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40 Alabama Coordinated Health Network (ACHN) Primary Care Physician (PCP) and ACHN Entities Billing

The Alabama Coordinated Health Network (ACHN) Manual has been developed by the Alabama Medicaid Agency to explain the policies and procedures of the ACHN program. Every effort has been made to present qualified providers a comprehensive guide to basic information concerning program requirements and billing procedures. The policies outlined in this manual are binding upon the provider. Providers should also refer to the Gainwell Provider Insiders, letters, transmittals or ALERTS regarding any updates or changes within this program.

If you have any questions about this program, please contact the Provider Assistance Center at 1 (800) 688-7989.

40.1 ACHN Overview

The ACHN Program will effectively link recipients, providers, and community resources in each of seven (7) newly defined regions to improve health outcomes for Medicaid recipients. Care Coordination within the ACHN is a single program that will allow the Agency and Providers a more effective platform for service delivery and improved quality.

The Networks are located in the Northwest, Northeast, Jefferson and Shelby, Central, East, Southeast, and Southwest regions. The ACHN Regional Map is available on the Medicaid's website at: www.Medicaid.Alabama.gov (Select the ***ACHN Providers*** tab)

See chart below for a listing of counties for each region:

Region	Counties
Central	Autauga, Butler, Chilton, Crenshaw, Dallas, Elmore, Lowndes, Marengo, Montgomery, Perry, and Wilcox counties
East	Blount, Calhoun, Cherokee, Clay, Cleburne, Coosa, DeKalb, Etowah, Randolph, Talladega, Tallapoosa, and St. Clair counties
Jefferson/Shelby	Jefferson, and Shelby counties
Northeast	Cullman, Jackson, Limestone, Madison, Marshall, and Morgan counties
Northwest	Bibb, Colbert, Fayette, Franklin, Greene, Hale, Lamar, Lauderdale, Lawrence, Marion, Pickens, Sumter, Tuscaloosa, Walker, and Winston counties
Southeast	Barbour, Bullock, Chambers, Coffee, Covington, Dale, Geneva, Henry, Houston, Lee, Macon, Pike, and Russell counties
Southwest	Baldwin, Choctaw, Clarke, Conecuh, Escambia, Mobile, Monroe, and Washington counties

Entities and their contact information:

Visit www.Medicaid.Alabama.gov and select the ***ACHN Providers*** tab, under Program Documents for the ACHN Contact Information for Providers.

40.2 ACHN Care Coordination Services

PCP Groups will partner with licensed social workers and nurses from the ACHN who will provide Care Coordination services. Care Coordination referrals may be requested by providers, recipients, or community sources.

The ACHN care coordinators can, among other things:

- Provide services in a setting of the recipient's choice, including provider offices, hospitals, ACHN entity office, public location, or in the recipient's home
- Help manage complex or non-compliant patients
- Perform a screening and assessment of the recipient's needs
- Assist recipients in obtaining transportation or applying for Medicaid
- Help recipients with appointments or appointment reminders
- Coordinate and facilitate referrals
- Educate or assist recipients with medication or treatment plans
- Help recipients seek care in the most appropriate setting (e.g., provider's office versus emergency room)
- Facilitate communication between the patient and care providers
- Help recipients locate needed community services

Recipients with abnormal lead levels, newborn metabolic screenings, and newborn hearing screenings will continue to receive Care Coordination from the Alabama Department of Public Health.

40.3 Agreements for Primary Care Physicians (PCPs)

40.3.1 *Enrollment*

Primary Care Physicians (PCPs) who want to receive Bonus Payments and ACHN Participation Rates in conjunction with the state's ACHN Program must sign **two** agreements beyond their Medicaid Enrollment. A PCP Group Enrollment Agreement with Medicaid and one agreement with an ACHN is required. The PCP must be enrolled with Medicaid as a Medicaid provider. The provider's enrollment with Medicaid and the ACHN must be fully processed as defined below to ensure bonus payments are made timely. The enrollment agreement must be on file by March 1st, June 1st, September 1st, or December 1st to ensure timely payment. Below are the guidelines for timely processing of agreements:

Medicaid PCP Group Agreement: Providers must complete and submit the agreement directly to Gainwell. The enrollment effective date for the ACHN PCP Group Agreement will the first day of the following month, if the agreement is received and contains no errors prior to the 15th of the month. For agreements received on or after the 15th of the month, the effective date of the enrollment will be the month following the next month.

- **Example 1:** If an agreement is received by Gainwell on December 14th and contains no errors will have an enrollment effective date of January 1st.

- **Example 2:** If an agreement is received by Gainwell on December 19th and contains no errors will have an enrollment effective date of February 1st.
- **Example 3:** If an agreement is received by Gainwell on December 5th but is returned for errors and the returned agreement is sent back to Gainwell, contains no errors, and received on December 16th, the enrollment effective date will be February 1st.

ACHN PCP Network Participation Agreement: In addition to the Medicaid PCP Group Agreement, providers must complete and submit an ACHN PCP Network Participation Agreement to an ACHN to qualify for participation rates and bonus payments. Providers must sign the agreement with the ACHN. On a monthly basis, the ACHNs will notify the Agency of all executed participation agreements. The PCPs and the ACHNs must ensure that the Medicaid Group Billing ID, NPI, Medicaid ID, and name listed on the ACHN PCP Network Participation Agreement is correct and consistent with what the Agency has on the provider's Medicaid file. The provider's file must also be in an active status with the Medicaid Agency. All information submitted must be based on the group level unless the provider is set up as an individual practice. If the information is not correct or consistent, the agreement will not be added to the provider's Medicaid file. In the absence of this agreement, PCPs will not be eligible for participation rates and will not receive bonus payments. If all information communicated to the Agency is correct, the enrollment effective date for the ACHN PCP Network Participation Agreement will be the first day of the following month. Contact the ACHN you intend to participate with to inquire about submission deadlines for the PCP Network Participation Agreement.

The following provider types are eligible to participate in the ACHN program:

- Family Practitioners
- General Practitioners
- Pediatricians
- Internists
- OB/GYN
- FQHCs and RHCs are eligible to participate with ACHN as a PCP

NOTE:

When in the best interest of a patient, a nontraditional PCP may choose to enroll as a PCP with Medicaid. Other physician types may be considered for PCP participation if willing to meet all contractual and participation requirements.

NOTE:

Out-of-state Providers who are interested in participating in the ACHN program, must be within 30 miles of the Alabama state border.

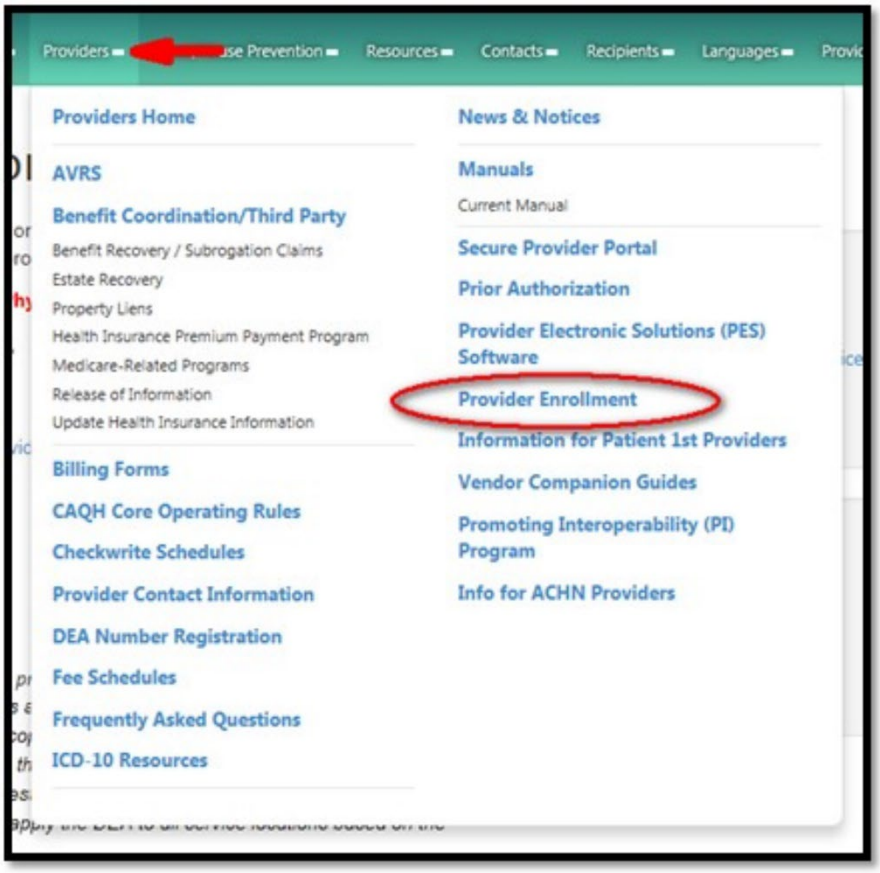
1. The PCP Group Enrollment Agreement may be obtained by visiting www.medicaid.alabama.gov, click ACHN tab, and then click on the Provider section. The ACHN PCP Group Enrollment Agreement must be electronically uploaded to Gainwell Technologies for processing. Instructions for uploading the agreement are posted on Medicaid's website.

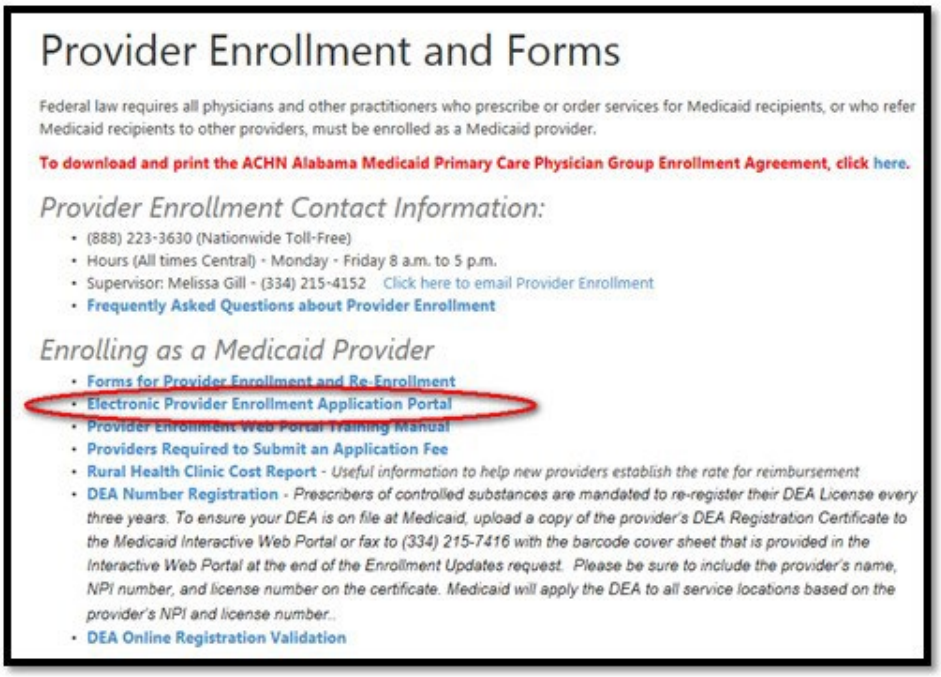
2. To obtain the PCP Group Agreement with the ACHN, email the ACHN Regional contact that is listed in the "ACHN Contact Information for Providers" located on Medicaid's website at www.Medicaid.Alabama.gov, select the ***ACHN Providers*** tab.

NOTE:
If you are completing the Medicaid PCP Group Agreement for a new enrollment that resulted in being issued a new Medicaid Billing Group ID from a previous enrollment, you must contact the Managed Care Operations (MCO) Division at Medicaid for additional processing. Failure to contact MCO may result in omitted attribution for the new Medicaid Billing Group ID. You may contact MCO at ACHN@medicaid.alabama.gov.

40.3.2 *Adding a Provider to an Existing ACHN PCP Group Agreement*

For providers who wish to be added to an existing ACHN PCP Group Enrollment, the provider must complete an "Individual within a Group" application. Completing this application will enroll the provider within the group that currently has a PCP Group Agreement on file. The application is submitted electronically via the application portal. This application is also the initial enrollment application for AL Medicaid. The application portal may be found at www.medicaid.alabama.gov. Go to the Providers tab, select Provider Enrollment, and click the hyperlink titled *Electronic Provider Enrollment Application Portal*. For assistance with adding the new provider to your ACHN enrollment, you may contact Provider Enrollment at 1-888-223-3630 or Provider Assistance at 1-800-688-7989.





40.3.3 *Adding/Updating a Nurse Practitioner's or Physician Assistant's Collaborating Physician*

Nurse practitioners (NPs) and physician assistants (PAs) must be collaborating with an active Medicaid enrolled physician to participate in the Medicaid program. The NP's and PA's collaborating physician must align with records from the Alabama Board of Medical Examiners (ALBME). In addition, the NP or PA, the group, and the collaborating physician must all be linked under the same group enrollment NPI. Inconsistent or incorrect collaborating physician information on the NP's or PA's Medicaid file may cause claims to deny. To add or update the collaborating physician on the NP's or PA's Medicaid file, a request must be submitted on letterhead requesting the addition or update. The letter must include the NP's name, NPI, Medicaid ID (for each location), the collaborating physician's name, collaborating physician's NPI, collaborating physician's Medicaid ID, and signature. A copy of the current collaborating license must be attached to the letter. The letter and license must be submitted through the secure web portal. For assistance with updating the NP's or PA's collaborating physician, contact Provider Enrollment at 1-888-223-3630.

