Provider Insider

Alabama Medicaid Bulletin *January 2020*

ALABAMA COORDINATED HEALTH NETWORK BONUS PAYMENTS

All Primary Care Provider (PCP) groups, including FQHCs and RHCs, who actively participate with the Alabama Coordinated Health Network (ACHN) qualify to receive bonus payments. Beginning January 2020, bonus payments will be made on the second checkwrite of the first month of the quarter (January, April, July, and October).

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

- In person attendance over a 12-month period to at least two quarterly medical management meetings and one webinar/facilitation exercise 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

All PCP groups (including FQHCs and RHCs) who actively participate with the ACHN will initially qualify, based on attributed recipients and participation, to receive bonus payments for meeting quality, cost effectiveness, and Patient Centered Medical Home (PCMH) recognition.

In This Issue

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.

A bonus pool has been established 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

Quality Bonus Payment

Beginning July 2021, the PCP group must achieve annual quality benchmarks determined by the Agency to earn a quality bonus payment. The quarterly payment made in July 2021, will be based on the actual quality measure performance calculated for the period between January 1, 2020, and December 31, 2020.

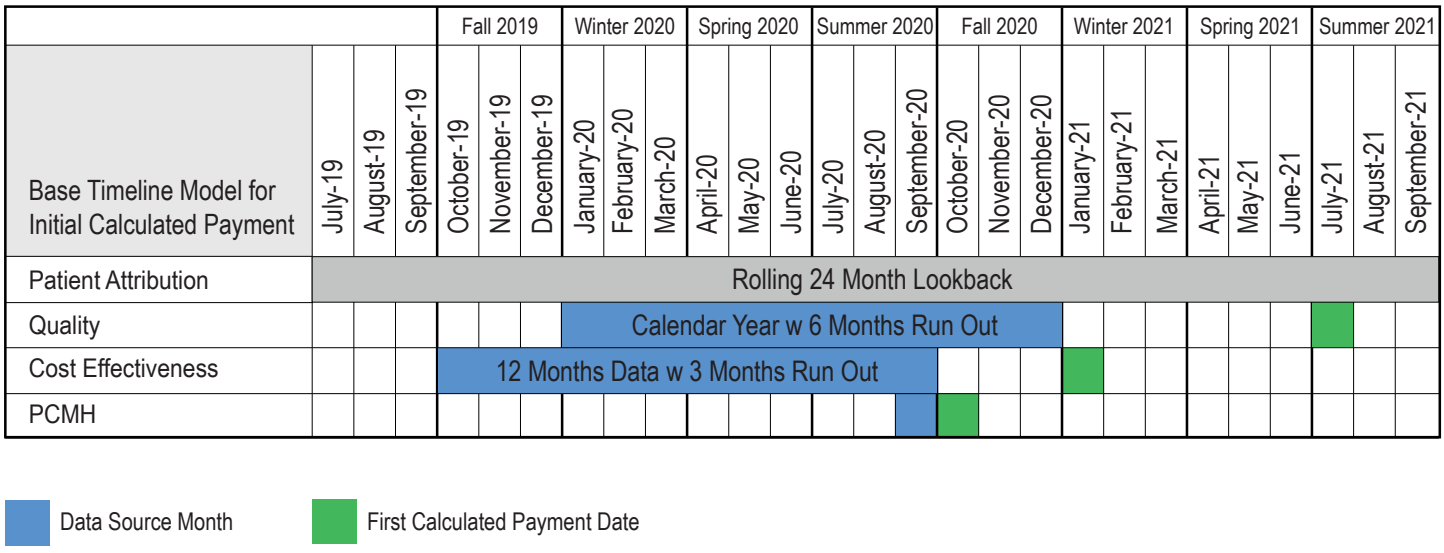
Cost Effectiveness Bonus Payment:

Beginning January 2021, PCP groups will be eligible for a bonus payment if the PCP group meets or exceeds the cost effectiveness criteria established by the Agency.
The quarterly payments made in January 2021, will be based on the actual cost effectiveness calculated for the period between October 1, 2019, and September 30, 2020.

