Alabama Medicaid Provider Enrollment

Individual Patient 1st Enrollment Agreement

CONTENTS

Forms should be mailed to HP Provider Enrollment Department at:
301 Technacenter Drive, Montgomery, AL 36117
OR
P. O. Box 241685, Montgomery, AL 36124

MEDICAID / PATIENT 1ST
INDIVIDUAL PHYSICIAN ENROLLMENT AGREEMENT

SECTION I – General Information

This application is to be completed for participation in the Patient 1st Program.

☐ **I have signed/intend to sign a contract to participate in the Health Home Program with the following**

Organization(s)_____ _____ _____

_____ _____ _____

Has this practice or anyone associated with this practice been terminated or sanctioned by either Medicare or Medicaid? ☐ Yes ☐ No – If answering Yes, please send documentation containing details.

Are you associated with an academic teaching facility? ☐ Yes ☐ No

Specialty: Family Practice General Practice Pediatrician OB/GYN Internal Medicine
(circle only 1 specialty)

Name:_____ Individual NPI:_____

Group/Clinic Name:_____ Organizational NPI:_____

Contact for Patient 1st referrals:_____

Contact person's phone number:_____

Physical Address (primary location):_____

_____

Mailing Address:_____

_____

Credentialing Contact Name_____

Credentialing contact phone number: _____ Email address: _____

NOTE: *The mailing address indicated above will be applied to the file of the provider for which this application is completed. Only Patient 1st Correspondence will be mailed to the address given.*

SECTION II – Participation Details
PMPs have the ability to decide the parameters under which they wish to participate in the Patient 1st Program. Changes to such parameters must be communicated in writing and can be faxed to HP Provider Enrollment Department at 334-215-4298.

Distance- Miles Patient travel to office (**Max Distance is 75 Miles**)	Number of Patients Requested	Patient Age Criteria (i.e. 5-8)	Do you wish to be published on Patient 1st List?
			Y N

NOTE: *Total caseload cannot exceed 1200 for a 32-40 hour work week. Up to two 40 hour per week physician extenders (mid-level associates) can be utilized for a max caseload of 2000. For caseloads greater than 2000, justification must be submitted with application. (Refer to Chapter 39 of the provider manual for allowed caseload maximums.)*

Section II (continued)

****List the Physician's Medicaid numbers for satellite locations that are associated with this enrollment.**
(The satellite location must be linked to the exact same tax id number.)

_____ _____ _____

A change in the tax id number will require an additional Medicaid application. If you have questions, please call HP Provider Enrollment Department at 1-888-223-3630.

*****NOTE: This request does not apply to FQHC or Rural Health Clinic (RHC) physicians. A separate Individual Patient 1st Enrollment Agreement is required for each clinic location up to a maximum of 3 locations.*****

Admitting Privileges:
Will you be admitting your own patients? ☐ Yes If yes, please indicate hospital name(s) below. ☐ No **If no, please complete attachment C of the contract.**

_____

EPSDT:
Are you currently enrolled in the EPSDT program? ☐ Yes ☐ No
If you are not currently enrolled, will you be doing your own EPSDT screenings? ☐ Yes ☐ No
If Yes, please be certain an EPSDT agreement is completed and submit it with a copy of your current CLIA certificate.
If No, you must designate an EPSDT enrolled provider to do your screening for you by completing **Attachment D of the contract**.

24/7 Coverage: Complete Attachment A
List your phone number for patient 24-hour access: _____
Describe your after-hours coverage below: **(Voice machines that do not allow a patient to speak with a live person are not allowed):**

_____

FTE Status:
How many hours per week do you practice at this location?_____

SECTION III – Mid Level Extenders

Indicate Physician Extender (Mid-Level Associate) Name(s) and NPI Number(s) below: **The physician must be the mid-levels supervising physician and no more than 2 mid-levels are allowed per physician.** ***The Physician Extender(s) must be linked to the exact same group and location/s as the physician.***

Mid-Level Practitioner Name	NPI Number	Hours per week	List MCD numbers for satellite locations.

I am applying to participate as a primary care provider in the Patient 1st Program sponsored by the Alabama Medicaid Agency. I have read and understand the Patient 1st Provider Manual, the Agreement for Participation and have completed all the necessary forms, including the case management fee components.

