

Provider Insider

Alabama Medicaid Bulletin

July 2019

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ALABAMA COORDINATED HEALTH NETWORK (ACHN)

Alabama Medicaid is moving closer to implementation of the Alabama Coordinated Health Network (ACHN), a new initiative to transform the Medicaid delivery system through a flexible and more cost-efficient effort which builds off the Agency's current case management program structure. The ACHN is designed as a quality program to transform health care provided to Medicaid recipients in Alabama.

The proposed program will more effectively link patients, providers and community resources in each of seven newly-defined regions to improve health outcomes for Medicaid recipients. The ACHN anticipated start date is October 1, 2019.

WHO ARE THE PROPOSED ENTITIES?

The following were notified of intent to award:

Northwest Region:	My Care Alabama Northwest, Inc.
Northeast Region:	North Alabama Community Care
Central Region:	My Care Alabama Central, Inc.
East Region:	My Care Alabama East, Inc.
Jefferson-Shelby Region:	Alabama Care Network Mid-State
Southeast Region:	Alabama Care Network Southeast
Southwest Region:	Gulf Coast TotalCare

Contact Information is available on the Alabama Medicaid Agency website:

https://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Special_Initiatives/2.7.6_ACHN/2.7.6_ACHN_Regional_Map_Contacts.pdf.

WHAT DO PRIMARY CARE PHYSICIANS NEED TO DO?

Primary Care Physicians (PCPs) who want to receive bonus and ACHN participation payments in conjunction with the state's planned ACHN program must sign **two** agreements. If you missed the July 1, 2019 deadline, please complete the agreements as soon as possible. Any agreements received after the deadline may result in a delay in payments.

The Alabama Medicaid Primary Care Physician Group Agreement (PCP Group Agreement)

Replaces the current Patient 1st enrollment agreement

Between **Medicaid** and the individual PCP practitioner or PCP group

Only one Medicaid agreement is required for an individual PCP practitioner or a PCP group and will cover all regions

The Agreement Between the ACHN and the Primary Care Provider

Replaces the current Health Home agreement

Between the **ACHN** and the PCP

Only one agreement is required for an individual PCP practitioner or a PCP group and will cover all regions

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Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- Office Manager
- Billing Dept.
- Medical/Clinical Professionals
- Other _____

The information contained within is subject to change. Please review your Provider Manual and all Provider Alerts for the most up to date information.

This agreement outlines the PCP’s responsibilities including:

- Hospital coverage
- EPSDT coverage
- 24/7 Voice-to-Voice coverage; similar to the requirements found in the current Patient 1st agreement

This agreement details the responsibilities of the PCP or PCP group to actively participate with the ACHN. These responsibilities are:

- Engagement in the ACHN’s Multidisciplinary Care Team and care plans
- Attendance at a minimum of three quarterly Medical Management Meetings
- Engagement in ACHN initiatives centered around quality measures
- Review data provided by the ACHN
- The ACHN will reach out to your practice in the next several months
- You may also reach out to the ACHN directly if you would like. Contact information for the ACHNs has been posted on Medicaid’s website

Download the agreement from Medicaid’s website:

***Medicaid website for agreement download**

**Mail the application package to:
DXC Provider Enrollment Unit
301 Technacenter Drive
Montgomery, AL 36117**

[*https://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Special_Initiatives/2.7.6_ACHN/2.7.6_PCP_Group_Enrollment_Agreement_with_Medicaid_5-10-19.pdf](https://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Special_Initiatives/2.7.6_ACHN/2.7.6_PCP_Group_Enrollment_Agreement_with_Medicaid_5-10-19.pdf)

The PCP Group Agreement deadline was July 1, 2019. Agreements received after this date may be delayed in receiving bonus and ACHN participation payments.

The Agreement Between the ACHN and the Primary Care Provider deadline was July 1, 2019. Agreements received after this date may be delayed in receiving bonus and ACHN participation payments.

The following provider types are eligible to participate with ACHN as a PCP:

- Family Practitioners
- General Practitioners
- Pediatricians
- Any provider listed above within a group may also be eligible to be a PCP group
- Internists
- OB/GYNs
- FQHCs and RHCs

Delivering Healthcare Professionals (DHCPs) who want to receive, without delay, reimbursement and bonus payments for providing services to maternity patients must sign a new agreement to participate with an ACHN. In the absence of this agreement, DHCPs will not be eligible for reimbursement for maternity services and will not receive bonus payments for performing first trimester and post-partum visits. This agreement replaces the current Maternity Contractor agreements and is between the ACHN and the individual DHCP practitioner or DHCP group.

DO I HAVE TO PARTICIPATE?