Patient Centered Medical Home (PCMH) Recognition Bonus Payment:

Beginning October 2020, PCP groups will be eligible for bonus payments based on actual PCMH recognition. The Agency will review attestation of PCMH recognition on an annual basis. More details of this annual review will be forthcoming.

ACHN PCP BONUS PAYMENT TIMELINES



Payments made quartely beginning Fall 2019. Payments prior to calculated payments above are distributed to all participating providers based on Attribution.

Evaluation of quality and cost effectiveness will be necessary for a PCP group to manage their actual performance. It is important that the provider review the quarterly Provider Profiler to visualize how the provider is performing throughout the year. The Provider Profiler provides the PCP with a mechanism to monitor areas that may need improvement to achieve quality and cost effectiveness for a higher bonus payment. The Provider Profiler will be released quarterly. The first Profiler report will be released in late January. More information about the Provider Profiler is detailed in Chapter 40 of the Provider Billing Manual.

Attribution vs. Assignment

Attribution is not equal to assignment. Attribution is retroactive and based on a two-year look back of the recipient's paid claims and eligibility history. Assignment was prospective and was based on patient panels in which providers were paid capitated payments in the Patient 1st program.

More information on attribution in the ACHN can be found at the following link: https://medicaid.alabama.gov/documents/2.0_Newsroom/2.5_Media_Library/2.5.1_Slide_Presentations/2.5.1_ACHN/2.5.1_ACHN_Attribution_9-12-19.pdf

ACHN Enrollment Effective Dates

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.

DHCPs who want to receive reimbursement and bonus payments for providing services to maternity patients must sign an 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 postpartum visits.

Below are the guidelines for timely processing of agreements:

Medicaid PCP Group Agreement:
Providers must complete and submit the agreement directly to DXC. The enrollment effective date for the ACHN PCP Group Agreement is 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 - An agreement containing no errors received on December 14, 2019, has an enrollment effective date of January 2020.
Example 2 - An agreement containing no errors received on December 19, 2019, has an enrollment effective date of February 2020.
Example 3 - An agreement is received on December 5, 2019, but is returned for errors. The returned agreement is sent back to DXC, contains no errors, and received on December 16, 2019, will have an enrollment effective date of February 2020.

ACHN PCP Network Participation Agreement:
In addition to the Medicaid PCP Group Agreement, providers must complete and submit an ACHN PCP Network Participation Agreement with 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 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.

ACHN DHCP Agreement:
All DHCPs must sign one additional agreement beyond their Medicaid Enrollment. The DHCP must sign an agreement with an ACHN in order to receive reimbursement of maternity services and bonus payments. On a monthly basis, ACHNs will notify the Agency of all executed ACHN DHCP agreements. DHCPs and ACHNs must ensure that the NPI, Medicaid ID, and name listed on the DHCP 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 DHCP 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, DHCPs will not be eligible for reimbursement for maternity services and will not receive bonus payments for performing first trimester and post-partum visits. If all information communicated to the Agency is correct, the enrollment effective date for the ACHN DHCP 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 DHCP Agreement.

Referrals

PCP Referrals:
PCP to PCP referrals are not required. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) referrals will continue to be required. Use Form 362 to complete EPSDT referrals. Form 362 has been updated and is available on the Medicaid website. More information on PCP referrals to specialists can be found in Chapter 40 of the Provider Billing Manual.

DHCP Referrals:
All maternity claims must have a DHCP selection referral number from the ACHN to receive payment from Medicaid. In order for the ACHN to issue the DHCP referral, the recipient must contact the ACHN in the region in which they live and inform ACHN that she is pregnant. If the recipient visits the doctor's office without a DHCP referral, the DHCP may contact the ACHN for a referral. Although DHCPs may have the ACHN's NPI number, it is the responsibility of the DHCP to ensure a referral is in the medical record and that contact has been made with the ACHN. This ensures that care coordination will be provided to the recipient and that payment is made to the DHCP for maternity services. More information on the DHCP Referral can be found in Chapter 40 of the Provider Billing Manual.

