the BMI requirement.

Providers may verify BMI reporting on a claim during a calendar year by accessing the recipient's eligibility benefit panel via Provider Electronic Solutions (PES) Software or the Automatic Voice Response System (AVRS). Under the Benefit Limits section, a response of "1" (or more) paid BMI visits indicates that the recipient had an annual BMI and a new BMI is not required for the claim to pay. A response of "0" paid BMI visits indicates that the recipient has not had an annual BMI reported and a BMI will be required for the claim to pay.

In instances where a BMI cannot be determined (e.g., wheelchair-bound recipients), an override request may be submitted after the claim has been filed and denied. See Chapter 40 of the Provider Billing Manual for BMI override request procedures.

The tables of the following page provide a description of procedure codes and a description of ICD-10 codes that require a percentile on the CMS 1500 claim for recipients.

Pediatric Body Mass Index (BMI) Codes

The table below provides a description of procedure codes and a description of ICD-10 codes that require a percentile on the CMS 1500 claim form for recipients <u>less than 20 years of age:</u>

Procedure Code Description	ICD-10 Diagnosis Code Description for Ages Less Than 20
99201 Office/Outpatient Visit New 99202 Office/Outpatient Visit New 99203 Office/Outpatient Visit New 99204 Office/Outpatient Visit New 99205 Office/Outpatient Visit New 99211 Office/Outpatient Visit Est 99212 Office/Outpatient Visit Est 99213 Office/Outpatient Visit Est 99214 Office/Outpatient Visit Est 99215 Office/Outpatient Visit Est 99241 Office Consultation 99242 Office Consultation 99243 Office Consultation 99244 Office Consultation 99245 Office Consultation	Z6851 BMI Pediatric, Less Than 5th Percentile for Age Z6852 BMI Pediatric, 5th Percentile to Less Than 85% for Age Z6853 BMI Pediatric, 85% To Less Than 95th Percentile for Age Z6854 BMI Pediatric, Greater Than or Equal To 95% for Age

Adult Body Mass Index (BMI) Codes

The table below provides a description of procedure codes and a description of ICD-10 codes that require a percentile on the CMS 1500 claim form for recipients <u>age 20 years or older:</u>

Procedure Code Description	ICD-10 Diagnosis Code Description for Ages 20 and Older
99201 Office/Outpatient Visit New 99202 Office/Outpatient Visit New 99203 Office/Outpatient Visit New 99204 Office/Outpatient Visit New 99205 Office/Outpatient Visit New 99211 Office/Outpatient Visit Est 99212 Office/Outpatient Visit Est 99213 Office/Outpatient Visit Est 99214 Office/Outpatient Visit Est 99215 Office/Outpatient Visit Est 99241 Office Consultation 99242 Office Consultation 99243 Office Consultation 99244 Office Consultation 99245 Office Consultation	Z6810 Body Mass Index (BMI) 19 Or Less, Adult Z6820 Body Mass Index (BMI) 20.0-20.9, Adult Z6821 Body Mass Index (BMI) 21.0-21.9, Adult Z6822 Body Mass Index (BMI) 22.0-22.9, Adult Z6823 Body Mass Index (BMI) 23.0-23.9, Adult Z6824 Body Mass Index (BMI) 24.0-24.9, Adult Z6825 Body Mass Index (BMI) 25.0-25.9, Adult Z6826 Body Mass Index (BMI) 26.0-26.9, Adult Z6827 Body Mass Index (BMI) 27.0-27.9, Adult Z6828 Body Mass Index (BMI) 28.0-28.9, Adult Z6829 Body Mass Index (BMI) 29.0-29.9, Adult Z6830 Body Mass Index (BMI) 30.0-30.9, Adult Z6831 Body Mass Index (BMI) 31.0-31.9, Adult Z6832 Body Mass Index (BMI) 32.0-32.9, Adult Z6833 Body Mass Index (BMI) 33.0-33.9, Adult Z6834 Body Mass Index (BMI) 34.0-34.9, Adult Z6835 Body Mass Index (BMI) 35.0-35.9, Adult Z6836 Body Mass Index (BMI) 36.0-36.9, Adult Z6837 Body Mass Index (BMI) 37.0-37.9, Adult Z6838 Body Mass Index (BMI) 38.0-38.9, Adult Z6839 Body Mass Index (BMI) 39.0-39.9, Adult Z6841 Body Mass Index (BMI) 40.0-44.9, Adult Z6842 Body Mass Index (BMI) 45.0-49.9, Adult Z6843 Body Mass Index (BMI) 50-59.9, Adult Z6844 Body Mass Index (BMI) 60.0-69.9, Adult Z6845 Body Mass Index (BMI) 70 or Greater, Adult

Pharmacy Preferred Drug Lists (PDL)

Pharmacy Preferred Drug Lists

Drugs selected for the PDL typically do not require prior authorization (PA). In most cases, all generic products are preferred and do not appear on the lists below. The lists are updated quarterly. For the most current lists, please the Alabama Medicaid Agency's Pharmacy page:

https://medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME.aspx

The specific link for the PDF listings in here:

https://medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME/4.3.7_Preferred_Drug_List.aspx

On the above link, you will find links to the most up-to-date:

- Alphabetical PDL
- Therapeutic PDL
- PDL Reference Tool
- 1st Generation Antihistamines, and
- Prenatal Vitamins (PNV)

Alabama Medicaid Agency Website & Presentations Alerts & Updates

ALABAMA MEDICAID AGENCY WEBSITE & PRESENTATIONS

- **ACHN** page on the Alabama Medicaid Agency's website can be located at:

https://medicaid.alabama.gov/content/5.0_Managed_Care/default.aspx

Alternatively, from the main page, you may select the ACHN option:

- **Webinars and presentations** presented by the Alabama Medicaid Agency can be located on their website under **Presentations**. Webinars are presented live and it is recommended that you sign up for email and/or text alerts for upcoming presentations

  http://medicaid.alabama.gov/content/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers.aspx

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ALABAMA MEDICAID AGENCY ALERTS & UPDATES

Also listed on the website mentioned in the previous section are links to sign up for email and/or text alerts. These are located under **Notifications**.

https://medicaid.alabama.gov/alerts.aspx