INVITATION TO BID NO: 10-X-2212639

STATE OF ALABAMA

DEPTARTMENT OF FINANCE
DIVISION OF PURCHASING

INVITATION TO BID

REQ. AGENCY : 062000
ALABAMA MEDICAID AGENCY
AGENCY REQ. NO. :
T-NUMBER : TA139
DATE ISSUED : 10/15/09
VENDOR NO. :
VENDOR PHONE NO. :
SNAP REQ. NO. : 1430089
BUYER NAME : BERNIE ARANT

FOR: MATERNITY CARE SERVICE - MED

BUYER PHONE NO. : (334) 242-4201-
PURCHASING PHONE NO: (334) 242-7250

BID MUST BE RECEIVED BEFORE:
DATE: 11/02/09 TIME: 5:00 PM

BIDS WILL BE PUBLICLY OPENED:
DATE: 11/03/09 TIME: 10:00 AM

TO BE COMPLETED BY VENDOR

INFORMATION IN THIS SECTION SHOULD BE PROVIDED, AS APPROPRIATE. BID RESPONSE MUST BE IN INK OR TYPED WITH ORIGINAL SIGNATURE AND NOTARIZATION.

1. DELIVERY: CAN BE MADE _____ DAYS OR _____ WEEKS AFTER RECEIPT OF ORDER

2. TERMS: _____(DISCOUNTS ARE TAKEN WITHOUT REGARD TO DATE OF PAYMENT.)

3. PRICE VALID FOR ACCEPTANCE WITHIN _____ DAYS.

4. VENDOR QUOTATION REFERENCE NUMBER, IF ANY: _____
(THIS NUMBER WILL APPEAR ON THE PURCHASE ORDER.)

5. E-MAIL ADDRESS: _____

INTERNET WEBSITE: _____

6. GENERAL CONTRACTOR'S LICENSE NO: _____

TYPE OF G.C. LICENSE: _____

***** IMPORTANT NOTE: *****
BIDDERS MUST COMPLY WITH ALL "BID RESPONSE INSTRUCTIONS" ON PAGE 2, TO INCLUDE ITEM 7 - COPY REQUIREMENT.

RETURN INVITATION TO BID:

US MAIL	COURIER
STATE OF ALABAMA DEPARTMENT OF FINANCE DIVISION OF PURCHASING P O BOX 302620 MONTGOMERY, AL 36130-2620	STATE OF ALABAMA DIVISION OF PURCHASING RSA UNION BUILDING 100 N. UNION ST., SUITE 192 MONTGOMERY, AL 36104

SIGNATURE AND NOTARIZATION REQUIRED

I HAVE READ THE ENTIRE BID AND AGREE TO FURNISH EACH ITEM OFFERED AT THE PRICE QUOTED. I HERBY AFFIRM I HAVE NOT BEEN IN ANY AGREEMENT OR COLLUSION AMONG BIDDERS IN RESTRAINT OF FREEDOM OF COMPETITION BY AGREEMENT TO BID AT A FIXED PRICE OR TO REFRAIN FROM BIDDING.

SWORN TO AND

SUBSCRIBED BEFORE ME THIS

_____ DAY OF _____

_____
NOTARY PUBLIC

TERM EXP: _____

_____
FEIN OR SSN

_____
COMPANY NAME

_____
MAIL ADDRESS

_____
CITY, STATE, ZIP

_____
PHONE INCLUDING AREA CODE

_____
AUTHORIZED SIGNATURE (INK)

_____
TYPE/PRINT AUTHORIZED NAME

_____
TITLE

_____
TOLL FREE NUMBER

_____
FAX NUMBER

STANDARD TERMS & CONDITIONS

VENDOR NAME :

VENDOR NUMBER: -
ITB NO. : 10-X-2212639 PAGE 2
INVITATION TO BID
OPEN DATE : 11/03/09 TIME: 10:00 AM
T-NUMBER : TA139
RETURN DATE: 11/02/09 TIME: 5:00 PM

AUTHORITY:
THE DEPARTMENT OF FINANCE CODE OF ADMINISTRATIVE PROCEDURE, CHAPTER 355-4-1 EFFECTIVE DECEMBER 20, 2001 IS INCORPORATED BY REFERENCE AND MADE A PART OF T HIS DOCUMENT. TO RECEIVE A COPY CALL (334)242-7250, OR OUR WEBSITE WWW.PURCHASING.ALABAMA.GOV .

INFORMATION AND ASSISTANCE TO MINORITY BUSINESSES IN THE TECHNICAL COMPLETION OF REQUIRED FORMS MAY BE OBTAINED FROM THE OFFICE OF MINORITY BUSINESS ENTERPRISE, 1-800-447-4191.

BID (ITB) RESPONSE INSTRUCTIONS REV: 09/18/09

1. TO SUBMIT A RESPONSIVE BID, READ THESE INSTRUCTIONS, ALL TERMS, CONDITIONS AND SPECIFICATIONS.

2. BID ENVELOPES/PACKAGES/BOXES MUST BE IDENTIFIED ON FRONT, PREFERABLY LOWER LEFT CORNER AND BE VISIBLE WITH THE BID NUMBER AND OPENING DATE. EACH INDIVIDUAL BID (IDENTIFIED BY A UNIQUE BID NUMBER) MUST BE SUBMITTED IN A SEPARATE ENVELOPE. RESPONSES TO MULTIPLE BID NUMBERS SUBMITTED IN THE SAME ENVELOPE/COURIER PACKAGE, THAT ARE NOT IN SEPARATE ENVELOPES PROPERLY IDENTIFIED, WILL BE REJECTED. THE DIVISION OF PURCHASING DOES NOT ASSUME RESPONSIBILITY FOR LATE BIDS FOR ANY REASON INCLUDING THOSE DUE TO POSTAL, OR COURIER SERVICE. BID RESPONSES MUST BE IN THE DIVISION OF PURCHASING OFFICE PRIOR TO THE "RECEIVE DATE AND TIME" INDICATED ON THE BID.

3. BID RESPONSES (PAGE 1, PRICE SHEET AND ADDENDUMS (WHEN SIGNATURE IS REQUIRED)) MUST BE IN INK OR TYPED ON THIS DOCUMENT. OR EXACT FORMAT WITH SIGNATURES BEING HANDWRITTEN ORIGINALS IN INK (PERSON SIGNING BID, NOTARY, AND NOTARY EXPIRATION), OR THE BID WILL BE REJECTED. UNLESS INDICATED IN THE BID, ALL PRICE PAGES MUST BE COMPLETED AND RETURNED. IF AN ITEM IS NOT BEING BID, IDENTIFY IT AS NB (NO-BID). PAGES SHOULD BE SECURED. THE DIVISION OF PURCHASING DOES NOT ASSUME RESPONSIBILITY FOR MISSING PAGES. FAXED BID RESPONSES WILL NOT BE ACCEPTED.

4. THE UNIT PRICE ALWAYS GOVERNS REGARDLESS OF THE EXTENDED AMOUNT. A UNIT PRICE CHANGE ON A LINE MUST BE INITIALED BY THE PERSON SIGNING THE BID, OR THAT LINE WILL BE REJECTED. THIS INCLUDES A CROSS-OUT, STRIKE-OVER, INK-OVER, WHITE-OUT, ERASURE, OR ANY OTHER METHOD CHANGING THE PRICE.

5. A "NO BID" MUST BE RETURNED TO REMAIN ON A CLASS/SUBCLASS. RETURN PAGE 1 OR NOTIFICATION PAGE MARKED "NO-BID". IDENTIFY IT ON THE ENVELOPE AS A "NO-BID". FAILING TO RESPOND TO 3 ITB'S WITHIN THE SAME CLASS/SUBCLASS WILL AUTOMATICALLY PURGE THE VENDOR FROM THAT CLASS/SUBCLASS. RESPONDING WITH 6 "NO-BIDS" WITHIN THE SAME CLASS/SUBCLASS WILL AUTOMATICALLY PURGE THE VENDOR FROM THAT CLASS/SUBCLASS. A "NO-BID" RECEIVED LATE IS CONSIDERED A NO RESPONSE.

6. THE DIVISION OF PURCHASING IS NOT RESPONSIBLE FOR MISINTERPRETATION OF DATA FAXED FROM THIS OFFICE.

7. THE DIVISION OF PURCHASING REQUIRES AN ORIGINAL AND A MINIMUM OF ONE COMPLETE EXACT COPY (TO INCLUDE SIGNATURE AND NOTARY) OF THE INVITATION-TO-BID RESPONSE. THE ORIGINAL AND THE COPY SHOULD BE SUBMITTED TOGETHER AS A BID PACKAGE. FAILURE TO MARK RESPONSES AS "ORIGINAL" AND/OR "COPY" COULD RESULT IN THE ENTIRE BID RESPONSE BEING REJECTED.

8. AN IMPROPERLY SUBMITTED BID, LATE BID, OR BID THAT IS CANCELLED ON OR BEFORE THE OPENING DATE WILL BE HELD FOR 90 DAYS AND THEN DESTROYED. THE BID MUST BE RETRIEVED DURING REGULAR WORK HOURS, MONDAY - FRIDAY, EXCEPT STATE HOLIDAYS. AFTER THE BID IS DESTROYED, THE DIVISION OF PURCHASING ASSUMES NO RESPONSIBILITY FOR THE DOCUMENT.

DISQUALIFIED/CANCELLED BID

BIDS THAT ARE IMPROPERLY SUBMITTED OR RECEIVED LATE WILL BE A RESPONSE FOR RECORD, BUT WILL NOT BE RETURNED OR A NOTIFICATION MAILED.

THE FOLLOWING IS A PARTIAL LIST WHEREBY A BID RESPONSE WILL BE DISQUALIFIED:

BID NUMBER NOT ON FACE OF ENVELOPE/COURIER PACKAGE/BOX
RESPONSES TO MULTIPLE BID NUMBERS IN SAME ENVELOPE NOT PROPERLY IDENTIFIED
BID RECEIVED LATE
BID NOT SIGNED/NOT ORIGINAL SIGNATURE
BID NOT NOTARIZED/NOT ORIGINAL SIGNATURE OF NOTARY AND/OR NO NOTARY EXPIRATION
NOTARIZED OWN SIGNATURE
REQUIRED INFORMATION NOT SUBMITTED WITH BID
FAILURE TO SUBMIT THE ORIGINAL BID AND A COMPLETE EXACT COPY

CERTIFICATION PURSUANT TO ACT NO. 2006-557

ALABAMA LAW (SECTION 41-4-116,CODE OF ALABAMA 1975) PROVIDES THAT EVERY BID SUBMITTED AND CONTRACT EXECUTED SHALL CONTAIN A CERTIFICATION THAT THE VENDOR, CONTRACTOR, AND ALL OF ITS AFFILIATES THAT MAKE SALES FOR DELIVERY INTO ALABAMA OR LEASES FOR USE IN ALABAMA ARE REGISTERED, COLLECTING, AND REMITTING ALABAMA STATE AND LOCAL SALES, USE, AND/OR LEASE TAX ON ALL TAXABLE SALES AND LEASES INTO ALABAMA. BY SUBMITTING THIS BID, THE BIDDER IS HEARBY CERTIFYING THAT THEY ARE IN FULL COMPLIANCE WITH ACT NO. 2006-557, THEY ARE NOT BARRED FROM BIDDING OR ENTERING INTO A CONTRACT PURSUANT TO 41-4-116, AND ACKNOWLEDGES THAT THE AWARDING AUTHORITY MAY DECLARE THE CONTRACT VOID IF THE CERTIFICATION IS FALSE.

INTENT TO AWARD

EFFECTIVE MAY 1, 2008, THE STATE OF ALABAMA - DIVISION OF PURCHASING WILL ISSUE AN 'INTENT TO AWARD' BEFORE A FINAL AWARD IS MADE. THE 'INTENT TO AWARD' WILL CONTINUE FOR A PERIOD OF FIVE (5) CALENDAR DAYS, AFTER WHICH A PURCHASE ORDER WILL BE PRODUCED. UPON FINAL AWARD, ALL RIGHTS TO PROTEST ARE FORFEITED. A DETAILED EXPLANATION OF THIS PROCESS MAY BE REVIEWED IN THE ALABAMA ADMINISTRATIVE CODE - CHAPTER 355-4-1(14).

ALTERNATE BID RESPONSE

UNLESS STATED ELSEWHERE IN THIS INVITATION-TO-BID (ITB) THE STATE OF ALABAMA WILL ACCEPT AND EVALUATE ALTERNATE BID SUBMITTALS ON ANY ITB'S. ALTERNATE BID RESPONSES WILL BE EVALUATED ACCORDING TO THE REQUIREMENTS AS ALL OTHER RESPONSES TO THIS ITB.

INTERNET WEBSITE LINK'S

INTERNET AND/OR WEBSITE LINKS WILL NOT BE ACCEPTED IN BID RESPONSES AS A MEANS TO SUPPLY ANY REQUIREMENTS STATED IN THIS ITB (INVITATION-TO-BID).

PRODUCT DELIVERY, RECEIVING AND ACCEPTANCE

IN ACCORDANCE WITH THE UNIVERSAL COMMERCE CODE (CODE OF ALABAMA, TITLE 7), AFTER DELIVERY, THE STATE OF ALABAMA HAS THE RIGHT TO INSPECT ALL PRODUCTS BEFORE ACCEPTING. THE STATE WILL INSPECT PRODUCTS IN A REASONABLE TIMEFRAME. SIGNATURE ON A DELIVERY DOCUMENT DOES NOT CONSTITUTE ACEPTANCE BY THE STATE. THE STATE WILL ACCEPT PRODUCTS ONLY AFTER SATISFACTORY INSPECTION.

SALES TAX EXEMPTION

PURSUANT TO THE CODE OF ALABAMA, 1975, TITLE 40-23-4 (A) (11), THE STATE OF ALABAMA IS EXEMPT FROM PAYING SALES TAX. AN EXEMPTION LETTER WILL BE FURNISHED UPON REQUEST.