40.4 PCP Determination

To be identified as a PCP a provider must be one of the following:

- A Teaching Facility
- A County Health Department
- A PCP group or individual participating with an ACHN
- An OB/GYN
- An FQHC
- An RHC

40.5 Requirements for PCP Active Participation with the ACHN

PCP requirements for "active participation" with one of the seven ACHNs are described below:

- In person or virtual attendance over a 12-month period to at least three (3) quarterly medical management meetings with the ACHN's medical director (one PCP or nurse practitioner/physician assistant from the group may attend to meet attendance requirements)
- Engagement in ACHN initiatives centered around Quality Measures
- Data review with the ACHN to help achieve Agency and ACHN Quality goals
- Engagement as appropriate in the ACHN's multidisciplinary care team and the development of an individualized and comprehensive care plan

If a PCP stops actively participating or terminates their agreement with the ACHN they signed the original agreement with, then the PCP Group must sign another agreement to actively participate with a different ACHN to continue receiving Participation Rates and Bonus payments.

In the absence of these agreements, PCP Groups will not be eligible to receive enhanced Participation Rates or Bonus Payments for Quality, Cost Effectiveness, and Patient Centered Medical Home (PCMH) recognition. If a provider chooses not to engage in active participation, they will receive regular fee-for-service rates and, if eligible, current BUMP rates.

40.6 Provider Directory

A Provider Directory is available via the Medicaid Web site to all providers and recipients to assist in selecting physicians/clinics in their regions. The Provider Directory can be used by recipients to help locate a doctor. The Provider Directory can also be used by providers to obtain contact information. Providers and recipients can filter to search by name, city, county, specialty or a combination of all. The Provider Directory is mobile and print friendly.

40.7 PCP Group/ PCP Disenrollment

The Agreement to participate in the ACHN program may be terminated by either the PCP Group or Agency, with cause or by mutual consent; upon at least 30 days written notice and will be effective on the first day of the month, pursuant to processing deadlines.

If a PCP dies, moves out of the service area, or loses Medicaid and/or **ACHN** provider status, the Agency must be notified by submitting a Disenrollment Form within 30 days of the PCP's departure.

NOTE:

For all Disenrollment situations listed above, a Disenrollment Request Form must be completed. You may obtain the form at:
http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.16_Provider_Enrollment_Forms.aspx

Disenrollment forms must be electronically uploaded to the Web Portal in PDF format. Failure to provide a 30-day notice may preclude future participation opportunities.

40.8 PCP Group Responsibilities, Functions, and Duties

In order to participate as a PCP Group, the following requirements must be met. Detailed information is provided on specific requirements in subsequent sections.

The PCP Group shall comply with all applicable federal and state statutes and regulations, and all amendments thereto, that are in effect when the ACHN Agreement became into effect during the term of the ACHN Agreement. This includes, but is not limited to, the Alabama State Plan and Title 42 of the Code of Federal Regulations (CFR).

The PCP Group agrees to the following:

- Enter a Participation Agreement with an Entity;
- Actively Participates (refer to section 40.5) with an Entity;
- Each PCP Group physician must be a licensed physician enrolled in the Alabama Medicaid Program who has not been sanctioned.
- Be listed as a Group in the ACHN Directory for the purpose of providing care to recipients and managing their health care needs as agreed in the ACHN agreement.
- Provide services to recipients pursuant to the terms of the ACHN Agreement.
- Provide or arrange for primary care coverage, twenty-four (24) hours per day and seven (7) days per week as defined in Attachment A of the PCP Group Agreement, for services, consultation, management or referral, and treatment for emergency medical conditions. Referral (by answering service staff, voice response, or medical practitioner without triage) to the hospital emergency department for services does not satisfy this requirement. The PCP Group must have at least one telephone line that is answered by the office staff during regular office hours.
- Provide EPSDT preventive care screenings to Medicaid eligible children age birth through 20. PCP Groups serving this population who do not provide EPSDT services are required to sign an agreement with another provider to provide EPSDT services. PCP Groups must retain a copy of this agreement in their files and must ensure that their records include information regarding the extent of these services.
    - Provide hospital admissions. (Refer to section 40.8.1: Hospital Admitting Privileges Requirement)
    - Maintain a unified patient medical record for each recipient following the medical record documentation guideline as defined by Medicaid Policy in Rule No. 560-X-1-.21 of the Alabama Medicaid Administrative Code and policy.
    - Promptly arrange referrals for medically necessary health care services that are not provided directly and document referral for specialty care in the medical record. Provide the NPI to the consulting provider.
    - Transfer the recipient medical record to the receiving PCP Group at the request of the new PCP Group and as authorized by the recipient within thirty (30) days of the date of the request. Recipients cannot be charged for copies of medical records.

NOTE:

Patients must request their records be transferred to the new PCP Group and must not be charged a fee for this service.

- Authorize care for the recipient or see the recipient based on the standards of appointment availability as defined by policy.
- Refer for a second opinion as defined by policy.
- Review and use all recipient utilization, quality improvement, and other reports provided by the Agency and/or Entity for the purpose of practice level utilization management, quality of care improvement, and advise the Agency of errors, omissions, or discrepancies.
- Participate with Agency utilization management, quality assessment, complaint and grievance, and administrative programs.
- Provide the Agency or 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 the PCP Group agreement as required by Medicaid policy in Rule No. 560-X-1-.21 of the Alabama Medicaid Administrative Code and 42 C.F.R. § 431.107.
- Maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following national and regional clinical practice guidelines.
- Notify the Agency of all changes to information provided on the initial application for participation in the ACHN Program. If such changes are not reported within thirty (30) days of change, future participation may be limited.
- Give written notice of termination of ACHN Agreement to each recipient who received his or her primary care from, or was seen on a regular basis, by the PCP Group within thirty (30) days after receipt of the termination notice or within thirty (30) days of notice of termination.
- Retain records in accordance with requirements of Rule No. 560-X-1-.21 of the Alabama Medicaid Administrative Code 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 retention period ends.
- 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.
- Receive prior approval from the Agency of any ACHN specific, or education materials prior to distribution.

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

NOTE:

Recipients can obtain assistance with language interpretation by calling the Recipient Call Center at 1(800) 362-1504.

- Provide the Agency with at least thirty (30) days prior notice of PCP Group disenrollment, change in practice site, Medicaid Group Billing ID, or NPI changes to allow for notification to recipients. Failure to provide thirty (30) day notice may preclude future participation.
- Have the 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.
- Have the ability to provide continuity of personal clinician assignment and clinician care, organization of clinical information, clinical information exchange, and specialized care settings.
- Have the capacity to provide culturally appropriate, and person- and family-centered 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.
- Upon termination of the Agreement, the PCP Group must supply all information necessary for reimbursement of outstanding Medicaid claims.

The PCP Group is prohibited from the following:

- Discriminating against Recipients on the basis of health status or the need for health care services.
- Discriminating against Recipients 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.
- Refrain from knowingly engaging in a relationship 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 non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or
  2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation.

Note: The relationship is described as follows:

a. As a director, officer, partner of the PCP Group; or

b. A person with beneficial ownership of more than five percent (5%) or more of the PCP Group's equity; or

c. A person with an employment, consulting or other arrangement with the PCP Group for the provision of items and services which are significant and material to the PCP Group's contractual obligation with the Agency.

40.8.1 *Hospital Admitting Privileges Requirement*

- PCP Group is 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 recipients. If a Group does not admit recipients, then the Hospital Admitting Agreement must be submitted to the Agency to address this requirement for participation. If the PCP Group has entered 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 resubmit within ten (10) days of when a change occurs regarding the PCP Group's management of inpatient hospital admissions.
- A formal arrangement is defined as a voluntary agreement between the PCP Group and the agreeable physician/group. The agreeable party is committing in writing to admit and coordinate medical care for the recipient throughout the inpatient stay. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a forty-five (45) minutes' drive time from the PCP Group's practice. If there is no hospital that meets the above geographical criteria, the hospital geographically closest to the PCP Group's practice will be accepted.
- Exception may be granted in cases where it is determined the benefits of a PCP Group's participation outweigh the PCP Group's inability to comply with this requirement.

See Attachment B of Alabama Medicaid Primary Care Physician Group Enrollment Agreement for more information on the Hospital Admitting Requirements.

40.8.2 *24/7 Coverage Requirement*

- The PCP Group must provide recipients with after-hours coverage. It is important that recipients be able to contact their PCP Group to receive instruction or care at all times, so that care will be provided in the most appropriate manner to the recipient's condition. After hours coverage must be available 24 hours a day every day of the year. The PCP Group can meet this requirement through a variety of methods. To qualify as an ACHN PCP Group, one of the following must be met:
  - The after-hours telephone number must connect the patient to the PCP Group's physician or an authorized medical practitioner.

- The after-hours telephone number must connect the recipient to a live voice call center system or answering service who will either direct the recipient to the appropriate care site or contact the PCP Group's physician or PCP Group's authorized medical practitioner. If the PCP Group's physician or authorized medical practitioner is contacted, then the recipient should receive instructions within one (1) hour.
- The after-hours telephone number can connect to a hospital if the PCP Group has standing orders with the hospital to direct recipients to the appropriate care site. (For example, if the recipient's symptoms are such that the recipient can be seen the next morning, the hospital should direct the recipient to contact the PCP Group in the morning to make an appointment).

An office telephone line that is not answered after hours or answered after hours by a recorded message instructing recipients to call back during office hours or to go to the emergency department for care is not acceptable. It is not acceptable to refer recipients to the PCP Group's home telephone if there is not a system in place as outlined above to respond to calls. Instructions that refer all requests to go physically to the Emergency Room are not acceptable. Failure to comply with the 24/7 coverage requirements may affect future participation opportunities. See Attachment A of Alabama Medicaid Primary Care Physician Group Enrollment Agreement for more information on the 24/7 Coverage Requirements.

40.8.3 *EPSDT Requirement*

For recipients of Medicaid, birth to age 21, the EPSDT Screening is a comprehensive preventive service at an age appropriate recommended schedule. It is the only reimbursable preventive medical service for this age group. There are numerous components of the EPSDT, all of which are required in the Federal Early Periodic Screening Diagnosis Treatment (EPSDT) program. All age appropriate components must be performed at the time of a screening exam. These components are listed and described in Appendix A of the Alabama Medicaid Provider Manual.

PCP's are requested to either perform or make arrangements for EPSDT screenings. The PCP is responsible for ensuring that age appropriate EPSDT screenings are provided. If a PCP cannot or chooses not to perform the comprehensive EPSDT screenings, the PCP may authorize another provider to perform the screenings for enrollees in the birth to 21 age group.

If the PCP enters into an agreement with a screener in order to meet this ACHN requirement for participation, the agreement containing the original signatures of the PCP or the authorized representative and the screener or an authorized representative must be submitted within the enrollment application. The PCP must keep a copy of this agreement on file. If this agreement is executed after enrollment a copy must be submitted within ten (10) days of execution.

The agreement can be entered into or terminated at any time by the PCP or the screener. The Agency and Gainwell must be notified immediately of any change in the status of the agreement.

If there is an agreement between the PCP and a Screener to provide EPSDT services, the PCP agrees to:

- Refer 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 ten (10) days.
- Maintain, in the office, a copy of the physical examination and immunization records as part of the patient's permanent record.
- Monitor the information provided by the Screener to assure that children in the ACHN program are receiving immunizations as scheduled and counsel patients appropriately if found in noncompliance with well child visits or immunizations.
- Review information provided by the Screener to coordinate any necessary treatment and/or follow-up care with patients as determined by the screening.
- Notify the Agency and Gainwell immediately of any changes to this agreement.

The Screener must agree to:

- Provide age appropriate EPSDT examinations and immunizations within sixty (60) days of the request for patients who are referred by the PCP or are self-referred.
- Send EPSDT physical examination and immunization records within 30 days to the PCP.
- Notify the PCP of significant findings on the EPSDT examination or the need for immediate follow-up care within 24 hours. Allow the PCP to direct further referrals for specialized testing or treatment.
- Notify the Agency and Gainwell immediately of any changes to this agreement.

40.9 Standards of Appointment Availability and Office Wait Times

The PCP Group must conform to the following standards for appointment availability:

- Emergency care – immediately upon presentation or notification
- Urgent care – within 24 hours of presentation or notification
- Routine sick care – within 3 days of presentation or notification
- Routine well care – within 90 days of presentation or notification (15 days if pregnant)

The PCP Group must conform to the following standards for office wait times:

- Walk-ins – within two hours or schedule an appointment within the standards of appointment availability
- Scheduled appointment – within one hour
- Life-threatening emergency – must be managed immediately

If these standards cannot be met due to extenuating circumstances, then the recipient should be informed within a reasonable amount of time and given an opportunity to reschedule the appointment.

40.10 PCP Medical Records Guidelines

Medical records should reflect the quality of care received by the recipient. However, many times medical records documentation for the level of care provided varies from provider to provider. Therefore, in order to promote quality and continuity of care, a guideline for medical record keeping has been established. All ACHN PCP Groups must implement the following guidelines as the standards for medical record keeping:

1. Each page, or electronic file in the record, contains the recipient's name or recipient's Medicaid identification number.
2. All entries are dated.
3. All entries are identified as to the author.
4. The record is legible to someone other than the writer, including the author.
5. Medication allergies and adverse reactions are prominently noted and easily identifiable as well as the absence of allergies.
6. Personal and demographic data is recorded and includes age, sex, address, employer, home and work telephone numbers, and marital status.
7. Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
8. There is a completed immunization record.
9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded in the medical record.
10. Notation concerning smoking, alcohol, and other substance abuse is present.
11. Notes from consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging results have an explicit notation in the record of the follow-up plans.
12. Emergency care is documented in the record.
13. Discharge summaries are included as part of the medical record for hospital admissions.
14. Documentation of individual encounters that provide adequate evidence of appropriate history, physical examination, diagnosis, diagnostic test, therapies, and other prescribed regimen, follow-up care, referrals and results thereof, and all other aspects of patient care, including ancillary services.

