

ALABAMA MEDICAID AGENCY MATERNITY CARE PROGRAM OPERATIONAL MANUAL

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OPERATIONAL MANUAL
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I. OVERVIEW

The Maternity Care Program Operational Manual is provided as a resource tool. For questions or clarification of program policy or requirements, you may contact the Maternity Care Program Associate Director.

A. Maternity Care Program Authority

The program is also governed by the existing State Plan, 1915(b) Waiver, Alabama Medicaid Agency Administrative Code, Alabama Medicaid Provider Billing Manual, Request for Proposal (RFP) Number **2015-MCMS-01** and the Code of Federal Regulations (CFR). It is the responsibility of the Primary Contractor to be aware of and maintain copies of all governing materials.

B. Districts

Primary Contractors for all districts are required to provide maternity care services to all women eligible for the program. The districts and counties are outlined in **Figure 1**.

Figure 1. Districts and Counties

Districts	Counties
1	Colbert, Franklin, Lauderdale, Marion
2	Jackson, Lawrence, Limestone, Madison, Marshall, Morgan
3	Calhoun, Cherokee, Cleburne, DeKalb, Etowah
4	Bibb, Fayette, Lamar, Pickens, Tuscaloosa
5	Blount, Chilton, Cullman, Jefferson, Shelby, St. Clair, Walker, Winston
6	Clay, Coosa, Randolph, Talladega, Tallapoosa
7	Greene & Hale
8	Choctaw, Marengo, Sumter
9	Dallas, Wilcox, Perry
10	Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, Pike
11	Barbour, Chambers, Lee, Macon, Russell
12	Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe, Washington
13	Coffee, Dale, Geneva, Henry, Houston
14	Mobile

C. Recipients to be Served

1. The following recipients who are pregnant are required to participate and must be enrolled by the district where the recipient resides:
 - a. Those certified under the Affordable Care Act using the Modified Adjusted Gross Income (MAGI) rules for pregnant women with the exception of the Department of Youth Services recipients identified with County Code 69
 - b. Those certified through the Parent Other Caretaker Relative (POCR)
 - c. Refugees
 - d. Supplemental Security Income (SSI) eligible women
2. The following recipients are not required to participate in the Maternity Care Program:
 - a. Dual eligible recipients (Medicare/Medicaid)
 - b. Individuals granted emergency Medicaid due to their non-citizen status
3. Primary Contractors must follow non-discriminatory standards of care for all recipients regardless of eligibility category.
 - a. Ensuring that no person shall, on the grounds of race, color, creed, national origin, age, health status or handicap, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program of services provided by Medicaid.
 - b. Compliance with Federal Civil Rights and Rehabilitation Acts is required of providers participating in the Alabama Medicaid Agency.

II. DEFINITIONS

Actuarially Sound Rates

CMS defines actuarially sound rates as rates that have been developed in accordance with generally accepted actuarial principles and practices appropriate for the populations to be covered and the services to be furnished under the contract and certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

Anesthesia

Any sensory and/or motor paralysis for the relief of pain including but not limited to epidural, saddle-block, pudendal block, inhalation central anesthesia, endotracheal anesthesia, or other, which is not medically contraindicated.

Antenatal Care

All usual prenatal services including, but not limited to, the initial visit at the time pregnancy is diagnosed, initial and subsequent histories, Care Coordination, risk assessments, physical exams, recordings of weight and blood pressure, fetal heart tones and rates, lab work appropriate to the level of care including hematocrit and chemical urinalysis, and any additional services required for high-risk women.

Application Assisters

Individuals trained by the Medicaid Agency to assist recipients in completing Medicaid applications.

Benchmark

A benchmark is a standard by which requirements can be measured or judged.

Recipients

Pregnant women who reside in Alabama, are certified for Medicaid and receive pregnancy related services under the Maternity Care Program.

Care Coordination

Management of obstetrical care including recruitment, outreach,

psychosocial assessment, service planning, assisting the recipient in arranging for appropriate services including, but not limited to, applying for Medicaid resolving transportation issues, education, counseling, and follow-up and monitoring to ensure services are delivered and continuity of care is maintained.

Clean Claim

A clean claim is one that can be processed without Medicaid obtaining additional information from the provider of service or a third party insurance carrier.

CMS

Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

Continuity of Care

Uninterrupted continual care of the Medicaid recipient that is coordinated to address the health care needs among practitioners and across organizations and time.

Contract Services

See "covered services".

Convicted

A judgment of conviction that has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

Covered Services

Health care services, as designated in Section 5, to be delivered by a Primary Contractor or through subcontracts.

Days

Calendar days unless otherwise specified.

Debarment

Debarment is exclusion from participation as a Medicare/Medicaid provider.

Delivery

Delivery is the birth of an infant via vaginal birth canal (with or without episiotomy and with or without forceps), or cesarean

section delivery.

Delivering Healthcare Professional (DHCP)

A licensed physician or nurse midwife who is qualified to perform deliveries, prenatal and postpartum care.

Disclosing Entity

The entity is a Medicaid provider or a fiscal agent.

Districts

Districts are geographic divisions of the State of Alabama as defined by the Alabama Medicaid Agency which comprise the entire state divided into fourteen districts.

Dropouts

A recipient who begins care in the district of her residence but does not deliver her infant within that district's network is considered a dropout. An example of dropout may include someone who moves to another district prior to delivery or one who miscarries prior to 21 weeks.

Eligible

A person certified as eligible to receive Medicaid benefits and who has been issued a Medicaid identification number.

Eligibility

A process of determination of eligibility for medical assistance performed by Medicaid.

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy or serious impairment of bodily functions; or serious dysfunction of any bodily organ or part.

Enrollee

An enrollee is a Medicaid recipient who is currently enrolled in the Maternity Care Program via her district of residence.

Encounter Data

Encounter data are the records of services delivered to Medicaid beneficiaries enrolled in Maternity Care Program for which a capitated payment is made. These records allow the Medicaid agency to track the services received by Maternity recipients enrolled in Maternity Program and set capitation rates. Encounter data typically comes from billed claims that Primary Contractors and providers submit to the Alabama Medicaid Agency for their services.

Fee for Service

A method of Medicaid reimbursement based upon payment to providers for services rendered to Medicaid recipients subsequent to, and specifically for, the rendering of those services. Those services that are payable outside the global fees.

Fiscal Agent

The company designated by Medicaid, through contract, to maintain the Medicaid claims processing system.

Fiscal Year

Defined as October 1 through September 30.

Global Fee

The reimbursement fee paid following delivery to the Primary Contractor for recipients who meet the requirements of the Medicaid Maternity Care Program. This fee is a global amount (based on actuarial soundness) paid to the Primary Contractor who, in turn, pays subcontractors who provided services to enrolled recipients. The amount paid to each subcontractor is a negotiated amount between the Primary Contractor and the subcontractor, with Medicaid minimums established for Delivering Healthcare Professionals.

Grievance

A grievance is a written expression of dissatisfaction about any matter.

Indicator

An indicator is a measurable dimension of care (e.g., a medical event, diagnosis, or outcome) to reflect aspects of care, the

importance of which is gauged by frequency, severity, or cost.

Material Omission

A fact, data or other information excluded from a report, contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.

Maternity Care Primary Contractor

A person or organization agreeing through a direct contract with the Alabama Medicaid Agency to provide those goods and services specified by contract in conformance with the requirements of the bid and state and federal laws and regulations. **Medicaid** A Federal/State program authorized by Title XIX of the Social Security Act, as amended, which provides Federal matching funds for a medical assistance program for recipients of federally aided public assistance and SSI benefits and other specified groups. Certain minimal populations and services shall be included.

Medically Necessary

Appropriate and necessary services as determined by health care practitioners according to national or community standards

Medical Record

The document that records all of the medical treatment and services provided to the Medicaid recipient.

Modified Adjusted Gross Income (MAGI)

A Federal mandate, effective January 1, 2014, authorizing States with eligibility coverage groups such as Pregnant Women, Children under age 19, Family Planning, Parents and Other Caretaker Relatives (POCR), and Former Foster Care Children who were affected by the Affordable Care Act of 2010 (aka Patient Protection and Affordable Care Act of 2010) to use Modified Adjusted Gross Income (MAGI) methodology for eligibility determinations for specific groups of Medicaid applicants and beneficiaries such as pregnant women, children under age 19, family planning, and parents and other caretaker relatives.

Party of Interest

A person or organization with an ownership interest with the

Primary Contractor of five percent or more or in which the Primary Contractor has ownership interest of five percent or more.

Performance Measure

A consistent measurement of service, practice, and governance of a health care organization. Measurements shall produce solid, statistically-based measurement of critical processes that, in turn, shall permit the organization to make solid decisions about improvements.

Postpartum Care

Postpartum care includes inpatient hospital visits, office visits and/or home visits by a physician, midwife or registered nurse following delivery for routine care through the end of the month of the 60-day postpartum period (e.g. whether the 60th day is on September 2nd or September 16th, the eligibility continues through the end of the month.)

Potential Enrollee

A Medicaid recipient who is subject to mandatory or voluntary enrollment, but is not yet enrolled.

Pregnant Women

Pregnant Women is an eligibility category for pregnant women within the Medicaid system. Pregnant Women is further defined as maternity services for a woman who is eligible for pregnancy only related care, postpartum and family planning services. These women are maternity eligible until the end of the month in which the 60th postpartum day falls. After Pregnant Women eligibility ends the women are covered by family planning services. These women are also identified as poverty level women.

Pre-Term Delivery

Deliveries occurring prior to 37 weeks gestation.

Program Exemption

A recipient who has an exemption is not required to receive care from the Primary Contractor's network. This is generally as a result of travel hardship or for individuals enrolled in a private Health Maintenance Organization (HMO). The claims for exempted

recipients are paid fee for service if provided by an authorized Alabama Medicaid provider.

Quality Assurance

An objective and systematic process that evaluates the quality and appropriateness of services provided.

Remittance Advice

An explanation of Alabama Medicaid Agency's check writes payment. It lists the paid, denied, adjusted and recouped claims. Remittance Advice was previously called the Explanation of Payment.

Risk Assessment

Medical and psycho-social assessment performed to determine the perinatal risk status of pregnant women. The purpose of the assessment is to determine the presence of any medical and/or social risk factors.

RMEDE

Realtime Medical Electronic Data Exchange, or RMEDE, is the service database for the collection of recipient data so that an accurate reflection of program impact can be obtained.

RMEDE Exemption

A recipient who has an exemption is not required to be entered into the Service database by the Primary Contractor's network. This is generally as a result of deliveries at or less than 21 weeks gestation or other reasons as approved by the Alabama Medicaid Agency.

Risk contract

A contract under which the contractor assumes risk for the cost of the services covered under the contract; and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Smoker

A person who is actively smoking or using any form of tobacco or who has ceased the use of tobacco products within the last 3 months prior to enrollment in the Maternity Care Program.

Subcontract

A subcontract is any written agreement between the Primary Contractor and another party for any services necessary to fulfill the requirements of the Medicaid Maternity Care Program contract

Third Party Liability (TPL)

Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for covered services furnished to enrollees. The recipient is still restricted to receiving care through the Primary Contractor unless the TPL is a HMO/Managed Care Plan with a restricted provider network, and then a program exemption shall be requested. Primary Contractor is responsible for collecting all third party payments prior to submitting a claim to Medicaid for payment.

Utilization Review

Prospective, concurrent and retrospective review and analysis of data related to utilization of health care resources in terms of cost effectiveness, efficiency, control, quality, and medical necessity.

III. ADMINISTRATIVE REQUIREMENTS

A. Standards for Primary Contractor

The Primary Contractor must comply with all the provisions of the executed contract, its amendments and referenced materials and shall act in good faith in the performance of the provisions of said contract. The following is a listing of the standards for the Primary Contractor:

1. Demonstrate the capability to serve all of the pregnant Medicaid eligible population in the designated geographical area whether the Medicaid eligible has or has not enrolled in your district.
2. Procure a network of providers within a maximum of 50 miles travel for all areas of their district.
3. Must designate a full time Director for the District(s) who has the authority to make day to day decisions, implement program policy, and oversee the provision of care to qualified recipients according to Federal and State regulations. This full time Director may simultaneously assume the directorship position of more than one district, and must participate in monthly status calls and all called meetings including, but not limited to, the annual face to face meeting.
4. Must establish business hours for the provision of Maternity services. The Director or an appropriately qualified designee must be available and accessible, during business hours for any administrative and/or medical problems which may arise.
5. Must have a system in place to direct after business hours calls for any administrative or any emergency medical problems which may arise. Require subcontractors providing direct medical care to be on call or make provisions for maternity call coverage 24-hours per day, seven days per week.
6. Require that all persons, including employees, agents, and subcontractors acting for or on behalf of the Primary Contractor, be properly licensed under applicable state laws and/or regulations. Any Delivering Healthcare Professional must have hospital privileges at a participating hospital within the Maternity Care program district. Some providers may elect to provide prenatal care only; another provider would provide delivery and postpartum care. In this case there would not be a requirement for the prenatal provider to have hospital privileges.

7. Comply with certification and licensing laws and regulations applicable to the Primary Contractor's practice, profession or business. The Primary Contractor agrees to perform services consistent with the customary standards of practice and ethics in the profession. The Primary Contractor agrees not to knowingly employ or subcontract with any health professional whose participation in the Medicaid or Medicare Program is currently suspended or has been terminated by Medicare or Medicaid.
8. Must require that network providers offer hours of operation that are not less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service.
9. Comply with all state and federal regulations regarding family planning services, including no restriction on utilization of services. The Plan First Program Manager can provide information on available contraception. The sterilization consent form is available on the Medicaid web site.
10. Require all subcontractors providing direct services to meet the requirements of and enroll as Medicaid providers as applicable. This will include any professionals that provide on-call coverage for the network provider.
11. Report suspected fraud and abuse to the Medicaid Agency. The Primary Contractor must have policies, procedures, a mandatory compliance plan, a compliance officer, compliance committee and training education for all of its employees. These policies and procedures must comply with all mandatory state guidelines and federal guidelines as specified in 42 CFR 438.608(b) (1).
12. Prohibit discrimination against recipients based on their health status or need for health services as specified at 42 CFR 438.6 (d) (3).
13. Ensure that medical records and any other health and enrollment information that identifies any individual enrollee must be handled in such a manner as to meet confidentiality requirements as specified in 42 CFR 438.224. Develop and implement procedures consistent with confidentiality requirements as specified in 42 CFR 438.224.
14. The Primary Contractor is not required to reimburse payment, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds in accordance with 42 CFR 438.102 (a)(2). If the Primary Contractor elects not to provide the service, then it must provide the related information to Medicaid so that it can be provided to the recipient.

15. Must comply with State and Federal laws regarding excluded Individuals and Entities. Excluded individuals and Entities are not allowed to receive reimbursement for providing Medicare and Medicaid services in any capacity, even if they are not on this listing by the Alabama Medicaid Agency.
16. Must comply with State and Federal laws regarding ensuring that contractors and subcontractors are not currently debarred from participation from Medicare/Medicaid programs by checking the System for Award Management, formerly Excluded Party List System (EPLS).
17. Must comply with State and Federal laws regarding checking Medicaid's Exclusion List and the List of Excluded Individuals and Entities (LEIE) on a monthly basis to determine if any existing employee or contractor has been excluded from participation in the Medicaid program.
18. Must ensure subcontractors are complying with State and Federal laws regarding checking Medicaid's Exclusion List and the List of Excluded Individuals and Entities (LEIE) on a monthly basis to determine if any existing employee or affiliated entities have not been excluded from participation in the Medicaid program.

B. Functions/Responsibilities

The Primary Contractor must comply with all the provisions of the executed contract, its amendments and referenced materials and must act in good faith in the performance of the provisions of said contract. The following is a listing of the functions and/or responsibilities of the Primary Contractor:

1. Provide the pregnant Medicaid eligible population obstetrical care through a comprehensive system of quality prenatal care, physician or midwife delivery care, and postpartum care. The care can be provided directly or through subcontracts. The successful bidder's delivery system will not include the hospital component.
2. Implement and maintain the Medicaid approved quality assurance system by which access, process and outcomes are measured.
3. Provide Application Assister services to Medicaid recipients. (Refer to the information in Attachment Six for details on Application Assisters.)
4. Utilize proper tools and service planning for women assessed to be at risk medically or psychosocially.

5. Provide recipient choice among Delivery Healthcare Professionals in its network.
6. Meet all requirements of the provider network including maintaining written subcontracts with providers to be used on a routine basis, including, but not limited to, obstetricians and general practitioners, nurse midwives, anesthesiologists, radiologists and Care Coordinators. The Primary Contractor must notify Medicaid, in writing, of changes in the subcontractor base including the subcontractor's name, specialty, address, telephone number, fax number and Medicaid provider number.
7. Maintain a toll-free line and adequate staff to enroll recipients and provide program information. If the Primary Contractor, subcontractors and recipients are within the local calling distance area a toll-free line is not necessary.
8. Develop, implement and maintain an extensive recipient education plan covering subjects such as appropriate use of the medical care system, purpose of care coordination, healthy lifestyles, planning for baby, self-care, etc. All materials shall be available in English and in the prevalent non-English language in the particular service area. The Primary Contractor is required to participate in Medicaid's efforts to promote the delivery of services in a culturally competent manner including those with limited English proficiency and with diverse cultural and ethnic backgrounds. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight or speech impairments. The Primary Contractor must make oral interpretation services available for all non-English languages free of charge to each enrollee and potential enrollee.
9. Develop, implement, and maintain a provider education plan, covering subjects such as minimum program guidelines, billing issues, updates from Medicaid, etc. Provide support and assistance to subcontractors to include, at minimum, program guidelines, billing issues, updates from Medicaid, etc. This education shall be provided semi-annually. Documentation of provider education including, but not limited to, records of educational programs, including providers' attendance, date, length of session, topics covered, and presenter(s). Information shall be maintained for Administrative Audits.
10. Develop, implement and maintain an effective outreach plan to make providers, recipients and the community aware of the purpose of Medicaid Maternity Care Program and the services it offers. The Primary Contractor is refrained from marketing activities as specified in Administrative Code 560-X-37-.01(17). At a minimum such education shall be provided semi-annually. Documentation of providers, recipients and the community

outreach, including, but not limited to, attendance, date, length of session, type of outreach and information presented shall be maintained for Administrative Audits.

11. Develop, implement and maintain a recipient educational program explaining how to access the Maternity Care Program including service locations. Materials shall provide information about recipient rights and duties, provisions for after-hours and emergency care, referral policies, notification of change of benefits, procedures for appealing adverse decisions, procedures for changing Delivering Healthcare Professionals, exemption procedures and grievance procedures. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight or speech impairments. The Primary Contractor must inform all enrollees and potential enrollees who have special needs that the information is available in alternative formats. All materials shall be available in English and in the prevalent non-English language in the particular service area. The Primary Contractor is required to participate in Medicaid's efforts to promote the delivery of services in a culturally competent manner including those with limited English proficiency and with diverse cultural and ethnic backgrounds. The Primary Contractor must make oral interpretation services available for all non-English languages free of charge to each enrollee and potential enrollee. This applies to all non-English languages not just those that the State identifies as prevalent. Each entity must notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services. Documentation must support that requirements are met and must be maintained for Administrative Audits.
12. Develop, implement and maintain a grievance procedure including an appeal process, that is easily accessible and that is explained to recipients upon entry into the system. Documentation must support that requirements are met and must be maintained for Administrative Audits.
13. Develop a system to ensure that all written materials are drafted in an easily understood language and format. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that the information is available in alternative formats and how to access those formats. Documentation must support that requirements are met and must be maintained for Administrative Audits.

14. Develop, implement and maintain a system for handling billing inquiries from recipients and subcontractors so that inquiries are handled in a timely manner.
15. Develop, implement and maintain a computer based data system that collects, integrates, analyzes and compiles reports of recipient information.
16. Give Medicaid immediate notification, by telephone and followed in writing, of any action or suit filed and prompt notice of any claim made against the Primary Contractor by any subcontractor which may result in litigation related in any way to the subject matter of this Contract. In the event of the filing of a petition of bankruptcy by or against any subcontractor or the insolvency of any subcontractor, the Primary Contractor must ensure that all tasks related to any subcontractor are performed in accordance with the terms of the contract.
17. Ensure the subcontractor maintain for each recipient a complete record, including care coordination notes, at one location of all services provided. Such information shall be accessible to the Primary Contractor and shall contain such information from all providers of services identified by recipient name, recipient number, date of service, and services provided prior to making payment to that provider of service. Any record requested by the Primary Contractor shall be provided free of charge.
18. Medicaid will request copies of all medical record documentation from the Primary Contractor for medical record reviews and other quality related activities as applicable.
19. Perform claims reviews prior to submission to Medicaid for administrative review.
20. Advise recipients of services that may be covered by Medicaid that are not covered through the Maternity Care Program.
21. Promptly provide to Medicaid all information necessary for the reimbursement of outstanding claims in the event of insolvency.
22. Coordinate care from out-of-network providers to ensure that there is no added cost to the enrollee.
23. Must designate a person to enter data and manage Medicaid's Service Database entries for each District. This designee is responsible for the transmission of valid, timely, complete and comprehensive data, along with auditing the database periodically. The designated person shall evaluate data for quantitative integrity, such as variances compared to the eligibility system and Service Report omissions. Other responsibilities

include, but are not limited to, ensuring that all recipients, excluding exemptions, are entered into the database with all required reporting elements, and correcting discrepancies to ensure an error rate of no greater than 5%. This designee must attend mandatory training as required by the Alabama Medicaid Agency.

24. Must coordinate Service Database data entries for recipients transferring from one district to another district to ensure transmission of valid, timely, complete and comprehensive data entries.

C. General

1. The Primary Contractor is responsible for the management of comprehensive obstetrical care. The success of the Maternity Care Program is contingent upon the Primary Contractors' provision of a network of quality caregivers, which considers the needs of the enrollees and enables each pregnant woman served to receive comprehensive obstetrical care.
2. The Primary Contractor must utilize resources such as American College of Obstetrics and Gynecologists Standards (ACOG), established community practice standards, etc. in the development of program guidelines, which are reviewed and updated periodically as appropriate. The Primary Contractor must disseminate the program guidelines to all affected providers and upon request to enrollees and potential enrollees.
3. Primary Contractor must ensure that decisions for utilization management, enrollee education, and coverage of services are consistent with the program guidelines.
4. It is unlikely that a Primary Contractor will be able to provide all of the necessary resources to participate in the program. Subcontracts must be developed with other providers capable of providing the requisite services. Primary Contractors must have sufficient resources and personnel with necessary education and experience or training to perform the requisite duties and responsibilities.
5. The Primary Contractor must use the Alabama Medicaid Agency's Web Service Database for reporting program demographics and other elements related to the pregnancy.

D. Program Director

Each Maternity Care Primary Contractor must have a full time Director. This person shall have the following minimum_ qualifications:

1. A BS or BA degree from an accredited college or, or a minimum of three years of management experience in a managed health care.
2. Experience in working with low-income populations.

The Program Director must have the authority to make day to day decisions, implement program policy, and oversee the provision of care to qualified recipients according to Federal and State regulations. Any changes in the Director's position must be approved by Medicaid. Medicaid must be notified in writing prior to the effective date of the change.

E. Computer System

Primary Contractors must maintain a HIPAA compliant computer system that collects, integrates, analyzes and reports. Minimum capabilities include:

1. Analysis of data and generation of reports including, but not limited to, utilization and financial services.
2. Database functionality that includes, but is not limited to, storage, analysis, and retrieval of information.
3. The ability to produce provider profiles including current overall recipient counts and the number of Medicaid recipients.
4. An automated tracking system that includes at a minimum the following information:
 - a. Recipient name
 - b. Medicaid number
 - c. Date of birth
 - d. Address
 - e. Estimated Date of Confinement
 - f. Telephone number
 - g. Delivering Healthcare Professional Chosen

- h. Care Coordinator Assigned
- i. Risk status, including medical and psychosocial.

F. Provider Network

Primary Contractors must have a delivery system that meets Medicaid standards. Primary Contractors shall ensure that this delivery system promotes continuity of care and quality care. Primary Contractors must provide all medically necessary services as covered services following Medicaid policies and procedures. The Primary Contractor must:

1. Offer participation opportunities for the first 30 days prior to the contract start date and for the first month of each succeeding contract year to all interested potential subcontractors within district boundaries. Thereafter, a yearly open enrollment period is required during the first month of each succeeding contract year. Subcontractors must be willing to adhere to program requirements and accept offered reimbursement for services provided.
2. Offer all willing subcontractors the opportunity to participate at a reimbursement level consistent with other like subcontractors.
3. Have written policies and procedures for the selection and retention, credentialing and re-credentialing requirements and non-discrimination of subcontractors as specified at 42 CFR 438.214.
4. Not offer participation to potential subcontractors who do not agree to adhere to program requirements nor to those who have been disqualified from participation in any federal program, nor any person convicted of an offense involving Medicaid or Medicare programs.
5. Give equal and fair participation opportunities to providers who are willing to adhere to program requirements and who otherwise qualify. Complaints of discrimination will be investigated by Medicaid.
6. Contract with subcontractors who are geographically appropriate (50 miles) to recipients within the district. If there are no in-district providers that would ensure that every recipient meets the 50 miles requirement, the Primary Contractor is responsible for establishing a network of providers and may have to pursue contracts with out of district providers.
7. Continually monitor the provider network to ensure that the capacity is sufficient to meet the needs of all Medicaid recipients in the district and that availability and accessibility are not hindered.

8. Monitor and evaluate provider performance of all subcontractors to ensure that Medicaid and Primary Contractor standards are met. Such monitoring and evaluation system must include a corrective action system.
9. Notify Medicaid within one business day of any unexpected changes that would impair its provider network. This notification shall include:
 - a. Information as to how the change shall affect the delivery of covered services, and
 - b. Primary Contractor's plans for maintaining the quality of member care if the provider network change is likely to result in deficient delivery of covered services.
10. Not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. This includes providers that serve high-risk populations or specialize in conditions that require costly treatment. If a Primary Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This should not be construed to require the Primary Contractor to contract with providers beyond the number necessary to meet the needs of its enrollees, preclude the Primary Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or preclude the Primary Contractor from establishing measures that are designed to maintain quality of services, control costs and be consistent with its responsibilities to the enrollee.
11. Make a good faith effort to give a written notification of the termination of a contracted provider within fifteen days of the receipt or issuance of the termination notice to each recipient who was being seen on a regular basis by that subcontractor.
12. Give the Delivering Healthcare Professionals the option of establishing a limited number of Medicaid recipients that he/she shall accept.

G. Subcontractor Requirements

Subcontracts executed for the purposes of meeting program requirements must meet the following requirements:

1. Be in writing;

2. Require provider to comply with accepted medical Standards of Care;
3. Require provider to comply with other terms and conditions contained in this bid;
4. Contain provider reimbursement provisions;
5. Contain a provision specifying that provider must agree that under no circumstances (including, but not limited to, situations involving non-payment by the Primary Contractor, insolvency of the Primary Contractor, or breach of agreement) shall the provider bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against Medicaid recipients, or persons acting on their behalf, for **covered** services, rendered during the term of provider's agreement or subcontract with the Primary Contractor. A provider may charge for non-covered services delivered on a fee-for-service basis to Medicaid recipients;
6. Contain a provision that states "payment for maternity-related services, not covered by the Maternity Care Program, does not make the recipient responsible for all of her maternity care";
7. Cover the same time period as the Primary Contractors' contract with Medicaid;
8. Contain a provision indicating that subcontracts may only be terminated for cause.

H. Annual Verification Requirements

The Primary Contractor must annually verify the following:

1. That the subcontractor possesses a current Alabama Medical License or certification and licensure as a Certified Nurse Midwife or other appropriate licensure requirements.
2. That the subcontractor is enrolled as a Medicaid provider.
3. That the subcontractor has current hospital privileges (as applicable), in good standing, at a Medicaid participating hospital within the Maternity Care Program district.

I. Monthly Verification Requirements

The Primary Contractor must monthly verify the following:

1. That the subcontractor or contractor is not currently debarred from participation from Medicare/Medicaid programs by checking the System for Award Management, formerly Excluded Party List System (EPLS).
2. That the subcontractor or contractor has not been excluded from participating in the Medicaid program by checking Medicaid's Exclusion List and documenting checks on Attachment Twenty-one, Exclusion List Check Form.
3. That the subcontractor or contractor has not been excluded from participating in the Medicaid program by checking the List of Excluded Individuals and Entities (LEIE) and documenting checks on Attachment Twenty-one, Exclusion List Check Form).

J. Outreach

The Primary Contractor is responsible for implementing and maintaining a Medicaid approved outreach program to inform and educate Medicaid recipients and the community on the Maternity Care Program's availability and services. The goal is to have all Medicaid eligible women enter care in their first trimester. The program components include, but are not limited to:

1. Medicaid approved printed material available at a sixth grade literacy level explaining program specifics. Outreach materials must include at a minimum explanations of how to access the Maternity Care Program. Medicaid must approve all outreach and educational material prior to actual usage. Review of the Primary Contractors' outreach materials will be done during the Administrative Audit.
2. Easily accessible program information available at sites such as hospitals, physician offices, Social Security offices, Department of Human Resources (DHR) offices, health departments, community resource centers, tax refund offices, family planning centers, or other community areas.
3. Coordination with local communities, other agencies, and service providers to ensure awareness of the program and to identify other services available to meet the needs of the Medicaid recipient.
4. A system for recipients to receive information and ask questions regarding the Maternity Care Program.

K. Recipient Education

The Primary Contractor is responsible for implementing and maintaining a

Medicaid approved education program to inform and educate Medicaid recipients on the Maternity Care Program. The program components include, but are not limited to:

1. Basic education, such as importance of early and continuous pregnancy care and the importance of following physician's instructions, and expectations of pregnancy and delivery.
2. Education regarding danger signs (e.g., spotting or bleeding, gush of fluid from vagina, etc.) during the pre and post natal period which includes information on when to seek medical care in an emergency situation.
3. Education on where and how to seek emergency care.
4. Education regarding nutrition and other components of a healthy lifestyle that are necessary for a good pregnancy outcome. Education regarding availability of newborn care classes, information about the Patient 1st Program and immunization schedules.
5. Education regarding importance of family planning along with written and oral instructions regarding all forms of birth control. The Plan First PT+3 materials are provided by Medicaid free of charge. The patient must also be made aware of and referred to the Plan First Program.
6. Discuss that over the counter and any other medicines must be approved by the Delivering Healthcare Professional, avoidance of smoking cigarettes, the availability of face-to-face Tobacco Cessation Counseling, products to assist with smoking cessation covered by Medicaid and the importance of avoiding use of drugs and alcohol.

L. Subcontractor Education

The Primary Contractor must provide a structured educational component for **each** subcontractor that participates in the program which includes, but is not limited to:

1. Program requirements
2. Billing procedures/claims resolution
3. Quality management protocols
4. Training sessions or provider meetings at least bi-annually or more often as needed to address problems and/or provide updated information

M. Billing Inquires/Claims Resolution

The Primary Contractor is responsible for implementing a system for responding to billing inquiries from recipients and subcontractors, and shall only refer claim inquiries to Medicaid that require an administrative review.

IV. ENROLLMENT REQUIREMENTS

A. Recipient Choice

Recipients must be allowed to select the Delivering Healthcare Professional of their choice at the time of entry (enrollment) into the care system. Primary Contractors must accept all women covered by the program and must not disenroll women from the program except through the exemption process (refer to Section V.E.). The Primary Contractor must comply with the requirements set forth at 42 CFR 438.56 regarding recipient disenrollment. If disenrollment is approved pursuant to Section V.E., the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee files the request. If the Primary Contractor fails to make a disenrollment determination within this timeframe, the disenrollment will not be approved.

Primary Contractor must have written policies and procedures governing recipient enrollment. The following guidelines apply:

B. List Requirements

1. A Delivering Healthcare Professional List must be available for use in the selection process.
2. Current Delivering Healthcare Professionals provider listings must be maintained. (NOTE: All listings, forms, etc. must be approved by the Agency prior to use).
 - a. The list must include Delivering Healthcare Professional choices available through the provider network listed alphabetically and must be provided to the enrollees. The list shall include: address and telephone number, any physician extenders such as nurse midwives, nurse practitioners, residents in training, or physician assistants.
 - b. Hospital where the Delivering Healthcare Professionals deliver, all sites where the Delivering Healthcare Professionals see recipients i.e., office, Health Department, satellite clinic, and all sites where prenatal care is provided.

- c. Any limitations on services. For example, some Delivering Healthcare Professionals do not perform sterilizations. This would be significant if the recipient states that she wants sterilization prior to discharge from the hospital when the delivery occurs.
3. A weekly updated Delivering Healthcare Professional List is required during the initial award period and up to 30 days after implementation date and during the yearly open enrollment. Otherwise, the list shall be submitted as outlined in Section X.B., Records and Reports, Reporting Requirements.

C. Recipient Choice Requirements

1. The recipient is required to indicate on the 'Agreement to Receive Care/Release of Information Form' (Attachment Two) her choice of Delivering Healthcare Professionals and a copy of the form must be provided to her.
2. A recipient enrolled in the Patient 1st Program may select the same Primary Medical Provider (PMP) if he/she is a subcontractor for the Maternity Care Program.
3. A staffed toll-free line is required to enroll recipients into the Maternity Care Program and to provide requested information. The toll-free line must be staffed, at minimum, during the hours of 8 a.m.-5 p.m. weekdays with an answering machine for after hours.
4. All enrollment material must be provided in a manner and format that may be easily understood in compliance with 42 CFR 438.10(b) (1).
5. The recipient should be asked whether she is a Medicaid recipient. If not, ask if she submitted an eligibility application and whether she needs assistance to apply. If assistance is needed, an immediate referral to the Care Coordinator should be arranged to get the application process started.

D. Delivering Healthcare Professional Selection Process

Recipients must be advised of the process that is to be used in selecting a Delivering Healthcare Professional. This process shall include:

1. Recipient selects the Delivering Healthcare Professional of her choice for Maternity Care services from a list of network providers.
2. Inform, in writing, the medical professionals who shall be involved in her care, e.g. nurse midwives, nurse practitioners, on-call physicians, etc.

Patients may not in any way be influenced when selecting a Delivering Healthcare Professional.

3. If the Delivering Healthcare Professional has no slots available, staff must work with recipients to have a Delivering Healthcare Professional selected within two working days.
4. If the recipient does not want to choose a Delivering Healthcare Professional on the day of enrollment, then she shall be informed that she must call back within five working days to choose a Delivering Healthcare Professional, or the Primary Contractor shall assign a Delivering Healthcare Professional to her on a rotation basis between other Delivering Healthcare Professionals listed on the panel. Recipients shall also be notified of the Delivering Healthcare Professional with whom they have been assigned.
5. In the event the recipient refuses to choose a Delivering Healthcare Professional or fails to choose a Delivering Healthcare Professional within the designated time frame, the Primary Contractor must assign her to a Delivering Healthcare Professional based on equivalent distribution among the Delivering Healthcare Professionals, with available openings to serve additional recipients. This process must include consideration of the distance the recipient lives from the provider and prior relationships, if the Primary Contractor has access to this information.

E. Delivering Healthcare Professional Notification

1. Each recipient's selected Delivering Healthcare Professional must be notified within five working days of the recipient's enrollment.
2. A monthly listing of Medicaid recipients electing to enroll with each Delivering Healthcare Professional shall be provided to the Delivering Healthcare Professional. This list must be provided prior to the first day of each month.

F. Changes in Selection of Delivering Healthcare Professionals

Guidelines for change of Delivering Healthcare Professional must include:

1. Allowing recipient to change Delivering Healthcare Professionals, without cause, once within the first 90 days of enrolling.
2. Establishing internal policies and procedures for changing Delivering Healthcare Professionals.

3. Allowing recipient to change Delivering Healthcare Professionals after the first 90 days with cause, which is defined as a valid complaint submitted to the Primary Contractor in writing explaining the reason the recipient wishes to change her Delivering Healthcare Professional.
4. Tracking of changes in Delivering Healthcare Professionals with grievance procedure time frames being met.

G. Program Enrollment

Enrollment is defined as the date that the Agreement to Receive Prenatal Care form is signed by the recipient. If the delivery has already occurred there is no reason to enroll the recipient. The following guidelines apply when processing a woman's enrollment into the program:

1. Recipients must be provided with all required information regarding rights and responsibilities, grievance process and fair hearing process, and appropriate telephone numbers, at the time of enrollment.
2. The person enrolling the recipient into the program must ascertain if the woman has third party liability. If TPL is available, obtain the name of the insurance company, the name on the policy (name of insured), recipient relationship to the insured, address, phone number and policy number. If possible, ascertain from the recipient what type of coverage the policy provides. Verify the information with the insurance company or Medicaid and record all information in the file. Some of this information may be available through the online eligibility systems maintained by Medicaid's Fiscal Agent. The recipient should be informed of coverage limits of pregnancy related illness through MAGI and allowed to make an informed choice regarding continued coverage of any previous insurance coverage. **It is vital that this type of information be collected at the beginning of prenatal care.**
3. Advise the recipient of her ability to change Delivering Healthcare Professional, without cause, within 90 days of enrollment, or at any time with cause. Continuity of care shall be stressed at the time of enrollment to encourage the recipient to select a Delivering Healthcare Professional with whom she is comfortable.

V. SERVICES

A. General

1. All maternity care services offered under the contract must be in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under fee-for-service

Medicaid. The Primary Contractor may not arbitrarily deny or reduce these services for any reason including the diagnosis, health status, type of illness, or condition. The Primary Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity, or for utilization control, provided the services furnished can be expected to achieve their purpose as defined in 42 CFR 438.210(a).

2. The Alabama Medicaid Administrative Code Rule 560-X-1-.07 states: “Providers who agree to accept Medicaid payment shall agree to do so for all medically necessary services rendered during a particular visit. For example, if pain management services are provided to Medicaid recipients during labor and delivery, these services are considered by Medicaid to be medically necessary when provided in accordance with accepted standards of medical care in the community. These services are covered by, and billable to Medicaid. Providers may not bill Medicaid recipients they have accepted as recipients for covered labor and delivery related pain management services.”
3. The Primary Contractor shall require that provisions be made available for a second opinion (if either the recipient or health care professional deems it necessary) from a qualified health care professional within the network, or arrange for a second opinion outside the network at no cost to the recipient as specified in 42 CFR 438.206(b)(3) and (4).
4. Out of network providers must coordinate with the Primary Contractor with respect to payment as specified in 42 CFR 438.206(b)(5).
5. Enrollees with special needs shall be allowed direct access to specialists as specified in 42 CFR 438.208(c) (4).
6. The Primary Contractor must have a mechanism in place to assess each Medicaid enrollee identified for special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular monitoring. The assessment must use appropriate health care professionals. The Primary Contractor must maintain a treatment plan for enrollees determined as having special care needs. The treatment plan must be developed by the enrollee’s primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee and must be reviewed and approved by the Primary Contractor within a timely manner. The treatment plan must be developed in accordance with applicable quality assurance and utilization review standards.
7. Recipients must use in-network providers.

B. Services Included in the Global Fee

1. The Primary Contractor will be responsible for implementation and coordination of a comprehensive maternity care delivery system with the exception of the inpatient hospital component that meets the needs of the Medicaid recipients. The time span of responsibility begins the date that pregnancy is determined and ends the last day of the month in which the 60th postpartum day falls.
2. Primary Contractors and their Delivering Healthcare Professionals are responsible for identification and referral of high risk recipients to the appropriate high risk referral site or appropriate high risk physician.
3. The fee shall include all usual prenatal services appropriate to the risk level of the woman including the initial visit at the time pregnancy is diagnosed.
4. Covered services must be medically necessary and encompass maternity related services as well as those that might otherwise complicate or exacerbate the pregnancy.
5. The Primary Contractor shall receive a fee upon pregnancy outcome (delivery or termination by miscarriage or stillbirth at 21 weeks or later).
6. Fees paid by Medicaid to the Primary Contractor represent payment in full.
7. Recipients cannot be billed for any service that is included in the Maternity Care Program.
8. Chapter 28 of the Alabama Medicaid Provider Manual provides additional details on the billing of services.
9. Services to be provided through the Primary Contractor network and which are reimbursed as part of the global are listed in Attachment Three and described below. If there is a question as to whether a service is covered, please contact the Alabama Medicaid Agency for verification and clarification.
 - a. Prenatal Visits
Visits to the Delivering Healthcare Professional include the initial prenatal visit as well as any subsequent visits. The components of the initial prenatal visit and any subsequent visits are defined by ACOG.
 - b. Ultrasounds
Maternity ultrasounds are unlimited in number and are a component

of the global fee. The global fee includes both the professional and technical components of **all** medically necessary ultrasounds. A Primary Contractor may develop an evidence-based prior authorization process to manage the number of ultrasounds performed. **Note: The professional component of ultrasounds performed in an outpatient setting is included in the global fee.**

- c. Delivery
The global fee includes vaginal delivery or cesarean section delivery. No more than one fee may be billed for a multiple birth delivery.
- d. Postpartum
Postpartum care includes inpatient hospital visits, office visits and home visits following delivery for postpartum care through the end of the month of the 60-day postpartum period. The postpartum Delivering Healthcare Professional exam shall be accomplished by the 60th day after delivery.
- e. Assistant Surgeon Fees
The global fee includes assistant surgeon fees for cesarean-section deliveries.
- f. Associated Services
The global fee includes identified services associated with treatment of the pregnancy during the antenatal delivery and postpartum period listed in Attachment Three.
- g. Laboratory Fees
The global fee includes routine chemical urinalysis, hemoglobin and hematocrit tests as listed in Attachment Three. Other laboratory tests may be billed to Medicaid's fiscal agent fee-for-service.
EXCEPTION: urinalysis, hemoglobin and hematocrit provided in conjunction with an emergency room visit are billable fee-for-service.
- h. Anesthesia Services
The global fee includes anesthesia services, performed by either an anesthesiologist, nurse anesthetist, or the Delivering Healthcare Professional, which are not medically contraindicated. The Primary Contractor shall provide for payment of anesthesia for Medicaid recipients to the same extent and under the same conditions as available to the general public. Attachment Three lists the anesthesia codes which are included in the global fee.
- i. Care Coordination Services
The global fee includes Care Coordination which is detailed in

Section VI.

j. Postpartum Home Visit

Home visits are optional. It is the opinion of the Alabama Medicaid Agency that home visits improve outcomes. Refer to Section VII for specific details related to home visits.

C. Excluded Services—Covered Fee-For-Service

A general description of those services outside the scope of the global fee is listed below. For these services, the provider of service shall bill using the appropriate CPT code and their regular provider Medicaid number. All claims for these services shall be sent directly to Medicaid’s Fiscal Agent and include, but are not limited to:

1. Inpatient Hospital Care

All hospital care will be billed fee for service and will include applicable limitations of 16 inpatient days per calendar year.

2. Drugs

Medications prescribed for a pregnant woman are covered if the drug is covered through the Medicaid Pharmacy Program. The medication must be prescribed by the Delivering Healthcare Professional or specialty physician and presented to an active Medicaid pharmacy provider. The prescribed drug will be subject to all applicable Medicaid policies. Pharmacy providers should dispense the drug at no cost to the recipient.

3. Durable Medical Equipment/Supplies

Pregnant women with Type I, Type II or gestational diabetes are eligible to receive diabetic equipment/supplies from an active Medicaid Equipment (DME) Supplier. Not all pharmacies are DME suppliers. In order to locate a DME supplier, you may contact the Clinical Services and Support Division at 334-242-5050 or by accessing the following link:

http://www.medicaid.alabama.gov/documents/4.0_Programs/4.3_LTC_Services/4.3.3_Other_LTC_Programs/4.3.3.1_DME/4.3.3.1_DME_Providers_Revised_5-1-14.pdf .

4. Lab Services

All lab services except hemoglobin, hematocrit, and chemical urinalysis may be billed fee-for-service. Pregnancy tests can be billed fee-for-service.

5. Radiology

Refer to the Global Associated Codes for radiology services which are covered in the global fee.

6. Dental

Dental services are covered for eligible recipients certified as children under age 21.

7. Physician

Physician fees for family planning procedures, circumcision code, routine newborn care code, standby and infant resuscitation code may be billed fee for service. Claims for circumcision, routine newborn care, standby and infant resuscitation may be billed under the mother's name and number.

8. Family Planning Services

Claims for physician services with a family planning procedure code or indicator may be billed fee-for- service.

9. Face-to-Face Tobacco Cessation Counseling, including referrals to the Quitline and medications to assist applicable recipients with smoking cessation efforts.

10. Outpatient Emergency Room Services

Outpatient emergency room service claims containing a facility fee charge of 99281-99285 and associated physician charges 99281-99288, may be billed fee-for-service. This includes outpatient observation. The Maternity Care Program does not restrict access to emergency services.

11. Transportation

Transportation as allowed by Medicaid's State Plan may be billed fee for service. The Medicaid Non Emergency Transportation (NET) Program covers non-emergency transportation.

12. Fees for Dropout/Miscarriages

- a. Claims for miscarriages must include the appropriate diagnosis code from the following range, 630-635, 637-639. Claims using these diagnosis codes may be billed directly to Hewlett Packard.
- b. If a woman begins care with any district's program, and subsequently moves out of district or miscarries (prior to 21 weeks), she is considered a dropout.
- c. The Primary Contractor shall be paid a dropout fee for recipients that have a miscarriage prior to 21 weeks gestation.
- d. Services for drop-outs may be billed fee-for-service.
- e. In order for the claims to process for a dropout, subcontractors must send all claims to the Primary Contractor. The Primary Contractor

must complete the Administrative Review Form and forward the claims to Medicaid for action.

- f. The Primary Contractor can bill the dropout fee directly to Hewlett-Packard (Medicaid's fiscal agent liaison).

13. Mental Health

Visits for the purpose of **outpatient** mental health services may be billed fee for service. Screening, Brief Intervention and Referral to Treatment (SBIRT) codes for pregnant women may be billed by Delivering Healthcare Professionals who have completed a training program and have had a specialty provider indicator added to the provider file. These services include alcohol and/or drug screening and/or brief intervention.

14. Referral to Specialists

Office or in-hospital visits provided by non-OB specialty physicians for problems complicated or exacerbated by pregnancy may be billed fee-for-service.

15. Program Exemptions

Claims for women who are granted a program exemption may be billed fee-for-service. Refer to Section E for details on the exemption process.

16. Non-Pregnancy Related Care

Services provided that are not pregnancy-related are the responsibility of the recipient unless she is eligible for regular Medicaid benefits.

17. High Risk Maternity Care Services Provided by a Teaching Physician As

defined in State Plan AL-11-022, 4.19-B, Attachment Thirty, the reimbursement for provision of high risk maternity care services provided by a teaching physician as defined in State Plan AL-11-022, 4.19-B, which states in whole or in part " Teaching physicians are defined as doctors of medicine or osteopathy employed by or under contract with (a) a medical school that is part of the public university system (The University of Alabama at Birmingham and The University of South Alabama) or (b) a children's hospital healthcare system which meets the criteria and receives funding under Section 340E (a) of the U.S. Public Health Service Act (42 USC 256e), and which operates and maintains a state license for specialty pediatric beds" is excluded from the global and may be billed fee-for-service.

- 18. High Risk Maternity Care Services Provided by a Medicaid Enrolled Board Certified Perinatologist-the reimbursement for provision of high risk maternity care services provided by a Medicaid enrolled Board Certified Perinatologist is excluded from the global and may be billed fee-for-service.

All routine maternity care services are subject to the Maternity

District's Plan. The Perinatologist must subcontract with a Primary Contractor for routine maternity care services. Reimbursement for provision of routine maternity care services will be through the global payment methodology according to contractor-subcontractor agreement.

19. Routine Maternity Care Services Provided by a Primary Contractor and/or Delivering Healthcare Professional to an Enrolled Recipient Before and After Transferring to a Medicaid Enrolled Teaching Physician or Medicaid Enrolled Board Certified Perinatologist -the reimbursement for provision of routine maternity care services provided by a Primary Contractor and/or Delivering Healthcare Professional to an enrolled recipient before and after transferring to a Medicaid enrolled teaching physician as defined in Section 4.19-B of the State Plan which states in whole or in part “ Teaching physicians are defined as doctors of medicine or osteopathy employed by or under contract with (a) a medical school that is part of the public university system (The University of Alabama at Birmingham and The University of South Alabama) or (b) a children’s hospital healthcare system which meets the criteria and receives funding under Section 340E (a) of the U.S. Public Health Service Act (42 USC 256e), and which operates and maintains a state license for specialty pediatric beds” or a Medicaid Enrolled Board Certified Perinatologist for high risk care will be reimbursed fee-for-service and will not be reimbursed through the global payment methodology. Reference Section VIII Payment for Service for additional information.

D. Referrals for High-Risk Care

1. Referrals for high-risk care are the responsibility of the Maternity Care Primary Contractor. Each recipient entering the care system must be assessed for high-risk pregnancy status and referred to a Delivering Healthcare Professional qualified to provide high-risk care if the assessment reflects a condition that cannot be appropriately handled in routine prenatal care sites.
2. Primary Contractor must clearly describe the way the program will manage high-risk pregnancies, including a process for identifying high-risk cases, a method to denote high-risk status and the reason for high risk-status, a network for care, policy and procedures for monitoring referrals and services to be provided to high-risk women.
3. High risk maternity services by a Board Certified Perinatologist must be coordinated with the Primary Contractor.

E. Program Exemptions

1. Purpose

The purpose of the program exemption is to allow recipients to receive care outside of their established Maternity Care districts. There must be policies and procedures developed by the Primary Contractor describing how the exemption will be handled including application of criteria. The Primary Contractor cannot request disenrollment because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees). A Maternity Care Program Exemption Request Form (Attachment Thirteen) must be completed and submitted to the Alabama Medicaid Agency for approval. Medical exemptions will not be granted under the Maternity Care Program.

a. Medicaid Eligibility Granted Late in Pregnancy

When the recipient applies for and receives Medicaid eligibility late in her pregnancy (third trimester which begins at 27 weeks gestation through delivery) or after delivery and has been receiving continuous care through a non-subcontracted provider, she may be eligible for a program exemption. The Primary Contractor must maintain documentation demonstrating a significant and unexpected financial change occurring after 27 weeks (e.g. loss of insurance or loss of job). The Primary Contractor must confirm the date of application.

b. Private Managed Care/HMO

If a recipient has insurance or a managed care plan, the Primary Contractor must maintain a copy of the policy or a letter from the insurer indicating the scope of coverage or that the recipient must use a prescribed provider network.

F. Services for Non-citizens

Services provided to Non-citizens are not part of the Maternity Care Program. The following is provided for information only: "Certification is done through the Medicaid out-stationed eligibility worker. Only the actual provider of service is reimbursed in these cases. For a pregnant woman, only the delivery is covered. If you are contacted by a Non-citizen, or someone who is helping a Non-citizen, refer them to the out-stationed eligibility worker. All payments for this eligibility category are processed outside the Maternity Care Program

through emergency services.”

VI. CARE COORDINATION

A. Overview

An integral part of the medical care delivered through the Maternity Care Program is Care Coordination. Care Coordination is the mechanism for linking and coordinating segments of a service delivery system to ensure the most comprehensive program meeting the clients’ needs for care. It may involve one person or a team that has responsibility for managing, assessing, planning, procuring or delivering, monitoring and evaluating services to meet the identified needs of the client. The approach to Care Coordination shall vary from case to case. The needs of the patient should dictate when services are provided and the number of visits that are needed.

1. Care Coordination can be generally defined in one of three ways:
 - a. A system of activities to link the service system to a recipient;
 - b. A balanced system of services; or
 - c. A process of ensuring that the recipient moves sequentially through a continuum of services.
2. Stratification of Case Management
 - a. Visit flexibility to meet the needs of the recipient is allowed. Minimums are established, but, beyond the minimum, the total number of visits should be dictated by the needs of the patient. The Care Coordinator will be required to assess the patient face to face at a minimum of two visits. The Care Coordinator will have flexibility to determine how to best improve outcomes.
 - b. If the medical or psychosocial status of the recipient changes, the Care Coordinator is responsible for adjusting the service plan and proceeding accordingly.
 - c. It is up to the Delivering Healthcare Professional and Care Coordinator to decide and develop a service plan that meets the patient’s needs.

B. Requirements for Maternity Care Coordinators

1. Social workers licensed and/or license-eligible for Alabama practice with a BSW or an MSW from a school accredited by the Council on Social Work Education. License-eligible social worker(s) must obtain license within 12 months of date of employment to function as a Care Coordinator.
2. Registered Nurses, licensed by the Alabama Board of Nursing, with a minimum of one year experience in care coordination, accessing resources, and coordinating care with low-income populations; or, if no care coordination experience, completion of a Care Coordinator training course provided by the Primary Contractor and supervision by an experienced Care Coordinator for at least six months. Documentation must support the Care Coordinator's training has been completed and supervision for the specified period was provided. Compliance with this requirement will be reviewed during the Administrative Audit.
3. Licensed Practical Nurse(s), licensed by the Alabama Board of Nurses, with at least two years of clinical experience and one year experience in care coordination, accessing resources and coordinating care with low-income populations.
4. The Primary Contractor has flexibility in determining how to perform the Application Assister function. Care coordinators are not required to be Application Assisters; however, the Application Assister function is required to be performed by the Primary Contractor. The Primary Contractor may choose to use a Care Coordinator for this function, while others may choose to have other staff provide this function. Application Assister training is provided free of charge by the Alabama Medicaid Agency staff (Attachment Six). The Contractor shall have an individual (s) designated as a trainer for the Train-the Trainer program. The designee must attend the Train-the-Trainer class and provide certification training to Application Assisters as deemed necessary in order to maintain compliance with certification and re-certification requirements. The certification period for Application Assisters and Train-the-Trainer designee is every two years.
5. Care Coordination is a professional skill and must be supported from within the Primary Contractor system. Skills and functions employed by the Care Coordinator include, but are not limited to:
 - a. Performing the initial encounter requirements, performing the psychosocial risk assessment, assessing the medical and social needs, developing service plans, providing information and education, making all appropriate referrals (including Plan First and CoIIN referrals), and tracking recipients throughout their pregnancy and postpartum period.
 - b. Community orientations, including the ability to locate, augment, and develop resources including information on services offered by other agencies.

- c. The Primary Contractor must advise all subcontractors of Care Coordinators services and must require that the subcontractors refer all Medicaid recipients to enroll in the program with the Primary Contractor within ten days of the first visit.
- d. The Care Coordinator shall provide the recipient with a business card that provides location and telephone number of the Care Coordinator should any questions arise.
- e. Care Coordinators must be located in an area which provides adequate recipient access and maintains recipient confidentiality. Private offices are preferred.
- f. Telephones must be available for use in recipient contacts.
- g. Primary Contractor must have a training plan for initial and on-going care coordination. These plans must at a minimum support the requirements of this document and include training specific to the maternity program and/or related topics on an on-going basis. Educational materials must include obtaining TPL information, the importance of keeping appointments with both the Care Coordinator and the DHCP, exemption candidates, current proper sleeping positions for the infant, domestic abuse, breast feeding, smoking & alcohol or other substance cessation, nutrition, and bonding for mother and infant. The effectiveness of the training plans will be monitored per quality outcome measures.
- h. Care Coordinators or other Primary Contractor staff will enroll the recipient in the Maternity Care Program and start the Medicaid application process.
- i. Primary Contractor must have a system for verification of current license for each Care Coordinator. Verification of current licensure will be checked during the Administrative Audit.

C. Initial Encounter

Time frame: entry into care

- ✓ Enrolled 0-6 weeks gestation - this encounter should be no later than 21 days after enrollment date
 - ✓ Enrolled 7-14 weeks gestation - this encounter should be no later than 14 days after enrollment date.
 - ✓ Enrolled 15 weeks gestation or more - this encounter should be no later than 7 days after enrollment date.
1. Intake form- The Care Coordinator will prepare the intake form for enrollment into the Maternity Care Program. Minimum elements to be included on the intake form of your choice are: Recipient Name; Date of Birth; Address; County of Residence; Social Security Number; Medicaid Number if they have

one; if the recipient has no Medicaid number make a note to assist with application as appropriate; Delivering Healthcare Professional choice; Date Delivering Healthcare Professional notified; and psychosocial risk status. A sample form is included as Attachment Twenty-six. This form will be faxed to the office of the Delivering Healthcare Professional of choice within five calendar days of the recipient's first Delivering Healthcare Professional's health visit. If the recipient does not have Medicaid financial eligibility, the Primary Contractor is responsible for immediately providing Application Assister services to aid the patient in completing the application process.

2. The following forms must be completed at the initial encounter:
 - a. Psychosocial/medical risk assessment
 - b. Agreement to Receive Care/Release of Information (Attachment Two)
 - c. Recipient Rights and Duties as described in Attachment Eight and required by 42 CFR 438.100
 - d. Maternity Care Program Fact Sheet (Attachment Five)
 - e. Maternity Care Program Smoking Cessation Form (Attachment Fourteen)
3. Information about facility location, hours of operation, services available, etc. should be shared. Explain your role as Care Coordinator and how you will be assisting the recipient during her pregnancy and postpartum period. Encourage the recipient to contact you as needed for assistance.
4. Explain the benefits and services provided through the Maternity Care Program. Explain that all pregnancy related care including prenatal, delivery and postpartum is available through the Primary Contractor network. Stress the importance of pre-natal and postpartum visits. Stress that birth control is frequently arranged at the postpartum visit. Explain that Medicaid also offers assistance with transportation to medical appointments, emergency ambulance coverage, family planning and pediatric services.
5. Provide written and oral education about the grievance process and explain how it is designed for her. Ensure that the recipient understands the process and the procedures for filing a grievance, an appeal and/or fair hearing.
6. Explain the importance of early and continuous prenatal care. Help her understand that she can play a key role in shaping the birth outcome.

Explain that if she encounters barriers such as transportation, medication, childcare, etc., she should contact the Care Coordinator for assistance.