INVOICES

INQUIRIES CONCERNING PAYMENT AFTER INVOICES HAVE BEEN SUBMITTED ARE TO BE DIRECTED TO THE RECEIVING AGENCY, NOT THE DIVISION OF PURCHASING

BID RESPONSES AND BID RESULTS

UNEVALUATED BID RESPONSES (NOT BID RESULTS) ARE AVAILABLE ON OUR WEB SITE AT WWW.PURCHASING.ALABAMA.GOV. BID RESULTS WILL BE MADE AVAILABLE FOR REVIEW IN THE DIVISION OF PURCHASING OFFICE, BUT ONLY AFTER THE BID HAS BEEN AWARDED. WE DO NOT FAX OR MAIL COPIES OF BID RESULTS. IF A VENDOR WISHES TO REVIEW BID RESULTS IN OUR OFFICE, THEY SHOULD FAX THEIR REQUEST TO REVIEW THE BID TWO DAYS IN ADVANCE TO THE "BID REVIEW CLERK" AT (334) 242-4419. BE SURE TO REFERENCE THE BID NUMBER.

FOREIGN CORPORATION - CERTIFICATE OF AUTHORITY

ALABAMA LAW PROVIDES THAT A FOREIGN CORPORATION (AN OUT-OF-STATE COMPANY/FIRM) MAY NOT TRANSACT BUSINESS IN THE STATE OF ALABAMA UNTIL IT OBTAINS A CERTIFICATE OF AUTHORITY FROM THE SECRETARY OF STATE. SECTION 10-2B-15.01, CODE OF ALABAMA 1975. TO OBTAIN FORMS FOR A CERTIFICATE OF AUTHORITY, CONTACT THE SECRETARY OF STATE, CORPORATIONS DIVISION, (334) 242-5324. THE CERTIFICATE OF AUTHORITY DOES NOT KEEP THE VENDOR FROM SUBMITTING A BID.

BID IDENTIFICATION

REFERENCE PAGE 2, ITEM 2. DUE TO THE POSTAL SERVICE PUTTING BAR CODE LABELS ON ENVELOPES, IT CONCEALS THE BID NUMBER AND DATE IF THE VENDOR HAS WRITTEN THEM OTHER THAN THE LOWER LEFT CORNER, THEREFORE THE BID WOULD BE REJECTED FOR NOT BEING PROPERLY IDENTIFIED.

****

AWARD:
THE AWARD SHALL BE MADE TO THE LOWEST RESPONSIBLE BIDDER MEETING ALL SPECIFICATIONS.

CONTRACT PERIOD:
ESTABLISH A 36 MONTH CONTRACT WITH AN OPTION TO EXTEND FOR A FOURTH, AND FIFTH 12 MONTH PERIOD WITH THE SAME PRICING, TERMS AND CONDITIONS. THE FOURTH, OR FIFTH 12 MONTH PERIOD, IF AGREED BY BOTH PARTIES, WOULD BEGIN THE DAY AFTER THE FIRST, 36 MONTH PERIOD EXPIRES. ANY SUCCESSIVE EXTENSION MUST HAVE WRITTEN APPROVAL OF BOTH THE STATE AND VENDOR NO LATER THAN 30 DAYS PRIOR TO EXPIRATION OF THE PREVIOUS 12 MONTH PERIOD.

NON-APPROPRIATION OF FUNDS:
CONTINUATION OF ANY AGREEMENT BETWEEN THE STATE AND A BIDDER BEYOND A FISCAL YEAR IS CONTINGENT UPON CONTINUED LEGISLATIVE APPROPRIATION OF FUNDS FOR THE PURPOSE OF THIS BID AND ANY RESULTING AGREEMENT. NON-AVAILABILITY OF FUNDS AT ANY TIME SHALL CAUSE ANY AGREEMENT TO BECOME VOID AND UNENFORCEABLE AND NO LIQUIDATED DAMAGES SHALL ACCRUE TO THE STATE AS A RESULT. THE STATE WILL NOT INCUR LIABILITY BEYOND THE PAYMENT OF ACCRUED AGREEMENT PAYMENT.

PRORATION:
ANY PROVISION OF A CONTRACT RESULTING FROM THIS BID TO THE CONTRARY NOTWITHSTANDING, IN THE EVENT OF FAILURE OF THE STATE TO MAKE PAYMENT HEREUNDER AS A RESULT OF PARTIAL UNAVAILABILITY, AT THE TIME SUCH PAYMENT IS DUE, OF SUCH SUFFICIENT REVENUES OF THE STATE TO MAKE SUCH PAYMENT (PRORATION OF APPROPRIATED FUNDS FOR THE STATE HAVING BEEN DECLARED BY THE GOVERNOR PURSUANT TO SECTION 41-4-90 OF THE CODE OF ALABAMA 1975), THE CONTRACTOR SHALL HAVE THE OPTION, IN ADDITION TO THE OTHER REMEDIES OF THE CONTRACT, OF RENEGOTIATING THE CONTRACT (EXTENDING OR CHANGING PAYMENT TERMS OR AMOUNTS) OR TERMINATING THE CONTRACT.

VENDOR NAME :

VENDOR NUMBER: -
ITB NO. : 10-X-2212639
OPEN DATE : 11/03/09 TIME: 10:00 AM
T-NUMBER : TA139
RETURN DATE: 11/02/09 TIME: 5:00 PM

THIS IS A RE-BID OF INVITATION TO BID 10-X-2193986. ONLY THOSE VENDORS THAT ATTENDED THE PRE-BID CONFERENCE FOR ITB 10-X-2193986 WILL BE ALLOWED TO SUBMIT A BID ON THIS INVITATION TO BID.

PRICE SHEET

INVITATION TO BID

VENDOR NAME :

VENDOR NUMBER: -
ITB NO. : 10-X-2212639
OPEN DATE : 11/03/09 TIME: 10:00 AM
T-NUMBER : TA139
RETURN DATE: 11/02/09 TIME: 5:00 PM

LINE NO.	COMMODITY/SERVICE DESCRIPTION	QUANTITY	UNIT	UNIT PRICE	EXTENDED AMOUNT
	UNLESS SPECIFIED OTHERWISE BELOW: SHIP TO: R1 / STATEWIDE				
00001	COMMODITY CODE: 961-54-085548 MATERNITY CARE SERVICES FOR THE ALABAMA MEDICAID AGENCY. DISTRICT EIGHT. THE CEILING PRICE FOR DISTRICT 8 IS $2268.00. ANY BID OVER THIS AMOUNT WILL NOT BE ACCEPTED.	1	LT	_____	_____

PAGE TOTAL _____

BID TOTAL _____

ALABAMA MEDICAID AGENCY
MATERNITY CARE PROGRAM
INVITATION TO BID (ITB)

Bid Number

10-X-2212639

Agency Contact:
Nancy Headley
Alabama Medicaid Agency
P.O. Box 5624
501 Dexter Avenue
Montgomery, Al 36103-5624
Email: Nancy.Headley@medicaid.alabama.gov
(334)-242-5584 Phone
(334)-353-4818 Fax

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F 2. Alabama Medicaid Administrative Code, 560-X-45
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H. Attachment 4.19-B of the State Plan
I. Maternity Care Program Operational Manual
J. Alabama Medicaid Administrative Code, 560-X-6-.09

ALABAMA MEDICAID AGENCY
MATERNITY CARE PROGRAM
INVITATION TO BID (ITB)

SECTION 1 INTRODUCTION TO PROCUREMENT

1.0 PURPOSE

The Alabama Medicaid Agency, hereinafter called Medicaid, an Agency of the State of Alabama, hereby solicits bids for the procurement of Maternity Care Services through a Primary Contractor in each specific geographic areas defined by this ITB. Services required are outlined throughout this ITB. The Primary Contractor shall provide methods and procedures to safeguard against unnecessary utilization of care and services to assure efficiency, economy and quality of care as required by law pursuant to section 1902 (a) (30) of the Social Security Act (ACT).

The Primary Contractor to whom a contract is awarded shall be responsible for the performance of all duties contained within this ITB for the firm and fixed price quoted in Primary Contractor's bid to this ITB. All bids must state a firm and fixed price for the services described.

The Primary Contractor will be responsible for implementation and coordination of a comprehensive maternity care delivery system with the exception of the inpatient hospital component that meets the needs of the Medicaid recipients as described within this ITB within specified geographic districts of the State of Alabama.

1.1 GENERAL ITB REQUIREMENTS

Medicaid will enter into one contract for each of the 14 geographical districts for a three year period commencing January 1, 2010 through December 31, 2012. The boundaries of the districts are described in Section, 2.3. Medicaid shall have two one-year options for extending this contract at the original contract price. Such option shall be exercised by written notice to the Contractor within 90 days prior to the termination date of the contract or any extension. The bid response must present a complete and detailed description of the bidder's qualifications to perform, and its approach to carry out the requirements of this ITB.

Successful bidders will act as Primary Contractors to provide a network of maternity services for all Medicaid recipients eligible for the Medicaid Maternity Care Program in the specified district.

All proposals must be received by the State of Alabama's Department of Finance, Division of Purchasing as specified in the Schedule of Activities.

1.2 PROJECT MANAGER

The individual designated by this bid to coordinate activities, resolve questions, monitor Contractor performance, ensure that all contract requirements are met, approve payments and act as Medicaid contact for the Contractor is:

Nancy Headley, Director
Maternity Care Program
Alabama Medicaid Agency
P.O. Box 5624
501 Dexter Avenue
Montgomery, Al 36103-5624
Email: Nancy.Headley@medicaid.alabama.gov
(334)-242-5684 Telephone
(334)-353-4818 Fax

1.3 SCHEDULE OF ACTIVITIES

The schedule of activities for this bid process is listed below. All dates are estimated and are subject to change. All times are central time (CT).

Bid Released	10/16/2009
Pre-Bid Questions Due	10/21/2009 5:00 p.m.
Responses to Final Questions	10/23/2009 5:00 p.m.
Bids Due	11/02/2009 5:00 p.m.
Bids Opened	11/03/2009 10:00 a.m.
Contract Award	11/06/2009
Contract Start Date	01/01/2010
Program Start Date	01/01/2010

1.4 BIDDER QUALIFICATIONS

General

This document outlines the qualifications which must be met in order for an entity to serve as a Primary Contractor. Medicaid solicits bids from persons/entities interested in serving as Maternity Primary Contractors. Any entity wishing to serve as a Primary Contractor must submit a written response to the invitation to bid for participation. A separate bid must be submitted for each bid district. Each bid submission must be complete and stand on its own. It is acceptable for a potential Primary Contractor to create a common management or administrative infrastructure that would serve more than one

district. Any such arrangement must be described and the functions must be satisfied for each bid.

Bids will be evaluated based on price and responsiveness to the bid specifications. All bids shall become the property of Medicaid.

It is imperative that the bidder (potential Contractors) describe **in detail** how it intends to approach the provision of all aspects of care specified in the ITB. The ability to perform these services must be carefully documented, even if the bidder has been or is currently participating in a Medicaid Program. Bids will be evaluated based on the written information that is presented in the bid and nothing else. This underscores the importance and the necessity of providing in-depth information in the bid with all supporting documentation necessary.

The bidder must demonstrate, in the bid, a thorough working knowledge of program policy requirements as described in these ITB specifications, including but not limited to the applicable Operational Manuals, State Plan for Medical Assistance, Administrative Code requirements and Code of Federal Regulations (CFR) requirements.

Entities that are currently excluded under federal and/or state laws from participation in Medicare/Medicaid or any State's health care programs are prohibited from submitting bids.

Bidders must:

a. Have all necessary business licenses, registrations and professional certifications at the time of the contracting to be able to do business in Alabama. Alabama law provides that a foreign corporation (an out-of-state company/firm) may not transact business in the state of Alabama until it obtains a Certificate of Authority from the Secretary of State, Section 10-2B-15.01, et seq., Code of Alabama 1975. To obtain forms for a Certificate of Authority, contact the Secretary of State, Corporations Division, (334) 242-5324, www.sos.state.al.us. The Certificate of Authority or a letter/form showing application has been made for a Certificate of Authority must be submitted with the bid.

b. Have demonstrated experience working with the provision of maternity care.

c. Be fiscally sound and possess adequate financial reserves.

d. Be organized primarily for the purpose of providing health care services.

e. Have the administrative capability to accept and pay claims.

f. Be able to provide reports to the state on utilization, expenses and quality

measures.

g. Possess an adequate provider network with proper credentialing and geographic coverage.

1.5 PRE-BID QUESTIONS

Pre-bid questions are intended to be an informal, interactive exchange of information. It is the opportunity to ask questions to clarify any uncertainties that exist.

Questions related to this solicitation must be directed, in writing, to the Project Manager. Bidders cannot contact or ask questions of other Medicaid staff. Contact with or questioning of Medicaid staff to obtain information about this ITB other than written inquiries to the Project Manager shall result in the rejection of the bid.

Questions must be received by the dates specified in the Schedule of Activities**. Questions received after this date cannot be considered.** Questions may be submitted hard copy via regular mail, fax, or by email. Questions pertaining to this solicitation should specifically reference the page and paragraph numbers in the ITB to which the question refers. Vague or non-specific questions may be returned to bidders for clarification. Medicaid must receive all clarifications by the deadline dates.