40.11 Recipient Education

Recipient education will be an integral part of the ACHN Program to help the recipients understand the program and their responsibilities. It is also imperative to stress the importance of contacting the ACHN and/or the Recipient Call Center (RCC) (1-800-362-1504) number anytime there is a question.

In addition, as the coordinator of care, it is important for PCP Groups to be actively involved in patient education. PCP Groups are encouraged to contact all new recipients by telephone or in writing.

Providers should address the following subjects with each new recipient:

- The PCP Group's requirement to provide medical advice and care 24 hours per day, 7 days per week and the preferred method for contacting the PCP Group
- The requirement that the recipient must contact the PCP Group before going to the emergency room unless the recipient feels that his/her life or health is in immediate danger
- The importance of regular preventive care visits such as Well Child Check-ups EPSDT screenings for children, immunizations, check-ups, mammography, cholesterol screenings, adult health assessments, and diabetic screenings
- The availability of additional information for recipients from the ACHN or the Agency's Recipient Call Center

40.12 Agreement Violation Provisions

Failure to meet the terms outlined in the ACHN PCP Group Enrollment 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 actions by the Agency:

- Referral to the Agency's Program Integrity for investigation of potential fraud
- Referral to the Board of Medical Examiners or other appropriate licensing board
- Termination of the PCP Group from the Alabama Medicaid Program

40.13 BMI Requirement

Primary Care Physicians (PCPs), nurse practitioners and physician assistants collaborating with a PCP, a PCP group or individual participating with an ACHN, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Public Health Departments, and OB/GYNs that bill procedure codes 99202-99205, 99211-99215, and 99242-99245 must include an annual BMI diagnosis on the claim or the claim will be denied. EPSDT procedure codes 99382-99385 and 99392-99395 must also include an annual BMI diagnosis on the claim or the claim will be denied. If a BMI has been reported on a recipient for the current calendar year (January 1 – December 31), the claim will pay without a new BMI. If the BMI has not been reported on the recipient for the current calendar year, a BMI will be required for the claim to pay. For additional information on changes to the BMI Requirement, see the *Changes to BMI Requirement* ALERT on the Alabama Medicaid Agency's website.
Medicaid ALERTs: https://medicaid.alabama.gov/alerts.aspx

BMI Requirement during Telemedicine/Telehealth Visits

The BMI will be required for all visits including the telemedicine visits. (Refer to Chapter 112, Telemedicine Services, for general benefit information and limitations.)

The table below provides a description of procedure codes and ICD-10 codes that require a percentile on the CMS 1500 claim form for **recipient's age 3-19 years**:

Procedure Code Description	ICD-10 Diagnosis Code Description for Ages 3-19
99202 Office/Outpatient Visit New 99203 Office/Outpatient Visit New 99204 Office/Outpatient Visit New 99205 Office/Outpatient Visit New 99211 Office/Outpatient Visit Est 99212 Office/Outpatient Visit Est 99213 Office/Outpatient Visit Est 99214 Office/Outpatient Visit Est 99215 Office/Outpatient Visit Est 99242 Office Consultation 99243 Office Consultation 99244 Office Consultation 99245 Office Consultation 99382 EPSDT New Patient 99383 EPSDT New Patient 99384 EPSDT New Patient 99385 EPSDT New Patient 99392 EPSDT Est Patient 99393 EPSDT Est Patient 99394 EPSDT Est Patient 99395 EPSDT Est Patient	Z6851 BMI Pediatric, Less Than 5th Percentile for Age Z6852 BMI Pediatric, 5th Percentile to Less Than 85% for Age Z6853 BMI Pediatric, 85% To Less Than 95th Percentile for Age Z6854 BMI Pediatric, 95th Percentile for Age to less than 120% of the 95th Percentile for Age Z68.55 BMI Pediatric, 120% of the 95th Percentile for Age to less than 140% of the 95th Percentile for Age Z68.56 BMI Pediatric, greater than or equal to 140% of the 95th Percentile for Age

Deleted: Greater Than or…95% for Age
Added: 95th Percentile for…Percentile for Age

NOTE:

For Pediatric BMI reporting: The same BMI code may be appended to the claim until the next well child check (where a BMI is typically determined) unless the physician considers the clinical need for a BMI redetermination sooner than the next well child check.

The table below provides a description of procedure codes and ICD-10 codes that require a BMI on the CMS 1500 claim form for **recipients age 20 and older**:

Procedure Code Description	ICD-10 Diagnosis Code Description For Ages 20 and Older
99202 Office/Outpatient Visit New 99203 Office/Outpatient Visit New 99204 Office/Outpatient Visit New 99205 Office/Outpatient Visit New 99211 Office/Outpatient Visit Est 99212 Office/Outpatient Visit Est 99213 Office/Outpatient Visit Est 99214 Office/Outpatient Visit Est 99215 Office/Outpatient Visit Est	Z681 Body Mass Index (BMI) 19 Or Less, Adult Z6820 Body Mass Index (BMI) 20.0-20.9, Adult Z6821 Body Mass Index (BMI) 21.0-21.9, Adult Z6822 Body Mass Index (BMI) 22.0-22.9, Adult Z6823 Body Mass Index (BMI) 23.0-23.9, Adult

99242 Office Consultation 99243 Office Consultation 99244 Office Consultation 99245 Office Consultation	Z6824 Body Mass Index (BMI) 24.0-24.9, Adult Z6825 Body Mass Index (BMI) 25.0-25.9, Adult Z6826 Body Mass Index (BMI) 26.0-26.9, Adult Z6827 Body Mass Index (BMI) 27.0-27.9, Adult Z6828 Body Mass Index (BMI) 28.0-28.9, Adult Z6829 Body Mass Index (BMI) 29.0-29.9, Adult Z6830 Body Mass Index (BMI) 30.0-30.9, Adult Z6831 Body Mass Index (BMI) 31.0-31.9, Adult Z6832 Body Mass Index (BMI) 32.0-32.9, Adult Z6833 Body Mass Index (BMI) 33.0-33.9, Adult Z6834 Body Mass Index (BMI) 34.0-34.9, Adult Z6835 Body Mass Index (BMI) 35.0-35.9, Adult Z6836 Body Mass Index (BMI) 36.0-36.9, Adult Z6837 Body Mass Index (BMI) 37.0-37.9, Adult Z6838 Body Mass Index (BMI) 38.0-38.9, Adult Z6839 Body Mass Index (BMI) 39.0-39.9, Adult Z6841 Body Mass Index (BMI) 40.0-44.9, Adult Z6842 Body Mass Index (BMI) 45.0-49.9, Adult Z6843 Body Mass Index (BMI) 50-59.9, Adult Z6844 Body Mass Index (BMI) 60.0-69.9, Adult Z6845 Body Mass Index (BMI) 70 or Greater, Adult

Some specialties are exempt from the BMI requirement. The table below lists provider specialties that are excluded from the BMI requirement:

Spec	Description	Spec	Description
021	Cardiac Electrophysiology	332	Otologist, Laryngologist, Rhinologist
023	Sports Medicine	337	Plastic Surgeon
180	Optometrist	339	Psychiatrist
310	Allergist	340	Pulmonary Disease Specialist
311	Anesthesiologist	341	Radiologist
312	Cardiologist	342	Thoracic Surgeon
313	Cardiovascular Surgeon	343	Urologist
314	Dermatologist	750	Colon and Rectal Surgery

317	Gastroenterologist	760	EENT
319	General Surgeon	770	Endocrinologist
321	Hand Surgeon	780	Hematology
324	Nephrologist	790	Infectious Disease
325	Neurological Surgeon	810	Orthopedic
326	Neurologist	830	Rheumatology
329	Oncologist	922	Perinatologist High-Risk Pregnancy
331	Orthopedic Surgeon		

NOTE:
Pregnant women with a pregnancy diagnosis code are excluded from the BMI requirement.

40.14 Referral Requirements

PCP to PCP referrals are not required. Under the ACHN program for specialty services, a referral from a PCP or an ACHN Network is no longer required (with the exception of Lock-in and EPSDT programs). EPSDT referrals will continue to be required. (Refer to Appendix A for EPSDT referral requirements.)

40.14.1 *Referrals for Specialty Providers Associated with Teaching Facilities*

Alabama Medicaid providers who are considered teaching specialty providers may provide services to Medicaid recipients without a Primary Care Physician (PCP) referral. Medicaid claims can be processed for payment without a referral, however, the absence of communication between PCPs and specialists may hinder optimal coordination of medical care. Therefore, communication is encouraged. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) referral remains in place to assist with managing the fourteen-office visit limit. For more information regarding referrals for Specialty Providers Associated with Teaching Facilities, you may access the Teaching Facility Referrals in the ACHN one-pager with the following link: https://medicaid.alabama.gov/documents/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers/5.1.3_Teaching_Facility_Referrals_ACHN_10-31-19.pdf.

40.14.2 *Referral Form*

All referrals must be documented on the *Alabama Medicaid Agency Referral Form (Form 362). (Applies to EPSDT and Lock-in programs)* Please refer to the Appendix A of the Medicaid Provider Manual for further information on EPSDT.

40.14.3 *EPSDT Screening Referrals*

Please refer to the Appendix A of the Medicaid Provider Manual for further information on EPSDT.

40.15 Override Requests

In extenuating circumstances, on a case-by-case basis, and after thorough review, Medicaid may determine that an override may be prudent in some situations. There may also be instances where a BMI cannot be determined (e.g. wheelchair bound recipients). In these cases, providers may request a BMI override using the **PCP Override Request form** to obtain payment. A copy of the **PCP Override Request**

form is in Appendix E of the Medicaid Provider Manual. An Override Request Form and a clean Red Drop Ink claim form (CMS Form 1450 (UB-04) or CMS Form 1500) must be submitted to the Network Provider Assistance Unit by mail within 90 days of the date of service. CMS Form 1450 (UB-04) or CMS Form 1500 must be an original and must be signed or the override request will not be approved and returned to the provider. Requests will be evaluated within 60 days of receipt. Overrides will not be approved for well visits.

The override request must be mailed to:

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

40.16 Reimbursements and Payments to PCP Groups

PCP Groups are eligible to earn higher payments for 13 Evaluation and Management (E&M) codes if they participate with the ACHNs. This higher payment is called the ACHN Participation Rate and includes the following E&M codes: 99202-99205, 99211-99215, and 99242-99245. Nurse Practitioners and Physician Assistants who are enrolled in the PCP Group will receive 80% of the physician rate for these E&M codes. FQHCs and RHCs are excluded from this payment as they receive encounter rates.

Definitions for Different Rates PCPs may earn:

Fee-For-Service Rates: This is the base fee-for-service rate a physician will receive for E&M codes if he/she chooses not to participate with the ACHN.

BUMP Rates: PCPs must qualify for the BUMP rates as described by the Physician Program. Follow the same attestation process as currently exists. (Refer to Chapter 28, Physician Program, for additional information.)

Participation Rates: Participation Rates are higher than BUMP rates and will be paid to providers that actively participate with the ACHN (refer to section 40.5). FQHCs and RHCs will not receive these rates, however, but will continue to receive encounter rates.

Bonus Payments: These payments will be made to all participating providers (including FQHCs and RHCs) during the start-up phase of the program and will be based on the attribution of recipients to providers (refer to section 40.19). After the start-up phase, bonuses will be based on performance. Nurse Practitioners, Physician Assistants, and Nurse Midwives will receive 80% of the physician rate for these Bonus Payments. These Bonus Payments also apply to FQHCs and RHCs.

NOTE:

Bonus payments will be made on the second or third checkwrite of the 1st month of the quarter (January, April, July, and October) unless otherwise noted.

Payment Types and Payment Cycles are described in the table below:

Type of Payment	When Paid
Fee-For-Service	Every checkwrite
ACHN Participation Rate	Every checkwrite
Bonus Payment	The second or third checkwrite of the first month of the quarter.
BUMP Payments	Every checkwrite

The table below shows four different scenarios for PCP Group Payments:

Alabama Medicaid Agency

ACHN Primary Care Physician Payment Chart

Primary Care Physician Scenarios	Base FFS Rates	Bump Rates	Participation Rates	Bonus Payments
PCP Scenario 1: PCPs not eligible for Bump Rates & not participating with ACHN	√	X	X	X
PCP Scenario 2: PCPs not eligible for Bump Rates & participating with ACHN	√	X	√	√
PCP Scenario 3: PCPs eligible for Bump Rates & not participating with ACHN	X	√	X	X
PCP Scenario 4: PCPs eligible for Bump Rates & participating with ACHN	X	√	√	√

The table below further describes the four different PCP Group payment scenarios listed above:

EXAMPLE
Participation Rate (PR) = Enhanced Rates for fifteen E & M codes
PCP Scenario 1 Example: Receive only Base FFS Rates for all codes, including the fifteen PR codes
PCP Scenario 2 Example: Receive PR for the fifteen E&M codes, FFS Rates for all other codes, and Bonus Payments
PCP Scenario 3 Example: Receive Bump Rates only (no Participation Rates or Bonus Payments)
PCP Scenario 4 Example: Receive PR for the fifteen E & M codes, Bump Rates for all other codes, and Bonus Payments

BUMP Rates vs. ACHN Participation Rates are described in the table below:

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

40.17 Urban/Rural Counties (for Providers)

A map showing urban and rural counties for providers may be accessed on the Medicaid website at: www.medicaid.alabama.gov, then select the ACHN tab, ACHN Providers, Medicaid's Designated Urban and Rural Map.

40.18 Agency Monitoring

Active Participation requirements will be monitored monthly by the Agency and the ACHN. The Agency will remove a PCP or PCP Group from the ACHN for not meeting requirements. Before a PCP Group is removed from ACHN participation, the Agency will confirm with the ACHN and the PCP Group that the Group did not meet the requirements.