7. Develop and document a service plan for coordinating total obstetrical care based on medical and psychosocial risk status that will best suit the needs of the recipient.
8. Screen the patient for partner abuse utilizing the screening tool in Attachment Nine. Be cognizant of verbal and non-verbal clues when assessing the patient.
9. Encourage breast feeding. Explain the benefits such as better infant tolerance, better immunity from childhood viruses and illnesses. Explain that pumping can be done and the milk stored for times when the mother will be away, and that nursing the infant, avoiding any artificial nipples, will produce more mother's milk. The Care Coordinator should utilize the most effective teaching methods for increasing the rate of breast feeding.
10. Explain that the recipient may be receiving a home visit. Inform her of the positive aspects of the visit and what can be accomplished.
11. Ask if the recipient is a smoker. Encourage smoking cessation. Discuss the effects of smoking on the infant to include: increased risk of prematurity, low birth weight, infant mortality, and a sicker infant. Use the most effective evidence-based method suitable to your area to assist moms to stop smoking. Encourage the use of the Alabama Department of Public Health Quitline for counseling and assist with the referral process, educate the recipient of available face to face counseling sessions, and ask her to discuss with her doctor the possibility of obtaining a prescription to help her stop smoking.

D. Subsequent Encounters

Care Coordinators will be required to assess the recipient face to face at a minimum of two encounters. One of the required encounters is the Initial Encounter defined above. The other encounter must occur while the mother is still in the hospital after delivery. Other encounters will be at the discretion of the Care Coordinator based on the level of complexity of the recipient needs, either medical or psychosocial. The encounters should be scheduled in order to help obtain the best outcomes.

1. Update the psychosocial assessment and service plan based on client interview and any other available information.

2. Encourage continuous compliance with prenatal care, reviewing the recipient's medical high-risk factors and explaining the importance of continued prenatal care.
3. Assess for understanding of medical conditions as well as the plan for managing them as outlined by medical staff. Assist in arranging further counseling by medical staff as needed.
4. Provide the recipient with the information about the various family planning services available. Counsel on the effects of each method and assist the recipient with consent forms as appropriate.
5. Ask about status of Medicaid eligibility. Assist with resolving the delay of approval, if possible.
6. Screen the patient for partner abuse utilizing the screening tool in Attachment Nine. Be cognizant of verbal and non-verbal clues when assessing the patient.
7. Determine the need for any third party exemptions.
8. Ensure that the recipient knows which hospital will be used for delivery. If Medicaid coverage is established, complete hospital preadmission for the hospital of choice.
9. Discuss the labor and delivery process. Begin talking with the recipient about what to expect and what to do at the onset of labor, etc.
10. Re-emphasize and encourage breast feeding.
11. Explain that the patient may meet the criteria for a home visit. Re-emphasize the purpose and the positive aspects.
12. Review smoking cessation with women who smoke. Utilize the most appropriate evidence based methods. Encourage to cut down and quit. Explain harmful effects to the fetus. If she states that she has quit or cut down on the number of cigarettes that she smokes, praise her efforts. Reference the Definition Section for the meaning of "Smoker".
13. Ask the recipient if she has considered who will provide pediatric care. If needed provide a list of Medicaid pediatric care providers. If she has not thought about a pediatric care provider, encourage her to do so. Provide information and services available for the newborn through the first year of life including Medicaid Patient 1st and EPSDT (Early Periodic Screening and Developmental Testing). Assist the patient in completing the Patient 1st Newborn Assignment Choice Form (Attachment Eleven). A copy of the

hospital information and the Medicaid Patient 1st Newborn Choice Form should be faxed to the selected health care professional at the time of the hospital visit.

14. Ensure that the patient is prepared for childbirth. If preadmission has not been completed, assist recipient in choosing hospital for delivery and completing preadmission. Assess transportation needs to the scheduled hospital.
15. Ensure home preparation, assistance with newborn and mother in immediate postpartum period, availability of an infant car seat, etc.
16. Verify that the recipient and father of the baby (if he is involved) have made preparations for the infant's arrival and that they have a bed and a space designated for the new infant.
17. Educate the recipient regarding SIDS and current methods of placement of the infant for sleep.
18. Explain to the recipient the need to contact the eligibility outstation worker/DHR worker/Social Security worker with information about the baby's birth to ensure a Medicaid number for the baby.
19. Explain to the recipient that in cases of early hospital discharge where the Care Coordinator or designee does not get to visit with her in the hospital, **a home visit will be made.** Explain the need for the visit and what services will be offered. Encourage the recipient to use this time for education.
20. Emphasize the importance of keeping the post-partum Delivering Healthcare Professional check-up appointment. If it has not been scheduled then screen for any barriers, e.g. transportation, childcare, etc. Assist the recipient as necessary in scheduling the postpartum exam.
21. Explain to the recipient that you or someone from the Primary Contractor's staff will make a visit to the recipient during the hospitalization after delivery.
22. Re-emphasize the positive aspects of the home visit if it is determined by the Care Coordinator that a home visit is necessary. Obtain phone numbers where the recipient may be contacted. Ask where she will be staying when she takes the infant home from the hospital. Assure her that this visit is to help her in caring for herself and the infant.
23. Stress the importance of preventive dental care for the infant. Utilize Medicaid's Smile Alabama educational material available via Medicaid's website.

24. Review the importance of effective family planning methods and availability of family planning services. Verify that the recipient has chosen birth control pills or any other method (condoms, injection contraception, etc.) of family planning and explain that this must be discussed with the Delivering Healthcare Professional during the hospitalization. A prescription may be necessary in order to obtain the chosen method. Explain the option of having a Long Acting Reversible Contraceptive implanted in the hospital immediately after delivery or in an outpatient setting immediately after discharge from an inpatient setting.
25. Make referrals, including, but not limited to, Plan First and Patient 1st Programs, and CoIIN if applicable.
26. Emphasize that the recipient can become pregnant while breast feeding if she is not using any contraception.

E. Missed Encounters/Attempts

If the inpatient hospital encounter is missed, a home visit must be completed. At least two attempts must be made to complete the missed encounter. All home visits or attempts must be completed within 20 days of the delivery date. Missed attempts must be **documented** in the recipient's medical record.

F. Tracking of Care Coordinator Visits

In an effort to ensure standard tracking of Care Coordination services provided, the following codes have been established for use by the Primary Contractor for internal tracking. **These codes cannot be billed separately to Medicaid.**

T1016 - U1	1 ST encounter
T1016 - U2	2 ND encounter
T1016 - U3	3 RD encounter
T1016 - U4	4 TH encounter
T1016 - U5	5 TH encounter

G. Oversight of Care Coordinator Activities

Primary Contractor has the responsibility of maintaining oversight activities regarding the provision of Care Coordination services.

VII. HOME VISITS

A. Purpose

Home visits are optional, unless the required visit in the hospital is missed. **If the hospital face to face encounter visit is missed, a home visit must be made within twenty days of the delivery date.** It is the opinion of the Alabama Medicaid Agency that home visits improve outcomes. The Primary Contractor may develop criteria within their respective district for the purpose of home visits. The home visit criteria must be submitted for review by the Medicaid Agency with the ITB response.

The following are recommendations for consideration of home visit criteria development.

1. Under 16 Years of Age

- At time of conception
- Late entry into care (20 weeks gestation and over)
- Not residing in home with parents or significant other
- Grossly overweight or underweight
- Not in school
- Use of tobacco and/or alcohol and/or drugs
- Transportation issues
- Lack of support from family or father of baby
- Any triggers that indicate a need for follow-up after delivery

2. Drug and Alcohol Abuse

- Self reported
- Psychosocial assessment
- Odor of alcohol
- Observations of track marks and/or bruises from needle use
- Unexplained late entry into care 20 weeks gestation and over
- At risk lifestyle (i.e., multiple sex partners)
- Suspicious behavior such as incessant talking, drug seeking behavior (i.e., narcotics for various pains) glazed eyes, lying, sedated, short attention span, etc.

3. Mental illness

- Postpartum depression (it is expected that these women may require a series of visits)
- Long term history of mental illness
- Taking psychotropic drugs for mental illness (ex. Mellaril, Haldol, Lithium, etc.)
- Taking anti-depressants and exhibiting outward signs of depression (i.e., flat affect depressed mood and thought process, lack of interest in personal appearance, lack of interest in planning for baby's arrival, etc.)

4. Birth weight 2500 grams or less
 - Lack of prenatal care
 - Previous birth outcomes including low birth weight births
 - Mom or others in the household are smokers
 - Whether the infant is enrolled in a hospital follow-up program
5. Partner Abuse (Attachment Nine)
 - Reported by the recipient
 - Unexplained visible injuries
 - Fear of partner & his uncontrollable temper
 - Reports of partner's threats to harm or kill recipient
 - Reports of extreme partner jealousy and/or being possessive
 - Reports of verbal abuse; yelling, cursing, name-calling, isolation
 - Other—Care Coordinator or Delivering Health Care Professional judgment

B. Documentation

Medical records must be maintained that support the need or lack of need and the outcome of home visits. Refer to Attachment Seven.

C. Tracking Of Home Visits

The following codes have been established to assist the Primary Contractor in tracking home visits. These are not separately billable codes but codes to be used for internal tracking systems and may be expanded dependent upon your district specific criteria.

- H001 – under 16 years of age
- H002 – Drug & Alcohol Abuse
- H003 – Mental Illness
- H004 – Low Birth-weight
- H005 – Partner Abuse
- H006 – Missed Inpatient Encounter
- H007 – Other

VIII. PAYMENT OF SERVICES

A. Global Fee

The following procedure codes must be billed when the enrolled recipient has received **total** obstetrical care through your program. Only with sufficient documentation that the women have received care as listed in **59400** and **59510 by the delivering healthcare professional** will the full global fee be

paid. For women who present for delivery only services, Primary Contractors are to bill the delivery only global fee.

Global fee codes to be used are:

59400 – Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care.

59510 – Routine obstetric care including antepartum care, cesarean delivery and postpartum care.

Delivery Only Services

For recipients who receive **no prenatal care** through the Primary Contractor's network, a Delivery-Only fee must be billed. The components of the Delivery-Only fee include those services provided from the time of delivery through the postpartum period including all the required encounters by the Care Coordinator. The reimbursement amount for a Delivery-Only is 80% of the global fee. This payment represents payment for those services occurring at delivery and postpartum.

The following Delivery-Only procedure codes must be used to bill Delivery-Only services:

59410 – Vaginal Delivery and Postpartum Care Only

59515 - Cesarean Delivery and Postpartum Care Only

Note:

The Global Fee Codes listed above must have one of the following modifiers appended:

UD Medically necessary delivery prior to 39 weeks of gestation

U9 Delivery at 39 weeks of gestation or later

UC Non-medically necessary delivery prior to 39 weeks of gestation

Claims that are submitted for deliveries without one of the required modifiers will be denied.

B. Dropout Fee

This fee must be billed when the recipient begins care in your program but does not deliver. In order to bill this service the woman must have been enrolled prior to delivery. The procedure code is **99199**.

C. Subcontractor Reimbursement

The Primary Contractor must have a HIPAA- compliant automated

reimbursement system for payments to subcontractors and out-of-plan providers. **Payments to subcontractors should be made within 20 calendar days of Medicaid payment and in all cases within 60 calendar days of date of delivery. Payments to out-of-plan providers must be made within 90 calendar days.** The only exception is when TPL is involved or when payment is under appeal. Medicaid payment is defined as the date the check-write is deposited in to the provider's account.

Delivering Healthcare Professionals, except those associated with a teaching facility as defined in Attachment Thirty, 4.19-B of the State plan, must be paid at a rate no less than the Medicaid fee-for-service urban rate for delivery only. Effective October 1, 2014 the current urban fee-for-service rate is \$1,000 for delivery only. Nurse midwives are paid at 80% of that rate. The physician teaching facility rate for delivery only is \$1,007.20 and caesarean delivery only is \$1,141.44.

D. Services Billed as Third Party Liability (TPL)

The Primary Contractor is responsible for collecting all third party payments prior to submitting a claim to Medicaid for payment. Recipients with third party coverage are required to follow all program guidelines. Global claims must reflect the payments made by the third party carrier to all subcontractors. Primary Contractor cannot ask maternity recipients to pay any part of another payer's co-pay/deductible. TPL requirements are:

1. TPL Maternity Coverage

- a. Primary Contractor is responsible for collecting all TPL information before submitting a request to Medicaid for payment.
- b. Subcontractors shall file with the other insurer and report amount collected to the Primary Contractor. Primary Contractor must collect the other payer amounts that were obtained from each of their subcontractors. The Primary Contractor will sum up the lesser of: a) the amount paid by the other payer, or b) the contracted rate between the Primary Contractor and the subcontractor. The total sum of all subcontractors will be reported as "**TPL Paid Amount**" on the Medicaid claim.
- c. Primary Contractor's claim shall reflect the total payments as outlined in b above or a documented denial from the TPL insurer.
- d. Denials must be submitted only when the entire claim is denied. If there is a TPL payment on any part of the claim, that amount shall be listed on the claim. When Primary Contractor sends a claim to AMA for drop-out, miscarriages, or other reasons that have TPL payment, the

subcontractor must attach form ALTPL-01 10/12 (Attachment Twenty-four). Providers are to submit TPL forms when third party payment is made. These forms are scanned and matched electronically with the related claims before processing, and no denial information is submitted.

- e. Primary Contractor is responsible for notifying Medicaid's TPL Division by telephone or by mail using Attachment Twenty-three if the recipient has TPL insurance, and it is not listed on the Medicaid file. Primary Contractor must review eligibility for current TPL information prior to submitting claims. To ensure payment, subcontractors should check Medicaid and third party eligibility prior to rendering services.
- f. Medicaid shall grant a program exemption for TPL carrier only if recipient is enrolled in an HMO or a managed care plan that requires assignment to a particular provider. An HMO is defined as a TPL carrier which requires the individual to utilize a limited network of providers. In many cases these providers do not accept Medicaid.

2. Recipients with TPL Coverage, excluding Maternity

- a. Primary Contractor may notify Medicaid's TPL Division if the recipient has TPL but the contract does not provide maternity coverage or maternity coverage is not provided for dependents. (If maternity coverage is not available due to a waiting period, deductible hasn't been met, etc., Medicaid cannot update its records. The provider must obtain a denial and submit it with the claim.)
- b. This information may be provided by phone directly to Medicaid's TPL Division or may be mailed to Medicaid's TPL Division using Attachment Twenty-three.
- c. The phone number for Medicaid's TPL Division is based on the recipient's last name. **If the last name of the recipient begins with A-H, call (334) 242-5249; I-P call (334) 242-5280; Q-Z call (334) 242-5254.** If the worker is not available, Primary Contractor may leave information on voice mail. Information which must be left includes: name of caller and phone number, recipient's name and Medicaid number, the name of the insurance company, and the message that the contract does not cover maternity or that recipient is a dependent and dependent maternity benefits are not available.
- d. Once this information is loaded into Medicaid's TPL file, Primary Contractor may submit claims without having to attach TPL denial.

3. Recipients with TPL coverage that has lapsed.

- a. Primary Contractor must notify Medicaid's TPL Division of the actual month, date, and year the policy lapsed.
- b. This information may be provided by phone directly to Medicaid's TPL Division or may be mailed to Medicaid's TPL Division using the form in Attachment Twenty-three.
- c. The phone numbers are the same as listed in 2.c. above.

4. The Administrative Review Process

The Administrative Review Process is designed as a mechanism for subcontractors to submit claims, through the Primary Contractor, for consideration of payment. The following guidelines apply:

- a. Claims that are received by the Agency from subcontractors will be returned to the Primary Contractor for follow up.
- b. When claims are sent through the Administrative Review Process, the Primary Contractor should review the claims to ensure that the claim meets requirements.
- c. The Maternity Care Program Administrative Review Form (Attachment Twelve) must be completed by the Primary Contractor and utilized in order for these requests to be processed.
- d. Any claim past the time filing limit must have a detailed explanation of why time filing limits were not met.
- e. The claim must be submitted to Medicaid within 5 calendar days of receipt of claims from the sub-contractor.
- f. When the Primary Contractor sends a claim to AMA for drop-out, miscarriages, high risk transfers, or other reasons that have TPL payment, the subcontractor must attach form ALTPL-01 10/12 (Attachment Twenty-four). Providers are to submit TPL forms when third party payment is made. These forms are scanned and matched electronically with the related claims before processing.

E. Encounter Claims Data

1. Purpose

Primary Contractors must have a system in place to collect, analyze and bill Encounter Claims Data. Encounter Claims Data are the records of services delivered to Medicaid beneficiaries/recipients enrolled in the Maternity Care Program for which a capitated payment is made. These records allow the Medicaid agency to track the services received by Maternity recipients. Encounter data typically comes from billed claims that Primary Contractors and providers submit to the Alabama Medicaid Agency for their services. Encounter Claims Data are essential for measuring and monitoring the Maternity service quality, service utilization, and compliance with contract requirements. The data are also a critical source of information used to set capitation rates.

2. Elements

Data elements which may be captured in Encounter Claims Data will be provided in an electronic format. Examples of data elements are outlined in Attachment Twenty-five. Primary Contractors are required to submit encounter claims on all claims/services reimbursed from the global capitation fee. Claims/services **may include, but are not limited to:**

- a. Antepartum Care
- b. Outpatient Care/Ultrasounds
- c. Deliveries
- d. Postpartum Care
- e. Assistant Surgeon
- f. Associated Services
- g. Anesthesia Services
- h. Home Visits
- i. Ultrasounds
- j. Care Coordination
- k. Referrals to specialty doctors
- l. Labs

3. Standards

- A. Encounter Claims Data must be complete and reflective of care provided to recipients.
- B. Encounter Claims Data must be submitted according to guidelines outlined in the Vendors Companion Guide located on Medicaid's website.

- C. A global payment will not be generated until all Encounter Claims Data have been submitted.
- D. All Encounter Claims Data must be submitted to Medicaid within 90 days of the date of delivery.
- E. Damages for cost associated with breach of contract may be imposed for Encounter Claims Data not submitted according to guidelines.

F. Billing for Other Districts

- a. When a recipient moves to another county outside of the district in which she is eligible and does not change her county code, the billing district will bill the global using their own global rate. The billing district will keep \$100 for its time (administrative fee) and send the remaining global and all claims due to the district in which the patient resides. **The Primary Contractor may not bill a drop out and use this policy.**
- b. It is the responsibility of every provider to check the recipients' eligibility and county code each time services are provided.
- c. The billing district must enter the Encounter Claims Data for the global being billed.

G. High Risk Care

Referrals for high-risk care are the responsibility of the Maternity Care Primary Contractor. High risk care is not carved out of the Maternity District Plan. This includes procedure codes 99241-99245. Each recipient entering the care system must be assessed for high-risk pregnancy status and referred to a Delivering Healthcare Professional qualified to provide high-risk care if the assessment reflects a condition that cannot be appropriately handled in routine prenatal care sites.

1. High Risk Transfers/Reimbursement Methodology

Routine maternity care services provided to a recipient by a Delivering Healthcare Professional and/or Primary Contractor before and after the transfer of a recipient to a teaching physician as defined in Section 4,19-B of the State Plan or to a Medicaid enrolled Board Certified Perinatologist will be reimbursed **fee-for-service**

- a. Services provided by Primary Contractors before and after a high risk transfer: The Primary Contractor may receive an administrative collaborative fee for enrolled recipients who are transferred to high risk care as described above. The Primary Contractor may also receive an administrative collaborative fee for enrolled recipients who receive routine” maternity services from a teaching physician.

The administrative collaborative fee is paid for services provided by the Primary Contractor which include, but are not limited to: administration services, processing administrative review claims for subcontractors, “RMEDE data collection, data entry, and data reporting from the time of enrollment by the Primary Contractor through services provided to the end of the postpartum period for “high risk” recipients and recipients under “routine” care by a teaching physician as defined in Section 4.19-B of the State Plan, and care coordination encounters.

The **administrative collaborative fee** can be billed to the Alabama Medicaid Agency electronically and is not subject to the Administrative Review Process.

Primary Contractors and/or Delivering Healthcare Professionals/Subcontractors cannot bill a delivery code or a full global code for high risk transfers or routine care provided by a teaching physician.

NOTE THE EXCEPTION TO THIS REQUIRMENT:

When maternity care services are subcontracted under the umbrella of a Federally Qualified Health Centers (FQHC) and a teaching physician (as defined in Section 4.19-B of the State Plan), the Primary Contractor may bill an applicable global CPT code. The reimbursement of the FQHC for provision of maternity care services will be the responsibility of the Primary Contractor. The teaching physician will be reimbursed for provision of maternity care services under the fee-for-service payment methodology. In this instance, the administrative collaborative fee cannot be billed by the Primary Contractor.”

The procedure code for the administrative collaborative fee is 99199 with a UA modifier indicating high risk transfer or routine maternity care by a teaching physician.

The administrative collaborative” fee is \$365.00.

- b. **Services Provided by a Delivering Healthcare Professional/Subcontractor for a High Risk Transfer**

Claims for the provision of services by a Delivering Healthcare Professional/Subcontractor for a high risk transfer will be submitted to the Alabama Medicaid Agency by the Primary Contractor. These claims will be considered for payment through the Administrative Review Process. Reference the Maternity Care Program Operational Manual, Section VIII, D.4., Payment of Services for additional information about the Administrative Review Process.

Types of Claims that may be submitted for consideration of payment include, but are not limited to:

1. Antepartum Care Claims
2. Postpartum Care Claims
3. Associated Services Claims
4. Ultrasounds Claims
5. Claims for Referrals to specialty doctors
6. Lab Claims

Reference the Maternity Care Program Operational Manual, Section V, Services, and the Provider Manual for further details regarding reimbursement methodology.

IX. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Quality Assurance and Performance Improvement (QAPI) is an integral part of the Maternity Care Program addressing both clinical and nonclinical areas. This section outlines the requirements of the program and the responsibilities of the Primary Contractor and Medicaid. The oversight of QAPI is the responsibility of the Maternity Care Program Associate Director. Each facet of the Quality Assurance and Performance Improvement process has its own unique roles and responsibilities.

A. Primary Contractor Requirements

1. Overall Plan
 - a. Is written, clear, and concise and addresses all program requirements including outcomes and processes;
 - b. Has defined processes for the collection, analyzing of and reporting of

data;

- c. Identifies areas of concern and allows for implementation of corrective action;
- d. Corrects significant systemic problems that may be identified through internal surveillance (monitoring and evaluation), complaints, or other mechanisms;
- e. Uses clinical care and practice standards that:
 - 1. Are based on reasonable scientific evidence and are reviewed by plan providers;
 - 2. Focus on the process and outcomes of health care delivery, as well as access to care;
 - 3. Are included in provider manuals developed for use by providers/subcontractors or otherwise disseminated to providers as they are adopted;
 - 4. Addresses preventive health education services;
 - 5. Are developed for the full spectrum of populations enrolled in the plan, and for which a mechanism is in place for continuously updating the standards/guidelines.
- f. Has sufficient material resources and staff with the necessary education, experience, and training, to effectively carry out its specified activities.

2. Quality Assurance Committee

Each Primary Contractor shall have a Quality Assurance Committee that delineates an identifiable structure responsible for performing Quality Assurance functions. This committee or structure has:

- a. Regular meetings – The committee meets on a regular basis at a specified frequency (at a minimum quarterly) to oversee Quality Assurance and Performance Improvement activities. This frequency must be sufficient to demonstrate that the structure/committee is following up on all findings and required actions, with sufficient documentation that is reported to Medicaid quarterly.
- b. Established parameters for operating – The role, structure, and function of the structure/committee are specified.

- c. Documentation – There are records documenting the structure and the committee’s activities, findings, recommendations, and actions. Attachment Sixteen is to be used in documenting quarterly Quality Assurance Committee meeting minutes for reporting to Medicaid.
- d. Accountability – The committee is accountable to the Primary Contractor and reports to it (or its designee) on a quarterly scheduled basis on activities, findings, recommendations and actions.
- e. Membership – There is active participation in the committee from subcontractors who are representative of the health plan’s providers. At a minimum, it is composed of the Program Director or designee, an OB/GYN physician or a delivering physician who practices as a Family Physician or a delivering physician who practices as a General Practitioner, a registered nurse with obstetrical experience, and a licensed social worker. A Medicaid consumer should be included in the meetings. Documentation must support the Primary Contractor efforts for inclusion.

3. Minimum Elements

Each Primary Contractor has the ability to structure its individual Quality Assurance Performance Improvement process to meet the needs of its service and program requirements. The following are the minimum elements that must be present:

- a. Mechanism to evaluate the enrollment and referral process.
- b. Have a system in place for enrollees that include a grievance process, an appeal process, and access to the State’s fair hearing system.
- c. Provides for quarterly and annual reporting of Quality Assurance Performance Improvement activities.
- d. Allows for the collection and inputting of service specific information into the Service Database. Refer to C. Service Database, of this section for information on the Service Database.
- e. Utilizes information obtained from Medicaid’s record reviews to incorporate relevant information into their Quality Assurance Performance Improvement process and reports best practices to Medicaid.
- f. Conducts ongoing performance improvement projects that focus on clinical and non clinical areas. Refer to F of this section.

- g. Conducts Delivering Healthcare Professional medical record reviews on deliveries collecting and reporting, via report card format, the Delivering Healthcare Professional measures indicated in D of this section.
- h. Detects both under and over utilization of services by subcontractors and recipients.
- i. Addresses the findings of the Delivering Healthcare Professional report cards in the overall Quality Assurance Performance Improvement process.

B. State Requirements

To ensure that the Primary Contractor is meeting program requirements and that the program is achieving its intended outcome, Medicaid must also have a formal Quality Assurance Performance Improvement strategy.

1. Overall Plan

- a. Have a written strategy formulated with the input of stakeholders and formally approved.
- b. Identifies areas of concern and allows for implementation of corrective action.
- c. Corrects significant systemic problems that may be identified through internal surveillance, (monitoring and evaluation), complaints, or other mechanisms.
- d. Provides for feedback to the Primary Contractor and other stakeholders.

2. Minimum State QAPI Elements

The State will conduct the following minimal activities with the assistance of the Primary Contractor.

- a. Perform medical record reviews to collect data.
- b. Create and maintain a Service Database (Refer to C of this section) to collect service characteristics and outcome information.
- c. Create Primary Contractor Profiles reflecting the elements in E of this section.

- d. Review and provide a disposition of Grievances reported to the Agency.
 - e. Provide oversight of Primary Contractor Quality Assurance and Performance Improvement Projects.
 - f. Conduct recipient surveys.
 - g. Review utilization and outcome data.
 - h. Perform on-site reviews to ensure compliance with program standards. Refer to Section XI of this manual for details on the administrative review process and elements.
 - i. Provide an annual report of Maternity Care Program activities.
3. State Quality Assurance Performance Improvement Activities

As described herein and further in Sections X and XI of this Manual, the State will conduct Quality Assurance and oversight activities through a combination of data analyses, Primary Contractor reporting, and onsite reviews. All of these activities will be interwoven to present a complete and accurate reflection of the work that is being accomplished. From these various activities the State will produce an annual report showcasing the impact of the Maternity Care Program to improve birth outcomes.

C. Service Database

1. Description and Purpose

The Agency will create and maintain a web based database. Primary Contractor will be required to enter certain data elements into the database on each delivery occurring in their program for which they bill a global fee. The purpose of the database will be to collect information on 100% of deliveries so that an accurate reflection of program impact can be obtained. The data will also be the basis of the information for compilation of the Primary Contractor Performance Measures on the Profile. Data input will be directly into the database via a form view or via spreadsheet upload. Attachment Fifteen contains the form delineating the database elements.

2. The database is designed so that Primary Contractor can enter data upon patient enrollment continuing through the postpartum period. All data entry on a patient must be completed within 90 days of the delivery date. Damages for cost associated with breach of contract will be imposed for data not entered within the required timeframe.

The database will be password protected and Primary Contractor will only be able to view information on their patients. Upon contract award additional passwords and training will be provided.

3. Reports

In addition to the Primary Contractor Profiles described below, the Agency will utilize the information from the database to analyze program demographics, care trends, potential quality issues as well as outcome factors.

4 Service Database (RMEDE) Exemptions

A recipient who is awarded exemption status is not required to be entered into the Service database by the Primary Contractor's network. This is generally as a result of deliveries at or less than 21 weeks gestation or other reasons as approved by the Alabama Medicaid Agency. Primary Contractors are required to email any exemption request to the Medicaid Maternity Nurse Review Coordinator assigned to their District. The information will be reviewed for approval or denial based on the criteria specifications. Contractors will be notified in writing if additional information is requested or if exemption request is denied. The request will be documented on a spreadsheet, maintained and filed by the Districts for auditing purposes.

D. Delivering Healthcare Professional Report Cards

DHCP Report cards are just one tool that will be used by the State to gauge program effectiveness in addition to the information provided through the performance improvement projects and recipient surveys. Performance measures will be reviewed for possible adjustment each contract year. Any changes will be communicated to Primary Contractor 60 days prior to effective date.

1. Delivering Healthcare Professional Report Card Measures

Every six months each Primary Contractor will be required to create a report card on each individual Delivering Healthcare Professional and Delivering Healthcare Professional group reporting the following measures:

- a. Percentage of medical records containing documentation of DHCP visits which contain the following elements: gestational age, blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery.

- b. Percentage of women who have had a determination of blood group (ABO) and negative D (Rh) by the second prenatal care visit.
- c. Percentage of Rh negative women with no antibodies who receive Rhogam between 26-32 weeks gestation.
- d. Percentage of women who have had glucose tolerance testing performed.
- e. Percentage of women who have at least one urine test to screen for asymptomatic bacteriuria.
- f. Percentage of Low Birth Weight (LBW < 2500 grams) babies born to Medicaid Mothers.
- g. Percentage of Very Low Birth Weight (VLBW < 1500 grams) babies born to Medicaid Mothers.
- h. Percentage of women who delivered at less than 37 weeks.
- i. Percentage of women (who do not opt out of the test) screened for HIV infection during the first or second prenatal care visit.

2. Definition of Data Elements

Primary Contractor must use the following definitions when applying the measures. This will ensure that all Delivering Healthcare Professionals are being measured consistently and that all Primary Contractors are reporting the measures consistently.

- a. Prenatal Visit Elements-DHCP records must contain at a minimum the following: gestational age, blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery at each visit. In the absence of uterine size, or fundal height measurements, documentation should contain evidence of serial ultrasounds to verify fetal growth and development.
- b. Blood Group Determination – Notation of results in the prenatal record.
- c. Rhogam Injection – notation in the prenatal chart that Rhogam (or equivalent) was given to medically eligible women between 26-32 weeks gestation. NOTE: This measure can only be applied to those women who entered care by 32 weeks gestation and have not been sensitized by a prior pregnancy.

- d. Glucose Tolerance Testing or other Diabetic Screening – notation of results in the prenatal record of one of the following tests: glucose tolerance test; 1 hour glucose screen; two hour random blood sugar after a meal or a fasting blood sugar. Testing is not necessary for patients with pre-existing diabetes.
 - e. Asymptomatic Bacteriuria Screening – notation of the results in the prenatal record.
 - f. Low Birth Weight – self-explanatory.
 - g. Very Low Birth Weight – self-explanatory.
 - h. Delivered less than 37 weeks – self-explanatory.
 - i. HIV Screening – notation of results in the prenatal record. Must be measured against the number of women who declined testing.
3. Quality Measures and benchmarks are indicated in **Figure 2**.

Figure 2. Delivering Healthcare Professional Quality Measures and Benchmarks.

Measures	Benchmarks
Prenatal Visit Elements	98%
Blood Group Determination	95%
Rhogam Injection	99%
Glucose Tolerance Testing	90%
Asymptomatic Bacteriuria Screening	95%
Low Birth Weight	11%
Very Low Birth Weight	2%
Delivered Less than 37 Weeks	13%
HIV Screening	95%

4. Delivering Healthcare Professionals Sampling Methodology

The Primary Contractor must perform a random sampling of each DHCP every 6 months for measurement of the required elements and the development of professional report cards. The sample size should be 10% but no less than 10 records for each Delivering Healthcare Professional for the period being reviewed.

5. Delivering Healthcare Professionals Review and Reporting Periods

To accommodate program implementation and in order for the review to be reflective of program efforts, a three month phase-in period will be allowed

before Primary Contractors are required to collect and report Delivering Healthcare Professionals measures. Within the District, Primary Contractor should develop a review schedule among their Delivering Healthcare Professionals to ensure that the prescribed numbers of records are reviewed. Delivering Healthcare Professionals Review and Reporting Periods schedule are outlined in **Figure 3**.

Figure 3. Delivering Healthcare Professionals Review and Reporting Period schedule

Delivery Date of Service	Review Period	Report Card Due
June-November	February-April	May
December-May	August-October	November

6. Delivering Healthcare Professional Report Card Format

Primary Contractor must use the format in Attachment One to report Delivering Healthcare Professionals measures. For those Delivering Healthcare Professionals in group practices, defined as three or more physicians, the measures are to be reported per Delivering Healthcare Professionals and per Group.

Primary Contractor is required to develop a system to mask their individual Delivering Healthcare Professionals so that results from all the district's DHCPs can be provided. The algorithm used to mask providers should contain logic that links providers within a group to allow for further analyses of the data that may be necessary.

E. Primary Contractor Profile Measures

1. Source of Data

Medicaid will use the Service Database, Grievance Log and results from the recipient surveys to create the Primary Contractor Profile.

a. Web Elements

Medicaid, based on information obtained through the Service Database, will produce biannual Primary Contractor Profiles reflecting data on 100% of all deliveries. In addition to program demographics, the following elements will be measured and reported.

1. Percentage of women with first doctor's visit less than 14 weeks gestation
2. Percentage of low birth weight (LBW < 2500 grams) babies born to Medicaid mothers

3. Percentage of very low birth weight (VLBW < 1500 grams) babies born to Medicaid mothers
4. Percentage of women who complete a family planning visit prior to the 60th postpartum day
5. Number of prenatal visits that contain all of the prenatal elements/number of paid deliveries
6. Percentage of very low birth weight babies born at appropriate facilities for high-risk deliveries and newborns
7. Percentage of babies born prior to 37 weeks gestation
8. Number of women who quit smoking while pregnant/number of smokers
9. Percentage of diabetic women who have at least one session with a registered dietician or certified diabetic educator at less than 32 weeks gestation.
10. Percentage of women identified as breast feeding at postpartum visit
11. Percentage of women who received a Care Coordination visit after delivery prior to discharge from the hospital
12. Percentage of women who complete a postpartum visit prior to the 60th postpartum day

b. Grievances and Appeals

Grievances and appeals as reported by category on the quarterly grievance log. Refer to H of this section for details on the grievance system.

c. Recipient Surveys

Refer to I of this section for details on the Recipient Explanation of Medicaid Benefits process.

2. Definition of Primary Contractor Data Elements

- a. Percentage of women with first doctor's visit less than 14 weeks gestation
- b. Percent of Low Birth Weight – self-explanatory

- c. Percent of Very Low Birth Weight – self-explanatory
 - d. Percent of family planning visits completed prior to the 60th postpartum day. Number of prenatal visits that contain all the prenatal elements
 - e. Percent of Very Low Birth Weight at high-risk facilities – Facilities as defined by the Alabama Department of Health as being as Level A or B hospital. **Level A: USA, UAB; Level B: Huntsville Hospital, DCH-Tuscaloosa, DCH-Northport, Brook Wood, , Princeton, St. Vincent’s East, St. Vincent’s, Trinity Medical Center, Montgomery Baptist South**, and Medical Center Inc., for Columbus Georgia.
 - f. Percentage of babies born prior to 37 weeks gestation – defined as 36 and 6/7ths weeks or earlier
 - g. Number of women-who quit smoking while pregnant – self-explanatory
 - h. Percentage of diabetic women who have at least one session with a registered dietician or certified diabetic educator – self-explanatory
 - i. Percentage of women identified as breast feeding at postpartum visit–self-explanatory
 - j. Care coordination
 - k. Percent of postpartum visits completed prior to the 60th postpartum day
3. The Alabama Medicaid Agency will generate performance reports to evaluate the performance of Primary Contractors, subcontractors and the effectiveness of the Maternity Care Program. The reports will capture delivery dates as indicated below and will be issued according to the established timeline in **Figure 4**.

In order to ensure timely reporting by the Alabama Medicaid Agency, the Primary Contractor is encouraged to enter information into the Alabama Medicaid Agency’s Maternity Care Program database on an ongoing basis.

Figure 4. Performance Reports Schedule

Delivery Date of Service	Profile Issued
January-March	July
April-June	October
July-September	January
October-December	April

F. Performance Improvement Projects (PIPS)

The purpose of conducting a Performance Improvement Project is to improve relevant areas of clinical and non-clinical care that significantly impact enrollee health, function, and satisfaction in the Maternity Care Program. One Performance Improvement Project will be required by Medicaid per year unless otherwise directed.

G. Quality Improvement Activity Summary (QIAS)

In addition to specific Performance Improvement Projects described above, each Primary Contractor must have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. The Quality Improvement Activity Summary allows the Primary Contractor to have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. Attachment Ten contains the reporting format. Attachment Ten-A is an example of a completed project.

The Quality Improvement Activity Summary records quality assessment and performance, providing an overview of activity, why activity is relevant, and opportunities for improvement and interventions for the District. This form is maintained by the Primary Contractor and sent to Medicaid on a quarterly basis.

Quality improvement activities must focus on clinical and nonclinical areas and involve the following:

1. Measurement of performance using objective quality indicators.
2. Implementation of system interventions to achieve improvement in quality.
3. Evaluation of the effectiveness of the interventions in improving birth outcomes.
4. Planning and initiation of activities for increasing or sustaining improvement.

H. Grievance and Appeal System

Each Primary Contractor must implement and maintain a grievance and appeal system that includes a grievance process, an appeal process and access to Medicaid's fair hearing process. The Primary Contractor is required to send a notice of any adverse action to the enrollee and such notice must meet the notice requirements set forth in 42 CFR 431, Subpart E. The regulations as

specified at 42 CFR 438.228 and 438.400 et al. must also be followed. The following is a general summation of the requirements.

1. General

- a. A grievance is defined as an expression of dissatisfaction about any matter other than an action.
- b. An action is the denial or limitation of a requested service, the reduction, suspension or termination of a previously authorized service, the denial of payment for a service or the refusal of the Primary Contractor or subcontractor to act in a timeframe specified.
- c. An appeal is defined as the request for review of an action.
- d. Medicaid and the Primary Contractor must have a process in place to receive and resolve grievances.
- e. The Primary Contractor must provide grievance and appeal procedures to all recipients and subcontractors, including recipients' right to a fair hearing.
- f. The Primary Contractor must have written policies that document and outline the grievance and appeal process.
- g. Primary Contractor must accept grievances either orally or in writing.
- h. Primary Contractor must notify subcontractors and recipients in writing of the disposition of the grievance at each level.
- i. The Primary Contractor must maintain records of grievances and appeals. On a quarterly basis, the Primary Contractor must submit to Medicaid the Grievance Log as defined in Attachment Eighteen. Instructions for completing the Grievance Log are defined in Attachment Eighteen-A.
- j. Medicaid will report any grievances received directly to the Primary Contractor. It is the responsibility of the Primary Contractor to handle the grievance as if it was received directly. Primary Contractors are required to report follow up, findings and outcome of the grievance back to the Medicaid within ten business days of receipt.

2. Primary Contractor Grievance System

The Primary Contractor must:

- a. Give recipients participating in the program reasonable assistance in completing forms and other procedural steps including, but not limited to, providing interpreter services and toll-free numbers with TY/TDD and interpreter capability.
- b. Acknowledge receipt of each grievance and appeal.
- c. Ensure that grievances and appeals are handled in an objective and fair manner.
- d. Make specific policies and procedures available addressing the grievance system including recipient rights, timeframes, assistance availability and the toll-free number to file oral grievances and appeals.

3. Grievance Process

Each Primary Contractor should have a designated individual who can receive the grievance and act to resolve the grievance on behalf of the recipient. These type grievances should be resolved within ten business days of receipt. If the grievance is of an urgent or immediate action, then it should be acted on within 48 hours. If an enrollee seeks disenrollment, the grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in 42 CFR 438.56(e).

If a grievance cannot be resolved at this level, then the grievance should be referred to the Primary Contractor's Grievance Committee. At this point the grievance becomes an appeal.

4. Appeal Process

Each Primary Contractor should have specific procedures for handling appeals based on the requirements found at 42 CFR 438.400 et al. Below is a general summation of the requirements.

- a. A recipient or a provider acting on behalf of the recipient can file an appeal to the Primary Contractor,
- b. The appeal must be filed within 45 calendar days from the date of the action.
- c. An appeal can be filed orally but must be followed with a timely written, signed appeal.
- d. The Primary Contractor must have written policies governing appeals.

- e. Appeals must be resolved within 45 calendar days of receipt. Extensions may be granted if requested by the enrollee.
- f. The Primary Contractor must have a documented process for expedited appeals.

5. State Fair Hearing Process

If a recipient is not satisfied with the resolution of her appeal by the Primary Contractor, she may request a fair hearing from Medicaid. Fair Hearings are governed by Chapter Three of the Alabama Medicaid Administrative Code. The Primary Contractor must make available to recipients the right to a fair hearing, the method for obtaining a fair hearing and the rules that govern representation. The same information must be available to subcontractors and recipients.

I. Recipient Explanation of Medicaid Benefits (REOMBs)

The Agency, through its fiscal agent liaison, sends a recipient survey to those women delivering through the Maternity Care Program. The purpose of the survey is to solicit the patient's input on the care received through the program. It is also intended to gauge whether program requirements are being met and the patient's overall perception of program impact.

The surveys are distributed on a monthly basis to two percent of women delivering three months prior to the requesting month. The REOMBs schedule is established on a quarterly basis

Medicaid will provide each Primary Contractor with the results from the women's surveys within their districts. Primary Contractor is required to share these findings with their subcontractors.

In addition, findings from the REOMBs will be reported on the Primary Contractor Profile comparing each district results.

J. Delegation of Quality Assurance Performance Improvement Activities

The Primary Contractor remains accountable for all Quality Assurance Performance Improvement functions, even if certain functions are delegated to other entities. If the Primary Contractor delegates any Quality Assurance Performance Improvement activities to contractors:

1. There must be written description of: the delegated activities; the delegate's accountability for these activities; and the frequency of reporting to the primary contractor.
2. The Primary Contractor must have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.
3. There must be evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and review of regular specified reports.

K. Coordination of Quality Assurance Activity with Other Management Activity

The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of Quality Assurance Performance Improvement activity are documented and reported to appropriate individuals within the organization and through established channels.

1. Quality Assurance Project information is used in re-credentialing, re-contracting, and for annual performance evaluations.
2. Activities are coordinated with other performance monitoring activities, including utilization management, risk management and resolution, and monitoring of member complaints and grievances.
3. There is a linkage between Quality Assurance and the other management functions of the health plan, such as:
 - a. network changes
 - b. benefits redesign
 - c. medical management systems (e.g. pre-certification)
 - d. practice feedback to physicians
 - e. recipient education

L. Performance Measures

The following is a list of the specific measures and process of review:

- a. Medical record documentation must support that the district has 25% of the total number of smoking mothers who enroll for care during the first year of the contract period to quit smoking while pregnant and continue to cease from smoking until the postpartum visit. This information will

be monitored through the Agency web data base (Real-time Medical Electronic Data Exchange) and through medical record reviews performed by Agency staff.

- b. The establishment and/or maintenance of at least one Centering Pregnancy site for the entire year per district. Agency Staff may provide an on-site visit to the site.
- c. Medical record documentation must support that 50% of all diabetic women enrolled for care in the district have at least one session with a registered dietician or certified diabetic educator at less than 32 weeks gestation. This information will be monitored through Real-time Medical Electronic Data Exchange and through medical record reviews performed by Agency staff. .
- d. Medical record documentation must support that 80% of all delivering women served by the district complete a family planning visit by the 60th postpartum day. This information will be monitored through Agency web data base and through medical record reviews performed by Agency staff.
- e. Medical record documentation must support that all delivering women served by the districts received 61-80% of the expected prenatal visits. This information will be monitored through Real-time Electronic Medical Data Exchange and through medical record reviews performed by Agency staff.
- f. Medical record documentation must support that 80% of documented prenatal visits per total number of paid deliveries contained all of the required prenatal visit elements. This information will be monitored through Real-time Electronic Medical Data Exchange and through medical record reviews performed by Agency staff.
- g. Medical record documentation must support that a minimum of 25% of the total number of deliveries served are identified as breast feeding mothers at their postpartum visit. This information will be monitored through Real-time Medical Electronic Data Exchange and through medical record reviews performed by Agency staff.
- h. Medical record documentation must support that 75% of the number of deliveries in the district annually complete the first doctor's visit at <14 weeks gestation. This information will be monitored through REMEDE and through medical record reviews performed by Agency staff.
- i. Medical record documentation must support that a minimum or 80% of all delivering women complete a postpartum visit prior to the 60th postpartum day.

X. RECORDS AND REPORTS

A. Record Requirements

1. Records

The Primary Contractor must maintain books, records, documents, and other evidence pertaining to the costs and expenses of this contract (hereinafter collectively called the “records”) to the extent and in such detail as must properly reflect all net costs for which payment is made under the provisions of any contract of which this contract is a part by reference or inclusion.

In accordance with 45 CFR §74.164, and 42 CFR 438.6(g), the Primary Contractor shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of three years from the date of the final payment made by Medicaid to Contractor under the contract. However, if audit, litigation, or other legal action by or on behalf of Medicaid or the Federal Government has begun but is not completed at the end of the three year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the three year period, the records shall be retained until resolution. Subsequent to the contract term, documents shall be returned to Medicaid within three working days following expiration or termination of the contract. Micro-media copies of source documents for storage may be used in lieu of paper source documents subject to Medicaid approval.

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

A file and report retention schedule must be developed by the Primary Contractor and approved by Medicaid. Primary Contractor must maintain

and Medicaid shall approve the retention schedule and all changes.

2. Substitution of Records

The Primary Contractor may, in fulfillment of its obligation to retain its records as required by this article, substitute clear and legible photographs, microphotographs or other authentic reproductions of such records after the expiration of three (3) years following the last day of the fiscal year in which payment to the Primary Contractor was made, unless a shorter period is authorized by Medicaid. The State Records Commission approves records retention schedules.

3. Medical Records

Primary Contractor and subcontractors shall ensure that a medical record system is maintained within the State of Alabama in accordance with §2091.3 and §2087.8 of the State Medicaid Manual which makes available to appropriate health professionals all pertinent information relating to the medical management of each recipient. All entries on medical records must be written in ink or typewritten and authenticated by the signature or initials of the health care professional.

B. Reporting Requirements

1. Report Submission

- a. Reports are to be submitted as specified in the description of reports (#2 below).
- b. Primary Contractor must be responsible for timeliness, accuracy, and completeness of reports as defined below:
 1. Timeliness – Reports and other required Service Database data must be received on or before scheduled due dates.
 2. Accuracy – Reports and other required Service Database data must be prepared in conformity with appropriate authoritative sources and/or Medicaid defined standards.
 3. Completeness – All required information must be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.
 4. Primary Contractor must agree to be responsible for continued reporting beyond the term of the contract. For example, processing claims and reporting encounter data must likely continue beyond the

term of the contract because of lag time in filing source documents by subcontractors.

5. Medicaid requirements regarding reports, report content and frequency of submission of reports are subject to change at any time during the terms of the contract. Primary Contractor must comply with all changes specified by Medicaid.
6. Reporting requirements are based on calendar dates.
7. The “to” contained in the subsequent chart indicates to where the report should be submitted. Maternity Care Program refers to the Associate Director or a designee as directed by the Associate Director. Specific email addresses will be provided prior to contract implementation.

2. Reports

The following are the reports that are required on a routine basis. Details on specific reporting requirements may have been contained in other sections of the Operational Manual and referred to below. Failure to deliver reports in the manner and timeframe specified in **Figure 5** may result in damages for cost associated with breach of contract. Form format and requirements may change as deemed necessary by Medicaid.

Figure 5. Reporting Requirements

Report Name	To	Media	Format	Timeframe	Due
Service Database	n/a	Web-based	In the format as designated in the Web based instructions	Data must be entered within 90 days of the delivery	Within 90 days of delivery
Global Summary Report	MCP	Email	Excel as indicated in the format as specified in Attachment Nineteen	Quarterly	Within 45 days of the end of the quarter being reported
Organizational Structure	MCP	e-mail	Word	Annual and upon change	January 1st and/or within 5 days of occurrence

Provider Network	MCP	e-mail	Excel as indicated in the format as specified in Attachment Twenty	Annual and upon change	January 1 st and/or within 5 days of occurrence (exception: due weekly for 30 days after contract award)
Application Assisters	MCP	e-mail	Word as indicated in the format specified in Attachment Six	Annual and upon change	Within 45 days of the end of the year and within 45 days of any change
Quality Improvement Activity Summary	MCP	e-mail	Word as indicated in the format specified in Attachment Ten	Quarterly	Within 45 days of the end of the quarter being reported
Grievance and Appeal Log	MCP	e-mail	Word or excel format as indicated in the format specified in Attachment Eighteen	Quarterly	Within 45 days of the end of the quarter being reported
Quality A Assurance Committee Meeting Minutes	MCP	e-mail	Word as indicated in the format specified in Attachment Sixteen	Quarterly	Within 45 days of the end of the quarter being reported
Managed Care Organization (MCO) Experience Report	MCP	email	As indicated in the format as provided by the Alabama Medicaid Agency	Annually	Within 45 days of the end of each calendar year
Quality Improvement Tracking Log	MCP	e-mail	Word as indicated in the format specified in Attachment Seventeen	Quarterly	Within 45 days of the end of the quarter being reported
Sale, Exchange, Lease of Property	MCP	Paper	Word	Occurrence	Within 5 days of occurrence
Loans and/or Extension of Credit	MCP	Paper	Word	Occurrence	Within 5 days of occurrence
Furnishing for Consideration of Goods &	MCP	Paper	Word	Occurrence	Within 5 days of occurrence

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3. Report Details

a. Service Database

The purpose of this report is to collect specifics on each delivery for which the Primary Contractor receives payment. Information will be entered via a web-based database as described in Section IX.C.

b. Global Summary Report:

The purpose of this report is to collect specifics on amounts paid to subcontractors for services reimbursed through the global fee. The format and instructions are included in Attachment Nineteen.

c. Organizational Structure

This report indicates for Medicaid the individuals involved in the Primary Contractors' organization. Significant changes must be reported to the Maternity Care Program Associate Director within 5 days of occurrence in a word format.

d. Provider Network

This report must be reflective of all subcontractors in the Primary Contractors' network. Complete demographic information must be included, the service offered and the providers NPI number. The format and instructions are included in Attachment Twenty.

e. Application Assister services Primary Contractor shall submit a list of counties and names of assigned Application Assistors and the name(s) of the Application Assistors' trainer to the Maternity Care Program Associate Director or designee annually and upon change. The format is included in Attachment Six.

f. Quality Improvement Activity Summary

This report must summarize the Primary Contractors' Quality Improvement activity for the quarter. Details are contained in Section IX.G. The format and instructions are included in Attachments Ten and Ten-A.

g. Grievance Log

This report allows Medicaid to track issues as they arise as well as assure that each issue is resolved. Details are contained in Section IX.H. The format and instructions are included in Attachments Eighteen and Eighteen-A.

h. Quality Assurance Committee Meeting Minutes

This report allows the Quality Assurance Division to focus on quality improvement and quality concerns in individual districts and how improvements initiatives are implemented and the concerns are being resolved. Details are contained in Section IX.A. The format for reporting Quality Assurance Committee Meeting minutes is located in Attachment Sixteen.

i. MCO Experience Report

This report will be used during the development of delivery rates for the Alabama Medicaid Population. Each Contractor will be required to complete the report for each of its districts.

j. Tracking Log

A means by which the Primary Contractor can identify and track problems and/or issues noted within their Districts. Identified problems or issues are taken to the QA Committee for discussion and recommendations.

k. Sale, Exchange, Lease or Property;

These reports are Centers for Medicare and Medicaid Services required for Managed Care Organizations and are required in a word format.

l. Loans or Extension of Credit

These reports are centers for Medicare and Medicaid Services requirements for Managed Care Organizations and are required in a word format.

m. Furnishing for Consideration of Goods and Services

These reports are centers for Medicare and Medicaid Services requirements for Managed Care Organizations and are required in a word format.

XI. MEDICAID OVERSIGHT

A. General

Medicaid shall monitor Primary Contractor performance through a combination of performance measures, medical record reviews and administrative reviews. The purpose of oversight activities is to ensure that contract requirements are being met, standards of care are being implemented and enforced, and that Primary Contractors are meeting the expectations of the Delivering Healthcare Professional.

B. Administrative Reviews

1. Purpose
To measure performance, each Primary Contractor will be visited at least annually on-site to ensure compliance with program requirements.
2. Elements of the Administrative Review are detailed in **Figure 6**.

Figure 6. Administrative Reviews Elements

Subcontractors not enrolled as Medicaid providers
Valid Subcontracts (credentialing and licensure)
Delivering Healthcare Professionals have hospital privileges at a facility that provides delivery services
Claim payment within timeframes
Staff knowledge of billing/reimbursement policies
Training (Subcontractor and Care Coordinator) as required
Application Assister Requirements
Delivering Healthcare Professional Choice Requirements

3. Standards
If after the Administrative review, the Primary Contractor is found to not be meeting the requirements, the following damages for cost associated with breach of contract as indicated in **Figure 7** will be imposed. As indicated, corrective action will be allowed for some program elements with imposition of damages for cost associated with breach of contract as a final act.

Figure 7. Administrative Measures and Damages for Cost Associated with Breach of Contract.

Measure	Damages for Cost Associated with Breach of Contract
Subcontractor not Enrolled with Medicaid	1 st occurrence: Corrective Action, 2 nd occurrence: \$500 per provider not enrolled
Valid Subcontracts	1 st occurrence: Corrective Action, 2 nd occurrence: \$500 per subcontract not meeting requirements
DHCP have hospital privileges	1 st occurrence: Corrective Action 2 nd occurrence: \$500 per DHCP not having hospital privileges
Claim payment within timeframes	95% audit sample of claims paid

	within timeframes, \$100 per incident for payments not meeting timeframes
Staff knowledge of billing/reimbursement policies	1 st occurrence:, Staff re-training 2 nd occurrence: \$100 per incident thereafter.
Training (Subcontractor and Care Coordinator) as required	\$500 training session not completed
Application Assister services	\$500 per week in which there is no access to an Application Assister in all counties
Delivering Healthcare Professional Choice Requirements	1 st occurrence: Corrective Action 2 nd occurrence: \$500 per choice requirements not being met

C. Medical Record Reviews

1. Purpose

The purpose of the Medical Record Reviews is to ensure that each Primary Contractor is providing quality maternity care to their recipients, determine the effectiveness of the Maternity program and to ensure services are provided according to federal and state guidelines. This will be accomplished by conducting periodic reviews to evaluate the effectiveness and adequacy of postpartum home visits, care coordination, and smoking cessation efforts. Medical Record Reviews will be performed in addition to the elements that are measured from the Web Database as described in Section IX.C.

2. Sample Size/Process

Reviews will be conducted on a semi-annual basis as explained in the Operational Manual, Section XI.C.2.

The sample number of records will be chosen randomly from a DSS Query generated for a specific period of time prior to the review but in no case reflective of less than three months prior to the review month. A request for recipient records will be sent to the Primary Contractor requesting that patient records be sent back to the Medicaid Managed Care Division for review. The Primary Contractor will be responsible for obtaining all record information for review which includes documentation from the DHCP, Hospital, etc. The subcontractor or the Primary Contractor cannot charge for these records.

3. Findings

After the review is completed and all data compiled, Primary Contractor will be provided a summary of the findings. Statewide statistical reports will be generated after all District reviews are completed, excluding Service Database reviews. Further review and/or a request for a corrective action plan may be necessary dependant on Medical Record and Service Database Review findings.

4. Elements and expectations of the Medical Record Review are detailed in **Figure 8.**

Figure 8. Medical Record Reviews Elements and Expectations

Measure	What it is	Expectation
Care Coordination Encounters	The percentage of recipients for which a care coordination encounter was completed in the hospital prior to discharge. If no encounter was completed in the hospital prior to discharge, were two attempts made to contact the recipient within 20 days of delivery so that the encounter could be accomplished.	90% of recipients receive an encounter.
Documentation of Care Coordination Activities	All encounters are documented	100% of encounters are documented
Content of Care Coordination	Required encounters meet the guidelines specified in Section VI of the Operational Manual.	95% of encounters meet the required guidelines.
Service Database Verification-Content of data elements in the Service Database	The percentage of recipients for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) entered into RMEDE is reflective	90% of the total selected audit sample Service Database elements should mirror medical record and claims

	of medical records and claims documentation.	documentation.
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5. Standards

If program requirements are not met, corrective action will be requested. Districts will implement a Plan of Correction and submit a signed report to the Medicaid Maternity Care Program via fax, email or United States Postal Service within 15 working days of the request from Medicaid. The Primary Contractor must follow-up on identified issues to ensure that actions for improvement have been effective with a written and signed report of findings submitted to the Medicaid Maternity Care Program six months after the Corrective Action Plan has been implemented. If improvement is not noted in subsequent reviews, further actions may be taken including damages for cost associated with breach of contract as described in **Figure 9**.

Figure 9. Medical Record Reviews Standards and Damages for Cost Associated with Breach of Contract.

Measure	Damages for Cost Associated with Breach of Contract
Care Coordination Encounters	1 st occurrence: Corrective Action 2 nd occurrence: if below established benchmark with no improvement noted, \$500 per recipient
No Documentation of Care Coordination Activity	1 st occurrence: Corrective Action 2 nd occurrence: if below established benchmark with no improvement noted, \$700 per recipient
Content of Care Coordination	1 st occurrence: Corrective Action 2 nd occurrence: if below established benchmark with no improvement noted, \$500 per recipient
Content of Service Database- RMEDE Verifications	1 st Occurrence: Letter of Concern 2 nd occurrence: Corrective Action Subsequent Occurrences if below established benchmark, \$500 per occurrence
Source: Medical Record Reviews and claims data	

D. Missing in Service Database (RMEDE) Reviews

1. Purpose

The purpose of the Missing in Service Database (RMEDE Review) is to

ensure the Primary Contractor has entered valid data into RMEDE in a timely fashion for recipients for whom a global fee was paid.