If you are a PCP and choose to not participate, you will receive regular fee for service rates for your Medicaid claims. You will **NOT** be eligible to receive enhanced participation rates for Medicaid claims or the additional payments that ACHN Certified PCPs will receive, such as bonus payments for cost effectiveness, quality and Patient Centered Medical Home (PCMH) recognition.

If you are a DHCP and choose not to participate, you will **NOT** receive reimbursement for maternity services or bonus payments..

WHAT DOES IT MEAN TO PARTICIPATE?

Participation Requirements	
PCPs	DHCPs
<ul style="list-style-type: none"> • Participating in the ACHN’s Multidisciplinary Care Team and care plans 	<ul style="list-style-type: none"> • Providing data to the ACHN
<ul style="list-style-type: none"> • Participating in at least three quarterly Medical Management Meetings 	<ul style="list-style-type: none"> • Participating in the development of the recipient’s care plan
<ul style="list-style-type: none"> • Participating in ACHN initiatives centered around quality measures 	<ul style="list-style-type: none"> • Participating in the DHCP selection and referral process
<ul style="list-style-type: none"> • Reviewing data provided by the ACHN 	

WHAT CAN I DO RIGHT NOW TO PREPARE FOR THE ACHN?

- Sign your PCP Agreement with Medicaid.
- Find out who the ACHN is for your region. The ACHN will contact you or you may reach out to them to sign your PCP or DHCP Participation Agreement.
- Prepare now for the move to attribution by working your current panel and seeing as many of your patients now so that they will be attributed to you later.

WHAT TRAINING IS AVAILABLE?

- Medicaid will host several webinars for providers throughout August and September prior to implementation of the ACHN program. Discussion will focus on various topics including:
 - o Paying for Quality: Understanding Measures and Data Availability
 - o Cost Effectiveness
 - o Attribution
 - o ACHN Participation: What Does It Mean
 - o DHCPs: A New World of Billing
 - o ACHN Procedures: BMI, Referrals, Understanding New Rates
 - o Town Halls – Questions and Answers

WHERE DO I FIND MORE INFORMATION?

The Alabama Medicaid Agency has more information about the ACHN program on the website:

https://www.medicaid.alabama.gov/content/2.0_Newsroom/2.7_Special_Initiatives/2.7.6_ACHN.aspx including a video presentation for providers: <https://www.youtube.com/watch?v=o2CcVmWBZ54&feature=youtu.be>

For more information related to the PCP agreement or the ACHN agreement with DHCPs, please contact DXC Provider Enrollment at 1-888-223-3630; select option one.

MME EDITS FOR OPIOID EXPERIENCED RECIPIENTS

Effective May 1, 2019, the Alabama Medicaid Agency began implementing cumulative daily MME edits for opioid experienced recipients.

Higher doses of opioids are associated with higher risk of overdose and death - even relatively low dosages (20-50 MME per day) may increase risk.¹ Therefore, Alabama Medicaid will limit the amount of cumulative MME allowed per day on opioid claims. The edit will begin at 250 cumulative MME per day and will gradually decrease over time. The final cumulative MME target is scheduled to be 90 MME per day. This edit is different, and in addition to, the short-acting opioid naïve edit implemented on November 1, 2018.

Phase-In Period:

Beginning May 1, 2019, Alabama Medicaid will begin with a “phase-in” period for three months. Claims that exceed the cumulative daily MME limit of 250 MME will be denied at the pharmacy Point of Sale (POS). The dispensing pharmacist will be provided a universal prior authorization (PA) number on the rejection screen and may enter this universal PA number on the claim to allow it to be paid. **Pharmacists are urged to notify the affected patient/prescriber to develop a plan to decrease the patient’s total daily MME.**

Hard Edit Implementation:

Beginning August 1, 2019, opioid claims that exceed the cumulative MME edit of 250 MME/day will be denied. The universal PA will no longer be valid to bypass the 250 MME edit. Pharmacy override requests for quantities exceeding the MME limit may be submitted to Health Information Designs (HID) and will be reviewed for medical necessity. Select the link below to download an override form.

Edit Details:

- The universal PA number to override the 250 MME edit will be 0009996321
- The universal PA number will be provided on each cumulative MME rejection screen for the pharmacist convenience
- Additional edits such as therapeutic duplication, maximum quantity limitations, early refill, non-preferred edits will still apply
- Claims prescribed by oncologists will bypass the edit
- Long term care and hospice recipients are excluded
- Children are included in the edit
- A Recipient Information Sheet for prescribers and pharmacists to provide to recipients can be found at http://www.medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME.aspx



Anticipated Phase Down:

The Agency anticipates gradually decreasing the daily cumulative MME limit every four months. The first decrease to 200 MME/day will be implemented on December 1, 2019. Prior to each decrease, a new universal PA number will be assigned to override claims that exceed the new threshold. Providers will be notified via an ALERT prior to each decrease. **Again, pharmacists are urged to notify the affected patient/prescriber to develop a plan to decrease the patient’s total daily MME.**