Physician Signature: _____ Date: _____

ALABAMA MEDICAID AGENCY

Agreement for Participation as a Primary Medical Provider in the Patient 1st Program

This provider agreement is between the Alabama Medicaid Agency, hereinafter referred to as the Agency and

_____ located in the city of _____,
(Name of Primary Medical Provider)

county of _____, state of _____, hereinafter referred to as the "Primary Medical Provider (PMP)."

WHEREAS, the Agency, as the single State agency designated to establish and administer a program to provide medical assistance to the indigent under Title XIX of the Social Security Act, is authorized to contract with health care providers for the provision of such assistance on a coordinated care basis;

NOW, THEREFORE, it is agreed between the AGENCY and the PMP, as follows:

I. General Statement of Purpose and Intent

The Agency desires to contract with providers willing to participate in the Patient 1st Program to provide primary care directly and to coordinate other health care needs through the appropriate referral and authorization of Medicaid services. The Patient First Program, applies to certain Medicaid recipients who may select or be assigned to the PMP. This agreement describes the terms and conditions under which this agreement is made and the responsibilities of the parties thereto.

Except as herein specifically provided otherwise, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this agreement, and all rights of action relating to such enforcement, shall be strictly reserved to the Agency and the named PMP. Nothing contained in this agreement shall give or allow any claim or right of action whatsoever by any other third person.

II. General Statement of the Law

Patient 1st is a primary care case management system implemented pursuant to an approved Alabama State Plan, and is subject to the provisions of The Alabama Medicaid Administrative Code and Alabama Medicaid Provider Manual. This agreement shall be construed as supplementary to the usual terms and conditions of providers participating in the Medicaid program, except to the extent superseded by the specific terms of this agreement. The PMP agrees to abide by all existing laws, regulations, rules, policies, and procedures pursuant to the Patient 1st and the Alabama Medicaid program.

III. Definitions-The following terms have the meaning stated for the purposes of this agreement:

Application – All forms and supplements to this agreement that the provider uses to apply for participation with the Patient 1st program. This agreement shall be effective subject to approval of the application by the Agency and/or its representative.

C.F.R. – Code of Federal Regulations.

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

Case Management Fee – The amount paid to the PMP per member per month for each Patient 1st recipient who has chosen or has been assigned to the PMP. Refer to section VI for details.

EHR-An electronic record of an individual's health-related information that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care Provider.

Eligible Team of Health Care Professionals-Responsible for ensuring that care is person-centered, culturally competent and linguistically capable.

Enrollee – A Medicaid recipient who chooses or is assigned to a Patient 1st PMP.

Entity- An organization certified by Alabama Medicaid as a Probationary Regional Care Organization.

Group /Clinic A Group/Clinic which (1) is a legal entity (e.g., corporation, partnership, etc.), (2) possesses a federal tax identification (employer) number, and (3) is designated as payee to the enrolling physician/PMP.

Health Home- A care model that includes a team-based approach to providing comprehensive, person-centered care and integrating the physical and mental health needs of recipients. Recipients eligible for participation in a health home include three groups; those with two chronic conditions, those with one chronic condition and risk of a second, and those with one "serious and persistent" mental health condition.

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Health Home Recipient- A person who has been assigned one or more Medicaid identification numbers, has been certified by the Agency as eligible for medical assistance under the State Plan, and meets the criteria for receiving Health Home services.

Medicaid – The Alabama Medicaid Agency, also known as the Agency.

Patient 1st Policy – All policies and procedures required by this agreement and incorporated herein by reference are published in the Alabama Medicaid Provider Manual, Chapter 39 which is published on the Agency's website at http://www.medicaid.alabama.gov.

Physician Extender – A Physician Assistant, Nurse Practitioner with the appropriate collaboration.

Potential Enrollee – 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 PMP.

Preventive Services – Services rendered for the prevention of disease in children as defined by Patient 1st policy, also known as EPSDT.

Primary Care – The ongoing responsibility for directly providing medical care (including diagnosis and/or treatment) to an enrollee regardless of the presence or absence of disease. It includes health promotion, identification of individuals at risk, early detection of serious disease, management of acute emergencies, rendering continuous care to chronically ill patients, and referring the enrollee to another provider when necessary.