1.6 AMENDMENTS TO BID

Amendments may be issued subsequent to the issue date of this ITB. Receipt of ITB amendments must be acknowledged by the potential bidder by signing and returning the signature page of the amendment to Medicaid. **A copy of acknowledgements must also be returned as a part of the bidder's proposal.**

1.7 BID REJECTION

Notwithstanding any other provision of this solicitation, Medicaid expressly reserves the right to:

a. Reject any or all bids, or portions thereof;
b. Reissue the ITB and/or;
c. Cancel all or part of this procurement

1.8 BID SUBMISSION REQUIREMENTS

General

a. All bids must be submitted in accordance with the requirements of the Department of Finance, Division of Purchasing of the State of Alabama.

b. Each bid must include a guarantee in the amount of $5000 payable to the State of Alabama. This bid guarantee ensures a firm bid for contracting purposes for 90 calendar days after the bid due date. Bid guarantees provided by unsuccessful bidders will be returned after 90 calendar days. The form of the bid guarantee shall be one of the following:
(1) Cashier's check (personal or company checks are not acceptable)

(2) Other type of bank certified check

(3) Money order

(4) Surety bond issued by a company authorized to do business within the State of Alabama

(5) An irrevocable letter of credit

c. Bids must be submitted with the following:
(1) One original and three original-quality copies under sealed cover

(2) One CD in Word 6.0 or later version format containing bid response. Attachments may be submitted in PDF or similar formats.

d. Sealed bid packages may be mailed or hand delivered and must be received by the date and time in the Schedule of Activities to:

State of Alabama
Department of Finance
Division of Purchasing
RSA Union Building
100 N. Union Street
Suite 192
Montgomery, AL 36130-2401
Attention: Bernie Arant

e. The outside cover of the package containing the bid shall be marked as follows:

Maternity Care Program
ITB #10-X-2212639
Bid Opening Date: November 3, 2009

Proposed Contract Award:	November 6, 2009
Contract Start Date:	January 1, 2010
Maternity District Being Bid:	District 8

f. Bids submitted in whole or part by email or fax will be rejected.

g. Bids submitted after the deadline listed in the Schedule of Activities will be rejected. It is the responsibility of the bidder to ensure the bid is delivered by the time specified.

h. Each bid must contain a technical and price bid. The technical component should present a complete and detailed description of the bidder's qualifications to perform and its approach to carry out the requirements in the Scope of Work of this ITB. Technical components will be evaluated by Medicaid on a Pass-Fail basis.

i. The bid price is a firm and fixed price for the requirements of this ITB. The bid price must appear on the Division of Purchasing pricing page. The successful bidder in each district will be paid a global fee per delivery. The global fee will be payment in full for all services, duties, and administrative requirements as specified in the ITB. This fee will not be cost settled or modified and therefore should be considered as a firm and fixed bid price. . High risk reimbursement is described further in Section 2.7., Reimbursement.

j. If the bid does not contain a firm and fixed price for each delivery then the bid will not be considered to meet bid submission requirements.

k. Numbers and estimates provided in this ITB are informational only and do not represent a binding agreement or guarantee by Medicaid.

l. Bidders are to submit a single price per district for a global delivery. In paying individual claims, those figures will be reduced by 20% for persons who only receive services at the time of delivery and during the postpartum period. Refer to Maternity Care Operational Manual for details.

m. As part of the firm and fixed price submission, bidders must include details to support the development of their price bid including the amounts/percentages of the bid to be spent on each component.

1.9 BID SUBMISSION FORMAT

Bids must demonstrate the ability to meet <u>all</u> program requirements. Failure to address <u>any of the required bid specifications will result in the bid not meeting the responsiveness requirement. Bids not deemed responsive will not</u>

be considered.

Bids submitted without all forms and attachments required by the Division of Purchasing will be rejected.

a. Contents:
Each bid (including all copies thereof) shall be; 1) clearly sequentially numbered on the bottom (center) of each page; 2) submitted in three-ring binders; and 3) use 8.5 x 11-inch paper, two-sided copies, and a type font size of 11 points or larger.

b. Presentation:
Program specifics and descriptive information must be inserted as appropriate. All attachments including flowcharts, provider subcontracts, and copies of other program information should be properly identified. Brochures or other presentations, beyond that sufficient to present a complete and effective bid, are not desired. Audio and/or videotapes are not allowed. Elaborate artwork or expensive paper is not necessary or desired.

c. Page Length**:**
Economy in preparation is encouraged. Additional credit is not given for extra description beyond that which is necessary. Bids must be within a 50 (front and back for a total of 100) page limit, with up to an additional 50 (front and back for a total of 100) pages as necessary for attachments. NOTE: The transmittal letter and its attachments are not considered in the page limits.

d. Bid Organization**:**
(1) The bid must contain an Executive Summary of no more than three pages and should provide a brief overview of the history of the organization submitting the bid, experience of the entity, and proposed administration.

(2) The bid must contain a cover sheet/transmittal letter (refer to Section 1.13) which identifies a contact person for the bid including full name, title, address, telephone number, e-mail address and fax number. All correspondence regarding the bid will be directed to this individual.

(3) Bids must be organized following the outline specified in Section 1.12. Medicaid will use the outline as a checklist to perform its first overall evaluation of the bid submitted, prior to a more in-depth evaluation. It is permissible to copy Medicaid forms if required.

(4) Medicaid discourages submission of bids that contain erasures, modifications or interlineations. Bids should be in final format at the time of submission. An authorized representative must initial erasures,

interlineations or other modifications of the bid in original ink.

1.10 BID OPENING

Bid openings will be conducted at the office of the Purchasing Director, Suite 192, RSA Union Building, 100 N. Union Street, Montgomery, Alabama based upon the date in the Schedule of Activities. Bid openings will be conducted by Purchasing in accordance with its policies and procedures.

1.11 WITHDRAWAL OF BID

A bid may be withdrawn at any time prior to the bid opening by submitting a withdrawal in writing signed by a person with appropriate authority. The withdrawal must be sent to the person at the address listed in 1.8 d.

1.12 TECHNICAL SPECIFICATIONS FORMAT

The bid must include six separate sections following the Department of Purchasing bid sheet with named tabs presented in the following order:

a. Transmittal Letter

b. Table of Contents

c. Executive Summary

d. Work plan for various required components

e. Sample subcontracts for each subcontracting entity (e.g. physician)

f. Appendices, including references

1.13 TRANSMITTAL LETTER

The Transmittal Letter is a cover letter addressed to Medicaid and the Division of Purchasing. It must include the following information:

a. Identification of all materials and enclosures being submitted collectively as the bid in response to this ITB.

b. Amendments may be issued subsequent to the issue date of this ITB. Receipt of ITB amendments, made by Medicaid, must be acknowledged by the potential bidder by signing and returning the signature page of the amendment to Medicaid. **A copy of acknowledgements must also be returned as a part of the bidder's proposal**.

c. Identification of the bidder that will be the Primary Contractor and the name of the corporation or other legal entity submitting the bid. The bidder must assume sole and exclusive responsibility for all of the contract responsibilities and work indicated in the ITB (including any and all addenda). Any effort to limit or qualify this responsibility, or assign any responsibility to a subcontractor will result in the bid being rejected as non-responsive to the bid requirements. Bidder must use this section to state whether it is a: partnership, non-profit corporation, Alabama corporation, non-Alabama corporation or some other structure.

d. A statement of compliance with Affirmative Action and Equal Employment Opportunity regulations that confirms that the bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, developmental disability, political affiliation, national origin, or handicap, and complies with all applicable provisions of Public Law 101-336, Americans with Disabilities Act of 1990.

e. A statement acknowledging and agreeing to all of the rights of Medicaid contained in the provisions of this ITB.

f. A statement that the bidder understands and will comply with all of the provisions of the ITB.

g. A statement that the prices proposed have been arrived at independently without consultation, communication, or agreement with any other bidder or competitor involved in the procurement for this contract.

h. A statement that the bidder, through its duly authorized representatives, has in no way entered into any arrangement or agreement with any other bidder or competitor which could lessen or destroy free competition in awarding the contract sought by the attached bid.

i. A statement that, unless otherwise required by law, the prices quoted must not be knowingly disclosed by the bidder, directly or indirectly, prior to award of the contract, to any other bidder, competitor or any other person or entity.

j. A statement that the bidder has not and will not make any attempt to induce any other person or firm to withhold or submit a bid for the purposes of restricting competition.

k. A statement that the person signing this bid is authorized to make decisions on behalf of the bidder's organization as to the prices quoted.

l. A statement that no person or agency has been employed or retained to

solicit or secure the proposed contract based on an agreement or understanding for a commission, percentage, brokerage, or contingent fee.

m. A statement that the bidder and its subcontractors will maintain a drug-free workplace.

n. A statement acknowledging that the successful bidder will be required to complete a financial disclosure statement and Health Insurance Portability and Accountability Act (HIPAA) business associate agreement with the executed contract. See Attachments A, B, and C.

o. A statement that Federal Funds have not been used for lobbying to obtain the contract.

p. A statement that the bidder will not disenroll recipients except pursuant to Operation Manual V.D.

1.14 SUBCONTRACTS

The contract shall not be assigned without written consent of Medicaid. Contractor may subcontract for the professional services necessary for the completion and maintenance of this contract and for the performance of its duties under this contract with advance written approval of both the subcontracted function and the subcontractor by Medicaid. Subcontractors shall demonstrate the capability to perform the function to be subcontracted at a level equal or superior to the requirements of the contract relevant to the service to be performed. All subcontracts shall be in writing, with the subcontractor functions and duties clearly identified, and shall require the subcontractor to comply with all applicable provisions of this ITB. Contractor shall at all times remain responsible for the performance by subcontractors approved by Medicaid. The use of subcontractors does not in any way relieve the Primary Contractor from its responsibilities under this ITB and/or contract. Contractor's performance guarantee and Contractor's responsibility for damages shall apply whether performance or non-performance was by Contractor or one of its subcontractors. Medicaid shall not release Contractor from any claims or defaults of this contract which are predicated upon any action or inaction or default by any subcontractor of Contractor, even if such subcontractor was approved by Medicaid as provided above. Contractor shall give Medicaid notice in writing by registered mail of any action or suit made against Contractor by any subcontractor or vendor, which, in the opinion of Contractor, may result in litigation related in any way to this contract with the State of Alabama.

If the use of subcontractors is necessary to meet bid requirements, the Letter of Intent to Contract (Attachment E) from each subcontractor, shall be attached

to the Transmittal Letter, signed by an individual authorized to legally bind the subcontractor to perform the scope of work as assigned, stating:

a. The general scope and volume of work to be performed by the subcontractor.

b. The subcontractor's willingness to perform the work indicated.

c. The names and titles of individuals who will be responsible for the subcontractor's efforts.

d. The rate or methodology (if a varying rate is to be paid) of reimbursement to be received for the subcontractor's efforts.

e. Contractor shall comply with Title VI of the Civil Rights Act of 1964 42 USC §2000d, et seq.), Section 504 of the Rehabilitation Act of 1973 (29 USC §6101, et seq.) and the Americans with Disabilities Act of 1990 (42 USC §2101, et seq.), and the regulations issued there under by the Department of Health and Human Services (45 CFR Parts 80, 84 and 90). No individual shall, on the ground of race, sex, color, creed, national origin, age or disability be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program of services.

1.15 DEVIATIONS

Program Requirements/Scope of Work

Any bid which deviates, in any way whatsoever, from the detailed specifications and requirements in the ITB, shall explicitly identify and explain these deviations in the Transmittal Letter. Medicaid reserves the right, in its sole discretion, to reject any bid containing such deviations or to require clarifications before acceptance.

Contract Terms and Conditions

Bidders shall not place any qualification, exceptions, conditions, reservations, limitations, or substitutions in their bid concerning the contract terms and conditions. Any such qualifications, exceptions, conditions, reservations, limitations or substitutions shall result in rejection of the bid.

1.16 EVALUATION OF BIDS

In accordance with the law of the State of Alabama, bids will be evaluated as follows:

a. The Director of Purchasing will review each bid to determine if it meets submission requirements. Bids not meeting said requirements will be rejected.

b. All bids meeting submission requirements will be forwarded to Medicaid for evaluation of technical specifications.

c. Medicaid will review the low price bid to determine if technical requirements are met.

d. If the low price bid does not meet technical requirements, Medicaid will evaluate the next lowest price bid.

e. The State reserves the right to reject any and all bids.

f. In evaluating a bid, Medicaid reserves the right to request clarification from bidders for information provided in the bid for the purpose of determining responsibility of the bidder and responsiveness to the technical bid requirements.

g. Bidders will be notified of their status by the Division of Purchasing pursuant to its policies and procedures.

1.17 PREBID CONFERENCE

Reserved

1.18 RIGHTS OF MEDICAID

This ITB does not commit the State of Alabama to award a contract, or pay any cost incurred in the preparation of the bid to this ITB. Medicaid reserves the right to reject all bids and at its discretion may withdraw or amend this ITB at any time. Medicaid may by written notice revise and amend the ITB prior to the due date for the bid. If, in the opinion of Medicaid, revisions or amendments will require substantive changes in the ITB, the due date may be extended at the sole discretion of Medicaid.

SECTION 2 PROGRAM REQUIREMENTS AND SPECIFICATIONS

2.0 PURPOSE

The successful bidder shall be responsible for implementation and coordination of a comprehensive maternity care delivery system that can meet the needs of all eligible Medicaid recipients within its district. The successful bidder's delivery system will not include the inpatient hospital component. The inpatient hospital will be outside of the global contractor reimbursement for maternity care. The mission of the program is to provide for the best possible birth outcome. This is accomplished through a coordinated system, augmented with case management and with an emphasis on quality.

2.1 AGENCY OVERVIEW

The Alabama Medicaid Agency is responsible for administration of the Alabama Medicaid Program under a federally approved State Plan for Medical Assistance. The mission of the Agency is to serve eligible, low income Alabamians by efficiently and effectively financing medical services in order to ensure patient-centered, quality focused health care. This goal is accomplished by providing a system, which facilitates access to necessary and high quality preventive care, acute medical services, long term care, health education, and related social services. Through teamwork, the Agency strives to operate and enhance a cost efficient system by building an equitable partnership with health care providers, both public and private.

Medicaid's central office is located at 501 Dexter Avenue, Montgomery, Alabama 36104 (mailing address is P.O. Box 5624, Montgomery, Al 36103-5624). The majority of Medicaid's budgeted administrative positions are located at this site. The central office personnel are responsible for data processing, program management, financial management, program integrity, general support services, professional services, and recipient eligibility services. For certain recipient categories, eligibility determination is made by Medicaid personnel located throughout the State.

2.2 THE MATERNITY CARE PROGRAM

The Program has been operational since 1988. Program authority through the years has been through the 1915 (b) waiver process and state plan authority. Medicaid will operate the program under the 1915 (b) waiver authority for this contract period. This authority allows the state to require pregnant women to receive their care through specified networks. Refer to Section 2.3 for a table of

statewide expenditures paid to Primary Contractors.