THE ADMINISTRATOR OF ESTATE DESIGNATION FORM

The purpose of this form is to allow the Medicaid recipient the ability to designate his/her patient/resident trust fund account to an adult next of kin after they have passed away. This form should **NOT** be sent to the Agency if the Medicaid recipient has discharged or transferred out of the facility. This form should only be sent to the Agency when a recipient has passed away. **If a recipient has discharged from your facility and/or transferred to another, please refer to your provider manual for instructions on handling the funds remaining in the patient/resident trust fund account or credit balances.**

The Alabama Medicaid Estate Recovery Program has provided additional information and/or clarification on the Agency's website regarding credit balances and how to handle the funds remaining in the patient/resident trust fund accounts after a Medicaid recipient has passed away.

The location of the Nursing Home FAQ has been updated. You can locate this information on the Agency's website under "LTC/Waivers". Here, you will select "Nursing Home Care" which is located under the subheading titled "Long Term Care Facilities". There are several documents provided: (1) ALERT-Handling Funds Following Death of Medicaid-Eligible Resident – 8/20/14, (2) NH Alert 08/20/14-Patient/Resident Trust Flow Chart, and (3) FAQs from ALERT of 8/20/14-Revised 3/23/17. The Agency will be happy to accept additional questions and will update any documentation when and if necessary.

A direct link: http://medicaid.alabama.gov/content/6.0_LTC_Waivers/6.2_LTC_Facilities/6.2.1_NH_Care.aspx

A few helpful hints for the most common mistakes/ issues presented thus far:

1. The Administrator of Estate Designation Form can only be signed by (1) Medicaid recipient or (2) a Person who has legal authority (i.e. Power of Attorney, Conservator, or Guardian). Please remember that a Medicaid or Nursing Home sponsor does not have any authority to sign this form unless they have legal authority to sign on the Medicaid recipient's behalf.
2. The Administrator of Estate Designation Form must be witnessed by two adults over the age of 18. This form is only valid if it is dated and has the signatures of the Medicaid recipient (or person with legal authority) and two witnesses.
3. If the Medicaid recipient cannot sign the form and does not have anyone with legal authority to sign on their behalf—the funds must be released to the State's Unclaimed Property Division (unless an estate is opened).
4. The nursing home **shall not** release the funds directly to a funeral home. The beneficiary designated on the Administrator of Estate Designation Form can pay the funds to the funeral home after they receive them; however, no check should be sent directly from the nursing home to the funeral home (even if the beneficiary requests it).
5. The beneficiary designated on the Administrator of Estate Designation Form must be the adult next of kin.
No exceptions!
6. If a Conservator, Guardian, or someone with legal authority to serve on the behalf of the Medicaid recipient is not the adult next of kin, they are not allowed to be listed as beneficiaries on the form. They will need documentation from the Probate Court showing an estate has been opened in the Medicaid recipient's name and showing they will serve as the Executor/Administrator of the Estate.

If you are unsure of how to handle a particular disbursement or have any other questions/issues, please feel free to contact either of the following:

Annie Harris,
Medicaid Eligibility Supervisor/Estate Recovery
(334) 242-5311 or Annie.Harris@Medicaid.Alabama.Gov

Codie Rowland,
Associate Director/Estate Recovery/Liens Section
(334) 242-5652 or Codie.Rowland@Medicaid.Alabama.Gov

ESTATE DESIGNATION





EPSDT EDUCATIONAL INFORMATION

The purpose of the EPSDT program is to find children with actual or potential health problems and to screen, diagnose, and treat the problems before they become permanent, lifelong disabilities. The program also offers preventive health services to Medicaid-eligible children under 21 years of age.

For initial and periodic screenings, providers should refer to the periodicity schedule and schedule visits as close as possible to the periodicity schedule. If a recipient gets off track or misses a screening, providers should 'catch up' the recipient as soon as possible. Screening codes can be found on page A-25 in Appendix A of the Provider Billing Manual.

An interperiodic screening should be performed when new problems BETWEEN screenings are identified. Interperiodic screenings are billed with the appropriate interperiodic visit code (CPT codes 99211-99215) and appending an EP modifier.

When a problem has been identified during a screening and follow-up care for the identified problem(s) is needed, screening providers should write a referral for the services and the services should then be billed as EPSDT referred. Services are billed as EPSDT referred by using the NPI of the referring provider on your electronic claim and indicating EPSDT or EPSDT/Patient 1st referred on your claim. If you use a software vendor, coordinate with them on how to bill EPSDT referred services. If you use the Medicaid Interactive Web Portal or Provider Electronic Solutions software, refer to your User Manual for information on submitting EPSDT referred claims.