Primary Medical Provider (PMP) – The participating physician or group practice/clinic selected by or assigned to the enrollee to provide and coordinate all of the enrollee's health care needs and to initiate and monitor referrals for specialized services when required.

Recipient Disenrollment – The deletion of the individual from the monthly list of enrollees furnished by the Agency to the PMP electronically.

IV. Functions and Duties of the Primary Medical Provider (PMP)

In the provision of services under this agreement, the **PMP** shall comply with all applicable federal and state statute and regulations, and all amendments thereto, that are in effect when the agreement is signed, or that come into effect during the term of the agreement. This includes, but is not limited to, the Alabama State Plan and Title 42 of the CFR.

The PMP is, and shall be deemed an independent PMP in the performance of this Agreement and as such shall be wholly responsible for the work to be performed and for the supervision of its employees. The PMP representative has, or shall secure at its own expense, all personnel required in performing the services under this Agreement. Such employees shall not be employees of, or have any individual contractual relationship within the Agency.

The PMP shall not subcontract any of the work under this Agreement without prior written approval from the Agency. Any approved subcontract shall be subject to all conditions of this agreement and applicable requirements of CFR 434.6. The PMP shall be responsible for the performance of any employee or subcontractor.

The PMP must have contracts with Alabama Medicaid Agency and the Health Home. The PMP must sign agreements that address core competencies. The PMP must cooperate with the Health Home to integrate, coordinate and address services for individuals with certain chronic conditions to achieve and improve health outcomes.

The Patient 1st PMP agrees to do the following:

4.1 Accept enrollees pursuant to the terms of this agreement and as a PMP in the Patient 1st Program for the purpose of providing care to enrollees and managing their health care needs.

4.2 Provide primary care and patient coordination services to each enrollee in accordance with the provisions of this agreement and the policies set forth in the Alabama State Plan, Alabama Medicaid Administrative Code, Medicaid Provider Manuals and Medicaid bulletins and as defined by Patient 1st Policy.

4.3 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, and seven (7) days per week as defined by Patient 1st Policy. See Attachment A.

4.4 Provide EPSDT services as defined by general Medicaid and Patient 1st Policy. Refer to Chapter 39.9.4.

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

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

4.7 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.

4.8 Transfer the Patient 1st enrollee's medical record to the receiving provider upon the change of PMP at the request of the new PMP and as authorized by the enrollee within thirty (30) days of the date of the request. Enrollees cannot be charged for copies of medical records.

4.9 Authorize care for the enrollee or see the enrollee based on the standards of appointment availability as defined by Patient 1st policy.

4.10 Refer for a second opinion as defined by Patient 1st policy.

4.11 Review and use all enrollee utilization, quality improvement, and cost reports provided by the Patient 1st Program for the purpose of practice level utilization management, quality of care improvement and advice the Agency of errors, omissions, or discrepancies. Review and use the monthly enrollment report as required by Patient 1st policy.

4.12 Participate with Agency utilization management, quality assessment, complaint and grievance, and administrative programs.

4.13 Provide the Agency, its duly authorized representatives and appropriate Federal Agency representatives' unlimited access (including onsite 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.

4.14 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 Council.

4.15 Notify the Agency of all changes to information provided on the initial application for participation. If such changes are not reported within 30 days of change, future participation may be limited.

4.16 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.

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

4.18 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.

4.19 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.

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

4.21 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 Centers for Medicare and Medicaid Services, the Federal or State government or similar entity.

4.22 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.

4.23 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 is significant and material to the PMP's contractual obligation with the Agency.

4.24 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.)

4.25 Provide the Agency within thirty day notice of PMP disenrollment, change in practice site, or tax identification changes. This will allow for an orderly reassignment of enrollees. Failure to provide thirty (30) day notice may preclude future participation and/or result in recoupment of case management fees.

4.26 Patient Outreach: At a minimum, if any patient on your panel has not been seen in over one year, outreach should be initiated to the patient regarding the need for regular exams, and the importance of a health home. This communication should be made via phone/letter or other means and documented in the chart. Audits of this outreach will be conducted on a sampling method and as indicated by agency initiatives.