Sample Size/Process

Reviews will be conducted quarterly, as explained in Operational Manual, Section XI.C.2.

All deliveries for an identified quarter will be chosen randomly from a DSS Query using claims data generated for a specific period of time.

2. Findings

After the review is completed and all data compiled, Primary Contractors will be provided a summary of the findings. Further review and/or a request for a corrective action plan may be necessary dependent on the review findings.

3. Elements and expectations of the Service Database (RMEDE) reviews are detailed in **Figure 10.**

Figure 10. Service Database (RMEDE) Reviews Elements and Expectations

Measure	What it is	Expectation
Timeliness and valid Service Database Entries for Missing in RMEDE Reviews	The percentage of recipients for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) are entered into the Service Database within 90 days of the delivery date and marked as complete.	100 % of patients for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) are entered into the Service Database within 90 days of the delivery date and marked as complete.
Validity of Service Database Entries for Missing in RMEDE Reviews	The percentage of recipients for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) are entered into the Service Database within 90 days of the delivery date with valid data compared to claims data.	95% of data entry for each recipient who delivered in the district review period will be without error.

4. Standards

If program requirements are not met, corrective action will be requested. Districts will implement a Plan of Correction and **submit written and signed report** to the Medicaid Maternity Care Program via fax, email or United States Postal Service within 15 working days of the request from Medicaid. The Primary Contractor must follow-up on identified issues to ensure that actions for improvement have been effective with a written and signed report of findings submitted to the Medicaid Maternity Care Program six months after the Corrective Action Plan has been implemented. If improvement is not noted in subsequent reviews, further actions may be taken including damages for cost associated with breach of contract as described **Figure 11**.

Figure 11. Service Database (RMEDE) Reviews Standards Damages for Cost Associated with Breach of Contract

Measure	Damages for Cost Associated with Breach of Contract
Timeliness of Service Database Data Entries for Missing in RMEDE Reviews Source: Claims Data	1 st occurrence: Corrective Action 2 nd occurrence: if below established benchmark, \$500 per recipient
Validity of Service Database Missing in RMEDE Reviews Source: Claims Data	1 st occurrence: Corrective Action 2 nd occurrence: if below established benchmark, \$100 per recipient

E. Corrective Action

The following standards will apply when the need for corrective action is identified:

1. There must be a written, defined corrective action plan.
2. The corrective action plan must be signed by the director.
3. The plan must be acceptable to and approved by AMA.
4. The Plan must be submitted within the required timeframe.
5. The plan must include:

- a. Specification of the types of problems requiring remedial/corrective action.
- b. Specification of the person(s) or body responsible for making the final determinations regarding quality problems.
- c. Specific actions to be taken.
- d. Provision of feedback to appropriate health professional, providers and staff.
- e. The schedule and accountability for implementing corrective actions.
- f. The approach to modifying the corrective action if improvements do not occur.
- g. Procedures for terminating the affiliation with the physician or other health professional or provider.
- h. Assessment of effectiveness of corrective actions. As actions are taken to improve care, there must be monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.
- i. Primary Contractor assures follow-up on identified issues to ensure that actions for improvement have been effective.

Imposition of these damages for cost associated with breach of contract may be in addition to other contract remedies and does not waive Medicaid's right to terminate the contract.

AGREEMENT TO RECEIVE CARE/RELEASE OF INFORMATION

I want to have good health while I am pregnant. I will try to do all things to help my baby to be born healthy.

I have been told that I can choose who will give me prenatal care.

I have chosen _____ (Doctor, midwife, clinic)

His/her address is _____. I want my baby to be delivered at

_____.

I have been told that I can change my mind about this choice within 90 days for any reason.

I have been told that I have the right to change my mind about who gives me care at any time there is a good reason.

I agree to go to doctors, clinics, hospitals and other places for care that are set up for me while I am pregnant and after my baby is born.

I agree to follow the plan of care that has been set up for me by my doctor, midwife or other person who provides my care.

I have been told that a real emergency is when I have a health problem that can cause death or lasting injury to my unborn baby or to me.

I have been told what my rights and responsibilities are under the Medicaid Maternity Care Program.

I have been told what I need to do if I have a problem that I cannot solve on my own.

I have reported other insurance that I have.

I have had the chance to ask questions about anything that I did not understand and to have my questions answered in a manner in which I understand.

I give my permission to _____ and any and all subcontractors, to perform tests and procedures necessary for my maternity care unless I have a religious or moral belief that prevents me from giving my permission. I give my permission for the release of my health information to providers for treatment purposes or to help with my care. I give my permission for the release of any information including medical records acquired in the course of my enrollment, treatment, or examination to the Alabama Medicaid Agency, my insurance company, or other entities as is necessary for reimbursement purposes.

I have been given a copy of:

_____ **Recipient Rights and Duties**

_____ **Agreement to Receive Care/Release of Information**

_____ **Enrollment Form (if different)**

_____ **Maternity Care Fact Sheet**

_____ **Care Coordinator Business Card with her name and telephone number**

Name _____ Medicaid # _____ DOB _____

Signature _____ Date Signed _____

Global Associated Codes

The following services are considered associated codes and are included in the global fee:

Procedure Code	Description
00842	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; amniocentesis
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium)
00942	Anesthesia for colpotomy, vaginectomy, colporrhaphy, and open urethral procedures)
00948	Anesthesia for cervical cerclage)
00950	Anesthesia for culdoscopy)
00952	Anesthesia for hysteroscopy and/or hysterosalpingography)
01958	Anesthesia for external cephalic version procedure
01960	Anesthesia for; vaginal delivery only
01961	Anesthesia for; cesarean delivery only
01965	Anesthesia for incomplete or missed abortions
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery
01968	Anesthesia for c-section delivery following neuraxial labor
01996	Daily hospital management of continuous epidural
10140	Incision and drainage of hematoma, seroma, or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst
10180	Incision and drainage, complex, postoperative wound infection
56405	Incision and drainage of vulva or perineal abscess
56420	Incision and drainage of Bartholin's gland abscess
56440	Marsupialization of Bartholin's gland cyst
56441	Lysis of labial adhesions
56820	Colposcopy of the vulva
56821	Colposcopy of the vulva with biopsy
57000	Colpotomy; with exploration
57010	Colpotomy
57020	Colpocentesis (separate procedure)
57022	Incision and drainage of vaginal hematoma; obstetrical/postpartum
57150	Irrigation of vagina and/or application of medicament
57400	Dilation of vagina under anesthesia
57410	Pelvic examination under anesthesia
57460	Colposcopy of the cervix including upper/adjacent vagina
59000	Amniocentesis, any method
59001	Therapeutic amniotic fluid reduction

Procedure Code	Description
59012	Cordocentesis (intrauterine), any method
59020	Fetal contraction stress test
59030	Fetal scalp blood sampling
59150	Removal of ectopic pregnancy
59160	Curettage, postpartum
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin)
59300	Episiotomy or vaginal repair by other than attending physician
59320	Cerclage of cervix, during pregnancy
59325	Cerclage of cervix, during pregnancy; abdominal
59350	Hysterorrhaphy of ruptured uterus
59400-U9	Routine obstetric care includes antepartum care, vaginal delivery (delivery at 39 weeks of gestation or later) (with or without episiotomy and/or forceps) and postpartum care
59400-UD	Routine obstetric care including antepartum care, vaginal delivery (medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy or forceps) and postpartum care
59400-UC	Routine obstetric care including antepartum care, vaginal delivery (non-medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy or forceps) and postpartum care
59409-U9	Vaginal delivery only (delivery at 39 weeks of gestation or later) (with or without episiotomy and/or forceps)
59409-UD	Vaginal delivery only (medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy and/or forceps)
59409-UC	Vaginal delivery only (non-medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy and/or forceps)
59410-U9	Vaginal delivery only (delivery at 39 weeks of gestation or later) (with or without episiotomy and/or forceps), including postpartum care
59410-UD	Vaginal delivery only (medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy and/or forceps), including postpartum care
59410-UC	Vaginal delivery only (non-medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy and/or forceps), including postpartum care
59412	Delivery; external Cephalic
59414	Delivery of placenta following delivery of infant outside of hospital
59425	Antepartum care only (4 to 6 visits)
59426	Antepartum care only (7 or more visits)
59430	Postpartum care only
59510-U9	Routine obstetric care including antepartum care, cesarean delivery (delivery at 39 weeks of gestation or later), and postpartum care
59510-UD	Routine obstetric care including antepartum care, cesarean delivery (medically necessary delivery prior to 39 weeks of gestation), and postpartum care
59510-UC	Routine obstetric care including antepartum care, cesarean delivery (non-medically necessary delivery prior to 39 weeks of gestation), and postpartum care
59514-U9	Cesarean delivery only (delivery at 39 weeks of gestation or later)

Procedure Code	Description
59514-UD	Cesarean delivery only (medically necessary delivery prior to 39 weeks of gestation)
59514-UC	Cesarean delivery only (non-medically necessary delivery prior to 39 weeks of gestation)
59515-U9	Cesarean delivery only (delivery at 39 weeks of gestation or later); including postpartum care
59515-UD	Cesarean delivery only (medically necessary delivery prior to 39 weeks of gestation) including postpartum care
59515-UC	Cesarean delivery only (non-medically necessary delivery prior to 39 weeks of gestation) including postpartum care
59610-U9	Routine obstetric care including antepartum care, vaginal delivery (delivery at 39 weeks of gestation or later) (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery
59610-UD	Routine obstetric care including antepartum care, vaginal delivery (medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery
59610-UC	Routine obstetric care including antepartum care, vaginal delivery (non-medically necessary delivery prior to 39 weeks of gestation) (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery
59612- U9	Vaginal delivery only (delivery at 39 weeks of gestation or later), after previous cesarean delivery (with or without episiotomy and/or forceps)
59612-UD	Vaginal delivery only (medically necessary delivery prior to 39 weeks of gestation), after previous cesarean delivery (with or without episiotomy and/or forceps)
59612-UC	Vaginal delivery only (non-medically necessary delivery prior to 39 weeks of gestation), after previous cesarean delivery (with or without episiotomy and/or forceps)
59614- U9	Vaginal delivery only (delivery at 39 weeks of gestation or later), after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59614-UD	Vaginal delivery only (medically necessary delivery prior to 39 weeks of gestation), after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59614-UC	Vaginal delivery only (non-medically necessary delivery prior to 39 weeks of gestation), after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59618- U9	Routine obstetric care including antepartum care, cesarean delivery (delivery at 39 weeks of gestation or later) and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59618-UD	Routine obstetric care including antepartum care, cesarean delivery (medically necessary delivery prior to 39 weeks of gestation) and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59618-UC	Routine obstetric care including antepartum care, cesarean delivery (non-medically necessary delivery prior to 39 weeks of gestation) and postpartum care, following attempted vaginal delivery after previous cesarean delivery

Procedure Code	Description
59620- U9	Cesarean delivery only (delivery at 39 weeks of gestation or later), following attempted vaginal delivery after previous cesarean delivery
59620-UD	Cesarean delivery only (medically necessary delivery prior to 39 weeks of gestation), following attempted vaginal delivery after previous cesarean delivery
59620-UC	Cesarean delivery only (non-medically necessary delivery prior to 39 weeks of gestation), following attempted vaginal delivery after previous cesarean delivery
59622- U9	Cesarean delivery only (delivery at 39 weeks of gestation or later), following attempted vaginal delivery after previous cesarean delivery; including postpartum care
59622-UD	Cesarean delivery only (medically necessary delivery prior to 39 weeks of gestation), following attempted vaginal delivery after previous cesarean delivery; including postpartum care
59622-UC	Cesarean delivery only (non-medically necessary delivery prior to 39 weeks of gestation), following attempted vaginal delivery after previous cesarean delivery; including postpartum care
59871	Removal of cerclage suture under anesthesia
59899	Unlisted procedure, maternity care and delivery
76801	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76802	Ultrasound, pregnant uterus, real time image documentation, with fetal and maternal evaluation
76805	Ultrasound, pregnant uterus, B-scan and/or real time with imagine documentation; complete
76810	Ultrasound, complete, multiple gestation, after the first trimester
76811	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76812	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76813	Ultrasound pregnant uterus, real time with image documentation, 1 st trimester
76814	Ultrasound for each additional gestation use in conjunction with 76813
76815	Ultrasound, limited (fetal size, heartbeat, placental location, fetal position, or emergency in the delivery room)
76816	Ultrasound, follow-up or repeat
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76818	Fetal biophysical profile
76819	Fetal biophysical profile; without non-stress testing
76820	Doppler velcocimetry, fetal, umbilical artery
76821	Doppler velocimetry, fetal, middle cerebral artery
76825	Echocardiography, fetal
76826	Echocardiography, fetal, follow-up or repeat study
76827	Doppler echocardiography, fetal
76828	Doppler echocardiography, fetal, follow-up or repeat study
81000	Urinalysis, by dipstick or tablet reagent

Procedure Code	Description
81001	Urinalysis, automated, with microscopy
81002	Urinalysis, non-automated, without microscopy
81003	Urinalysis, automated, without microscopy
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81007	Urinalysis; bacteriuria screen, except by culture or dip stick
81015	Urinalysis; microscopic only
81020	Urinalysis; two or three glass test
83026	Hemoglobin, by copper sulfate method, non-automated
83036	Hemoglobin, glycated
85013	Spun micro-hematocrit
85014	Blood count; other than spun hematocrit
85018	Blood count; hemoglobin
99058	Office services provided on an emergency basis
99201	Office or other outpatient visit for E&M
99202	Office or other outpatient visit for E&M
99203	Office or other outpatient visit for E&M
99204	Office or other outpatient visit for E&M
99205	Office or other outpatient visit for E&M
99211	Office or other outpatient visit for E&M
99212	Office or other outpatient visit for E&M
99213	Office or other outpatient visit for E&M
99214	Office or other outpatient visit for E&M
99215	Office or other outpatient visit for E&M
99217	Observation care discharge day management
99218	Initial observation care, per day, for E&M
99219	Initial observation care, per day, for E&M
99220	Initial observation care, per day, for E&M

DHCP EXPECTATIONS OF THE PRIMARY CONTRACTOR

As a subcontracting Delivering HealthCare Professional (DHCP) in the Maternity Care Program, you should expect the following considerations from your Primary Contractor (PC). The relationship between the DHCP and the Primary Contractor is a contractual relationship and in many ways is not specifically governed by the Agency. Each DHCP will need to appoint a representative to participate in a bi-annual conference call with Agency staff to discuss the Maternity Care Program.

- A Negotiation of reimbursement dependent on the array of services performed (e.g. delivery only, prenatal and delivery, anesthesia, etc.);
- Annual open enrollment for subcontractors;
- An adequate network of subcontractors to meet patient needs;
- Timely payment once claims are submitted to the PC. Current standards are within 20 calendar days of Medicaid payment no later than 60 calendar days of delivery with the exception of TPL;
- Strict Compliance with HIPAA and patient confidentiality standards;
- Implementation and maintenance of Quality Assurance system by which access, outcome and processes are measured on both a program and provider specific basis;
- Patient choice of DHCP;
- Community based outreach program to ensure awareness of the Maternity Care Program;
- A provider education plan (what to expect, how the system works, etc.);
- To fully explain what services are included in their global payment as well as what services are included in your contractual payment. For example, lab services (other than hemoglobin, hematocrit and u/a) are billable fee-for-service; however cerclages are in the global fee paid to the PC and may or may not be included in your contractual payment;
- To have a Director to be available, accessible, and/or on-call for any medical or administrative problems which may arise;
- Prohibition of discrimination against any recipient based on their health status or need for health services;
- Toll-free telephone service for recipients to ask questions, enroll in the program, etc.;
- An established education plan for recipients to include healthy life styles, planning for the baby, self-care, family planning, appropriate use of the medical system, etc.;
- A grievance procedure for both subcontractors and recipients that is easily accessible and is explained to the recipients upon entry into care;
- A Care Coordinator assigned to each of your patients to assist with the Medicaid enrollment process, psychosocial issues, education and other needs that may arise.

LETTER OF INTENT TO CONTRACT

The provider signing below is willing to enter into a contract with the __ (name of Primary Contractor) _____ as a subcontractor for the provision of covered services to Medicaid eligibles enrolled with the __ (name of Primary Contractor) _____. This provider agrees to sign a contract with __ (name of Primary Contractor) _____, if said Primary Contractor is awarded a Medicaid contract beginning January 1, 2010 for __ (district #) _____ eligibles. Signing this letter of intent obligates the provider to sign a contract with __ (name of Primary Contractor) _____.

All subcontractors shall comply with Title VI of the Civil Rights Act of 1964 (42 USC §2000d, et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 USC §6101, et seq.), the Americans with Disabilities Act of 1990 (42 USC §2101, et seq.), and the regulations issued thereunder by the Department of Health and Human Services (45 CFR Parts 80, 84 and 90). No individual shall, on the ground of race, sex, color, creed, national origin, age or disability be excluded from participation in, be denied the benefits or, or be otherwise subjected to discrimination under any program of services.

The following information is furnished by the subcontracting provider:

1. Check all that apply: ___ DHCP ___ Prenatal Care Only
___ Other: specify: _____
2. Printed Name: _____ NPI: _____
3. Address: _____ City _____ State _____ Zip _____
(where services will be provided)
4. Telephone: _____ Fax: _____ Email: _____
5. Counties from which I will take patients: _____
6. If DHCP, hospital privileges held at: _____
7. Payment Arrangement: _____

Provider Signature

Date Signed

Printed Name/Relation of Signer

Office Contact

MATERNITY CARE PROGRAM FACT SHEET

1. To enroll in the Maternity Care Program you must apply for Medicaid. You must be eligible for Medicaid to participate in the Maternity Care Program.
2. You must live in one of these counties: (list counties of your district)
3. You may only go to doctors, nurse midwives, clinics, hospitals and other maternity providers that are a part of the name of your program goes here. Example, Viva, Alabama Baby Care) Program.
4. Medicaid will not pay for any of your maternity care if you go to any medical provider that you are not enrolled with or one who is not part of the Maternity Care Program where you live. If you do this and it is not an emergency you will have to be responsible for paying the bill.
5. Tell your Care Coordinator if: you change your address or phone number; you move to another county or state; you miss a doctor's appointment; you go to the emergency room at a hospital for any reason; you have a question about your pregnancy or you need help with something.
6. You should follow all instructions given to you by your care coordinator and doctor or nurse midwife you have chosen.
7. If you change your mind about your choice of doctor or nurse midwife or hospital where you want your baby to be delivered tell your Care Coordinator.
8. Keep the card that has the name and information about your Care Coordinator on it and your Medicaid card. You will be asked to show both of these cards during your pregnancy.

Application Assisters

Application Assisters are individuals that have been trained to assist an individual with the Medicaid application process. Primary Contractors are required to provide Application Assister services to Medicaid recipients. The intent is to address barriers that may prevent the individual from becoming Medicaid eligible in a timely manner and, more importantly, beginning her prenatal care as soon as possible.

Application Assisters should understand that their functions are limited to initial processing activities and that Medicaid employees continue to make all eligibility determinations.

Application Assisters will conduct themselves in a manner so as to avoid any conflict of interests. The Application Assisters will not process applications for relatives, friends, or any other persons for whom doing so could reasonably be perceived as constituting a conflict of interest. The Application Assisters will refer any questionable cases to Medicaid for handling.

Primary Contractor Responsibilities

The Primary Contractor will ensure that Application Assister services are provided to Medicaid recipients.

The Primary Contractor will ensure that the Application Assister understands that functions are limited to assisting applicants in these ways:

- Taking/accepting applications
- Completing the Medicaid eligibility application #291, preferably online at www.insurealabama.org.
- Use of online applications is preferred, however, if a paper application is used, the Contractor will forward all completed #291 applications to the designated Medicaid eligibility contact person.
- Providing information and referral on related programs and services.
- Obtaining required documentation needed to complete processing of the application.
- Assuring completeness of the information contained on the application.
- Conducting interviews.

Training

Application Assister training is provided free of charge by the Alabama Medicaid Agency staff. The Contractor shall have an individual (s) designated as a trainer for the Train-the-Trainer program. The designee must attend the Train-the-Trainer class and provide certification training to Application Assisters as deemed necessary in order to maintain compliance with certification and re-certification requirements. The certification period for Application Assisters and the Train-the-Trainer designee is every two years. Each Application Assister must be trained prior to assisting with the application process. The training will cover all requirements under initial processing functions.

POSTPARTUM HOME VISIT SUMMARY

MOTHER'S INFORMATION

Patient Name:	Medicaid #:	DOB:	Age:	Race:
Delivery Date:	Type of Delivery:	Delivery Time:	Gest Age @ Delivery:	Hospital D/C Date:
Address:			County:	
Phone Number:		Alternate Phone Number:		
Directions to Home:				

REASON FOR HOME VISIT

VISIT ATTEMPTS

(Check all that apply)		Date	Type of Attempt
<input type="checkbox"/> Under 16 years of age	<input type="checkbox"/> Birth weight	_____	_____
<input type="checkbox"/> Drugs and Alcohol	<input type="checkbox"/> Other: (specify)	_____	_____
<input type="checkbox"/> Missed hospital encounter	<input type="checkbox"/> Partner Abuse	_____	_____
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> No Home Visit Needed	_____	_____

PSYCHOSOCIAL ASSESSMENT

Problems/Issues	YES	NO	Comments
Poor previous parenting experience			
Poor support system			
Literate			
Areas of anxiety noted			
Drugs, Alcohol, Tobacco Usage			
Conflict/ Violence noted in home			
Appropriate newborn/mother attachment			
Support systems present			
Mother able/willing to provide needed infant care			
Father able/willing to provide needed infant care			
Emotional status (Tearful, moody, anxious, depressed)			
Fatigue/Exhaustion			
Sleep disturbances			
Adequate living arrangements			
Other areas of need			
Referrals made			

PHYSICAL ASSESSMENT

Temperature:	BP:		Pulse:	Respirations:
Problems	Yes	No	Comments	
Breasts				
Perineum				
Lochia				
Abdomen (fundus)				
Incision site (signs of infection)				
Edema (location)				
Respiratory status				
Pain				
Appetite/Fluid intake				
Bladder/Bowel Function				

EDUCATION/COUNSELING

Teaching (Check areas discussed/or pamphlets given)
<input type="checkbox"/> Breast Care <input type="checkbox"/> Breast Feeding <input type="checkbox"/> Perineum Care <input type="checkbox"/> Hygiene <input type="checkbox"/> Nutrition <input type="checkbox"/> Incision Care <input type="checkbox"/> Bathing <input type="checkbox"/> Family Planning/Birth Control <input type="checkbox"/> Sexual Relations <input type="checkbox"/> Educational Materials/Pamphlets provided <input type="checkbox"/> Other
Comments:

SAFETY ASSESSMENT

<input type="checkbox"/> Workable Smoke Detector <input type="checkbox"/> Car Seat Available/Used <input type="checkbox"/> Inside Pets <input type="checkbox"/> Crib Safety <input type="checkbox"/> Telephone <input type="checkbox"/> Refrigeration <input type="checkbox"/> Adequate Cooling <input type="checkbox"/> Adequate Heating <input type="checkbox"/> Vermin infestation
Comments:

Visiting Nurse Signature:	Date of Visit:
----------------------------------	-----------------------

POSTPARTUM HOME VISIT SUMMARY

INFANT INFORMATION			
Infant name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth complications:	
Birth weight:	Current weight:	<input type="checkbox"/> Bottle fed <input type="checkbox"/> Breast fed	<input type="checkbox"/> Tolerates Feedings
Formula:	<input type="checkbox"/> Ounces every <input type="checkbox"/> Hour	<input type="checkbox"/> Ounces Water per day	<input type="checkbox"/> Wet Diapers per day <input type="checkbox"/> Stools per day
Medications:			
Pediatric Provider:			

INFANT PHYSICAL ASSESSMENT

Temperature:	Heart rate:	Respiratory rate:	
Problems	Yes	No	Comments
Skin: Pink nail beds/Mucous membranes			
Jaundice			
Rash			
Other			
Neurological: Lethargic			
Hyper/Hypotonic			
Crying (high pitched, non-consoling)			
Symmetrical eye movement			
Other			
Cardiovascular: Tachycardia/Bradycardia			
Irregular heart rate			
Other			
Respiratory: Rales/Rhonchi			
Cough (dry, productive, etc.)			
Nasal drainage (color, consistency)			
Other			
Gastrological: Abdominal distention			
Other			
Genitourinary: Abnormal genitalia			
Circumcision			

MEDICAID MATERNITY CARE PROGRAM RECIPIENT RIGHTS AND DUTIES

You have the following rights and duties when you agree to be a part of the Maternity Care Program.

You have the right:

- To get good medical care for your pregnancy close to where you live.
- To get care during your pregnancy regardless of your overall health, your past medical history or any health problems you have now.
- To have care or treatments explained to you ahead of time and to refuse any care or treatment you do not want or that goes against your religious or personal beliefs.
- To decide about the care you get during your pregnancy and to give your permission before the start of treatment or surgery.
- To be told about any treatments that are proper for your condition in a way that you can understand.
- To know about all of the people who will be taking care of you during your pregnancy.
- To get care that is free of any restraint or action that is meant to force you to do something, punish you, or to get even with you.
- To get emergency care from **any hospital** if you have a **real emergency**. A real emergency is when you have a health problem that can cause lasting injury or death to you or your unborn baby.
- To choose where you want to get medical care for your baby.
- To choose what kind of birth control you want and where you want to get it.
- To be treated with respect, dignity and privacy.
- To have your medical records kept private.
- To get a copy of your medical record and to ask that the record be changed if it is not correct.
- To sign an Advance Directive saying what kind of care you want if you are too sick or hurt to decide about your care.
- To donate your organs if you die.
- To file a grievance or complaint if you are not satisfied with your care, how you were treated, or if your rights were not respected and you want action taken to solve the problem.

Filing a grievance:

- ✓ You have the right to have someone to talk with you about how you feel.
- ✓ Call the person who signed you up with the maternity care program or write a letter explaining why you are not pleased. Give the letter to that person or mail it to Medicaid, P.O. Box 5624, Montgomery Alabama 36103-5624.
- ✓ Medicaid will still pay for your pregnancy care if you were on Medicaid at the time you filed the grievance.
- ✓ If there is no action within 10 working days, you have the right to file an appeal to ask that someone else look into your complaint
- ✓ You have the right to an interpreter if you do not understand English or if you have any type of speaking or hearing disability
- ✓ If you need help to file a grievance, call your Care Coordinator or the toll free number for the district where you live.
- ✓ If your grievance is against the doctor that you picked, you may choose another doctor.

You have the duty:

- To go to doctors and hospitals in your area that you have agreed to see for pregnancy care. Your Care Coordinator will show you a list of all the doctors and hospitals in your area and you will choose a doctor and hospital.
- To go to all of your appointments. If you have a problem getting to your appointment, your Care Coordinator will help you with getting transportation.
- To follow the directions you get from your doctor or nurse for your pregnancy. You also have the duty to follow the plan of care that you and your Care Coordinator set up to help you have a healthy baby.
- To meet with your Care Coordinator and let her know if anything about you or your pregnancy changes.
- To report to the Care Coordinator if you move, if your Medicaid changes, or if you miscarry the baby.
- To take only the medicine that your doctor has told you to take. This includes over the counter medicine like aspirin, Tylenol, Tums, etc.

- To have a healthy lifestyle and to eat right.
- Not to smoke cigarettes or use drugs.
- To notify the Medicaid office worker of the birth of your baby

Federal rules require that Medicaid recipients take steps to prevent fraud and abuse of the program. These steps include:

- Keeping their Medicaid identification card in a safe place
- Not selling, loaning or altering their Medicaid card in order to obtain services for others
- Following the rules for Medicaid and the doctor's/clinic's office
- Telling Medicaid about third party insurance or payments
- Notifying Medicaid of any changes in income, living arrangements or resources

All cases of suspected fraud, abuse or misuse by recipients are investigated by the Alabama Medicaid Agency. Recipients who are proven to have abused or misused the Medicaid programs be required to repay the agency for any misspent funds and/or may be suspended from the program for at least one year and until full restitution is made.

Reporting Fraud and Abuse

Recipients may report suspected fraud, abuse or misuse of the Alabama Medicaid program by calling or writing the Agency's Program Integrity Division.

To call: 1-866-452-4930 (Toll-free call)

To write: Program Integrity Division, PO Box 5624, Montgomery, AL 36103-5624

A person reporting suspected fraud and abuse is not required to give his/her name. Any information provided is kept confidential.

PROTOCOLS FOR SCREENING PREGNANT WOMEN
FOR PARTNER ABUSE

All pregnant women shall be asked routine questions regarding domestic violence issues in their lives. A sample of questions that may be used is listed below:

- Is your partner excited about the baby?
- How is your family reacting to this pregnancy?
- How are you and your partner getting along? Is he helping you to complete tasks that you are unable to do?
- How are things at home?
- Is anything preventing you from coming to the clinic?
- Since your pregnancy began, have you been kicked, slapped, or otherwise physically hurt by someone?
- Within the last year has anyone forced you to engage in sexual activities that made you feel uncomfortable?
- Do you feel that you are being stalked by anyone?
- Has your partner ever destroyed things that you cared about?
- We all disagree at times at home. What happens when you or your partner fight or disagree?
- Has your partner ever prevented you from leaving the house, seeing friends, getting a job or continuing your education?
- Is your partner jealous of the time you spend with your family or friends?
- Does your partner drink alcohol or use drugs?
Is there a gun in the house?

If yes to any of the above:

- Would you like help with any of this now?
- Would you like us to send a copy of this form to your DHCP?

The following indicators require timely follow-up:

- Late and/or sporadic access to prenatal care
- Injury to the breast(s) and/or the abdomen
- Divorce or separation during pregnancy
- Vaginal bleeding
- Self-induced or attempted abortion
- Increased alcohol or drug use
- Miscarriage
- Multiple abuse injury sites
- Low maternal weight gain
- Short inter-pregnancy interval
- Poor nutrition
- Premature labor
- Depression or less happiness about the pregnancy
- Suicidal ideation
- Frequent clinic/visits for somatic complaints (insomnia, hyperventilation, etc.)
- Recurrent STDs, pelvic infections or HIV
- Evidence of noncompliance with treatment/care plan

If a case of domestic violence is identified and the woman is willing, the referral process shall be implemented. Alabama has shelters statewide that can provide counseling support for victims of domestic violence. The statewide hotline number is **1-800-650-6522**. If a woman is not willing to call the shelter, the case manager should encourage the completion of a safety plan. The plan can help the woman better prepare for her safety when a violent situation arises.

District:

Quality Improvement Activity Form

Activity Number		Activity Name:		By Whom or How was issue / concern identified:	
Initial Submission:					
Continued:					
Discontinued:					
Overview of Activity:					
Numerator	Denominator	Baseline	Benchmark:	Measurement Period:	
Description of Population:		Sample Size:		Sampling Methodology:	
				Data Collection Method <input type="checkbox"/> Administrative <input type="checkbox"/> MRR <input type="checkbox"/> Claims <input type="checkbox"/> Other, explain	
Why is Activity Relevant?					
Opportunities for Improvement			Barriers		
Interventions		Timeline		Outcome	
Plan:					
Analysis Conducted by:			Responsible Party:		

The following is an example of the form and format to be used when reporting a quality improvement activity.

District Quality Improvement Activity Form Example

Activity Number: 003 Initial Submission: 2003 Q1 Continued: Yes Discontinued:	Activity Name: VLBW Deliveries at non high-risk facilities.	By Whom or How was issue / concern identified: QI Committee / Administration		
Overview of Activity: The QI Committee reviewed statistics presented at the August 2002 committee meeting for FYI 2000 and FYI 2001 program data. It was noted at this time that an overall decrease in LBW and preterm deliveries had occurred from one year to the next, however the percentage of these deliveries being VLBW deliveries increased in both districts. The QI committee recommended requesting data from the state to determine if there was a statewide trend. Sue requested and received masked data from the other State programs, which confirmed a statewide trend for increased VLBW deliveries as a total percentage of LBW deliveries. This data comparison was presented at the November 2002 committee meeting and Sue expressed interest in conducting a focused review of the VLBW population, this idea was supported and quality indicators were identified. The plan at this time was to develop an auditing tool for presentation at the next quality committee meeting. This review would be conducted to evaluate trends in VLBW deliveries, in particular the site of delivery and determine intervention strategies, as determined appropriate.				
Numerator N/A D0- LBW 2000 = 12% 2001 = 9.4% D0- VLBW 2000 = 13% OF LBW 2001 = 20% OF LBW	Denominator D0- LBW 2003 - 10.92% D0- VLBW 2003 - 13.67% of LBW D0 - 2003 HR Facility delivery of VLBW = 50%	Baseline VLBW = 20% of LBW FYI 2001 VLBW 63% at HHS 10% at UAB = 73% at subspecialty care facility. FYI 2001 VLBW 9% of the total program VLBW deliveries occurred outside of a high risk facility in D1 FYI 2003 VLBW	Benchmark: Alabama Medicaid Agency = 15% of LBW population is VLBW. “VLBW neonates should be delivered in a subspecialty care facility whenever possible.” Perinatal Standards of Care Fifth Edition, Page 163	Measurement Period: April through June 2004. July-September 2004 October-December 2004 Jan - Mar 2005 March 2005 – October 2005
Description of Population: Medicaid eligible women enrolled in the Program.	Sample Size: 100% of VLBW deliveries occurring outside of a recognized high-risk facility. (HHS or UAB)	Sampling Methodology: <input type="checkbox"/> Medical Record reviews	Data Collection Method <input type="checkbox"/> Administrative <input type="checkbox"/> MRR <input type="checkbox"/> Claims <input type="checkbox"/> Other, explain	

<p>Why is Activity Relevant? Medical Record Review of the VLBW deliveries occurring at non high-risk facility will determine if any trends exist. If trends are identified these can be addressed, which could potentially contribute to an increase in the number of VLBW occurring at high-risk facilities. Increasing the number of VLBW deliveries occurring at subspecialty care facilities ensures optimal care delivery resulting in improving neonatal outcomes and decreased cost to the State of Alabama.</p>		
<p>Opportunities for Program / Activity Improvement See above (Why is Activity Relevant?)</p>		<p>Barriers</p> <ol style="list-style-type: none"> 1. Timeliness of notification of VLBW deliveries. 2. Access to medical records for out of network high risk services i.e. UAB.
<p>Interventions (number each step)</p> <ol style="list-style-type: none"> 1. Develop a tool based on quality indicators presented at the November 2002 QI committee meeting for presentation at the next committee meeting. 2. Based on VLBW tool as proposed prior to the March QI meeting. Run statistics on the indicator data for 2001 VLBW deliveries. 3. Present percentage of VLBW deliveries by hospital 4. Finalize the assessment tool based on feedback from the March 2003 QI committee meeting. 5. Review VLBW deliveries occurring outside of high-risk facilities using the tool as approved by the QI Committee. 6. Provide feedback on reviews to the QI committee 	<p>Timeline</p> <ol style="list-style-type: none"> 1. QI meeting March 2003 2. QI meeting March 2003 3. QI meeting March 2003 4. April – May 2003 5. Begin Quarter 2 2003 (<i>Variance reviews began quarter 3</i>) ** could not justify travel to review one record at each Site. Reviews are scheduled in conjunction with random and focused folic acid assessment reviews. 6. Quarter 3 2003 (September 19th 2003) QI meeting 	<p>Desired Outcome</p> <ol style="list-style-type: none"> 1. Positive Committee feedback on the quality of the tool 2. That the data will help to identify trends, provide insight into what needs to be added to the review tool, contribute to the overall understanding of our VLBW population and stimulate interest in the project. 3. That committee would have a baseline idea of the significance of the problem. Note: Committee members present at the March meeting were pleased that 73% of the VLBW deliveries had occurred at high-risk facilities. 4. Tool will be ready for identified VLBW deliveries beginning Quarter 2 2003 5. That potential VLBW deliveries are identified, that appropriate prenatal assessment is conducted, that plans are in place for delivery at a high-risk facility and that delivery occurs at a high-risk facility, when appropriate. 6. Feedback on identified trends and recommended interventions. One VLBW delivery was reviewed for

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<p>7. Follow-up with hospital to assess level of care (OB and Neonatal), policies and procedures for: initial assessment and maternal and neonatal transfer</p> <p>8. Provide feedback on reviews to the QI committee for DHCP patients: 000 - delivered at ___ at 28 wks, baby transported to high risk hospital 5 days after delivery of IUGR 28 wk 2-6 baby, PROM. HX. PTD</p> <p>9. Establish a mechanism for review of records onsite to allow for more through examination of record. This will allow for review by Medical Director, as indicated.</p> <p>10. Mail to office request for records for all VLBW deliveries that did not deliver at a high risk facility according to the Service Report data keyed into a database for statistical analysis...</p> <p>11. Review VLBW deliveries with the Medical Directors evaluation of those deliveries, which are questionable.</p> <p>12. Run complete statistics for 2002 on this quality indicator and continue individualized reviews as the records are obtained from the offices</p> <p>13. Present a summary of the VLBW records reviewed at the QI committee meeting set for March 12, 2004</p> <p>14. Request 2 outstanding records from 000 and 000.</p>	<p>7. Prior to next QI meeting Quarter 4 2003 <i>*scheduled November 2003</i></p> <p>8. Prior to next QI meeting Quarter 4 2003 November 14, 2004</p> <p>9. Deadline: 01-2004</p> <p>10. Deadline: 02-2004</p> <p>11. Deadline QI meeting 03-12-2004</p> <p>12. Deadline QI meeting 03-12-2004</p> <p>13. Deadline QI meeting 03-12-2004</p> <p>14. Deadline 04-01-2004</p>	<p>Quarter 1 2003 District 0. Time for transfer from hospital to high-risk facility noted. This was presented at the September meeting with the following recommendations:</p> <p>7. Care was provided according to recognized standards of care and in accordance with hospital policies and procedures based on the level of care provided at the hospital</p> <p>8. Maternal transport occurs if appropriate</p> <p>9. Provide a more comprehensive review that allows for MD oversight</p> <p>10. Complete medical record for evaluation by staff and Medical Director, as indicated</p> <p>11. Complete medical record for evaluation by staff and Medical Director, as indicated.</p> <p>12. To meet program goals for VLBW as percentage of LBW deliveries and determine areas of focused concentration.</p> <p>13. To review 100% of the sample available through the program.</p> <p>14. To improve accurate recording of data on the Service Report to ensure appropriate sampling for VLBW deliveries occurring at non</p>
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<p>15. Discuss with the Care Coordinators the significance of recording delivery site accurately</p> <p>16. Develop a policy and procedure for medical record handling.</p> <p>17. Run statistics on VLBW deliveries by DHCP and site of delivery in addition to an overall statistical summary.</p> <p>18. Determine QI Committee opinion on activity continuation.</p> <p>19. Run statistics on VLBW deliveries by DCHP and site Of delivery. Continue to trend for 6 additional Months.</p> <p>20. Run statistics on VLBW deliveries by DHCP and site Of delivery. Continue to trend for 3 months.</p> <p>21. Run statistics on VLBW deliveries by DHCP and site of delivery. Continue to trend for 3 months.</p> <p>22. Run statistics on VLBW deliveries by DHCP and site of delivery. Medicaid reported at Jam Session on 09/30/05 that this was now considered a known measure and should be reported, but not as a quality measure...</p> <p>23. Continue to run statistics of V LBW deliveries by DHCP and site of delivery. Taking the recommendations made by Medicaid, we will continue to gather data but not for a quality measure. Dr. voiced concern over outliers and suggests that we continue to trend a while longer to also gather data, but not for a quality measure.</p>	<p>15. Deadline next Care Coordinator meeting - tentatively set for 05-14-2004</p> <p>16. Deadline next QI Committee meeting 06-2004. Cancelled and rescheduled to 08-20-2004 per State approval.</p> <p>17. Next QI Committee meeting tentatively scheduled for 08-2004.</p> <p>18. QI meeting scheduled for 08-20-2004</p> <p>19. QI meeting December 3, 2004.</p> <p>20. QI Committee Meeting March 11, 2005.</p> <p>21. Present to QI Committee Meeting in October 2005 for recommendation</p> <p>22. Present Medicaid's recommendation to QI Committee meeting in October 2005 and discuss closure of activity 003.</p> <p>23. Re-evaluate trends at February 2006 QI Committee meeting and discuss closure of activity 003.</p>	<p>high-risk facilities.</p> <p>15. Awareness of the consequence of inaccurate recordings.</p> <p>16. Protection of PHI</p> <p>17. Assess for any statistical trends in delivery by DHCP for VLBW infants at non high-risk facilities</p> <p>18. Continue or discontinue activity.</p> <p>19. Assess trends. Continue to trend data. Report findings to QI Committee.</p> <p>20. Continue to trend data for 3 months. Report findings to QI Committee. Request re-review of activity continuance.</p> <p>21. Continue to trend data for 3 months. Report findings to QI Committee. Request re-reviews of activity continuance.</p> <p>22. Continue to trend data awaiting final approval by QI Committee in October 2005 to discontinue activity.</p> <p>23. Continue to trend data awaiting approval by QI Committee in February 2006 to discontinue activity.</p>
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<p>24. Continue to run statistics by DHCP and site of delivery. Since Medicaid recommended this activity is a known measure, Medicaid and PC will continue to trend the data, but not for a quality measure. Recent trending analysis results revealed that from Jan. – Nov. 2005 revealed 23 VLBW babies born outside High Risk facilities. Of the 23, a rate of 26% belonging to DHCP 000. There were 2 sets of twins in which 1 baby fit the criteria and 1 did not, in both sets. The QI Committee voted to investigate the twins' records of DHCP 000 further before deciding whether to include them in the data gathered for final analysis.</p> <p>25. Seventeen prenatal and delivery records of VLBW were received for review. There were 2 records from District that were questionable as to whether the babies should have been transferred to a High Risk facility for delivery. We will continue to trend this activity but not for a quality measure. Presented the summaries at the May 2006 QI committee meeting.</p> <p>26. Four prenatal / delivery records of patient's with VLBW were received for review from Districts. There was one VLBW delivery recorded from 000 in District. This record was reviewed by the QI Committee. There were no trends noted for confrontation with any DHCP's at this time. We will continue to trend this activity but not for a quality measure. Presented the summaries at the August 2006 QI committee meeting.</p> <p>27. Four prenatal / delivery records of patient's with VLBW were received for review from District. Summaries of each patient were presented at the Dec. 2006 QI Meeting. The QI committee members reviewed the records. Although two of the VLBW records were from (000), OB/GYN and two were noted from (000) –</p>	<p>24. Re-evaluate and present trends at May 2006 QI Committee meeting and discuss recommendations.</p> <p>25. Re-evaluate and present trends at August 2006 QI Committee meeting and discuss recommendations.</p> <p>26. Re-evaluate and present trends at December 2006 QI Committee meeting and discuss recommendations.</p> <p>27. Re-evaluate and present trends at March 2007 QI Committee meeting and discuss recommendations</p>	<p>24. Continue to trend and assess data. Report findings to QI Committee. Request review of activity continuance.</p> <p>25. Continue to trend and assess data. Report findings to QI Committee. Request review of activity continuance.</p> <p>26. Continue to trend and assess data. Report findings to QI Committee. Request review of activity continuance.</p> <p>27. Continue to trend and assess data. Report findings to QI Committee. Request review of activity continuance.</p>
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<p>Dr O., the QI members all agreed that the deliveries occurred abruptly and were monitored appropriately. The committee did not find anything inappropriate with the 4 VLBW deliveries. We will continue to trend this activity but not for a quality measure.</p> <p>28. Continue to run statistics by DHCP and site of delivery. Since Medicaid recommended this activity is a known measure, Medicaid and PC will continue to trend the data, but not for a quality measure. Recent trending analysis results revealed that from 09/06 – 10/06, 3 VLBW babies were born outside of high risk facilities in District. Summaries of each patient were reviewed at the March QI meeting by committee members. QI members agreed that all the deliveries were monitored appropriately. The committee did not find anything inappropriate with the 3 VLBW deliveries.</p>	<p>28. Re-evaluate and present trends at June 2007 QI Committee meeting and discuss recommendations.</p>	<p>28. Continue to trend and assess data. Report findings to QI Committee. Request review of activity continuance</p>
<p>Plan: Presented the summaries of the VLBW records received for review to the March 2007 QI Committee meeting. The committee voted to continue to trend this activity but not for a quality measure. Will continue to utilize the Medicaid database to run report on VLBW deliveries for each quarter. Continue to trend and gather data for those deliveries occurring outside high risk facilities. Present any trends at each QI Committee and Care Coordinator update meetings. Continue trending, analysis, and reporting indefinitely or until closure of</p>		
<p>Analysis Conducted by: Clinical Program Specialist</p>	<p>Responsible Party: Clinical Program Specialist</p>	

Purpose: To provide a summary of the affect of quality assurance activities undertaken in response to concerns identified by the Primary Contractor (PC). This form is to be completed for each activity undertaken prompted by the Medicaid’s QI Program or the Primary Contractor’s internal QA committee.

- In completing the Quality Improvement Activity Summary provide complete details of the activity undertaken.
- Noting the following:
- Was there improvement?
- Was the process by which improvement measured valid?
- Were data analyses appropriate?
- Were strong actions implemented?
- Were actions timely?
- Does this activity demonstrate meaningful improvement?
- Is there clarification as to why this activity has or has not demonstrated meaningful improvement?
- Is follow- up required? If so what is the Plan?

**MATERNITY CARE PROGRAM
ADMINISTRATIVE REVIEW REQUEST FORM**

___ **ONLY Check this box if it is a HIGH RISK claim related to a delivery at USA or UAB**

Please attach original red drop-out claim forms for the recipient listed. If the claim is not included, this form will be sent back to you. This will cause a delay in administrative review process and claim processing. Primary Contractors are required to forward claims received from subcontractors to Medicaid within 5 working days.

Recipient Name _____ **DOB** _____

Medicaid # _____ **County Code** ___ **EDC** _____

Type (check one) ___ **Dropout** ___ **Outdated claim** ___ **Other**

Explanation for review request: _____

Claims Attached:

- | | |
|--|--|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Anesthesiology |
| <input type="checkbox"/> Clinic Antepartum Provider | <input type="checkbox"/> Other |
| <input type="checkbox"/> Radiology/Ultrasound | |

Date Dropout Fee Claim Filed?: **Yes** **No** **Date:** _____

Primary Contractor: _____ **District:** _____

Submitted By: _____ **Phone No.:** _____

Medicaid Use Only:

Date Reviewed: _____ Date Sent to EDS: _____ Date Returned to PC for add info: _____

Notes by Reviewer:

**MATERNITY CARE PROGRAM
EXEMPTION REQUEST FORM**

MEDICAID RECIPIENT INFORMATION

NAME _____ DOB _____ EDC _____

ADDRESS _____ City _____

COUNTY _____ ZIP _____ DISTRICT _____

MEDICAID # _____ PRIMARY CONTRACTOR _____

DATE STARTED PRENATAL CARE: _____

Signature of Program Director _____ Date _____

REASON FOR EXEMPTION REQUEST

1. MEDICAID ELIGIBILITY GRANTED LATE IN PREGNANCY _____

Date of Medicaid application _____ (date must be verified)

Has the non-subcontracted provider agreed to continue pregnancy care and delivery for the recipient? _____

2. HMO INSURANCE

Name of Insurance Company _____

Policy # _____ Effective Date _____

3. Other ___ Please attach documentation

FOR MEDICAID USE ONLY

Date Returned _____ Approved _____ Denied _____

Reason _____

Maternity Care Program Smoking Cessation

1. _____ was smoking _____ cigarettes per day at her first visit.
2. _____ was not smoking at her first visit.
3. Smoking Cessation information given on _____.
4. Provided **Smoking Quitline number 1-800-Quit-Now (1-800-784-8669)** on _____.
5. Counseled on Smoking and Effects on Pregnancy on _____.
6. _____ was not smoking as per interview at postpartum visit.

1st Encounter

Date	Smoking Status	Action Taken	Initials
	<input type="checkbox"/> Smoking <input type="checkbox"/> Has Quit <input type="checkbox"/> Using Patches	Counseled and <input type="checkbox"/> Provided support <input type="checkbox"/> Praised and provided support	

2nd Encounter

Date	Smoking Status	Action Taken	Initials
	<input type="checkbox"/> Smoking <input type="checkbox"/> Has Quit <input type="checkbox"/> Using Patches	Counseled and <input type="checkbox"/> Provided support <input type="checkbox"/> Praised and provided support	

Other Encounter

Date	Smoking Status	Action Taken	Initials
	<input type="checkbox"/> Smoking <input type="checkbox"/> Has Quit <input type="checkbox"/> Using Patches	<input type="checkbox"/> Counseled <input type="checkbox"/> Praised	

Service Database Web Elements

Medicaid ID Number
Social Security Number
Last Name, First Name
Date of Birth
Race
County Code
Prenatal Provider Number
Prenatal Gravida/Para
Date of 1 st Prenatal Visit
Weeks Gest. At 1 st Visit
Total # PNC Visits
Psychosocial Risk Status At Time of Enrollment
Date of Last Pregnancy
Previous Fetal Loss
Previous Preterm Births Less Than 37 Weeks
Diabetic Counseling
Diabetic Counseling Visit Date
Pre Maternal Weight
Post Maternal Weight
Smoker or Recent Quitter
Smoking Cessation until Postpartum Visit
Delivery Provider
Delivery Hospital
Delivery Date
Postpartum Care Coordination Encounter
Postpartum Encounter Completed within 20 Days
Total # of Care Coordination Encounters Completed
Psychosocial Risk at Delivery
Delivery Induced
Delivery Induced Reason
Gestational Age at Delivery Weeks
Pregnancy Outcome
Maternal Death
Maternal Death Pregnancy Related
Maternal Death Date
Type of Delivery
Infant Number 1
Infant Weight # 1
Infant in NICU #1
Infant Number 2
Infant Weight #2
Infant in NICU #2

Service Database Web Elements

Infant Number #3
Infant Weight #3
Infant in NICU #3
Infant Number 4
Infant Weight #4
Infant in NICU #4
Infant Number 5
Infant Weight #5
Infant in NICU #5
Home Visit Completed
Postpartum Visit Date
Breastfeeding at hospital discharge
Breastfeeding at Postpartum Medical Visit
Family Planning Visit Completed
Postpartum Visit Completed
Birth control method
Status

This format is to be used to report meeting minutes to the Agency.

PRIMARY CONTRACTOR'S NAME QUALITY ASSURANCE COMMITTEE MEETING MINUTES

District:
Date:
Quarter:
Location:

Members Required	Members Name	Present/Absent	Comments
Program Director			
OB/GYN or Family Practice/Delivering Physician			
RN w/ OB experience			
Licensed Social Worker			
Members Recommended			
Medicaid Consumer			
Other			

Call to Order:

Approval of Minutes:

Agenda:

(To include but not limited to)

- I. Evaluation of Enrollment Process
- II. Grievances
- III. Internal and External QAPI activities
- IV. Performance Improvement Project
- V. Subcontractors and Recipients under and over utilization detection
- VI. Utilization of Medical Record Review information
- VII. Provider Network Issues

General Discussion:

Question and Answer:

Adjournment:

PROVIDER AND RECIPIENT GRIEVANCE AND APPEAL LOG/SUMMARY REPORT

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DISTRICT (SITE): _____ QUARTER: _____
 PRIMARY CONTRACTOR: _____
 TOTAL GRIEVANCES _____
 (ALL PATIENTS)

P-Provider R-Recipient	PATIENT/ PROVIDER NAME/ADDRESS	PATIENT MEDICAID NUMBER	DATE RECEIVED	DATE OF OCCURRENCE	COMPLAINT CODE	SITE	GRIEVANCE: BRIEF EXPLANATORY SUMMARY	RESOLU- TION CODE	RESOLU- TION SUMMARY	DATE RESOLVED	LEVEL OF GRIEVANCE

COMPLAINT CODES: A. Staff, B. Medical/MD, C. Environment, D. Billing, E. Communication, F. Time, G. Transportation, H. Other
 RESOLUTION CODES: 1. Resolved 2. Unresolved--Additional action needed, 3. Unresolved--Appeal process, 4. Unresolved--Fair Hearing
 LEVEL CODES: S - Standard, E - Expedited

Instructions for Completion of Grievance and Appeal Log

The Complaint and Grievance Log is a mechanism of documenting and tracking complaints/grievances submitted by recipients or providers. It is an at-a-glance record of complaints from registration until resolution. It is maintained by the Primary Contractor and is submitted to the Medicaid QI Division quarterly. After grievances are logged in on the grievance log, the Primary Contractor will e-mail the Maternity Care Associate Director within three working days of the grievance stating recipient name, Medicaid number, nature of grievance and disposition of grievance.

Document appeals process and fair hearing process discussed with recipient.

All appeal resolutions must be provided will be notified in writing to the recipient by the Primary Contractor.

Items to be recorded are identified by column headers and are self-explanatory. A more detailed explanation of the codes required follows:

Complaint Codes

- A. **Staff** – can refer to problems or conflicts with staff in MD office, hospital, other medical facilities or care coordination.
- B. **Medical/MD** – refers to concerns related to care provided by MD or other medical professionals.
- C. **Environment** – refers to issues related to MD office, hospital or other facilities encountered by the recipient.
- D. **Billing** – refers to coverage and payment issues encountered by the recipient
- E. **Communication** – refers to any problems encountered by the recipient related to the timely transmission of information from those involved in providing prenatal care.
- F. **Time** – refers to any issues the recipient has related to time spent waiting for MD or Care Coordinator, scheduling issues, etc.
- G. **Transportation** – any difficulties related to transportation to MD visits, other health visits required due to pregnancy, etc.
- H. **Other** – refers to any complaint or issue not identified in the above codes.

Resolution Codes

- A. **Resolved:** issue resolved satisfactorily between recipient and those involved.
- B. **Unresolved – additional action needed:** issue has not been resolved and may require referral to the Grievance Committee.
- C. **Unresolved – appeal process:** issue has not been resolved satisfactorily by the Grievance Committee and the recipient appeals for further action.
- D. **Unresolved – fair hearing:** the recipient does not accept issue resolution and requests a fair hearing with Medicaid.

Level Codes

- A. **S – Standard:** resolved within 90 days.
- B. **E – Expedited:** requires more immediate resolution within 48 hours.

GLOBAL SUMMARY REPORT

Quarter Being Reported:

1	Number of deliveries	
2	\$ for DHCP delivery services	
3	\$ for DHCP and other services	
4	\$ other services	
5	\$ for anesthesia	
6	# ultrasounds	
7	\$ ultrasounds	
8	# home visits	
9	\$ home visits	
10	\$ associated cost	
11	\$ administrative cost	
12	\$ administrative and other services	
13	\$ care coordinator total	
14	\$ postpartum total	
15	Adjustments/recoups	
	Total	
16	TPL collected	
17	TPL reported	

Definition of Elements:

ONLY REPORT COSTS IN ONE CATEGORY

- 1 Report number of deliveries for which you received a global payment, including those with TPL.
- 2 If your physician payment only includes delivery services, indicate total paid.
- 3 If your physician payment includes delivery and other services, indicate total paid.
- 4 If your hospital payment is for services other than inpatient , indicate total paid.
- 5 Total paid for anesthesia services.
- 6 Number of ultrasounds provided
- 7 Total paid for ultrasound services.
- 8 Number of completed home visits.
- 9 Total paid for completed home visits.
- 10 Total paid for other services not defined in another category
- 11 If your administrative costs is only for operating expenses, indicate total paid.
If your administrative costs includes other
- 12 costs and operating expenses, indicate total paid.

- 13 Total paid for care coordination services
- 14 Total paid for postpartum visits
- 15 The total dollar amount of monies recouped
or adjusted this quarter
- 16 Total TPL collected from other payers
- 17 Total TPL amounts reported via claims

Provider Network

Subcontractor Last Name	Subcontractor First Name	Subcontractor Middle Initial	Group Name	Service	Street Address	City	State	Office Phone	Fax	Email	24-Hour Number	Contact
--------------------------------	---------------------------------	-------------------------------------	-------------------	----------------	-----------------------	-------------	--------------	---------------------	------------	--------------	-----------------------	----------------

DHCP
Anesthesia
Care Coordinator
Home Visit
Asst. Surgeon
Ultrasounds

Exclusion List Check Form

Self Attestation of Initial and Monthly Checks of Excluded Individuals and Entities (attach list of names of individuals/entities)

Name of Provider or Entity:

Month	Year	Complete	Exclusion List	None Identified	Identified/reported to AMA (see attached)	*Initials	Date
January	20__	<input type="checkbox"/>	Checked the LEIE List	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	Checked the AMA Exclusion List	<input type="checkbox"/>	<input type="checkbox"/>		
February	20__	<input type="checkbox"/>	Checked the LEIE List	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	Checked the AMA Exclusion List	<input type="checkbox"/>	<input type="checkbox"/>		
March	20__	<input type="checkbox"/>	Checked the LEIE List	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	Checked the AMA Exclusion List	<input type="checkbox"/>	<input type="checkbox"/>		
April	20__	<input type="checkbox"/>	Checked the LEIE List	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	Checked the AMA Exclusion List	<input type="checkbox"/>	<input type="checkbox"/>		
May	20__	<input type="checkbox"/>	Checked the LEIE List	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	Checked the AMA Exclusion List	<input type="checkbox"/>	<input type="checkbox"/>		
June	20__	<input type="checkbox"/>	Checked the LEIE List	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	Checked the AMA Exclusion List	<input type="checkbox"/>	<input type="checkbox"/>		
July	20__	<input type="checkbox"/>	Checked the LEIE List	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	Checked the AMA Exclusion List	<input type="checkbox"/>	<input type="checkbox"/>		
August	20__	<input type="checkbox"/>	Checked the LEIE List	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	Checked the AMA Exclusion List	<input type="checkbox"/>	<input type="checkbox"/>		

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September	20__	<input type="checkbox"/>	Checked the LEIE List	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	Checked the AMA Exclusion List	<input type="checkbox"/>	<input type="checkbox"/>
October	20__	<input type="checkbox"/>	Checked the LEIE List	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	Checked the AMA Exclusion List	<input type="checkbox"/>	<input type="checkbox"/>
November	20__	<input type="checkbox"/>	Checked the LEIE List	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	Checked the AMA Exclusion List	<input type="checkbox"/>	<input type="checkbox"/>
December	20__	<input type="checkbox"/>	Checked the LEIE List	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	Checked AMA Exclusion List	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the above named entity has completed the monthly exclusion checks on both the LEIE Website and the AMA Website on potential/existing employees, and contractors (list attached) according to federal guidelines and regulations.