2.3 DISTRICTS AND ELIGIBLES

Maternity Care Program Districts

For purposes of this ITB, the state has been divided into fourteen separate districts. The table below contains the district division and FY 08 delivery counts by county for each district. The numbers are provided as estimates of the number of deliveries to be expected under this contract period. NOTE: Not all deliveries may be reflected due to a lag time in filing claims.

District	Counties	FY 2008 Deliveries	
District 1	Colbert	355	
	Franklin	204	
	Lauderdale	505	
	Marion	201	
	*Others	18	
District 2	Jackson	309	
	Lawrence	215	
	Limestone	373	
	Madison	1594	
	Marshall	599	
	Morgan	660	
	*Others	44	
District 3	Calhoun	907	
	Cherokee	134	
	Cleburne	111	
	Dekalb	428	
	Etowah	639	
	*Others	39	
District 4	Bibb	147	
	Fayette	118	
	Lamar	113	
	Pickens	143	
	Tuscaloosa	1098	
	*Others	35	

District 5	Blount	272	
	Chilton	268	
	Cullman	459	
	Jefferson	3882	
	St. Clair	507	
	Shelby	466	
	Walker	463	
	Winston	159	
	*Others	131	
District 6	Clay	77	
	Coosa	67	
	Randolph	147	
	Talladega	629	
	Tallapoosa	274	
	*Others	28	
District 7	Greene	76	
	Hale	133	
	*Others	5	
District 8	Choctaw	103	
	Marengo	168	
	Sumter	114	
	*Others	8	
District 9	Dallas	525	
	Perry	115	
	Wilcox	119	
	*Others	15	
District 10	Autauga	310	
	Bullock	111	
	Butler	199	
	Crenshaw	103	
	Elmore	405	
	Lowndes	113	
	Montgomery	1869	
	Pike	235	
	*Others	47	
District 11	Barbour	172	
	Chambers	257	
	Lee	680	
	Macon	149	
	Russell	410	
	*Others	19	

District 12	Baldwin Clarke Conecuh Covington Escambia Monroe Washington *Others	955 181 110 284 344 193 85 33	
District 13	Coffee Dale Geneva Henry Houston *Others	262 316 209 73 777 15	
District 14	Mobile *Others	3542 23	
TOTAL		30616	

Based on Medicaid paid deliveries

*Others are deliveries for recipients from other counties but delivered or paid by this district.

Recipients to be Served

a. The following Medicaid recipients who are pregnant are required to participate in the Maternity Care Program:

(1) Those certified through the SOBRA (Sixth Omnibus Budget Reconciliation Act) Program with the exception of Department of Youth Services recipients identified with County Code 69.

(2) Those certified through the Medicaid for Low Income Families Program

(3) Refugees

(4) Supplemental Security Income (SSI) eligible women

b. The following Medicaid recipients are not required to participate and should not be enrolled:

(1) Dual eligible (Medicare/Medicaid)

(2) Individuals granted emergency Medicaid due to their illegal alien status

Recipients are notified at the time of Medicaid application of the requirement to participate in the program. Additionally, Primary Contractors are required to have an outreach plan in their district to inform women of program requirements.

2.4 MATERNITY CARE PROGRAM ADMINISTRATION

The bid must address the bidder's approach to complying with each program requirement. Complete program details are included in the Maternity Care Program Operational Manual referred to as Operational Manual (Attachment I). Bidders must review the Operational Manual in detail to gain a complete understanding of program requirements. In addition, bidders are encouraged to review the Administrative Code (www.medicaid.alabama.gov); Code of Federal Regulations (www.access.gpo.gov); and the Medicaid Provider Billing Manual (www.medicaid.alabama.gov) prior to completing their bid to ensure that all program requirements are understood and can be met. The bid must explain how the requirements set forth will be met including examples where appropriate.

STANDARDS FOR PRIMARY CONTRACTORS (please refer to the Maternity Care Program Operational Manual for complete details on each standard)

a. Must demonstrate the capacity to serve the pregnant Medicaid population in the designated geographical area.

b. Must procure a network of subcontractors within 50 miles of all areas in their district. This is determined through the ITB evaluation process using letters of intent from all subcontractors (which must list sites where they are located).

c. Must designate a Director or other designee to be available, accessible, and/or on call at all times for any administrative and/or medical problems which may arise.

d. Must require subcontractors providing direct care to be on call or make provisions for medical problems 24-hours per day, seven days per week.

e. Must require that all persons, including employees, agents, and subcontractors acting for or on behalf of the Primary Contractor, be properly licensed under applicable state laws and/or regulations.

f. Must comply with certification and licensing laws and regulations applicable to the Primary Contractors' practice, profession or business. The Primary Contractor agrees to perform services consistent with the customary standards of practice and ethics in the medical profession. The Primary

Contractor agrees not to knowingly employ or subcontract with any health provider whose participation in the Medicaid and/or Medicare Program, or SCHIP is currently suspended or has been terminated by Medicaid and/or Medicare or SCHIP. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP except for emergency services.

g. Must require that network provider's offer hours of operation to Medicaid recipients that are not less than the hours of operation to other patients.

h. Must comply with all State and Federal regulations regarding family planning services, including that an enrollee will not be restricted in freedom of choice of providers of family planning services.

i. Must require subcontractors providing direct services to meet the requirements of and enroll as Medicaid providers as applicable.

j. Must cooperate with external review agents who have been selected by the State to review the program.

k. Must report suspected fraud and abuse to Medicaid. The report must include the number of complaints of fraud and abuse made to the Primary Contractor that warrant an investigation. If an investigation is warranted, the Primary Contractor must supply the name, identification number, source of the complaint, type of provider, nature of complaint, approximate dollars involved and legal and administrative disposition of the case.

l. Must prohibit discrimination against recipients based on health status or need for health services.

m. Must comply with the requirements of 42 CFR 438.224 in confidentially handling health and enrollment information.

n. Must comply with the requirements of 42 CFR Part 438 (Attachment G).

o. Must comply with the applicable requirements of Alabama Medicaid Administrative Code, 560-X-37 (Attachment F1)and 560-X-45. (Attachment F2).

p. The Primary Contractor is not required to provide, reimburse payment, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds in accordance with 42 CFR 438.102(a)(2).

q. If the Primary Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service, because of an objection on moral or religious grounds, it must furnish information about the services it

does not cover as follows:

- to the State,
- with its application for a Medicaid contract,
- whenever it adopts such policy during the term of the contract; and
- it must be consistent with the provisions of 42 C.F.R. 438.10,
- it must be provided to potential enrollees before and during enrollment,
- it must be provided to enrollees within 90 days after adopting the policy with respect to any particular service.

FUNCTIONS/RESPONSIBILITIES OF PRIMARY CONTRACTORS (please refer to the Operational Manual for complete details on each standard)

a. Provide the pregnant Medicaid eligible population obstetrical care through a comprehensive system of quality care. The care can be provided directly or through subcontracts. The successful bidder's delivery system will not include the hospital component. The hospital will be outside of the global contractor reimbursement for maternity care.

b. Implement and maintain the Medicaid approved quality assurance improvement system by which access, process and outcomes are measured.

c. Provide Application Assister services to Medicaid recipients.

d. Utilize proper tools and service planning for women assessed to be at risk medically or psychosocially.

e. Provide recipient choice among delivering health care professionals.

f. Meet all requirements of the Provider Network, including but not limited to, maintaining written subcontracts, notifying Medicaid of any changes in the network, and maintaining a network of providers to meet program requirements.

g. Maintain a toll-free line and designated staff to enroll recipients and provide program information.

h. Develop, implement and maintain an extensive recipient education plan.

i. Develop, implement and maintain a provider education plan.

j. Develop, implement and maintain an effective outreach plan to make providers, recipients and the community aware of the purpose of the Maternity Care Program and the services offered.

k. Develop, implement and maintain an educational program explaining how

to access the Maternity Care Program including service locations.

l. Develop, implement and maintain a grievance procedure that is easily accessible and that is explained to recipients upon entry into the system.

m. Develop, implement and maintain a system for handling billing inquiries from recipients and subcontractors so that inquiries are handled in a timely manner.

n. Maintain a computer based data system that collects, integrates, analyzes and reports recipient information.

o. Give Medicaid immediate notification, by telephone and followed in writing, of any action or suit filed and prompt notice of any claim made against the Primary Contractor by any subcontractor which may result in litigation related in any way to this contract. In the event of the filing of a petition for bankruptcy by or against any subcontractor or the insolvency of any subcontractor, the Primary Contractor must ensure that all tasks related to any subcontractor are performed in accordance with the Terms of the Agreement.

p. Maintain for each recipient a complete record at one location of all services provided. The Primary Contractor shall obtain such information from all providers of services and identify by recipient name, recipient number, date of service, and services provided prior to making payment to that provider of service.

q. Perform claims review prior to submission to Medicaid for Administrative Review.

r. Advise recipients of services that may be covered by Medicaid that are not covered through the Maternity Care Program.

s. Promptly provide to Medicaid all information necessary for the reimbursement of outstanding claims in the event of insolvency.

t. Coordinate care from out-of-network providers to ensure that there is no added cost to the enrollee. If the Primary Contractor is unable to provide the necessary care covered under this contract, the Primary Contractor must adequately and timely cover these services out of network for the enrollee with the exception of an exemption granted by the AMA. The exemption would be paid fee for service.

u. Must use the Medicaid Web Service Database for reporting program demographics and other elements related to the pregnancy.

2.5 HEALTHCARE PROFESSIONAL PANEL

Provider Network

a. Primary Contractors must have a delivery system that meets Medicaid standards and that promotes continuity of care and quality care. Primary Contractors must ensure that all medically necessary services, included as covered services pursuant to this bid, are provided. The bid, as part of the transmittal letter, must contain documentation that the Primary Contractor has a provider network in place.

b. Primary Contractor must offer participation opportunities for 30 days after contract award and for the first month of each succeeding contract year to all interested potential subcontractors within district boundaries. Subcontractors must be willing to abide by all program requirements and accept offered reimbursement for services provided. For purposes of offering and awarding subcontracts, Primary Contractor must offer the reimbursement level consistent with other like subcontractors.

c. Primary Contractor is not required to offer participation to potential subcontractors who do not agree to abide by program requirements or to those who have been disqualified from participation in any federal program or any person convicted of an offense involving Medicaid. However, providers who are willing to abide by program requirements must be given equal and fair participation opportunities. Complaints of discrimination will be investigated by Medicaid.

d. Primary Contractor must contract with subcontractors who are geographically appropriate (50 miles) to recipients within the district.

e. Primary Contractor must continually monitor the provider network to ensure that the capacity is sufficient to meet the needs of all Medicaid recipients and availability and accessibility are not hindered. The Primary Contractor must submit documentation to the State when there are changes in services, benefits, geographic service area or payments in order to assure adequate capacity and services.

f. Primary Contractor must monitor and evaluate provider performance to ensure that Medicaid and Primary Contractor standards are met. Such monitoring and evaluation system shall include a corrective action system. Bidder must include full documentation of the proposed monitoring system in the bid.

g. Primary Contractor must notify Medicaid within one working day of any unexpected changes which would impair its provider network. This notification shall include:
   (1) Information about how the change will affect the delivery of covered services, and

   (2) Primary Contractor's plans for maintaining the quality of member care if the provider network change is likely to result in deficient delivery of covered services

h. Primary Contractor is held accountable for any functions and responsibilities that it delegates to any subcontractor.

i. Provider subcontract(s) must:
   (1) Require subcontractors to fulfill the requirements of 42 C.F.R. 438.

   (2) Require that the Primary Contractor evaluate the subcontractors' ability to perform the activities delegated.

   (3) Be in writing and specify the responsibilities delegated and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

   (4) Require the Primary Contractor to monitor subcontractor's performance and conduct a formal review.

   (5) Require provider to comply with accepted Medicaid standards of care.

   (6) Require provider to comply with all applicable other terms and conditions contained in this bid.

   (7) Contain provider reimbursement provisions.

   (8) Contain a provision specifying that provider must agree that under no circumstances (including, but not limited to, situations involving non-payment by the Primary Contractor, insolvency of the Primary Contractor, or breach of agreement) shall the provider bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against Medicaid recipients, or persons acting on their behalf, for covered services, rendered during the term of provider's agreement or sub-contract with the Primary Contractor. A provider may charge for non-covered services delivered on a fee-for-service basis to Medicaid recipients.

(9) Contain a provision that states payment for maternity-related services, not covered by the Maternity Care Program, does not make the recipient responsible for all of her maternity care.

(10) Require that the contract term covers the same time period as the Primary Contractors' contract with Medicaid.

(11) Only be terminated for cause.

(12) Require the Primary Contractor to identify deficiencies and require the subcontractor to take corrective action.

Requirements for Subcontractors

Primary Contractors must have written policies for the selection and retention, credentialing and re-credentialing and non-discrimination of subcontractors. Primary Contractors may enter into subcontracts only where the subcontractor meets the following requirements:

a. Must have current Alabama Medical License or certification and licensure as a Certified Nurse Midwife or other appropriate licensure requirements.

b. Must be enrolled as a Medicaid provider.

c. Delivering Health Care Professional must have current privileges at a hospital which participates in Medicaid, and be in good standing at that hospital.

d. Must not be currently debarred or sanctioned from participation by any Federal department or agency. Maternity Care Primary Contractors are required to notify Medicaid within two business days of time that a debarred provider is identified. The quarterly sanctions report that is distributed by Medicaid as well as the Debarred Provider List that is maintained at the federal level should be monitored on an ongoing basis to identify these individuals.

Recipient Choice

Recipients must be allowed to choose a Delivering Health Care Professional at the time of entry into the Maternity Care Program. If the recipient is enrolled in the Patient First Program, care continues through that program for non-maternity related services. A Delivering Healthcare Professional List must be available for use in the selection process. The bid should specify the bidder's approach in complying with choice requirements.