40.19 Attribution

Under the ACHN Program, Medicaid recipients will be attributed to physicians based on historical claims data utilization. ***To determine the provider types that are identified as PCPs, refer to section 40.4: PCP Determination.*** Reference Rule No. 560-X-37-.09, "Attribution under the Alabama Coordinated Health Network Program." Attribution is the process that will be used to associate a Medicaid recipient to the PCP Group that provides primary care to that recipient. Attribution is a critical factor in determining distribution of Bonus Payments among eligible providers. On a quarterly basis, the Medicaid Agency will determine attribution for each Medicaid recipient under the ACHN Program in accordance with the following process:

- The Medicaid Agency will review the previous two-year history of provider visit utilization for each Medicaid recipient. Utilization will consider both preventive visits and regular office visits.
- Points will only be awarded for claims that are in a paid status before the end of the attribution run period.
- If a specialist group has the highest number of points, then the specialist group will be attributed the Medicaid recipient; however, a specialist group shall not be eligible to receive the bonus payments described above.
- The Medicaid Agency will review the previous 12-month history of filled prescriptions for chronic care conditions for each Medicaid recipient.
- The point values described below associated with the visits and prescriptions will be assigned to the individual doctor that performed the service. The individual PCP scores will be combined to form the PCP Group's total point score for each patient.
- PCP Groups will receive points based on the number of preventive visits (CPT 99381-99387, 99391-99397) and regular office visits (CPT 99202-99205, 99211-99215) conducted by the PCP Group. Points will be awarded as follows:

	Type of Visit	0-6 Months Ago	6-12 Months Ago	12-18 Months Ago	18-24 Months Ago
PCP	Standard	4	4	2	2
	Preventative	8	4	4	2
Non-PCP Specialist	Standard	2	2	1	1
	Preventative	4	2	2	1

- PCP Groups will receive points based on the number of prescriptions filled for chronic care conditions. For the purposes of this rule, prescriptions for chronic care conditions shall mean more than one prescription filled for a chronic condition (e.g., asthma) and must correspond to an office visit from the prescribing provider within the previous two (2) years.
- The PCP Group with the highest number of points will have the Medicaid recipient attributed to that PCP Group. The Medicaid recipient must have met criteria for the ACHN Program for three (3) out of the previous twenty-four (24) months to be attributed.

40.19.1 *Attribution Report*

The attribution report is a listing of attributed recipients issued to providers that have recipients attributed to their group. The report is produced quarterly after the attribution process is complete. The report will list new attributions, continuing attributions, and terminated attributions. The report is available to providers from the Alabama Medicaid Interactive Services Web Site (web portal).

The following table lists the timeframe in which attribution reports will be available via the secure web portal for fiscal year 2025:

Attribution Period	Attribution Run Month	Attribution Reports Available
October 1, 2024 – December 31, 2024 (Quarter 1)	August 2024	First or second week of September 2024
January 1, 2025 – March 31, 2025 (Quarter 2)	November 2024	First or second week of December 2024
April 1, 2025 – June 30, 2025 (Quarter 3)	February 2025	First or second week of March 2025
July 1, 2025 – September 30, 2025 (Quarter 4)	May 2025	First or second week of June 2025

Each quarter, the provider group can obtain a listing of new recipients, continuing recipients, and terminated recipients. The listing will include the recipient's demographic information, Medicaid number, aid category, and county code. The recipient status will be noted at the top of each page as new, continuing or terminated.

- New Attributions– recipients that are new to your attribution.
- Continuing Attributions – recipients that have been previously attributed and continue to be attributed to the PCP.
- Terminated Attributions – recipients that have been deleted from the PCP's attribution. A termination code will be listed on the report indicating the reason the recipient was terminated from the provider's attribution list. Below is the code legend that will be listed on the last sheet of the attribution report explaining the recipient's reason for termination.

Termination Reason Code	Description
1	RECIPIENT HAS BEEN ATTRIBUTED TO A NEW PROVIDER
2	RECIPIENT NO LONGER ASSIGNED TO AN ACHN NETWORK
3	RECIPIENT NOT MET MONTHS OF ELIGIBILITY REQUIRED
4	RECIPIENT HAD NO CLAIMS IN THE EVALUATION PERIOD
5	RECIPIENT HAS BEEN REKEYED. THIS ID IS NO LONGER ACTIVE

40.19.2 *Reconsideration of Attribution*

A PCP Group may request the attribution calculation for any Medicaid recipient who has received care from the group. If a PCP Group believes the Medicaid Agency has not properly attributed one or more Medicaid recipients to the PCP Group, it may request the Medicaid Agency reconsider its attribution calculation.

- A request for reconsideration must be submitted to the Medicaid Agency in writing and within seven business days of the quarterly attribution notification. The written request for reconsideration must contain:
    - the period of attribution
    - the name(s) of the Medicaid recipient(s) that the PCP Group believes was/were not properly attributed
    - supporting information and/or documentation demonstrating that the Medicaid Agency either failed to or improperly considered information which had a material impact on the result of the attribution
- The PCP Group that has been attributed the Medicaid recipient(s) subject to the request for reconsideration shall be notified by the Medicaid Agency of the request and be permitted to submit information for Medicaid Agency consideration within three business days of the notice. If the PCP Group that has been attributed the Medicaid recipients subject to the request for reconsideration does not respond to Medicaid within the three-day time frame—Medicaid will continue the review without additional information from the attributed group.
- The Medicaid Agency will review all relevant information and complete any adjustments to the PCP Group's Medicaid recipient attribution within seven business days of receipt of the request for reconsideration.

  Reconsideration requests must be submitted to Patricia Toston at patricia.toston@medicaid.alabama.gov.

40.20 Quality Assurance Activities

Quality assurance activities and program monitoring will be the responsibility of the Managed Care Operations Division. Monitoring efforts will look at all facets of the program including measuring the PCP against established program goals, determining contract compliance, and focusing on program outcomes – all of which involve both administrative and performance measures.

Bonus Payments for the PCP Group will be available if the PCP Group:

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

Bonus Payments for Quality, Cost Effectiveness, and PCMH Recognition

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

- 50% for Quality
- 45% for Cost Effectiveness
- 5% for PCMH Recognition

The quarterly bonus payments will be made on the second or third checkwrite of the 1st month of the quarter (January, April, July, October).

The Alabama Medicaid Agency will set aside funds from the annual Alabama Coordinated Health Network (ACHN) bonus payment pool. The reserved funds will help assist with unforeseen situations that would cause the Agency to recoup and redistribute the bonus pool. The Agency will reserve a total of $400,000 from the annual $15 million bonus pool. This is equivalent to a reserve of $100,000 per quarter. If a primary care physician (PCP) group is inadvertently omitted from the bonus payment distribution, the Agency will use the reserve funds to pay the PCP group(s). In addition, if funds are recouped from a PCP group, the recouped amount will be added to the reserve funds. During the last quarter of the fiscal year, the Agency will distribute any remaining reserve funds to actively participating ACHN PCP groups.
For more information about the reserve funds, refer to the Changes to the Alabama Coordinated Health Network (ACHN) Bonus Payment Distribution ALERT on the Medicaid website.
Medicaid ALERTs: https://medicaid.alabama.gov/alerts.aspx

Quality Bonus Payments: PCP Groups will be eligible for a Quality Bonus Payment if the PCP Group meets the requirements described below:

- The Group must achieve at least half of the annual quality benchmarks determined by the Medicaid Agency
- Quality benchmarks are statewide, updated annually, and will be posted to the Agency's website at www.medicaid.alabama.gov (Click the ACHN tab/Provider).

PCP Quality Measures are listed below:

CHL-CH	Chlamydia Screening in Women (Ages 16 - 20)
CIS-CH	Childhood Immunization Status (Combo 3)
IMA-CH	Immunizations for Adolescents (Combo 2)
WCV-CH1	Child and Adolescent Well-Care Visits (Ages 3 - 11)
WCV-CH2	Child and Adolescent Well-Care Visits (Ages 12 - 17)
CHL-AD	Chlamydia Screening in Women (Ages 21 - 24)
HBD-AD	Hemoglobin A1C Control for Patients with Diabetes (Ages 18-75)
PPC-AD	Postpartum Care Visits

Deleted: ~~WV~~
Added: WCV
Added:2

Added: (Ages 18-75)

Cost Effectiveness Bonus Payments:

PCP Groups will be eligible for a Cost Effectiveness bonus payment if the PCP group meets or exceeds the Cost Effectiveness criteria established by the Agency. Payments will be distributed to each PCP group that has met criteria. The Cost Effectiveness bonus calculation payment is described below:

- Compares a 12-month per member per month (PMPM) to a risk-adjusted expected PMPM based on the costs of similar PCP groups that treat Medicaid recipients
- Groups ranked by an efficiency score that is derived from actual PMPM versus the expected PMPM
- Bonus payment is paid for PCP groups with a cost effectiveness score of less than 1.0

- Recipients with total costs more than $250,000 will be removed from the PCP group's PMPM calculations and the ACHN statewide PMPM calculations
- Calculation occurs three months after the previous twelve (12) month's performance has been derived.

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

Recipients with total costs more than $250,000 will be removed from the PCP group's PMPM calculations and the ACHN statewide PMPM calculations.

A Cost Effectiveness Q&A document is available on the ACHN providers section of the Medicaid website, by visiting https://medicaid.alabama.gov/content/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers.aspx. The Cost Effectiveness Q&A document is a great resource for commonly asked questions and formulas used for cost effectiveness calculations.

Patient Centered Medical Home (PCMH) Recognition Bonus Payments:

The purpose of the PCMH Recognition Bonus payment is to incentivize providers to attain PCMH recognition ensuring Medicaid recipients are receiving care through a nationally recognized medical home model. Participating PCP groups can obtain PCMH recognition or certification through nationally recognized entities such as National Committee for Quality Assurance (NCQA), the Compliance Team, or the Joint Commission among others. The PCP group's PCMH Recognition certification of achievement and/or supporting documentation (proof) as adequate progress towards achievement must be in an active status on the last day in September of the (current) fiscal year in order to receive approval for the next fiscal year.

Details from NCQA can be found at: https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/?utm_source=ncqa&utm_medium=homepage-link&utm_campaign=pcmh&utm_content=left .

Details from the Compliance Team can be found at: https://thecomplianceteam.org/our-accreditation-programs/patient-centered-medical-home-pcmh/

Details from the Joint Commission can be found at:https://www.jointcommission.org/certification/primary_care_medical_home_certification.aspx

All PCP groups will be required to attest to Medicaid no later than October 1st **annually**. All PCP groups will be required to submit the PCMH Attestation Form, regardless of which PCMH certifying agency the provider used to become PCMH recognized.

The PCMH Recognition bonus payment attestation and proof of (achievement or progress towards achievement) are due to Medicaid **annually**, **no later than the deadline date/time of October 1, by 5:00 P.M. (CST)**.

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

a. National Committee for Quality Assurance (NCQA)- PCP groups must have completed at least 1 (one) check-in and met 1 or more Cores within the qualifying timeline for the upcoming fiscal year. Core met proof of supporting documentation must show continued progress until full PCMH Recognition has been obtained. Providers can send a screen print of the 'transforming' page in their dashboard from the NCQA website.

b. The Compliance Team- PCP groups must provide proof that progress has been made on their Quarterly PCMH Quality Reporting. Progress is defined as improvement in numbers as the months proceed. A blank PCMH Quality Reporting is unacceptable. The PCP group must have completed at least one (1) quarter with said entity and show continued progress towards PCMH Recognition accreditation.

c. The Joint Commission- PCP groups must provide proof that they have reached the 'Prepare for Survey' stage and/or beyond of the PCMH process. Additionally, at least 1 (one) of the tools within 'Prepare for Survey' must have been utilized or accessed to demonstrate progress.

PCMH achievement or progress toward PCMH achievement will be required from all PCP Groups that would like to receive a bonus payment for PCMH recognition.

PCP Groups that received or making progress towards PCMH Recognition through NCQA, the Joint Commission, the Compliance Team or another certifying entity must submit an Attestation Form and proof of their PCMH Recognition certification to the Medicaid Agency.

For those PCP Groups who are working toward PCMH Recognition with a nationally recognized entity, progress toward completion of PCMH Recognition must be shown. The Agency will determine the appropriate level of progress to receive the 5% bonus payment. A screen print of this progress must be attached to the attestation form and can be obtained from the nationally recognized entity. The Agency will review the Attestation Form with the required attachments and will process based on established guidelines. If the Agency disapproves the submitted Attestation Form and attachments, a formal letter will be mailed to the PCP Group explaining the reason(s) for the disapproval.

Send the completed PCMH Attestation Form and its supporting documentation (proof) by:

Email: ACHN@medicaid.alabama.gov

or

Fax: 334-353-3856

Bonus Payment Timeline & Schedule

The timeline below represents the schedule the Agency will use to capture data and calculate bonus payments:

ACHN Physician Incentive Payment Timeline (begins October 2024)

				FY25Q1			FY25Q2			FY25Q3			FY25Q4			FY26Q1			FY26Q2			FY26Q3		
Base Timeline Model For Initial Calculated Payment	July-24	August-24	September-24	October-24	November-24	December-24	January-25	February-25	March-25	April-25	May-25	June-25	July-25	August-25	September-25	October-25	November-25	December-25	January-26	February-26	March-26	April-26	May-26	June-26
Patient Attribution	*Rolling 24 Month Lookback*																							
Quality	*12 Months Data w 9 Months Roll Out*																							
Cost Effectiveness *																								
PCMH																								
			Data Source Month									*First Calculated Payment*												

Note:

**12 Months Data w 3 Months Roll Out*

40.21 The Profile Report

The Profile Report (Profiler) is the scorecard for providers to easily determine why they receive or did not receive quality bonus payments. This report is based on claims information and one is produced for each PCP Group. The data in the report is collected from paid claims and is processed to produce a visual representation of how providers are performing within a peer group. More information on the Profile Report is posted on the Medicaid Agency's website.