OB/GYN Referrals:
Effective October 1, 2019, OB/GYNs may see Medicaid recipients without a referral. OB/GYNs may also issue referrals to specialists. It is the discretion of the OB/GYN whether to provide referrals to specialists.

Teaching Facility Specialists Referrals:
Alabama Medicaid providers who are considered teaching specialty providers may provide services to Medicaid recipients without a 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. Communication between the PCP and the specialist is strongly encouraged. The EPSDT referral remains in place to assist with managing the 14-office visit limit. A handout about teaching facility referrals is available under the ACHN Providers tab on the Medicaid website.

ACHN Referrals:
After all options have been exhausted to identify a PCP and obtain a referral, the ACHN may be contacted for a PCP referral. The ACHN will only provide a referral For Billing Purposes Only, and the ACHN will work with the recipient to establish a relationship with a PCP for subsequent referrals.

BMI

Effective 10/1/19, a BMI must be appended to all claims for providers who bill procedure codes 99201-99205, 99211-99215, and 99241-99245. EPSDT procedure codes 99382-99385 and 99392-99395 must also include a BMI diagnosis on the claim or the claim will be denied. Plan First claims must include a BMI diagnosis, or the claim will be denied. Pregnant women with a pregnancy diagnosis code are excluded from the BMI requirement.

> **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.

Some specialties are exempt from the BMI requirement. Refer to Chapter 40 of the Provider Billing Manual for a list of specialties that are exempt from the BMI requirement.

Reporting Parity and Gravidity for DHCPs

The Medicaid Agency uses the American College of Obstetricians and Gynecologists (ACOG) definition for parity and gravidity. According to ACOG, gravidity is defined as the number of pregnancies, current and past, regardless of the pregnancy outcome. ACOG's definition of parity is the number of pregnancies reaching 20 weeks and 0 days of gestation or beyond, regardless of the number of fetuses or outcomes. In cases of multiple pregnancies, parity is only increased with birth of the last fetus.

Hence, parity cannot be greater than gravida. DHCPs should adhere to the ACOG's current definitions to report consistent information. For additional information on ACOG's definitions, visit the following link: https://www.acog.org/-/media/Departments/Patient-Safety-and-Quality-Improvement/2014reVITALizeObstetricDataDefinitionsV10.pdf

OPIOID CUMULATIVE DAILY MORPHINE MILLIGRAM EQUIVALENTS (MME) LIMIT – MME DECREASE

Effective December 2, 2019, the Alabama Medicaid Agency will implement hard edits on cumulative daily MME claims exceeding 200 MME/day. A phase-in period for claims exceeding 150 MME/day, but less than 200 MME/day, will also be implemented.

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 began at 250 cumulative MME per day and is gradually being decreased over time. The final cumulative MME target is scheduled to be 90 MME per day.

Hard Edit Implementation (Greater than 200 MME):

Effective December 2, 2019, opioid claims that exceed a cumulative MME of 200 MME/day will be denied. **The universal PA 0009996322 will no longer be valid to bypass the 200 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. See the link below for an override form.

Phase-In Period (150 MME – 200 MME):

Effective December 2, 2019, claims that exceed the cumulative daily MME limit of 150 MME/day will be denied. 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.**

Edit Details:

- The universal PA number to override the 150 MME (but less than 200 MME) edit will be 0009996323.
- The universal PA number will be provided on each cumulative MME rejection screen for the pharmacist's convenience.
- Additional edits, such as therapeutic duplication, maximum quantity limitations, early refill, non-preferred edits, etc., 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 plans to gradually decrease the daily cumulative MME limit every four months. The next decrease will be a hard edit on claims exceeding 150 MME/day with a phase-in edit for claims that exceed 120 MME/day. This will be implemented on April 1, 2020. 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.**