4. 27 Members of the "Health Home Team of Health Care Professionals":

- Must ensure that care is person-centered, culturally appropriate, and person and family centered health home services;
- Provide quality-driven, cost effective, culturally appropriate, and person-and-family centered health home services;
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
- Coordinate and provide access to preventive and health promotion services, including prevention of certain chronic conditions;
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings.
- Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning;
- Facilitating transfer from a pediatric to an adult system of health care;
- Coordinate and provide access to chronic disease management, including self -management support to individuals and their families;
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
- Management of care including recruitment, outreach, psychosocial assessment, service planning, assisting the recipient in arranging for appropriate services, including but not limited to, resolving transportation issues, education, counseling and follow-up and monitoring to ensure services are delivered and continuity of care is maintained**.**
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non- clinical health-care related needs and services;
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
- Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
- Establish a partnership/relationship with local Community Mental Health and Substance Abuse Centers.
- Provide patient education to the individual, family or care-giver, and members of the health care delivery team about treatment options, community resources, insurance benefits, psychosocial concerns, care management, etc., so that timely and informed decisions can be made.
- Provide educational materials specific to an individual's chronic conditions.
- Provide educational materials to a parent or guardian regarding the importance of immunizations and screenings, child physical and emotional development.
- Provide health-promoting lifestyle interventions, such as substance use disorders, nutritional counseling, obesity reduction and prevention and increasing physical activity.

- Supporting health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.
- Promoting evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, cancer, COPD, HIV, mental health conditions, transplants, Sickle Cell, Heart Disease, Hepatitis C, and other services based on the individual needs and preferences.

4. 28 The following Alabama standards, which may be met on-site or through coordination and/or offering of these services through partnerships with or in the surrounding community, are addressed through a contract between the State and Patient 1st PMP and Health Home and in the contract between the Patient 1st Health Home and their providers.

4.29 The PMPs and Health Home must sign agreements with the state and each other. The Agency standards may be amended as necessary and appropriate.

- Capacity to provide access to care that includes in-person, afterhours and telephone. The PMP must provide voice to voice access to medical advice and care for enrollees 24 hours a day 7 days a week.
- Ability to provide comprehensive whole person care that includes a comprehensive health care assessment (including mental health and substance use), coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders, medical and health care services informed by evidence-based clinical practice guidelines, mental health, substance abuse, and developmental services, and chronic disease management, including self-management support to individuals and their families, and interventions.
- Ability to provide continuity of personal clinician assignment and clinician care, organization of clinical information, clinical information exchange and specialized care settings.
- Capability to coordinate and integrate that includes capacity for population data management; to use health information technology (health-IT); to develop a comprehensive health plan for each individual that coordinates and integrates clinical and non-clinical health-care related needs and services; for test and result tracking; to coordinate and provide access to Health Homes and provide comprehensive care management (PMPs), care management Health Homes, and transitional care across settings Health Homes and PMPs), and to coordinate and provide access to long-term care supports and services and end of life planning.
- Capacity to provide culturally appropriate, and person- and family-centered health home services, coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services, and provide a positive experience of care.

V. Functions and Duties of the Agency

The Agency agrees to do the following:

5.1 List the PMP's name by specialty as a primary medical provider in the Patient 1st Program. Per the PMP's request on the Patient 1st application.

5.2 Pay the PMP on a fee-for-service basis in accordance with the Medicaid fee schedule and billing guidelines. Any monthly management/coordination fee paid in addition to the fee-for service Medicaid payments will be paid per member per month, subject to the maximum number of enrollees under paragraph 7.1.A. The amount of the management/coordination fee, if any, may be adjusted according to practice and performance parameters as defined by the Agency. Changes will be made on a quarterly basis.

5.3 Provide the PMP with an electronic monthly list of enrollees assigned to him for managing their health care needs.

5.4 Provide training and technical assistance regarding the Patient 1st Program.

5.5 Provide the PMP with periodic utilization, quality, and cost reports.

5.6 Gather and analyze data relating to service utilization by enrollees to determine whether PMPs are within acceptable Patient 1st comparison parameters.