40.22 Eligible Recipients

The Agency is responsible for recipient enrollment in Managed Care programs. ACHN is mandatory for most Medicaid recipients. Medicaid recipients that must participate in **ACHN** are those for whom eligibility has been determined as listed below. Eligibility categories include but are not limited to:

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

Medicaid recipients listed in the below categories of Medicaid eligibility / in the following circumstances are **excluded from participation in ACHN:**

- Medicaid Dual Eligibles (covered by Medicare & Medicaid);
- Long-term institutional care;

- Home and Community-Based Services Waiver;
- Children in the custody of the Department of Youth Services;
- Inmates and people living in Institutions for Mental Diseases (IMDs);
- Aged, blind or disabled individuals receiving only optional state supplements;
- Individuals participating in the Program of All-Inclusive Care for the Elderly (PACE);
- Individuals utilizing hospice services;
- Individuals receiving Refugee Medical Assistance;
- Individuals with other commercial managed care insurance or participating in the Health Insurance Premium Payment (HIPP) program; and
- Individuals with limited or no Medicaid coverage (e.g., some non-citizens only eligible for emergency services, or individuals receiving short-term hospital presumptive eligibility).

40.23 Lock-in Recipients

The Alabama Medicaid Agency closely monitors program usage to identify recipients who may be potentially overusing or misusing Medicaid services and benefits. For those identified recipients, qualified Alabama Medicaid staff performs medical desk reviews to determine overuse and/or misuse of services. If the review indicates overuse and/or misuse of services, the recipient may be locked in to one physician and/or one pharmacy. Additional limitations may be placed on certain medications such as controlled drugs and/or other habit-forming drugs.

Recipients who are placed on lock-in status are notified by letter of the pending restriction. They are asked to contact the Recipient Review Unit or the Clinical Services and Support Division at the Alabama Medicaid Agency with the names of their chosen physician and/or pharmacy. The physician and pharmacy are contacted by the Recipient Review Unit or the Clinical Services and Support Division to determine if they will agree to serve as primary care physician/designated pharmacy while the recipient is restricted.

40.23.1 *Referring Recipients with Lock-in Status*

Physicians who serve as a restricted recipient's lock-in provider should use the Alabama Medicaid Agency Referral Form (Form 362) when referring the restricted recipient to another physician. The referral may cover one visit or multiple visits so long as those visits are part of the plan of care and are medically necessary. No referral can last more than one year. This form can be obtained by accessing Medicaid’s website.

NOTE:
The message indicating the recipient is restricted is part of the general eligibility response provided AVRS or Provider Electronic Solutions software.

40.24 Eligibility Verification

Always verify eligibility. It is the provider's responsibility to verify that a person is eligible for Medicaid at the time of service. There are three sources available for obtaining recipient information:

- The Provider Electronic Solution (PES) is a point of service device or PC based software system, which accesses recipient information.
- The Automated Voice Response System may be accessed by dialing 1 (800) 727-7848 using a touch-tone telephone. This is an automated telephone system available approximately 24 hours a day, 7 days a week unless down for maintenance.
- The Web User Guide provides instructions for performing recipient eligibility verification via the web portal. Instructions for accessing and login are also included in the guide. The Web Portal verification system will provide contact information for the recipient's attributed PCP. Providers can access the Web User Guide at the following link: https://www.medicaid.alabamaservices.org/ALPortal.

40.25 Emergency Services

Access to certified emergency services will not be restricted by the **ACHN** Program. Certified emergencies in outpatient emergency room settings do not require referral or prior authorization by the PCP. However, documentation should be maintained by the provider of service to support emergency certification.

40.26 Certified Emergency Services

Hospitals and physicians who provide "certified emergency" services in the Emergency Room (ER) are not required to have a referral from the PCP. Please note that follow-up care should not be certified as an emergency.

For certified emergencies, there must be an "E" indicator in the appropriate claim block. Refer to the Chapter Five of the Billing Manual for further instructions.

Providers should bill certified emergency services separately from those of non-certified emergency services.

The Agency stresses the importance of coordinating with the PCPs and ACHNs regarding the care of Medicaid recipients in order to preserve the continuity of care and the "medical home" concept.

40.27 Immunizations

Immunizations do not require PCP referral; however, the PCP must maintain documentation of immunizations received. Documentation must include the following: the date the immunization was given, the type of immunization, and who provided the immunization. PCPs are required to ensure that immunizations are up-to-date for children.

Providers should be aware that the parent/guardian of children will be looking to the PCP for immunizations and/or documentation of immunizations, especially in the months prior to school starting. PCPs should be prepared to immunize these children or make arrangements to get appropriate information from the immunizing provider to meet the school rush. **ALL PCPs SHOULD MAKE EVERY EFFORT TO WORK**

WITH OTHER PROVIDERS IN THE COMMUNITY TO ENSURE THAT ALL CHILDREN ARE FULLY AND APPROPRIATELY IMMUNIZED.

40.28 Program Enhancements

The following enhancements are designed to help the PCP achieve the overall program goal of establishing a medical home for our recipients that is accountable and cost-effective:

40.28.1 *Remote Patient Monitoring (RPM)*

Refer to Chapter 111 for more information on Remote Patient Monitoring (RPM).

40.29 Obtaining Educational Materials

Some materials that are available for download from the website include:

"Your Guide to Alabama Medicaid". This booklet describes the services covered, co-payments, the different types of eligibility, patient responsibilities, as well as other useful information.

"Alabama Medicaid Covered Services and Co-Payments" Handout (English or Spanish). Describes services covered by Medicaid and associated co-payments.

"EPSDT Brochure". This is a colorful pamphlet that encourages Well-Child checkups and outlines the periodicity schedule.

NOTE:

Educational materials are also available for use by providers and may be obtained using the online ordering form on the Agency's website at www.medicaid.alabama.gov. A catalog listing these materials is also on the website. Educational materials can be provided in other languages.

40.30 Medicaid Forms

The following forms can be found in Appendix E and/or on the Medicaid website www.medicaid.alabama.gov under Resources/Forms Library/ACHN/PCP Forms:

Form ID	Form Description
Form 172	EPSDT Child Health Medical Record
Form 284	To enroll children of Medicaid-eligible mothers (including SSI mothers) from birth to first birthday - with instructions
Form 391	PCP Override Request Form
ACHN Disenrollment Request Form	Group/PCP Disenrollment Requests
Immunization Documentation	Link to ADPH website regarding Pediatric, Adolescent and Adult Immunization Records

40.31 PCP Billing Instructions

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

40.32 Primary Care Case Management Entity (PCCM-e) Providers

PCCM-e Overview

Each region's Primary Care Case Management entity (PCCM-e) is responsible for developing and implementing a comprehensive person-centered care management program that includes case management and care coordination services. Each program must include information, education and focused service delivery as it relates to population health management, health literacy, and the identification of social determinants of health (SDoH). The ACHN program will provide the Agency and providers a more effective platform for service delivery and improved quality statewide for Medicaid recipients.

Application Assistance
Application assistance can be offered to anyone that is interested in applying for Medicaid. The PCCM-e will have Certified Application Assisters available to assist individuals with completing the Medicaid application process, and follow-up with the person until Medicaid eligibility is determined.

The PCCM-e shall submit names to the Agency's Networks Division of all certified application assisters and the name(s) of the Certified Application Assisters trainers served by the Region at program implementation, within forty-five (45) calendar days of the end of the year and within thirty (30) calendar days of any change.

The PCCM-e has flexibility in determining how to perform the application assister function. Care managers are not required to be Certified Application Assisters; however, the application assister function must be performed by Agency approved staff who meet the qualification as outlined in the Key Staff and Other Positions Requirements.

The Certified Application Assisters Eligibility Encounter must include the following:

- Documentation of eligibility status at screening intake.
- Assistance with completing the application electronically or paper format.
- Follow-up with the person until a Medicaid eligibility determination is made.
- Assistance with any other barriers to the application process.
- Completion of the initial screening; and
- Documentation of activities associated with the encounter in the Health Information Management System (HIMS), when applicable

40.33 Enrollments, Disenrollments and Reenrollments

The PCCM-e must have policies established to identify processes for enrolling, disenrolling and re-enrolling recipients. These policies must in accordance all applicable federal and state regulations and guidelines. Below details regarding the Agency's expectations.

Enrollment

The PCCM-e must not, on the basis of health status or need for health care services, discriminate against recipients. This includes but is not limited to, termination of enrollment or refusal to reenroll a recipient except as permitted under this contract, or any practice that would reasonably be expected to discourage enrollment or reenrollment by recipients whose medical condition or history indicates probable need for substantial future medical services. Violation of this requirement may result in sanctions listed in the RFP.

- The PCCM-e must not discriminate against recipients to enroll with the PCCM-e on the basis of any protected category listed in 42 C.F.R. § 438.3(d) and must not use any policy or practice that has the effect of discriminating on the basis of any protected category listed in 42 C.F.R. § 438.3(d).

- The PCCM-e must accept new enrollment from individuals in the order in which they apply without restriction, unless authorized by the Center for Medicare and Medicaid Services (CMS), up to the limits set under the contract in accordance with 42 C.F.R § 438.3(d)(1).

Disenrollment

In accordance with 42 C.F.R. § 438.56(b)(1), the PCCM-e may request disenrollment of a recipient for the following reasons:

- The recipient loses Medicaid eligibility;
- The recipient's eligibility category changes to a category ineligible for the ACHN (e.g., recipient becomes dually eligible for Medicare and Medicaid);
- The recipient otherwise becomes ineligible to participate in the ACHN
- The recipient has become incarcerated;
- The recipient has died; or
- The recipient moves out of the Region.

The recipient exhibits uncooperative or disruptive behavior which inhibits the PCCM-e's ability to provide services. The PCCM-e must be able to demonstrate, to the Agency's satisfaction, that it has exhausted all reasonable efforts to effectively coordinate the recipient's care.

- The PCCM-e may not request disenrollment because of:
- An adverse change in the recipient's health status;
- The recipient's utilization of medical services;
- The recipient's diminished mental capacity; or
- The recipient's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the PCCM-e's ability to furnish services to the recipient or other recipients).

The PCCM-e must not request disenrollment for reasons other than those permitted under this RFP or Contract.

- A recipient has the right to disenroll from a PCCM-e:
- For cause, at any time;

- Without cause ninety (90) calendar days after initial enrollment or during the ninety (90) calendar days following notification of enrollment, whichever is later;
- Without cause at least once every twelve (12) months; or
- Without cause upon reenrollment if a temporary loss of enrollment has caused the recipients to miss the annual disenrollment period.
- A recipient has the right to disenroll from a PCCM-e without cause when the Agency imposes intermediate Sanctions on the PCCM-e.

A recipient may request disenrollment if, the recipient moves out of the Region; or the plan does not cover the service the recipient seeks, because of moral or religious objections.

A recipient may request disenrollment if the recipient needs related services to be performed at the same time and not all related services are available within the Region.

The recipient's PCP or another provider must determine that receiving the services separately would subject the recipient to unnecessary risk.

A recipient may request disenrollment for other reasons, including poor quality of care, lack of access to services covered under the RFP, or lack of access to Providers experienced in dealing with the recipient's care needs.

A recipient (or his or her representative) must request disenrollment by submitting an oral or written request to the Agency.

The PCCM-e shall refer any disenrollment request it receives to the Agency. 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 recipient requests disenrollment or the PCCM-e refers the request to the Agency.

If the Agency fails to make a disenrollment determination within the specified timeframes (i.e., the first day of the second month following the month in which the recipient requests disenrollment or the PCCM-e refers the request to the Agency), the disenrollment is considered approved for the effective date that would have been established had the Agency made a determination in the specified timeframe.

Reenrollment

A recipient is automatically reenrolled if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of two (2) months or less.

A recipient may choose to reenroll at any time.

Enrollee Rights.

The PCCM-e must have written policies guaranteeing each enrollee's right to:

- Receive information on the PCCM-e into which he/she is enrolled.
- Be treated with respect and with due consideration for his or her dignity and privacy.

- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
- Participate in decisions regarding his or her health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of his or her medical records, and to request that they be amended or corrected.
- Freely exercise his or her rights without the PCCM-e treating the recipient adversely.

Recipient Refusal of Services
The recipient has the right to refuse care management services. If the recipient refuses care management, the PCCM-e will notify the recipient, via postal letter, that they may request care management services at any time. Proof of postal service mailing must be maintained and documented in HIMS for auditing and compliance purposes. A hand-delivered or mailed notification to the recipient are acceptable routes of notifications. The delivery format, when the letter was mailed or hand delivered to the recipient, a copy of the letter and the recipient's refusal must be documented and maintained in HIMS.

40.34 Referrals

The PCCM-e shall receive referrals for care management, which must be screened no later than five business days from the receipt of the referral, from the following but not limited to:

- PCPs;
- Medical or psychiatric facilities;
- State or Community Agencies; and/or
- Recipients

The PCCM-e shall use a process to screen and stratify recipients who are determined to need care management services. The PCCM-e must use the results of the screening and risk stratification to assign an initial risk level to each recipient and place those recipients into appropriate categories of risk which will determine the timeframe of the assessment and assignment to a Care Manager.

For recipients identified as needing care management services and stratified as indicated by the screening and assessment results, the PCCM-e shall provide the level of care management service for the indicated health risk in accordance with the Agency's established criteria. The health risk levels are high, medium, and low.

Once a recipient who needs care management services has been identified, contact must be attempted by the PCCM-e within five business days of screening. At least three attempts must be made at a minimum of 30 calendar days, including a written letter, mailed via postal service, to offer care management services. Proof of postal service mailing and other attempted contact methods must be maintained and documented in the

HIMS for auditing and compliance purposes. A hand-delivered or mailed notification to the recipient are acceptable routes of notifications. The delivery format, when the letter was mailed or hand delivered to the recipient, and a copy of the letter must be documented and maintained in HIMS. The documentation must show all efforts to contact up to closure of the case file.