*Signatures must match initials

Signature:

Signature:

Websites:

HHS Office of Inspector General LEIE Website: <http://www.oig.hhs.gov/fraud/exclusions.asp>

Alabama Medicaid' Website/Fraud and Prevention Tab: www.medicaid.alabama.gov

References:

Alabama Medicaid Agency's Provider Billing Manual, Chapter 7; Sections 7.3.1 and 7.3.2

Alabama Medicaid Agency Program Integrity Division/Fraud and Abuse-1-866-452-4930

Attachment Twenty-two
 Maternity Care Program
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**Maternity Program District Plan Codes Expenditures
 Paid Dates Between FY 10/01/2012 - 09/30/2013**

District Plan Code	Procedure Code & Description	Recipient County Code and Description	Undup Recipients	Undup Claims	Paid Amount
P01	59400 - Obstetrical Care	02 - Baldwin	1	1	\$2,159.00
		17 - Colbert	187	197	\$385,956.74
		26 - Elmore	1	1	\$2,349.00
		29 - Fayette	1	1	\$2,226.00
		30 - Franklin	137	141	\$288,240.11
		37 - Jefferson	1	1	\$2,473.00
		38 - Lamar	1	1	\$2,473.00
		39 - Lauderdale	331	334	\$688,754.51
		42 - Limestone	1	2	\$2,226.00
		45 - Madison	1	1	\$2,226.00
		47 - Marion	114	116	\$245,528.86
		63 - Tuscaloosa	1	2	\$(1,920.00)
		64 - Walker	2	2	\$4,699.00
		67 - Winston	4	4	\$9,274.00
	59400 - Obstetrical Care		Sum:	804	\$1,636,665.22

	59410 - Obstetrical Care	17 - Colbert	6	6	\$7,517.40
		30 - Franklin	3	3	\$3,290.40
		39 - Lauderdale	9	9	\$15,666.00
		47 - Marion	2	3	\$5,540.40
	59410 - Obstetrical Care		Sum:	21	\$32,014.20
	59510 - Cesarean Delivery	17 - Colbert	136	139	\$291,133.48
		30 - Franklin	89	91	\$186,697.71
		37 - Jefferson	1	1	\$0.00
		39 - Lauderdale	178	180	\$378,197.95
		40 - Lawrence	1	1	\$2,226.00
		47 - Marion	79	80	\$167,551.73
		67 - Winston	1	1	\$2,473.00
	59510 - Cesarean Delivery		Sum:	493	\$1,028,279.87
	59515 - Cesarean Delivery	17 - Colbert	7	7	\$10,877.94
		30 - Franklin	2	2	\$2,409.40
		37 - Jefferson	1	1	\$1,781.00
		39 - Lauderdale	3	3	\$5,835.80
		47 - Marion	6	6	\$6,798.40
	59515 - Cesarean Delivery		Sum:	19	\$27,702.54
P01			Sum:	1,337	\$2,724,661.83

P02	59400 - Obstetrical Care	02 - Baldwin	1	1	\$2,159.00
		05 - Blount	1	1	\$2,475.00
		08 - Calhoun	1	1	\$2,753.00

		22 - Cullman	1	1	\$2,753.00
		24 - Dallas	1	1	\$2,159.00
		25 - Dekalb	2	2	\$5,368.00
		28 - Etowah	1	1	\$2,753.00
		33 - Hale	1	1	\$2,180.00
		36 - Jackson	217	221	\$545,386.82
		40 - Lawrence	134	141	\$308,687.54
		42 - Limestone	222	224	\$543,229.26
		45 - Madison	1,141	1,161	\$2,747,775.79
		48 - Marshall	381	383	\$960,364.07
		49 - Mobile	1	1	\$2,159.00
		52 - Morgan	464	478	\$1,127,940.70
		58 - St.Clair	2	2	\$5,231.00
	59400 - Obstetrical Care		Sum:	2,620	\$6,263,374.18
	59410 - Obstetrical Care	28 - Etowah	1	1	\$2,202.40
		36 - Jackson	5	5	\$9,031.20
		40 - Lawrence	7	7	\$12,660.20
		42 - Limestone	13	14	\$18,803.40
		45 - Madison	57	58	\$92,974.34
		48 - Marshall	12	12	\$17,641.60
		52 - Morgan	12	13	\$19,375.06
		67 - Winston	1	1	\$1,982.00
	59410 - Obstetrical Care		Sum:	111	\$174,670.20

	59510 - Cesarean Delivery	02 - Baldwin	1	1	\$2,159.00
		09 - Chambers	2	2	\$5,254.00
		22 - Cullman	1	1	\$2,753.00
		25 - Dekalb	2	2	\$2,795.79
		28 - Etowah	2	2	\$5,231.00
		36 - Jackson	102	103	\$255,567.40
		37 - Jefferson	1	1	\$2,475.00
		40 - Lawrence	67	68	\$163,073.35
		42 - Limestone	110	116	\$267,045.36
		45 - Madison	548	554	\$1,288,763.07
		46 - Marengo	1	1	\$2,753.00
		48 - Marshall	175	177	\$418,633.07
		52 - Morgan	213	217	\$513,383.68
		67 - Winston	1	1	\$2,478.00
	59510 - Cesarean Delivery		Sum:	1,246	\$2,932,364.72
	59515 - Cesarean Delivery	40 - Lawrence	1	1	\$632.00
		42 - Limestone	2	2	\$2,834.40
		45 - Madison	31	32	\$45,591.31
		48 - Marshall	1	1	\$2,202.40
		52 - Morgan	5	5	\$8,546.40
	59515 - Cesarean Delivery		Sum:	41	\$59,806.51
P02			Sum:	4,018	\$9,430,215.61
P03	59400 - Obstetrical Care	08 - Calhoun	560	593	\$1,201,857.50

		10 - Cherokee	97	108	\$210,096.54
		14 - Clay	2	2	\$4,489.00
		15 - Cleburne	61	62	\$139,028.00
		25 - Dekalb	296	321	\$605,446.76
		28 - Etowah	470	502	\$995,460.51
		36 - Jackson	3	3	\$6,763.00
		37 - Jefferson	2	2	\$4,461.00
		48 - Marshall	1	1	\$2,159.00
		49 - Mobile	1	1	\$2,159.00
		56 - Randolph	1	1	\$2,159.00
		61 - Talladega	7	7	\$15,685.00
		67 - Winston	1	1	\$2,187.00
	59400 - Obstetrical Care		Sum:	1,604	\$3,191,951.31
	59410 - Obstetrical Care	08 - Calhoun	5	5	\$7,251.80
		10 - Cherokee	1	1	\$1,727.00
		15 - Cleburne	2	2	\$2,580.00
		25 - Dekalb	3	3	\$5,885.60
		28 - Etowah	10	10	\$14,068.20
		36 - Jackson	1	1	\$1,727.00
		37 - Jefferson	1	2	\$1,841.60
	59410 - Obstetrical Care		Sum:	24	\$35,081.20
	59510 - Cesarean Delivery	05 - Blount	1	1	\$2,187.00
		08 - Calhoun	226	237	\$474,262.10

		10 - Cherokee	39	39	\$82,998.00
		14 - Clay	1	1	\$2,159.00
		15 - Cleburne	34	34	\$75,806.00
		25 - Dekalb	117	127	\$243,454.72
		28 - Etowah	224	240	\$480,165.96
		36 - Jackson	1	2	\$2,187.00
		37 - Jefferson	2	2	\$4,387.00
		45 - Madison	2	2	\$5,231.00
		48 - Marshall	2	2	\$4,346.00
		61 - Talladega	4	5	\$5,038.00
	59510 - Cesarean Delivery		Sum:	692	\$1,382,221.78
	59515 - Cesarean Delivery	08 - Calhoun	2	2	\$3,477.00
		10 - Cherokee	1	1	\$1,727.00
		15 - Cleburne	1	1	\$1,750.00
		25 - Dekalb	1	1	\$2,092.00
		28 - Etowah	1	1	\$1,841.60
	59515 - Cesarean Delivery		Sum:	6	\$10,887.60
P03			Sum:	2,326	\$4,620,141.89

P04	59400 - Obstetrical Care	02 - Baldwin	2	2	\$1,214.50
		04 - Bibb	86	86	\$192,054.00
		29 - Fayette	69	71	\$138,135.13
		32 - Greene	1	1	\$2,159.00
		33 - Hale	2	2	\$4,760.00

		37 - Jefferson	10	11	\$20,063.00
		38 - Lamar	46	46	\$98,797.55
		46 - Marengo	3	3	\$5,050.00
		47 - Marion	1	1	\$2,159.00
		54 - Pickens	68	68	\$148,287.00
		59 - Shelby	1	2	\$0.00
		60 - Sumter	1	1	\$2,261.00
		61 - Talladega	1	1	\$2,159.00
		63 - Tuscaloosa	714	736	\$1,532,431.87
	59400 - Obstetrical Care		Sum:	1,031	\$2,149,531.05
	59410 - Obstetrical Care	04 - Bibb	4	4	\$5,575.00
		37 - Jefferson	1	1	\$0.00
		38 - Lamar	1	1	\$1,904.00
		54 - Pickens	2	2	\$1,904.00
		63 - Tuscaloosa	37	40	\$50,496.40
	59410 - Obstetrical Care		Sum:	48	\$59,879.40
	59510 - Cesarean Delivery	01 - Autauga	1	1	\$2,286.00
		02 - Baldwin	1	1	\$2,159.00
		04 - Bibb	40	40	\$91,069.00
		16 - Coffee	1	1	\$2,414.00
		29 - Fayette	36	36	\$74,896.76
		35 - Houston	1	1	\$679.00
		37 - Jefferson	3	3	\$6,919.00

		38 - Lamar	35	36	\$73,647.60
		49 - Mobile	1	1	\$2,159.00
		54 - Pickens	51	53	\$100,715.00
		59 - Shelby	2	2	\$3,785.00
		63 - Tuscaloosa	385	398	\$803,628.29
		64 - Walker	1	1	\$2,228.00
	59510 - Cesarean Delivery		Sum:	574	\$1,166,585.65
	59515 - Cesarean Delivery	04 - Bibb	2	2	\$2,381.00
		29 - Fayette	2	2	\$3,536.00
		38 - Lamar	2	2	\$3,631.00
		54 - Pickens	2	2	\$2,381.00
		63 - Tuscaloosa	13	15	\$16,796.00
	59515 - Cesarean Delivery		Sum:	23	\$28,725.00
P04			Sum:	1,676	\$3,404,721.10

P05	59400 - Obstetrical Care	01 - Autauga	1	1	\$2,228.00
		02 - Baldwin	2	2	\$4,456.00
		05 - Blount	194	196	\$431,538.00
		08 - Calhoun	3	3	\$7,425.00
		11 - Chilton	180	181	\$416,029.86
		18 - Conecuh	1	1	\$2,228.00
		22 - Cullman	317	322	\$692,571.28
		24 - Dallas	2	2	\$4,408.00
		27 - Escambia	2	2	\$4,703.00

		28 - Etowah	2	2	\$3,663.88
		29 - Fayette	5	6	\$8,066.50
		30 - Franklin	1	1	\$2,349.00
		36 - Jackson	1	1	\$2,228.00
		37 - Jefferson	2,562	2,592	\$5,801,695.09
		39 - Lauderdale	1	1	\$2,475.00
		41 - Lee	2	2	\$4,703.00
		42 - Limestone	1	1	\$2,475.00
		45 - Madison	3	3	\$6,934.00
		47 - Marion	1	1	\$2,473.00
		48 - Marshall	1	1	\$2,228.00
		49 - Mobile	3	3	\$6,477.00
		52 - Morgan	2	2	\$4,950.00
		58 - St.Clair	289	295	\$651,800.58
		59 - Shelby	376	380	\$831,751.14
		60 - Sumter	1	1	\$2,228.00
		61 - Talladega	4	4	\$7,490.00
		63 - Tuscaloosa	5	5	\$9,648.00
		64 - Walker	283	288	\$624,360.53
		66 - Wilcox	1	1	\$2,159.00
		67 - Winston	100	101	\$229,611.80
	59400 - Obstetrical Care		Sum:	4,401	\$9,775,353.66
	59410 - Obstetrical Care	05 - Blount	10	10	\$14,407.80

		08 - Calhoun	1	1	\$(1,782.00)
		11 - Chilton	7	7	\$9,504.00
		22 - Cullman	8	8	\$11,538.00
		37 - Jefferson	70	74	\$100,261.41
		47 - Marion	1	1	\$554.00
		58 - St.Clair	5	6	\$6,674.00
		59 - Shelby	14	16	\$16,288.00
		63 - Tuscaloosa	1	1	\$1,109.49
		64 - Walker	6	6	\$11,484.00
		67 - Winston	1	1	\$1,782.00
	59410 - Obstetrical Care		Sum:	131	\$171,820.70
	59510 - Cesarean Delivery	01 - Autauga	1	1	\$2,351.00
		04 - Bibb	1	1	\$2,475.00
		05 - Blount	85	85	\$184,431.35
		11 - Chilton	88	89	\$204,730.49
		22 - Cullman	153	155	\$335,413.26
		24 - Dallas	2	2	\$4,950.00
		27 - Escambia	1	1	\$2,159.00
		29 - Fayette	1	1	\$2,475.00
		37 - Jefferson	1,288	1,305	\$2,906,462.87
		45 - Madison	2	2	\$3,586.00
		46 - Marengo	1	1	\$2,228.00
		48 - Marshall	3	3	\$6,931.00

		51 - Montgomery	2	2	\$4,456.00
		52 - Morgan	1	1	\$2,475.00
		58 - St.Clair	157	158	\$347,746.40
		59 - Shelby	172	176	\$380,651.73
		61 - Talladega	3	3	\$7,056.00
		63 - Tuscaloosa	1	1	\$2,159.00
		64 - Walker	127	128	\$281,688.42
		67 - Winston	49	50	\$102,020.00
	59510 - Cesarean Delivery		Sum:	2,165	\$4,786,445.52
	59515 - Cesarean Delivery	05 - Blount	7	7	\$6,240.96
		11 - Chilton	2	2	\$965.00
		17 - Colbert	1	1	\$1,782.00
		22 - Cullman	6	6	\$7,036.50
		37 - Jefferson	25	26	\$20,244.58
		59 - Shelby	4	4	\$5,068.00
		64 - Walker	6	6	\$6,848.00
		67 - Winston	1	1	\$280.00
	59515 - Cesarean Delivery		Sum:	53	\$48,465.04
P05			Sum:	6,750	\$14,782,084.92

P06	59400 - Obstetrical Care	01 - Autauga	1	1	\$2,477.00
		08 - Calhoun	2	2	\$4,706.00
		09 - Chambers	1	1	\$2,477.00
		11 - Chilton	1	1	\$2,353.00

		14 - Clay	45	48	\$95,626.71
		15 - Cleburne	1	1	\$2,477.00
		19 - Coosa	26	26	\$56,121.00
		26 - Elmore	1	1	\$2,477.00
		47 - Marion	1	1	\$2,226.00
		56 - Randolph	83	87	\$194,849.62
		58 - St.Clair	1	1	\$2,228.00
		61 - Talladega	304	313	\$650,961.58
		62 - Tallapoosa	126	136	\$278,378.82
		64 - Walker	1	1	\$2,753.00
	59400 - Obstetrical Care		Sum:	620	\$1,300,111.73
	59410 - Obstetrical Care	14 - Clay	1	1	\$1,783.00
		19 - Coosa	1	1	\$1,783.00
		56 - Randolph	4	4	\$5,882.00
		61 - Talladega	5	6	\$5,427.80
		62 - Tallapoosa	3	3	\$4,944.80
		64 - Walker	1	1	\$0.00
	59410 - Obstetrical Care		Sum:	16	\$19,820.60
	59510 - Cesarean Delivery	01 - Autauga	1	1	\$2,229.00
		08 - Calhoun	1	1	\$2,229.00
		14 - Clay	42	43	\$91,715.88
		19 - Coosa	23	23	\$52,035.00
		26 - Elmore	1	1	\$2,229.00

		52 - Morgan	1	1	\$2,478.00
		56 - Randolph	56	58	\$130,442.42
		58 - St.Clair	2	2	\$2,874.88
		61 - Talladega	247	256	\$537,453.20
		62 - Tallapoosa	170	179	\$374,258.92
	59510 - Cesarean Delivery		Sum:	565	\$1,197,945.30
	59515 - Cesarean Delivery	56 - Randolph	1	1	\$1,981.60
		61 - Talladega	3	3	\$5,746.20
		62 - Tallapoosa	6	7	\$7,512.54
	59515 - Cesarean Delivery		Sum:	11	\$15,240.34
P06			Sum:	1,212	\$2,533,117.97

P07	59400 - Obstetrical Care	32 - Greene	47	47	\$92,791.00
		33 - Hale	80	82	\$165,737.50
		46 - Marengo	2	2	\$4,318.00
		60 - Sumter	1	1	\$2,175.00
		63 - Tuscaloosa	2	2	\$4,339.00
	59400 - Obstetrical Care		Sum:	134	\$269,360.50
	59410 - Obstetrical Care	32 - Greene	2	2	\$3,471.00
		33 - Hale	3	4	\$3,938.00
	59410 - Obstetrical Care		Sum:	6	\$7,409.00
	59510 - Cesarean Delivery	32 - Greene	31	32	\$59,655.00
		33 - Hale	49	51	\$98,915.00
		63 - Tuscaloosa	4	4	\$8,496.58

	59510 - Cesarean Delivery		Sum:	87	\$167,066.58
	59515 - Cesarean Delivery	33 - Hale	3	3	\$3,948.00
	59515 - Cesarean Delivery		Sum:	3	\$3,948.00
P07			Sum:	230	\$447,784.08

P08	59400 - Obstetrical Care	12 - Choctaw	61	64	\$124,946.60
		46 - Marengo	77	80	\$159,872.61
		60 - Sumter	59	62	\$119,324.94
		63 - Tuscaloosa	1	1	\$2,175.00
	59400 - Obstetrical Care		Sum:	207	\$406,319.15
	59410 - Obstetrical Care	12 - Choctaw	6	6	\$10,401.00
		46 - Marengo	1	1	\$1,727.00
		60 - Sumter	1	1	\$1,727.00
	59410 - Obstetrical Care		Sum:	8	\$13,855.00
	59510 - Cesarean Delivery	12 - Choctaw	19	19	\$37,969.15
		37 - Jefferson	1	1	\$2,159.00
		38 - Lamar	1	1	\$2,380.00
		46 - Marengo	77	81	\$155,658.26
		53 - Perry	1	1	\$2,175.00
		60 - Sumter	48	52	\$99,591.26
		63 - Tuscaloosa	1	1	\$2,159.00
	59510 - Cesarean Delivery		Sum:	156	\$302,091.67
	59515 - Cesarean Delivery	12 - Choctaw	2	2	\$3,467.00
		46 - Marengo	1	1	\$1,740.00

		60 - Sumter	1	1	\$1,727.00
	59515 - Cesarean Delivery		Sum:	4	\$6,934.00
P08			Sum:	375	\$729,199.82

P09	59400 - Obstetrical Care	24 - Dallas	272	287	\$541,903.83
		46 - Marengo	1	1	\$2,159.00
		51 - Montgomery	4	4	\$6,540.00
		53 - Perry	49	50	\$98,397.17
		63 - Tuscaloosa	1	1	\$2,159.00
		66 - Wilcox	79	81	\$167,989.00
	59400 - Obstetrical Care		Sum:	424	\$819,148.00
	59410 - Obstetrical Care	24 - Dallas	15	17	\$24,071.23
		51 - Montgomery	1	1	\$1,744.00
		53 - Perry	4	4	\$3,906.00
		66 - Wilcox	2	2	\$469.00
	59410 - Obstetrical Care		Sum:	24	\$30,190.23
	59510 - Cesarean Delivery	01 - Autauga	1	1	\$2,159.00
		11 - Chilton	1	1	\$334.00
		24 - Dallas	130	134	\$261,695.83
		51 - Montgomery	1	1	\$2,286.00
		53 - Perry	29	29	\$57,054.81
		63 - Tuscaloosa	1	1	\$2,180.00
		66 - Wilcox	36	36	\$76,594.00
	59510 - Cesarean Delivery		Sum:	203	\$402,303.64

	59515 - Cesarean Delivery	24 - Dallas	10	16	\$7,479.00
		53 - Perry	1	2	\$744.00
		66 - Wilcox	1	1	\$1,727.00
	59515 - Cesarean Delivery		Sum:	19	\$9,950.00
P09			Sum:	670	\$1,261,591.87

P10	59400 - Obstetrical Care	01 - Autauga	173	178	\$343,808.96
		03 - Barbour	1	1	\$416.00
		06 - Bullock	51	52	\$104,515.00
		07 - Butler	109	110	\$224,397.80
		09 - Chambers	1	1	\$2,286.00
		11 - Chilton	1	1	\$503.00
		16 - Coffee	1	1	\$2,286.00
		18 - Conecuh	1	1	\$2,286.00
		20 - Covington	1	1	\$2,286.00
		21 - Crenshaw	53	53	\$109,134.60
		23 - Dale	1	1	\$2,159.00
		24 - Dallas	3	4	\$6,433.00
		26 - Elmore	279	286	\$571,600.72
		33 - Hale	1	1	\$2,159.00
		35 - Houston	1	1	\$2,172.00
		37 - Jefferson	2	2	\$2,669.00
		41 - Lee	2	2	\$815.00
		43 - Lowndes	62	63	\$121,760.13

		44 - Macon	1	1	\$2,172.00
		47 - Marion	1	1	\$2,473.00
		49 - Mobile	4	4	\$6,988.00
		51 - Montgomery	1,099	1,111	\$2,311,023.89
		55 - Pike	123	131	\$252,234.50
		62 - Tallapoosa	3	3	\$6,731.00
	59400 - Obstetrical Care		Sum:	2,010	\$4,083,309.60
	59410 - Obstetrical Care	01 - Autauga	10	10	\$15,149.00
		06 - Bullock	2	2	\$2,587.60
		07 - Butler	3	3	\$1,702.80
		21 - Crenshaw	1	1	\$1,738.00
		26 - Elmore	7	7	\$7,317.20
		43 - Lowndes	1	1	\$1,828.80
		51 - Montgomery	40	40	\$65,758.00
		55 - Pike	3	3	\$5,282.80
	59410 - Obstetrical Care		Sum:	67	\$101,364.20
	59510 - Cesarean Delivery	01 - Autauga	92	94	\$188,130.60
		06 - Bullock	25	25	\$54,916.00
		07 - Butler	71	71	\$145,000.00
		11 - Chilton	1	1	\$419.00
		16 - Coffee	1	1	\$2,159.00
		21 - Crenshaw	30	30	\$61,947.84
		24 - Dallas	1	1	\$2,286.00

		26 - Elmore	164	166	\$343,456.60
		43 - Lowndes	41	42	\$85,662.00
		49 - Mobile	1	1	\$2,159.00
		50 - Monroe	1	1	\$2,172.00
		51 - Montgomery	610	629	\$1,239,529.28
		55 - Pike	85	87	\$170,079.00
		59 - Shelby	1	1	\$2,286.00
		62 - Tallapoosa	1	1	\$466.00
	59510 - Cesarean Delivery		Sum:	1,151	\$2,300,668.32
	59515 - Cesarean Delivery	07 - Butler	1	1	\$1,727.00
		26 - Elmore	4	4	\$5,766.60
		43 - Lowndes	1	1	\$1,727.00
		51 - Montgomery	9	9	\$12,126.28
	59515 - Cesarean Delivery		Sum:	15	\$21,346.88
P10			Sum:	3,243	\$6,506,689.00

P11	59400 - Obstetrical Care	03 - Barbour	122	123	\$318,099.00
		09 - Chambers	162	162	\$406,704.00
		17 - Colbert	1	2	\$606.00
		23 - Dale	2	2	\$5,168.00
		41 - Lee	510	521	\$1,276,651.00
		42 - Limestone	2	2	\$5,231.00
		44 - Macon	86	86	\$215,332.00

		48 - Marshall	1	1	\$2,478.00
		51 - Montgomery	1	1	\$2,286.00
		57 - Russell	287	290	\$734,346.00
		63 - Tuscaloosa	1	1	\$2,159.00
	59400 - Obstetrical Care		Sum:	1,191	\$2,969,060.00
	59410 - Obstetrical Care	03 - Barbour	4	4	\$8,296.00
		09 - Chambers	12	12	\$21,600.00
		41 - Lee	27	27	\$46,662.00
		44 - Macon	4	5	\$7,794.00
		57 - Russell	11	11	\$23,780.00
	59410 - Obstetrical Care		Sum:	59	\$108,132.00
	59510 - Cesarean Delivery	03 - Barbour	50	51	\$126,096.00
		09 - Chambers	88	90	\$216,681.00
		37 - Jefferson	1	1	\$2,489.00
		41 - Lee	176	179	\$407,950.00
		44 - Macon	39	39	\$100,295.00
		47 - Marion	1	1	\$2,473.00
		52 - Morgan	1	1	\$2,478.00
		57 - Russell	125	127	\$319,803.00
		62 - Tallapoosa	1	1	\$2,765.00
	59510 - Cesarean Delivery		Sum:	490	\$1,181,030.00
	59515 - Cesarean Delivery	03 - Barbour	2	2	\$4,424.00
		09 - Chambers	3	3	\$3,899.00

		41 - Lee	7	7	\$10,268.00
		44 - Macon	6	6	\$10,070.00
		57 - Russell	7	7	\$15,043.00
	59515 - Cesarean Delivery		Sum:	25	\$43,704.00
P11			Sum:	1,765	\$4,301,926.00

P12	59400 - Obstetrical Care	02 - Baldwin	685	696	\$1,427,853.19
		08 - Calhoun	1	1	\$2,316.00
		13 - Clarke	84	84	\$173,813.62
		16 - Coffee	1	1	\$2,541.00
		18 - Conecuh	63	64	\$131,797.00
		20 - Covington	208	214	\$422,009.21
		21 - Crenshaw	1	1	\$2,159.00
		23 - Dale	1	1	\$2,316.00
		27 - Escambia	145	147	\$294,756.03
		32 - Greene	1	1	\$2,200.00
		37 - Jefferson	1	1	\$2,475.00
		49 - Mobile	4	4	\$8,950.00
		50 - Monroe	75	76	\$149,590.16
		51 - Montgomery	1	2	\$589.11
		63 - Tuscaloosa	1	1	\$2,380.00
		65 - Washington	39	39	\$82,581.00
	59400 - Obstetrical Care		Sum:	1,333	\$2,708,326.32

	59410 - Obstetrical Care	02 - Baldwin	11	11	\$13,589.20
		18 - Conecuh	2	2	\$2,149.80
		20 - Covington	8	9	\$11,807.20
		27 - Escambia	5	5	\$9,012.40
		50 - Monroe	4	4	\$7,285.40
	59410 - Obstetrical Care		Sum:	31	\$43,844.00
	59510 - Cesarean Delivery	02 - Baldwin	294	297	\$615,696.04
		13 - Clarke	72	74	\$151,464.14
		18 - Conecuh	48	48	\$95,478.20
		20 - Covington	76	77	\$158,969.83
		27 - Escambia	159	162	\$324,171.34
		46 - Marengo	1	1	\$2,316.00
		49 - Mobile	3	3	\$4,734.00
		50 - Monroe	68	69	\$138,270.95
		51 - Montgomery	1	1	\$2,159.00
		65 - Washington	28	28	\$62,773.00
	59510 - Cesarean Delivery		Sum:	760	\$1,556,032.50
	59515 - Cesarean Delivery	02 - Baldwin	4	4	\$4,658.80
		18 - Conecuh	1	1	\$1,852.80
		20 - Covington	1	1	\$1,727.00
		27 - Escambia	2	2	\$2,156.00
		46 - Marengo	1	1	\$697.06
		49 - Mobile	1	1	\$1,852.80

		50 - Monroe	1	1	\$1,852.80
	59515 - Cesarean Delivery		Sum:	11	\$14,797.26
P12			Sum:	2,135	\$4,323,000.08

P13	59400 - Obstetrical Care	03 - Barbour	2	2	\$4,828.00
		16 - Coffee	217	220	\$473,853.09
		20 - Covington	1	1	\$2,287.00
		21 - Crenshaw	1	1	\$2,287.00
		23 - Dale	168	170	\$374,132.83
		31 - Geneva	124	124	\$277,975.50
		34 - Henry	55	57	\$123,063.57
		35 - Houston	435	448	\$996,385.49
		55 - Pike	2	2	\$3,034.17
	59400 - Obstetrical Care		Sum:	1,025	\$2,257,846.65
	59410 - Obstetrical Care	16 - Coffee	4	4	\$5,490.00
		23 - Dale	4	4	\$7,725.60
		31 - Geneva	1	1	\$1,830.00
		35 - Houston	3	3	\$5,895.60
	59410 - Obstetrical Care		Sum:	12	\$20,941.20
	59510 - Cesarean Delivery	03 - Barbour	2	2	\$4,903.00
		16 - Coffee	68	69	\$157,216.52
		21 - Crenshaw	1	1	\$0.00
		23 - Dale	102	105	\$231,756.63
		31 - Geneva	80	80	\$192,356.27

		34 - Henry	32	35	\$74,321.30
		35 - Houston	313	320	\$732,809.51
		37 - Jefferson	1	1	\$2,475.00
		49 - Mobile	1	1	\$2,159.00
		51 - Montgomery	1	1	\$2,172.00
	59510 - Cesarean Delivery		Sum:	615	\$1,400,169.23
	59515 - Cesarean Delivery	16 - Coffee	1	1	\$1,830.00
		23 - Dale	1	1	\$2,032.80
		34 - Henry	1	1	\$1,830.00
		35 - Houston	4	4	\$7,595.30
	59515 - Cesarean Delivery		Sum:	7	\$13,288.10
P13			Sum:	1,659	\$3,692,245.18

P14	59400 - Obstetrical Care	02 - Baldwin	8	8	\$17,900.00
		05 - Blount	1	1	\$2,159.00
		35 - Houston	1	1	\$2,541.00
		48 - Marshall	1	1	\$2,159.00
		49 - Mobile	2,028	2,066	\$4,194,422.26
		58 - St.Clair	1	1	\$2,475.00
		65 - Washington	2	2	\$4,318.00
		66 - Wilcox	1	1	\$2,159.00
	59400 - Obstetrical Care		Sum:	2,081	\$4,228,133.26
	59410 - Obstetrical Care	02 - Baldwin	1	1	\$1,852.80
		23 - Dale	1	1	\$1,830.00

		49 - Mobile	10	10	\$17,272.00
	59410 - Obstetrical Care		Sum:	12	\$20,954.80
	59510 - Cesarean Delivery	02 - Baldwin	1	1	\$2,316.00
		07 - Butler	1	1	\$2,159.00
		46 - Marengo	1	1	\$2,159.00
		49 - Mobile	1,200	1,221	\$2,459,328.97
		62 - Tallapoosa	1	1	\$2,159.00
		63 - Tuscaloosa	1	1	\$2,159.00
	59510 - Cesarean Delivery		Sum:	1,226	\$2,470,280.97
	59515 - Cesarean Delivery	49 - Mobile	5	6	\$6,908.80
	59515 - Cesarean Delivery		Sum:	6	\$6,908.80
P14			Sum:	3,325	\$6,726,277.83
			Sum Total :	30,721	\$65,483,657.18

Maternity Care Program Third Party Insurance Verification

To Whom It May Concern:

The following is a form seeking verification of health/medical insurance information – as required by Medicaid – for the following person. Please note that a release of information is included.

I, _____ give permission for the _____
(patient's full name) (Insurance Company)
and/or Personnel Department of _____ to release the following
(Work place of insurance holder)
information concerning my insurance coverage to _____.
(name of Primary Contractor)

Patient Signature: _____ Date: _____

PATIENT INFORMATION

Name _____ Date of Birth _____
Address _____
City _____ County _____ State _____
Zip _____ SS# _____
Name and Address of Insurance Company _____
Phone _____
Policyholder's Name _____
Relationship to Patient _____
Policy # _____
Other Pertinent Data _____

TO BE COMPLETED BY INSURANCE COMPANY/PERSONNEL DEPARTMENT
--

Does the above named person have maternity coverage? Yes ___ No ___
When did coverage begin? Month ___ Day ___ End Date: Month ___ Day ___ Year ___
Is Pre-Certification required? Yes ___ No ___
Additional Comments: _____
Signed: _____
Where should claims be filed? _____
Telephone Verification: Yes ___ No ___ Date _____ Made by: _____

Please return form within 30 days to: _____

If you have any questions, please call _____
(If possible, please include copy of policy booklet or pertinent sections. Thank you for your assistance)

Encounter Data Request

Field at Header Level	Comment	Format	Example
ICN	Claim Reference Number	Character	123456
Recipient ID	Unique identification number for a recipient	Character	55555555
Medicaid ID	Medicaid ID of the recipient if it is different from the Recipient ID	Character	500009999999
Recipient Age		Numeric	45
Billing Provider NPI		Character	7654321891
Performing Provider NPI		Character	6543219876
Referring Provider NPI		Character	7412589635
From Date of Service		mm/dd/yyyy	01/31/2012
Admission Date		mm/dd/yyyy	01/31/2012
Discharge Date		mm/dd/yyyy	02/02/2012
To Date of Service		mm/dd/yyyy	02/02/2012
Paid Date		mm/dd/yyyy	03/24/2012
Claim Type		Character	I
Fund Code		Character	Physician
Place of Service Code		Character	IP
Claim Status	Paid, denied, etc.	Character	xyz
Emergency Code		Character	xyz
Allowed Amount		Numeric	100
Billed Amount		Numeric	65
Copay Amount		Numeric	5

Encounter Amount		Numeric	65
Other Insurance Amount		Numeric	35
Paid Amount		Numeric	50
Hdr Diagnosis 1 - Code		Character	V91.99
Hdr Diagnosis 2 - Code		Character	580.0
Hdr Diagnosis 3 - Code		Character	800.45
Hdr Diagnosis 4 - Code		Character	999.9
Hdr Diagnosis 5 - Code		Character	845.45
Hdr Diagnosis 6 - Code		Character	046.1
Hdr Diagnosis 7 - Code		Character	E001.1
Hdr Diagnosis 8 - Code		Character	390
Hdr Diagnosis 9 - Code		Character	285.5
Hdr Diagnosis 10 - Code		Character	189.7
Hdr Diagnosis 11 - Code		Character	E999.1
Hdr Diagnosis 12 - Code		Character	139.8

Field at Detail Level	Comment	Format	Example
ICN		Character	123456
Detail Number		Character	3
Current Recipient ID		Character	55555555
Detail Status		Character	xyz
Paid Amount		Numeric	50
Billed Quantity		Numeric	10
Primary Diagnosis Code		Character	90545
Secondary Diagnosis Code		Character	E8002
Diagnosis Code 3		Character	82125
Diagnosis Code 4		Character	00100
Procedure Code		Character	90545
First Modifier Code		Character	26
Second Modifier Code		Character	54

Third Modifier Code		Character	TC
Fourth Modifier Code		Character	62

Maternity Care Program Intake Form



Recipient Name _____

Date of Birth _____

Address _____

County of Residence _____

Social Security Number _____

Medicaid Number _____

If no assistance is required with Medicaid application, provide to eligibility ____

DHCP selected _____

Notified DHCP & 1st appointment obtained _____

Risk Status assigned _____

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MANAGED CARE

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Rule No. 560-X-37-.01 General

(1) The Agency may, at its discretion, and in consultation with local communities, organize and develop area specific systems as part of an overall managed care system.

(a) Flexibility. Since community needs and resources differ from area to area, the Agency will maintain the flexibility to design plans which are consistent with local needs and resources.

(b) Waiver Programs. Plans may be either voluntary or mandatory pursuant to waiver(s) granted by the Centers for Medicare and Medicaid Services (CMS) or the Office of State Health Reform Demonstration. Some plans may start as voluntary and subsequently become mandatory. All required federal waivers must be obtained by Medicaid before any system or contract can become effective.

(c) State Plan Programs. Amendments to the state plan must be approved by CMS before any system or contract can become effective.

(d) Models. It is anticipated that managed care will be accomplished through a combination of primary care case management systems (PCCM), health maintenance organizations (HMO), managed care organizations (MCO), prepaid Inpatient health plans, and regional care organizations (RCO).

(e) Purpose. The purposes of managed care are to:

- (i) Ensure needed access to health care;
- (ii) Provide health education;
- (iii) Promote continuity of care;
- (iv) Strengthen the patient/physician relationship; and
- (v) Achieve cost efficiencies.

(2) (a) Any managed care system established shall comply with the approved Alabama State Plan for Medical Assistance, Alabama Medicaid Administrative Code, the Alabama Medicaid Provider Manual and/or operational protocols, all other guidelines of Medicaid program areas, all state and federal laws and regulations, and any federally approved waivers in effect in the geographical areas of the State in which the system is operational and providing medical services to eligible Medicaid enrollees.

(b) The regulations of CMS at 42 CFR Parts 430, 432, 434, 438, 440, and 447, as promulgated in 67 Federal Register 40988 (June 14, 2002) and 68 Federal Register 3586 (January 24, 2003), and as may be subsequently amended, are adopted by reference. Copies of these regulations may be obtained from the US Government Printing Office, Washington, DC 20402 or at www.gpo.gov/su_docs/aces/aces140.html. Copies are also available from Medicaid at a cost of \$7.00.

(3) Any managed care system or provider shall comply with all federal and state laws, rules and regulations relating to discrimination and equal employment opportunity, Titles VI and VII of the Civil Rights Act of 1964, as amended, the Federal Age Discrimination Act, Section 504 of the Rehabilitation Act of 1973, and Americans with Disabilities Act of 1990.

(4) The terminology and definitions in this chapter may be referenced in their entirety in 42 CFR 438.2. An abbreviated list follows:

(a) *Capitation payment* means a payment the state agency makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the state plan.

(b) *Capitated risk contract* means a risk contract that covers comprehensive services, that is, inpatient hospital services and any of the services listed in Rule 560-X-37-.03 (2).

(c) *Federally qualified HMO* means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

(d) *Health care professional* means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(e) *Health insuring organization (HIO)* means a county operated entity that in exchange for capitation payments covers services for recipients through payments to, or arrangements with, providers under a comprehensive risk contract with the state.

(f) *Managed care organization (MCO)* means an entity that has, or is seeking to qualify for, a comprehensive risk contract as defined in 42 CFR, Part 438, and that is a federally qualified HMO that meets the requirements of 42 CFR, Part 489, Subpart I.

(g) *Nonrisk contract* means a contract under which the contractor is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR, Section 447.362.

(h) *Prepaid ambulatory health plan (PAHP)* means an entity that provides medical services to enrollees under contract with the state agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

(i) *Prepaid inpatient health plan (PIHP)* means an entity that provides medical services to enrollees under contract with the state agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

(j) *Primary care* means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

(k) *Primary care case management* means a system under which a PCCM contracts with the state to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients.

(l) *Primary care case manager (PCCM)* means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services.

(m) *Primary medical provider (PMP)* means a family practitioner, general practitioner, internist, or pediatrician, an entity that provides or arranges for PMP coverage for services, consultation, or referrals 24 hours a day, seven days a week.

(n) *Risk contract* means a contract under which the contractor assumes risk for the cost of the services covered under the contract; and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

(o) *Regional Care Organization (RCO)* means an organization of health care providers contracting with the Medicaid Agency to provide a comprehensive package of Medicaid benefits to Medicaid beneficiaries within a defined region of the state and that meets the requirements set forth in the law.

(5) The contract requirements in this chapter may be referenced in their entirety in 42 CFR 438.6. An abbreviated list follows:

(a) The CMS Regional Office must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in 438.806.

(b) Payments under risk contracts must be based on actuarially sound capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; and are appropriate for the populations to be covered, and the services to be furnished under the contract.

(c) All contracts in this chapter must comply with all applicable federal and state laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

(d) Physician incentive plans (PIP) do not apply to contracts in this chapter.

(e) All MCO and PIHP contracts must provide for compliance with the requirements of 422.128 for maintaining written policies and procedures for advance directives. The entity subject to this requirement must provide adult enrollees with written information on advance directives policies, and include a description of applicable state law.

(f) PCCM contracts must meet the following requirements:

(i) Provide for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.

(ii) Restrict enrollment to recipients who reside sufficiently near one of the manager's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation.

(iii) Provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

(iv) Prohibit discrimination in enrollment, disenrollment, and reenrollment, based on the recipient's health status or need for health care services.

(v) Provide that enrollees have the right to disenroll from their PCCM in accordance with 438.56 (c).

(6) The information requirements in this chapter may be referenced in their entirety in 42 CFR 438.10. An abbreviated list follows:

(a) *Enrollee* means a Medicaid recipient who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.

(b) *Potential enrollee* means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, or PCCM.

(c) Each state enrollment broker must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.

(d) The state must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.

(e) The state must establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the state. *Prevalent* means a non-English language spoken by a significant number of potential enrollees and enrollees in the state.

(f) The state and each managed care entity must make available written information in the prevalent non-English languages.

(g) The state must notify enrollees and potential enrollees and require each managed care entity to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages.

(7) The provider discrimination prohibitions in this chapter may be found in their entirety in 42 CFR 438.12. An abbreviated list follows:

(a) A managed care entity may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his license or certification under applicable state law, solely on the basis of that license or certification. If a managed care entity declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

(b) In all contracts with health care professionals, a managed care entity must comply with the requirements in 438.214.

(8) The enrollment requirements in this chapter may be found in their entirety in 42 CFR 438.50 through 438.66. An abbreviated list follows:

(a) A state plan that requires Medicaid recipients to enroll in managed care entities must comply with the provisions of this section, except when the state imposes the requirement as part of a demonstration project under section 1115 of the Act; or under a waiver granted under section 1915(b) of the Act.

(b) The state plan must specify the types of entities with which the state contracts; whether the payment method is fee for service or capitated; whether it contracts on a comprehensive risk basis; and the process the state uses to involve the public in both design and initial implementation of the program and the methods it uses to ensure ongoing public involvement once the state plan has been implemented.

(c) The plan must provide assurances that the state meets applicable requirements of section 1903(m) of the Act for MCOs; section 1905(t) of the Act for PCCMs; and section 1932(a)(1)(A) of the Act for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities.

(d) The state must provide assurances that, in implementing the state plan managed care option; it will not require the following groups to enroll in an MCO or PCCM:

- (i) Medicare eligible recipients;
- (ii) Indians who are members of federally recognized tribes, except when the MCO or PCCM is the Indian Health Service or an Indian health program operated under a contract, grant, etc., with the Indian Health Service;
- (iii) Children under 19 years of age who are eligible for SSI under title XVI; eligible under section 1902(e)(3) of the Act; in foster care or out of home placement; receiving foster care or adoption assistance; or receiving services through a community based care system.

(e) The state must have an enrollment system under which recipients already enrolled in an MCO or PCCM are given priority to continue that enrollment if the MCO or PCCM does not have the capacity accept all those seeking enrollment under the program.

(f) For recipients who do not choose an MCO or PCCM during their enrollment period, the state must have a default enrollment process for assigning those recipients to contracting MCOs and PCCMs.

(g) The process must seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients.

(h) An *existing provider-recipient relationship* is one in which the provider was the main source of Medicaid services for the recipient during the previous year.

(i) A provider is considered to have *traditionally served* Medicaid recipients if it has experience in serving the Medicaid population.

(9) The recipient choice requirements in this chapter may be found in their entirety in 42 CFR 438.52. An abbreviated list follows:

(a) A state that requires Medicaid recipients to enroll in an MCO, PIHP, PAHP or PCCM system must give those recipients a choice of at least two entities.

(b) A state may limit a rural area recipient to a single managed care entity with the exceptions noted in 438.52(b).

(c) A state may limit recipients to a single HIO if the recipient has a choice of at least two primary care providers within the entity.

(d) A state's limitation on an enrollee's freedom to change between primary care providers may be no more restrictive than the limitations on disenrollment noted in 438.56.

(10) The disenrollment requirements and limitations in this chapter may be found in their entirety in 42 CFR 438.56. An abbreviated list follows:

(a) The provisions of this section apply to all managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with an MCO, a PIHP, a PAHP, or a PCCM.

(b) All contracts must specify the reasons for which the entity may request disenrollment of an enrollee.

(c) The entity may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

(d) All contracts must specify the methods by which the entity assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.

(e) All contracts must specify that a recipient may request disenrollment for cause at any time or without cause at the following times:

(i) During the 90 days following the date of the recipient's initial enrollment with the entity or the date the state sends the recipient notice of the enrollment, whichever is later.

(ii) At least once every 12 months thereafter.

(iii) Upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

(f) Recipients (or their representatives) must submit oral or written requests for disenrollment to the state agency or the managed care entity (if the state permits the entity to process such requests).

(g) The following are cause for disenrollment:

(i) The enrollee moves out of the entity's service area.

(ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks.

(iii) The enrollee needs related services to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

(iv) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

(h) The state agency must complete the determination on the recipient's (or the entity's) request so that the effective date of disenrollment is no later than the first day of the second month following the month in which the recipient (or the entity) files the request.

(11) The state must have in effect safeguards against conflict of interest on the part of employees and agents of the state who have responsibilities relating to the managed care contracts. Medicaid employees must comply with the state ethics laws including, but not limited to, Code of Alabama (1975), Sections 36-25-5, -7, -8, -11, -12, and -13.

(12) The state must ensure that no payment is made to a provider other than the managed care entity for services available under the contract between the state and the entity. Medicaid ensures compliance with 438.60 through the systematic plan code determination at the detail level of a claim.

(13) The state must arrange for Medicaid services to be provided without delay to any Medicaid enrollee of a managed care entity whose contract is terminated and for any Medicaid enrollee who is disenrolled from an entity for any reason other than ineligibility for Medicaid.

(14) The state must have in effect procedures for monitoring the entity's operations, including at a minimum, operations related to the following:

- (a) Recipient enrollment and disenrollment.
- (b) Processing of grievances and appeals.
- (c) Violations subject to intermediate sanctions.
- (d) Violations of the conditions for FFP.
- (e) All other conditions of the contract as appropriate.

(15) The enrollee rights in this chapter may be found in their entirety in 42

CFR 438.100. An abbreviated list follows:

- (a) The state must ensure that each managed care entity has written policies regarding the enrollee rights specified in 438.100.
- (b) Each entity shall comply with any applicable federal and state laws that pertain to enrollee rights and shall ensure that its staff and providers take those rights into account when furnishing services to enrollees.
- (c) An enrollee of a managed care entity has the right to:
 - (i) Receive information in accordance with 438.10.
 - (ii) Be treated with respect and with due consideration for this or her dignity and privacy.
 - (iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
 - (iv) Participate in decisions regarding his or her health care.
 - (v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
 - (vi) Request and receive a copy of his or her medical records, and request that they be amended or corrected.
- (d) An enrollee of a managed care entity has the right to be furnished health care services in accordance with 438.206 through 438.210.
- (e) The state must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the managed care entity and its providers treat the enrollee.
- (f) The state must ensure that each entity complies with any other applicable federal and state laws.

(16) The provider-enrollee communications in this chapter may be found in their entirety in 42 CFR 438.102. An abbreviated list follows:

- (a) A managed care entity may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is his or her patient, for the following:
 - (i) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - (ii) Any information the enrollee needs in order to decide among all relevant treatment options.
 - (iii) The risks, benefits, and consequences of treatment or nontreatment.

(iv) The enrollee's rights to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(17) The marketing activities described in this chapter may be found in their entirety in 42 CFR 438.104. An abbreviated list follows:

(a) *Cold-call marketing* means any unsolicited personal contact by the managed care entity for the purpose of marketing.

(b) *Marketing* means any communication from a managed care entity to a Medicaid recipient who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular entity's Medicaid product, or either to not enroll in, or to disenroll from, another entity's Medicaid product.

(c) Each contract with a managed care entity must provide that the entity does not distribute any marketing materials without first obtaining state approval.

(18) The rules concerning liability for payment may be found in their entirety in 42 CFR 438.106. An abbreviated list follows:

(a) Each managed care entity must provide that its Medicaid enrollees are not held liable for any of the following:

(i) The entity's debts in the event of insolvency.

(ii) Covered services provided to the enrollee for which the state does not pay the entity, or the state or the entity does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.

(iii) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the entity provided the services directly.

(19) All contracts must provide that any cost sharing imposed on Medicaid enrollees is in accordance with 447.50 through 447.60.

(20) The rules concerning emergency and post stabilization services may be found in their entirety in 42 CFR 438.114. An abbreviated list follows:

(a) *Emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(ii) Serious impairment to bodily functions.

(iii) Serious dysfunction of any bodily organ or part.

(b) *Emergency services* means covered inpatient and outpatient services that are as follows:

(i) Furnished by a provider that is qualified to furnish these services.

(ii) Needed to evaluate or stabilize an emergency medical condition.

(c) *Post stabilization care services* means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

(21) The solvency standards in this chapter may be found in their entirety in 42 CFR 438.116. An abbreviated list follows:

(a) Each MCO, PIHP, and PAHP that is not a federally qualified HMO must provide assurances to the state showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the managed care entity's debts if the entity becomes insolvent.

(b) Federally qualified HMOs are exempt from this requirement.

(22) The quality assessment and performance improvement standards in this chapter may be found in their entirety in 42 CFR, 438.200. An abbreviated list follows:

(a) The state must have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

(b) The state must obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it as final.

(c) The state must ensure that MCOs, PIHPs, and PAHPs comply with standards established by the state consistent with the regulations found in 42 CFR, Part 438.

(d) The state must conduct periodic reviews to evaluate the effectiveness of the strategy and update the strategy periodically as needed.

(e) The state must submit to CMS a copy of the initial strategy and the revised strategy whenever significant changes are made, as well as regular reports on the effectiveness of the strategy.

(23) The elements of state quality strategies in this chapter may be found in their entirety in 42 CFR 438.204. An abbreviated list follows:

(a) The contracts with MCOs and PIHPs must contain procedures that:

(i) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.

(ii) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. The state must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.

(iii) Regularly monitor and evaluate the MCO and PIHP compliance with the standards.

(iv) Arrange for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered.

(24) The rules concerning availability of services in this chapter may be found in their entirety in 42 CFR 438.206. An abbreviated list follows:

(a) The state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs and PAHPs.

(b) The state must ensure through its contracts that each entity, consistent with the entity's scope of contracted services, meets the following requirements:

(i) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.

(ii) Considers the anticipated Medicaid enrollment.

(iii) Considers the expected utilization of services, taking into account the characteristics and health care needs of specific Medicaid populations represented in the particular entity.

(iv) Considers the numbers and types of providers required to furnish the contracted Medicaid services.

(v) Considers the numbers of network providers who are not accepting new Medicaid patients.

(vi) Considers the geographic location of providers and enrollees.

(c) Each entity must do the following:

(i) Meet and require its providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services.

(ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service.

(iii) Make services included in the contract available 24 hours a day, seven days a week when medically necessary.

(iv) Establish mechanisms to ensure compliance by providers.

(v) Monitor providers regularly to determine compliance.

(vi) Take corrective action if there is a failure to comply.

(25) The assurances of adequate capacity and services in this chapter may be found in their entirety in 42 CFR 438.207. An abbreviated list follows:

(a) The state must ensure, through its contracts that each entity gives assurances to the state and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state's standards for access to care.

(b) Each entity must submit documentation to the state, in a format specified by the state, to demonstrate that it complies with the following requirements:

(i) Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area.

(ii) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

(c) Each entity must submit the documentation to the state at the time it enters into a contract with Medicaid and at any time there has been a significant change in the entity's operations that would affect capacity and services.

(26) The requirements for coordination and continuity of care in this chapter may be found in their entirety in 42 CFR 438.208. An abbreviated list follows:

(a) Each managed care entity must implement procedures to deliver primary care and to coordinate health care service for all the entity's enrollees. These procedures must meet state requirements and must do the following:

(i) Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

(ii) Coordinate the services the entity furnishes to the enrollee with the services the enrollee receives from any other entity.

(iii) Share with other entities serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.

(iv) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with state and federal requirements to the extent that they are applicable.

(27) The requirements for coverage and authorization of services in this chapter may be found in their entirety in 42 CFR 438.210. An abbreviated list follows:

(a) Each contract with a managed care entity must identify, define, and specify the amount, duration, and scope of each service that the entity is required to offer.

(b) The services identified in each entity's contract must be furnished in the same manner that recipients receive under fee-for-service Medicaid.

(c) Each contract must ensure that the services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services were furnished.

(d) The entity may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of a diagnosis, type of illness, or condition of the beneficiary.

(28) The requirements for provider selection in this chapter may be found in their entirety in 42 CFR, 432.214. An abbreviated list follows:

(a) Medicaid must ensure through its contracts that each entity implements written policies and procedures for selection and retention of providers.

(b) Medicaid must establish a uniform credentialing and recredentialing policy that each entity must follow.

(c) Each entity must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the entity.

(d) The entity's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(e) The managed care entities may not employ or contract with providers excluded from participation in federal health care programs.

(f) Each entity must comply with any additional requirements established by Medicaid.

(29) The enrollee information requirements that the state must meet under the regulations in 438.10 constitute part of Medicaid's quality strategy at 438.204.

(30) Medicaid must ensure, through its contracts, for medical records and any other health and enrollment information that identifies any particular enrollee, each entity uses and discloses such information in accordance with applicable state and federal laws.

(31) Medicaid must ensure that each entity's contract complies with the enrollment and disenrollment requirements and limitations set forth in 438.56.

(32) Medicaid must ensure, through its contracts, that each entity has in effect a grievance system that meets the requirements of 438.400 through 438.424.

(33) The requirements concerning subcontractual relationships and delegation in this chapter may be found in their entirety in 42 CFR 438.230. An abbreviated list follows:

(a) Medicaid must ensure, through its contracts, that each entity oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.

(b) Before any delegation, each entity must evaluate the prospective subcontractor's ability to perform the activities to be delegated.

(c) A written agreement between the entity and the subcontractor must specify the activities and report responsibilities delegated to the subcontractor; and must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

(34) The requirements for practice guidelines in this chapter may be found in their entirety in 42 CFR 438.236. An abbreviated list follows:

(a) Medicaid must ensure, through its contracts, that each entity adopts practice guidelines that meet the following requirements:

(i) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(ii) Consider the needs of the entity's enrollees.

(iii) Are adopted in consultation with contracting health care professionals.

(iv) Are reviewed and updated periodically as appropriate.

(35) The requirements for quality assessment and performance improvement programs in this chapter may be found in their entirety in 42 CFR 438.240. An abbreviated list follows:

(a) Medicaid must require, through its contracts that each entity has an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.

(b) At a minimum, Medicaid must require that each entity comply with the following requirements:

(i) Conduct performance improvement projects that are designed to achieve significant improvement in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

(ii) Submit performance measurement data to Medicaid annually.

(iii) Have in effect mechanisms to detect both underutilization and overutilization of services.

(iv) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

(36) The requirements for health information systems in this chapter may be found in their entirety in 42 CFR 438.242. An abbreviated list follows:

- (a) Medicaid must ensure, through its contracts that each entity maintains a health information system that collects, analyzes, integrates, and reports data.
- (b) The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.
- (c) The entity must make all collected data available to Medicaid and upon request to CMS.

(37) The requirements for grievance systems in this chapter may be found in their entirety in 42 CFR 438.400. An abbreviated list follows:

- (a) The Medicaid state plan provides an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.
- (b) The Medicaid state plan provides for methods of administration that are necessary for the proper and efficient operation of the plan.
- (c) Medicaid must require, through its contracts that entities establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.
- (d) In the case of an entity, *action* means:
 - (i) The denial or limited authorization of a requested service
 - (ii) The reduction, suspension, or termination of a previously authorized service.
 - (iii) The denial, in whole or in part, of payment for a service.
 - (iv) The failure to provide services in a timely manner as defined by the state.
 - (v) The failure of the entity to act within the timeframes provided in 438.408.
- (e) *Appeal* means a request for review of an action, as "action" is defined above.
- (f) *Grievance* means an expression of dissatisfaction about any matter other than an action, as "action" is defined above.

(38) The grievance system requirements in this chapter may be found in their entirety in 42 CFR 438.402. An abbreviated list follows:

- (a) Each entity must have a system in place for enrollees that include a grievance process, an appeal process, and access to the state's fair hearing system.
- (b) An enrollee, or a provider acting on behalf of the enrollee, may file an appeal, a grievance, or request a fair hearing.
- (c) Medicaid will specify a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the entity's notice of action.

(39) The requirements for notice of action in this chapter may be found in their entirety in 42 CFR 438.404. An abbreviated list follows:

- (a) The notice must be in writing and must meet the language and format requirements of 438.10(c) and (d) to ensure ease of understanding
- (b) The notice must explain the following:
 - (i) The action the entity or its contractor has taken or intends to take.
 - (ii) The reasons for the action.
 - (iii) The enrollee's or the provider's right to file an appeal.

- (iv) The enrollee's right to request a state fair hearing.
- (v) The procedures for exercising the rights specified in this section.
- (vi) The circumstances under which expedited resolution is available and how

to request it.