Changes in Selection

Recipients must be allowed to change healthcare professionals once without cause within the first 90 days of enrolling in the maternity program and at any time for just cause, which is defined as a valid complaint submitted to the Primary Contractor in writing. Valid causes for disenrollment by the enrollee are set forth in 42 C.F.R. 438.56 (d) (2) (Attachment G). Such request must be submitted by the recipient (or his/her representative) orally or in writing. The Primary Contractor must notify all enrollees, at the time of enrollment, of the enrollee's rights to change providers or disenroll enrollment for cause. The recipient may request disenrollment without cause during the 90 days following the date of the recipient's initial enrollment with the Primary Contractor or the date the Primary Contractor sends the recipient notice of the enrollment, whichever is later. The Primary Contractor must notify the enrollee of their right to request and obtain the information regarding disenrollment or changes in providers at least once per year. The Primary Contractor must provide enrollee's of their disenrollment rights at a minimum annually. If there are any changes in the information the Primary Contractor must notify the enrollee of the changes at least 30 days before the effective date of the change. If there are sanctions imposed upon the Primary Contractor as specified in 42 C.F.R 438.702 (a)(3), the recipient may request disenrollment.

2.6 MEDICAL CARE SYSTEM

Covered Services

a. Bidders must have or arrange for a comprehensive system of maternity care that provides for pregnancy – related care, including high risk care, to all pregnant recipients that reside in the district, with the exception of those recipients that are exempted from the program. Refer to Operational Manual for further details of covered services.

b. Below is a listing of the services that must be covered at a minimum.

   (1) Antenatal Services, excluding inpatient care

   (2) Delivery Services, excluding inpatient care

   (3) Postpartum care services, excluding hospital inpatient care but including home visits when indicated

   (4) Care Coordination Services

   The bid must describe protocols for service delivery, including the process for managing high-risk pregnancies. Covered services must be medically

necessary and encompass maternity related services as well as those that might otherwise complicate or exacerbate the pregnancy. The services to be provided through the Primary Contractor's network and which will be reimbursed as part of the global fee are described in the Operational Manual.

c. The Primary Contractor is responsible for pregnancy-related services as defined in this ITB from the time the pregnancy is diagnosed until the end of the month in which the 60th postpartum day falls. Maternity Care services are those that are pregnancy-related, medically necessary, and encompass maternity-related services as well as services to treat conditions that might otherwise complicate or exacerbate the pregnancy.

d. Specific CPT (current procedural terminology) codes included in the global rate are specified in the Operational Manual.

e. The bid must contain an overview of the care delivery system that includes, but is not limited to:

(1) Flowchart addressing both high and low risks patient flow through the care system from entry into care to the conclusion of postpartum care;

(2) A narrative explaining the patient flow;

(3) Protocols to be followed by providers for providing maternity care which prescribe services for prenatal visits, risk assessment, referral and follow up arrangements for those patients at high risk, and postpartum services;

(4) List of all the proposed delivering health care professional subcontractors with specialty;

(5) Documentation that subcontractors are located within 50 miles of the location of recipients receiving care through the program;

(6) Estimated Delivering Health Care Professionals/patient ratio;

(7) Specialty (high risk) hospital arrangements which are utilized by Delivering Health Care Professionals;

(8) Descriptive information of patient care and protocols;

(9) List of available ancillary services (e.g. lab work, provision of anesthesia).

Excluded Services

The following services are excluded from the Maternity Care Program global payment as further defined in the Operational Manual and are reimbursed by Medicaid as fee-for-service, as applicable:

a. Inpatient Care

b. Prescription Drugs

c. Injections

d. Family Planning visits

e. Lab services other than Hemoglobin, Hematocrit and Urinalysis

f. Radiology services with the exception of maternity ultrasounds. Maternity ultrasounds are unlimited in number and are a component of the global fee payment. A Primary Contractor may develop an evidence-based prior authorization process to manage the number of ultrasounds performed.

g. Dental services

h. Circumcision

i. Physician charges for routine newborn care, standby and infant resuscitation

j. Non-pregnancy related care

k. Emergency Room Care (facility and physician)

l. Medicaid emergency and non-emergency transportation

m. Drop out fees

n. Specialist referrals

o. Miscarriages <21 weeks

p. Program Exemptions

q. High-Risk consults (Procedure Codes 99241– 99245)

Service Delivery

Primary Contractor shall have a delivery system that meets Medicaid

requirements as defined in this bid and any attachment and references hereto, as amended. All services defined in this bid must be available, accessible and there must be an accessible and adequate number of facilities, locations and personnel for the provision of covered services 24 hours a day, seven days a week. Medicaid recipients must be offered the same access to provider office appointments and services that are available to all other maternity patients of the Delivering Health Care Professional.

High Risk Protocols

Each recipient entering the care system must be assessed for high-risk pregnancy status and referred to a Delivering Health Care Professional qualified to provide high-risk care if the assessment reflects a condition that cannot be appropriately handled in routine prenatal care sites. Referrals for high-risk care are the responsibility of the Maternity Care Primary Contractor. The following guidelines apply.

a. **High Risk Exempt** – For patients meeting the exemption criteria described in the Operation Manual, Section V.D, care is provided fee for service and the primary Contractor will be reimbursed a drop out-fee.

b. **Care Provided at Teaching Facility** – For any service provided by a physician associated with a teaching facility, as defined in Attachment 4.19-B of the State Plan, the service is excluded from the global.

The bid must clearly describe the way the program will manage high-risk pregnancies, including: a process for identifying high-risk cases, a method to denote high-risk status and the reason for high risk-status, a network for care, policy and procedures for monitoring referrals and services to be provided to high-risk women.

Care Coordination

An integral part of the medical care delivered through the Maternity Care Program is Care Coordination. Care Coordination is the mechanism for linking and coordinating segments of a service delivery system to ensure that the most comprehensive program meets the recipient's needs for care. Care Coordination is to be utilized as a resource by which the system can be brought together for the betterment of the recipient.

Care Coordinator duties are as varied as the recipients served. Care Coordinators serve a vital role in ensuring that the medical care women receive is augmented with the appropriate psychosocial support. Care Coordinator responsibilities include, but are not limited to, performing the initial encounter requirements, post partum encounter requirements, performing the psychosocial risk assessment, assessing the medical and social needs,

developing service plans, providing information and education, and tracking recipients throughout their pregnancy and postpartum period. Care Coordination is a professional skill and should be supported from within the Primary Contractor system.

Each bid must describe the care coordination component of the program, including how the administrative component, medical component and other elements of the program are supported by the efforts of the Care Coordinators.

Home Visits

Home visits are optional. Refer to the Operational Manual.

2.7 PAYMENT FOR SERVICES

Global /Delivery Only Fees

Primary Contractors will receive a payment fee upon completion of the services provided. These fees encompass all components of care as defined in Covered Services.

Reimbursement for Services

Global/delivery-only fees paid by Medicaid to the Primary Contractor represent payment in full. Recipients may not be billed for any services covered under this bid.

For recipients who receive total care through the Primary Contractor network, a global fee should be billed.

For recipients who receive no prenatal care through the Primary Contractor's network, a delivery-only fee must be billed. The components of the delivery-only fee include those services provided from the time of delivery through the postpartum period. Reimbursement will be 80% of the global fee.

Subcontractor Reimbursement System

The Primary Contractor shall implement an automated reimbursement system for payments to subcontractors, out-of-plan providers and Primary Contractors in other districts.

a. Payments to subcontractors should be made within 20 calendar days of the date of Medicaid payment (date funds deposited).
b. In all cases payments to subcontractors must be within 60 calendar days of the date of delivery.

c. Primary Contractor must specify the payment methodology, i.e. capitation, fee for service, or partial capitation in provider subcontracts. The reimbursement system must comply with Health Insurance Portability and Accountability Act requirements.
d. Out-of-plan providers must be paid within 90 calendar days of submission of a clean claim to the Primary Contractor, unless the payment is under appeal.

Delivering Health Care Professional Payment

Delivering Health Care Professionals, except for those associated with a teaching facility as defined in Attachment 4.19-B of the State plan, must be paid at a rate no less than the Medicaid fee-for-service urban rate for delivery only. The current urban fee-for-service rate is $1,000 for delivery only. Nurse midwives are paid at 80% of that rate. The physician teaching facility rate for delivery only is $1,161 and caesarean delivery only is $1,383.

Third Party Liability

The Primary Contractor is responsible for collecting all third party insurance information prior to submitting a request for payment to Medicaid. Recipients with third party coverage are required to follow program guidelines.

High Risk Payment

Reimbursement for high-risk care will be as follows:

a. **High Risk Exempt** – For patients meeting the exemption criteria described in the Operations manual, Section V.D, care is provided fee for service and the primary Contractor will be reimbursed a drop out fee.

b. **Care Provided at Teaching Facility** – For any service provided by a physician associated with a teaching facility, as defined in Attachment 4.19-B of the State Plan, the service is excluded from the global.

2.8 QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Quality Assurance and Performance Improvement (QAPI) is an integral part of the Maternity Care Program. Through it the adequacy and effectiveness, both in clinical and nonclinical areas, of the program can be addressed. This section outlines the requirements of the program and the responsibilities of the Primary Contractor and Medicaid. Within Medicaid, the Maternity Care Program Associate Director has primary responsibility for Quality Assurance Performance Improvement activities. Each facet of the Quality Assurance and Performance Improvement process has its own unique roles and responsibilities.

Details on the requirements of the Quality Assurance Performance Improvement process are included in the Operational Manual, Sections IX and X. Components include:

- Delivering Heath Care Professionals Report Cards
- Primary Contractor Report Cards (Refer to Operational Manual Section IX)
- Grievance Procedures
- Medicaid Agency Web Based Service Database
- Performance Improvement Projects
- Recipient Surveys

2.9 MEDICAID OVERSIGHT

Medicaid shall monitor Primary Contractor performance through a combination of performance measures, Delivering Health Care Professionals' report cards, medical record reviews and administrative reviews. The purpose of oversight activities is to ensure that contract requirements are being met, standards of care are being implemented and enforced and that Primary Contractors are meeting the expectations of the Delivering Health Care Professional.

Details on the requirements of Oversight process are included in the Operational Manual Section IX.

a. Administrative Reviews

(1) Purpose

To measure performance, each Primary Contractor may be visited or have an annual desk audit to ensure compliance with program requirements.

(2) Elements

Subcontractors Not Enrolled as Medicaid Providers
Valid Subcontracts
Delivering Health Care Professionals have hospital privileges
Claim payment within timeframes
Staff knowledge of billing/reimbursement policies
Training (Subcontractor and Care Coordinator) as required
Application Assister
Delivering Health Care Professional Choice Requirements

(3) Standards

If after the administrative review, the Primary Contractors are found to not be meeting the requirements, then the following penalties will be imposed. As indicated, corrective action will be allowed for some program elements with imposition of penalties as a final act.

Measure	**Penalty**
Subcontractor Enrolled with Medicaid	1st occurrence: Corrective Action, 2nd occurrence: $500 fine per provider not enrolled
Valid Subcontracts	1st occurrence: Corrective Action, 2nd occurrence: $500 fine per subcontract not meeting requirements
DHCP have hospital privileges	1st occurrence: Corrective Action, 2nd occurrence: $500 fine per DHCP not having hospital privileges
Claim payment within timeframes	95% of claims paid within timeframes, $100 per incident for payments not meeting timeframes
Staff knowledge of billing/reimbursement policies	1st occurrence: Corrective Action, 2nd occurrence: Staff re-training, fine of $100 per incident thereafter.
Training (Subcontractor and Care Coordinator) as required	$500 per training session not completed
Application Assister services	$500 per week that there is no Application Assister in all counties; Primary Contractors must submit a list of counties and names of assigned Application Assisters monthly to the Maternity Care Program Associate Director
Delivering Health Care Professional Choice Requirements	1st occurrence: Corrective Action 2nd occurrence: $500 per choice requirements not being met

b. Medical Record Reviews

(1) Purpose

The purpose of the Medical Record Reviews is to ensure that each Primary contractor is providing quality maternity care to its recipients. This will be accomplished by conducting periodic reviews to evaluate the effectiveness and adequacy of postpartum home visits, care coordination,

and smoking cessation efforts. Medical Record Reviews will be performed in addition to the elements that are measured from the Web Database as described in Section IX.C.

(2) Sample Size/Process
Reviews will be conducted on an annual basis. Samples will be based on the methodology explained in Operational Manual, Section IX.D.4.

The sample number of records will be chosen randomly from a DSS Query generated for a specific period of time prior to the review but in no case reflective of less than three months prior to the review month. A request for recipient records will be sent to the subcontracting provider requesting that patient records be sent back to the Medicaid Quality Improvement Division for review. The subcontractor or the Primary Contractor cannot charge for these records.

(3) Findings
After the review is completed and all data compiled, Primary Contractors will be provided a summary of the findings.

Statewide statistical reports will be generated after all District reviews are completed. The Statewide statistical averages are computed by using weighted District averages to present a more accurate measurement due to the variation in the volume of deliveries per District. Further review and/or a request for a corrective action plan may be necessary dependant on Medical Record review findings.

(4) Elements

Measure	What it is	Expectation
Care Coordination Encounters	The percentage of patients in which a care coordination encounter was done. If no encounter was done, were two attempts made to contact patient so that the encounter could be accomplished?	90% of patients receive an encounter. If no encounter was done, was there documentation present that two attempts were made to contact patient?
Content of Care Coordination	That required encounters met the guidelines specified in Section VI of the Operational Manual. For example: were risks	90% of encounters meet the required guidelines.

	identified? Were referrals made that addressed identified risk(s)? Were appropriate forms completed?	

(5) Standards

If program requirements are not met, corrective action will be requested. Districts will implement a Plan of Correction and submit to the Medicaid Maternity Care program for approval. The Primary Contractor must follow-up on identified issues to ensure that actions for improvement have been effective. A written report of findings is to be submitted to the Medicaid Maternity Care Program six months after the Corrective Action Plan has been implemented. If improvement is not noted on the second incident, further actions may be taken including the penalties described below:

Measure	**Penalty**
Care Coordination Encounters	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark with no improvement noted, $500 per recipient
Content of Care Coordination	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark with no improvement noted, $500 per recipient

c. Corrective Action

The following standards will apply when the need for corrective action is identified:

(1) There must be a written, defined corrective action plan.