40.35 PCP Selection Process

The PCCM-e must have policies and procedures in place to assist the recipient in selecting his/her choice of a PCP, to include changes in PCP selection.

Recipients must be allowed to change a PCP once without cause within the first ninety (90) calendar days of selecting an PCP and at any time for just cause, which is defined as a valid complaint submitted verbally or in writing to the PCCM-e.

- The PCCM-e must inform the recipient of the recipient's rights to change PCPs, with and without cause at the initial contact and at least once per year.
- The PCCM-e must provide, at the time of initial contact, all required information regarding rights and responsibilities, and appropriate telephone numbers.

40.36 Network Adequacy Development and Maintenance

The PCCM-e must develop, maintain and distribute a provider directory to recipients as detailed in the Recipient Materials Requirements, Provider Directory documents located in the Procurement Library. The Provider Directory must meet the requirements in 42 C.F.R. § 438.10(h).

40.37 Non-Emergency Transportation (NET) Coordination.

The PCCM-e does not provide NET services; however, the entity may assist recipients in arranging transportation or coordinating with the Agency's NET program for transportation services. A recipient or his/her representative may arrange transportation for the recipient receiving care management services, or request assistance through the PCCM-e by contacting their assigned care management staff. Any staff member with the PCCM-e may assist with coordinating NET services.

The PCCM-e must:

- Ensure the Agency does not pay for NET services if the recipient has access to free transportation;
- Determine availability of and least costly means of transportation to include, but not limited to, free transportation, including the recipient's vehicle, transportation by relative or friend, or volunteer services;
- Establish recipient's eligibility for date of service five (5) calendar days prior to appointments or within twenty-four (24) hours after

urgent care appointments to ensure transportation is provided for Medicaid covered services only;
- Confirm the least expensive mode of transportation that meets the needs of the recipient, such as: Automobile; Transporter; or Other
- Contact the NET Coordinator in the area or the Medicaid Recipient Call Center to arrange transportation if the recipient cannot make the contact on their own;
- Assist recipients in submitting the necessary receipts or confirmation of expenses required for reimbursement for overnight travel;
- Coordinate in-state and out-of-state commercial, bus, train, or air transportation for review to Medicaid on a case-by-case basis to include but not limited to requesting and receiving necessary support documentation from the PCP for any out-of-state services to assure that such services cannot be obtained in-state; and
- Validate appointment with provider by confirming the date, time, and attendance of appointment with the Medicaid provider.

40.38 Recipient Assignment and Stratification

Recipient Assignment and Stratification

Each month, the Medicaid Agency's fiscal agent will share a list of assigned recipients for each PCCM-e. The Agency will also provide historical medical claims information, enrollment information, and recipient contact information. Additionally, the Agency will provide supplemental files with a list of recipients that might benefit from case management or care coordination. The goal will be to provide a list sufficient to reach active care management targets set by the Agency, provide fiscal stability for the PCCM-e and reside within the budget limitations.

The list of recipients in the supplemental files will be based on the Agency's criteria for Medical Complexity and High Risk. The lists will use the previously outlined stratification criteria and available claims data. This means that the lists will not include data unknown to Agency, which the PCCM-e will need to document the additional information appropriately.

From the assignment list, recipients will be assessed for care management assignment as indicated by the stratification mandates and/or criteria established by the Agency.

These stratification criteria have been developed with the intention of delineating areas where care coordination and case management can garner the greatest impact on cost and recipients' health. All recipients must be assessed and provided care management services at the intensity that correlates with their risk stratification level as outlined in the Care Management Activity Criteria and the ACHN Payment, Activity, & staffing documents.

The needs identified in this assessment will be the basis for the recipient's comprehensive care plan. It is not anticipated that each of these recipients will be appropriate for case management and care coordination. From the provided list, recipients will be assessed for care management assignment

as indicated by the stratification mandates and/or criteria established by the Agency.

If the PCCM-e is exceeding targets and fiscal limitations, the Agency will limit assignments. The Agency may also change or update the algorithm, or create a new algorithm, as needed to best identify recipients.

All data and reports will be provided directly to the PCCM-e through the HIMS. The Population Health Data Analyst, Quality Care Director and applicable staff should work closely to ensure recipients are stratified and managed appropriately.

All recipients must be assessed and provided care management services at the intensity that correlates with their risk stratification level as outlined in the Care Management Activity Schedule, Care Management Activity Criteria, and the ACHN Payment, Activity, & staffing documents.

The needs identified in this assessment will be the basis for the recipient's comprehensive care plan.

The recipient's comprehensive care plan shall be current and contain five components: the assessment of identified needs, goals, interventions, rationales, and evaluations. The care plan shall be evaluated and/or updated as applicable, with documentation to support a completion of an update and/or evaluation process.

As the recipient's needs are identified or goals are met, the recipient's risk level may change. The PCCM-e will complete a risk reassessment including a Social Determinants of Health (SDoH) assessment to redetermine the recipient's risk level.

A risk assessment using the Agency approved reassessment tool(s) must be completed in accordance with the Care Management Activity Schedule, Care Management Activity Criteria, and the ACHN Payment, Activity, & staffing documents.

Documentation to support the need for a change in the risk level not captured during the risk assessment/reassessment, must be appropriately documented within the HIMS, with new goals and interventions documented in the care plan.

Additional assessments required for each recipient receiving care management include:

- PHQ-A for recipients ages 12-17;
- PHQ-2 for recipients age 18 and older;
- PHQ-9 for recipients age 18 and older that score a four (4) or higher on the PHQ-2;
- Substance abuse screening tool approved by the Agency; and
- CRAFFT – A health screening tool designed to identify substance abuse, substance-related riding/driving risk, and substance use disorder among youth between the ages 12 and 18, or
- UNCOPE – A six question screening tool used as a quick means of identifying whether a person, age 18 and over, is at risk for abuse or dependence for alcohol and other drugs.

If the recipient is between the ages of 18 and 21 but is still in high school or otherwise considered a dependent, then the ACHN should use CRAFFT and recommendations would be made for adolescent treatment. If the recipient is between the ages of 18 and 21 but has graduated high school or obtained a GED, use UNCOPE to provide a recommendation for adult treatment services.

40.39 Comprehensive Care Management Program

The PCCM-e is responsible for developing and implementing a comprehensive person-centered care management program which includes case management and care coordination components with emphasis on population health management, health literacy and identification of Social Determinant of Health (SDoH). Case management and care coordination under the ACHN Program shall be provided under a triaged, tiered down approach.

The Agency will identify recipients in need of screening for possible case management and care coordination and forward on a monthly basis, to the vendor, the identified recipients for prioritization. The Vendor will also receive case management and care coordination referrals from physicians, other providers, community agencies, etc. The Vendor must evaluate the identified and referred recipients and provide care management services to those in need based on their prioritization.

ACHN Care Management Services

Case management and care coordination under the ACHN Program shall be provided under a triaged, tiered down approach.

The Agency will identify recipients in need of screening for possible case management and care coordination and forward monthly, to the PCCM-e, the identified recipients for prioritization. The PCCM-e will also receive case management and care coordination referrals from physicians, other providers, community agencies, etc. The PCCM-e must evaluate the identified and referred recipients and provide care management services to those in need based on their prioritization.

- The PCCM-e shall establish processes to support case management and care coordination for recipients, primarily those that are at highest risk and cost. The processes shall include, but are not limited to, the following:
- Developing and implementing person centered holistic plans of care;
- Improving health literacy, health outcomes, and self-management;
- Promoting effective use of the healthcare system and community resources;
- Reducing the potential for risks of catastrophic or severe illness;
- Preventing disease exacerbations and complications;
- Minimizing inappropriate utilization;
- Working to identify additional key resources and incorporate these into the strategies such as partnerships with Alabama Department of

Public Health (ADPH), Alabama Department of Mental Health (ADMH), and Children's Rehabilitation Services (CRS);
- Utilizing evidence-based clinical practice guidelines; and
- Promoting the importance of the Medical Home through recipient education.
- Included and Excluded Populations

The following groups of eligible Medicaid recipients shall be included for care management services under the ACHN Program:

- Medically complex recipients
- Maternity care recipients
- Children under age 19;
- Parents or other caretaker relatives (POCR);
- Foster children;
- Former Foster Care;
- Breast and Cervical Cancer; and
- American Indians (note: may opt-out at any time).

The following groups of eligible Medicaid recipients shall be excluded for care management services under the ACHN Program:

- Medicare/Medicaid dual-eligible population;
- Long-term institutional care;
- Home and Community-Based Services waiver;
- Children in the custody of the Department of Youth Services;
- Inmates and people living in Institutions for Mental Diseases (IMDs);
- Aged, blind or disabled individuals receiving only optional state supplements;
- Individuals participating in the Program of All-Inclusive Care for the Elderly (PACE);
- Individuals utilizing hospice services;
- Individuals receiving Refugee Medical Assistance;
- Individuals with other commercial managed care insurance or participating in the Health Insurance Premium Payment (HIPP) program; and
- Individuals with limited or no Medicaid coverage (e.g., some non-citizens only eligible for emergency services, or individuals receiving short-term hospital presumptive eligibility).

The Agency may also provide additional lists of recipients or other Medicaid recipients that are categorized as a member of a population that is of concern or interest of the Agency (e.g., recipients with sickle cell disease). It is the expectation of the Agency that the PCCM-e provide care management services or focused monitoring of these recipients in collaboration with the Agency.

Care Management Populations

General Population

The General population mostly consists of children and adult recipients who have or who are at risk of having certain chronic conditions: asthma, diabetes, cancer, hepatitis C, COPD, HIV, mental health conditions, SUD, transplants, SCD, BMI >25, and/or heart disease.

Maternity (includes postpartum)

The maternity population includes all pregnant and postpartum women from the following benefit types: full Medicaid (TXIX) and full Medicaid/Pregnancy through Postpartum (SBRW). All pregnant recipients must be risk stratified as high for the first three (3) months of care management.

The Agency extended postpartum coverage to twelve (12) months after end of pregnancy for pregnant recipients. The postpartum recipient will continue to receive care management services throughout the postpartum period. The intensity of the care management will be determined by the assigned risk stratification level. Additionally, the PCCM-e must ensure that the recipient has been informed of their need to apply for Medicaid to determine if they qualify for Plan First (family planning services) eligibility.

Medically Complex

The Medically Complex population includes, but is not limited to, children with medical complexities, those recipients with a substance use disorder (SUD) and/or other mental illness diagnosis and those recipients with a Sickle Cell Disease (SCD) diagnosis.

- ACHN entities to target 100% of the population of Medicaid recipients with a diagnosis of SCD for focused intensive care coordination.
- Children with medical complexities (CMCs) require the highest level of intensity of care, and frequently numerous pediatric specialists are required to care for their conditions.
- These children are generally medically fragile with congenital/acquired multi-system disease.
- They also must have a qualifying diagnosis/condition and/or social assessment to meet CMC criteria for this program.
- Primary Care Provider (PCPs), in concurrence with the PCCM-e Medical Director, may also identify additional recipients for this group.

Training Requirements for Staff Who Provide Care Management Services for the Medically Complex Population

The PCCM-e shall provide training for staff providing Care Management services to the Medically Complex Population. The basis of this training will be modules produced by The National Center of Care Coordination Technical Assistance. A description of these modules are as follows:

Introduction to New Models of Care and Healthcare Trends

- Overview of the U.S. Healthcare System
- Introduction to Care Coordination
- New models of care

Interdisciplinary Teams

- Working on interdisciplinary teams
- Building positive relationships on a team
- Communication with team members

- Participating in team huddles
- Dealing with team conflicts

Person-centered and Communication

- Defining person-centered Care Planning
- Recognizing family and patient needs
- Communication and patient engagement techniques (part 1)
- Communication and patient engagement techniques (part 2)

Health literacy

Complex Medical Conditions

- Overview of complex medical conditions (part 1)
- Overview of complex medical conditions (part 2)
- Social determination of health
- Self-management

Cultural Competence

- Recognizing patients' families' cultural needs/factors that may affect their choices or engagement.
- Communicating with patients and families in a culturally competent manner

Ethics and Professional Boundaries

- Ethical and professional responsibilities
- Professional boundaries

Quality Improvement

- The quality improvement process
- Quality improvement methods and processes

Community Orientation

- Connecting patients and families to community resources
- Supporting families as they seek resources in the community.

Health Information Technology, Documentation and Confidentiality

- Basic technology skills and electronic health records
- Documentation
- Confidentiality and guidelines

Family Planning

Family planning promotes the well-being of families, responsible behavior, and healthy mothers and babies. Appropriate family planning care management is paramount to a recipient's life outcomes. Although the PCCM-e will not provide family planning care management services, it is expected that the PCCM-e will refer recipients to family planning services providers when needed. The PCCM-e is also expected to follow up with the recipient to determine compliance or other issues that may have developed since the initial and on-going referrals.

Care Management Program Components

Care Management is a collaborative process that facilitates communication and care coordination along a continuum that includes those connected to and/or directly involved in the care of a recipient. Members of the collaboration can include the recipient, nurses, social workers, counselors, physicians, other practitioners, caregivers, and the community.

The Agency's care management model is comprised of the following components: case management, care coordination, application assistance and medical monitoring review. Care management activities can be provided in person, virtually and telephonically as indicated in each population's Care Management Activity Schedule, Care Management Activity Criteria, and the ACHN Payment, Activity, & staffing documents.

Care management activities rendered to the recipients must be documented in accordance with the applicable chapters in the Agency's Administrative Code (Chapter 1: General) and Provider Manual. When provided by the state, forms, models, templates and Agency-provided data must be used.