(vii) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(40) The requirements for the handling of grievances and appeals in this chapter may be found in their entirety in 42 CFR 438.406. An abbreviated list follows:

(a) In handling grievances and appeals, each entity must meet the following requirements:

(i) Give enrollees any reasonable assistance in completing forms and taking other procedural steps.

(ii) Acknowledge receipt of each grievance and appeal.

(iii) Ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making; or are health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease.

(41) The requirements for resolution and notification of grievances and appeals may be found in their entirety in 42 CFR 438.408. An abbreviated list follows:

(a) The managed care entity must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within the timeframes established by the state.

(b) The entity may extend the timeframes by up to 14 days if the enrollee requests the extension; or the entity demonstrates that there is need for additional information and how the delay is in the enrollee's interest.

(42) The requirements for expedited resolution of appeals in this chapter may be found in their entirety in 42 CFR 438.410. Each entity must establish and maintain an expedited review process for appeals, when the entity determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health.

(43) The managed care entity must provide the information specified at 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

(44) Medicaid must require, through its contracts, each entity to maintain records of grievances and appeals and must review the information as part of the state quality strategy.

(45) The requirements concerning continuation of benefits (while an appeal or fair hearing is pending) in this chapter may be found in their entirety in 42 CFR 438.420. The managed care entity must continue the enrollee's benefits if:

(a) The enrollee or the provider files the appeal timely.

(b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

(c) The services were ordered by an authorized provider.

(d) The original period covered by the original authorization has not expired.

(e) The enrollee requests extension of benefits.

(46) The requirements for effectuation of reversed appeal resolutions may be found in their entirety in 42 CFR 438.424.

(47) The requirements concerning fair hearings in this chapter may be found in their entirety in 42 CFR 431.200, et seq., and Chapter Three of this code. The Medicaid state plan must ensure that the regulations in these sections apply when a fair hearing is requested by an enrollee.

(48) The requirements concerning certifications and program integrity in this chapter may be found in their entirety in 42 CFR 438.600 through 438.610. An abbreviated list follows:

(a) When state payments to a managed care entity are based on data submitted by the entity, the state must require certification of the data as provided in 438.606.

(b) The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the state.

(c) The data submitted to the state must be certified by either the entity's chief executive officer, chief financial officer, or an individual who has been delegated the authority to sign for these officers.

(d) The certification must attest to the accuracy, completeness, and truthfulness of the submitted data.

(e) The entity must have procedures that are designed to guard against fraud and abuse.

(f) The entity must have written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable state and federal standards.

(g) The entity may not knowingly have a relationship with an individual who is debarred, suspended, or otherwise excluded from participation in state or federal health care programs.

(49) The requirements concerning sanctions in this chapter may be found in their entirety in 42 CFR 438.700 through 438.730. An abbreviated list follows:

(a) Medicaid must establish, through its contracts with managed care entities, intermediate provider sanctions that may be imposed upon the state's findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(b) Medicaid may impose sanctions that include the following:

(i) Civil money penalties.

(ii) Appointment of temporary management for the entity.

(iii) Granting enrollees the right to terminate enrollment without cause.

(iv) Suspension of all new enrollments after the effective date of the sanction.

(v) Suspension of payment for recipients enrolled after the effective date of

the sanction.

(50) The requirements concerning federal financial participation (FFP) in this chapter may be found in their entirety in 42 CFR 438.602 through 438.812. An abbreviated list follows:

(a) FFP is not available in an MCO contract that does not have prior approval from CMS.

(b) Under a risk contract, the total amount Medicaid pays for carrying out the contract provisions is a medical assistance cost.

(c) Under a nonrisk contract, the amount Medicaid pays for the furnishing of medical services to eligible recipients is a medical assistance cost; and the amount paid for the contractor's performance of other functions is an administrative cost.

(51) The requirements for timely processing of claims and cost-sharing in this chapter may be found in their entirety in 42 CFR 447.45 through 447.60. An abbreviated list follows:

(a) A contract with a managed care entity must provide that the entity will meet the requirements of 447.45 and abide by those specifications.

(b) The managed care entity and its providers may, by mutual agreement, establish an alternative payment schedule, which must be stipulated in their contract.

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Statutory Authority: Alabama State Plan for Medical Assistance (hereinafter State Plan), Section 2.1(c), Attachment 2.1-A; Social Security Act, Title XI and Title XIX, Section 1903(m); 42 C.F.R. Section 434.26, 42 C.F.R. Section 434.6; Part 438; Civil Rights Act of 1964, Titles VI and VII, as amended; The Federal Age Discrimination Act; Rehabilitation Act of 1973; The Americans with Disabilities Act of 1990; Act 2013-261. **History:** Effective date July 12, 1996. Amended December 14, 2001. **Amended:** Filed March 20, 2003; effective June 16, 2003. **Amended:** Filed August 13, 2013; effective September 17, 2013.

Rule No. 560-X-37-.02 Primary Care Case Management (PCCM)

(1) Under this model of managed care, each patient/recipient is assigned to a primary medical provider (PMP) who in most cases is a physician who is responsible for managing the recipient's health care needs. This management function neither reduces nor expands the scope of covered services.

(a) PCCM services means case management related services that include location, coordination, and monitoring of primary health care services; and are provided under a contract between Medicaid and one of the providers listed in (2) below.

(b) PCCM services may be offered by the state as a voluntary option under the Medicaid state plan; or on a mandatory basis under a 1915(b) waiver.

(2) Primary Medical Providers (PMP)

(a) Physician PMPs are generally family practitioners, general practitioners, internists or pediatricians. If a patient's condition warrants, PMPs of another specialty may be assigned if he/she is willing to meet all contractual requirements. Patients may be assigned to the individual physician or a group of physicians.

(b) Clinics - In cases of Federally Qualified Health Centers (FQHCs) and Provider Based Rural Health Clinics (PBRHCs) and Independent Rural Health Clinics (IRHCs) patients will be assigned to the clinic.

(3) The Patient 1st PMP agrees to do the following:

(a) Accept enrollees as a primary medical provider in the Patient 1st Program for the purpose of providing care to enrollees and managing their health care needs.

(b) Provide Primary Care and patient coordination services to each enrollee in accordance with the provisions of the Patient 1st agreement and the policies set forth in the Alabama Medicaid Administrative Code, Medicaid provider manuals and Medicaid bulletins and as defined by Patient 1st Policy.

(c) Provide or arrange for Primary Care coverage for services, consultation, management or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week as defined by Patient 1st Policy.

(d) Provide EPSDT services as defined by general Medicaid and Patient 1st Policy.

(e) Establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of enrollees as defined by Patient 1st Policy.

(f) Maintain a unified patient medical record for each enrollee following the medical record documentation guidelines as defined by Patient 1st Policy.

(g) Promptly arrange referrals for medically necessary health care services that are not provided directly, document referral for specialty care in the medical record and provide the authorization number to the referred provider.

(h) Transfer the Patient 1st enrollee's medical record to the receiving provider upon the change of primary medical provider at the request of the new primary care provider and as authorized by the enrollee within 30 days of the date of the request. Enrollees can not be charged for copies.

(i) Authorize care for the enrollee or see the enrollee based on the standards of appointment availability as defined by Patient 1st Policy.

(j) Refer for a second opinion as defined by Patient 1st Policy.

(k) Review and use all enrollee utilization and cost reports provided by the Patient 1st Program for the purpose of practice level utilization management and advise the Agency of errors, omissions, or discrepancies. Review and use the monthly enrollment report as required by Patient 1st Policy.

(l) Participate with Agency utilization management, quality assessment, complaint and grievance, and administrative programs.

(m) Provide the Agency, its duly authorized representatives and appropriate federal Agency representatives unlimited access (including on site inspections and review) to all records relating to the provision of services under this agreement as required by Medicaid policy and 42 C.F.R. 431.107.

(n) Maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following national and regional clinical practice guidelines or guidelines approved by the Patient 1st Advisory Group.

(o) Notify the Agency of any and all changes to information provided on the initial application for participation. If such changes are not made within 30 days of change, then future participation may be limited.

(p) Give written notice of termination of this agreement, within 15 days after receipt of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis, by the PMP.

(q) Refrain from discriminating against individuals eligible to enroll on the basis of health status or the need for health care services.

(r) Refrain from discriminating against individuals eligible to enroll on the basis of race, color, or national origin and will refrain from using any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

(s) Comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education of Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

(t) Make oral interpretation services available free of charge to each potential enrollee and enrollee. This requirement applies to all non-English languages.

(u) Receive prior approval from the Agency of any Patient 1st specific materials prior to distribution. Materials shall not make any assertion or statement (whether written or oral) that the recipient must enroll with the PMP in order to obtain benefits or in order not to lose benefits. Materials shall not make any assertion or statement that the PMP is endorsed by CMS, the Federal or State government or similar entity.

(v) Refrain from door-to-door, telephonic or other 'cold-call' marketing or engaging in marketing activities that could mislead, confuse, or defraud Medicaid Recipients, or misrepresent the PMP, its marketing representatives, or the Agency.

(w) Refrain from knowingly engaging in a relationship with the following:

- an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
- an individual who is an affiliate, as defined in the Federal Acquisition Regulation.

Note: The relationship is described as follows:

- As a director, officer, partner of the PMP,
- A person with beneficial ownership of more than five percent (5%) or more of the PMP's equity; or,
- A person with an employment, consulting or other arrangement with the PMP for the provision of items and services that are significant and material to the PMP's contractual obligation with the Agency.

(x) Retain records in accordance with requirements of 45 C.F.R. 74 (3 years after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the records is started before the original 3 year period ends.)

(y) Provide the Agency within 30 days notice of PMP disenrollment or change in practice site. This will allow for an orderly reassignment of enrollees. Failure to provide 30

days notice may preclude future participation and/or result in recoupment of case management fees.

(4) Recipients can choose or will be assigned to a PMP prior to the lock-in date to the PCCM program. Recipients have the ability to change PMPs on a monthly basis. Changes must be requested prior to the 20th of the month for the change to be effective the first of the following month.

(5) In order to participate in the PCCM system, a provider must sign an agreement with Medicaid that will detail the requirements of the PCCM system. PMPs will be paid a monthly medical case management fee for primary care case management services in an amount determined by the Agency. The fee will be based on the number of recipients enrolled for the provider on the first day of each month.

(6) The Case Management fee will be automatically paid to the PMP on the 1st checkwrite of each month. The monthly case management fee will be determined by the components of care to which the PMP has agreed. Case Management fees will be adjusted quarterly. The monthly enrollment summary report will indicate the individual amount of case management fee being paid for that month. As additional case management components are offered, PMPs will be given the opportunity to decide participation. Case management fees are not subject to third party liability requirements as specified in 42 CFR 434.6(a)(9). All direct services are paid fee-for-service through medical claims processing procedures based on the regular Medicaid fee schedule. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) will not receive the case management fee each month.

(7) PMPs are limited to 1200 recipients unless additional numbers are approved by Medicaid. The Agency may increase the number of recipients based on historical caseload; documentation of a predominately Medicaid practice and/or employment of midlevel practitioners.

(8) The failure of a PMP to comply with the terms of this agreement or other provisions of the Medicaid Program governed under Social Security Act Sections 1932, 1903(m) and 1905(t) may result in the following sanctions by the Agency:

- (a) Limiting member enrollment with the PMP.
- (b) Withholding all or part of the PMP's monthly Patient 1st management/coordination fee.
- (c) Referral to the Agency's Program Integrity or Quality Assurance Unit for investigation of potential fraud or quality of care issues.
- (d) Referral to Alabama Medical Board or other appropriate licensing board.
- (e) Termination of the PMP from the Patient 1st program.

One or more of the above sanctions may be initiated simultaneously at the discretion of the Agency based on the severity of the agreement violation. The Agency makes the determination to initiate sanctions against the PMP. The PMP will be notified of the initiation of a sanction by certified mail. Sanctions may be initiated immediately if the Agency determines that the health or welfare of an enrollee(s) is endangered or within a specified period of time as indicated in the

notice. If the PMP disagrees with the sanction determination, he has the right to request an evidentiary hearing as defined by Patient 1st Policy.

Failure of the Agency to impose sanctions for an agreement violation does not prohibit the Agency from exercising its rights to do so for subsequent agreement violations.

Author: Kim Davis-Allen, Director, Medical Services

Statutory Authority: Sections 1915(b)(1)(2)(3), and (4); Sections 1902 (a)(i), (10) and (23) of the Social Security Act, 42 CFR 431.55; 438.2; 440.168.

History: New Rule: Filed June 21, 2004; effective September 15, 2004

Rule No. 560-X-37-.03 Prepaid Inpatient Health Plan (PIHP)

(1) A prepaid inpatient health plan (PIHP) is one that provides services to enrolled recipients on a capitated basis but does not qualify as a HMO.

(2) Capitated PIHPs do not need to meet the requirements of §1903(m)(2)(A) of the Social Security Act if services are less than fully comprehensive. Comprehensive services are defined as:

(a) Inpatient hospital services and one or more services or groups of services as follows:

- (i) Outpatient hospital services;
- (ii) Laboratory and X-ray services;
- (iii) Nursing facility (NF) services
- (iv) Physician services;
- (v) Home health services;
- (vi) Rural health clinic services;
- (vii) FQHC services;
- (viii) Early and periodic screening, diagnostic, and treatment

(EPSDT) services; and

- (ix) Family planning services.

(b) No inpatient services, but three or more services or groups of services listed in Section (2)(a).

(3) If inpatient services are capitated, but none of the additional services listed in Section (2)(a) above are capitated, the entity may be considered a PIHP.

(4) The Partnership Hospital Program (PHP) is a non-comprehensive Prepaid Inpatient Health Plan (PIHP) operating under the Medicaid state plan. The following further describes the Partnership Hospital Program:

(a) It is an inpatient care program.

(b) It is mandatory for Medicaid recipients, with the exception of recipients with Part A Medicare coverage, SOBRA adults who are enrolled in and receive inpatient care through the Maternity Care program in counties covered by the PHP, and children certified through the Children's Health Insurance Program (CHIP).

(c) It is composed of prepaid inpatient health plans organized by districts in the State of Alabama.

(d) PIHPs operate under the authority granted in the Partnership Hospital Program, a state plan service as approved by CMS.

(e) Medicaid reimburses the prepaid inpatient health plans participating in the Partnership Hospital Program on a per member per month capitation basis.

(f) Prepaid inpatient health plans provide medically necessary inpatient care for covered Medicaid recipients including:

- (i) Bed and board
- (ii) Nursing services and other related services
- (iii) Use of hospital facilities
- (iv) Medical social services
- (v) Drugs, biologicals, supplies, appliances and equipment
- (vi) Certain other diagnostic and therapeutic services, and
- (vii) Medical or surgical services provided by certain interns or residents-in-

training.

(viii) Excluded are inpatient family planning services and inpatient emergency services.

(g) Prepaid inpatient health plans will assist the participant in gaining access to the health care system and will monitor on an inpatient basis the participant's condition, health care needs, and service delivery.

(h) Prepaid inpatient health plans are responsible for locating, coordinating, and monitoring all inpatient care in acute care hospitals within the state.

(i) Systems required of prepaid health plans, at a minimum, include:

- (i) Quality assurance and utilization review systems
- (ii) Grievance systems
- (iii) Systems to furnish required services, including utilization review
- (iv) Systems to prove financial capability
- (v) Systems to pay providers of care

(5) The PIHP and Medicaid shall operate a quality assurance (QA) program sufficient to meet those quality review requirements of 42 CFR Part 438, Subpart D, applicable to PIHPs and their providers. The QA Program and any revisions must be approved in writing by Medicaid.

(a) The PIHP shall appoint a QA Committee to implement and supervise the QA Program. This committee shall consist of not less than three healthcare professionals, who may be members of the PIHP board, employees of providers or such other persons in the healthcare field as the PIHP believes will be required to oversee the creation and control of a successful QA Program for the PIHP.

(b) The QA Program shall be a written program specifying:

(i) Utilization control procedures for the on-going evaluation, on a sample basis, of the need for, and the quality and timeliness of care provided to Medicaid eligibles by the PIHP.

(ii) Review procedures by appropriate health professionals of the process, following the provision of health services.

(iii) Procedures for systematic data collection of performance and patient results.

(iv) Procedures for interpretation of these data to the provider.

(v) Procedures for making needed changes.

(c) The QA Committee shall employ a professional staff to obtain and analyze data from Medicaid information systems, the provider hospitals, and such other sources as the staff deems necessary to carry out the QA Program. All costs of the QA Program shall be paid by the PIHP.

(d) PIHP member hospitals shall conduct continuing internal reviews of their own QA programs. The QA Committee staff shall be given all such assistance and direction by such provider QA programs and shall obtain such reasonable information from such providers as may be necessary to implement the PIHP QA Programs.

(e) The staff shall implement such focused medical reviews of the providers as may be required by Medicaid, required under the QA Program, or believed necessary the staff.

(f) Medicaid staff shall coordinate with the PIHP's QA Committee and staff on QA matters. Medicaid shall make such audits and surveys as it deems reasonably required, but shall do at least one annual medical audit on each PIHP and all of its providers. The PIHP shall provide all information, medical records, or assistance as may be reasonably required for Medicaid to conduct such audits.

(g) Medicaid QA personnel will make periodic on-site visits to review and monitor the QA Program and assess improvements in quality. The PIHP shall make certain all necessary information and records are available at such sites.

Author: Lynn Sharp, Associate Director, Institutional Services

Statutory Authority: 42 CFR Part 434 and 438; State Plan Attachment 4.19-A(f)

History: Rule amended July 12, 1996. Emergency rule effective October 1, 1996. Amended January 14, 1997; January 12, 1998; June 16, 2003.

Amended: Filed April 7, 2004; effective July 16, 2004.

Rule No 560-X-37-.04 Health Maintenance Organizations (HMO)

(1) Health Maintenance Organizations (HMOs) means any entity or corporation that undertakes to provide or arrange for basic health care services through an organized system which combines the delivery and financing of health care to enrollees. The organization shall provide physician services directly through physician employees or under contractual arrangements with either individual physicians or a group of physicians. The organization shall provide basic health care services directly or under contractual arrangements. When reasonable and appropriate, the organization may provide physician services and basic health care services through other arrangements. The organization may provide, or arrange for, health care services on a prepayment or other financial basis.

(2) Covered services shall be provided to each eligible enrollee and will be reimbursed on a monthly capitation basis.

(3) The HMO is required to obtain a Certificate of Authority to operate as a HMO in the State of Alabama, issued by the Department of Insurance prior to providing services. HMOs

must obtain a Certificate of Need (CON) or a letter of non-reviewability from the State Health Planning Agency. When applicable, the HMO may also be required to participate in an Invitation to Bid process as directed by the Medicaid Agency.

(4) The HMO shall make adequate provisions against the risk of insolvency as contained in the Code of Alabama Section 27-21A-12 and as specified in the contract between the HMO and Medicaid. The HMO must ensure that individuals eligible for benefits are never held liable for debts of the plan.

(5) HMOs desiring to participate as a managed care provider should contact the Medical Services Division at Medicaid. HMOs must submit written documentation for approval which includes, but is not limited to, the following:

- (a) Description of services to be provided
- (b) Marketing Plan and any marketing materials to be used by the plan
- (c) Quality Assurance Plan
- (d) Enrollment Plan
- (e) Education Plan
- (f) Copy of Certificate of Authority
- (g) Copy of Certificate of Need or letter of non-reviewability
- (h) Examples of subcontracts to be utilized by the plan
- (i) Proposed enrollment sites
- (j) Enrollment area
- (k) Grievance procedures

All of the above information must be sent before the review can be completed.

(6) The HMO must ensure contracted health services required by the enrollees are available and accessible through a system that arranges for primary and preventive care provided by and coordinated through a Medicaid enrolled Primary Care Physician (PCP).

(7) Enrollment

(a) In geographical areas that are served by a freedom-of-choice waiver, enrollment in an approved HMO is mandatory for those recipients included in the waiver. Recipients will have the opportunity to voluntarily enroll in an HMO during the open enrollment period, if applicable.

(b) In the event that a recipient who resides in an area that has a freedom-of-choice waiver does not select an HMO, Medicaid will mandatorily assign that recipient to an HMO. In an area where only one HMO is operational under an approved 1115 waiver, the recipient will be required to select a PCP within the HMO's network or be assigned. This will be done according to a formula which meets the needs of the State and the recipients and which is communicated to all health plans in advance. This formula may consist of rotation among the HMOs. Medicaid will notify the HMO of the recipients mandatorily enrolled in their plan via computer compatible media. Recipients that have been mandatorily assigned will also be notified by Medicaid. The effective date of enrollment generally will be the first day of the month following a full calendar

month after assignment to an HMO. It is the HMO's responsibility to send to Medicaid monthly, on computer compatible media, all current enrollees, new enrollees and disenrollments.

(8) Disenrollment

(a) When an enrollee becomes ineligible for Medicaid benefits, is deceased, moves out of the service area, or is changed to a non-covered aid category; the effective date of disenrollment will be the first day of the month following documentation of the change on the Managed Care File.

(b) Any enrollee may elect to disenroll from an HMO, with or without cause, and enroll in another where multiple HMOs participate in the Medicaid program in that area. Recipients are required to submit a written disenrollment request to the HMO with a reason documented in the patient file and on the monthly enrollment information. Disenrollment is effective the first day of the month following a full calendar month after receipt of the disenrollment on the monthly enrollment information.

(c) Unless otherwise specified in an approved waiver, an HMO may disenroll an enrollee whose behavior is disruptive, unruly, abusive, or uncooperative, and not caused by a medical condition, to the extent that his membership in the HMO seriously impairs the HMO's ability to furnish services to that enrollee or other members of the HMO. The HMO is required to provide at least one verbal and one written warning to the enrollee regarding the implication of his actions. No member can be involuntarily disenrolled without the prior written approval of Medicaid.

(d) Unacceptable reasons for an HMO to disenroll an enrollee include pre-existing medical conditions, changes in health status, and periodic missed appointments.

(e) Enrollees may be disenrolled for knowingly committing fraud or permitting abuse of their Medicaid card. Disenrollment of this nature must be promptly reported to Medicaid and must be prior authorized by Medicaid.

(f) The HMO's responsibility for all disenrollments includes supplying disenrollment forms to enrollees desiring to disenroll; ensuring that completed disenrollment forms are maintained in an identifiable enrollee record; ensuring that disenrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so; and ensuring that disenrollees receive written notification of the effective date of and reason for disenrollment. HMOs must submit voluntary disenrollments on the first electronic submission sent to Medicaid after the request is received by the HMO.

(9) Marketing

(a) The Medicaid Agency may elect to enroll recipients through contracted enrollment vendors. If the State chooses to use vendors, HMOs will not be allowed to enroll or recruit patients through marketing representatives.

(b) The HMO shall submit the written marketing plan, procedures, and materials to Medicaid for approval prior to implementation. Enrollment of recipients may not begin until the marketing plan has been approved by Medicaid.

(c) The HMO shall not engage in marketing practices that mislead, confuse, or defraud enrollees, providers, or Medicaid. Mailings, gifts of a material nature, telecommunication and door-to-door marketing are subject to prior approval by the Alabama Medicaid Agency.

(d) Accurate, clear, readable, and concise information shall be made available to eligible recipients and providers in the area serviced by the HMO. Such information shall include, but not be limited to: covered services, location, telephone number, hours of service, enrollment, disenrollment, grievance procedures, and what to do in case of an emergency.

(e) No more than fifty percent (50%) of a marketing representative's total annual compensation, including salary, benefits, bonuses and commission, shall come from commissions.

(10) Grievance Procedures

(a) The HMO shall have a written internal grievance procedure that is approved by Medicaid.

(b) The HMO must have written procedures for prompt and effective resolution of written enrollee grievances.

(c) The HMO must include a description of the grievance system including the right to appeal decisions.

(d) The HMO must maintain records of all oral complaints and written grievances in a log (hard copy or automated).

(e) The HMO must make provisions to accept and resolve grievances filed by individuals other than enrollees.

(11) Quality Assurance

(a) The HMO's Quality Assurance Plan (QAP) must objectively and systematically monitor and evaluate the quality and age appropriateness of care and services through quality of care studies and related activities by following written guidelines predicated on the Quality Assurance Reform Initiative (QARI) which must include:

(i) Goals and objectives;

(ii) Scope;

(iii) Specific activities;

(iv) Continuous activities;

(v) Provider review; and

(vi) Focus on health outcomes.

(b) The Governing Body of the HMO must be responsible for, or designate an accountable entity within the organization to be responsible for, oversight of the QAP.

(c) Each HMO must designate a committee responsible for the performance of QA functions accountable to the Governing Body.

(d) The QAP must objectively and systematically monitor and evaluate the quality and appropriateness of care and service through quality of care studies and related activities.

(e) Each HMO must designate a senior executive to be responsible for QAP implementation and the Medical Director must have subsequent involvement in QAP activities.

(f) The QA Committee must have, as members HMO providers representative of the composition of all providers of service.

(g) The QAP must include provisions for credentialing and recredentialing of health care professionals who are licensed by the State.

(h) HMOs shall allow Medicaid's authorized representative, on an annual basis, to conduct an external independent quality review to analyze the quality of services furnished by the HMO to ensure adequate delivery of care. The results of the review shall be made available

to Medicaid, and upon request, to the Secretary of HHS, the Inspector General, and the Comptroller General.

(12) Records

(a) An appropriate record system shall be maintained for all services (including ancillary services) provided to all enrollees. Such records shall be stored in a safe manner to prevent damage and unauthorized use. Records will be reasonably accessible for review.

(b) Entries on medical records shall be authenticated and written legibly in ink or typewritten.

(c) Records must contain all pertinent information relating to the medical management of each enrollee reflecting all aspects of patient care in a detailed, organized and comprehensive manner consistent with medical practice standards.

(d) The HMO shall make available at no cost to Medicaid, the Department of Health and Human Services, and to their designees, any records of the provider and/or subcontractors which relate to the HMO's ability to bear risks for the services performed, amounts paid for benefits, quality review, and any other requested documentation.

(13) Reporting

(a) The HMO shall furnish any information from its records to HHS, the Comptroller General, and/or their agents which may be required to administer the contract. At a minimum, the HMO shall furnish to Medicaid, and to authorized representatives, in a manner and form specified by Medicaid:

(i) Business transactions to include:

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

b. Any lending of money or other extension of credit between the HMO and a party in interest; and

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

The information which must be disclosed in the transactions listed above between an HMO and a party in interest includes the name of the party in interest for each transaction, a description of each transaction and the quality of units involved, the accrued dollar value of each transaction during the fiscal year and justification of the reasonableness of each transaction.

(ii) Proposed changes to the marketing plan, procedures or materials;

(iii) Monthly enrollment data to include name, Medicaid number, payee number, and PCP assignment number;

(iv) Utilization data concerning enrollees in the Plan as required by contract;

(v) Summaries of all complaints and all grievances received by the HMO under this contract and actions taken to resolve complaints and grievances quarterly and annually.

(vi) Summaries of amounts recovered from third parties for services rendered to enrollees under the HMO;

(vii) A list of payments made by the HMO during the past month for services purchased through referral and subcontracted providers;

(viii) Encounter data claims submitted directly to Medicaid's fiscal agent for all services paid for or provided by the HMO to enrollees in previous months; and

(x) All other reports as specified and defined in the Managed Care Provider Manual/Operational Protocol and contract.

(b) The HMO will keep and make available to Medicaid, HHS, the Comptroller General, and their agents or authorized representatives, any of the HMO's records which are necessary to fully disclose and substantiate the nature, quality, cost, and extent of items and services provided to enrollees. The HMO shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of five years from the date of the last payment made by Medicaid to the HMO under this contract. However, when audit, litigation, or other action involving records is initiated prior to the end of the five (5) years period, records shall be maintained for a period of five (5) years following the completion of such action and the resolution of all actions which arise from it. Plans shall fully complete and submit to Medicaid quarterly financial statements. Quarterly reports are due for periods ending March 31, June 30, September 30, and December 31 and must be submitted within 45 days of the end of the reporting period or the HMO shall pay a penalty of \$100.00 for each day the financial report is delinquent. In addition, the National Association of Insurance Commissioner's Annual Statement Blank, must be fully completed by Contractor annually and submitted to Medicaid. The HMO's annual report must be submitted no later than March 1 or Contractor shall pay to Medicaid a penalty of \$100.00 for each day the annual report is delinquent. However, the Commissioner of Medicaid shall have the option to waive the penalty with shown proof by the HMO of good cause for the delay. In addition, the HMO must submit an audited financial statement to Medicaid covering the fiscal year within 90 days of the end of its fiscal year. Contractor shall also promptly submit any and all other financial information requested by Medicaid, HHS, or the Comptroller General.

(14) Payment

(a) Capitation payments to the HMO for all eligible enrollees shall be made monthly.

(b) The HMO shall accept the capitation fees as payment in full for Medicaid benefits provided and shall require its providers to accept payments in full for Medicaid benefits provided.

(c) Neither managed care enrollees nor Medicaid shall be held liable for debts of the HMO in the event of the organization's insolvency.

(d) In-plan covered services must be provided by the HMO chosen by the recipient. These services can be provided directly, through subcontract providers, or by non-contract out-of-plan providers when appropriately referred.

(e) If an enrollee utilizes a non-contract provider for in-plan service, other than emergency services, family planning services, and services provided by a Federally Qualified Health Center (FQHC), the HMO, to the extent allowed by law, may not be held liable for the cost of such utilization unless the HMO referred the enrollee to the non-contract provider or authorized the out-of-plan utilization. Payment by the referring HMO for properly documented claims shall not exceed the maximum fee-for-service rates applicable for the provider for similar services rendered under the Alabama Medicaid Program, unless otherwise agreed upon by the

HMO and the non-contract provider. No reimbursement shall be available directly from Medicaid for in-plan services provided by non-contract providers. If there is an FQHC in the geographical area being served by a HMO that contracts with one or more HMO's, an enrollee may elect to join the HMO contracting with the FQHC in order to receive the services offered by the FQHC. If no FQHC in the area agrees to contract with any of the HMOs, the HMOs are obligated to reimburse the FQHC if an enrollee elects to receive services from this entity.

(15) Compliance Review Committee

(a) Alabama Medicaid shall establish a Compliance Review Committee (CRC).

The purpose of the CRC is to facilitate resolution of issues related to compliance with the requirements of the contract between the HMO and Medicaid.

(b) Administrative sanctions are reserved for managed care program abuses. Sanctions may be imposed by the Agency for failure to comply with Agency program requirements.

(c) In all cases of HMO abuse, restitution of improper payments or monetary sanctions may be pursued in addition to any administrative sanctions imposed. Administrative sanctions include, but are not limited to, probation. During probation, an HMO may have the number of enrollees it serves limited to a fixed number by the Agency for a set period of time. The HMO will be notified if probation has been authorized for a specific period of time and at the termination of the probation, the HMO will be subject to a follow-up review of its Medicaid Managed Care practice.

(d) The decision as to the sanction(s) to be imposed shall be at the discretion of the Medicaid Commissioner based on the recommendation(s) of the staff of the Managed Care Division, the CRC or other appropriate program review personnel.

(e) The following factors shall be considered in determining the sanctions to be imposed:

- (i) Seriousness of the offense(s)
- (ii) Extent of violations and history of prior violations
- (iii) Prior imposition of sanctions
- (iv) Actions taken or recommended by Peer Review Organizations or licensing

boards

- (v) Effect on health care delivery in the area

When an HMO is reviewed for administrative sanctions, the Agency shall notify the HMO of its final decision and the HMO's entitlement to a hearing in accordance with the Alabama Administrative Procedure Act.

(16) Childrens Health Insurance Program (CHIP)

Children eligible as CHIP children, aged up to 19, who reside in counties in which HMO coverage is available may be included in the program.

Author: Lynn Sharp, Associate Director, Institutional Services

Statutory Authority: Alabama State Plan for Medical Assistance (hereinafter State Plan), Section 2.1(c), Attachment 2.1-A; Attachment 4.18-A; Social Security Act, Title XI and Title XIX, Section 1903(m); 42 C.F.R. Section 434 et seq.; Civil Rights Act of 1964, Titles VI and

VII, as amended. Code of Alabama 1975, Section 22-21-20, et seq., Section 27-21A-1, et seq., and 41-22-1, et seq. The Federal Age Discrimination Act. Rehabilitation Act of 1973. The Americans with Disabilities act of 1990.

History: Effective date is July 12, 1996. Amended January 12, 1998. **Amended:** Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-37-.05 Medicare Health Maintenance Organizations (MHMOs) and Competitive Medical Plans (CMPs)

(1) A Medicare Health Maintenance Organizations (MHMO) and Competitive Medical Plans (CMP) are organizations which may contract with the Health Care Financing Administration (HCFA) to enroll Medicare beneficiaries and other individuals and groups to deliver a specified comprehensive range of high quality services efficiently, effectively, and economically to its Medicare enrollees. An HMO or CMP must be organized under the laws of the State and must meet HCFA's qualifying criteria, as specified in 42 C.F.R. §417.410-.418, in order to enter into a contract with HCFA to enroll Medicare beneficiaries.

A Competitive Medical Plan, as defined in 42 C.F.R. §417.407(c), is a legal entity, which provides to its enrollees at least the following services: services performed by physicians; laboratory, x-ray, emergency, and preventive services; out-of-area coverage; and inpatient hospital services. The entity receives compensation by Medicaid for the health care services it provides to enrollees on a periodic, prepaid capitation basis regardless of the frequency, extent, or kind of services provided to any enrollee. The entity provides physician services primarily through physicians who are employees or partners of the entity or physicians or groups of physicians (organized on a group or individual practice basis) under contract with the entity to provide physician services. The entity assumes full financial risk on a prospective basis for provision of health care services, but may obtain insurance or make other arrangements as specified in 42 C.F.R. §417.120 and .407. The entity must provide adequately against the risk of insolvency by meeting the fiscal and administrative requirements of 42 C.F.R. §417.120(a)(1)(i) through (a)(1)(iv) and 417.122(a).

(2) The Alabama Medicaid Agency may reimburse a fixed per member per month (PMPM) capitated payment established by Medicaid to HMOs and CMPs which have an approved Medicare risk contract with the Health Care Financing Administration for beneficiaries who enroll in a Medicare HMO or CMP for which Medicaid is responsible for payment of medical cost sharing. Medicare beneficiaries must receive Part A or Parts A&B coverage to be eligible for this program. This PMPM payment will cover, in full, any premiums or cost sharing required from the Medicare Plan. The PMPM payment will be established based on historical costs and negotiations.

(3) Medicare HMOs and CMPs may enroll with the Medicaid Agency to receive capitated payments for beneficiary premiums and cost sharing by executing a Memorandum Of Understanding with the Medicaid Agency. To enroll the following must be submitted to Medicaid:

(a) A copy of HCFA approval for a Medicare risk contract to enroll Medicare beneficiaries;

- (b) A copy of the HMO or the CMP's member services handbook; and
- (c) A copy of Certificate of Authority (COA) from the Alabama Insurance Department and appropriate approvals for a material modification to a COA.

(4) All services covered by Medicare shall be covered by the HMO or CMP at no cost to the beneficiary. In addition, the HMO or CMP may offer additional services to the beneficiary (e.g. hearing exams, annual physical exam, eye exams, etc.). The HMO or CMP must notify the Alabama Medicaid Agency prior to adding additional services (identified by procedure code) available to the beneficiary through the Plan. Services covered directly by Medicaid which are not covered by Medicare are not included in the Plan.

(5) The beneficiary will be given freedom of choice in selecting a primary care provider through the Medicare HMO or CMP.

(6) The Medicare HMO or CMP is required to submit a monthly electronic enrollment listing to Medicaid in a format specified by Medicaid.

Authority: State Plan 3.2(a)(10)(E)(i). Social Security Act §1905(p)(1). 42 C.F.R. Section 434.20, Section 434.26, Section 434.23, Section 434.29, Section 434.38, Section 434.6. Effective date is July 12, 1996.

Rule No. 560-X-37-.06 Reserved

Rule No. 560-X-37-.07 Regional Care Organizations (RCO)

The Alabama Medicaid Agency is responsible for the development and oversight of a Regional Care Organization (RCO) program as part of an overall managed care system within the state. This program will promote accountability for a patient population, coordinate items and services under Medicaid, and encourage investment in the infrastructure of care processes for higher quality and more efficient services provided to Medicaid beneficiaries.

Geographic Boundaries

(a) Effective October 1, 2013 the following designations of geographic boundaries have been established for RCO locations:

Region A includes Colbert, Cullman, Franklin, Jackson, Lauderdale, Lawrence, Limestone, Madison, Marshall, and Morgan counties.

Region B includes Blount, Calhoun, Cherokee, Chilton, Cleburne, Clay, Coosa, Dekalb, Etowah, Jefferson, Randolph, Shelby, St. Clair, Talladega, Tallapoosa and Walker counties.

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

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

Region E includes Baldwin, Clarke, Conecuh, Escambia, Mobile, Monroe, and Washington counties.

(b) Each region will be capable of supporting a minimum of two RCOs or alternate care providers.

Author: Nancy Headley, Director, Managed Care Division

Statutory Authority: Alabama State Plan for Medical Assistance (hereinafter State Plan), Section 2.1(c), Attachment 2.1-A; Social Security Act, Title XI and Title XIX, Section 1903(m) (2) (B); Act 2013-261.

History: New Rule filed: August 13, 2013. Effective: September 17, 2013.

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MATERNITY CARE PROGRAM

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Chapter 45 Maternity Care Program

Rule No. 560-X-45-.01 Authority and Purpose

(1) Pregnancy related care for Medicaid eligible women provided through the Maternity Care Program (MCP) is provided pursuant to the Alabama State Plan as approved by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) and the approved 1915(b) Waiver. The purpose of the program is to provide a comprehensive, coordinated system of obstetrical care to pregnant recipients.

(2) Coverage for the MCP includes the provisions of the Balanced Budget Act of 1997 and the subparts of the BBA Medicaid Managed Care regulation at 42 CFR Part 438.

(3) Program specifics are delineated in the Invitation to Bid (ITB) that is utilized for selection of Primary Contractors for the program.

Author: Gloria S. Luster, Associate Director, Maternity Care Program

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.

History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.02 Eligibility

(1) Pregnant women participating in the program are determined Medicaid eligible by Medicaid and/or other approved certifying agencies through the normal eligibility process. Persons eligible for the MCP are women deemed pregnant through medical examination and/or laboratory tests.

(2) Recipients eligible for both Medicare and Medicaid shall not be enrolled.

(3) Providers shall access eligibility information through the Medicaid Automated Voice Response System or the appropriate electronic software for specific information on the county of residence and the pregnancy restriction to a Primary Contractor.

Author: Gloria S. Luster, Associate Director, Maternity Care Program

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.

History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.03 Primary Contractor Standards

Primary Contractors must comply with the provisions of the executed contract, its amendments and referenced materials, the approved 1915(b) Waiver, and all other state and federal regulations governing the Medicaid program. The following outlines the standards for the Primary Contractor.

- (1) Demonstrate the capability to serve all of the pregnant Medicaid eligible population in the designated geographical area.
- (2) Procure a network of providers within a maximum of 50 miles travel for all areas of their district.
- (3) Designate a full time Director for the district(s) who has the authority to make day to day decisions, implement program policy, and oversee the provision of care to qualified recipients according to Federal and State regulations.
- (4) Establish business hours for the provision of maternity services. The Director or an appropriately qualified designee must be available and accessible during business hours for any administrative and/or medical problems which may arise.
- (5) Require subcontractors providing direct care to be on call or make provisions for medical problems 24-hours per day, seven days per week.
- (6) Require that all persons including employees, agents, subcontractors acting for or on behalf of the Primary Contractor, be properly licensed under applicable state laws and/or regulations.
- (7) Comply with certification and licensing laws and regulations applicable to the Primary Contractor's practice, profession or business. The Primary Contractor agrees to perform services consistent with the customary standards of practice and ethics in the profession.
- (8) Comply with State and Federal laws regarding excluded Individuals and Entities. The Primary Contractor agrees not to knowingly employ or subcontract with any health professional whose participation in the Medicaid and/or Medicare Program is currently suspended or has been terminated by Medicaid and/or Medicare.
- (9) Require that network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider only serves Medicaid recipients as required at 42 CFR 438.206(c)(1)(i).
- (10) Establish mechanisms to ensure that the network providers comply with timely access requirements. The primary contractor shall monitor regularly to determine

compliance and shall take corrective action if there is a failure to comply. Access requirements are further defined at 42 CFR 438.206(c)(1)(iv)(v)(vi).

(11) Comply with all State and Federal regulations regarding family planning services and sterilizations, including no restriction on utilization of services.

(12) Require all subcontractors providing direct services to meet the requirements of and enroll as Medicaid providers as applicable

(13) Require accurate completion and submission of encounter data claims to support the validity of data used for statistical purposes and to set actuarial sound capitation rates.

(14) Cooperate with external review agents who have been selected by the State to review the Program.

(15) Report suspected fraud and abuse to the Alabama Medicaid Agency. In addition, these policies and procedures must comply with all mandatory State guidelines and federal guidelines as specified at 42 CFR 438.608(b)(1).

(16) Prohibit discrimination against recipients based on their health status or need for health services as specified at 42 CFR 438.6(d)(3)(4).

(17) Ensure that medical records and any other health and enrollment information that identifies any individual enrollee must be handled in such a manner as to meet confidentiality requirements as specified in 42 CFR 438.224. Each Primary Contractor must establish and implement procedures consistent with confidentiality requirements as specified in 42 CFR 438.224.

(18) The Primary Contractor is not required to provide, reimburse payment, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds in accordance with 42 CFR 438.102(a)(b). If the Primary Contractor elects not to provide the service, then it must provide the related information to the State so that it can be provided to the recipient.

Author: Yulonda Morris, Program Coordinator and QA/QI Nurse, Maternity Care Program.

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.

History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005. **Amended:** Filed April 10, 2015; effective May 15, 2015.

Rule No. 560-X-45-.04 Primary Contractor Functions/Responsibilities

(1) Provide the pregnant Medicaid eligible population obstetrical care through a comprehensive system of quality care. The care can be provided directly or through subcontracts.

(2) Implement and maintain the Medicaid approved quality assurance system by which access, process and outcomes are measured.

(3) Utilize proper tools and service planning for women assessed to be medically or psychosocially at risk.

(4) Provide recipient choice among Delivering Healthcare Professionals in their network.

(5) Meet all requirements of the Provider Network including maintaining written subcontracts with providers to be used on a routine basis including but not limited to, delivering physicians including obstetricians, family practitioners, general practitioners, anesthesiologists, hospitals, and care coordinators. For the first 30 days prior to contract start date and for the 1st month of each succeeding contract year, the Primary Contractor must offer opportunities for participation to all interested potential subcontractors.

(6) Notify the Agency, in writing, of changes in the subcontractor base including the subcontractor's name, specialty, address, telephone number, fax number and Medicaid provider number.

(7) Maintain a toll-free line and designated staff to enroll recipients and provide program information. If the Primary Contractor, subcontractors and recipients are within the local calling distance area a toll-free line is not necessary.

(8) Require subcontractors to comply with advance directives requirements.

(9) Develop, implement and maintain an extensive recipient education plan covering subjects, including but not limited to, appropriate use of the medical care system, purpose of care coordination, healthy lifestyles, planning for baby, and self-care. All materials shall be available in English and the prevalent non-English language in the particular service area. The Primary Contractor is required to participate in the Agency's efforts to promote the delivery of services in a culturally competent manner including to those with limited English proficiency and with diverse cultural and ethnic backgrounds. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight and/or speech impairments. The Primary Contractor must make oral interpretation services available for all non-English languages free of charge to each enrollee and potential enrollee.

(10) Develop, implement, and maintain a provider education plan, covering

subjects including but not limited to, program guidelines, billing issues, and updates from Medicaid. Provide support and assistance to subcontractors including but not limited to, program guidelines, billing issues, and updates from Medicaid. Education shall be provided semi-annually.

(11) Develop, implement and maintain an effective outreach plan to make providers, recipients and the community aware of the purpose of the Alabama Medicaid Agency MCP and the services it offers. The Primary Contractor is refrained from marketing activities as specified in Administrative Code 560-X-37-.01(17) and as further defined in 42 CFR 438.104(a) and 438.104(b)(1) et al. At a minimum, such education shall be provided semi-annually.

(12) Develop, implement and maintain a recipient program explaining how to access the MCP including service locations. Materials shall provide information about recipient rights and responsibilities, provisions for after-hours and emergency care, referral policies, notification of change of benefits, procedures for appealing adverse decisions, procedures for changing DHCP, exemption procedures and grievance procedures. All materials shall be available in English and in the prevalent non-English language in the particular service area. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight and/or speech impairments, and make oral interpretation services available for all non-English languages free of charge to each enrollee and potential enrollee.

(13) Develop, implement and maintain a grievance procedure that is easily accessible and that is explained to recipients upon entry into the system.

(14) Develop, implement and maintain a system for handling billing inquiries from recipients and subcontractors so that inquiries are handled in a timely manner.

(15) Develop, implement and maintain a computer based data system that collects, integrates, analyzes and reports. Minimum capabilities include recipient tracking, billing and reimbursement, data analysis and the generation of reports regarding recipient services and utilization.

(16) Give Medicaid immediate notification, by telephone and followed in writing, of any action or suit filed and prompt notice of any claim made against the Primary Contractor by any subcontractor which may result in litigation related in any way to the subject matter of this Contract. In the event of the filing of a petition of bankruptcy by or against any subcontractor or the insolvency of any subcontractor, the Primary Contractor must ensure that all tasks related to any subcontractor are performed in accordance with the executed office.

(17) Ensure that subcontractor maintain for each recipient a complete record, including care coordination notes, at one location, of all services provided. Such information shall be accessible to the Primary Contractor and shall contain such information from all providers of service identified by recipient name, recipient number,

date of service, and services provided prior to making payment to that provider of service. It is acceptable to maintain one medical record and one administrative record (e.g. care coordination billing).

(18) Perform claims review prior to submission to Medicaid for Administrative Review.

(19) Advise recipients of services that may be covered by Medicaid that are not covered through the MCP.

(20) Promptly provide to Medicaid all information necessary for the reimbursement of outstanding claims in the event of insolvency.

(21) Coordinate care from out-of-network providers to ensure that there is no added cost to the enrollee.

(22) Provide Application Assister services to Medicaid recipients.

(23) Develop a system to ensure all written materials are drafted in an easily understood language and format. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

(24) Provide Medicaid copies of all medical record documentation from subcontractors for medical record reviews and other quality related activities as applicable.

(25) Designate a person to enter data and manage Medicaid's Service Database entries for each district. This designee is responsible for the transmission of valid, timely, complete and comprehensive data, along with auditing the database periodically.

(26) Coordinate Service Database data entries for recipients transferring from one district to another district to ensure transmission of valid, timely, complete and comprehensive data entries.

Author: Yulonda Morris, Program Coordinator and QA/QI Nurse, Maternity Care Program.

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.

History: New ruled filed: August 22, 2005; effective November 16, 2005. **Amended:** Filed April 10, 2015; effective May 15, 2015.

Rule No. 560-X-45-.05 Payment to Primary Contractors

- (1) Primary Contractors shall be reimbursed at a rate per global delivery as established through the open and competitive bid process.
- (2) Reimbursement rates per global delivery shall be actuarially sound and must be approved by Centers for Medicare and Medicaid Services (CMS).
- (3) Claims shall be submitted to Medicaid's Fiscal Agent for payment of the established rate through normal claim submission procedures.
- (4) Payment for the delivery of the infant(s) and all pregnancy care is payment in full for all services provided that are covered by the MCP.
- (5) Primary Contractors are not allowed to operate Physician Incentive Plans (PIPs) as explained in 42 CFR 422.208, 422.210 and 438.6(h) and 1903(m)(2)(A)(x) of the Social Security Act.
- (6) Primary Contractors cannot hold the enrollee liable for covered services in the event of the entity's insolvency, non-payment by the State, or excess payments as specified at 1932 (b)(6) of the Social Security Act and 42 CFR 438.106, 438.6, 438.230 and 438.204.

Author: Yulonda Morris, Program Coordinator and QA/QI Nurse, Maternity Care Program.

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Wavier.

History: New ruled filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005. **Amended:** Filed April 10, 2015; effective May 15, 2015.

Rule No. 560-X-45-.06 Covered Services

- (1) Primary Contractor Contractors shall have or arrange for a comprehensive system of maternity care that includes all services specified in the ITB used for selection of contractors. Detailed information regarding specific services covered by the MCP is provided in the ITB as well as the MCP Operational Manual
- (2) Excluded services shall be covered fee for service by Medicaid. Any fee for service payment is made according to the benefit limits and coverage limitations applicable for the eligibility classification.

Author: Gloria S. Luster, Associate Director, Maternity Care Program.

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.

History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.07 Complaints and Grievances

(1) Each Primary Contractor shall implement an approved written grievance system that meets the requirements of 42 CFR 431.201 including, but not limited to:

(a) Designation of a responsible Grievance Committee.

(b) Two levels of review for the resolution of grievances. The time frame for these reviews shall be based on the nature of the grievance and the immediacy or urgency of the health care needs of the Medicaid recipient.

(c) The primary entry level for complaints shall be a designated responsible representative of each Primary Contractor.

(d) Resolution of grievances of an immediate or urgent nature (life threatening situations, perceived harm, etc.) shall not exceed a forty-eight hour review within the Primary Contractor's review process, which includes subcontractor's review. The Grievance Committee's decision shall be binding unless the Medicaid recipient files a written appeal.

(e) If the Medicaid recipient is not satisfied with the findings of the Grievance Committee, the Medicaid recipient may appeal to the Medicaid Agency for an administrative fair hearing.

(f) All grievances shall be maintained in a log as specified in the MCP Manual.

(2) Handling of Grievance and Appeals. The Primary Contractor must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State established timeframes and as specified in CFR 438.408, 438.410, 438.416, 438.420 and 438.424, including but not limited to:

(a) General Requirements. In handling grievances and appeals, the following requirements must be met:

1. Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing numbers that have adequate TTY/TTD and interpreter capability.

2. Acknowledge receipt of each grievance and appeal.

3. Ensure that the individuals who make decisions on grievances and appeals are individuals-

(i) Who were not involved in any previous level of review or decision making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(I) An appeal of a denial that is based on lack of medical necessity.

(II) A grievance regarding denial of expedited resolution of an appeal.

(III) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

1. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

2. Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The Primary Contractor must inform the enrollee of the limited time available for this in the case of expedited resolution.)

3. Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

4. Include, as parties to the appeal-

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's estate.

(3) Service Authorizations and Notice of Action

(a) An action is defined as the Primary Contractor

including the type or level of service;

authorized service;

1. denying or limiting authorization of a requested service;

2. reduction, suspension or termination of a previously

authorized service;

3. the denial, in whole or part, of payment for a service;

4. the failure to provide services in a timely manner;

5. the failure to act within specified timeframes

(b) Adverse actions taken by the Primary Contractor must meet the requirements of 42 CFR 438.10, 438.12, 438.404 and 438.210-214.

(c) A service authorization is defined as an enrollee's request for the provision of a service.

(d) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must meet the requirements of 42 CFR 438.210.

Author: Gloria S. Luster, Associate Director, Maternity Care Program

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.

History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.08 District Designation and Selection of Primary Contractors

(1) The number of Primary Contractors shall be restricted to one in each of the geographic districts within the State. Geographic districts are based on county designation and are generally comprised of multiple counties. Counties for specific districts shall be identified during the open and competitive bid process for a specified time period as per the ITB.

(2) Primary Contractors shall be selected through evaluation of the ability of the provider's ability to provide required components of the MCP submitted by prospective entities during the competitive bid process as more fully described in the MCP ITB specifications.

Author: Gloria S. Luster, Associate Director, Maternity Care Program

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.

History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.09 Quality Improvement

(1) Each Primary Contractor shall provide an internal quality assurance (QA) system that meets all applicable state and federal guidelines and all quality requirements specified in the procurement document used in the bid process.

(2) Each Primary Contractor's Quality Assurance system shall include an ongoing quality assessment and performance improvement program as specified in 42 CFR 438.20 and a minimum of the following:

- (a) Utilization control procedures for the on-going evaluation, on a sample basis, of the quality and accessibility of care provided to program participants
- (b) Provide for review by appropriate health professionals of the process followed for providing health services
- (c) Provide for systematic data collection of performance and patient results
- (d) Provide for interpretation of this data
- (e) Provide for making needed changes

(3) Primary Contractors shall have a structured and active Quality Assurance Committee, which shall:

- (a) Be composed of, at a minimum, Program Director or designee, a board certified OB/GYN physician, a registered nurse with obstetrical experience, a licensed social worker, and hospital representation
- (b) Meet at least quarterly, but more often as needed, to demonstrate that the Committee is following up on all findings and required actions
- (c) Operates under the following parameters:

1. Information shall be treated as confidential in accordance with Medicaid rules and regulations and HIPAA - Health Insurance Portability and Accountability Act standards;
2. Committee shall identify actual and potential problems;
3. Committee shall develop appropriate recommendations for corrective action;
4. Committee shall perform follow-up on the recommendations to assure implementation of actions and continued monitoring, if necessary;
5. Committee shall collect data and analyze data;
6. Committee shall include utilization in quality assurance activities;
7. Committee shall include grievances in quality assurance activities;
8. Committee shall document all activities

(4) Each Primary Contractor shall have a written Quality Assurance (QA) Program description including:

- (a) A scope of work which addresses both the quality and clinical care as well as non-clinical care.
- (b) A written Quality Management plan which documents activities including: policies/procedures for performing chart reviews, utilization of provider and enrollee surveys, policies and procedures for analysis of data, procedures for analysis of administrative data and procedures for implementation of corrective action.
- (c) A methodology for measurement which includes all demographic groups.
- (d) Continuous performance of the activities to be tracked and the timeframes for reporting
- (e) Feedback to health professionals regarding performance and patient results.
- (f) Identification of individuals/organizations responsible for implementation of the QA plan.
- (g) Identification of relevant and measurable standards of care (minimum requirements are contained in the MCP Operational Manual).
- (h) Demonstration of measurable improvement of services being received through benchmarks (minimum requirements) are contained in the MCP Operational Manual).

(5) The Primary Contractor shall include in all subcontractor contracts and employment agreements a requirement securing cooperation with the Quality Assurance Program including access to records and responsible parties.

(6) Beneficiary survey results must be made available to the State upon request.

Author: Gloria S. Luster, Associate Director, Maternity Care Program

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.

History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.10 High Risk Protocols

(1) High risk care under the Maternity Care Program (MCP) shall be provided as outlined in the Invitation to Bid and the Maternity Care Operational Manual.

(2) Each recipient entering the MCP shall be assessed for high risk pregnancy status and referred to a Delivering Healthcare Professional qualified to provide high-risk care if the assessment reflects a condition that cannot be appropriately handled in routine prenatal care sites.

(3) Primary Contractors and their Delivering Healthcare Professionals are responsible for identification and referral of high risk recipients to the appropriate high risk referral site or appropriate high risk physician.

(4) A high-risk assessment tool approved by the Medicaid Agency shall be utilized in performing risk assessments.

(5) The reimbursement for high risk care provided by a Teaching Physician (as defined in Section 4.19-B of the State Plan) is excluded from the global and may be billed fee-for-service.

(6) The reimbursement for high risk care provided by a Medicaid Enrolled Board Certified Perinatologist is excluded from the global and may be billed fee-for-service.

Author: Yulonda Morris, Program Coordinator and QA/QI Nurse, Maternity Care Program.

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.

History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005. **Amended:** Filed April 10, 2015; effective May 15, 2015.

Rule No. 560-X-45-.11 Care Coordination

(1) Each Primary Contractor shall ensure that each woman enrolled in the program receives care coordination. Care coordination is the mechanism for linking and coordinating segments of the service delivery system and assuring that the recipient

care needs are met and provided at the appropriate level of care. Care Coordination is a resource that ensures that the care received in the program is augmented with appropriate psychosocial support.

(2) Care coordination requirements are delineated in the bid specification and MCP Operational Manual and include, but are not limited to:

- (a) Performing the initial encounter requirements
- (b) Psychosocial risk assessment
- (c) Assessing medical and social needs
- (d) Developing service plans
- (e) Providing information and education
- (f) Patient tracking
- (g) Encounters as specified throughout the course of the pregnancy.

Author: Gloria S. Luster, Associate Director, Maternity Care Program

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.

History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.12 Health Care Professional Panel

(1) Primary Contractors shall have a delivery system that meets Medicaid standards as defined in the bid. The Primary Contractor shall ensure that there are sufficient health care professionals and hospitals to perform the required duties as specified in the ITB and contract with Medicaid.

(2) Participation opportunities for Delivering Health Care Professionals shall be offered as specified in the ITB.

(3) Primary Contractors shall continually monitor the health care panel to assure adequate access to care for program recipients. Services shall be available to the recipients within the 50-mile/50 minute standard as required by Medicaid.

(4) Primary Contractors shall utilize in-state providers if time/distance or medical necessity is not a factor.

(5) Primary Contractor shall notify Medicaid within one working day of any unexpected changes that would impair the network or create access to care issues.

(6) All subcontracts must meet the requirements of 42 CFR 438.6.

Author: Gloria S. Luster, Associate Director, Maternity Care Program

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.

History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.13 Recipient Choice

(1) Women participating in the MCP shall be allowed to select the Delivering Health Care Professional of their choice from within the participating Delivering Health Care Professionals of the Primary Contractor. They may change professionals for cause at any time or without cause within 90 days of enrollment.

(2) Recipients who refuse to select a Delivering Health Care Professional shall be assigned one by the Primary Contractor who must follow assignment procedures specified in the MCP ITB.

(3) Lists of Delivering Health Care Professionals shall be maintained and utilized in the selection process.

(4) Recipients shall be provided all pertinent information about Delivering Health Care Professional as needed to make an informed selection. A toll free number must be available to recipients for use in selection of Delivering Health Care Professionals as well as for other questions/information.

