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

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

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

(b) PCCM services may be offered by the state as a mandatory~~voluntary~~ option under the Medicaid state plan; with the exception of beneficiaries who are dually eligible for Medicare and Medicaid, American Indians/Alaska Natives, or children with special health care needs. ~~or on a mandatory basis under a 1915(b)~~

(2) Primary Medical Providers (PMP)

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

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

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

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

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

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

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

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

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

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

(h) Transfer the Patient 1st enrollee's medical record to the receiving provider upon the change of primary medical provider at the request of the new primary care provider and

as authorized by the enrollee within 30 days of the date of the request. Enrollees can not be charged for copies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Note: The relationship is described as follows:

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

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

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

(4) Recipients can choose or will be assigned to a PMP prior to the PMP assignment ~~lock-in date to~~in the PCCM program. Recipients have the ability to change PMPs on a monthly basis. Changes must be requested prior to the 15~~20~~th of the month for the change to be effective the first of the following month.

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

(6) The Case Management fee will be automatically paid to the PMP on the 1st checkwrite of each month. The PMP will be reimbursed ~~$.50~~ a capitation fee per member per month for each recipient assigned and will receive an additional ~~$8.00~~ fee for those recipients identified with chronic conditions if the PMP is contracted with a Health Home. ~~The monthly case management fee will be determined by the components of care to which the PMP has agreed. Case Management fees will be adjusted quarterly.~~ The monthly enrollment summary report will indicate the individual amount of case management fee being paid for that month. ~~As additional case management components are offered, PMPs will be given the opportunity to decide participation.~~ Case management fe~~s~~es are not subject to third party liability requirements as specified in 42 CFR 434.6(a)(9). All direct services are paid fee-for-service through medical claims processing procedures based on the regular Medicaid fee schedule. Federally Qualified

Health Centers (FQHCs) and Rural Health Centers (RHCs) will not receive the case management fee each month.

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

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

(a) Limiting member enrollment with the PMP.

(b) Withholding all or part of the PMP's monthly Patient 1st management/coordination fee.

(c) Referral to the Agency's Program Integrity or Quality Assurance Unit for investigation of potential fraud or quality of care issues.

(d) Referral to Alabama Medical Board or other appropriate licensing board.

(e) Termination of the PMP from the Patient 1st program.

One or more of the above sanctions may be initiated simultaneously at the discretion of the Agency based on the severity of the agreement violation. The Agency makes the determination to initiate sanctions against the PMP. The PMP will be notified of the initiation of a sanction by certified mail. Sanctions may be initiated immediately if the Agency determines that the health or welfare of an enrollee(s) is endangered or within a specified period of time as indicated in the notice. If the PMP disagrees with the sanction determination, he has the right to request an evidentiary hearing as defined by Patient 1st Policy.

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

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