5.7 Publish the Alabama Medicaid Provider Manual, specifically Chapter 39 and the Medicaid General and Special Bulletins on the Agency's website at http://www.medicaid.alabama.gov. All such policies, procedures, Medicaid provider bulletins and manuals are incorporated into this agreement by reference.

5.8 Provide an ongoing quality assurance program to evaluate the quality of health care services rendered to enrollees.

5.9 Provide program education to all enrollees during eligibility reviews or within a reasonable timeframe.

5.10 Provide potential enrollees and enrollees with information that contains program information including enrollee rights and protections, program advantages, enrollee responsibilities, complaint and grievance instructions as specified in 42 CFR 438.10 The information will also be published on the Agency's website at http://www.medicaid.alabama.gov.

5.11 Notify enrollees that oral interpretation is available for any language and written material is available in prevalent languages and how to access these services.

5.12 Provide written materials that use easily understood language and format. Written material will 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.

5.13 Inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.

VI. Case Management Fee

The PMP is paid a case management fee per month and an enhanced fee for each Health Home enrolled recipients; as of the first day of each month. However; Federally Qualified Health Centers, Independent Rural Health Clinics and Provider Based Rural Health Clinics are not paid an enhanced fee for each Health Home enrolled recipients.

The case management fee and the enhanced fee for Health Home enrolled recipients will be paid on the 1st check-write of each month. The monthly case management fee will be determined by the components of care delineated in Attachment B of the contract. All required components must be provided before being considered for enrollment in the Patient 1st Program. Verification of the PMP's ability/willingness to provide the services will be accomplished through the regular Medicaid enrollment process, the complaints and grievances process and individual Agency verification. A monthly enrollment summary report will indicate the individual amount of case management fee being paid for that month.

The PMP must outreach, plan and communicate with other primary and specialty care providers regarding the high-risk enrollees' care identified through the referral process.

The PMP must develop a comprehensive health plan informed by the patient, which integrates care across various systems (i.e. Mental Health, Substance Abuse, Health Home, and PMP).

The PMP must clarify and communicate the patient's preference to all involved providers while assuring timely delivery of services.

Case management fees are not subject to third party liability requirements as specified in 42 CFR 434.6(a)(9).

VII. General Terms and Conditions

7.1 Recipient Enrollment and Disenrollment

A. Recipient Enrollment

1. The PMP must accept individuals in the order in which they apply without restriction up to the limits set by the agreement. The PMP may specify a limit on the number of enrollees on the Patient 1st Application for Participation subject to the following terms and conditions:

- Maximum enrollment is set at 1200 enrollees per physician unless otherwise approved by the Agency. An additional 400 enrollees per physician extender (up to 2) will be allowed.
- The PMP may set enrollment criteria on the Application, but must accept recipients who meet the enrollment criteria up to the limit specified.
- The PMP may change the enrollee limit by notifying the Agency in writing and/or its representative.
- The PMP must restrict enrollment to recipients who reside sufficiently near the delivery site to reach that site within a reasonable time using available and affordable modes of transportation.

B. Recipient Choice

1. Eligible recipients may choose from among participating PMPs' who are available within the Health Home distance from their residence when those PMPs' enrollment limits have not been exceeded.

2. All recipient enrollments, disenrollments, and changes are effective on the first day of the month, pursuant to processing deadlines and will be indicated on the Enrollment Reports.

C. Recipient Disenrollment

1. Enrollees shall be permitted to change primary care providers according to Patient 1st policy. Transfer of medical records is addressed in Section 4.8 of this agreement.

2. The PMP may request the disenrollment of an enrollee for good cause as defined by Patient 1st policy.

3. The PMP 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 with the PMP seriously impairs the PMP's ability to furnish services to either this particular enrollee or other enrollees).

4. The *Patient 1st Medicaid Managed Care Recipient Handbo*ok includes complaint and grievance instructions and are provided to potential enrollees and enrollees. This handbook is also published on the Agency's website at http://www.medicaid.alabama.gov.

7.2 Agreement Violation Provisions

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.

Federal Financial Participation (FFP) is not available for amounts expended for PMPs excluded by Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP), except for emergency services.

7.3 Application Process

The PMP will complete an Application to submit with the signed agreement for review and approval by the Agency and/or its representative.