(2) The plan must be approved by all parties.

(3) The plan must include:
   (a) Specification of the types of problems requiring remedial/corrective action
   (b) Specification of the person(s) or body responsible for making the final determinations regarding quality problems
   (c) Specific actions to be taken

(d) Provision of feedback to appropriate health professional, providers and staff
(e) The schedule and accountability for implementing corrective actions
(f) The approach to modifying the corrective action if improvements do not occur
(g) Procedures for terminating the affiliation with the physician or other health professional or provider

(4) There must be an assessment of effectiveness of corrective actions
(a) As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.
(b) Primary Contractors assures follow-up on identified issues to ensure that actions for improvement have been effective.

Imposition of these penalties may be in addition to other contract remedies and does not waive Medicaid's right to terminate the contract.

Primary Contractor Incentives

The provisions of contractor incentives are intended to promote improved safety and quality outcomes by supporting the use of best practice guidelines to the Medicaid maternity population. A bonus of up to 5% of the payments for that contract year may be awarded to the Primary Contractor based on performance of specific outcome and process measures on an annual basis. The bonus payments will be calculated within six months of the end of the annual contract date and are contingent upon the availability of funds. Refer to Operational Manual, Section IX.M. for the specific outcome measures.

2.10 REPORTS

Reporting Requirements

a. Report Submission
(1) Reports are to be submitted as specified in the description of reports.

(2) Primary Contractors are responsible for timeliness, accuracy, and completeness of reports as defined below:

(a) Timeliness – Reports or other required data must be received on or before scheduled due dates.

(b) Accuracy – Reports or other required data must be prepared in conformity with appropriate authoritative sources and/or Medicaid defined standards.

(c) Completeness – All required information must be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.

(d) Primary Contractors are responsible for continued reporting beyond the term of the contract. For example, processing claims and reporting encounter data must likely continue beyond the term of the contract because of lag time in filing source documents by subcontractors.

(e) Medicaid requirements regarding reports, report content and frequency of submission of reports are subject to change at any time during the terms of the contract. Primary Contractors must comply with all changes specified by Medicaid.

(f) Reporting requirements are based on calendar dates.

(g) The "to" contained in the subsequent chart indicates to where the report should be submitted. Maternity Care Program refers to the Associate Director, Maternity Care Program. Specific email addresses will be provided prior to contract implementation.

b. Reports

The following are the reports that are required on a routine basis. Details on specific reporting requirements may have been contained in other sections of the Operational Manual and referred to below. Failure to deliver reports in the manner and timeframe specified may result in penalties.

Report Name	**To**	**Media**	**Format**	**Timeframe**	**Due**
Service Database	n/a	Web-based	n/a	Data must be entered within 60 days of the delivery	Within 60 days of delivery
Global Summary Report	MCP	Email	Excel	Quarterly	Within 45 days of the end of the quarter being reported
Organizational Structure	MCP	E-mail	Word	Annual and upon change	January 1st and/or within 5 days of occurrence

Provider Network	MCP	e-mail	Excel	Annual and upon change	January 1st and/or within 5 days of occurrence (exception: due weekly for 30 days after contract award)
QI Activity Report	MCP	e-mail	Word	Quarterly	Within 45 days of the end of the quarter being reported
Grievance Log	MCP	e-mail	Word	Quarterly	Within 45 days of the end of the quarter being reported
QI Meeting Minutes	MCP	e-mail	Word	Quarterly	Within 45 days of the end of the quarter being reported
Sale, Exchange, Lease of Property	MCP	Paper	Word	Occurrence	Within 5 days of occurrence
Loans and/or Extension of Credit	MCP	Paper	Word	Occurrence	Within 5 days of occurrence
Furnishing for Consideration of Goods & Services	MCP	Paper	Word	Occurrence	Within 5 days of occurrence

Medicaid will confirm receipt of reports via e-mail within 3 working days.

C. Report Details

(1) Service Database
The purpose of this report is to collect specifics on each delivery for which the Primary Contractor receives payment. Because Primary Contractors are paid through a single procedure code, details on services and outcomes are not captured. Information will be entered via a web-based database as described in Section IX.C.

(2) Global Summary Report:
The purpose of this report is to collect specifics on amounts paid to subcontractors for services reimbursed through the global fee. The format and instructions are included in Attachment 18.

(3) Organizational Structure
This report indicates for Medicaid, the individuals involved in the

Primary Contractors' organization. Significant changes must be reported within 5 days of occurrence in a word format.

(4) Provider Network
This report must be reflective of all subcontractors in the Primary Contractors' network. Complete demographic information must be included including the service offered and the providers NPI number. The format and instructions are included in Attachment 19.

(5) Quality Improvement Activity
This report must summarize the Primary Contractors' Quality Improvement Activity Summary activities for the quarter. Details are contained in Section IX.G.

(6) Grievance Log
This report allows Medicaid to track issues as they arise as well as assure that each issue is resolved. Details are contained in Section IX.H.

(7) Quality Improvement Meeting Minutes
This report allows the Quality Assurance Division to focus on quality concerns in individual districts and how the concerns are being resolved. Details are contained in Section IX.A.

(8) Sale, Exchange, Lease or Property
Extensions of Credit; These reports are Centers for Medicare and Medicaid Services requirements for Managed Care Organizations and are required in a word format.

(9) Loans and/or Extensions of Credit
These reports are Centers for Medicare and Medicaid Services requirements for Managed Care Organizations and are required in a word format.

(10) Furnishing for Consideration
These reports are Centers for Medicare and Medicaid Services requirements for Managed Care Organizations and are required in a word format.

SECTION 3 TERMS AND CONDITIONS

3.1 INTENT TO AWARD

The Division of Purchasing shall provide a notice of intent to award of all contracts let by competitive bid by electronic posting to the Division of Purchasing website. Any bidder adversely affected by intent to award a contract let by competitive bid shall file with the Director of Purchasing a notice of protest within five calendar days after the notice of intent to award is electronically posted. The notice of protest may be filed by mail, by hand delivery, by email or by facsimile. The notice of protest must be filed with the Director of Purchasing by 5:00 PM, Central Time, on the fifth calendar day after the notice of intent to award is electronically posted. A formal written protest shall be filed within seven days, excluding Saturday, Sunday, and State holidays, after the notice of protest is filed. The formal written protest may be filed by email in PDF format or by mail or hand delivery. The formal written protest must be filed with the Director of Purchasing by 5:00 PM, Central Time, on the seventh day after filing the notice of protest. The bidder or its legal representative must sign the formal written protest or it will not be accepted. Failure to file either the notice of protest or the formal written protest within the time limits prescribed herein shall constitute a waiver of any protest of the award of contract.

The formal written protest shall state with particularity the facts and law upon which the protest is based. Within 30 calendar days of receipt of the timely filed, formal written protest, the Director of Purchasing shall issue a written decision with respect to the protest. Should the decision by the Director of Purchasing be adverse to the bidder, the bidder may seek relief in accordance with section 41-16-31 of the Code of Alabama.

3.2 CONTRACT OFFERING

A bid filed in response to this ITB is an offer to contract with Medicaid based upon the terms, conditions, scope of work and specifications of the ITB. Bids do not become contracts unless and until the Division of Purchasing accepts them. A contract is formed when the Division of Purchasing provides written notice of award to the successful bidder and has delivered to the successful bidder, all of the terms and conditions of the contract contained in this solicitation, solicitation amendments and subsequent contract modifications, if any, signed by Medicaid. After such contract is fully executed and approved by all applicable authorities, it will be considered binding. Medicaid may also, at its option, modify any requirements described herein. The successful bidder will be notified of award.

Submission of a response to this ITB and signing of the contract and applicable

attachments constitute evidence of Contractor's understanding of an agreement to the terms and conditions expressed in this bid and contract.

This contract can only be offered in conjunction with an approved 1915(b) waiver. If the waiver is not granted or continued, then Medicaid does not have the legal authority to operate this program as explained in this ITB.

3.3 GENERAL

This ITB and any amendments thereto, the Maternity Care Program Operational Manual, Contractor's bid, and all questions and answers made final shall be incorporated into the contract by the execution of a formal agreement. No alteration or variation of the terms of the contract shall be valid unless made in writing and duly signed by the parties thereto.

3.4 CONTRACT REQUIREMENTS MEETING

After contract award, but prior to commencement of work, Medicaid and the successful Contractor may meet to ensure that Contractor understands, and agrees to accept the obligations contained in the ITB, including the applicable rules and regulations, any amendments to the bid, the Maternity Care Program Operational Manual and ITB questions and answers. Any areas in the Primary Contractor's proposal which require, at the sole discretion of Medicaid, further clarification to ensure understanding and acceptance by the Primary Contractor of all the duties and responsibilities required by Medicaid for the firm and fixed price bid shall be addressed by Medicaid prior to commencement of work. Any unwillingness by Primary Contractor to meet these requirements may result in cancellation of the award, and consideration by Medicaid of the proposal submitted by the next lowest, responsive and responsible bidder. The meeting is to be conducted within 20 calendar days of contract award. Subsequent meetings may be scheduled when deemed necessary for the execution of this contract.

3.5 CONTRACT TERM

The initial contract term shall be for three years beginning January 1, 2010. Medicaid shall have two, one-year options for extending this contract. At the end of the contract period Medicaid may at its discretion, exercise the extension option and allow the period of performance to be extended at the **same rate** paid by Medicaid for the initial contract term. In no event shall the term of the original contract plus the extension options exceed a total of five years. Any extension will operate under the same terms and conditions as the initial contract.

Contractor acknowledges and understands that this contract is not effective

until it has received all requisite state and federal government approvals. Contractor shall not begin performing work under this contract until notified to do so by Medicaid. Contractor is entitled to no compensation for work performed prior to the effective date of this contract.

3.6 CONTRACT ELEMENTS

The contract shall include the following:

a. Executed contract, (Attachment A).

b. ITB, and any amendments thereto,

c. Primary Contractor's response to the ITB,

And the applicable provisions of:

a. Title XIX of the Social Security Act (SSA), as amended and regulations promulgated there under by HHS and any other applicable federal statutes and regulations

b. The statutory and case law of the State of Alabama

c. The Alabama State Plan for Medical Assistance under Title XIX of the SSA as amended

d. The Alabama Medicaid Agency Administrative Code

e. Medicaid's written response to prospective bidder's questions

f. Medicaid Provider Billing Manual

g. Maternity Care Program Operational Manual

h. The approved 1915(b) Waiver

It is the responsibility of the Contractor to be aware of and maintain current copies of the contract elements.

3.7 COOPERATION

Effective implementation and maintenance of these services shall require close cooperation between Medicaid and Contractor. To this end, the parties agree to work mutually in solving problems. Contractor shall make known and fully describe to Medicaid, in writing, any difficulties encountered that threaten required performance or when such a potential exists. Such difficulties may include, but are not limited to:

a. interpretation of Medicaid policies and procedures

b. meeting reporting requirements

c. identification of errors in calculations submitted

Primary Contractor shall notify Medicaid's designee for Program Management by telephone within one business day of discovery of any problem that has already occurred, or within one working day of the identification of potential problems that threaten required performance. All telephone notices shall be followed up in writing, including any action taken, within three business days.

3.8 COMPLIANCE WITH STATE AND FEDERAL REGULATIONS

Primary Contractor shall perform all services under the contract in accordance with applicable federal and state statutes and regulations that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees. Medicaid retains full operational and administrative authority and responsibility over this contract in accordance with the requirements of the federal statutes and regulations as the same may be amended from time to time.

3.9 CONFIDENTIALITY

Primary Contractor shall treat all information, and in particular information relating to enrollees that is obtained by or through its performance under the contract, as confidential information to the extent confidential treatment is provided under State and Federal laws including 45 CFR §160.101 – 164.534. Primary Contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and duties under this contract.

All information as to personal facts and circumstances concerning enrollees obtained by Primary Contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged to anyone other than the agencies already specified without written consent of Medicaid or the enrollee, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify particular individuals. The use or disclosure of information concerning enrollees shall be limited to purposes directly connected with the administration of the State Plan. Upon signing of this contract by all parties, the terms of the contract become available to the public pursuant to Alabama law.

Primary Contractor agrees to allow Medicaid or its designee access to all

documents, papers, letters, or other material generated under this contract. Primary Contractor will not allow access to such documents to any other person or entity without express written consent of Medicaid.

Primary Contractor shall ensure safeguards that restrict the use or disclosure of information concerning applicants and recipients to the purpose directly connected with the administration of the State Plan in accordance with 42 CFR Part 431, Subpart F, as specified in 42 CFR § 434.6(a)(8). Purposes directly related to the State Plan administration include:

a. Establishing eligibility;

b. Determining the amount of medical assistance;

c. Providing services for recipients; and

d. Conducting or assisting an investigation, prosecution, or civil or criminal proceedings related to the administration of the State Plan.

Pursuant to requirements of the Health Insurance Portability and Accountability Act (HIPPA) of 1996 (Public Law 104-191), the successful Contractor shall be required to sign a Business Associate agreement with Medicaid (Attachment B).

3.10 FEDERAL NON-DISCLOSURE REQUIREMENTS

Each officer or employee of any person to whom Social Security information is or may be disclosed shall be notified in writing by such person that Social Security information disclosed to such officer or employee can be only used for authorized purposes and to that extent and any other unauthorized use herein constitutes a felony punishable upon conviction by a fine of as much as $5,000 or imprisonment for as long as five years, or both, together with the cost of prosecution. Such person shall also notify each such officer or employee that any such unauthorized further disclosure of Social Security information may also result in an award of civil damages against the officer or employee in an amount not less than $1,000 for each instance of unauthorized disclosure. These penalties are prescribed by IRC Sections 7213 and 7431 and set forth at 26 CFR 301.6103(n).

Additionally, it is incumbent upon the Contractor to inform its officers and employees of penalties for improper disclosure implied by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically 5 U.S.C. 552a(i)(1), which is made applicable to contractors by 5 U.S.C. 552a(m)(1), provides that any officer or employee of a Contractor, who by virtue of his/her employment or official position, has possession of or access to agency records which contain identifiable

information, the disclosure of which is prohibited by the Privacy Act or regulations established there under, and who knowing that disclosure of specific material is prohibited, willfully discloses that material in any manner to any person or agency, not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5000.