Author: Gloria S. Luster, Associate Director, Maternity Care Program

Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.

History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

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Title 42: Public Health

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AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

SOURCE: 67 FR 41095, June 14, 2002, unless otherwise noted.

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Subpart A—General Provisions

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§438.1 Basis and scope.

(a) *Statutory basis.* This part is based on sections 1902(a)(4), 1903(m), 1905(t), and 1932 of the Act.

(1) Section 1902(a)(4) requires that States provide for methods of administration that the Secretary finds necessary for proper and efficient operation of the State plan. The application of the requirements of this part to PIHPs and PAHPs that do not meet the statutory definition of an MCO or a PCCM is under the authority in section 1902(a)(4).

(2) Section 1903(m) contains requirements that apply to comprehensive risk contracts.

(3) Section 1903(m)(2)(H) provides that an enrollee who loses Medicaid eligibility for not more than 2 months may be enrolled in the succeeding month in the same MCO or PCCM if that MCO or PCCM still has a contract with the State.

(4) Section 1905(t) contains requirements that apply to PCCMs.

(5) Section 1932—

(i) Provides that, with specified exceptions, a State may require Medicaid beneficiaries to enroll in MCOs or PCCMs;

(ii) Establishes the rules that MCOs, PCCMs, the State, and the contracts between the State and those entities must meet, including compliance with requirements in sections 1903(m) and 1905(t) of the Act that are implemented in this part;

(iii) Establishes protections for enrollees of MCOs and PCCMs;

(iv) Requires States to develop a quality assessment and performance improvement strategy;

(v) Specifies certain prohibitions aimed at the prevention of fraud and abuse;

(vi) Provides that a State may not enter into contracts with MCOs unless it has established intermediate sanctions that it may impose on an MCO that fails to comply with specified requirements; and

(vii) Makes other minor changes in the Medicaid program.

(b) *Scope.* This part sets forth requirements, prohibitions, and procedures for the provision of Medicaid services through MCOs, PIHPs, PAHPs, and PCCMs. Requirements vary depending on the type of entity and on the authority under which the State contracts with the entity. Provisions that apply only when the contract is under a mandatory managed care program authorized by section 1932(a)(1)(A) of the Act are identified as such.

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§438.2 Definitions.

As used in this part—

Capitation payment means a payment the State agency makes periodically to a contractor on behalf of each beneficiary enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

Comprehensive risk contract means a risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

- (1) Outpatient hospital services.
- (2) Rural health clinic services.
- (3) FQHC services.
- (4) Other laboratory and X-ray services.
- (5) Nursing facility (NF) services.
- (6) Early and periodic screening, diagnostic, and treatment (EPSDT) services.
- (7) Family planning services.
- (8) Physician services.
- (9) Home health services.

Federally qualified HMO means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

Health care professional means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Health insuring organization (HIO) means a county operated entity, that in exchange for capitation payments, covers services for beneficiaries—

- (1) Through payments to, or arrangements with, providers;
- (2) Under a comprehensive risk contract with the State; and
- (3) Meets the following criteria—

(i) First became operational prior to January 1, 1986; or

(ii) Is described in section 9517(e)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990).

Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is—

- (1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or
- (2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:

(i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

(ii) Meets the solvency standards of §438.116.

Nonrisk contract means a contract under which the contractor—

- (1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in §447.362 of this chapter; and
- (2) May be reimbursed by the State at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

Prepaid ambulatory health plan (PAHP) means an entity that—

- (1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
- (2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
- (3) Does not have a comprehensive risk contract.

Prepaid inpatient health plan (PIHP) means an entity that—

- (1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
- (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
- (3) Does not have a comprehensive risk contract.

Primary care means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary care case management means a system under which a PCCM contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries.

Primary care case manager (PCCM) means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services or, at State option, any of the following:

- (1) A physician assistant.
- (2) A nurse practitioner.
- (3) A certified nurse-midwife.

Risk contract means a contract under which the contractor—

- (1) Assumes risk for the cost of the services covered under the contract; and
- (2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

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§438.6 Contract requirements.

(a) *Regional office review.* The CMS Regional Office must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in §438.806.

(b) *Entities eligible for comprehensive risk contracts.* A State agency may enter into a comprehensive risk contract only with the following:

- (1) An MCO.
- (2) The entities identified in section 1903(m)(2)(B)(i), (ii), and (iii) of the Act.
- (3) Community, Migrant, and Appalachian Health Centers identified in section 1903(m)(2)(G) of the Act. Unless they qualify for a total exemption under section 1903(m)(2)(B) of the Act, these entities are subject to the regulations governing MCOs under this part.
- (4) An HIO that arranges for services and became operational before January 1986.
- (5) An HIO described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as added by section 4734(2) of the Omnibus Budget Reconciliation Act of 1990).

(c) *Payments under risk contracts—(1) Terminology.* As used in this paragraph, the following terms have the indicated meanings:

(i) *Actuarially sound capitation rates* means capitation rates that—

- (A) Have been developed in accordance with generally accepted actuarial principles and practices;
- (B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; and

(C) Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

(ii) *Adjustments to smooth data* means adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

(iii) *Cost neutral* means that the mechanism used to smooth data, share risk, or adjust for risk will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.

(iv) *Incentive arrangement* means any payment mechanism under which a contractor may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract.

(v) *Risk corridor* means a risk sharing mechanism in which States and contractors share in both profits and losses under the contract outside of predetermined threshold amount, so that after an initial corridor in which the contractor is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses, and receives a portion of any additional profits.

(2) *Basic requirements.* (i) All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound.

(ii) The contract must specify the payment rates and any risk-sharing mechanisms, and the actuarial basis for computation of those rates and mechanisms.

(3) *Requirements for actuarially sound rates.* In setting actuarially sound capitation rates, the State must apply the following elements, or explain why they are not applicable:

(i) Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population.

(ii) Adjustments made to smooth data and adjustments to account for factors such as medical trend inflation, incomplete data, MCO, PIHP, or PAHP administration (subject to the limits in paragraph (c)(4)(ii) of this section), and utilization;

(iii) Rate cells specific to the enrolled population, by—

(A) Eligibility category;

(B) Age;

(C) Gender;

(D) Locality/region; and

(E) Risk adjustments based on diagnosis or health status (if used).

(iv) Other payment mechanisms and utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk sharing, or other appropriate cost-neutral methods.

(v) For rates covering CYs 2013 and 2014, complying with minimum payment for physician services under paragraph (c)(5)(vi) of this section, and part 447, subpart G, of this chapter.

(4) *Documentation.* The State must provide the following documentation:

(i) The actuarial certification of the capitation rates.

(ii) An assurance (in accordance with paragraph (c)(3) of this section) that all payment rates are—

(A) Based only upon services covered under the State plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).

(B) Provided under the contract to Medicaid-eligible individuals.

(iii) The State's projection of expenditures under its previous year's contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract.

(iv) An explanation of any incentive arrangements, or stop-loss, reinsurance, or any other risk-sharing methodologies under the contract.

(5) *Special contract provisions.* (i) Contract provisions for reinsurance, stop-loss limits or other risk-sharing methodologies must be computed on an actuarially sound basis.

(ii) If risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments will not be considered actuarially sound to the extent that they result in total payments that exceed the amount Medicaid would have paid, on a fee-for-service basis, for the State plan services actually furnished to enrolled individuals, plus an amount for MCO, PIHP, or PAHP administrative costs directly related to the provision of these services.

(iii) Contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered to be actuarially sound.

(iv) For all incentive arrangements, the contract must provide that the arrangement is—

(A) For a fixed period of time;

(B) Not to be renewed automatically;

(C) Made available to both public and private contractors;

(D) Not conditioned on intergovernmental transfer agreements; and

(E) Necessary for the specified activities and targets.

(v) If a State makes payments to providers for graduate medical education (GME) costs under an approved State plan, the State must adjust the actuarially sound capitation rates to account for the GME payments to be made on behalf of enrollees covered under the contract, not to exceed the aggregate amount that would have been paid under the approved State plan for FFS. States must first establish actuarially sound capitation rates prior to making adjustments for GME.

(vi) For CYs 2013 and 2014, and payments to an MCO, PIHP or PAHP for primary care services furnished to enrollees under part 447, subpart G, of this chapter, the contract must require that the MCO, PIHP or PAHP meet the following requirements:

(A) Make payments to those specified physicians (whether directly or through a capitated arrangement) at least equal to the amounts set forth and required under part 447, subpart G, of this chapter.

(B) Provide documentation to the state, sufficient to enable the state and CMS to ensure that provider payments increase as required by paragraph (c)(5)(vi)(A) of this section.

(d) *Enrollment discrimination prohibited.* Contracts with MCOs, PIHPs, PAHPs, and PCCMs must provide as follows:

(1) The MCO, PIHP, PAHP, or PCCM accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by the Regional Administrator), up to the limits set under the contract.

(2) Enrollment is voluntary, except in the case of mandatory enrollment programs that meet the conditions set forth in §438.50(a).

(3) The MCO, PIHP, PAHP, or PCCM will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.

(4) The MCO, PIHP, PAHP, or PCCM will not discriminate against individuals eligible to enroll on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

(e) *Services that may be covered.* An MCO, PIHP, or PAHP contract may cover, for enrollees, services that are in addition to those covered under the State plan, although the cost of these services cannot be included when determining the payment rates under §438.6(c).

(f) *Compliance with contracting rules.* All contracts must meet the following provisions:

(1) Comply with all applicable Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1990 as amended.

(2) Provide for the following:

(i) Compliance with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in §434.6(a)(12) and §447.26 of this subchapter.

(ii) Reporting all identified provider-preventable conditions in a form or frequency as may be specified by the State.

(3) Meet all the requirements of this section.

(g) *Inspection and audit of financial records.* Risk contracts must provide that the State agency and the Department may inspect and audit any financial records of the entity or its subcontractors.

(h) *Physician incentive plans.* (1) MCO, PIHP, and PAHP contracts must provide for compliance with the requirements set forth in §§422.208 and 422.210 of this chapter.

(2) In applying the provisions of §§422.208 and 422.210 of this chapter, references to "M+C organization", "CMS", and "Medicare beneficiaries" must be read as references to "MCO, PIHP, or PAHP", "State agency" and "Medicaid beneficiaries", respectively.

(i) *Advance directives.* (1) All MCO and PIHP contracts must provide for compliance with the requirements of §422.128 of this chapter for maintaining written policies and procedures for advance directives.

(2) All PAHP contracts must provide for compliance with the requirements of §422.128 of this chapter for maintaining written policies and procedures for advance directives if the PAHP includes, in its network, any of those providers listed in §489.102(a) of this chapter.

(3) The MCO, PIHP, or PAHP subject to this requirement must provide adult enrollees with written information on advance directives policies, and include a description of applicable State law.

(4) The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

(j) *Special rules for certain HIOs.* Contracts with HIOs that began operating on or after January 1, 1986, and that the statute does not explicitly exempt from requirements in section 1903(m) of the Act, are subject to all the requirements of this part that apply to MCOs and contracts with MCOs. These HIOs may enter into comprehensive risk contracts only if they meet the criteria of paragraph (a) of this section.

(k) *Additional rules for contracts with PCCMs.* A PCCM contract must meet the following requirements:

(1) Provide for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.

(2) Restrict enrollment to beneficiaries who reside sufficiently near one of the manager's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation.

(3) Provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

(4) Prohibit discrimination in enrollment, disenrollment, and re-enrollment, based on the beneficiary's health status or need for health care services.

(5) Provide that enrollees have the right to disenroll from their PCCM in accordance with §438.56(c).

(l) *Subcontracts.* All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

(m) *Choice of health professional.* The contract must allow each enrollee to choose his or her health professional to the extent possible and appropriate.

[67 FR 41095, June 14, 2002, as amended at 76 FR 32837, June 6, 2011; 77 FR 66699, Nov. 6, 2012]

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§438.8 Provisions that apply to PIHPs and PAHPs.

(a) The following requirements and options apply to PIHPs, PIHP contracts, and States with respect to PIHPs, to the same extent that they apply to MCOs, MCO contracts, and States for MCOs.

(1) The contract requirements of §438.6, except for requirements that pertain to HIOs.

(2) The information requirements in §438.10.

(3) The provision against provider discrimination in §438.12.

(4) The State responsibility provisions of subpart B of this part except §438.50.

(5) The enrollee rights and protection provisions in subpart C of this part.

(6) The quality assessment and performance improvement provisions in subpart D of this part to the extent that they are applicable to services furnished by the PIHP.

(7) The grievance system provisions in subpart F of this part.

(8) The certification and program integrity protection provisions set forth in subpart H of this part.

(b) The following requirements and options for PAHPs apply to PAHPs, PAHP contracts, and States.

(1) The contract requirements of §438.6, except requirements for—

(i) HIOs.

(ii) Advance directives (unless the PAHP includes any of the providers listed in §489.102) of this chapter.

(2) All applicable portions of the information requirements in §438.10.

(3) The provision against provider discrimination in §438.12.

(4) The State responsibility provisions of subpart B of this part except §438.50.

(5) The provisions on enrollee rights and protections in subpart C of this part.

(6) Designated portions of subpart D of this part.

(7) An enrollee's right to a State fair hearing under subpart E of part 431 of this chapter.

(8) Prohibitions against affiliations with individuals debarred by Federal agencies in §438.610.

[67 FR 41095, June 14, 2002, as amended at 67 FR 65505, Oct. 25, 2002]

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§438.10 Information requirements.

(a) *Terminology.* As used in this section, the following terms have the indicated meanings:

Enrollee means a Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.

Potential enrollee means a Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, or PCCM.

(b) *Basic rules.* (1) Each State, enrollment broker, MCO, PIHP, PAHP, and PCCM must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.

(2) The State must have in place a mechanism to help enrollees and potential enrollees understand the State's managed care program.

(3) Each MCO and PIHP must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.

(c) *Language.* The State must do the following:

(1) Establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State. "Prevalent" means a non-English language spoken by a significant number or percentage of potential enrollees and enrollees in the State.

(2) Make available written information in each prevalent non-English language.

(3) Require each MCO, PIHP, PAHP, and PCCM to make its written information available in the prevalent non-English languages in its particular service area.

(4) Make oral interpretation services available and require each MCO, PIHP, PAHP, and PCCM to make those services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.

(5) Notify enrollees and potential enrollees, and require each MCO, PIHP, PAHP, and PCCM to notify its enrollees—

(i) That oral interpretation is available for any language and written information is available in prevalent languages; and

(ii) How to access those services.

(d) *Format.* (1) Written material must—

(i) Use easily understood language and format; and

(ii) Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

(2) All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

(e) *Information for potential enrollees.* (1) The State or its contracted representative must provide the information specified in paragraph (e) (2) of this section to each potential enrollee as follows:

(i) At the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program.

(ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHPs, PAHPs, or PCCMs.

(2) The information for potential enrollees must include the following:

(i) General information about—

(A) The basic features of managed care;

(B) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; and

(C) MCO, PIHP, PAHP, and PCCM responsibilities for coordination of enrollee care;

(ii) Information specific to each MCO, PIHP, PAHP, or PCCM program operating in potential enrollee's service area. A summary of the following information is sufficient, but the State must provide more detailed information upon request:

(A) Benefits covered.

(B) Cost sharing, if any.

(C) Service area.

(D) Names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs, this includes at a minimum information on primary care physicians, specialists, and hospitals.

(E) Benefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service.

(f) *General information for all enrollees of MCOs, PIHPs, PAHPs, and PCCMs.* Information must be furnished to MCO, PIHP, PAHP, and PCCM enrollees as follows:

(1) The State must notify all enrollees of their disenrollment rights, at a minimum, annually. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 days before the start of each enrollment period.

(2) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must notify all enrollees of their right to request and obtain the information listed in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least once a year.

(3) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must furnish to each of its enrollees the information specified in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, within a reasonable time after the MCO, PIHP, PAHP, or PCCM receives, from the State or its contracted representative, notice of the beneficiary's enrollment.

(4) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must give each enrollee written notice of any change (that the State defines as "significant") in the information specified in paragraphs (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least 30 days before the intended effective date of the change.

(5) The MCO, PIHP, and, when appropriate, the PAHP or PCCM, must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

(6) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must provide the following information to all enrollees:

(i) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs this includes, at a minimum, information on primary care physicians, specialists, and hospitals.

(ii) Any restrictions on the enrollee's freedom of choice among network providers.

(iii) Enrollee rights and protections, as specified in §438.100.

(iv) Information on grievance and fair hearing procedures, and for MCO and PIHP enrollees, the information specified in §438.10(g)(1), and for PAHP enrollees, the information specified in §438.10(h)(1).

(v) The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.

(vi) Procedures for obtaining benefits, including authorization requirements.

(vii) The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers.

(viii) The extent to which, and how, after-hours and emergency coverage are provided, including:

(A) What constitutes emergency medical condition, emergency services, and poststabilization services, with reference to the definitions in §438.114(a).

(B) The fact that prior authorization is not required for emergency services.

(C) The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.

(D) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services covered under the contract.

(E) The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.

(ix) The poststabilization care services rules set forth at §422.113(c) of this chapter.

(x) Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.

(xi) Cost sharing, if any.

(xii) How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service.

(g) *Specific information requirements for enrollees of MCOs and PIHPs.* In addition to the requirements in §438.10(f), the State, its contracted representative, or the MCO and PIHP must provide the following information to their enrollees:

(1) Grievance, appeal, and fair hearing procedures and timeframes, as provided in §§438.400 through 438.424, in a State-developed or State-approved description, that must include the following:

(i) For State fair hearing—

(A) The right to hearing;

(B) The method for obtaining a hearing; and

(C) The rules that govern representation at the hearing.

(ii) The right to file grievances and appeals.

(iii) The requirements and timeframes for filing a grievance or appeal.

(iv) The availability of assistance in the filing process.

(v) The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.

(vi) The fact that, when requested by the enrollee—

(A) Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and

(B) The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.

(vii) Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.

(2) Advance directives, as set forth in §438.6(i)(2).

(3) Additional information that is available upon request, including the following:

(i) Information on the structure and operation of the MCO or PIHP.

(ii) Physician incentive plans as set forth in §438.6(h) of this chapter.

(h) *Specific information for PAHPs.* The State, its contracted representative, or the PAHP must provide the following information to their enrollees:

(1) The right to a State fair hearing, including the following:

- (i) The right to a hearing.
- (ii) The method for obtaining a hearing.
- (iii) The rules that govern representation.

(2) Advance directives, as set forth in §438.6(i)(2), to the extent that the PAHP includes any of the providers listed in §489.102(a) of this chapter.

(3) Upon request, physician incentive plans as set forth in §438.6(h).

(i) *Special rules: States with mandatory enrollment under State plan authority—(1) Basic rule.* If the State plan provides for mandatory enrollment under §438.50, the State or its contracted representative must provide information on MCOs and PCCMs (as specified in paragraph (i)(3) of this section), either directly or through the MCO or PCCM.

(2) *When and how the information must be furnished.* The information must be furnished as follows:

- (i) For potential enrollees, within the timeframe specified in §438.10(e)(1).
- (ii) For enrollees, annually and upon request.
- (iii) In a comparative, chart-like format.

(3) *Required information.* Some of the information is the same as the information required for potential enrollees under paragraph (e) of this section and for enrollees under paragraph (f) of this section. However, all of the information in this paragraph is subject to the timeframe and format requirements of paragraph (i)(2) of this section, and includes the following for each contracting MCO or PCCM in the potential enrollees and enrollee's service area:

- (i) The MCO's or PCCM's service area.
- (ii) The benefits covered under the contract.
- (iii) Any cost sharing imposed by the MCO or PCCM.
- (iv) To the extent available, quality and performance indicators, including enrollee satisfaction.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

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§438.12 Provider discrimination prohibited.

(a) *General rules.* (1) An MCO, PIHP, or PAHP may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If an MCO, PIHP, or PAHP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

(2) In all contracts with health care professionals, an MCO, PIHP, or PAHP must comply with the requirements specified in §438.214.

(b) *Construction.* Paragraph (a) of this section may not be construed to—

- (1) Require the MCO, PIHP, or PAHP to contract with providers beyond the number necessary to meet the needs of its enrollees;
- (2) Preclude the MCO, PIHP, or PAHP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
- (3) Preclude the MCO, PIHP, or PAHP from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

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Subpart B—State Responsibilities

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§438.50 State Plan requirements.

(a) *General rule.* A State plan that requires Medicaid beneficiaries to enroll in managed care entities must comply with the provisions of this section, except when the State imposes the requirement—

- (1) As part of a demonstration project under section 1115 of the Act; or
- (2) Under a waiver granted under section 1915(b) of the Act.

(b) *State plan information.* The plan must specify—

- (1) The types of entities with which the State contracts;
- (2) The payment method it uses (for example, whether fee-for-service or capitation);
- (3) Whether it contracts on a comprehensive risk basis; and

(4) The process the State uses to involve the public in both design and initial implementation of the program and the methods it uses to ensure ongoing public involvement once the State plan has been implemented.

(c) *State plan assurances.* The plan must provide assurances that the State meets applicable requirements of the following statute and regulations:

(1) Section 1903(m) of the Act, for MCOs and MCO contracts.

(2) Section 1905(t) of the Act, for PCCMs and PCCM contracts.

(3) Section 1932(a)(1)(A) of the Act, for the State's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities.

(4) This part, for MCOs and PCCMs.

(5) Part 434 of this chapter, for all contracts.

(6) Section 438.6(c), for payments under any risk contracts, and §447.362 of this chapter for payments under any nonrisk contracts.

(d) *Limitations on enrollment.* The State must provide assurances that, in implementing the State plan managed care option, it will not require the following groups to enroll in an MCO or PCCM:

(1) beneficiaries who are also eligible for Medicare.

(2) Indians who are members of Federally recognized tribes, except when the MCO or PCCM is—

(i) The Indian Health Service; or

(ii) An Indian health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.

(3) Children under 19 years of age who are—

(i) Eligible for SSI under title XVI;

(ii) Eligible under section 1902(e)(3) of the Act;

(iii) In foster care or other out-of-home placement;

(iv) Receiving foster care or adoption assistance; or

(v) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the State in terms of either program participation or special health care needs.

(e) *Priority for enrollment.* The State must have an enrollment system under which beneficiaries already enrolled in an MCO or PCCM are given priority to continue that enrollment if the MCO or PCCM does not have the capacity to accept all those seeking enrollment under the program.

(f) *Enrollment by default.* (1) For beneficiaries who do not choose an MCO or PCCM during their enrollment period, the State must have a default enrollment process for assigning those beneficiaries to contracting MCOs and PCCMs.

(2) The process must seek to preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries. If that is not possible, the State must distribute the beneficiaries equitably among qualified MCOs and PCCMs available to enroll them, excluding those that are subject to the intermediate sanction described in §438.702(a)(4).

(3) An "existing provider-beneficiary relationship" is one in which the provider was the main source of Medicaid services for the beneficiary during the previous year. This may be established through State records of previous managed care enrollment or fee-for-service experience, or through contact with the beneficiary.

(4) A provider is considered to have "traditionally served" Medicaid beneficiaries if it has experience in serving the Medicaid population.

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§438.52 Choice of MCOs, PIHPs, PAHPs, and PCCMs.

(a) *General rule.* Except as specified in paragraphs (b) and (c) of this section, a State that requires Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

(b) *Exception for rural area residents.* (1) Under any of the following programs, and subject to the requirements of paragraph (b)(2) of this section, a State may limit a rural area resident to a single MCO, PIHP, PAHP, or PCCM system:

(i) A program authorized by a plan amendment under section 1932(a) of the Act.

(ii) A waiver under section 1115 of the Act.

(iii) A waiver under section 1915(b) of the Act.

(2) A State that elects the option provided under paragraph (b)(1) of this section, must permit the beneficiary—

(i) To choose from at least two physicians or case managers; and

(ii) To obtain services from any other provider under any of the following circumstances:

(A) The service or type of provider (in terms of training, experience, and specialization) is not available within the MCO, PIHP, PAHP, or PCCM network.

(B) The provider is not part of the network, but is the main source of a service to the beneficiary, provided that—

(1) The provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO, PIHP, PAHP, or PCCM network as other network providers of that type.

(2) If the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the enrollee will be transitioned to a participating provider within 60 days (after being given an opportunity to select a provider who participates).

(C) The only plan or provider available to the beneficiary does not, because of moral or religious objections, provide the service the enrollee seeks.

(D) The beneficiary's primary care provider or other provider determines that the beneficiary needs related services that would subject the beneficiary to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.

(E) The State determines that other circumstances warrant out-of-network treatment.

(3) As used in this paragraph, "rural area" is any area other than an "urban area" as defined in §412.62(f)(1)(ii) of this chapter.

(c) *Exception for certain health insuring organizations (HIOs).* The State may limit beneficiaries to a single HIO if—

(1) The HIO is one of those described in section 1932(a)(3)(C) of the Act; and

(2) The beneficiary who enrolls in the HIO has a choice of at least two primary care providers within the entity.

(d) *Limitations on changes between primary care providers.* For an enrollee of a single MCO, PIHP, PAHP, or HIO under paragraph (b) or (c) of this section, any limitation the State imposes on his or her freedom to change between primary care providers may be no more restrictive than the limitations on disenrollment under §438.56(c).

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

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§438.56 Disenrollment: Requirements and limitations.

(a) *Applicability.* The provisions of this section apply to all managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with an MCO, a PIHP, a PAHP, or a PCCM.

(b) *Disenrollment requested by the MCO, PIHP, PAHP, or PCCM.* All MCO, PIHP, PAHP, and PCCM contracts must—(1) Specify the reasons for which the MCO, PIHP, PAHP, or PCCM may request disenrollment of an enrollee;

(2) Provide that the MCO, PIHP, PAHP, or PCCM may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, or PCCM seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees); and

(3) Specify the methods by which the MCO, PIHP, PAHP, or PCCM assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.

(c) *Disenrollment requested by the enrollee.* If the State chooses to limit disenrollment, its MCO, PIHP, PAHP, and PCCM contracts must provide that a beneficiary may request disenrollment as follows:

(1) For cause, at any time.

(2) Without cause, at the following times:

(i) During the 90 days following the date of the beneficiary's initial enrollment with the MCO, PIHP, PAHP, or PCCM, or the date the State sends the beneficiary notice of the enrollment, whichever is later.

(ii) At least once every 12 months thereafter.

(iii) Upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.

(iv) When the State imposes the intermediate sanction specified in §438.702(a)(3).

(d) *Procedures for disenrollment—(1) Request for disenrollment.* The beneficiary (or his or her representative) must submit an oral or written request—

(i) To the State agency (or its agent); or

(ii) To the MCO, PIHP, PAHP, or PCCM, if the State permits MCOs, PIHP, PAHPs, and PCCMs to process disenrollment requests.

(2) *Cause for disenrollment.* The following are cause for disenrollment:

(i) The enrollee moves out of the MCO's, PIHP's, PAHP's, or PCCM's service area.

(ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks.

(iii) The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

(iv) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

(3) *MCO, PIHP, PAHP, or PCCM action on request.* (i) An MCO, PIHP, PAHP, or PCCM may either approve a request for disenrollment or refer the request to the State.

(ii) If the MCO, PIHP, PAHP, PCCM, or State agency (whichever is responsible) fails to make a disenrollment determination so that the beneficiary can be disenrolled within the timeframes specified in paragraph (e)(1) of this section, the disenrollment is considered approved.

(4) *State agency action on request.* For a request received directly from the beneficiary, or one referred by the MCO, PIHP, PAHP, or PCCM, the State agency must take action to approve or disapprove the request based on the following:

(i) Reasons cited in the request.

(ii) Information provided by the MCO, PIHP, PAHP, or PCCM at the agency's request.

(iii) Any of the reasons specified in paragraph (d)(2) of this section.

(5) *Use of the MCO, PIHP, PAHP, or PCCM grievance procedures.* (i) The State agency may require that the enrollee seek redress through the MCO, PIHP, PAHP, or PCCM's grievance system before making a determination on the enrollee's request.

(ii) The grievance process, if used, must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in §438.56(e)(1).

(iii) If, as a result of the grievance process, the MCO, PIHP, PAHP, or PCCM approves the disenrollment, the State agency is not required to make a determination.

(e) *Timeframe for disenrollment determinations.* (1) Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the MCO, PIHP, PAHP, or PCCM files the request.

(2) If the MCO, PIHP, PAHP, or PCCM or the State agency (whichever is responsible) fails to make the determination within the timeframes specified in paragraph (e)(1) of this section, the disenrollment is considered approved.

(f) *Notice and appeals.* A State that restricts disenrollment under this section must take the following actions:

(1) Provide that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period.

(2) Ensure access to State fair hearing for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment.

(g) *Automatic reenrollment: Contract requirement.* If the State plan so specifies, the contract must provide for automatic reenrollment of a beneficiary who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

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§438.58 Conflict of interest safeguards.

(a) As a condition for contracting with MCOs, PIHPs, or PAHPs, a State must have in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or the default enrollment process specified in §438.50(f).

(b) These safeguards must be at least as effective as the safeguards specified in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

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§438.60 Limit on payment to other providers.

The State agency must ensure that no payment is made to a provider other than the MCO, PIHP, or PAHP for services available under the contract between the State and the MCO, PIHP, or PAHP, except when these payments are provided for in title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract, in accordance with §438.6(c)(5)(v), to make payments for graduate medical education.

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§438.62 Continued services to beneficiaries.

The State agency must arrange for Medicaid services to be provided without delay to any Medicaid enrollee of an MCO, PIHP, PAHP, or PCCM whose contract is terminated and for any Medicaid enrollee who is disenrolled from an MCO, PIHP, PAHP, or PCCM for any reason other than ineligibility for Medicaid.

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§438.66 Monitoring procedures.

The State agency must have in effect procedures for monitoring the MCO's, PIHP's, or PAHP's operations, including, at a minimum, operations related to the following:

- (a) beneficiary enrollment and disenrollment.
- (b) Processing of grievances and appeals.
- (c) Violations subject to intermediate sanctions, as set forth in subpart I of this part.
- (d) Violations of the conditions for FFP, as set forth in subpart J of this part.
- (e) All other provisions of the contract, as appropriate.

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Subpart C—Enrollee Rights and Protections

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§438.100 Enrollee rights.

(a) *General rule.* The State must ensure that—

- (1) Each MCO and PIHP has written policies regarding the enrollee rights specified in this section; and
- (2) Each MCO, PIHP, PAHP, and PCCM complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees.

(b) *Specific rights—(1) Basic requirement.* The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (b)(3) of this section.

(2) An enrollee of an MCO, PIHP, PAHP, or PCCM has the following rights: The right to—

- (i) Receive information in accordance with §438.10.
- (ii) Be treated with respect and with due consideration for his or her dignity and privacy.
- (iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in §438.10(f)(6)(xii).)
- (iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.
- (v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
- (vi) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.

(3) An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with §§438.206 through 438.210.

(c) *Free exercise of rights.* The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, or PCCM and its providers or the State agency treat the enrollee.

(d) *Compliance with other Federal and State laws.* The State must ensure that each MCO, PIHP, PAHP, and PCCM complies with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

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§438.102 Provider-enrollee communications.

(a) *General rules.* (1) An MCO, PIHP, or PAHP may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following:

- (i) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- (ii) Any information the enrollee needs in order to decide among all relevant treatment options.
- (iii) The risks, benefits, and consequences of treatment or nontreatment.
- (iv) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(2) Subject to the information requirements of paragraph (b) of this section, an MCO, PIHP, or PAHP that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement in paragraph (a)(1) of this section is not required to do so if the MCO, PIHP, or PAHP objects to the service on moral or religious grounds.

(b) *Information requirements: MCO, PIHP, and PAHP responsibility.* (1) An MCO, PIHP, or PAHP that elects the option provided in paragraph (a)(2) of this section must furnish information about the services it does not cover as follows:

(i) To the State—

- (A) With its application for a Medicaid contract; and
- (B) Whenever it adopts the policy during the term of the contract.

(ii) Consistent with the provisions of §438.10—

- (A) To potential enrollees, before and during enrollment; and
- (B) To enrollees, within 90 days after adopting the policy with respect to any particular service. (Although this timeframe would be sufficient to entitle the MCO, PIHP, or PAHP to the option provided in paragraph (a)(2) of this section, the overriding rule in §438.10(f)(4) requires the State, its contracted representative, or MCO, PIHP, or PAHP to furnish the information at least 30 days before the effective date of the policy.)

(2) As specified in §438.10, paragraphs (e) and (f), the information that MCOs, PIHPs, and PAHPs must furnish to enrollees and potential enrollees does not include how and where to obtain the service excluded under paragraph (a)(2) of this section.

(c) *Information requirements: State responsibility.* For each service excluded by an MCO, PIHP, or PAHP under paragraph (a)(2) of this section, the State must provide information on how and where to obtain the service, as specified in §438.10, paragraphs (e)(2)(ii)(E) and (f)(6)(xii).

(d) *Sanction.* An MCO that violates the prohibition of paragraph (a)(1) of this section is subject to intermediate sanctions under subpart I of this part.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

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§438.104 Marketing activities.

(a) *Terminology.* As used in this section, the following terms have the indicated meanings:

Cold-call marketing means any unsolicited personal contact by the MCO, PIHP, PAHP, or PCCM with a potential enrollee for the purpose of marketing as defined in this paragraph.

Marketing means any communication, from an MCO, PIHP, PAHP, or PCCM to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's, PIHP's, PAHP's, or PCCM's Medicaid product, or either to not enroll in, or to disenroll from, another MCO's, PIHP's, PAHP's, or PCCM's Medicaid product.

Marketing materials means materials that—

- (1) Are produced in any medium, by or on behalf of an MCO, PIHP, PAHP, or PCCM; and
- (2) Can reasonably be interpreted as intended to market to potential enrollees.

MCO, PIHP, PAHP, or PCCM include any of the entity's employees, affiliated providers, agents, or contractors.

(b) *Contract requirements.* Each contract with an MCO, PIHP, PAHP, or PCCM must comply with the following requirements:

(1) Provide that the entity—

- (i) Does not distribute any marketing materials without first obtaining State approval;
- (ii) Distributes the materials to its entire service area as indicated in the contract;
- (iii) Complies with the information requirements of §438.10 to ensure that, before enrolling, the beneficiary receives, from the entity or the State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll;
- (iv) Does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and
- (v) Does not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

(2) Specify the methods by which the entity assures the State agency that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the beneficiaries or the State agency. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that—

- (i) The beneficiary must enroll in the MCO, PIHP, PAHP, or PCCM in order to obtain benefits or in order to not lose benefits; or
- (ii) The MCO, PIHP, PAHP, or PCCM is endorsed by CMS, the Federal or State government, or similar entity.

(c) *State agency review.* In reviewing the marketing materials submitted by the entity, the State must consult with the Medical Care Advisory Committee established under §431.12 of this chapter or an advisory committee with similar membership.

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§438.106 Liability for payment.

Each MCO, PIHP, and PAHP must provide that its Medicaid enrollees are not held liable for any of the following:

- (a) The MCO's, PIHP's, or PAHP's debts, in the event of the entity's insolvency.

(b) Covered services provided to the enrollee, for which—

(1) The State does not pay the MCO, PIHP, or PAHP; or

(2) The State, or the MCO, PIHP, or PAHP does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.

(c) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the MCO, PIHP, or PAHP provided the services directly.

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§438.108 Cost sharing.

The contract must provide that any cost sharing imposed on Medicaid enrollees is in accordance with §§447.50 through 447.57 of this chapter.

[67 FR 41095, June 14, 2002, as amended at 78 FR 42305, July 15, 2013]

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§438.114 Emergency and poststabilization services.

(a) *Definitions.* As used in this section—

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are as follows:

(1) Furnished by a provider that is qualified to furnish these services under this title.

(2) Needed to evaluate or stabilize an emergency medical condition.

Poststabilization care services means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition.

(b) *Coverage and payment: General rule.* The following entities are responsible for coverage and payment of emergency services and poststabilization care services.

(1) The MCO, PIHP, or PAHP.

(2) The PCCM that has a risk contract that covers these services.

(3) The State, in the case of a PCCM that has a fee-for-service contract.

(c) *Coverage and payment: Emergency services—*(1) The entities identified in paragraph (b) of this section—

(i) Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO, PIHP, PAHP, or PCCM; and

(ii) May not deny payment for treatment obtained under either of the following circumstances:

(A) An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of *emergency medical condition* in paragraph (a) of this section.

(B) A representative of the MCO, PIHP, PAHP, or PCCM instructs the enrollee to seek emergency services.

(2) A PCCM must—

(i) Allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnishes the services; and

(ii) Pay for the services if the manager's contract is a risk contract that covers those services.

(d) *Additional rules for emergency services.* (1) The entities specified in paragraph (b) of this section may not—

(i) Limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms; and

(ii) Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, PIHP, PAHP or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

(2) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

(3) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment.

(e) *Coverage and payment: Poststabilization care services.* Poststabilization care services are covered and paid for in accordance with provisions set forth at §422.113(c) of this chapter. In applying those provisions, reference to "M+C organization" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section.

(f) *Applicability to PIHPs and PAHPs.* To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the PIHP or PAHP is responsible, the rules under this section apply.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

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§438.116 Solvency standards.

(a) *Requirement for assurances* (1) Each MCO, PIHP, and PAHP that is not a Federally qualified HMO (as defined in section 1310 of the Public Health Service Act) must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the MCO's, PIHP's, or PAHP's debts if the entity becomes insolvent.

(2) Federally qualified HMOs, as defined in section 1310 of the Public Health Service Act, are exempt from this requirement.

(b) *Other requirements*—(1) *General rule.* Except as provided in paragraph (b)(2) of this section, an MCO or PIHP, must meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity.

(2) *Exception.* Paragraph (b)(1) of this section does not apply to an MCO or PIHP, that meets any of the following conditions:

(i) Does not provide both inpatient hospital services and physician services.

(ii) Is a public entity.

(iii) Is (or is controlled by) one or more Federally qualified health centers and meets the solvency standards established by the State for those centers.

(iv) Has its solvency guaranteed by the State.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

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Subpart D—Quality Assessment and Performance Improvement

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§438.200 Scope.

This subpart implements section 1932(c)(1) of the Act and sets forth specifications for quality assessment and performance improvement strategies that States must implement to ensure the delivery of quality health care by all MCOs, PIHPs, and PAHPs. It also establishes standards that States, MCOs, PIHPs, and PAHPs must meet.

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§438.202 State responsibilities.

Each State contracting with an MCO or PIHP must do the following:

(a) Have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

(b) Obtain the input of beneficiaries and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final.

(c) Ensure that MCOs, PIHPs, and PAHPs comply with standards established by the State, consistent with this subpart.

(d) Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy periodically, as needed.

(e) Submit to CMS the following:

(1) A copy of the initial strategy, and a copy of the revised strategy whenever significant changes are made.

(2) Regular reports on the implementation and effectiveness of the strategy.

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§438.204 Elements of State quality strategies.

At a minimum, State strategies must include the following:

(a) The MCO and PIHP contract provisions that incorporate the standards specified in this subpart.

(b) Procedures that—

- (1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.
- (2) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.
- (3) Regularly monitor and evaluate the MCO and PIHP compliance with the standards.
- (c) For MCOs and PIHPs, any national performance measures and levels that may be identified and developed by CMS in consultation with States and other relevant stakeholders.
- (d) Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO and PIHP contract.
- (e) For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.
- (f) An information system that supports initial and ongoing operation and review of the State's quality strategy.
- (g) Standards, at least as stringent as those in the following sections of this subpart, for access to care, structure and operations, and quality measurement and improvement.

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ACCESS STANDARDS

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§438.206 Availability of services.

- (a) *Basic rule.* Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs.
- (b) *Delivery network.* The State must ensure, through its contracts, that each MCO, and each PIHP and PAHP consistent with the scope of the PIHP's or PAHP's contracted services, meets the following requirements:
 - (1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO, PIHP, and PAHP must consider the following:
 - (i) The anticipated Medicaid enrollment.
 - (ii) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO, PIHP, and PAHP.
 - (iii) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.
 - (iv) The numbers of network providers who are not accepting new Medicaid patients.
 - (v) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.
 - (2) Provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.
 - (3) Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.
 - (4) If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, or PAHP must adequately and timely cover these services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP is unable to provide them.
 - (5) Requires out-of-network providers to coordinate with the MCO or PIHP with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.
 - (6) Demonstrates that its providers are credentialed as required by §438.214.
- (c) *Furnishing of services.* The State must ensure that each MCO, PIHP, and PAHP contract complies with the requirements of this paragraph.
 - (1) *Timely access.* Each MCO, PIHP, and PAHP must do the following:
 - (i) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.
 - (ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
 - (iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

- (iv) Establish mechanisms to ensure compliance by providers.
- (v) Monitor providers regularly to determine compliance.
- (vi) Take corrective action if there is a failure to comply.

(2) *Cultural considerations.* Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

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§438.207 Assurances of adequate capacity and services.

(a) *Basic rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this subpart.

(b) *Nature of supporting documentation.* Each MCO, PIHP, and PAHP must submit documentation to the State, in a format specified by the State to demonstrate that it complies with the following requirements:

(1) Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area.

(2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

(c) *Timing of documentation.* Each MCO, PIHP, and PAHP must submit the documentation described in paragraph (b) of this section as specified by the State, but no less frequently than the following:

(1) At the time it enters into a contract with the State.

(2) At any time there has been a significant change (as defined by the State) in the MCO's, PIHP's, or PAHP's operations that would affect adequate capacity and services, including—

- (i) Changes in MCO, PIHP, or PAHP services, benefits, geographic service area or payments; or
- (ii) Enrollment of a new population in the MCO, PIHP, or PAHP.

(d) *State review and certification to CMS.* After the State reviews the documentation submitted by the MCO, PIHP, or PAHP, the State must certify to CMS that the MCO, PIHP, or PAHP has complied with the State's requirements for availability of services, as set forth in §438.206.

(e) *CMS' right to inspect documentation.* The State must make available to CMS, upon request, all documentation collected by the State from the MCO, PIHP, or PAHP.

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§438.208 Coordination and continuity of care.

(a) *Basic requirement—(1) General rule.* Except as specified in paragraphs (a)(2) and (a)(3) of this section, the State must ensure through its contracts, that each MCO, PIHP, and PAHP complies with the requirements of this section.

(2) *PIHP and PAHP exception.* For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to—

- (i) Meet the primary care requirement of paragraph (b)(1) of this section; and
- (ii) Implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in paragraph (c) of this section.

(3) *Exception for MCOs that serve dually eligible enrollees.* (i) For each MCO that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare+Choice plan, the State determines to what extent the MCO must meet the primary care coordination, identification, assessment, and treatment planning provisions of paragraphs (b) and (c) of this section with respect to dually eligible individuals.

(ii) The State bases its determination on the services it requires the MCO to furnish to dually eligible enrollees.

(b) *Primary care and coordination of health care services for all MCO, PIHP, and PAHP enrollees.* Each MCO, PIHP, and PAHP must implement procedures to deliver primary care to and coordinate health care service for all MCO, PIHP, and PAHP enrollees. These procedures must meet State requirements and must do the following:

(1) Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

(2) Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP, or PAHP.

(3) Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.

(4) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

(c) *Additional services for enrollees with special health care needs—(1) Identification.* The State must implement mechanisms to identify persons with special health care needs to MCOs, PIHPs and PAHPs, as those persons are defined by the State. These identification mechanisms—

(i) Must be specified in the State's quality improvement strategy in §438.202; and

(ii) May use State staff, the State's enrollment broker, or the State's MCOs,

PIHPs and PAHPs.

(2) *Assessment.* Each MCO, PIHP, and PAHP must implement mechanisms to assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph (c)(1) of this section) and identified to the MCO, PIHP, and PAHP by the State as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

(3) *Treatment plans.* If the State requires MCOs, PIHPs, and PAHPs to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be—

(i) Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;

(ii) Approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO, PIHP, or PAHP; and

(iii) In accord with any applicable State quality assurance and utilization review standards.

(4) *Direct access to specialists.* For enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with §438.208(c)(2)) to need a course of treatment or regular care monitoring, each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

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§438.210 Coverage and authorization of services.

(a) *Coverage.* Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in §440.230.

(3) Provide that the MCO, PIHP, or PAHP—

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service—

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes "medically necessary services" in a manner that—

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require—

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP—

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

(c) *Notice of adverse action.* Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.

(d) *Timeframe for decisions.* Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—

(i) The enrollee, or the provider, requests extension; or

(ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(2) *Expedited authorization decisions.* (i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.

(ii) The MCO, PIHP, or PAHP may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(e) *Compensation for utilization management activities.* Each contract must provide that, consistent with §438.6(h), and §422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

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STRUCTURE AND OPERATION STANDARDS

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§438.214 Provider selection.

(a) *General rules.* The State must ensure, through its contracts, that each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of providers and that those policies and procedures include, at a minimum, the requirements of this section.

(b) *Credentialing and recredentialing requirements.* (1) Each State must establish a uniform credentialing and recredentialing policy that each MCO, PIHP, and PAHP must follow.

(2) Each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO, PIHP, or PAHP.

(c) *Nondiscrimination.* MCO, PIHP, and PAHP provider selection policies and procedures, consistent with §438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(d) *Excluded providers.* MCOs, PIHPs, and PAHPs may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

(e) *State requirements.* Each MCO, PIHP, and PAHP must comply with any additional requirements established by the State.

[67 FR 41095, June 14, 2002; 67 FR 54532, Aug. 22, 2002]

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§438.218 Enrollee information.

The requirements that States must meet under §438.10 constitute part of the State's quality strategy at §438.204.

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§438.224 Confidentiality.

The State must ensure, through its contracts, that (consistent with subpart F of part 431 of this chapter), for medical records and any other health and enrollment information that identifies a particular enrollee, each MCO, PIHP, and PAHP uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.

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§438.226 Enrollment and disenrollment.

The State must ensure that each MCO, PIHP, and PAHP contract complies with the enrollment and disenrollment requirements and limitations set forth in §438.56.

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§438.228 Grievance systems.

(a) The State must ensure, through its contracts, that each MCO and PIHP has in effect a grievance system that meets the requirements of subpart F of this part.

(b) If the State delegates to the MCO or PIHP responsibility for notice of action under subpart E of part 431 of this chapter, the State must conduct random reviews of each delegated MCO or PIHP and its providers and subcontractors to ensure that they are notifying enrollees in a timely manner.

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§438.230 Subcontractual relationships and delegation.

(a) *General rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP—

- (1) Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor; and
- (2) Meets the conditions of paragraph (b) of this section.

(b) *Specific conditions.* (1) Before any delegation, each MCO, PIHP, and PAHP evaluates the prospective subcontractor's ability to perform the activities to be delegated.

(2) There is a written agreement that—

- (i) Specifies the activities and report responsibilities delegated to the subcontractor; and
- (ii) Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

(3) The MCO, PIHP, or PAHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.

(4) If any MCO, PIHP, or PAHP identifies deficiencies or areas for improvement, the MCO, PIHP, or PAHP and the subcontractor take corrective action.

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MEASUREMENT AND IMPROVEMENT STANDARDS

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§438.236 Practice guidelines.

(a) *Basic rule:* The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) *Adoption of practice guidelines.* Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

- (1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
- (2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.
- (3) Are adopted in consultation with contracting health care professionals.
- (4) Are reviewed and updated periodically as appropriate.

(c) *Dissemination of guidelines.* Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) *Application of guidelines.* Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

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§438.240 Quality assessment and performance improvement program.

(a) *General rules.* (1) The State must require, through its contracts, that each MCO and PIHP have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.

(2) CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by States in their contracts with MCOs and PIHPs.

(b) *Basic elements of MCO and PIHP quality assessment and performance improvement programs.* At a minimum, the State must require that each MCO and PIHP comply with the following requirements:

(1) Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

- (2) Submit performance measurement data as described in paragraph (c) of this section.
- (3) Have in effect mechanisms to detect both underutilization and overutilization of services.
- (4) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

(c) *Performance measurement.* Annually each MCO and PIHP must—

(1) Measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements of §§438.204(c) and 438.240(a)(2);

(2) Submit to the State, data specified by the State, that enables the State to measure the MCO's or PIHP's performance; or

(3) Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section.

(d) *Performance improvement projects.* (1) MCOs and PIHPs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following:

(i) Measurement of performance using objective quality indicators.

(ii) Implementation of system interventions to achieve improvement in quality.

(iii) Evaluation of the effectiveness of the interventions.

(iv) Planning and initiation of activities for increasing or sustaining improvement.

(2) Each MCO and PIHP must report the status and results of each project to the State as requested, including those that incorporate the requirements of §438.240(a)(2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

(e) *Program review by the State.* (1) The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's quality assessment and performance improvement program. The review must include—

(i) The MCO's and PIHP's performance on the standard measures on which it is required to report; and

(ii) The results of each MCO's and PIHP's performance improvement projects.

(2) The State may require that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.

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§438.242 Health information systems.

(a) *General rule.* The State must ensure, through its contracts, that each MCO and PIHP maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

(b) *Basic elements of a health information system.* The State must require, at a minimum, that each MCO and PIHP comply with the following:

(1) Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.

(2) Ensure that data received from providers is accurate and complete by—

(i) Verifying the accuracy and timeliness of reported data;

(ii) Screening the data for completeness, logic, and consistency; and

(iii) Collecting service information in standardized formats to the extent feasible and appropriate.

(3) Make all collected data available to the State and upon request to CMS, as required in this subpart.

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Subpart E—External Quality Review

SOURCE: 68 FR 3635, Jan. 24, 2003, unless otherwise noted.

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§438.310 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart is based on sections 1932(c)(2), 1903(a)(3)(C)(ii), and 1902(a)(4) of the Act.

(b) *Scope.* This subpart sets forth requirements for annual external quality reviews of each contracting managed care organization (MCO) and prepaid inpatient health plan (PIHP), including—

(1) Criteria that States must use in selecting entities to perform the reviews;

(2) Specifications for the activities related to external quality review;

(3) Circumstances under which external quality review may use the results of Medicare quality reviews or private accreditation reviews; and

(4) Standards for making available the results of the reviews.

(c) *Applicability.* The provisions of this subpart apply to MCOs, PIHPs, and to health insuring organizations (HIOs) that began on or after January 1, 1986 that the statute does not explicitly exempt from requirements in section 1903(m) of the Act.

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§438.320 Definitions.

As used in this subpart—

EQR stands for external quality review.

EQRO stands for external quality review organization.

External quality review means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their contractors furnish to Medicaid beneficiaries.

External quality review organization means an organization that meets the competence and independence requirements set forth in §438.354, and performs external quality review, other EQR-related activities as set forth in §438.358, or both.

Financial relationship means—

(1) A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or

(2) A compensation arrangement with an entity.

Quality, as it pertains to external quality review, means the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Validation means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

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§438.350 State responsibilities.

Each State that contracts with MCOs or PIHPs must ensure that—

(a) Except as provided in §438.362, a qualified EQRO performs an annual EQR for each contracting MCO or PIHP;

(b) The EQRO has sufficient information to use in performing the review;

(c) The information used to carry out the review must be obtained from the EQR-related activities described in §438.358.

(d) For each EQR-related activity, the information must include the elements described in §438.364(a)(1)(i) through (a)(1)(iv);

(e) The information provided to the EQRO in accordance with paragraph (c) of this section is obtained through methods consistent with the protocols established under §438.352; and

(f) The results of the reviews are made available as specified in §438.364.

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§438.352 External quality review protocols.

Each protocol must specify—

(a) The data to be gathered;

(b) The sources of the data;

(c) The activities and steps to be followed in collecting the data to promote its accuracy, validity, and reliability;

(d) The proposed method or methods for validly analyzing and interpreting the data once obtained; and

(e) Instructions, guidelines, worksheets, and other documents or tools necessary for implementing the protocol.

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§438.354 Qualifications of external quality review organizations.

(a) *General rule.* The State must ensure that an EQRO meets the requirements of this section.

(b) *Competence.* The EQRO must have at a minimum the following:

(1) Staff with demonstrated experience and knowledge of—

(i) Medicaid beneficiaries, policies, data systems, and processes;

(ii) Managed care delivery systems, organizations, and financing;

(iii) Quality assessment and improvement methods; and

(iv) Research design and methodology, including statistical analysis.

(2) Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities.

(3) Other clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractors.

(c) *Independence.* The EQRO and its subcontractors are independent from the State Medicaid agency and from the MCOs or PIHPs that they review. To qualify as "independent"—

(1) A State agency, department, university, or other State entity may not have Medicaid purchasing or managed care licensing authority; and

(2) A State agency, department, university, or other State entity must be governed by a Board or similar body the majority of whose members are not government employees.

(3) An EQRO may not—

(i) Review a particular MCO or PIHP if either the EQRO or the MCO or PIHP exerts control over the other (as used in this paragraph, "control" has the meaning given the term in 48 CFR 19.101) through—

(A) Stock ownership;

(B) Stock options and convertible debentures;

(C) Voting trusts;

(D) Common management, including interlocking management; and

(E) Contractual relationships.

(ii) Deliver any health care services to Medicaid beneficiaries;

(iii) Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO or PIHP services, except for the related activities specified in §438.358; or

(iv) Have a present, or known future, direct or indirect financial relationship with an MCO or PIHP that it will review as an EQRO.

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§438.356 State contract options.

(a) The State—

(1) Must contract with one EQRO to conduct either EQR alone or EQR and other EQR-related activities; and

(2) May contract with additional EQROs to conduct EQR-related activities as set forth in §438.358.

(b) Each EQRO must meet the competence requirements as specified in §438.354(b).

(c) Each EQRO is permitted to use subcontractors. The EQRO is accountable for, and must oversee, all subcontractor functions.

(d) Each EQRO and its subcontractors performing EQR or EQR-related activities must meet the requirements for independence, as specified in §438.354(c).

(e) For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.

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§438.358 Activities related to external quality review.

(a) *General rule.* The State, its agent that is not an MCO or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities in this section.

(b) *Mandatory activities.* For each MCO and PIHP, the EQR must use information from the following activities:

(1) Validation of performance improvement projects required by the State to comply with requirements set forth in §438.240(b)(1) and that were underway during the preceding 12 months.

(2) Validation of MCO or PIHP performance measures reported (as required by the State) or MCO or PIHP performance measure calculated by the State during the preceding 12 months to comply with requirements set forth in §438.240(b)(2).

(3) A review, conducted within the previous 3-year period, to determine the MCO's or PIHP's compliance with standards (except with respect to standards under §438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) established by the State to comply with the requirements of §438.204(g).

(c) *Optional activities.* The EQR may also use information derived during the preceding 12 months from the following optional activities:

(1) Validation of encounter data reported by an MCO or PIHP.

(2) Administration or validation of consumer or provider surveys of quality of care.

(3) Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO.

(4) Conduct of performance improvement projects in addition to those conducted by an MCO or PIHP and validated by an EQRO.

(5) Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

(d) *Technical assistance.* The EQRO may, at the State's direction, provide technical guidance to groups of MCOs or PIHPs to assist them in conducting activities related to the mandatory and optional activities that provide information for the EQR.

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§438.360 Nonduplication of mandatory activities.

(a) *General rule.* To avoid duplication, the State may use, in place of a Medicaid review by the State, its agent, or EQRO, information about the MCO or PIHP obtained from a Medicare or private accreditation review to provide information otherwise obtained from the mandatory activities specified in §438.358 if the conditions of paragraph (b) or paragraph (c) of this section are met.

(b) *MCOs or PIHPs reviewed by Medicare or private accrediting organizations.* For information about an MCO's or PIHP's compliance with one or more standards required under §438.204(g), (except with respect to standards under §438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) the following conditions must be met:

(1) The MCO or PIHP is in compliance with standards established by CMS for Medicare+Choice or a national accrediting organization. The CMS or national accreditation standards are comparable to standards established by the State to comply with §438.204(g) and the EQR-related activity under §438.358(b)(3).

(2) Compliance with the standards is determined either by—

(i) CMS or its contractor for Medicare; or

(ii) A private national accrediting organization that CMS has approved as applying standards at least as stringent as Medicare under the procedures in §422.158.

(3) The MCO or PIHP provides to the State all the reports, findings, and other results of the Medicare or private accreditation review applicable to the standards provided for in §438.204(g); and the State provides the information to the EQRO.

(4) In its quality strategy, the State identifies the standards for which the EQR will use information from Medicare or private accreditation reviews, and explains its rationale for why the standards are duplicative.

(c) *Additional provisions for MCOs or PIHPs serving only dually eligibles.* The State may use information obtained from the Medicare program in place of information produced by the State, its agent, or EQRO with respect to the mandatory activities specified in §438.358 (b)(1) and (b)(2) if the following conditions are met:

(1) The MCO or PIHP serves only individuals who receive both Medicare and Medicaid benefits.

(2) The Medicare review activities are substantially comparable to the State-specified mandatory activities in §438.358(b)(1) and (b)(2).

(3) The MCO or PIHP provides to the State all the reports, findings, and other results of the Medicare review from the activities specified under §438.358(b)(1) and (b)(2) and the State provides the information to the EQRO.

(4) In its quality strategy, the State identifies the mandatory activities for which it has exercised this option and explains its rationale for why these activities are duplicative.

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§438.362 Exemption from external quality review.

(a) *Basis for exemption.* The State may exempt an MCO or PIHP from EQR if the following conditions are met:

(1) The MCO or PIHP has a current Medicare contract under part C of title XVIII or under section 1876 of the Act, and a current Medicaid contract under section 1903(m) of the Act.

(2) The two contracts cover all or part of the same geographic area within the State.

(3) The Medicaid contract has been in effect for at least 2 consecutive years before the effective date of the exemption and during those 2 years the MCO or PIHP has been subject to EQR under this part, and found to be performing acceptably with respect to the quality, timeliness, and access to health care services it provides to Medicaid beneficiaries.