Examples of MME calculations/day include:

- 10 tablets per day of hydrocodone/acetaminophen 5/325 = 50 MME/day
- 6 tablets per day of hydrocodone/acetaminophen 7.5/325 = 45 MME/day
- 5 tablets per day of hydrocodone/acetaminophen 10/325 = 50 MME/day
- 2 tablets per day of oxycodone 15 mg = 45 MME/day
- 3 tablets per day of oxycodone 10 mg = 45 MME/day
- 10 tablets per day of tramadol 50 mg = 50 MME/day
- 1 patch per 3 days of fentanyl 25mcg/hr = 60 MME/day

A link with more information regarding MME calculations is https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf.

A link to the U.S. Department of Health and Human Services Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics can be found at https://medicaid.alabama.gov/documents/4.0_Programs/4.3_Pharmacy-DME/4.3_HHS_Guidance_Dosage_Reduction_Discontinuation_Opioids_10-28-19.pdf.

IMPORTANT: Only when the override is denied will the excess quantity above the maximum unit limit be deemed a non-covered service. Then the recipient can be charged as a cash recipient for that amount in excess of the limit. A prescriber must not write separate prescriptions, one to be paid by Medicaid and one to be paid as cash, to circumvent the override process. FAILURE TO ABIDE BY MEDICAID POLICY MAY RESULT IN RECOUPMENTS AND/OR ADMINISTRATIVE SANCTIONS. Source: Provider Billing Manual 27.2.3

Override Requests:

Once the hard edit is implemented, the MME Override Request Form will be used by the prescriber when requesting an override. The form will be found at: http://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.13_Pharmacy_Forms.aspx.
Any policy questions concerning this information should be directed to the Pharmacy Program at (334) 242-5050.

[1] https://www.cdc.gov/drugoverdose/prescribing/guideline.html

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. This includes initial, periodic, interperiodic, vision, dental, hearing, emotional, and behavioral screening.

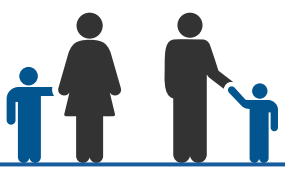
For initial and periodic screenings, providers should refer to the periodicity schedule and schedule visits as close as possible to the periodicity schedule. If a recipient gets off track or misses a screening, providers should 'catch up' the recipient as soon as possible. Screening codes can be found in section A.3.6 of the provider manual and should be used appropriately when billing.

An interperiodic screening should be performed when new problems BETWEEN screenings are identified. Interperiodic screenings are billed with the appropriate level of office visit and appending an EP modifier. When a problem has been identified during a screening and follow-up care for the identified problem(s) are 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/ACHN referred on your claim. If you use a software vendor, ask them how to bill for 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 EPSDT screening 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 can be 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 is found in Appendix A of the Provider Billing Manual found by visiting the Alabama Medicaid website, www.medicaid.alabama.gov. Select Providers, Manuals, Provider Billing Manuals, accept the user agreement, and select the most recent version.



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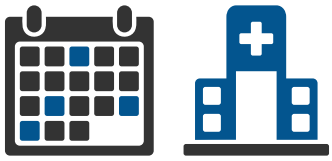

The release of funds is normally the second Monday after the checkwrite (remittance advice) date.
Please verify direct deposit status with your bank. As always, the release of direct deposit and checks depends on the availability of funds.

CHECK WRITE SCHEDULE REMINDER:

- October 4, 2019
- October 18, 2019
- November 1, 2019
- November 15, 2019
- December 6, 2019
- December 13, 2019
- January 3, 2020
- January 17, 2020
- February 7, 2020
- February 21, 2020
- March 6, 2020
- March 20, 2020
- April 3, 2020
- April 17, 2020
- May 1, 2020
- May 15, 2020
- June 5, 2020
- June 19, 2020
- July 3, 2020
- July 17, 2020
- August 7, 2020
- August 21, 2020
- September 4, 2020
- September 11, 2020