7.4 Exceptions to the Agreement

The Agency may approve exceptions to this agreement if, in the opinion of the Agency, the benefits of the PMP's participation outweigh the PMP's inability to comply with a portion of this agreement.

In order to amend this agreement, the PMP shall submit a written request to the Agency for consideration for exception from a specific agreement requirement. The request shall include the reasons for the PMP's inability to comply with this agreement requirement. The request shall be submitted at the time this agreement is submitted to the Agency for consideration. Approval of the Application constitutes acceptance of the request for an exception.

7.5 Transfer of Agreement

This agreement may not be transferred.

7.6 Changes in Program

The PMP understands that the Agency may make modifications to the program throughout the course of the Agreement. Changes will be communicated to the PMP within 10 days of the change with the Alabama State Plan and the Provider Manual updated accordingly.

7.7 Agreement Termination

This agreement may be terminated by either party, with cause, or by mutual consent, upon at least 30 days written notice and will be effective only on the first day of the month, pursuant to processing deadlines. If the PMP does not allow for 30 days' notice, then future participation may be limited and/or result in recoupment of case management fees.

The Agency under the following conditions may terminate this agreement immediately:

1. In the event that state or federal funds that have been allocated to the Agency are eliminated or reduced to such an extent that, in the sole determination of the Agency, continuation of the obligations at the levels stated herein may not be maintained. The obligations of each party shall be terminated to the extent specified in the notice of termination immediately upon receipt of notice of termination from the Agency;

2. If the approved Alabama State Plan is discontinued either by the state or CMS;

3. If the PMP (a) is determined to be in violation of terms of this agreement, or applicable federal and state laws, regulations, and policy, and/or (b) fails to maintain program certification or licensure;

4. Upon the death of the PMP, the sale of the PMP's practice, or termination of participation as a Medicaid or Medicare provider; or

5. In the event of conduct by the PMP justifying termination, including but not limited to breach of confidentiality or any other covenant in this agreement, and/or failure to perform designated services for any reason.

6. Upon termination, the PMP must supply all information necessary for reimbursement of outstanding Medicaid claims.

VIII. Effective Date and Duration

This agreement shall be effective April 1, 2015 or the first day of the month in which this agreement is fully executed pursuant to the terms of this agreement and remain in effect until amended or terminated.

_____ _____

Alabama Medicaid Agency Representative **Signature of Physician PMP**

_____

Printed Name of Physician PMP

PMP Provider NPI_____

Medicaid ID #_____

Attachment A

ALABAMA MEDICAID AGENCY

PRIMARY MEDICAL PROVIDER 24/7 VOICE-TO-VOICE COVERAGE AGREEMENT

Primary Medical Providers (PMP) must provide enrollees with after-hours coverage. It is essential patients and/or other providers are able to contact the PMP to receive instructions for care or referrals at all times in order for care to be provided in the most appropriate manner to the patient's condition. To qualify as a PMP and ensure continued participation/enrollment in the program, the PMP must meet one of the following requirements:

- The after hour telephone number must connect the patient to the PMP or an authorized medical practitioner.

- The after hour telephone number must connect the patient to a live voice call center system or answering service who will contact the PMP or PMP authorized medical practitioner. If the PMP is contacted, then the patient should receive instructions within 1 hour.

An office telephone line that is not answered after hours or answered after hours by a recorded message instructing enrollees to call back during office hours or to go to the emergency department for care is **not acceptable.**

It is not acceptable for a recipient to call the office and a recorded message instructs the recipient to leave a message and a call will be returned.

It is not acceptable to refer enrollees to the PMP's home telephone. Exceptions to this requirement must be approved by the Alabama Medicaid Agency.

The 24/7 voice-to-voice requirement will be monitored regularly. If during the monitoring process a provider is not meeting the requirement as stated above, the following will occur:

- The provider will be contacted in writing and asked to submit a corrective action plan (CAP) within 10 business days of receipt of the letter describing what steps will be taken to comply with the requirement. The PMP'S panel will be placed on hold and no new recipients assigned until after the follow-up monitoring call to check compliance with the requirement.

  Upon receipt and approval of the CAP, a letter will be generated by the Alabama Medicaid Agency informing the PMP CAP has been approved and that the Panel assignment hold will be released.