Case Management

Case management is a set of activities designed to assist recipients in managing health conditions and related psychosocial problems with the goals of improving or maintaining patients' functional health status, enhancing the coordination of care, eliminating the duplication of services, and reducing the use of unnecessary services. It also recognizes the significance of the SDoH, the complexities of care and the importance of recipients to be involved in care decisions and their right to participate in the process.

Case management services must be provided by appropriately credentialed and state governing board licensed staff. Examples of appropriately credentialed staff include, but are not limited to, counselors, nurses, social workers and therapists.

Examples of duties to be completed by these staff members include but are not limited to assessments, reassessments, care plan development and monitoring, referrals, case documentation, face-to-face and virtual or telephonic encounters with recipients.

Case management activities will be provided to ACHN participants who are stratified as high risk and therefore, require a more intensive level of care management activity.

The PCCM-e will be given stratification criteria by the Agency to determine the appropriate stratification levels for the recipients. However, the recipients within the categories below must be stratified as high:

- Maternity for the first three months of pregnancy or initial enrollment; and
- Medically complex for the first three (3) months of eligible diagnosis(es)/conditions or initial enrollment or engagement

Care Coordination

Care Coordination is a process through which assessment, planning and interventions appropriately integrate, ensure, and advance the plan of care to support positive health outcomes and successful transitions. Care coordination is the deliberate organization of health and related support activities between two or more participants (including the Medicaid recipient) involved in the recipient's care to facilitate the appropriate delivery of needed services. Organizing care involves arranging personnel and other resources needed to carry out all required activities and is often managed by the exchange of information among participants responsible for different aspects of care.

Care coordination activities will be provided to ACHN recipients who are risk stratified as medium or low and therefore, require a moderate or low level of care management activity.

Care coordination services can be provided by appropriately credentialed professional staff.

Medical Monitoring Review

Medical monitoring is the review and analysis of claims and electronic medical records (EMR) data for recipients outside of the top twenty percent (20%) who are not currently receiving care coordination services to determine cost efficiency, clinical appropriateness and the need for other services. The PCCM-e will be given stratification criteria by the Agency to determine when the medical monitoring review is the appropriate assignment for the recipients.

Guidelines for Care Management Encounters

The following components of care management visits/encounters maybe provided telephonically, face to face, or virtually according to the applicable Care Management Activity Schedule. Below is more information on these components.

Telephonic Encounters

The Agency's expectation for telephonic encounters requires a team approach to the delivery of thorough, conscientious, and person-centered care management that is consistent with that of face-to-face visits. Telephonic encounters may be provided as outlined in each population's Care Management Activity Schedule.

Prior to providing services a verbal consent to receive care management services shall be discussed and obtained from the recipient. Documentation of a verbal consent shall be maintained in the HIMS for each date of service for which payment is requested.

Some case management tasks can be completed via text messages (e.g., texting a recipient to notify them of a scheduled call, or to advise them of your attempts to reach). However, no paid care management activity is allowed via text messaging. The PCCM-e must adhere to all HIPAA standards regarding texting recipients for the provision of health care services.

Face-to-Face Encounters (F2F)

Face-to-face encounters are those with the recipient that are in-person at a location of the recipient's choosing. This encounter allows for a more personable approach that supports the gathering of objective and subjective data. Documentation must include the location of the encounter and a recipient signature for the date of service for which payment is requested in the HIMS.

Virtual Encounters

Virtual encounters are an alternate method of providing care to recipients in lieu of face-to-face visits and should not be construed as a more convenient or simpler method of coordinating the care of recipients. Recipient signatures for virtual encounters must be attained within seven calendar days of the encounter. Visits without a valid recipient signature maybe subject to recoupment.

Virtual encounters include audio and visual capabilities and must be HIPAA compliant. The Agency does not support the use of Facebook, including instant messaging for contacting the recipient or for conducting any ACHN care management related activities. Texting is not a paid care management activity.

PCCM-e staff may opt for virtual encounters in the following instances:

- To maintain contact with recipients when a previously scheduled in-person/face-to-face encounter cannot occur due to recipient's illness, illness in the recipient's home or other unforeseen circumstances.
- Care plan reviews
- Multidisciplinary Care Team (MCT) meetings
- Maternity delivery encounters
- To maintain contact with recipients when a previously scheduled in-person/face-to-face encounter cannot occur due to transportation related issues.

Note the examples listed above are not intended as an all-inclusive list. Documentation explaining the choice of a virtual visit must be included in the HIMS.

Encounters that require the recipient to attend F2F or virtually, for which the recipient is not in attendance, are not eligible for payment. Payments made in error are subject to recoupment.

40.40 Documentation

Care management activities provided and not supported with documentation according to
Agency guidelines are recoupable and will require completion of a Corrective Action Plan.
The PCCM-e must make available to Medicaid, at no charge, all information describing services provided to eligible recipients. The provider must also permit access to all records and facilities for the purpose of claims audit,

program monitoring, and utilization review by duly authorized representatives of Federal and State agencies.

Required HIMS Documentation includes but is not limited to:

- Recipient's name and Medicaid Id number
- Medical and Psychological diagnosis
- Individualized person -centered care plan
- Verification that the recipient's Medicaid Eligibility was checked at enrollment and at least once a month, thereafter.
- Documentation must include the type of service rendered (i.e. activity code, method of contact, place of service),
- The date of service for which payment is requested.
- Progress notes for each care management encounter must be documented as outlined within the Agency's policies and procedures.
- Documentation of each encounter must be complete, signed, and dated according to Agency guidelines before a request for payment is requested.
- Progress notes must not be prepopulated or pre/postdated.
- The progress note must summarize the care plan and the interaction with the recipient for the date of service for which payment is submitted.
- Progress Notes must provide enough detail and explanation to justify the request for payment.
- There must be clear continuity between the documentation.
- All documentation must be legible, signed and dated by the person (identified by name and discipline) who is responsible for providing or evaluating the service furnished.
- Additionally, the author of each entry must either, personally or electronically sign his or her entry. A stamped signature is not acceptable.
- Care Plans (as described in the Care Management Care Plan Requirements Policy).
- Consent for services
- Recipient signature when applicable
- Referrals
- Letters/notices

All documentation must be present and complete in an Agency approved HIMS and meet all program guidelines for sufficient documentation standards including but not limited to:

Electronic Records

- When a hard copy is generated from an electronic record the recipient's name and at a minimum date of birth or Medicaid Id number must be visible.
- Contain name, signature, and credentials of the person completing the entry.
- The entry must lock upon submission and indicate time and date of edits.
- Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current

date, time, reason for the change and initials of person making the correction.
- When a hard copy is generated from an electronic record, both records must show the correction.
- Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

Mistaken Entry

A mistaken entry in the record shall be corrected by a method that does not obliterate, white-out, or destroy the entry. Corrections to a record shall have the name or initials of the individual making the correction and the date of the correction.

Amended Records

Documentation submitted for review may include amended records. Amended records are legitimate occurrences in the documentation of clinical services and include a late entry, an addendum and/or a correction to the medical record.

Amended records must:

- clearly and permanently identify any amendment, correction or delayed entry as such,
- clearly indicate the date and author of any amendment, correction or delayed entry,
- clearly identify all original content, without deletion, and
- be amended prior to claims submission and/or medical record request. Records that have been amended and do not meet the Agency standards will be subject to recoupment.
- Records that have been incorrectly amended during an audit period will be subject to recoupment.

Signatures

- The PCCM-e must obtain a signature to be kept on file, (such as release forms or sign-in sheets) as verification that the recipient was present on the date of service for which the provider seeks payment for face-to-face encounters.
- When payment has been made on claims for which a signature is not available and one of the Agency accepted exceptions is not applicable, the funds paid to the provider covering this claim will be recouped.
- The recipient's signature is only required one time per day that services are provided.
- Any non-face-to-face services that can be provided by telephone do not require recipient signatures, yet recipient consent must be documented.

40.41 Care Management Care Plan Requirements

Each recipient receiving care management services with the ACHN shall have a care plan documented in an Agency approved Health Information Management System (HIMS). The PCCM-e shall apply evidence-based guidelines and best practices when developing and implementing the care plan. The process shall involve the recipient, their caregiver/family member (when appropriate and/or requested by the recipient), applicable healthcare providers, and community-based providers as appropriate.

- The care plan shall be current, person-centered, individualized and identify
- and address each of the recipient's diagnoses and needs.
- Staff shall specify those services necessary to meet the client's needs (The needs may include functional, social, spiritual, cognitive, educational, barriers to care such as
- cultural and language, community resources or lack thereof, transition of care,
- access to care, and self-care.
- Include referrals as appropriate for needed services and identify the expected outcomes for each specific issue.
- The care plan shall include, at a minimum, five components: an assessment of
- identified needs, goals, intervention, rationale, and evaluation.
- The care plan shall be evaluated for the recipient's progress to the goals and
- the effectiveness of the established interventions with each encounter.

- The care plan will be updated with new goals and/or interventions as needed with
- documentation in the Agency approved HIMS to support the completion of an
- update and evaluation process.

Care Management Records Requirements
Provider's records must contain, but is not limited to, the following information:

- Name of recipient
- Date of service
- Name of provider agency and person (including credentials) providing services
- Type of services provided.
- Method of service provided.
- Place of service
- The identification of the specific services rendered.
- The signature of the staff person who rendered the services.
- A written assessment of the client's progress, or lack thereof, related to each of the identified issues discussed.
- Documented Referral Source
- Medical and Psychological diagnosis
- Individualized person -centered care plan

- Verification that the recipient's Medicaid Eligibility was checked at enrollment and at least once a month, thereafter.
- Family history
- Educational history
- Medical history
- Substance use history.

All entries must be legible and complete and must be authenticated and dated (prior to being submitted for reimbursement) by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his or her entry. Authentication may include handwritten signatures, written initials (for treatment plan reviews), or computer entry (associated with electronic records—not a typed signature). A stamped signature is not acceptable.

PCCM-e providers must maintain the following documentation in the recipient's record when billing for care management activities:

- A current psychosocial assessment
- Any required additional assessments and screenings
- Progress notes
- A current comprehensive individualized care plan that identifies the medical, nutritional, social, educational, transportation, housing and other service needs that have not been adequately accessed.
- A time frame to reassess service needs.

Services must consist of at least one of the following activities:

- Establishment of a comprehensive case file for development and implementation of an individualized care plan to meet the assessed services and needs of the recipient.
- Assistance for the recipient in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the care plan.
- Assessment of the recipient and service providers to determine that the services received are adequate in meeting the identified needs.
- Reassessment of the recipient to determine services needed to resolve any situation resulting from changes in the family structure, living conditions, or other events.
- Documentation of referrals to medical and community resource services, with follow-up denoting if the services were received and the outcome of the referral.

40.42 Care Management Progress Notes Requirements

Progress notes should not be prepopulated or predated each recipient must have individualized documentation that is specific to his/her interaction with the PCCM-e as it relates to their care. The progress note should match the goals on the care plan and the care plan should match the needs of the recipient. The actions should be appropriate to meet the goals.

Documentation must provide enough detail and explanation to justify the reimbursement requested. If care management services are rendered to more than one eligible recipient in a household on the same day, the case management documentation must include the following information:

- All documentation must be individualized to each eligible recipient's visit.
- There must be enough documentation in the recipient's file that support that the services rendered are specific to his/hers care plan.
- Documentation must meet all other requirements.

Documentation should not be repetitive. Examples include, but are not limited to the following:

- Progress notes that look the same for other recipients.
- Progress notes that state the same words with no evidence of progression, maintenance, or regression.
- Care plans that look the same for other recipients.
- Care plans with goals and actions that stay the same and have no progression.

40.43 Components of the Care Plan

At a minimum, the care plan shall include the following components:

Assessment of Identified Needs

The PCCM-e shall identify and assess the clinical and psychosocial issue that will be the focus of care management. The recipient's individualize needs are based on the recipient's psychosocial assessment and through the collection of objective and subjective data during recipient encounters. The identified needs shall also include documenting of the recipient's risk stratification. The assessment of identified needs process shall include, but not be limited to:

- Engaging the recipient, recipient's family and /or caregiver in the care plan process. Identified persons shall have the opportunity to participate in the care plan process during the development,
- implementation, and ongoing assessment of the recipient's care plan.
- Meeting and addressing communication barriers.
- Engaging the Primary Care Provider (PCP), Maternity Care Provider (MCP), other Providers, and/or a legal representative, as applicable and appropriate. Identified persons shall have the opportunity to participate in the care plan process during the development, implementation, and ongoing assessment of the recipient's care plan.
- Identify and form support systems as needed.
- Identifying and addressing the recipient's personal or cultural preferences related to the types or amounts of services.
- Identifying and addressing the recipient's preference of providers and any preferred characteristics, such as gender or language.
- Identifying and addressing barriers and obstacles that may impede the recipient achieving optimal physical, mental, or social health outcomes.

- Identifying and arranging a back-up plan for receiving critical services (i.e., emergency health issues, behavioral health issues, substance use relapse).
- Identifying and establishing crisis plans for a recipient with behavioral health conditions, as applicable.
- Identifying and addressing other needs through ongoing care management

Goals

Goals are recipient centered actions specifically chosen to resolve an identified need or achieve a want or desire. The recipient's goals should be SMART Goals:

- Specific,
- Measurable,
- Achievable,
- Relevant,
- and Time based.

Interventions

Interventions are actions taken by the care management staff to assist the recipient in achieving their goal(s). The intervention process shall include, but not be limited to:

- Referrals to community or social service agencies, as needed (calling or submitting a written request on behalf of the recipient, provider, caregiver/family) and validate the recipient received the service.
- Linking recipient to needed resources or healthcare providers (Perform activities to assist the recipient connect to the resource or provider, and validate the recipient received the service).
- Conducting timely follow-up with the recipient, referral resources, and his/ her providers as appropriate.
- Performing medication reconciliation, as applicable.
- Establishing support systems.
- Providing relevant education
- Conducting transitions of care between care settings which may include obtaining the discharge / transition plan/summary.