(b) *Information on exempted MCOs or PIHPs.* When the State exercises this option, the State must obtain either of the following:

(1) *Information on Medicare review findings.* Each year, the State must obtain from each MCO or PIHP that it exempts from EQR the most recent Medicare review findings reported on the MCO or PIHP including—

(i) All data, correspondence, information, and findings pertaining to the MCO's or PIHP's compliance with Medicare standards for access, quality assessment and performance improvement, health services, or delegation of these activities;

(ii) All measures of the MCO's or PIHP's performance; and

(iii) The findings and results of all performance improvement projects pertaining to Medicare enrollees.

(2) *Medicare information from a private, national accrediting organization that CMS approves and recognizes for Medicare+Choice deeming.* (i) If an exempted MCO or PIHP has been reviewed by a private accrediting organization, the State must require the MCO or PIHP to provide the State with a copy of all findings pertaining to its most recent accreditation review if that review has been used for either of the following purposes:

(A) To fulfill certain requirements for Medicare external review under subpart D of part 422 of this chapter.

(B) To deem compliance with Medicare requirements, as provided in §422.156 of this chapter.

(ii) These findings must include, but need not be limited to, accreditation review results of evaluation of compliance with individual accreditation standards, noted deficiencies, corrective action plans, and summaries of unmet accreditation requirements.

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§438.364 External quality review results.

(a) *Information that must be produced.* The State must ensure that the EQR produces at least the following information:

(1) A detailed technical report that describes the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP. The report must also include the following for each activity conducted in accordance with §438.358:

- (i) Objectives.
- (ii) Technical methods of data collection and analysis.
- (iii) Description of data obtained.
- (iv) Conclusions drawn from the data.

(2) An assessment of each MCO's or PIHP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

(3) Recommendations for improving the quality of health care services furnished by each MCO or PIHP.

(4) As the State determines, methodologically appropriate, comparative information about all MCOs and PIHPs.

(5) An assessment of the degree to which each MCO or PIHP has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

(b) *Availability of information.* The State must provide copies of the information specified in paragraph (a) of this section, upon request, through print or electronic media, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO or PIHP, beneficiary advocacy groups, and members of the general public. The State must make this information available in alternative formats for persons with sensory impairments, when requested.

(c) *Safeguarding patient identity.* The information released under paragraph (b) of this section may not disclose the identity of any patient.

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§438.370 Federal financial participation.

(a) FFP at the 75 percent rate is available in expenditures for EQR (including the production of EQR results) and EQR-related activities set forth in §438.358 conducted by EQROs and their subcontractors.

(b) FFP at the 50 percent rate is available in expenditures for EQR-related activities conducted by any entity that does not qualify as an EQRO.

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Subpart F—Grievance System

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§438.400 Statutory basis and definitions.

(a) *Statutory basis.* This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) *Definitions.* As used in this subpart, the following terms have the indicated meanings:

Action means—

In the case of an MCO or PIHP—

- (1) The denial or limited authorization of a requested service, including the type or level of service;
- (2) The reduction, suspension, or termination of a previously authorized service;
- (3) The denial, in whole or in part, of payment for a service;
- (4) The failure to provide services in a timely manner, as defined by the State;
- (5) The failure of an MCO or PIHP to act within the timeframes provided in §438.408(b); or

(6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under §438.52 (b)(2)(ii), to obtain services outside the network.

Appeal means a request for review of an action, as "action" is defined in this section.

Grievance means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

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§438.402 General requirements.

(a) *The grievance system.* Each MCO and PIHP must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system.

(b) *Filing requirements—(1) Authority to file.* (i) An enrollee may file a grievance and an MCO or PIHP level appeal, and may request a State fair hearing.

(ii) A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.

(2) *Timing.* The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the MCO's or PIHP's notice of action. Within that timeframe—

(i) The enrollee or the provider may file an appeal; and

(ii) In a State that does not require exhaustion of MCO and PIHP level appeals, the enrollee may request a State fair hearing.

(3) *Procedures.* (i) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO or the PIHP.

(ii) The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.

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§438.404 Notice of action.

(a) *Language and format requirements.* The notice must be in writing and must meet the language and format requirements of §438.10(c) and (d) to ensure ease of understanding.

(b) *Content of notice.* The notice must explain the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take.

(2) The reasons for the action.

(3) The enrollee's or the provider's right to file an MCO or PIHP appeal.

(4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.

(5) The procedures for exercising the rights specified in this paragraph.

(6) The circumstances under which expedited resolution is available and how to request it.

(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(c) *Timing of notice.* The MCO or PIHP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1).

(4) If the MCO or PIHP extends the timeframe in accordance with §438.210(d)(1), it must—

(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in §438.210(d).

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§438.406 Handling of grievances and appeals.

(a) *General requirements.* In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals—

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(b) *Special requirements for appeals.* The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal—

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's estate.

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§438.408 Resolution and notification: Grievances and appeals.

(a) *Basic rule.* The MCO or PIHP must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.

(b) *Specific timeframes—*(1) *Standard disposition of grievances.* For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 days from the day the MCO or PIHP receives the grievance.

(2) *Standard resolution of appeals.* For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(3) *Expedited resolution of appeals.* For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(c) *Extension of timeframes—*(1) The MCO or PIHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—

(i) The enrollee requests the extension; or

(ii) The MCO or PIHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.

(2) *Requirements following extension.* If the MCO or PIHP extends the timeframes, it must—for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.

(d) *Format of notice—*(1) *Grievances.* The State must establish the method MCOs and PIHPs will use to notify an enrollee of the disposition of a grievance.

(2) *Appeals.* (i) For all appeals, the MCO or PIHP must provide written notice of disposition.

(ii) For notice of an expedited resolution, the MCO or PIHP must also make reasonable efforts to provide oral notice.

(e) *Content of notice of appeal resolution.* The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the enrollees—

(i) The right to request a State fair hearing, and how to do so;

(ii) The right to request to receive benefits while the hearing is pending, and how to make the request; and

(iii) That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the MCO's or PIHP's action.

(f) *Requirements for State fair hearings*—(1) *Availability*. The State must permit the enrollee to request a State fair hearing within a reasonable time period specified by the State, but not less than 20 or in excess of 90 days from whichever of the following dates applies—

(i) If the State requires exhaustion of the MCO or PIHP level appeal procedures, from the date of the MCO's or PIHP's notice of resolution; or

(ii) If the State does not require exhaustion of the MCO or PIHP level appeal procedures and the enrollee appeals directly to the State for a fair hearing, from the date on the MCO's or PIHP's notice of action.

(2) *Parties*. The parties to the State fair hearing include the MCO or PIHP as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

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§438.410 Expedited resolution of appeals.

(a) *General rule*. Each MCO and PIHP must establish and maintain an expedited review process for appeals, when the MCO or PIHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

(b) *Punitive action*. The MCO or PIHP must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(c) *Action following denial of a request for expedited resolution*. If the MCO or PIHP denies a request for expedited resolution of an appeal, it must—

(1) Transfer the appeal to the timeframe for standard resolution in accordance with §438.408(b)(2);

(2) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.

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§438.414 Information about the grievance system to providers and subcontractors.

The MCO or PIHP must provide the information specified at §438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

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§438.416 Recordkeeping and reporting requirements.

The State must require MCOs and PIHPs to maintain records of grievances and appeals and must review the information as part of the State quality strategy.

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§438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending.

(a) *Terminology*. As used in this section, "timely" filing means filing on or before the later of the following:

(1) Within ten days of the MCO or PIHP mailing the notice of action.

(2) The intended effective date of the MCO's or PIHP's proposed action.

(b) *Continuation of benefits*. The MCO or PIHP must continue the enrollee's benefits if—

(1) The enrollee or the provider files the appeal timely;

(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(3) The services were ordered by an authorized provider;

(4) The original period covered by the original authorization has not expired; and

(5) The enrollee requests extension of benefits.

(c) *Duration of continued or reinstated benefits*. If, at the enrollee's request, the MCO or PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

(1) The enrollee withdraws the appeal.

(2) Ten days pass after the MCO or PIHP mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.

(3) A State fair hearing Office issues a hearing decision adverse to the enrollee.

(4) The time period or service limits of a previously authorized service has been met.

(d) *Enrollee responsibility for services furnished while the appeal is pending.* If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in §431.230(b) of this chapter.

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§438.424 Effectuation of reversed appeal resolutions.

(a) *Services not furnished while the appeal is pending.* If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO or PIHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

(b) *Services furnished while the appeal is pending.* If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the PIHP or the State must pay for those services, in accordance with State policy and regulations.

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Subpart G [Reserved]

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Subpart H—Certifications and Program Integrity

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§438.600 Statutory basis.

This subpart is based on sections 1902(a)(4), 1902(a)(19), 1903(m), and 1932(d)(1) of the Act.

(a) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(b) Section 1902(a)(19) requires that the State plan provide the safeguards necessary to ensure that eligibility is determined and services are provided in a manner consistent with simplicity of administration and the best interests of the beneficiaries.

(c) Section 1903(m) establishes conditions for payments to the State with respect to contracts with MCOs.

(d) Section 1932(d)(1) prohibits MCOs and PCCMs from knowingly having certain types of relationships with individuals excluded under Federal regulations from participating in specified activities, or with affiliates of those individuals.

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§438.602 Basic rule.

As a condition for receiving payment under the Medicaid managed care program, an MCO, PCCM, PIHP, or PAHP must comply with the applicable certification, program integrity and prohibited affiliation requirements of this subpart.

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§438.604 Data that must be certified.

(a) *Data certifications.* When State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP, the State must require certification of the data as provided in §438.606. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals, and related documents.

(b) *Additional certifications.* Certification is required, as provided in §438.606, for all documents specified by the State.

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§438.606 Source, content, and timing of certification.

(a) *Source of certification.* For the data specified in §438.604, the data the MCO or PIHP submits to the State must be certified by one of the following:

(1) The MCO's or PIHP's Chief Executive Officer.

(2) The MCO's or PIHP's Chief Financial Officer.

(3) An individual who has delegated authority to sign for, and who reports directly to, the MCO's or PIHP's Chief Executive Officer or Chief Financial Officer.

(b) *Content of certification.* The certification must attest, based on best knowledge, information, and belief, as follows:

(1) To the accuracy, completeness and truthfulness of the data.

(2) To the accuracy, completeness and truthfulness of the documents specified by the State.

(c) *Timing of certification.* The MCO or PIHP must submit the certification concurrently with the certified data.

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§438.608 Program integrity requirements.

(a) *General requirement.* The MCO or PIHP must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

(b) *Specific requirements.* The arrangements or procedures must include the following:

(1) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.

(2) The designation of a compliance officer and a compliance committee that are accountable to senior management.

(3) Effective training and education for the compliance officer and the organization's employees.

(4) Effective lines of communication between the compliance officer and the organization's employees.

(5) Enforcement of standards through well-publicized disciplinary guidelines.

(6) Provision for internal monitoring and auditing.

(7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's or PIHP's contract.

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§438.610 Prohibited affiliations with individuals debarred by Federal agencies.

(a) *General requirement.* An MCO, PCCM, PIHP, or PAHP may not knowingly have a relationship of the type described in paragraph (b) of this section with the following:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.

(b) *Specific requirements.* The relationships described in this paragraph are as follow:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP.

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity.

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

(c) *Effect of Noncompliance.* If a State finds that an MCO, PCCM, PIHP, or PAHP is not in compliance with paragraphs (a) and (b) of this section, the State:

(1) Must notify the Secretary of the noncompliance.

(2) May continue an existing agreement with the MCO, PCCM, PIHP, or PAHP unless the Secretary directs otherwise.

(3) May not renew or otherwise extend the duration of an existing agreement with the MCO, PCCM, PIHP, or PAHP unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

(d) *Consultation with the Inspector General.* Any action by the Secretary described in paragraphs (c)(2) or (c)(3) of this section is taken in consultation with the Inspector General.

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Subpart I—Sanctions

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§438.700 Basis for imposition of sanctions.

(a) Each State that contracts with an MCO must, and each State that contracts with a PCCM may, establish intermediate sanctions, as specified in §438.702, that it may impose if it makes any of the determinations specified in paragraphs (b) through (d) of this section. The State may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(b) A State determines whether an MCO acts or fails to act as follows:

(1) Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.

(2) Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

(3) Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

(4) Misrepresents or falsifies information that it furnishes to CMS or to the State.

(5) Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.

(6) Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in §§422.208 and 422.210 of this chapter.

(c) A State determines whether an MCO, PIHP, PAHP or PCCM has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

(d) A State determines whether—

(1) An MCO has violated any of the other requirements of sections 1903(m) or 1932 of the Act, and any implementing regulations;

(2) A PCCM has violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act and any implementing regulations;

(3) For any of the violations under paragraphs (d)(1) and (d)(2) of this section, only the sanctions specified in §438.702, paragraphs (a)(3), (a)(4), and (a)(5) may be imposed.

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§438.702 Types of intermediate sanctions.

(a) The types of intermediate sanctions that a State may impose under this subpart include the following:

(1) Civil money penalties in the amounts specified in §438.704.

(2) Appointment of temporary management for an MCO as provided in §438.706.

(3) Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll.

(4) Suspension of all new enrollment, including default enrollment, after the effective date of the sanction.

(5) Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

(b) State agencies retain authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in §438.700, as well as additional areas of noncompliance. Nothing in this subpart prevents State agencies from exercising that authority.

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§438.704 Amounts of civil money penalties.

(a) *General rule.* The limit on, or the maximum civil money penalty the State may impose varies depending on the nature of the MCO's or PCCM's action or failure to act, as provided in this section.

(b) *Specific limits.* (1) The limit is \$25,000 for each determination under the following paragraphs of §438.700:

(i) Paragraph (b)(1) (Failure to provide services).

(ii) Paragraph (b)(5) (Misrepresentation or false statements to enrollees, potential enrollees, or health care providers).

(iii) Paragraph (b)(6) (Failure to comply with physician incentive plan requirements).

(iv) Paragraph (c) (Marketing violations).

(2) The limit is \$100,000 for each determination under paragraph (b)(3) (discrimination) or (b)(4) (Misrepresentation or false statements to CMS or the State) of §438.700.

(3) The limit is \$15,000 for each beneficiary the State determines was not enrolled because of a discriminatory practice under paragraph (b) (3) of §438.700. (This is subject to the overall limit of \$100,000 under paragraph (b)(2) of this section).

(c) *Specific amount.* For premiums or charges in excess of the amounts permitted under the Medicaid program, the maximum amount of the penalty is \$25,000 or double the amount of the excess charges, whichever is greater. The State must deduct from the penalty the amount of overcharge and return it to the affected enrollees.

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§438.706 Special rules for temporary management.

(a) *Optional imposition of sanction.* The State may impose temporary management only if it finds (through onsite survey, enrollee complaints, financial audits, or any other means) that—

(1) There is continued egregious behavior by the MCO, including but not limited to behavior that is described in §438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or

(2) There is substantial risk to enrollees' health; or

(3) The sanction is necessary to ensure the health of the MCO's enrollees—

(i) While improvements are made to remedy violations under §438.700; or

(ii) Until there is an orderly termination or reorganization of the MCO.

(b) *Required imposition of sanction.* The State must impose temporary management (regardless of any other sanction that may be imposed) if it finds that an MCO has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Act, or this subpart. The State must also grant enrollees the right to terminate enrollment without cause, as described in §438.702(a)(3), and must notify the affected enrollees of their right to terminate enrollment.

(c) *Hearing.* The State may not delay imposition of temporary management to provide a hearing before imposing this sanction.

(d) *Duration of sanction.* The State may not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not recur.

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§438.708 Termination of an MCO or PCCM contract.

A State has the authority to terminate an MCO or PCCM contract and enroll that entity's enrollees in other MCOs or PCCMs, or provide their Medicaid benefits through other options included in the State plan, if the State determines that the MCO or PCCM has failed to do either of the following:

(a) Carry out the substantive terms of its contract; or

(b) Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Act.

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§438.710 Due process: Notice of sanction and pre-termination hearing.

(a) *Notice of sanction.* Except as provided in §438.706(c), before imposing any of the intermediate sanctions specified in this subpart, the State must give the affected entity timely written notice that explains the following:

(1) The basis and nature of the sanction.

(2) Any other due process protections that the State elects to provide.

(b) *Pre-termination hearing—(1) General rule.* Before terminating an MCO or PCCM contract under §438.708, the State must provide the entity a pre-termination hearing.

(2) *Procedures.* The State must do the following:

(i) Give the MCO or PCCM written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;

(ii) After the hearing, give the entity written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination; and

(iii) For an affirming decision, give enrollees of the MCO or PCCM notice of the termination and information, consistent with §438.10, on their options for receiving Medicaid services following the effective date of termination.

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§438.722 Disenrollment during termination hearing process.

After a State notifies an MCO or PCCM that it intends to terminate the contract, the State may do the following:

(a) Give the entity's enrollees written notice of the State's intent to terminate the contract.

(b) Allow enrollees to disenroll immediately without cause.

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§438.724 Notice to CMS.

(a) The State must give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in §438.700.

(b) The notice must—

(1) Be given no later than 30 days after the State imposes or lifts a sanction; and

(2) Specify the affected MCO, the kind of sanction, and the reason for the State's decision to impose or lift a sanction.

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§438.726 State plan requirement.

(a) The State plan must include a plan to monitor for violations that involve the actions and failures to act specified in this part and to implement the provisions of this part.

(b) A contract with an MCO must provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under section 438.730(e).

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§438.730 Sanction by CMS: Special rules for MCOs

(a) *Basis for sanction.* (1) A State agency may recommend that CMS impose the denial of payment sanction specified in paragraph (e) of this section on an MCO with a contract under this part if the agency determines that the MCO acts or fails to act as specified in §438.700(b)(1) through (b)(6).

(b) *Effect of an Agency Determination.* (1) The State agency's determination becomes CMS's determination for purposes of section 1903(m)(5)(A) of the Act unless CMS reverses or modifies it within 15 days.

(2) When the agency decides to recommend imposing the sanction described in paragraph (e) of this section, this recommendation becomes CMS's decision, for purposes of section 1903(m)(5)(B)(ii) of the Act, unless CMS rejects this recommendation within 15 days.

(c) *Notice of sanction.* If the State agency's determination becomes CMS's determination under section (b)(2), the State agency takes the following actions:

(1) Gives the MCO written notice of the nature and basis of the proposed sanction;

(2) Allows the MCO 15 days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommended sanction;

(3) May extend the initial 15-day period for an additional 15 days if—

(i) the MCO submits a written request that includes a credible explanation of why it needs additional time;

(ii) the request is received by CMS before the end of the initial period; and

(iii) CMS has not determined that the MCO's conduct poses a threat to an enrollee's health or safety.

(d) *Informal reconsideration.* (1) If the MCO submits a timely response to the notice of sanction, the State agency—

(i) Conducts an informal reconsideration that includes review of the evidence by a State agency official who did not participate in the original recommendation;

(ii) Gives the MCO a concise written decision setting forth the factual and legal basis for the decision; and

(iii) Forwards the decision to CMS.

(2) The agency decision under paragraph (d)(1)(ii) of this section becomes CMS's decision unless CMS reverses or modifies the decision within 15 days from date of receipt by CMS.

(3) If CMS reverses or modifies the State agency decision, the agency sends the MCO a copy of CMS's decision.

(e) *Denial of payment.* (1) CMS, based upon the recommendation of the agency, may deny payment to the State for new enrollees of the HMO under section 1903(m)(5)(B)(ii) of the Act in the following situations:

(i) If a CMS determination that an MCO has acted or failed to act, as described in paragraphs (b)(1) through (b)(6) of §438.700, is affirmed on review under paragraph (d) of this section.

(ii) If the CMS determination is not timely contested by the MCO under paragraph (c) of this section.

(2) Under §438.726(b), CMS's denial of payment for new enrollees automatically results in a denial of agency payments to the HMO for the same enrollees. (A new enrollee is an enrollee that applies for enrollment after the effective date in paragraph (f)(1) of this section.)

(f) *Effective date of sanction.* (1) If the MCO does not seek reconsideration, a sanction is effective 15 days after the date the MCO is notified under paragraph (b) of this section of the decision to impose the sanction.

(2) If the MCO seeks reconsideration, the following rules apply:

(i) Except as specified in paragraph (d)(2)(ii) of this section, the sanction is effective on the date specified in CMS's reconsideration notice.

(ii) If CMS, in consultation with the State agency, determines that the MCO's conduct poses a serious threat to an enrollee's health or safety, the sanction may be made effective earlier than the date of the agency's reconsideration decision under paragraph (c)(1)(ii) of this section.

(g) *CMS's role.* (1) CMS retains the right to independently perform the functions assigned to the State agency under paragraphs (a) through (d) of this section.

(2) At the same time that the agency sends notice to the MCO under paragraph (c)(1)(i) of this section, CMS forwards a copy of the notice to the OIG.

(3) CMS conveys the determination described in paragraph (b) of this section to the OIG for consideration of possible imposition of civil money penalties under section 1903(m)(5)(A) of the Act and part 1003 of this title. In accordance with the provisions of part 1003, the OIG may impose civil money penalties on the MCO in addition to, or in place of, the sanctions that may be imposed under this section.

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Subpart J—Conditions for Federal Financial Participation

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§438.802 Basic requirements.

FFP is available in expenditures for payments under an MCO contract only for the periods during which the contract—

- (a) Meets the requirements of this part; and
- (b) Is in effect.

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§438.804 Primary care provider payment increases.

(a) For MCO, PIHP or PAHP contracts that cover calendar years 2013 and 2014, FFP is available at an enhanced rate of 100 percent for the portion of the expenditures for capitation payments made under those contracts to comply with the contractual requirement under §438.6(c)(5) (vi) only if the following requirements are met:

(1) The state must submit to CMS the following methodologies for review and approval.

(i) The state develops a reasonable methodology, based on rational and documented data and assumptions, for identifying the provider payments that would have been made by MCO, PIHP or PAHP for specified primary care services furnished as of July 1, 2009. This methodology can take into consideration the availability of data, and the costs and burden of administering the method, but should produce a reliable and accurate result to the fullest extent possible.

(ii) The state develops a reasonable methodology, based on rational and documented data and assumptions, for identifying the differential in payment between the provider payments that would have been made by the MCO, PIHP or PAHP on July 1, 2009 and the amount needed to comply with the contractual requirement under §438.6(c)(5)(vi). This methodology can take into consideration the availability of data, and the costs and burden of administering the method, but should produce a reliable and accurate result to the fullest extent possible.

(2) The state must submit the methodologies in paragraphs (a)(1)(i) and (ii) of this section to CMS for review no later than the end of the first quarter of CY 2013.

(3) CMS will use the approved methodologies required under this section in the review and approval of MCO, PIHP or PAHP contracts and rates consistent with §438.6(a).

(b) [Reserved]

[77 FR 66699, Nov. 6, 2012]

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§438.806 Prior approval.

(a) *Comprehensive risk contracts.* FFP is available under a comprehensive risk contract only if—

(1) The Regional Office has confirmed that the contractor meets the definition of an MCO or is one of the entities described in paragraphs (b)(2) through (b)(5) of §438.6; and

(2) The contract meets all the requirements of section 1903(m)(2)(A) of the Act, the applicable requirements of section 1932 of the Act, and the implementing regulations in this part.

(b) *MCO contracts.* Prior approval by CMS is a condition for FFP under any MCO contract that extends for less than one full year or that has a value equal to, or greater than, the following threshold amounts:

(1) For 1998, the threshold is \$1,000,000.

(2) For subsequent years, the amount is increased by the percentage increase in the consumer price index for all urban consumers.

(c) FFP is not available in an MCO contract that does not have prior approval from CMS under paragraph (b) of this section.

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§438.808 Exclusion of entities.

(a) *General rule.* FFP is available in payments under MCO contracts only if the State excludes from the contracts any entities described in paragraph (b) of this section.

(b) *Entities that must be excluded.* (1) An entity that could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual.

(2) An entity that has a substantial contractual relationship as defined in §431.55(h)(3) of this chapter, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act.

(3) An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

(i) Any individual or entity excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

(ii) Any entity that would provide those services through an excluded individual or entity.

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§438.810 Expenditures for enrollment broker services.

(a) *Terminology.* As used in this section—

Choice counseling means activities such as answering questions and providing information (in an unbiased manner) on available MCO, PIHP, PAHP, or PCCM delivery system options, and advising on what factors to consider when choosing among them and in selecting a primary care provider;

Enrollment activities means activities such as distributing, collecting, and processing enrollment materials and taking enrollments by phone or in person;

Enrollment broker means an individual or entity that performs choice counseling or enrollment activities, or both, and;

Enrollment services means choice counseling, or enrollment activities, or both.

(b) *Conditions that enrollment brokers must meet.* State expenditures for the use of enrollment brokers are considered necessary for the proper and efficient operation of the State plan and thus eligible for FFP only if the broker and its subcontractors meet the following conditions:

(1) *Independence.* The broker and its subcontractors are independent of any MCO, PIHP, PAHP, PCCM, or other health care provider in the State in which they provide enrollment services. A broker or subcontractor is not considered "independent" if it—

- (i) Is an MCO, PIHP, PAHP, PCCM or other health care provider in the State;
- (ii) Is owned or controlled by an MCO, PIHP, PAHP, PCCM, or other health care provider in the State; or
- (iii) Owns or controls an MCO, PIHP, PAHP, PCCM or other health care provider in the State.

(2) *Freedom from conflict of interest.* The broker and its subcontractor are free from conflict of interest. A broker or subcontractor is not considered free from conflict of interest if any person who is the owner, employee, or consultant of the broker or subcontractor or has any contract with them—

- (i) Has any direct or indirect financial interest in any entity or health care provider that furnishes services in the State in which the broker or subcontractor provides enrollment services;
- (ii) Has been excluded from participation under title XVIII or XIX of the Act;
- (iii) Has been debarred by any Federal agency; or
- (iv) Has been, or is now, subject to civil money penalties under the Act.

(3) *Approval.* The initial contract or memorandum of agreement (MOA) for services performed by the broker has been reviewed and approved by CMS.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

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§438.812 Costs under risk and nonrisk contracts.

(a) Under a risk contract, the total amount the State agency pays for carrying out the contract provisions is a medical assistance cost.

(b) Under a nonrisk contract—

- (1) The amount the State agency pays for the furnishing of medical services to eligible beneficiaries is a medical assistance cost; and
- (2) The amount the State agency pays for the contractor's performance of other functions is an administrative cost.

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Need assistance?

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF ALABAMA

Payment for Medical Care and Services, Excluding
Inpatient Hospitals and Long Term Care Services

A description of the policy and methods to be used in establishing payment rates for each type of service, except for inpatient hospital and long term care services, listed in Section 1905(a) of the Social Security Act and included in the Alabama Medical Assistance Program, is set forth in this attachment. Payment methodology for inpatient hospital services is covered in Attachment 4.19-A. Payment for long-term care services is covered in Attachment 4.19-D.

1. Rural Health Clinic Services and Other Ambulatory Services
Furnished by a Rural Health Clinic

Effective Date: 01/01/01

- a. The Medicaid Prospective Payment System (PPS) for Rural Health Clinics (RHCs) was enacted into law under Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Until the final methodology approved by HCFA is implemented, the Alabama Medicaid Agency will reimburse in the interim based on the provisions contained in our State Plan as of December 31, 2000.

In the first phase of the PPS (January 1, 2001, through September 30, 2001), Alabama Medicaid Agency will pay RHCs 100% of the average of their reasonable costs of providing Medicaid covered services by calculating a per visit rate, computed from the RHC cost reports, for FY1999 and FY2000 separately, then add those rates together and divide by two. This rate will be adjusted to take into account any increase (or decrease) in the scope of services furnished during FY 2001 by the RHC. When our new system is approved by HCFA, in place, and tested, all claims paid under the old payment methodology during calendar year 2001 will be reversed and will be paid under PPS.

The Alabama Medicaid Agency fiscal year is from October 1st through September 30th. Beginning in FY 2002, and for each fiscal year thereafter, each RHC is entitled to the payment amount (on a per visit basis) to which the RHC was entitled to in the previous year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the RHC during that fiscal year.

A new RHC provider or a provider who constructs, leases, or purchases a facility, or has a Medicaid approved change in the scope of services, can request reimbursement based on an operating budget, subject to the ceiling established under this rule. After the actual cost report is received and desk reviewed for the budget period, an actual encounter rate will be determined. In this event, the RHC may be subject to a retroactive adjustment based on the difference between budgeted and actual allowable costs. This difference may be subject to settlement within thirty (30) days after written notification by Medicaid to the provider of the amount of the difference. After the initial year, payment shall be set using the MEI methods used for other RHCs. A RHC that has a change of ownership can retain the previous owner's encounter rate if desired.

2. Other Laboratory and X-Ray Services

Effective Date: 04/01/83

- a. Payment to laboratories and x-ray facilities will be based on customary charges calculated by methods consistent with Federal Regulations.

- c. For crossover claims the allowable payment to the provider is determined not by the Alabama Medicaid Agency but by Medicare. The Alabama Medicaid Agency will pay no more than the part of the allowable payment not paid by Medicare and other insurers who are obligated to pay part of the claim.

3. Physicians and Other Practitioners

Effective Date: 01/01/12

- a. Physician Fee Schedule Payment: A statewide maximum payment will be calculated for each service designated by a procedure code recognized by the Alabama Medicaid Agency as designating a covered service. To determine payments for procedure codes without an established Medicaid rate, the Alabama Medicaid Agency will base rates on the current Medicare rate, and if not available the average commercial rate. Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates effective January 1, 2012. Current rates are published and maintained on the agency's website at http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx. Payment rates are the same for both governmental and non-governmental providers except as noted below.
1. Rural Physician (Supplemental/Enhanced) Payment:
 - (i) Providers in rural counties whose specialty is OB/GYN, Family Practice, General practice or Pediatrics, will be paid an enhanced rate for global delivery codes and delivery codes only. These rates can be found at the following link: http://www.medicaid.alabama.gov/documents/6.0_Providers/6.6_Fee_Schedules/6.6_Physician_Rural_Rate_Fee_Sched_3-25-12.pdf
 - (ii) In order to increase provider participation and improve access to care, both governmental and non-governmental providers of all specialties in rural counties will be paid an additional \$1.00 per office visit or hospital visit.
 2. Physician Access (Supplemental/Enhanced) Payment: In order to maintain adequate access to specialty faculty physician (all specialties including general practice, family practice, and general pediatrics) services as required by 42 USC 1396(a) (30) and 42 CFR 447.204, enhanced rates will be paid to teaching physicians. Teaching physicians are defined as doctors of medicine or osteopathy employed by or under contract with (a) a medical school that is part of the public university system (The University of Alabama at Birmingham and The University of South Alabama) or (b) a children's hospital healthcare system which meets the criteria and receives funding under Section 340E (a) of the U.S. Public Health Service Act (42 USC 256e), and which operates and maintains a state license for specialty pediatric beds. Payments will be added to the fee-for-service rate and reconciled annually. The provider's average commercial rate demonstration will be updated annually. Enhanced rates have been established based on 2011 Medicare rates. The Agency's rates were set as of January 1, 2012, and are effective for services provided on or after that date. These rates can be found at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx

- a. Calculation of the rates for teaching physicians is described as follows:
- (i) Identify Medicare rates for the most recent full calendar year.
Applicable rates are obtained in the following manner:
 - a. If more than 50 percent of the claims identified in the calculation period were performed in a non facility setting, Medicaid will use the non facility Medicare physician fee schedule.
 - b. If 50 percent or more of the claims identified in the calculation period were performed in a facility setting, Medicaid will use the facility Medicare physician fee schedule for that teaching facility.
 - (ii) Obtain the rates paid by the top five commercial insurance companies in Alabama for each public university system for the most recent full calendar year.
 - (iii) Obtain the adjudicated units of service by procedure code for the, most recent full calendar year. The State identifies adjudicated claims through Medicaid's MMIS system, that were processed during the most recent full calendar year for services performed by eligible physicians at approved places of service. Approved places of service include a hospital sponsored location such as an inpatient hospital, outpatient hospital, hospital-based clinic or a hospital-affiliated clinic. The following services are excluded from these claims: clinical diagnostic lab procedures, services provided to dual eligibles, and the technical component of radiology services. Anesthesia payment is based on a fifteen minute unit of service as well as a base payment.
 - (iv) Calculate the aggregate commercial payment equivalent for the most recent full calendar year by multiplying the Medicaid units identified in (iii) above by the commercial rates identified in (ii), then combine the payments for all services. This produces the Total Commercial Equivalent Payment Amount.
 - (v) Calculate the equivalent Medicare payments for the most recent full calendar year by multiplying the Medicaid units from (ii) above by the Medicare rates identified in (i), then combine the payments for all services. This produces the Total Medicare Equivalent Payment Amount.

(vi) Divide the Total Commercial Payment Amount by the Total Medicare Equivalent Payment Amount to determine the aggregate Average Commercial Rate Percentage of Medicare.

(vii) Based on the average commercial rate demonstration results, the rates for the teaching physicians shall be 150% of the applicable Medicare rate.

(viii) Calculated reimbursement rates for all numeric procedure codes will be rounded to the nearest dollar. Rates for procedure codes starting with an alpha character will be rounded to the nearest penny.

(ix) Procedure codes not recognized by Medicare are ineligible for the enhanced payment.

Effective Date: 04/01/90

- b. For Medicare crossover claims, refer to item 19 in this attachment.

Effective Date: 01/01/12

- c. Payment to Certified Registered Nurse Anesthetists is 80% of the maximum allowable rate paid to physicians for providing the same service.

Effective Date: 01/01/12

- d. Payment to physician-employed Physician Assistants and Certified Registered Nurse Practitioners is 80% of the maximum allowable rate paid to physicians for providing the same service except for injectables and laboratory procedure. Injectable and Laboratory procedures are reimbursed at 100% of the amount paid to physicians.

Effective Date: 01/01/12

- e. Pharmacists, employed by pharmacies participating in the Alabama Medicaid program, are reimbursed a vaccine administration fee established at the same rate paid to physicians. The Agency's rate for vaccine administration was set as of January 1, 1999, and is effective for services on or after that date. All rates are published on the Agency's website at www.Medicaid.alabama.gov. Except as otherwise noted in the plan, state developed rates are the same for both governmental and private providers.

Physician Services

Attachment 4.19-B: Physician Services

The state will continue to reimburse for services provided by physicians with a primary specialty designation of family medicine, pediatric medicine or internal medicine as if the requirements of 42 C.F.R. § 447.400 remain in effect. The rates will be those in effect for these services and providers during CY 2014. State of Alabama, general fund fiscal year 2015 appropriations allow for enhanced payments with dates of service January 1, 2015 through September 30, 2015. A provider must meet one of the following requirements listed below to qualify for the Alabama Medicaid Physicians Primary Care Enhanced Rates "Bump" Program.

- a. A provider must be Board certified with a specialty or subspecialty designation in family medicine, general internal medicine, or pediatrics that is recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA), and must actually practice in their specialty.
- b. A NON-board certified provider who practices in the field of family medicine, general internal medicine, or pediatrics or a subspecialty under one of these specialties, is eligible if he/she can attest that sixty percent of their paid Medicaid procedures billed are for certain specified procedure codes for evaluation and management (E&M) services and certain Vaccines for Children (VFC) vaccine administration codes during the most recently completed CY or, for newly eligible physicians, the prior month.

Method of Payment

The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

Primary Care Services Affected by this Payment Methodology

This payment applies to Evaluation and Management (E&M) billing codes 99201 through 99499 that are considered reimbursable by Alabama Medicaid. A list of codes and current rates are published and maintained on the agency's website at

http://medicaid.alabama.gov/documents/6.0_Providers/6.6_Fee_Schedules/6.6_Physician_ACA%20Primary_Care_Fee_Schedule_Revised_3-1-14.pdf

Physician Services – Vaccine Administration

The state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 C.F.R. § 447.400(a) at the regional maximum administration fee set by the Vaccines for children program.

The Alabama Medicaid Agency requires VFC administration fees to be billed using the specific product code (vaccine codes).

The following single product (vaccine) codes have been billed in lieu of vaccine administration codes since the inception for the VFC Program in Alabama.

90633 90636 90645 90647 90648 90649 90650 90655 90656 90657 90658 90660
90669 90670 90680 90681 90696 90698 90700 90702 90707 90710 90713 90714
90715 90716 90718 90721 90723 90732 90733 90734 90744 90748.

These codes will be cross walked to procedure 90460 for vaccine administration for eligible providers under 42 C.F.R. § 447.400.

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered between January 1, 2015 and September 30, 2015. All rates are published at (www.medicaid.alabama.gov).

Vaccine Administration

This reimbursement methodology applies to services delivered between January 1, 2015 and September 30, 2015. All rates are published at (www.medicaid.alabama.gov).

Supersedes Page: None

4. Prescribed Drugs

Effective Date: 07/01/91

a. Medicaid pays for covered outpatient drugs prescribed by doctors of medicine, osteopathy, and dentistry legally licensed to prescribe the drugs authorized under the program and dispensed by a licensed pharmacist or licensed authorized physician in accordance with state and federal laws.

Effective Date: 10/01/13

b. Multiple Source Drugs. Reimbursement for covered multiple source drugs in the Medicaid Program shall not exceed the lowest of:

- (1) The federally mandated upper limit (FUL) for certain multiple source drugs as established and published by CMS plus a reasonable dispensing fee; or
- (2) The Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee. AEAC is defined by Medicaid as the Average Acquisition Cost (AAC) of the drug or, in cases where no AAC is available, Wholesale Acquisition Cost (WAC) + 0%; or
- (3) The provider's Usual and Customary charge to the general public for the drug; or
- (4) The Alabama State Maximum Allowable Cost (State MAC) plus a reasonable dispensing fee. The Alabama State MAC is defined as the AAC of a drug multiplied by 1.0 that will apply to all multiple source drugs within a particular grouping.

(a) **Reimbursement Methodology for the Alabama State MAC**

The State MAC reimbursement will apply to certain multiple source drug products that meet therapeutic equivalency, market availability, and other criteria deemed appropriate by the Alabama Medicaid Agency.

- Drugs are subject to a State MAC if there is at least one non-innovator multiple source alternative product available.
- The Alabama Medicaid Agency or its designated representative will collect and review pharmacy invoices and other information deemed necessary by the Alabama Medicaid Agency in an effort to determine AAC in accordance with applicable State and Federal law.
- This information will be collected from Medicaid-participating pharmacies via surveys. The AAC is multiplied by 1.0 to derive the State MAC rate that will apply to all multiple source drugs within the particular grouping.
- If the AAC no longer represents a drug's market price due to a drug shortage or other emergency situation, the Alabama Medicaid Agency will conduct a review and, if applicable, adjust the AAC to represent the drug's current market price, or apply WAC +0%.

EXCEPTION:

The FUL and/or State MAC may be waived for a brand innovator multiple-source drug. For these cases the prescriber must provide documentation of the medical necessity for the brand name rather than the available generic equivalent and receive an override.

- c. Other Drugs. Reimbursement for covered drugs other than multiple source drugs shall not exceed the lowest of:
- (1) The Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee. AEAC is defined by Medicaid as the Average Acquisition Cost (AAC) of the drug or, in cases where no AAC is available, Wholesale Acquisition Cost (WAC) +0%; or
 - (2) The provider's Usual and Customary charge to the general public for the drug; or
 - (3) For blood clotting factor products, the Average Sales Price (ASP) + 6% plus a reasonable dispensing fee.
- d. Dispensing Fees. A reasonable dispensing fee is set by the Agency. This fee is reviewed periodically for reasonableness and, when deemed appropriate by Medicaid, may be adjusted. The dispensing fee paid by the Agency effective 9/22/10 is \$10.64.

No payments made pursuant to methods and standards described in this Attachment 4.19-B will exceed upper limits established in 42 CFR Section 447, Subpart D.

- e. The upper limits detailed in 42 CFR §447.512 which govern Medicaid State Agency reimbursement to providers of prescribed drugs shall also apply in cases where prescribed drugs are furnished as part of SNF or ICF services or under prepaid capitation arrangements. Contracts between the State Agency and the underwriter, carrier, foundation, health maintenance organization, or other insurers containing the terms of such prepaid capitation arrangements shall include a provision imposing the same upper limits for reimbursement of prescribed drugs.
- f. The Medicaid recipient shall pay the maximum allowable copayment under Federal law or administrative regulations for each prescribed drug received under the Medicaid program, except for designated exemptions. The allowable copayment amount shall be collected by the dispensing pharmacy and credited against the Medicaid payment to the pharmacy for drugs per copay table in Attachment 4.18-A. Designated exemptions include prescriptions for pregnant women, Family Planning drugs, those used for Medicaid recipients under 21 years of age, and drugs for Medicaid recipients institutionalized in long term facilities.

5. Prosthetic Devices

Reasonable, customary charges submitted by the vendor, not to exceed the amount payable under Title XVIII, Part B or the amount paid by the general public.

Effective Date: 10/1/14

The pricing methodology is 80% of the 2005 Medicare allowable amount as listed on the Alabama Supplies, Appliances, and DME Fee Schedule. The agency's fee schedule rate is in effect for services provided on or after October 1, 2014. All rates are published on the Medicaid Agency's website (www.medicaid.alabama.gov). Except as otherwise noted in the plan, the Medicaid developed fee schedule rates are the same for both governmental and private providers.

6. Eyeglasses

- a. Eyeglasses are procured from a central source selected through the State competitive bid system. Payment is based on reasonable charges, obtained through the bidding procedures, which are included in a contract between Medicaid and the central source contractor. The contracted charges will not exceed the amount paid by the general public or other third party organizations.
- b. The contract between Medicaid and the central source contractor will be on file and available for review in the office of the Single State Agency.
- c. Eyeglasses may, at the option of the provider, be procured from the central source contractor or from any other source, but at a price not to exceed the contract price charged by the central

source. However, the quality of the eyeglasses must be equal to or better than that provided by the central source contractor.

TN No: AL-14-009

Supersedes Approval Date: 12-16-14

Effective Date: 10/01/2014 TN No: AL-13-006

Effective Date: 01/01/92

7. Early and Periodic Screening Diagnosis and Treatment of Individuals under 21 Years of Age
- a. Screening providers (including physicians - not included elsewhere in this State Plan) - Governmental providers will be paid on an interim rate which will be the present rate paid to the Department of Public Health for screening. This rate will be adjusted to actual cost for each governmental agency. Non-governmental providers will be paid their usual and customary charge not to exceed the maximum allowable rate established by Medicaid.
 - b. Hearing aid vendors - Providers will be paid their usual and customary charge not to exceed the maximum allowable rate established by Medicaid.
 - c. Physical Therapy - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19-B, Number 3a of the State Plan.
 - d. Occupational Therapy - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
 - e. Speech-Language-Hearing Therapy - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
 - f. Psychology - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
 - g. Chiropractic - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
 - h. Podiatry - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
 - i. Christian Science - the reimbursement methodology is 75% of the usual and customary charge for licensed Christian Science providers in the State of Alabama.

TN No. AL-91-36
Supersedes
TN No. AL-90-20

Approval Date 10/2/92

Effective Date 01/01/92

- j. Private Duty Nursing - the reimbursement methodology is based on an hourly rate for a registered nurse or licensed practical nurse. Rates are established using the lowest rates for agencies surveyed.
- k. Transplant (heart-lung, pancreas-kidney and lung) - the reimbursement methodology is the same as identified in Attachment 4.19-B, Number 18 of the State Plan.
- l. Air Ambulance - the reimbursement methodology is the same as identified in Attachment 4.19B, Number 11 of the State Plan.

m. School Based Services: Medicaid services provided in schools are services that are medically necessary and provided in schools to Medicaid recipients in accordance with an Individualized Education Program, (IEP) or an Individual Family Service Plan (IFSP). Covered services include the following:

1. Audiology Services
2. Occupational Therapy
3. Physical Therapy
4. Counseling Services
5. Personal Care Services
6. Speech/Language Services
7. Nursing Services
8. Transportation Services

For the purpose of making interim Medicaid payments to LEA providers, the Alabama Medicaid Fee Schedule will be applied to claims submitted to the Medicaid Management Information System (MMIS) for the above services. Except as noted otherwise in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Audiology Services, Occupational Therapy, Physical Therapy, Counseling Services, Personal Care Services, Speech/Language Services, and Nursing Services. The agency's fee schedule rate is in effect for services provided on or after 4/1/12. All rates are published at:

http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx.

For transportation services, an interim rate will be determined based on a rate that represents the actual cost of providing the transportation service, upon final approval of the SPA and cost allocation plan

- (A). Direct Medical Services Payment Methodology:
Beginning with cost reporting period April 1, 2012, the Alabama Medicaid Agency will begin settling Medicaid reimbursement for direct medical services at cost for all Local Education Agencies (LEA's). This reimbursement at cost methodology will include a quarterly Random Moment Time Study, an annual cost report and reconciled settlement as well as quarterly interim settlements. The quarterly interim settlements for services will be based on the quarterly Random Moment Time Study and use of the interim cost reports compiled on a quarterly basis. However, for transportation services, Item (b) provides the transportation payment services methodology.

Effective for services provided on or after April 1, 2012 school based services will be reimbursed at cost according to this methodology described in the state plan.

To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid-eligible clients in the LEA, the following steps are performed:

1. Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation of direct services personnel listed in the descriptions for the covered Medicaid services delivered by school districts. Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as purchased services, direct materials, supplies, and equipment. Medical devices and equipment are only allowable for the provision of direct medical services. For items not previously approved, the LEA must use a pre-approval process to determine suitability, coverage, and reimbursement of medical supplies, material, and equipment. The following process must be followed by the schools at a minimum:
 - a) The medical device must be approved and effective (i.e., not experimental) and within the scope of the school based services shown as covered in the Medicaid state plan;
 - b) The use of the device must be determined suitable for the individual; and
 - c) The service or device must be approved by one of the covered medical professionals and reviewed by the Alabama Medicaid Agency.

These direct costs are accumulated on the annual cost report, resulting in total direct costs. The cost report contains the scope of the cost and methods for cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

2. The net direct cost for each service is calculated by applying the direct medical services percentage from the CMS-approved time study to the direct cost in 1 above. A time study, which

incorporates a CMS-approved Random Moment Time Study methodology, is used to determine the percentage of time medical service personnel spend on IEP-related medical services, and general and administrative time. This time study will assure that there is no duplicate claiming relative to claiming for administrative costs.

3. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its net direct costs. Alabama public school districts use predetermined fixed rates to indirect costs. The State Department of Education (SDE) is the cognizant agency for the school districts, and approves unrestricted indirect cost rates for school districts for the US Department of Education (USDE). Only Medicaid-allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.
4. Net direct costs and indirect costs are combined.
5. Medicaid's portion of total net costs is calculated by multiplying the results for Item 4 by the ratio of the total number of Medicaid covered children with IEPs and IFSPs by the total number of children with IEPs and IFSPs.

(B) Transportation Services Payment Methodology

Effective dates of services on or after April 1, 2012, providers will be paid on an interim cost basis. Providers will be reimbursed interim rates for school based health services, specialized transportation services at the lesser of the providers billed charges or the interim rate. On an annual basis, a cost reconciliation and cost settlement will be processed for all over and under payments.

Transportation to and from school may be claimed as a Medicaid services when the following conditions are met:

- 1) Special transportation is specifically listed in the IEP as a required service;

- 2) A medical service is provided on the day that specialized transportation is provided; and
- 3) The service billed only represents a one-way trip

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education. The cost identified in the cost report includes the following:

- 1) Bus Drivers
- 2) Bus Aides/Monitors
- 3) Mechanics
- 4) Substitute Drivers
- 5) Fuel
- 6) Repairs and Maintenance
- 7) Rentals
- 8) Contract Use Cost
- 9) Vehicle Depreciation

The source of these costs will be audited Chart of Accounts data kept at the school district and the Department of Education level. The Chart of Accounts is uniform throughout the State of Alabama. Costs will be reported on an accrual basis.

- 1) A rate will be established and applied to the total transportation cost of the school system. This rate will be based on the *Total IEP/IFSP Special Education Department (SPED) Students in the District Receiving Transportation*. The result of this rate (%) multiplied by the *Total District or Department of Education Transportation Cost* for each of the categories listed above will be included on the cost report. It is important to note that this cost will be further discounted by the ratio of *Medicaid Eligible SPED IEP/IFSP One Way Trips* divided by the total number of *SPED IEP/IFSP One Way Trips*. This data will be provided from transportation logs. The process will ensure that only one way trips for Medicaid eligible Special Education children with IEP's are billed and reimbursed for.
- 2) Indirect costs are determined by applying the school districts specific unrestricted indirect cost rate to its net direct costs. Alabama school

systems use predetermined fixed rates for indirect costs. The State Department of Education is the cognizant agency for the school systems, and approves unrestricted indirect cost rates for the school systems for the US Department of Education (USDE). Only Medicaid allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.

3) Net Direct Costs and Indirect costs are combined.

(C). Certification of Costs Process:

On a quarterly basis, each provider will certify through its cost report, its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

(D). Cost Report Process:

For Medicaid services listed in Paragraph (a) 1-10 provided in schools during the state fiscal year, each LEA provider must complete the following:

1. Quarterly Interim Settlement Cost Report. This Interim Settlement Cost Report is due within 90 days from the close of a quarterly reporting period,
2. Annual Settlement Cost Report. An annual cost report to reconcile the LEA's final settlement is due on or before April 1 following the reporting period.

The primary purposes of the cost report process are to:

1. Document the provider's total CMS-approved, Medicaid-allowable costs of delivering Medicaid coverable services using a CMS-approved cost allocation methodology.

2. Reconcile any interim payments to its total CMS-approved, Medicaid-allowable costs using a CMS approved cost allocation methodology.

The Quarterly Interim Settlement Cost Report and the Annual Settlement Cost Report includes a certification of costs statement to be completed certifying the provider's actual incurred costs/expenditures. All filed annual Cost Reports are subject to desk review by the Alabama Medicaid Agency.

(E). The Cost Reconciliation Process:

The cost reconciliation process must be completed by the Alabama Medicaid Agency within twenty-four (24) months of the end of the reporting period covered by the Annual Settlement Cost Report. The total Medicaid-allowable costs based on CMS-approved cost allocation methodology procedures are compared to any LEA provider's Medicaid interim payments delivered during the reporting period as documented in the Medicaid Management Information System (MMIS) as well as amounts received from Quarterly Interim Settlements, to determine the final cost reconciliation and settlement. For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes.

Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

(F). The Cost Settlement Process

EXAMPLE:

- For services delivered for the period covering January 1, through March 31, the Quarterly Interim Settlement Cost Report is due on or before June 30.
- For services delivered for the period covering April 1, through June 30, the Quarterly Interim Settlement Cost Report is due on or before September 30.

- For services delivered for the period covering July 1, through September 30, the Quarterly Interim Settlement Cost Report is due on or before November 30.
- The Annual Settlement Cost Report will reconcile the costs and payments received through the Interim Claiming process and will be due by April 1 of each year.

If a provider's interim payments exceed the actual, certified costs for Medicaid services provided in schools to Medicaid clients, the provider will remit the federal share of the overpayment at the time the Annual Settlement Cost Report is submitted. The Alabama Medicaid Agency will submit the federal share of the overpayment to CMS within 60 days of identification. If the actual, certified costs of a LEA provider exceed total interim payments, the Alabama Medicaid Agency will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

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Chapter 6. Physicians.

Rule No. 560-X-6-.01.- Physician Program - General.

(1) The term "physician" shall mean (a) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which the doctor performs such functions; (b) a doctor of dentistry or of dental or oral surgery who is licensed to practice in the state in which the service is rendered, and legally authorized to perform such function but only with respect to: surgery related to the jaw, the reduction of any fracture related to the jaw or facial bones, or surgery within the oral cavity for removal of lesions or the correction of congenital defects.

(2) Participation. Providers who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program. An enrollment application may be requested from HP Enterprise Services (HPES) Provider Enrollment, 301 Technacenter Drive, Montgomery, AL 36117, or downloaded from the Medicaid website at www.medicaid.alabama.gov. Completed enrollment applications should be returned to HPES Provider Enrollment.

Physicians having limited licenses will not be enrolled by the Medicaid fiscal agent unless complete information as to the limitations and reasons is submitted in writing to the Provider Enrollment Unit for review and consideration for enrollment.

(3) Non-physician Practitioner Services--Medicaid payment may be made for the professional services of the following physician-employed practitioners:

physician assistants (PAs)
certified registered nurse practitioners (CRNPs)

PAs and CRNPs: The Alabama Medicaid Agency will make payment for services of certified physician assistants (PAs) and certified registered nurse practitioners (CRNPs) who are legally authorized to furnish services and who render the services under the supervision of an employing physician with payment made to the employing physician. Medicaid will not make payment to the PA or CRNP.

a. The employing-physician must be an Alabama Medicaid provider in active status.

b.. The PA or CRNP must enroll with the Alabama Medicaid Agency and receive an Alabama Medicaid provider number with the employing-physician as the payee.

c. Covered services furnished by the PA or CRNP must be billed under the PAs or CRNPs name and National Provider Identifier (NPI) number.

d. PA or CRNP approved services include all injectable drugs, all laboratory services in which the laboratory is CLIA certified to perform, and select CPT

codes authorized for independent CRNPs and are listed in Appendixes H and O of the Alabama Medicaid Billing Manual.

e. The office visits performed by the PA or CRNP will count against the recipient's yearly benefit limitation.

f. The PA or CRNP must send a copy of the prescriptive authority granted by the licensing board for prescriptions to be filled. This information must be sent to:

HPES Provider Enrollment
301 Technacenter Drive
Montgomery, AL 36117

g. The PA or CRNP cannot make physician-required visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits.

h. The employing-physician need not be physically present with the PA or CRNP when the services are being furnished to the recipient; however, he/she must be immediately available to the PA or CRNP for direct communication by radio, telephone, or telecommunication.

i. The PA's or CRNP's employing physician is responsible for the PA's or CRNP's professional activities and for assuring that the services provided are medically necessary and appropriate for the patient.

j. There shall be no independent, unsupervised practice by PAs or CRNPs.

(4) Physicians are expected to render medically necessary services to Medicaid patients in the same manner and under the same standards as for their private patients, and bill the Alabama Medicaid Agency their usual and customary fee.

(5) Payments from Medicaid funds can be made only to physicians who provide the services; therefore, no reimbursement can be made to patients who may personally pay for the service rendered.

(6) Refer to Chapter 20 concerning third-party insurance carriers.

(7) The physician agrees when billing Medicaid for a service that the physician will accept as payment in full, the amount paid by Medicaid for that service, plus any cost-sharing amount to be paid by the recipient, and that no additional charge will be made. The physician shall not charge or bill the recipient for cancelled or missed appointments. Conditional collections from patients, made before Medicaid pays, which

are to be refunded after Medicaid pays, are not permissible. The physician may bill the patient, in addition to the cost-sharing fee, for services rendered in the following circumstances:

- (a) When benefits are exhausted for the year,
- (b) When the service is a Medicaid non-covered benefit.

(8) A hospital-based physician who is a physician employed by and paid by a hospital may not bill Medicaid for services performed therein and for which the hospital is reimbursed. A hospital-based physician shall bill the Medicaid Program on a CMS-1500, Health Insurance Claim Form or assign their billing rights to the hospital, which shall bill the Medicaid Program on a CMS-1500 form. A hospital-based physician who is not a physician employed by and paid by a hospital shall bill Medicaid using a CMS-1500 Health Insurance Claim Form.

(9) A physician enrolled in and providing services through a residency training program shall not bill Medicaid for services performed. Medicaid will no longer require physicians enrolled in and providing services through a **residency** training program be assigned a pseudo Medicaid license number to be used on prescriptions written for Medicaid recipients. Effective for claims submitted on or after January 1, 2012, interns and non-licensed residents must use the NPI or license number of the teaching, admitting, or supervising physician.

(10) Supervising physicians may bill for services rendered to Medicaid recipients by residents enrolled in and providing services through a residency training program. The following rules shall apply to physicians supervising residents:

(a) The supervising physician shall sign and date the admission history and physical and progress notes written by the resident.

(b) The supervising physician shall review all treatment plans and medication orders written by the resident.

(c) The supervising physician shall be available by phone or pager.

(d) The supervising physician shall designate another physician to supervise the resident in his/her absence.

(e) The supervising physician shall not delegate a task to the resident when regulations specify that the physician perform it personally or when such delegation is prohibited by state law or the facility's policy.

(11) Off Site Mobile Physician's Services shall comply with all Medicaid rules and regulations as set forth in the State Plan, Alabama Medicaid Administrative Code, and Code of Federal Regulations including but not limited to the following requirements:

(a) Shall provide ongoing, follow-up, and treatment and/or care for identified conditions,

(b) Shall provide ongoing access to care and services through the maintenance of a geographically accessible office with regular operating business hours within the practicing county or within 15 miles of the county in which the service was rendered,

(c) Shall provide continuity and coordination of care for Medicaid recipients through reporting and communication with the Primary Medical Provider,

(d) Shall maintain a collaborative effort between the off-site mobile physician and local physicians and community resources. A matrix of responsibility shall be developed between the parties and available upon enrollment as an off-site mobile physician,

(e) Shall provide for attainable provider and recipient medical record retrieval,

(f) Shall maintain written agreements for referrals, coordinate needed services, obtain prior authorizations and necessary written referrals for services prescribed. All medical conditions identified shall be referred and coordinated, for example:

1. Eyeglasses,
2. Comprehensive Audiological services,
3. Comprehensive Ophthalmological services,
4. Patient 1st and EPSDT Referrals,

(g) Shall not bill Medicaid for services which are free to anyone. Provider shall utilize a Medicaid approved sliding fee scale based on Federal Poverty Guidelines,

(h) Shall ensure that medical record documentation supports the billing of Medicaid services, and

(i) Shall obtain signed and informed consent prior to treatment.

(12) (a) Effective April 1, 2008, all prescriptions for outpatient drugs for Medicaid recipients which are executed in written (and non-electronic) form must be executed on tamper-resistant prescription pads. The term "written prescription" does not include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy, or prescriptions communicated to the pharmacy by telephone by a prescriber. This requirement does not apply to refills of written prescriptions which were executed before April 1, 2008. It also does not apply to drugs provided in nursing facilities, intermediate care facilities for the mentally retarded, and other institutional and clinical settings to the extent the drugs are reimbursed as part of a per diem amount, or where the order for a drug is written into the medical record and the order is given directly to the pharmacy by the facility medical staff.