Primary Contractors shall take all reasonable precautions to ensure the safety and security of all information, data, procedures, methods, and funds involved in the performance under the contract, and shall require the same from all employees so involved. In compliance with 42 CFR §431.300 et seq. Contractor shall conform to the requirements of federal and state regulations regarding confidentiality of information about eligible recipients. Primary Contractors shall not release any data or other information relating to the Medicaid Program without prior written consent of Medicaid. This provision covers both general summary data as well as detailed, specific data. Contractor shall not be entitled to use of Medicaid Program data in its other business dealings without prior written consent of Medicaid. All requests for program data shall be referred to Medicaid for response by the Commissioner only.

3.11 CONTRACT AMENDMENTS

Only amendments in writing and signed by duly authorized representatives of the Primary Contractor, Medicaid and the Governor of the State of Alabama shall be effective. No covenant, condition, duty, obligation or undertaking contained in or made a part of the contract shall be waived except by written agreement of the parties. The contract may be amended by written agreement duly executed by the parties. Every such amendment shall specify the date its provisions will be effective as agreed to by the parties. The contract and amendments, if any, are subject to approval by the Governor of the State of Alabama and the Agency of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

3.12 NOTICE TO PARTIES

Any notice to Medicaid under the contract shall be sufficient when mailed to the project manager listed in Section 1.2. Any notice to the Contractor shall be sufficient when mailed to Contractor at the address given in the response to this ITB or on the contract after signing. All notices shall be given by certified mail, return receipt requested.

3.13 FORCE MAJEURE

Both parties to this contract shall be excused from performance hereunder for any period that the State or Contractor is prevented from performing such services pursuant hereto in whole or in part as a result of an act of God, war,

civil disturbance, epidemic, or court order; such non-performance shall not be a ground for termination for default.

3.14 DISASTER RECOVERY PLAN

Primary Contractor shall provide Medicaid, for approval, prior to contract start date, a written implementation plan addressing satisfactory back-up arrangements for data processing equipment and files to provide continued contract performance in the event of machine failure or loss of records.

3.15 WARRANTIES AGAINST BROKER'S FEES

Primary Contractor warrants that no person or selling agent has been employed or retained to solicit or secure the contract upon an agreement or understanding for a commission percentage, brokerage or contingency fee excepting bona fide employees.

In the event of a breach of this warranty by the Primary Contractor, Medicaid shall have the right to terminate this contract without any liability whatsoever, or, in its discretion, to deduct from the contract price or consideration or otherwise recover the full amount of such fee, commission, percentage, brokerage fee, gift or contingent fee.

3.16 PROHIBITION AGAINST ASSIGNMENT

Contractor may not assign this contract to any third party without prior written approval of Medicaid.

3.17 NOVATION

In the event of a change in the corporate or company ownership of Primary Contractor, Medicaid shall retain the right to continue the contract with the new owner or terminate the contract. The new corporate or company entity must agree to the terms of the original contract and any amendments thereto. During the interim between legal recognition of the new entity and Medicaid execution of the novation agreement, a valid contract will continue to exist between Medicaid and the original Primary Contractor. When, to Medicaid's satisfaction, sufficient evidence has been presented of the new owner's ability to perform under the terms of the contract, Medicaid may approve the new owner and a novation agreement shall be executed.

3.18 EMPLOYMENT BASIS

All services rendered by Primary Contractor or any subcontractor shall be as an independent contractor and not as an employee (merit or otherwise) of the

state of Alabama, and Contractor shall not be entitled to or receive merit system benefits.

3.19 DISPUTES

Except in those cases where the bid response exceeds the requirements of the ITB, any conflict between the bid response of the Primary Contractor and the ITB shall be controlled by the provisions of the ITB. Any dispute concerning a question of fact arising under this contract which is not disposed of by agreement shall be decided by the Commissioner of Medicaid.

The Primary Contractor's sole remedy for the settlement of any and all disputes arising under the terms of this contract shall be limited to the filing of a claim with the Board of Adjustment for the State of Alabama. Pending a final decision of a dispute hereunder, the Primary Contractor must proceed diligently with the performance of the contract in accordance with the disputed decision.

For any and all disputes arising under the terms of this contract, the parties hereto agree, in compliance with the recommendations of the Governor and Attorney General, when considering settlement of such disputes, to utilize appropriate forms of non-binding alternative dispute resolution including, but not limited to, mediation by and through the Attorney General's Office of Administrative Hearings or where appropriate, private mediators.

3.20 LITIGATION

Any litigation brought by Medicaid or the Primary Contractor regarding any provision of these contracts shall be brought in either the Circuit Court of Montgomery County, Alabama, or the United States District Court for the Middle District of Alabama, Northern Division, according to the jurisdictions of these courts. This provision shall not be deemed an attempt to confer any jurisdiction on these courts which they do not by law have, but is a stipulation and agreement as to forum and venue only.

3.21 ATTORNEY FEES

In the event that the State shall prevail in any legal action arising out of the performance or non-performance of this contract, Primary Contractor must pay, in addition to any damages, all expenses of such action including reasonable attorneys' fees and costs. This requirement applies regardless of whether Medicaid is represented by staff counsel or outside counsel. Fees and costs of defense shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

3.22 WAIVERS

No covenant, condition, duty, obligation, or undertaking contained in or made a part of the contract can be waived except by written agreement of the parties.

3.23 NOT TO CONSTITUTE A DEBT OF THE STATE

Under no circumstances shall any commitments by Medicaid constitute a debt of the State of Alabama as prohibited by Article XI, Section 213, Constitution of Alabama of 1901, as amended by Amendment 26. It is further agreed that if any provision of this contract shall contravene any statute or Constitutional provision or amendment, whether now in effect or which may, during the course of this Contract, be enacted, then that conflicting provision in the contract shall be deemed null and void.

3.24 DEBARMENT

Primary Contractor hereby certifies that neither it nor its principals nor any subcontractor or its principals, is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation by any Federal Department or Agency.

Primary Contractor may not knowingly have 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 12549; an individual who is an affiliate, as defined in the Federal Acquisition Regulation. The relationship is described as a director, officer, or partner of the Primary Contractor, a person with beneficial ownership of 5% or more of the Primary Contractor's equity, or a person with an employment, consulting or other arrangement with the Primary Contractor's obligations under this Contract.

3.25 TERMINATION OF CONTRACT

This Contract may be terminated by Medicaid for any or all of the following reasons:

- For any default by the Primary Contractor;
- For the convenience of Medicaid;
- In the event of the insolvency of or declaration of bankruptcy by the Primary Contractor;
- In the event sufficient appropriated or otherwise obligated

funds, either state or federal, no longer exist for the payment of Medicaid's obligation hereunder.

Each of these is described in the following subsections.

3.26 TERMINATION FOR DEFAULT

The failure of the Primary Contractor to perform or comply with any term, condition, or provision of this contract shall constitute a default by the Primary Contractor. In the event of default, Medicaid shall notify the Primary Contractor by certified or registered mail, return receipt requested, of the specific act or omission of the Primary Contractor which constitutes default. A copy of written notice shall be sent to any surety for Primary Contractor's Performance Guarantee.

Primary Contractor will have 30 calendar days from the date of receipt of such notification to cure such default. In the event of default, and during the above-specified period, performance under the contract shall continue as though the default had never occurred. In the event the default is not cured in 30 calendar days, Medicaid may, at its sole option, terminate the contract for default and proceed to seek appropriate relief from Primary Contractor and Surety. Such termination shall be accomplished by written notice of termination forwarded to the Primary Contractor by certified or registered mail, return receipt requested, and shall be effective at the close of business on the date specified in the notice. If it is determined, after notice of termination for default, that the Primary Contractor's failure was due to causes beyond the control of and without error or negligence of the Primary Contractor, the termination shall be deemed a termination for convenience.

3.27 TERMINATION FOR CONVENIENCE

Medicaid may terminate performance of work under the Contract in whole or in part whenever, for any reason, Medicaid shall determine that such termination is in the best interest of the State. In the event that Medicaid elects to terminate the contract, pursuant to this provision, it shall so notify the Primary Contractor by certified or registered mail, return receipt requested. The termination shall be effective as of the date specified in the notice.

3.28 TERMINATION FOR BANKRUPTCY OR INSOLVENCY

The filing of a petition for voluntary or involuntary bankruptcy of a company or a corporate reorganization pursuant to the Bankruptcy Act shall, at the option of Medicaid, constitute default by Primary Contractors effective the date of such filing. Primary Contractors must inform Medicaid in writing of any such action(s) immediately upon occurrence by the most expeditious means

possible. Recipients and/or subcontractors cannot be held liable for unpaid debt caused by the Primary Contractor's bankruptcy or insolvency.

3.29 TERMINATION FOR UNAVAILABILITY OF FUNDS

Performance by the State of Alabama of any of its obligations under the contract is subject to and contingent upon the availability of state and federal monies lawfully applicable for such purposes. This contract is conditional upon the availability of funds. Should funds become unavailable during the term of the contract, the contract shall terminate upon notice by Medicaid to Primary Contractors and Primary Contractors will be entitled to reimbursement for services provided prior to termination upon submission of a certified itemized invoice that details the work performed prior to termination.

3.30 PROCEDURE FOR TERMINATION

Primary Contractor must:

a. Stop work under the contract on the date and to the extent specified in the notice of termination;

b. Place no further orders or subcontracts for materials, services, except as may be necessary for completion of such portion of work under the contract as is not terminated;

c. Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination;

d. Assign to Medicaid in the manner and to the extent directed by Medicaid all of the rights, title, and interest of the Primary Contractor under the orders or subcontracts so terminated, in which case Medicaid shall have the right, in its discretion, to settle or pay any and all claims arising out of termination of such orders and subcontracts;

e. With the approval or ratification of Medicaid, settle all outstanding liabilities and all claims arising out of such termination or orders and subcontracts, the cost of which would be reimbursable in whole or in part, in accordance with the provisions of contract;

f. Complete the performance of such part of the work as shall not have been terminated by the notice of termination; and

g. Take such action as may be necessary, or as Medicaid may direct for the protection and preservation of any and all property or information related to the contract which is in the possession of the Primary Contractor and in which Medicaid has or may acquire an interest.

3.31 TERMINATION CLAIMS

After a receipt of a notice of termination, Primary Contractor must submit to Medicaid any termination claim in the form and with the certification prescribed by Medicaid. Such claims shall be submitted promptly but in no event later than 60 days from the effective date of termination. Upon failure of the Primary Contractor to submit its termination claims within the time allowed, Medicaid may, subject to any review required by State procedures in effect as of the date of execution of the contract, determine, on the basis of information available, the amount, if any, due to the Primary Contractor by reason of termination and shall thereupon cause to be paid to the Primary Contractor the amount determined.

Primary Contractor has no entitlement to receive any amount for lost revenues or anticipated profits or for expenditures associated with this or in any other contract. Primary Contractor will be paid only by the following upon termination:

a. At the contract price(s) for completed deliverables and services delivered to and accepted by Medicaid;

b. At a price mutually agreed upon by the Primary Contractor and Medicaid for partially completed deliverables.

In the event of the failure of the Primary Contractor and Medicaid to agree in whole or in part as to the amounts with respect to costs to be paid to the Contractor in connection with the total or partial termination of work pursuant to this article, Medicaid shall determine on the basis of information available the amount, if any, due to the Primary Contractor by reason of termination and shall pay to the Primary Contractor the amount so determined.

3.32 CONTRACTOR'S DUTIES UPON EXPIRATION/TERMINATION

Transfer of Documents

At Medicaid's discretion but no later than three working days following the expiration or termination of the contract, Primary Contractor at its own expense, shall box, label, and deliver to Medicaid or, at Medicaid's direction,

the successor primary contractor:

a. Any information, data, manuals, records, claims or other documentation which shall permit Medicaid to continue contract performance or contract for further performance with another Primary Contractor. Primary Contractor shall organize and label this documentation by contract component.

Dialogue

Primary Contractor shall at any time during the transition period and up to 90 calendar days after expiration of the contract answer all questions and provide all dialogue and training that Medicaid deems necessary to enable the successor Primary Contractor to take over the provision of maternity care services. All such communications shall be with or through the Associate Director of the Maternity Program.

3.33 EMPLOYMENT PRACTICES

Nondiscrimination Compliance

Primary Contractor shall comply with Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendment of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Executive Order No. 11246, as amended by Executive Order No. 11375, both issued by the President of the United States, the Americans with Disabilities Act of 1990, and with all applicable federal and state laws, rules and regulations implementing the foregoing statutes with respect to nondiscrimination in employment.

Small and Minority Business Enterprise Utilization

In accordance with the provisions of 45 CFR Part 74 and Attachment 0, paragraph 9 of OMB Circular A-102, affirmative steps shall be taken to ensure that small and minority businesses are utilized when possible as sources of supplies, equipment, construction, and services.

Worker's Compensation

Primary Contractor shall provide and maintain workman's compensation insurance for all of its employees under the contract or any subcontract thereof, if required by state law during the life of this contract.

Employment of State Staff

Primary Contractor shall not knowingly engage on a full-time, part-time, or

other basis during the term of this contract any professional or technical personnel or contractual consultants who are or have been in the employment of Medicaid during the 12 months prior to the effective date of this contract without the written consent of Medicaid. Certain Medicaid employees may be subject to more stringent employment restrictions under the Alabama Code of Ethics, §36-25-1 et seq. Code of Alabama 1975.

Non Discrimination in Providing Services

Primary Contractor shall follow non-discriminatory standards of care, which includes but are not limited to:

a. Providing the same standard of care for all Medicaid Recipients regardless of the eligibility category.

b. Ensuring that no person will, on the grounds of race, color creed, national origin, age, or handicap be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program of services provided by Medicaid.

c. Compliance with Federal Civil Rights and Rehabilitation Acts.