  The PMP will receive a follow-up monitoring call within thirty (30) calendar days to determine implementation of the CAP and continuing compliance. If after the follow-up monitoring call the PMP is not maintaining compliance with the requirement, a letter will be generated by the Alabama Medicaid Agency informing the PMP that the Panel assignment will be placed on suspension and case management payment fees will cease until further notice. Notification of the suspension status will be forwarded to the Alabama Medicaid Agency's Chief Medical Officer.

- If the PMP fails to submit a CAP within the allotted time, the PMP's panel assignment will be placed on suspension and case management payment fees will cease until further notice. The provider will be notified in writing of the non-compliance status with Patient 1st standards and 24/7 case management fee suspension. The PMP will be asked to submit a CAP within 5 business of receipt of the letter.

- If the CAP is received in the allotted time and approved, a letter will be generated by the Alabama Medicaid Agency informing the PMP that the panel assignment suspension will be released for new assignments.

- The PMP will receive a follow-up monitoring call within 30 calendar days to determine implementation of the CAP and continuing compliance. If after the follow-up monitoring call the PMP is not maintaining compliance with the requirement, a letter will be generated by the Alabama Medicaid Agency, informing the PMP that the panel assignment will be placed on suspension and case management payment fees will cease until further notice. Notification of the suspension status will be forwarded to the Alabama Medicaid Agency's Chief Medical Officer.

- If the provider fails to submit a CAP, after the second request or within the allotted time, the provider will be notified by certified mail of failure to comply with Patient 1st guidelines related to 24/7 requirements and as a result has become disenrolled in the Patient 1st program as a Primary Medical Provider.

_____ _____

Printed Physician Name NPI Number

_____

Signature of PMP

PMP's 24/7 Call Number: (_____) _____

Brief Description of your Arrangements for 24/7 Coverage

1. **What is your 24/7 telephone coverage?**

2. **If you have an answering service; what is the name and phone number of the service?**

3. **Explain your telephone coverage for after hours? (i.e. Sunday to Saturday all day and M-F 5pm – 7am following morning -all calls go to answering service)**

4. **How does your service respond to non-emergency calls?**

5. **List the physician/s that will be responding to calls for this site:**

Attachment B

Components of Monthly Case Management Fee

Components	Case Management Fee Description
Participation in the Patient 1st program	$0.50 Per Member Per Month (PMPM) will be paid to all Patient 1st providers other than Federal Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)
Participation with a Health Home for Recipients with an identified chronic disease is OPTIONAL. *The PMP must sign a contract with the Health Home to received payment.*	$8.00 PMPM will be paid for each Health Home Recipient; other than Federal Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). All Health Home Recipients receive comprehensive care management through the PMP. PMPs will review individual monthly reports on recipient. The Health Home will work to educate PMPs in evidenced-based care management practices and provide data on recipients.
PMP in a RHC or FQHC	There is no case management fee.

To clarify:

(A) The $0.50 is for all Patient 1st providers other than FQHC and RHC physicians.

(B) The $8.00 is for Patient 1st providers other than FQHC's and RHC's physicians who participate with the Health Home Recipients.

Notation: PMPs must provide voice-to-voice access to medical advice and care for enrolled recipients 24 hours a day 7 days a week. The PMP's 24/7 contact information will be obtained from Attachment A of the submitted documents.

ALABAMA MEDICAID AGENCY

Attachment C

PATIENT 1st HOSPITAL ADMITTING AGREEMENT

Patient 1st Primary Medical Providers (PMPs) are required to establish and maintain hospital admitting privileges or have a formal arrangement with a hospitalist group or another physician or group for the management of inpatient hospital admissions that addresses the needs of all enrollees or potential enrollees. If a PMP does not admit patients, then the *Patient 1st Hospital Admitting Agreement* form must be submitted to the Agency to address this requirement for participation. **If the Patient 1st provider has entered into a formal arrangement for inpatient services, this form must be completed by both parties, and the applicant must submit the original form with the application for enrollment or within 10 days of when a change occurs regarding the provider's management of inpatient hospital admissions.**

A formal arrangement is defined as a voluntary agreement between the Patient 1st PMP and the agreeable physician/group. The agreeable party is committing in writing to admit and coordinate medical care for the Patient 1st enrollee throughout the inpatient stay. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a distance of thirty (30) miles or forty-five (45) minutes' drive time from the Patient 1st PMP's practice. If there is no hospital that meets the above geographical criteria, the hospital geographically closest to the Patient 1st PMP's practice will be accepted.