A provider should never bill a claim with the appropriate level of office visit and append an EP modifier to exclude a claim from benefit limits. This is inappropriate billing and is subject to post-payment review. If a recipient under 21 has exhausted benefits, and a chronic condition exists, a provider should contact the recipient's Patient 1st provider and ask for an EPSDT referral. If an EPSDT referral has not been done for the problem which is being treated, the recipient should go to their primary care provider and receive an Interperiodic screening. Then a referral can be issued and services performed billed as EPSDT referred.

A child under the age of 21 should not run out of office visits. The EPSDT program is a vital component to ensure screenings are performed on schedule, and appropriate referrals are given when needed. If the primary care provider has performed a screening and identified problems, when a recipient returns for follow up care related to the problems identified during the screening, the provider should do a self-referral, billing as EPSDT referred.

When a child is screened, all problems should be documented during the screening so appropriate screenings can be made when specialty or follow-up care is needed.

Additional information related to EPSDT can be found in Appendix A of the Provider Manual at the following link:
http://medicaid.alabama.gov/content/Gated/7.6.1G_Provider_Manuals/7.6.1.1G_April2017.aspx



RY 2020 PERM CYCLE UNDERWAY

The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and the State Children's Health Insurance Program (SCHIP) and produces state and national-level error rates for each program.

PERM audits authorized by the Centers for Medicare and Medicaid Services (CMS) for Reporting Year 2020 (RY 2020) are in progress. CMS has contracted with NCI AdvanceMed, Inc. (AdvanceMed) to serve as the Review Contractor (RC) to conduct the data processing and medical records reviews for this cycle.

AdvanceMed will start contacting providers soon to request medical records for claims and payments originally paid between July 1, 2018, and June 30, 2019. If providers are contacted by AdvanceMed requesting medical records, providers are required to comply with the request as referenced in the Administrative Code, the Provider Manual, as well as their provider agreements. Providers are asked to submit accurate and complete documentation in a timely manner.

For questions or additional information, please contact Patricia Jones, PERM Program Manager at 334-242-5609 or

Patricia.Jones@medicaid.alabama.gov

STAY UP TO DATE WITH ALABAMA MEDICAID'S NEW TEXT MESSAGING SERVICE

Providers and recipients now have a new way to receive important information from the Alabama Medicaid Agency. The Text Messaging Service will provide immediate or important communication (i.e. for providers, brief messages could include approaching deadlines, new programs or agreements, Medicaid meetings and training, office closures, or other vital information which may impact your practice).

We hope you will take advantage of this service to stay up to date. Subscribing is quite simple. Text **ALPROVIDERS** to **888777** to receive provider notifications. You may get three to four text messages in a month. You can opt-out at any time. Please note that recipients have a separate keyword and text messaging list to subscribe to in order to receive important recipient information from the Agency.

The Agency will continue to provide regular communication through the Provider Insider newsletter, the Medicaid website, the subscription-based electronic mailing list, and Alerts.

For additional information about the Text Messaging Service for Medicaid, please visit www.Medicaid.Alabama.gov or call (334) 353-9363.

Text ALPROVIDERS to 888777 to receive provider notifications.

DXC Provider Representatives may be reached by dialing

1-855-523-9170

and entering the appropriate seven digit extension.

Provider Representatives travel throughout the state of Alabama and into bordering states within a 30 mile radius. They are available for onsite training for issues related to billing, Medicaid Interactive Web Portal, or Provider Electronic Solutions software.

Please contact any Provider Representative for assistance with billing related issues.



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ALABAMA MEDICAID'S DISTRICT OFFICE IN OPELIKA MOVED TO AUBURN

The Alabama Medicaid Agency relocated the Opelika District Office to a new location in Auburn. On **Monday, May 20, 2019**, the new district office opened for operation at 687 North Dean Road, Suite 300, Auburn, Alabama 36830.



For additional information regarding the relocation of this office, please call (334) 741-5800 or visit

https://www.medicaid.alabama.gov/content/10.0_Contact/10.1_Medicaid_Contacts/10.1.1_Medicaid_Locations.aspx

Check Write Schedule Reminder:

01/04/19	03/01/19	05/03/19	07/05/19	09/06/19	11/01/19	01/03/20
01/18/19	03/15/19	05/17/19	07/19/19	09/13/19	11/15/19	01/17/20
02/01/19	04/05/19	06/07/19	08/02/19	10/04/19	12/06/19	02/07/20
02/15/19	04/19/19	06/21/19	08/16/19	10/18/19	12/13/19	02/21/20

The release of funds is normally the second Monday after the check write (remittance advice) date. Please verify direct deposit status with your bank. As always, the release of direct deposit and checks depends on the availability of funds.