(b) To be considered tamper-resistant on or after April 1, 2008, a prescription pad must contain at least one of the following three characteristics:

1. one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form; or
2. one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or
3. one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

(c) To be considered tamper-resistant on or after October 1, 2008, a prescription pad must contain all of the foregoing three characteristics.

Author: Desiree Nelson; Program Manager; Medical Support

Statutory Authority: Title XIX, Social Security Act; 42 CFR, §§ 447.15, 405.522, .523, 401, et seq.; Code of Alabama §§ 34-24-75(d)(1975); State Plan.

History: Rule effective October 1, 1982. **Amended:** effective April 15, 1983, March 12, 1984, May 9, 1984, June 9, 1985, March 12, 1987; March 15, 1994; January 12, 1995; March 13, 1998; June 12, 2000; March 12, 2001; June 14, 2002; May 16, 2003; March 17, 2005; September 14, 2006; July 16, 2008. **Amended:** Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.02. Submission of Claims - General

(1) Effective March 1, 2010, all claims that do not require attachments (TPL denial), manual review (unclassified J codes), and an Administrative Review override by Medicaid or additional information to be printed on the claim (Work Incentive Program) must be submitted electronically to HPES. All paper claims received by HPES which do not meet the above requirements will be returned to the provider without being processed. Paper claims meeting the requirements should be submitted on CMS-1500 (Health Insurance Claim) forms. Each claim filed by a physician constitutes a contract with Medicaid.

(2) For claim filing limitations, refer to Chapter 1, Rule 560-X-1-.17.

(3) Physicians who want to participate in the Alabama Medicaid Program must be enrolled and receive a provider number.

(4) Claims must include the name and NPI number of the physician who takes responsibility for the services. The NPI number must identify the responsible individual, not a group or institution. Reimbursement may be made to a physician submitting a claim for services furnished by another physician in the event there is a reciprocal arrangement. The regular physician shall identify the services as substitute physician services by entering HCPCS modifier **Q5** (Service Furnished by a Substitute Physician under a Reciprocal Arrangement) or HCPCS modifier **Q6** (Service Furnished by a Locum Tenens Physician) after the procedure code. The substitute physician must be enrolled with Medicaid as an active provider. The reciprocal arrangement may not exceed 14 continuous days in the case of an informal arrangement or 60 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. The regular physician should keep a record on file of each service provided by the substitute physician and make this record available to Medicaid upon request. Payment may not be made for services provided by providers who have been suspended or terminated from participation in the Medicaid program. See Rule No. 560-X-4-.04 for details. Claims will be subject to post-payment review. Refer to the Alabama Medicaid Provider Manual, Chapter 28 for information regarding modifiers Q5 and Q6.

(5) Incomplete or inaccurate claim forms submitted for processing will be returned to the provider by the Medicaid fiscal agent for the necessary information.

(6) Before submitting a claim, a careful check should be made to see that the Medicaid identification number agrees with the number and exact spelling of the name on the patient's plastic Medicaid eligibility card.

(7) In filling out claim forms, providers must use diagnosis codes from the ICD-9-CM Code Book and procedure codes from the CPT Code Book, or approved procedure codes designated by Medicaid.

(8) Factoring arrangements in connection with the payment of claims under Medicaid are prohibited.

(9) Medicaid's fiscal agent will furnish to new providers a manual containing billing instructions.

(10) Pharmacists must have the physician's license number prior to billing for prescriptions. Refer to Chapter 16.

(11) Fragmentation of procedures, including laboratory procedures, under the Medicaid program is prohibited.

Author: Desiree Nelson; Program Manager; Medical Support

Statutory Authority: Title XIX, Social Security Act; 42 C.F.R., §§ 401, et seq.; State Plan; Omnibus Budget Reconciliation Act of 1990 (Public Law 105-508).

History: Rule effective October 1, 1982. **Amended:** effective March 12, 1984; November 11, 1985; March 12, 1987. **Emergency rule** effective April 1, 1991.

Amended: effective July 13, 1991; October 13, 1992; March 15, 1994; January 12, 1995; June 14, 2002. **Amended:** Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.03. Submission of Claims by Hospital-Based Physicians.

Hospital-based physicians will be reimbursed under the same general system as is used in Medicare. Bills for services rendered will be submitted as follows:

(1) All hospital-based physicians, including emergency room physicians, radiologists, and pathologists, shall bill the Medicaid program on a CMS-1500, Health Insurance Claim form or assign their billing rights to the hospital, which shall bill the Medicaid program on a CMS-1500 (Health Insurance Claim) form.

(a) Physician services personally rendered for individual patients will be paid only on a reasonable charge basis (i.e., claims submitted under an individual provider number on a physician claim form). This includes services provided by a radiologist and/or pathologist.

(b) Reasonable charge services are: 1) personally furnished for a patient by a physician; 2) ordinarily require performance by a physician and; 3) contribute to the diagnosis or treatment of an individual patient.

(2) Services of hospital-based physicians that do not meet the criteria of reasonable charge as define above, but benefit a hospital or its patient are reimbursable only on a reasonable cost basis through the hospital cost report. Please refer to Laboratory, Radiology, and Hospital Chapters of this code for further details.

Author: Desiree Nelson; Program Manager; Medical Support

Statutory Authority: Title XIX, Social Security Act; 42 C.F.R., §§ 405.401, et seq.; State Plan.

History: Rule effective October 1, 1982. **Emergency rule** effective October 1, 1984; January 8, 1985. **Amended:** effective March 12, 1987; January 12, 1995. **Amended:** Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.04. Submission of Claims: Routing of Claims.

(1) MEDICAID ELIGIBLES.

(a) Claims should be submitted to the fiscal agent in accordance with instructions for these patients who are enrolled for MEDICAID ONLY.

(b) Reimbursement for physicians' services will NOT be made to the patient, sponsor, or nursing facility. The Medicaid program does not provide for reimbursement of this expense to these individuals or facilities.

(2) MEDICARE ELIGIBLES.

(a) For Medicaid patients who are also enrolled for benefits under Part B refer to Chapter 1, this Code and the Alabama Medicaid Provider Manual.

Authority: Title XIX, Social Security Act; 42 CFR, Section 401, Et seq.; and State Plan. Rule effective October 1, 1982. Amended May 9, 1984, and March 12, 1987. Emergency rule effective February 1, 1989. Amended May 12, 1989. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.05. Submission of Claims: Out-of-State Claims DO NOT Need Prior Approval.

Except for those services which require prior approval as stated in Chapters 1 and 6 of this Administrative Code (i.e. transplants and select surgeries), medical care outside the State of Alabama does not require prior authorization by the Alabama Medicaid Agency.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective October 1, 1982. Amended October 9, 1984; March 12, 1987 and October 13, 1992. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.06. Medicaid Provider Payments.

Payment from Medicaid funds can be made to the actual provider of service only. The only exceptions to this rule are payments made within the same group, or for substitute physicians.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective March 15, 1994.

Rule No. 560-X-6-.07. Enrollment of Out-of-State Providers.

An out-of-state physician who wishes to participate in the Alabama Medicaid Program must enroll with the Alabama Medicaid Program and be assigned a provider identification number. To do so, the physician should send a written request to Medicaid's fiscal agent, Provider Enrollment Division. The following information must be included in the enrollment application:

1. Name;
2. Address of Place of Business;
3. Provider Type and specialty;
4. Social Security Number;
5. Federal Employer Identification Number;
6. Medicaid License Number;
7. Personal Historical Data; and
8. Original Provider Signature.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective October 1, 1982. Amended May 9, 1984, March 12, 1987 and March 15, 1994. Effective date of this amendment January 12, 1995.

Rule No. 560-X-6-.08. Consent Statements Required Before Services Are Provided.

Refer to the rules regarding consent and authorization contained in paragraphs within this chapter regarding sterilization, and abortions, Chapter 14 of this Code, and to Title 22, Chapter 8, Code of Alabama, 1975. NOTE: Non-therapeutic sterilization performed for the sole purpose of rendering a person permanently incapable of reproducing is not available to persons under twenty-one (21) years of age under the Medicaid Program.

Arthur: Mary Timmerman, Associate Director, Medical Services Program

Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 441.257; Section 401, Et seq.; State Plan.

History: Rule effective October 1, 1982 and March 12, 1987. Amended March 15, 1994. Amended: Filed March 20, 2002; effective June 14, 2002.

Rule No. 560-X-6-.09. Consent Forms Required Before Payments Can Be Made.

(1) Abortions: A claim seeking payment for an abortion must be accompanied by one or more (depending on the circumstance) of the forms required by federal law and a copy of the medical records. Payment is available for abortions as provided under federal law.

In the event the abortion does not meet the requirements of federal law, and the recipient elects to have the abortion, the provider may bill the recipient for the abortion.

(2) Sterilization: A claim seeking payment for sterilization must be accompanied by a sterilization form (Form 193) or Medicaid approved substitute.

Sterilization by Hysterectomy

(a) Payment is not available for a hysterectomy if:

1. It was performed solely for the purpose of rendering an individual permanently incapable of reproducing, or
2. If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Hysterectomy procedures performed for the sole purpose of rendering an individual incapable of reproducing are no longer covered under Medicaid. Hysterectomies done as a medical necessity as treatment of disease can be paid for by the Medicaid funds under the physician's program.

(b) A claim seeking payment for a hysterectomy performed for reasons of medical necessity, and not for purpose of sterilization, must be accompanied by a Hysterectomy Consent Form PHY-81243 (rev. 02-10-2010) or Medicaid approved substitute. The doctor's explanation to the patient that the operation will make her sterile, and the doctor's and recipient's signature must precede the operation except in the case of unusual circumstances.

The physician who performed the hysterectomy must complete Part IV. Unusual Circumstances of the revised hysterectomy consent form certifying that, (1) the patient was already sterile when the hysterectomy was performed; the cause of sterility must be stated and supporting medical records (history and physical, operative notes, and discharged summary) must be attached, or (2) the hysterectomy was performed under a life-threatening emergency situation in which prior acknowledgement was not possible. Medical records supporting life-threatening emergency situation must be attached, or (3) the hysterectomy was performed during a period of retroactive Medicaid eligibility, and before the operation was performed, the physician informed the recipient that she would be permanently incapable of reproducing as a result of the operation.

Surgeons are responsible for submitting hard copy hysterectomy consent forms to HPES. The form must be signed by both the patient, or a representative, and the physician.

Author: Desiree Nelson; Program Manager; Medical Support.

Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. §§ 401, et seq.; State Plan.

History: Rule effective October 1, 1982. **Amended:** effective March 12, 1987.

Emergency rule effective March 1, 1989. **Amended:** June 16, 1989; March 15, 1994; June 14, 2002; May 16, 2003. **Amended:** Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.10. Physician's Role in Certification and Recertification.

(1) For information about hospital certification and recertification see Rule No. 560-X-7-.16.

(2) In a skilled or intermediate nursing care facility, in the hospital and for the Home Health Care Program, Medicaid patients must be recertified by a physician at least every sixty (60) days. The certification form will be made a permanent part of the patient's record.

Authority: Title XIX, Social Security Act, 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective October 1, 1982. Amended July 8, 1983 and March 12, 1987. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.11. Physician's Role in Extension of Hospital Days.

(1) With the exception of Medicaid recipients eligible for treatment under the EPSDT (MediKids) program, additional hospital days are not covered. Refer to Chapter 7, Hospital Program and Chapter 11, EPSDT, for specifics.

Authority: Title XIX, Social Security Act, 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective October 1, 1982. Amended July 8, 1983 and March 12, 1987. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.12. Covered Services: General

(1) In general, physician services are covered by Medicaid if the services are:
(a) Considered medically necessary by the attending physician. However, when the persons designated responsible for utilization review have issued a denial for inpatient days, no ancillary charge or professional charges will be reimbursed during the denied period.

(b) Designated by procedure codes in Physicians' Current Procedural Terminology (CPT), or designated by special procedure codes created by Medicaid for its own use.

(2) Physicians will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories. Physicians may submit claims for laboratory work done by them in their own offices or own laboratory facilities. For specific information concerning the "professional component" and drawing and extraction reimbursement, see the laboratory chapter.

(3) If a physician is not sure whether a service is covered, that physician can contact the HPES Provider Assistance Center.

Author: Desiree Nelson, Program Manager; Medical Support

Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. §§401, et seq.; State Plan.

History: Rule effective October 1, 1982. **Amended:** effective June 5, 1983; May 9, 1984; May 8, 1985; March 12, 1987; March 15, 1994; January 12, 1995; June 14, 2002.

Amended: Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.13. Covered Services: Details on Selected Services.

(1) Acupuncture: Not covered.

(2) Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure which is a covered service under the Alabama Medicaid Program. Medical direction by an anesthesiologist of more than four Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs) concurrently will not be covered. For billing purposes, anesthesia services rendered with medical direction for one CRNA or AA is considered a service performed by the anesthesiologist. In order to bill for medical supervision, the anesthesiologist must be physically present and available within the operating suite. "Physically present and available" means the anesthesiologist would not be available to render direct anesthesia services to other patients. However, addressing an emergency of short duration or rendering the requisite CRNA or AA supervision activities (listed below in a. through g.) within the immediate operating suite is acceptable as long as it does not substantially diminish the scope of the supervising anesthesiologist's control. If a situation occurs which necessitates the anesthesiologist's personal continuing involvement in a particular case, medical supervision ceases to be available in all other cases. In order for the anesthesiologist to be reimbursed for medical supervision activities of the CRNA or AA, the anesthesiologist must document the performance of the following activities:

- (a) performs a pre-anesthesia examination and evaluation;
- (b) prescribes the anesthesia plan;
- (c) personally participates in the most demanding procedures in the anesthesia plan, including induction as needed, and emergencies;
- (d) ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
- (e) monitors the course of anesthesia administration at frequent intervals;

- (f) remains physically present and available for immediate diagnosis and treatment of emergencies; and
- (g) provides indicated post-anesthesia care.

Administration of anesthesia by a self-employed Certified Registered Nurse Anesthetist (CRNA) is a covered service when the CRNA has met the qualifications and standards set forth in Rule No. 610-X-9-.01 through 610-X-9-.04 of the Alabama Board of Nursing Administrative Code. The CRNA must enroll and receive a provider number to bill under the Alabama Medicaid Program. When billing for anesthesia services, providers shall follow the guidelines set forth in the current Relative Value Guide published by the American Society of Anesthesiologists for basic value and time units. No Physical Status Modifiers can be billed.

Administration of anesthesia by a qualified Anesthesiology Assistant (AA) is a covered service when the AA has met the qualifications and standards set forth in the Alabama Board of Medical Examiners Administrative Code. Reimbursement shall be made only when the AA performs the administration of anesthesia under the direct medical supervision of the anesthesiologist.

Anesthesia services may include, but are not limited to, general anesthesia, regional anesthesia, supplementation of local anesthesia, or other supportive treatment administered to maintain optimal anesthesia care deemed necessary by the anesthesiologist during the procedure. Anesthesia services include all customary preoperative and postoperative visits, the anesthesia care during the procedure, the administration of any fluids deemed necessary by the attending physician, and any usual monitoring procedures. Therefore, additional claims for such services should not be submitted.

(h) Local anesthesia is usually administered by the attending surgeon and is considered to be part of the surgical procedure being performed. Thus, additional claims for local anesthesia by the surgeon should not be filed. Any local anesthesia administered by an attending obstetrician during delivery (i.e. pudendal block or paracervical block) is considered part of the obstetrical coverage. Thus, additional claims for local anesthesia administered by an attending obstetrician during delivery should not be filed.

(i) When regional anesthesia (i.e., nerve block) is administered by the attending physician during a procedure, the physician's fee for administration of the anesthesia will be billed at one-half the established rate for a comparable service when performed by an anesthesiologist. When regional anesthesia is administered by the attending obstetrician during delivery (i.e., saddle block or continuous caudal), the obstetrician's fee for administration of the anesthesia will be billed at one-half the established rate for a comparable service performed by an anesthesiologist. When regional anesthesia is administered by an anesthesiologist during delivery or other procedure, the anesthesiologist's fee will be covered and should be billed separately.

(j) When a medical procedure is a noncovered service under the Alabama Medicaid Program, the anesthesia for that procedure is also considered to be a noncovered service.

- (3) Artificial Eyes: Must be prescribed by a physician.
- (4) Autopsies: Not covered.
- (5) Biofeedback: Not covered.
- (6) Blood Tests: Not covered for marriage licenses.
- (7) CAT Scans, CTA's, MRI's, MRA's and PET scans: See Chapter 34 of this code for specific details.
- (8) Chiropractors: Not covered, except for QMB recipients and for services referred directly as a result of an EPSDT screening.
- (9) Chromosomal Studies: Chromosomal studies (amniocentesis) on unborn children being considered for adoption are not covered. Medicaid can pay for these studies in the case of prospective mothers in an effort to identify conditions that could result in the birth of an abnormal child.
- (10) Circumcision: Circumcision of newborns is a covered service. If medically necessary, non-newborn circumcision is covered.
- (11) Diet Instruction: Diet instruction performed by a physician is considered part of a routine visit.
- (12) Drugs:
 - (a) Non-injectable drugs: See Chapter 16 of this Code.
 - (b) Injectable drugs: Physicians who administer injectable drugs to their patients may bill Medicaid for the cost of the drug by using the procedure code designated by Medicaid for this purpose. The injectable administration code may be used only when an office visit or nursing home visit is not billed.
- (13) Examinations: Office visits for examinations are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this limit.
 - (a) Annual routine physical examinations are not covered.
 - (b) Medical examinations for such reasons as insurance policy qualifications are not covered.
 - (c) Physical examinations for establishment of total and permanent disability status if considered medically necessary are covered.
 - (d) Medicaid requires a physician's visit once each 60 days for patients in a nursing home. Patients in intermediate care facilities for the mentally retarded will receive a complete physical examination at least annually.

(e) Physical examination, including x-ray and laboratory work, will be payable for recipients eligible through the EPSDT Program if the physician has signed an agreement with Medicaid to participate in the screening program.

(14) Experimental Treatment and/or Surgery: Not covered.

(15) Eyecare:

(a) Eye examinations by physicians are a Medicaid covered service.

(b) Office visits for eyecare disease are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(16) Filing Fees: Not covered.

(17) Foot Devices: See Chapter 13 (Supplies, Appliances, and Durable Equipment) for specific details.

(18) Hearing Aids: See Hearing Aids Chapter in this Code.

(19) Hypnosis: Not covered.

(20) Immunizations: Payment for immunizations against communicable diseases will be made if the physician normally charges his patients for this service.

(a) The Department of Public Health provides vaccines at no charge to Medicaid physicians enrolled in the Vaccines For Children (VFC) Program and as recommended by the Advisory Committee on Immunization.

(b) Effective October 1, 1994, the Alabama Medicaid Agency will begin reimbursement of administration fees for vaccines provided free of charge through the Vaccines For Children (VFC) Program.

(c) Medicaid tracks usage of the vaccine through billing of the administration fee using the appropriate CPT codes.

(d) The Omnibus Budget Reconciliation Act of 1993 mandated that Medicaid can no longer cover a single antigen vaccine if a combined antigen vaccine is medically appropriate. This change will become effective January 1, 1994. The single antigen vaccines may still be billed only if prior approved before given and a medical justification is given. These vaccines are diphtheria, measles, mumps, and rubella. In order to request the prior approval for these vaccines, providers should contact the HPES, Prior Authorization Unit at P.O. Box 244036, Montgomery, AL 36124-4036.

(21) Infant Resuscitation: Newborn resuscitation (procedure code 99465) is a covered service when the baby's condition is life threatening and immediate resuscitation is necessary to restore and maintain life functions. Intubation, endotracheal, emergency procedure (procedure code 31500) cannot be billed in conjunction with newborn resuscitation.

(22) Intestinal Bypass: Not covered for obesity.

(23) Laetrile Therapy: Not covered.

(24) Newborn Claims: The five kinds of newborn care performed by physicians in the days after the child's birth when the mother is still in the hospital that may be filed under the mother's name and number or the baby's name and number are routine newborn care and discharge codes, circumcision, newborn resuscitation, standby services following a caesarean section or a high-risk vaginal delivery, and attendance at delivery (when requested by delivering physician) and initial stabilization of newborn. Standby services (procedure code 99360) are covered only when the pediatrician, family practitioner, neonatologist, general practitioner, or OB/GYN is on standby in the operating or delivery room during a cesarean section or a high-risk vaginal delivery. Attendance of the standby physician in the hospital operating or delivery room must be documented in the operating or delivery report. When filing claims for these five kinds of care, CPT codes shall be utilized. All other newborn care (any care other than routine newborn care for a well-baby), before and after the mother leaves the hospital, must be billed under the child's name and number.

(25) Obstetrical Services and Related Services: Office visits for obstetrical care are counted as part of each recipient's annual office visit limit under certain conditions. See Rule No. 560-X-6-.14 for details about this quota.

(a) Family Planning: See the Family Planning Chapter in this Code.

(b) Abortions: See Rule No. 560-X-6-.09 (1).

(c) Hysterectomy: See Rule No. 560-X-6-.09.

(d) Maternity Care and Delivery: The services normally provided in maternity cases include antepartum care, delivery, and postpartum care. When a physician provides total obstetrical care, the procedure code which shall be filed on the claim form is the code for all-inclusive "global" care. The indicated date of service on "global" claims should be the date of delivery. If a woman is pregnant at the time she becomes eligible for Medicaid benefits, only those services provided during the time she is eligible will be covered. When a physician provides eight (8) or more prenatal visits, performs the delivery, and provides the postpartum care, the physician shall use a "global" obstetrical code in billing. If a physician submits a "global" fee for maternity care and delivery, the visits covered by these codes are not counted against the recipient's limit of annual office visits. For purposes of "global" obstetrical billing, services rendered by members of a group practice are to be considered as services rendered by a single provider.

1. Antepartum care includes all usual prenatal services such as initial office visit at which time pregnancy is diagnosed, initial and subsequent histories, physical examinations, blood pressure recordings, fetal heart tones, maternity counseling, etc.; therefore, additional claims for routine services should not be filed. Antepartum care also includes routine lab work (e.g., hemoglobin, hematocrit, chemical urinalysis, etc.); therefore, additional claims for routine lab work should not be filed.

(i) To justify billing for global antepartum care services, physicians must utilize the CPT antepartum care global codes (either 4-6 visits, or 7 or

more visits), as appropriate. Claims for antepartum care filed in this manner do not count against the recipient's annual office visit limit. Physicians who provide less than four (4) visits for antepartum care must utilize CPT codes under office medical services when billing for these services. These office visit codes will be counted against the recipient's annual office visit limit.

(ii) Billing for antepartum care services in addition to "global" care is not permissible; however, in cases of pregnancy complicated by toxemia, cardiac problems, diabetes, neurological problems or other conditions requiring additional or unusual services or hospitalization, claims for additional services may be filed. If the physician bills fragmented services in any case other than high-risk or complicated pregnancy and then bills a "global" code, the fragmented codes shall be recouped. Claims for such services involved in complicated or high risk pregnancies may be filed utilizing CPT codes for Office Medical Services. Claims for services involving complicated or high risk pregnancies must indicate a diagnosis other than normal pregnancy and must be for services provided outside of scheduled antepartum visits. These claims for services shall be applied against the recipient's annual office visit limit.

2. Delivery and postpartum care: Delivery shall include vaginal delivery (with or without episiotomy) or cesarean section delivery and all in-hospital postpartum care. More than one delivery fee may not be billed for a multiple birth (twins, triplets, etc.) delivery, regardless of delivery method(s). Delivery fees include all professional services related to the hospitalization and delivery which are provided by the physician; therefore, additional claims for physician's services in the hospital such as hospital admission, may not be filed in addition to a claim for delivery or a claim for "global" care.

EXCEPTION: When a physician's first and only encounter with the recipient is for delivery ("walk-in" patient) he may bill for a hospital admission (history and physical) in addition to delivery charges.

3. Postpartum care includes office visits following vaginal or cesarean section delivery for routine postpartum care within sixty-two (62) days post delivery. Additional claims for routine visits during this time should not be filed.

4. Delivery only: If the physician performs the delivery only, he must utilize the appropriate CPT delivery only code (vaginal delivery only or C-section delivery only). More than one delivery fee may not be billed for a multiple birth (twins, triplets, etc.) delivery, regardless of the delivery method(s). Delivery fees include all professional services related to the hospitalization and delivery which are provided by the physician; therefore, additional claims for physician's services in the hospital such as hospital admission, may not be filed in addition to a claim for delivery only.

EXCEPTION: When a physician's first and only encounter with the recipient is for delivery ("walk-in" patient) he may bill for a hospital admission (history and physical) in addition to delivery charges.

5. Obstetrical ultrasounds are limited to two per pregnancy. Generally, first ultrasounds are conducted to detect gestational age, multiple pregnancies, and major malformations. Second ultrasounds may be conducted to detect fetal growth disorders (intrauterine growth retardation, macrosomia) and anomalies that would appear later or may have been unrecognizable in the earlier scan.

Additional ultrasounds may be prior approved by the Alabama Medicaid Agency if a patient's documented medical condition meets any of the following criteria:

- (i) Gestational diabetes with complications (Type 1 diabetes, vascular disease, hypertension, elevated alpha-fetoprotein values, poor patient compliance);
- (ii) Failure to gain weight, evaluation of fetal growth;
- (iii) Pregnancy-induced hypertension;
- (iv) Vaginal bleeding of undetermined etiology;
- (v) Coexisting adnexal mass;
- (vi) Abnormal amniotic fluid volume (polyhydramnios, oligohydramnios);
- (vii) Pregnant trauma patient;
- (viii) Congenital diaphragmatic hernia (CDH);
- (ix) Monitoring for special tests such as fetoscopy, amniocentesis, or cervical cerclage placement;
- (x) Assist in operations performed on the fetus in the uterus;
- (xi) Detection of fetal abnormalities with other indicators or risk factors (Low human chorionic gonadotrophin (HCG) and high unconjugated oestriol (uE3) are predictive of an increased risk for Trisomy 18. Echogenic bowel grades 2 and 3 are indicative of an increased risk of cystic fibrosis and Trisomy 21);
- (xii) Determination of fetal presentation;
- (xiii) Suspected multiple gestation, serial evaluation of fetal growth in multiple gestation;
- (xiv) Suspected hydatidiform mole;
- (xv) Suspected fetal death;
- (xvi) Suspected uterine abnormality;
- (xvii) Suspected abruptio placenta;
- (xviii) Follow-up evaluation of placental location for identified placenta previa.

Fee-for-service providers should submit requests for additional obstetrical ultrasounds to:

Prior Authorization Program
Alabama Medicaid Agency
P. O. Box 5624
Montgomery, AL 36103-5624

Maternity Waiver subcontractors should contact their Primary Provider for information regarding obstetrical ultrasounds.

- (e) Sterilization: See the Family Planning Chapter in this Code.

(26) Medical Materials and Supplies: Costs for medical materials and supplies normally utilized during office visits or surgical procedures are to be considered part of the total fee for procedures performed by the physician and therefore are not generally a separately billable service.

(27) Oxygen and Compressed Gas: A physician's fee for administering oxygen or other compressed gas is a covered service under the Medicaid program. Oxygen therapy is a covered service based on medical necessity and requires prior authorization. Please refer to the Alabama Medicaid Administrative Code, Rule No. 560-X-13-.15 and the Alabama Medicaid Billing Manual Chapter 14, DME, for more information.

(28) Podiatrist Service: Covered for QMB or EPSDT referred services only.

(29) Post Surgical Visits:

(a) Hospital Visits: Post-surgical hospital visits for conditions directly related to the surgical procedures are covered by the surgical fee and cannot be billed separately the day of, or up to 90 days post surgery.

(b) Office Visits: Post-surgical office visits for procedures directly related to the surgical procedure are covered by the surgical fee and are not separately covered the day of, or up to 90 days post surgery, and cannot be billed separately, e.g. suture removal.

(c) Visits by Assistant Surgeon or Surgeons: Not covered.

(30) Preventive Medicine: The Medicaid program does not cover preventive medicine other than EPSDT screening.

(31) Prosthetic Devices: External prosthetic devices are not a covered benefit under the Physician's Program. Internal prosthetic devices (i.e., Smith Peterson Nail, pacemaker, vagus nerve stimulator, etc.) are a covered benefit only when implanted during an inpatient hospitalization. The cost of the device is reimbursed through the payment of the inpatient hospital per diem rate and is not separately reimbursable.

(32) Psychiatric Services: Office visits for psychiatric services are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Psychiatric Evaluation or Testing: Are covered services under the Physicians' Program if services are rendered by a physician in person and are medically necessary. Psychiatric evaluations shall be limited to one per calendar year, per provider, per recipient.

(b) Psychotherapy Visits: Shall be included in the annual office visit limit. Office visits shall not be covered when billed in conjunction with psychotherapy codes.

(c) Psychiatric Services: Under the Physicians' Program shall be confined to use with psychiatric diagnosis (290-319) and must be performed by a physician.

(d) Hospital Visits: Are not covered when billed in conjunction with psychiatric therapy on the same day.

(e) Services Rendered by Psychologist: See Chapter 11 (EPSDT) for specific information.

(f) Psychiatric Day Care: Not a covered benefit under the Physicians' Program.

(33) Second Opinions: Office visits for second opinions are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Optional Surgery: Second opinions (regarding non-emergency surgery) are highly recommended in the Medicaid program when the recipients request them. Payment is made in accordance with the provider's reasonable charge profile allowance for an initial office visit for the appropriate level of service.

(b) Diagnostic Services: Payment may be made for covered diagnostic services deemed necessary by the second physician.

(34) Self-Inflicted Injury: Covered.

(35) Surgery

(a) Cosmetic: Covered only when prior approved for medical necessity. Examples of medical necessity include prompt repair of accidental injuries or improvement of the functioning of a malformed body member.

(b) Elective: Covered when medically necessary.

(c) Multiple:

1. When multiple and/or bilateral surgical procedures, which add significant time or complexity are performed at the same operative session, payment may be made for the procedure with the highest allowed amount and half of the allowed amount for each subsequent procedure code that is not considered to be an integral part of the covered service. This also applies to laser surgical procedures. See Medicaid National Correct Coding Initiatives at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicaid-Nation-Correct-Coding-Initiative.html>. Exceptions are noted in Rule No. 560-X-6-.14, Limitations on Services.

2. Certain procedures are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. When incidental procedures (e.g. excision of previous scar or puncture of ovarian cyst) are performed during the same operative session, the reimbursement will be included in that of the major procedure only.

3. Laparotomy is covered when it is the only surgical procedure performed during the operative session or when performed with an unrelated surgical procedure.

4. CPT defined Add On codes are considered for coverage only when billed with the appropriate primary procedure code.

5. Appropriate use of CPT and HCPCs modifiers is required to differentiate between sites and procedures. For Medicaid approved modifiers, refer to the Alabama Medicaid Provider Manual.

(36) Telephone Consultations: Not covered.

(37) Therapy: Office visits for therapy are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Occupational and Recreational Therapies: Not covered.

(b) Physical Therapy: Is not covered when provided in a physician's office. Physical therapy is covered only when prescribed by a physician and provided in a hospital setting. See Rule No. 560-X-7-.12 for further requirements of coverage.

(c) Group Therapy: Shall be a covered service when a psychiatric diagnosis is present and the therapy is prescribed, performed, and billed by the physician personally.

(1) Group Therapy is included in the annual office visit limit.

(2) Group Therapy is not covered when performed by a case worker, social services worker, mental health worker, or any counseling professional other than a physician.

(d) Speech Therapy: The patient must have a speech related diagnosis, such as stroke (CVA) or partial laryngectomy. To be a covered benefit speech therapy must be prescribed by and performed by a physician in his office. Speech therapy performed in an inpatient or outpatient hospital setting, or in a nursing home is a covered benefit, but is considered covered as part of the reimbursement made to the facility and should not be billed by the physician.

(e) Family Therapy: Shall be a covered service when a psychiatric diagnosis is present and the physician providing the service supplies documentation which justifies the medical necessity of the therapy for each family member. Family therapy is not covered unless the patient is present. Family Therapy is included in the annual office visit limit. Family Therapy is not covered when performed by a case worker, social service worker, mental health worker, or any counseling professional other than a physician.

(38) Transplants: See Rule No. 560-X-1-.27 for transplant coverage.

(39) Ventilation Study: Covered if done in physician's office by the physician or under the physician's direct supervision. Documentation in the medical record should contain all of the following:

(a) Graphic record;

(b) Total and timed vital capacity;

(c) Maximum breathing capacity;

(d) Always indicate if the studies were performed with or without a bronchodilator.

(40) Well-Baby Coverage: Covered only on the initial visit, which must be provided within eight (8) weeks of the birth.

(41) Work Incentive: A claim stating physical examination for a child to be put into a day-care center for mother to work is a covered procedure. (Must state "Work Incentive Program.")

Author: Desiree Nelson, Program Manager; Medical Support

Statutory Authority: Title XIX, Social Security Act; 42 CFR, §§ 405.310(k), 440.50, et seq.; State Plan.

History: Rule effective October 1, 1982. **Amended:** effective April 15, 1983; June 5, 1983; July 8, 1983; November 10, 1983; April 12, 1984; June 8, 1984; October 9, 1984; January 8, 1985; May 8, 1985; June 8, 1985; July 9, 1985; September 9, 1985;

Emergency rule effective January 22, 1986. **Amended:** effective April 11, 1986.

Emergency rule effective December 1, 1986. **Amended:** effective March 12, 1987.

Emergency rule effective March 4, 1987. **Amended:** effective June 10, 1987; June 10, 1988; October 12, 1988; July 13, 1989; May 15, 1990; June 14, 1990; October 13, 1990; April 17, 1991. **Emergency rule** effective July 1, 1991. **Amended:** effective October 12, 1991. **Emergency rule** effective January 1, 1992. **Amended:** effective April 14, 1992; March 15, 1994; January 12, 1995; January 14, 1997, and October 11, 2000; June 14, 2002; May 16, 2003; April 16, 2004; November 16, 2004; March 17, 2005. **Amended:** Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.14. Limitations on Services.

(1) Within each calendar year each recipient is limited to no more than a total of 14 physician office visits in offices, hospital outpatient settings, nursing homes, or Federally Qualified Health Centers. Visits counted under this quota will include, but not be limited to, visits for: prenatal care, postnatal care, family planning, second opinions, consultations, referrals, psychotherapy (individual, family, or group), for ESRD services not covered by the monthly capitation payment, and care by ophthalmologists for eye disease. Physician visits provided in a hospital outpatient setting that have been certified as an emergency do not count against the annual office visit limit.

(a) If a patient receives ancillary services in a doctor's office, by the physician or under his/her direct supervision, and the doctor submits a claim only for the ancillary services but not for the office visit, then the services provided will not be counted as a visit.

(b) For further information regarding outpatient maintenance dialysis and ESRD, refer to 560-X-6-.19 and Chapter 24.

(c) New patient office visit codes shall not be paid to the same physician or the same physician group practice for a recipient more than once in a three-year period.

(2) Physician services to hospital inpatients. In addition to the office visits referred to in paragraph (1) above, Medicaid covers up to 16 inpatient dates of service per physician, per recipient, per calendar year. For purposes of this limitation, each specialty within a group or partnership is considered a single provider.

(a) Physician hospital visits are limited to one visit per day, per recipient, per provider.

(b) Physician(s) may bill for inpatient professional interpretation(s) when that interpretation serves as the official and final report documented in the patient's medical record. Professional interpretation may be billed in addition to a hospital visit if the rounding physician also is responsible for the documentation of the final report for the

procedure in the patient's medical record. Professional interpretation may not be billed in addition to hospital visits if the provider reviews results in the medical record or unofficially interprets medical, laboratory, or radiology tests. Review and interpretation of such tests and results are included in the evaluation and management of the inpatient. Medicaid will cover either one hospital visit or professional interpretation(s) up to the allowed benefit limit for most services. Refer to the Alabama Medicaid Provider Manual for additional guidelines.

(c) Professional interpretations for lab and x-ray (CPT code 70000 through 80000 services) in the inpatient setting should be billed only by the specialist responsible for the official medical record report of interpretation. Professional interpretations performed by physicians of other specialties for services in this procedure code range are included in the hospital visit reimbursement.

(d) Professional interpretations for lab and x-ray services performed in an outpatient setting are considered part of the evaluation and management service and may not be billed in addition to the visit. Professional interpretations may be billed separately only by the specialist responsible for the official medical record report of interpretation. Only one professional interpretation per x-ray will be paid. Claims paid in error will be recouped.

(e) Professional interpretations for lab and x-ray services performed in an office setting are included in the global fee and should not be billed separately.

(f) A physician hospital visit and hospital discharge shall not be paid to the same physician on the same day. If both are billed, only the discharge shall be paid.

(3) Eyecare: Refer to Chapter Seventeen of this Code.

(4) Orthoptics: Orthoptics may be prior authorized by the Alabama Medicaid Agency when medically necessary.

(5) Telemedicine: Telemedicine services are covered. Physicians allowed to participate in telemedicine services include those with an Alabama license, regardless of location. Refer to the Alabama Medicaid Provider Manual, Chapter 28 for details on coverage.

(6) Telephone consultations: Telephone consultations are not authorized.

(7) Prior authorized services: These are subject to all limitations of the Alabama Medicaid Agency Program.

(8) Post surgical benefits: See Rule No. 560-X-6-.13.

(9) Surgery: When multiple and/or bilateral procedures are billed in conjunction with one another and meet the CPT's definition of "Format of Terminology" (bundled or subset), and/or comprehensive/component (bundled) codes, then the procedure with the highest allowed amount will be paid while the procedure with the

lesser allowed amount will not be considered for payment as the procedure is considered an integral part of the covered service.

(a) Operating microscope procedure coverage is limited. For details on coverage, refer to the Physician Chapter of the Alabama Medicaid Provider Manual.

(b) Mutually exclusive procedures are defined as those codes that cannot reasonably be performed in the same session and are considered not separately allowable or reimbursable. An example of this would be an abdominal and vaginal hysterectomy billed for the same recipient on the same date of service.

(c) Incidental procedures are defined as those codes which are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. An example of this would be lysis of adhesions during the same session as an abdominal surgery.

(d) Casting and strapping codes as defined in the CPT and billed in conjunction with related surgical procedure codes are considered not separately allowable or reimbursable as the fracture repair or surgical code is inclusive of these services.

(e) Laparotomy Codes are covered when the laparotomy is the only surgical procedure during an operative session or when performed with an unrelated surgical procedure.

Author: Teresa Thomas, Program Manager, EPSDT/Related Svcs.

Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 441.57, 441.56, Part 401, et seq.; State Plan, 42CFR Section 410.78.

History: Rule effective October 1, 1982. Amended July 8, 1983; February 8, 1984; October 9, 1984; January 8, 1985; March 11, 1985; June 8, 1985; September 9, 1985; December 1, 1986; March 12, 1987; July 10, 1987; January 12, 1990; December 12, 1990; January 1, 1992; April 14, 1992; March 15, 1994; January 12, 1995, and December 11, 2000; Amended: Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed February 18, 2003; effective May 16, 2003. **Amended:** Filed May 20, 2003; effective August 18, 2003. **Amended:** Emergency Rule filed and effective April 9, 2004.

Amended: Filed April 21, 2004; effective July 16, 2004. **Amended:** Filed August 20, 2004; effective November 16, 2004. **Amended:** Filed December 17, 2004, effective March 17, 2005. **Amended:** Filed November 18, 2009; effective February 15, 2010.

Amended: Filed October 20, 2011, effective January 16, 2012.

Rule No. 560-X-6-.15. Reserved

Rule No. 560-X-6-.16. Billing of Medicaid Recipients by Providers.

(1) A provider may bill Medicaid recipients for the copay amount, for Medicaid noncovered services and for services provided to a recipient who has exhausted his/her yearly limitations. Conditional collections to be refunded post payment by Medicaid and partial charges for balance of Medicaid allowed reimbursement are not permissible. Billing recipient for services not paid by Medicaid due to provider correctable errors on claims submission or untimely filing is not permissible.

Authority: Title XIX, Social Security Act, 42 C.F.R. Section 447.15, Et seq.; State Plan. Amended July 9, 1984, June 8, 1985, and March 12, 1987. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.17. Copayment (Cost-Sharing).

(1) Medicaid recipients are required to pay, and physician providers are required to collect, the designated copayment amount on each physician visit.

(2) Exceptions to the copayment requirement are listed in Rule No. 560-X-1-.25.

(3) A provider may not deny services to any eligible individual due to the individual's inability to pay the cost-sharing amount imposed.

Author: Desiree Nelson; Program Manager; Medical Support

Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. §§ 447.50, 447.53, 447.55, et seq.; and State Plan Attachment 4.18-A.

History: Rule effective June 8, 1985. **Amended:** effective July 9, 1985; March 12, 1987; January 12, 1995. **Amended:** Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.18. Critical Care

(1) When caring for a critically ill patient in which the constant attention of the physician is required, the appropriate critical care procedure code must be billed. Refer to the CPT and the Alabama Medicaid Provider Manual for additional guidance and clarification.

(2) The actual time period, per day, spent in attendance at the patient's bedside, or performing duties specifically related to that patient, irrespective of breaks in attendance, must be documented in the patient's medical record.

(3) Only the following individual procedures related to critical care may be billed:

(a) Procedure code 99360 (stand by) and either procedure code 99221, 99222, or 99223 (initial hospital care) may be billed once with each hospital stay.

(b) An EPSDT screening may be billed in lieu of the initial hospital care (Procedure code 99221, 99222, or 99223).

(c) Procedure code 99082 (transportation/escort of patient) may be billed only by the attending physician. Residents or nurses who escort a patient may not bill either service.

(4) Pediatric and Neonatal Critical Care

The purpose of the following policy statements is to provide assistance to providers seeking to bill procedures for critical care. Refer to the CPT and the Alabama Medicaid Provider Manual for additional guidance and clarification.

(a) Pediatric and neonatal critical care codes begin with the day of admission and may be billed once per patient, per day, in the same facility.

(b) The pediatric and neonatal critical care codes include management, monitoring and treatment of the patient, including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematologic maintenance, parent/family counseling, case management services and personal direct supervision of the health care team in the performance of their daily activities.

(c) Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes should be billed.

(d) Refer to the Alabama Medicaid Provider Manual for guidelines on what additional procedures may be billed in conjunction with critical care. General guidelines are:

1. Initial history and physical or EPSDT screen may be billed in conjunction with 99293 or 99295. Both may not be billed. One EPSDT screen for the hospitalization will encompass all diagnoses identified during the hospital stay for referral purposes.

2. Standby (99360) or resuscitation (99465) at delivery or attendance at delivery (99464) may be billed in addition to critical care. Only one of the codes may be billed in addition to critical care.

3. Subsequent Hospital Care codes (99231-99233) may not be billed.

4. Critical care is considered to be an evaluation and management service. Although usually furnished in a critical or intensive care unit, critical care may be provided in any inpatient health care setting. Services provided which do not meet critical care criteria should be billed under the appropriate hospital care codes. If a recipient is readmitted to the NICU/ICU, the provider must be the primary physician in order for NICU/ICU critical care codes to be billed again.

5. Transfers to the pediatric unit from the NICU cannot be billed using neonatal critical care codes.

6. Global payments encompass all care and procedures which are included in the rate. Physicians may not perform an EPSDT screen and refer to partner or other physician to do procedures. All procedures which are included in the daily critical care rate, regardless of who performed them, are included in the global critical care code.

7. Consultant care rendered to children for which the provider is not the primary attending physician must be billed using consultation codes. Appropriate procedures may be billed in addition to consultations. If, after the consultation the provider assumes total responsibility for care, critical care may be billed using the appropriate critical care codes as defined in the Alabama Medicaid Provider Manual. The medical record must clearly indicate that the provider is assuming total responsibility for care of the patient and is the primary attending physician for the patient. Consultation and critical care cannot be billed on the same patient on the same day.

(5) Intensive (Non-Critical) Low Birthweight Services

The purpose of the following policy statement is to provide assistance to neonatology providers seeking to bill for intensive (non-critical) low birthweight services. Refer to the CPT and the Alabama Medicaid Provider Manual for additional guidelines and clarification. Intensive (non-critical) low birthweight services codes are used to report care subsequent to the day of admission provided by a neonatologist directing the continuing intensive care of the very low birthweight infant who no longer meets the definition of being critically ill. Low birthweight services are reported for neonates less than 2500 grams who do not meet the definition of critical care but continue to require intensive observation and frequent services and intervention only available in an intensive care setting.

Author: Desiree Nelson; Program Manager; Medical Support.

Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. § 440.50; CPT.

History: Rule effective May 9, 1986. **Amended:** March 12, 1987, October 12, 1988, and June 12, 1991. **Emergency rule** effective January 1, 1992. **Amended:** effective April 14, 1992. **Emergency rule** effective May 7, 1992. **Amended:** effective August 12, 1992; March 13, 1993; March 15, 1994; June 14, 2002; August 18, 2003; March 17, 2005. **Amended:** Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.19. Physician Services for End-Stage Renal Disease (ESRD).

(1) All physician services rendered to each outpatient maintenance dialysis patient provided during a full month on an ongoing basis without interruption of the treatment regime (uninterruptedly) shall be billed on a monthly capitation basis. The monthly capitation payment is limited to once per month, per recipient, per provider.

(2) Physician services rendered to each outpatient maintenance dialysis patient not performed consecutively (interruptedly) during a full month, i.e., preceding and/or following the period of hospitalization, are allowed. Please refer to the physician's chapter of the Provider Manual for further details.

(3) Services not covered by the monthly capitation payment (MCP) and which are reimbursed in accordance with usual and customary charge rules are limited to:

- (a) Declotting of shunts.
- (b) Covered physician services furnished to hospital inpatients by a physician who elects not to receive the MCP for these services.
- (c) Nonrenal related physician services. These services may be furnished either by the physician providing renal care or by another physician. They may not be incidental to services furnished during a dialysis session or office visit necessitated by the renal condition.

(4) Refer to the Renal Dialysis chapter for further details.

Author: Brenda Vaughn, Program Manager, Medical Services Program.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 405.542, and Federal Register dated July 2, 1986.

History: Emergency Rule effective January 1, 1987. Amended January 14, 1987, March 12, 1987, and March 15, 1994. Amended: Filed February 18, 2003; effective May 16, 2003.

PROVIDER AGREEMENT

As a condition for participation as a provider under the Alabama Medicaid Program (MEDICAID), the provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 Agreement and Documents Constituting Agreement.

A copy of the current *Alabama Medicaid Provider Manual* and the *Alabama Medicaid Administrative Code* has been or will be furnished to the Provider. This Agreement is deemed to include the applicable provisions of the State Plan, *Alabama Medicaid Administrative Code*, and *Alabama Medicaid Provider Manual*, as amended, and all State and Federal laws and regulations. If this Agreement is deemed to be in violation of any of said provisions, then this Agreement is deemed amended so as to comply therewith. Invalidity of any portion of this Agreement shall not affect the validity, effectiveness, or enforceability of any other provision. Provider agrees to comply with all of the requirements of the above authorities governing or regulating MEDICAID. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the above authorities.

1.2 State and Federal Regulatory Requirements.

- 1.2.1 Provider has not been excluded or debarred from participation in any program under Title XVIII (Medicare) or any program under Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. § 1320a-7), or Executive Order 12549. Provider also has not been excluded or debarred from participation in any other state or federal health-care program. Provider must notify MEDICAID or its agent within ten (10) business days of the time it receives notice that any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B), which could result in exclusion from the Medicaid program
- 1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B, and provide such information on request to MEDICAID, the Alabama Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current by informing MEDICAID or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, or provider business addresses, at least thirty (30) business days prior to making such changes. Provider also agrees to notify MEDICAID or its agent within ten (10) business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services, and Provider must provide to MEDICAID complete information related to any such suspension or restriction.
- 1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud and abuse in health care and the Medicaid program. As required by 42 C.F.R. §431.107, Provider agrees to keep any and all records necessary to disclose the extent of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. Provider also agrees to provide, on request, access to records required to be maintained under 42 C.F.R. §431.107 and copies of those records free of charge to MEDICAID, its agent, the Alabama Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. All such records shall be maintained for a period of at least three years plus the current year. However, if audit, litigation, or other action by or on behalf of the State of Alabama or the Federal Government has begun but is not completed at the end of the above time period, or if audit findings, litigation, or other action has not been resolved at the end of the above time period, said records shall be retained until resolution and finality thereof.
- 1.2.4 The Alabama Attorney General's Medicaid Fraud Control Unit, Alabama Medicaid Investigators, and internal and external auditors for the state/federal government and/or MEDICAID may conduct interviews of Provider employees, subcontractors and its employees, witnesses, and recipients without the Provider's representative or Provider's legal counsel present unless the

person voluntarily requests that the representative be present. Provider's employees, subcontractors and its employees, witnesses, and recipients must not be coerced by Provider or Provider's representative to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied with, in the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control cooperate fully in any investigation conducted by the Alabama Attorney General's Medicaid Fraud Control Unit and/or MEDICAID. Subcontractors are those persons or entities who provide medical goods or services for which the Provider bills the Medicaid program or who provide billing, administrative, or management services in connection with Medicaid-covered services.

- 1.2.5 Provider must not exclude or deny aid, care, service or other benefits available under MEDICAID or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid recipients in the same manner, by the same methods, and at the same level and quality as provided to the general public.
- 1.2.6 Provider agrees to comply with all state and federal laws relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records.
- 1.2.7 Under no circumstances shall any commitments by MEDICAID constitute a debt of the State of Alabama as prohibited by Article XI, Section 213, Constitution of Alabama of 1901, as amended by Amendment 26. It is further agreed that if any provision of this Agreement shall contravene any statute or Constitutional provision or amendment, whether now in effect or which may, during the course of the Agreement, be enacted, then that conflicting provision in the Agreement shall be deemed null and void. The Provider's sole remedy for the settlement of any and all disputes arising under the terms of this Agreement shall be limited to the filing of a claim against Medicaid with the Board of Adjustment for the State of Alabama.
- 1.2.8 In the event litigation is had concerning any part of this Agreement, whether initiated by Provider or MEDICAID, it is agreed that such litigation shall be had and conducted in either the Circuit Court of Montgomery County, Alabama, or the United States District Court for the Middle District of Alabama, Northern Division, according to the jurisdiction of those respective courts. This provision is not intended to, nor shall it operate to, enlarge the jurisdiction of either of said courts, but is merely an agreement and stipulation as to venue.

1.3 Claims and Encounter Data

- 1.3.1 Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by MEDICAID, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true, accurate, complete, and that such information can be verified by source documents from which data entry is made by the Provider. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and/or federal laws.
- 1.3.2 Provider must submit encounter data required by MEDICAID or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement.
- 1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with MEDICAID rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the *Alabama Medicaid Provider Manual*, and within the time limits established by MEDICAID for submission of claims. Claims for payment or encounter data submitted by the provider to a managed care entity or MEDICAID are governed by the Provider's contract with the managed care entity. Provider understands and agrees that MEDICAID is not liable or responsible for payment for any Medicaid-covered services provided under the managed care Provider contract, or any agreement other than this Medicaid Provider Agreement.
- 1.3.4 Federal and state law prohibits Provider from charging a recipient or any financially responsible relative or representative of the recipient for Medicaid-covered services, except where a

- copayment is authorized under the Medicaid State Plan. (42 C.F.R. §447.20). The provider (or its staff) must advise each recipient when MEDICAID payment will not be accepted prior to services being rendered, and the recipient must be notified of responsibility for the bill. The fact that Medicaid payment will not be accepted must be recorded in the recipient's medical record.
- 1.3.5 As a condition for eligibility for Medicaid benefits, a recipient assigns all rights to recover from any third party or any other source of payment to MEDICAID (42 C.F.R. §433.145 and §22-6-6.1, Code of Alabama 1975). Except as provided by MEDICAID's third-party recovery rules (*Alabama Medicaid Administrative Code*, Chapter 20), Provider agrees to accept the amounts paid under MEDICAID as payment in full for all covered services. (42 C.F.R. §447.15).
 - 1.3.6 Provider must refund to MEDICAID any overpayments, duplicate payments, and erroneous payments which are paid to Provider by MEDICAID as soon as the payment error is discovered.
 - 1.3.7 Provider has an affirmative duty to verify that claims and encounters are received by MEDICAID or its agent and implement an effective method to track submitted claims against payments made by MEDICAID.
 - 1.3.8 MEDICAID'S obligation to make payments hereunder is subject to the availability of State and Federal funds appropriated for MEDICAID purposes. Further, MEDICAID'S obligation to make payments hereunder is and shall be governed by all applicable State and Federal laws and regulations. In no event shall the MEDICAID payment exceed the amount charged to the general public for the same service.
 - 1.3.9 Provider shall not charge MEDICAID for services rendered on a no-cost basis to the general public.
 - 1.3.10 Provider is prohibited from offering incentives (such as discounts, rebates, refunds, or other similar unearned gratuity or gratuities) other than an improvement(s) in the quality of service(s), for the purpose of soliciting the patronage of MEDICAID recipients. Should the Provider give a discount or rebate to the general public, a like amount shall be adjusted to the credit of MEDICAID on the MEDICAID claim form, or such other method as MEDICAID may prescribe. Failure to make a voluntary adjustment by the Provider shall authorize MEDICAID to recover same by then existing administrative recoupment procedures or legal proceedings.
 - 1.3.11 Provider agrees and hereby acknowledges that payments made under this agreement are subject to review, audit adjustment and recoupment action. In the event that Provider acquires or has acquired ownership of another MEDICAID provider through transfer, sale, assignment, merger, replacement or any other method, whether or not a new Agreement is required, Provider shall be responsible for any unrecovered improper MEDICAID payments made to the previous provider. An indemnification agreement between Provider and the previous provider shall not affect MEDICAID'S right to recovery.
 - 1.3.12 Provider agrees to comply with the provisions of the *Alabama Medicaid Provider Manual* regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to MEDICAID or its agent are received and accepted. Provider is responsible for tracking claims transmissions against claims payments and detection and correcting all claims errors. If Provider contracts with third parties to provide claims and/or eligibility verification data from MEDICAID, the Provider remains responsible for verifying and validating all transactions and claims, and ensuring that the third party adheres to all client data confidentiality requirements.

II. RECIPIENT RIGHTS

- 2.1. Provider must maintain the recipient's state and federal right of privacy and confidentiality to the medical and personal information contained in Provider's records.
- 2.2. The recipient must have the right to choose providers unless that right has been restricted by MEDICAID or by waiver of this requirement from CMS. The recipient's acceptance of any service must be voluntary.
 - 2.2.1 The recipient must have the right to choose any qualified provider of family planning services.

III. ADVANCE DIRECTIVES - HOSPITAL, HOME HEALTH, HOSPICE, AND NURSING HOME PROVIDERS

- 3.1 The provider shall comply with the requirements of §1902(w) of the Social Security Act (42 USC §1396a(w)) as described below:
- 3.1.1 Maintain written policies and procedures in respect to all adult individuals receiving medical care by or through the provider about patient rights under applicable state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
- 3.1.2 Provide written information to all adult individuals on patient policies concerning implementation of such rights;
- 3.1.3 Document in the patient's medical record whether or not the individual has executed an advance directive;
- 3.1.4 Not condition the provision of care or otherwise discriminate against a patient based on whether or not he/she has executed an advance directive;
- 3.1.5 Ensure compliance with requirements of state law (whether statutory or recognized by the courts) concerning advance directives;
- 3.1.6 Provide (individually or with others) for education for staff and the community on issues concerning advance directives; and
- 3.1.7 Furnish the written information described above to adult individuals as required by law.

IV. TERM, AMENDMENT, AND TERMINATION

This Agreement will be effective from the date all enrollment documentation has been received and verified until the date the Agreement is terminated by either party. This Agreement may be amended as required, provided such amendment is in writing and signed by both parties concerned. Either party may terminate this Agreement by providing the other party with fifteen (15) days written notice. MEDICAID may immediately terminate the Agreement for cause if the Provider is excluded from the Medicare or Medicaid programs for any reason, loses its licenses or certificates, becomes ineligible for participation in the Medicaid program, fails to comply with the provisions of this Agreement, or if the Provider is or may be placing the health and safety of recipients at risk. MEDICAID may terminate this Agreement without notice if the Provider has not provided services to Medicaid recipients in excess of five (5) claims or \$100.00 during the last fiscal year.

V. CIVIL RIGHTS COMPLIANCE

Assurance is hereby given that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990, and the Regulations issued thereunder by the Department of Health and Human Services (45 CFR Parts 80, 84, and 90) no individual shall, on the ground of race, sex, color, creed, national origin, age, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or services by this institution.

VI. SIGNATURE AUTHENTICATION STATEMENT

To the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to HP and the Alabama Medicaid Agency for the purpose of enrolling with Alabama Medicaid.

I hereby authorize, consent to, and request the release to the Alabama Medicaid Agency of any and all records concerning me, including, but not limited to, employment records, government records, and professional licensing records, and any other information requested by the Alabama Medicaid Agency for purposes of acting on my application to be an enrolled provider under the Alabama Medicaid program. Signature of applicant (or an authorized representative if you are enrolling as a provider group/supplier)

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who in any matter within jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent

statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. § 3571 Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against an individual who "knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under a Federal health care program. **The offender is subject to fines of up to \$25,000 and/or imprisonment for up to five years.**

3. The Civil False Claims Act, 31 U.S.C. § 3729 imposes civil liability, in part, on any person who:
a) knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;
b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
c) conspire to defraud the Government by getting a false or fraudulent claim allowed or paid.

4. Section 1128B(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency.

A claim that the Secretary determines is for a medical or other item or service that the person knows or should know:

- a) was not provided as claimed; and/or
- b) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to \$10,000 per each item or service, an assessment of up to 3 times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The Government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment." **Remedies include compensatory and punitive damages, restitution and recovery of the amount of the unjust profit.**

Provider Signature _____
(Must be an original signature)

Date _____

Name of Provider: _____

NPI: _____ ATN: _____