Exception may be granted in cases where it is determined the benefits of a provider's participation outweigh the provider's inability to comply with this requirement.

To ensure a complete understanding, the Patient 1st Program has adopted the Patient 1st Hospital Admitting Agreement. This agreement serves as a formal written agreement established between the two parties as follows:

- The Patient 1st Primary Medical Provider is privileged to refer Patient 1st patients for hospital admission. The below named provider is agreeing to treat and administer to the medical needs of these patients while they are hospitalized.
- The below named provider will arrange coverage for Patient 1st enrollee admissions during their vacations.
- Either party may terminate this agreement at any time by giving written 30 days advance notice to the other party or by mutual agreement.
- The Patient 1st Primary Medical Provider will notify the Patient 1st program in writing of any changes to or terminations of this agreement.
- The Patient 1st Primary Medical Provider will provide the below named provider with the appropriate payment authorization number.

Physician or Group Agreeing to Cover Hospital Admissions

Physician/Group Name: _____ NPI Number_____

Mailing Address: _____

_____

Specialty: _____ Ages Admitted: _____

Hospital Affiliation(s) and Location(s): _____

_____

Contact Person: _____ Telephone Number: _____

Authorized Signature: _____ Date: _____

Questions regarding hospital admitting privileges may be directed to the Patient 1st Program.

ALABAMA MEDICAID AGENCY

Attachment D

EPSDT AGREEMENT

For recipients of Medicaid, birth to age 21, the Early, Periodic Screening, Diagnosis and Treatment (EPSDT) examination is a comprehensive preventive service at an age appropriate recommended schedule. There are numerous components of the EPSDT, and are listed and described in Appendix A of the Alabama Medicaid Provider Manual.

If a PMP cannot or chooses not to perform the comprehensive EPSDT screenings, this agreement allows the PMP to contract with another Medicaid Screener (hereinafter known as Screener) serving the PMP's area to perform the screenings for enrollees in the birth to 21 year age group.

The agreement requires the PMP to:

1. Refer Patient 1st patients for EPSDT Screenings. If the patient is in the office, the physician/office staff will assist the patient in making a screening appointment with the Screener within 10 days.
2. Maintain, in the office, a copy of the physical examination and immunization records as a part of the patient's permanent record.
3. Monitor the information provided by the Screener to assure that children in the Patient 1st program are receiving immunizations as scheduled and counsel patients appropriately if found in noncompliance with well child visits or immunizations.
4. Review information provided by the Screener to coordinate any necessary treatment and/or follow up care with patients as determined by the screening.
5. Immediately, notify the Agency and Hewlett Packard Enterprises (HP) formerly EDS of any changes to this agreement.

The Screener agrees to:

1. Provide age appropriate EPSDT examinations and immunizations within 60 days of the request for patients who are referred by the PMP or are self-referred.
2. Send EPSDT physical examination and immunization records within 30 days to the PMP.
3. Notify the PMP of significant findings on the EPSDT examination or the need for immediate follow-up care within 24 hours. Allow the PMP to direct further referrals for specialized testing or treatment.
4. Immediately, notify the Agency and HP of any changes to this agreement.

If the PMP chooses to utilize this agreement in order to meet this Patient 1st requirement for participation, the agreement containing the original signatures of the PMP or the authorized representative and the screener or an authorized representative must be submitted within the enrollment application. The PMP must keep a copy of this agreement on file. If this agreement is executed after enrollment, a copy must be submitted to HP within 10 days of execution.

This agreement can be entered into or terminated at any time by the PMP or the screener. The Agency and HP EDS must be notified immediately of any change in the status of the agreement. Questions regarding this agreement can be addressed to HP.

By signing the PMP agreement and below, both the PMP and the Screener agree to the above provisions.

_____	_____
Signature of Screener/Designee	Date
_____	_____
Printed Name of Screener/Designee	Screener NPI Number
_____	_____
Signature of PMP	PMP NPI Number