Rationale

The rationale is the "why" of the care plan. It is the explanation a Care Manager provides for choosing an intervention.

Evaluation

The evaluation process includes documenting follow-up and monitoring of the recipient's progress toward the goals and determining if the interventions were appropriate. This process includes determining if the goal and or intervention will improve the recipient's quality of health (mental physical, social, etc.) and meet their needs. Care management staff shall:

- Document the recipient's progress toward accomplishing each goal.

- Documentation shall include the status of each goal i.e., met, unmet, or in progress along with a summary what was (un)accomplished and why.
- Document the effectiveness of the intervention; determine if new or revised interventions are needed along with the need for continued management.
- The care plan shall be evaluated with each recipient encounter with documentation to support the completion of an evaluation process.

Revisions

Care plan revisions include modifying the goals and interventions based on the evaluation of the recipient's progress and needs to ensure the appropriateness of the services to suit the recipient's needs. Revisions are required when:

- There is a change in the recipient's health status or needs.
- There is a change in recipient's diagnosis.
- There is a change in recipient's caregiver status.
- The recipient experiences a significant health care event (e.g., hospital admission or transition between care settings).
- There is a request or need identified by the recipient or the recipient's caregiver.
- There is a request of need identified and by the recipient's healthcare providers.
- There is a change to the recipient's goals.
- The intervention chosen is not suitable to aid in achieving the goal.
- There is a lack of progress with achieving a goal after 90 days (modify/change the goal and or intervention).
- During reassessments.
- After a change stratification level

The care plan is valid when the recipient/legally responsible person and the person who developed the plan sign and date it. Unless clinically contraindicated, the recipient will sign or mark the care plan to document the recipient's participation in developing /revising the plan. If the recipient is under the age of 14 or adjudicated incompetent, the parent, foster parent or legal guardian must sign the care plan.

40.44 MULTIDISCIPLINARY CARE TEAM (MCT)

The PCCM-e must establish a Multidisciplinary Care Team (MCT), a group of health care professionals (such as physicians, nurses, social workers, pharmacists), who are members of different disciplines, each providing specific services to the recipient. The recipient, caregiver, or designated family member shall have the right to participate in the recipient's MCT meeting and the planning of the meeting(s).

The MCT allows for health professionals from different disciplines to work together to provide coordinated and individualized care to patients with complex or chronic needs. The team collaborates on a detailed care plan of care, communicates regularly, and accesses a range of health and community services to support the recipient's goals and well-being. The

team also works to prevent unnecessary hospital care and adapts to the changing needs and circumstances of the recipient over time.

MCT Meeting

A MCT meeting is defined as a setting where all of the attendees are present at the same time to discuss the identified issue(s) collaboratively. Examples of an appropriate MCT meeting setting:

- In-person/face-to-face
- Virtual with, at a minimum, audio capability; audio and visual preferred
- MCT meetings are held in accordance with the Care Management Activity Schedule.

The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-e's office, hospital, community mental health center, clinical practice or clinical group practice, an academic health center, or virtual platform.

The following criteria must be met to be eligible for payment:

- Recipient or their designee must be present.
- If the recipient chooses to not attend prior to the meeting being scheduled, the PCCM-e must maintain attestation documentation within the HIMS to support the refusal. In these instances, Agency approval will be needed prior to payment. This approval must be granted prior to the meeting being conducted.
- If the recipient had agreed to attend but due to unforeseen circumstances cannot attend, the PCCM-e must maintain attestation documentation within the HIMS and document the unforeseen circumstance. In these instances, the MCT meeting can still occur and be eligible for payment.
- Primary care provider or their designee must be present.
- Attendee presence must be documented.
- If face-to-face, signatures are required.
- If virtual, documentation of presence required.
- Document in detail, activities of the MCT and subsequent meetings, in an approved HIMS, including the name and title of participating MCT members and method of participation.

Additionally, the MCT must:

- Include the recipient as an integral member of the MCT meetings.
- Include multi-disciplines.
- Hold meetings that are person-centered, built on the recipient's specific preferences, needs, and input.
- Discuss recipient's needs, solutions, and potential outcomes and timelines for addressing such needs.
- Document, in detail, issues as described above and participating staff; and
- Be an essential component of the care plan process and documented as care plan activities in an approved HIMS.

PCCM-e Responsibilities

The PCCM-e must:

- Assign a Care Manager or Transitional Care Management staff to establish and coordinate a MCT for eligible actively managed recipients.
- Inform the recipient, in writing, of their rights and responsibilities to participate in the MCT meeting. The PCCM-e shall notify the recipient, in writing, of the date, time, location, and purpose of the MCT at least 10 business days before the date of the recipient's MCT meeting. The notification can be telephonic but must be followed-up with a written recipient MCT meeting notification letter via postal service.
- Maintain documentation that a recipient MCT meeting notification letter was generated and mailed to the recipient. Documentation shall be maintained in an approved HIMS for auditing and compliance purposes.
- Organize a MCT that will develop a comprehensive person-centered care plan to meet the needs of the recipient and independently address various issues a recipient may have, focusing on the issues in which each professional specializes.

The PCCM-e shall ensure that the MCT includes the following:

- transparency,
- individualization,
- support,
- acknowledgement and respect for linguistic and cultural differences, competences, and
- Preservation of dignity.

The PCCM-e's designated care manager shall serve as the lead professional in the MCT process. The care manager shall:

- Coordinate the recipient's MCTs by connecting with healthcare professionals who were an essential part of the recipient's care and who would be instrumental in contributing to the recipient's health outcomes.
- Review the each MCT member's documentation related to the recipient.
- Ensure delivery of the care plan to each MCT member to assist the recipient with achieving goals documented within the care plan.
- Be present at various meetings / appointments, if requested.
- Assist the recipient and/or their caregiver by answering questions pertaining to their care plan and its related services, as well as, helping the recipient obtain the treatment and services needed.
- Correspond with the recipient's family or caregiver as needed and/or requested by the recipient when appropriate.
- Determine when additional MCT meetings are needed with other specialized professionals.

- Engage the PCP in the MCT process. The care manager shall determine the best way to engage the PCP and communicate with the PCP to support a collaborative, seamless process. A nurse, nurse practitioner (NP) or physician assistant (PA) or physician extender employed by the provider can serve for the PCP as an active participant in the MCT process. A general office staff, clerk, receptionist, lab technician or any other personnel, employed, contracted or a volunteer, cannot participate in the MCT process on the PCP's behalf. Active participation of PCPs is required for all MCT meetings.
- Ensure the person-centered care plan exhibits a team approach, supported through documentation. The care plan shall serve as the center of the MCT process.
- Review all specialty and MCT entries in the care plan, collaborate with other disciplines as needed for reviews and updates, ensure the care plan is current, interventions are implemented, and goals are identified and evaluated timely. Documentation of completion of this requirement shall be maintained in HIMS for auditing and compliance purposes.
- Ensure the recipient's needs are addressed based on care plan documentation in HIMS.

Ensure care plans are reviewed by MCT members as specified in the Care Management Activity Schedule:

Ensure the care plan is updated when:

- there is a change in the recipient's health status or needs,
- there is a change in diagnosis(es),
- there is a change in caregiver status,
- changes in functional status or a significant health care event occurs (e.g., hospital admission or transition between care settings), or
- as requested by the recipient's caregiver and/or the recipient's provider; and
- Close care plan when goals are met.

MCT Composition

The MCT, under the ACHN Program, may consist of the recipient and at least six different disciplines or professionals. The disciplines/professionals may include, but not limited to, the following:

- PCCM-e Care Manager (required): The leader of the MCT and care plan process.
- Primary Care Provider or appropriate representative (required): The PCP, through review of medical record documentation, shall contribute to the care plan process through consulting with the PCCM-e staff, other members of the team and the recipient, as applicable and documenting identified needs, goals and intervention in the care plan.
- Pharmacist (required): Through the medication list and medication reconciliation process, the pharmacist shall contribute to the care

plan process through consulting with the PCCM-e staff, other members of the team and the recipient, as applicable and documenting identified needs, goals and intervention in the care plan.

- Transitional Care Staff (when applicable): Through the transitional care process, the transitional care nurse shall contribute to the care plan by addressing the recipient identified needs, consulting with the PCCM-e staff and other members of the MCT and documenting identified needs, goals and intervention in the care plan.
- Behavior Health Staff (when applicable): Through the behavior health process and contact with the recipient, the Behavior Health staff shall contribute to the care plan and address the recipient's needs through consulting with the PCCM-e staff, substance use disorder screening processes, reflecting goals, needs and interventions in the care plan.
- Community Health Worker (when applicable): Through working with the recipient and identifying recipient needs, valuable information can be shared to support the MCT process.

To be considered a valid MCT meeting, the meeting shall consist of any three of the six disciplines/ professionals based on the recipient's needs. At least one of the three disciplines must be the recipient's PCP or appropriate PCP representative. The recipient, his or her family member, or caregiver cannot be counted as one of the three levels of disciplines.

Recipient Participation

If the recipient cannot attend the MCT meeting in person or virtually on the scheduled date and time of the MCT, the PCCM-e's care manager shall review with the recipient notes from the MCT and the recipient's care plan during the next face-to-face encounter. This encounter must be documented in the HIMS and the recipient's signature for the encounter is required. The documentation must be maintained in an approved HIMS for monitoring and compliance purposes. Should the recipient choose not to sign, all efforts to attempt to collect the signature must be documented in the PCCM-e's HIMS.

40.45 Medical Management Meeting

Each PCCM-e Medical Director is required over a 12-month period to host at least three quarterly Medical Management Meetings with the Regional Medical Management Committee to discuss and when appropriate, resolve any issues the Primary Care Provider (PCP) or the PCCM-e may encounter in providing care to recipients. These meetings maybe in-person or virtual.

Regional Medical Management Committee
Each PCCM-e is responsible to establish a Regional Medical Management Committee.
The Committee must satisfy the following requirements:

- Chaired by the Medical Director.
- Composed of at least one representative (PCP, Physician Assistant, or Nurse Practitioner) from all participating providers within the Region.
- Medical Management Meeting Objectives:

- Assist in developing and implementing initiatives centered around quality measures.
- Reviews data provided by the PCCM-e to help achieve and improve the Agency and PCCM-e quality goals.
- Review and assist the PCCM-e in implementing and evaluating its Quality Improvement Projects (QIPs).
- Discuss and when appropriate, resolve any issues the PCPs or the PCCM-e may encounter while providing services to recipients.

Recipients with abnormal lead levels, newborn metabolic screenings, and newborn hearing screenings will continue to receive Care Coordination from the Alabama Department of Public Health.

40.46 ACHN Call Center

Services Telephone Line
The PCCM-e shall provide and maintain a number allowing toll-free calls from PCPs, potential and current recipients in the PCCM-e. This is to provide health related support and access. This line shall be available on Business Days, between the hours of 8:00 a.m. and 5:00 p.m. CT (central time). The PCCM-e must also have policies and procedures for handling emergency calls.

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

The PCCM-e shall develop, implement, and monitor performance standards for the toll-free recipient services telephone line. Such standards and monitoring activities must be submitted to the Agency for approval.

Call Center Reports

The Agency shall monitor the Vendor call center through call center reports. The Vendor shall submit to the Agency quarterly call center reports using an Agency approved template. The call center report shall be due no later than the fifteenth (15th) Business Day of the month following the end of the quarter.

The PCCM-e must conduct ongoing call quality assurance to ensure these minimum performance standards are met. If the Agency determines, in its sole discretion, that it is necessary to conduct onsite monitoring of the PCCM-e's recipient services telephone line functions, the PCCM-e will be responsible for all reasonable costs incurred by the Agency or its authorized designee(s) relating to such monitoring.

The toll-free recipient services telephone line must have the capability to handle calls from any language for non-English speaking recipients, as well as recipients with communications impairment, including the use of translators, auxiliary aids such as the telecommunications relay service

(TRS), and text telephone (TTY)/telecommunication device for the deaf (TDD) lines.

The PCCM-e shall have an automated system available every Business Day between the hours of 5:00 p.m. and 8:00 a.m. CT and during weekends and legal holidays. The automated system must include a voice mailbox for callers to leave messages. The PCCM-e shall ensure that the voice mailbox has adequate capacity to receive the reasonably anticipated maximum volume of messages.

The PCCM-e must return messages on the next Business Day. This automated system must provide callers with operating instructions on what to do in case of an emergency which must include, at a minimum, the following information in accordance with 42 C.F.R. § 438.10(g)(2)(v):

- What constitutes an Emergency Medical Condition and Emergency Services; and
- The fact that the recipient has a right to use any hospital or other setting for emergency care.
- Noncompliance with requirements for the recipient services telephone line may result in Sanctions.

40.47 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
Becoming a Medicaid Provider	Chapter 2
Verifying Recipient Eligibility	Chapter 3
Obtaining Prior Authorization	Chapter 4
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Maternity Care	Chapter 24
Physicians	Chapter 28
Long Acting Reversible Contraception (LARC)	Chapter 19
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Family Planning	Appendix C
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Tobacco Cessation	Appendix Q

40.48 Contact Information Summary

For general ACHN billing questions or to request an application package, call the Provider Assistance Center: 1 (800) 688-7989.

To disenroll from the program, the request may be faxed to Gainwell Provider Enrollment: (334) 215-4298 or mailed to Gainwell Provider Enrollment, PO Box 241685, Montgomery, AL 36124

To obtain recipient information on eligibility, benefit limits, or coverage, call the Provider Assistance Center: 1 (800) 688-7989

Automated Voice Response System: 1 (800) 727-7848

To address program and policy questions, for recipient language interpretation services or to report patients enrolled in ACHN who should not be enrolled, call the Recipient Call Center: 1(800) 362-1504

ACHN forms may be requested on Medicaid's website at www.medicaid.alabama.gov.

For written correspondence to the Agency: Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624.