3.34 GUARANTEES, WARRANTIES, CERTIFICATIONS

Indemnification

Primary Contractor shall hold harmless, defend and indemnify Medicaid as to any penalties or federal recoupment and any interest incurred by reason of any Title XIX noncompliance due to the fault of Primary Contractor and/or any subcontractors. The term "Title XIX noncompliance" shall be construed to mean any failure or inability of Medicaid to meet the requirements of Title XIX of the Social Security Act and/or any regulations promulgated by the federal government therewith due to an act or omission of Primary Contractor or subcontractor.

Primary Contractor shall be liable and agrees to be liable for and shall indemnify, defend, and hold the State and Medicaid and their officers, employees and agents harmless from all claims, suits, judgments or damages, including court costs and attorney fees, arising out or in connection with this contract due to negligent or intentional acts of omissions of the Primary Contractor and/or any subcontractors. Primary Contractor shall hold the State and Medicaid harmless from all subcontractor liabilities under the terms of this contract.

Primary Contractor agrees to indemnify, defend, and hold harmless Medicaid, its officers, agents, and employees from:

Any claims or losses attributable to a service rendered by Primary Contractor or any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the contract regardless of whether Medicaid knew or should have known of such improper service, performance, materials or supplies unless otherwise specifically approved by Medicaid in writing in advance;

Any claims or losses attributable to any person or firm injured or damaged by the erroneous or negligent acts, including without limitation, disregard of Federal or State Medicaid regulations or statutes, of Primary Contractor, its officers, employees, or subcontractors in the performance of the contract, regardless of whether Medicaid knew or should have known of such erroneous or negligent acts;

Any failure of Primary Contractor, its officers, employees, or subcontractors to observe Alabama laws, including, but not limited to, labor laws and minimum wage laws, regardless of whether Medicaid knew or should have known of such failure.

If at any time during the operation of this contract, Medicaid gains actual knowledge of any erroneous, negligent, or otherwise wrongful acts by Primary Contractor, its officers, employees, or subcontractors, Medicaid agrees to give Primary Contractor written notice thereof. Failure by Medicaid to give said notice does not operate as a waiver of the Primary Contractor's obligations to Medicaid, or as a release of any claims Medicaid may have against Primary Contractor.

Security

Primary Contractor shall take all reasonable precautions to ensure the safety and security of all information, data, procedures, methods, and funds involved in the performance under the contract, and shall require the same from all employees so involved.

Share of Contract

No official or employee of the State of Alabama shall be entitled to any share of the contract or to any benefit that may arise there from.

Conflict of Interest

The Primary Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner

or degree with its performance hereunder. The Primary Contractor further covenants that in the performance of the contract, no person having any such interest is presently employed or will be employed in the future by the Primary Contractor.

Performance Guarantee

In order to assure full performance of all obligations imposed on a Primary Contractor contracting with the State of Alabama, the Primary Contractor will be required to provide a performance guarantee in an amount equal to one percent of the expected annual Medicaid payment. The actual figure will be based on the firm and fixed price multiplied by the expected number of annual deliveries multiplied by one percent. The performance guarantee must be submitted by Contractor at least ten calendar days prior to the contract start date. The form of performance guarantee shall be one of the following:

a. Cashier's check (personal or company checks are not acceptable)

b. Other type of bank certified check

c. Money order

d. An irrevocable letter of credit

e. Surety bond issued by a company authorized to do business within the State of Alabama

The Director of Purchasing or designee shall be the custodian of the performance guarantee. The performance guarantee shall reference this ITB and it shall be made payable to the State of Alabama.

If Primary Contractor fails to deliver the required performance guarantee, the proposal shall be rejected and the contract may be awarded to the provider of the next responsive bidder.

In the event of a breach of contract, Medicaid will notify Primary Contractor in writing of the default and may assess reasonable charges against the Primary Contractor's performance guarantee. If after notification of default, the Primary Contractor fails to remedy the State's damages within 30 calendar days, Medicaid may initiate procedures for collection against Primary Contractor's performance guarantee.

Failure of the Primary Contractor to perform satisfactorily, breach of contract, or termination of contract pursuant to Sections 3.26 or 3.28 shall cause the performance guarantee to become due and payable to the state of Alabama to

the extent necessary to cover the costs incurred by Medicaid as a result of the Primary Contractor's failure to perform its contractual obligations.

These costs include, but are not limited to, costs to correct any Medicaid errors caused by the Primary Contractor's default and costs incurred by Medicaid for completion of contracted work including any costs associated with preparation, solicitation, and award of a competitive bid for these contract services and any federal, state or other penalties, sanctions, disallowances, or any other costs incurred by Medicaid as a result of the Primary Contractor's default and any liquidated damages necessary as a result of the Primary Contractor's default.

In order to achieve the greatest economy for the State, Medicaid may choose the next responsive bidder, re-release the ITB, or complete any other action consistent with state purchasing laws. The performance guarantee will be released within 60 days of the end of the contract term.

Provision of Gratuities

Neither the Primary Contractor nor any person, firm or corporation employed by the Primary Contractor in the performance of this contract shall offer or give, directly or indirectly, to any employee or agent of the State, any gift, money or anything of value, or any promise, obligation or contract for future reward or compensation at any time during the term of this contract.

3.35 CONTRACT SANCTIONS

Liquidated Damages

In the event that Primary Contractor fails to meet the ITB and contract requirements, and damages are sustained by Medicaid, Primary Contractor agrees to pay Medicaid the sums set forth below as liquidated damages unless these damages are waived by Medicaid**.**

a. Failure to deliver requisite reports/services/deliverables as defined by the ITB by the date specified by Medicaid- $100 per day per report or review.

b. Failure to provide documentation as required by the ITB- $1000 per instance.

c. Failure to comply with any other requirement of the ITB - $1000 per instance.

d. Failure to perform tasks as specified in the ITB within the time specified by Medicaid, including but not limited to data entered into the Service Database- $100 per instance.

e. Failure to submit an acceptable required corrective action plan-$1000 per instance.

f. Failure to maintain adequate staffing levels necessary to perform the requirements of the ITB- $1000 per instance.

g. Failure to meet technical requirements- $1000 per instance.

h. Failure of Content of Care Coordination documentation to meet required benchmark -$500.00 per medical record.

i. Misrepresentation or falsification of information furnished to Centers for Medicare/Medicaid Services, to the State, to an enrollee, potential enrollee or health care provider- $5000 per instance.

j. Primary Contractor shall be liable for any penalties or disallowance of Federal Financial Participation incurred by Medicaid due to Primary Contractor's failure to comply with the terms of the contract. Total dollars may include state funds as well as federal funds.

k. Imposition of liquidated damages may be in addition to other contract remedies and does not waive Medicaid's right to terminate the contract.

l. Unauthorized use of information shall be subject to the imposition of liquidated damages in the amount of ten thousand dollars ($10,000) per instance.

m. Failure to safeguard confidential information of providers, recipients or the Medicaid program shall be subject to the imposition of $10,000 per instance plus any penalties incurred by Medicaid for said infractions.

Primary Contractor shall receive written notice from Medicaid upon a finding of failure to comply with contract requirements, which contains a description of the events that resulted in such a finding. Primary Contractor shall be allowed to submit rebuttal information or testimony in opposition to such findings. Medicaid shall make a final decision regarding implementation of liquidated damages.

Claim Recoupment

Failure to provide requisite services under this ITB shall result in recoupment of claims or the requirement to bill for a lowered level of reimbursement.

Notice and Hearing

Except as provided in 42 CFR §438.706, before imposing any of the intermediate sanctions specified, the State must give timely written notice that explains the basis and nature of the sanction, and any other due process protections that the State elects to provide.

Before terminating a contract under 42 CFR §438.708, the State must provide the Primary Contractor a pre-termination hearing. The State must give the Primary Contractor notice of its intent to terminate, the reason for termination, and the time and place of the hearing; after the hearing, written notice of the decision affirming or reversing the proposed termination of the contract, and for an affirming decision, the termination and information.

After a State notifies a Primary Contractor that it intends to terminate the contract, the State may give the program's enrollees written notice of the State's intent to terminate the contract and allow enrollees to disenroll immediately without cause.

The State must give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR § 438.700 within 30 days after the State imposes or lifts a sanction.

3.36 METHOD OF PAYMENT AND INVOICES

Use of Federal Cost Principles

For any terms of the contract which allow reimbursement for the cost of procuring goods, materials, supplies, equipment, or services, such procurement shall be made on a competitive basis (including the use of competitive bidding procedures) where practicable, and reimbursement for such cost under the contract shall be in accordance with 48 CFR, Part 31. Further, if such reimbursement is to be made with funds derived wholly or partially from federal sources, such reimbursement shall be subject to Contractor's compliance with applicable federal procurement requirements, and the determination of costs shall be governed by federal cost principles.

Claim Submission

Primary Contractor shall submit claims for reimbursement for services provided according to the terms and conditions of this agreement. Primary Contractor shall submit a CMS-1500 claim as specified in the Medicaid Provider Billing Manual; Chapter 24, upon completion of the pregnancy.

Payment

Medicaid will make payment based on Primary Contractor's claims for services performed. All claims are subject to verification that services were performed and were acceptable as specified in the Scope of Work. All payments may be withheld until reports, and/or requirements specified in the ITB during the applicable period are received and accepted by Medicaid as in compliance with contract requirements, less the assessment of any applicable liquidated damages. Payment will be made in the same manner during any optional contract extension periods.

3.37 RETENTION AND STORAGE

The Primary Contractor must maintain books, records, documents, and other evidence pertaining to the costs and expenses of this contract (hereinafter collectively called the "records") to the extent and in such detail as must properly reflect all net costs for which payment is made under the provisions of any contract of which this contract is a part by reference or inclusion.

A file and report retention schedule must be developed by the Primary Contractor. Primary Contractor must maintain and Medicaid shall approve the retention schedule and all changes.

In accordance with 45 CFR §74.164, and 42 CFR§ 438.6(g), Primary Contractor shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of three years from the date of the final payment made by Medicaid to the Contractor under this contract.

However, if audit, litigation, or other legal action by or on behalf of the State or Federal Government has begun but is not completed at the end of the three-year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the three-year period, the records shall be retained until resolution. Subsequent to the contract term, documents shall be returned to Medicaid within three working days following expiration or termination of the contract. Macromedia copies of source documents for storage may be used in lieu of paper source documents subject to Medicaid approval.

Primary Contractors and subcontractors shall ensure that a medical record system is maintained within the State of Alabama in accordance with §2091.3 and §2087.8 of the State Medicaid Manual which makes available to appropriate health professionals all pertinent information relating to the medical management of each recipient. All entries on medical records must be written in ink or typewritten and authenticated by the signature or initials of the health care professional.

3.38 INSPECTION AND AUDIT OF RECORDS

Primary Contractor and subcontractors agree that representatives of the Comptroller General, HHS, the General Accounting Office, the State of Alabama Department of Examiners of Public Accounts, Medicaid and their authorized representatives shall have the right during business hours to inspect and audit and copy Primary Contractor's/subcontractor's books and records pertaining to contract performance and costs thereof. Primary Contractor/subcontractor shall cooperate fully with requests from any of the agencies listed above and shall furnish **free** of charge copies of all requested records. Primary Contractors/subcontractor may require that a receipt be given for any original record removed from their premises.

Primary Contractor and subcontractors agree that there will be no restrictions on the right of the State or federal government to conduct what ever inspections and audits are necessary to assure, quality, appropriateness, or timeliness of services and reasonableness of their costs.

Primary Contractors and subcontractors shall ensure that a medical record system is maintained within the State of Alabama in accordance with §2091.3 and §2087.8 of the State Medicaid Manual which makes available to appropriate health professionals all pertinent information relating to the medical management of each recipient. All entries on medical records must be written in ink or typewritten and authenticated by the signature or initials of the health care professional.

3.39 CHOICE OF LAW

The construction, interpretation, and enforcement of this contract shall be governed by the substantive contract law of the State of Alabama without regard to its conflict of laws provisions. In the event any provision of this contract is unenforceable as a matter of law, the remaining provisions will stay in full force and effect.

Primary Contractors and subcontractors shall ensure that a medical record system is maintained within the State of Alabama in accordance with §2091.3 and §2087.8 of the State Medicaid Manual which makes available to appropriate health professionals all pertinent information relating to the medical management of each recipient. All entries on medical records must be written in ink or typewritten and authenticated by the signature or initials of the health care professional.

3.40 CLEAN AIR ACT AND FEDERAL WATER POLLUTION CONTROL ACT

The Primary Contractor shall ensure compliance with all applicable standards, orders, or regulations pertaining to the Clean Air Act and Federal Water Pollution Control Act.

3.41 BYRD ANTI-LOBBYING AMENDMENT

Primary Contractors shall file the required certification that each tier will not use Federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any Federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier shall also disclose any lobbying with non-federal funds that takes place in connection with obtaining any Federal award. Such disclosures shall be maintained as per 45 CFR Part 93.

3.42 CLINICAL LABORATORY IMPROVEMENT ACT

Primary Contractor shall ensure that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

SECTION 4 TRANSITION AND IMPLEMENTATION ACTIVITIES

4.0 TRANSITION PLAN

At the end of the contract period to be covered by this ITB (January 1, 2010–December 31, 2012 – unless extended); the following payments will be made for transitioning patients. Transitioning patients are women who entered care with a Primary Contractor and she have not delivered the infant when the new contract begins..

a. If the **same** Primary Contractor is awarded the contract for the district payment for all services will be at the new global rate beginning with the new contract period. There will be no settlement for women who transition from one contract period to the next.

b. If a **new** Primary Contractor is awarded the contract for a district :

   (1) The incumbent Primary Contractor will be paid $100 for each patient that did not deliver prior to the end of the contract period. It will be a lump sum payment to cover costs incurred. The incumbent Primary Contractor will be responsible for payment to subcontractors for services rendered to the end of the contract period.

   (2) New Primary Contractor will receive payment for deliveries from Medicaid as follows for women that have not delivered and were enrolled with the prior Primary Contractor:

   - 1st month --97% of global delivery fee paid for recipients delivering in the first month of the new contract.
   - 2nd month--98% of global delivery fee paid for recipients delivering in the second month of the new contract period
   - 3rd month--99% of global delivery fee paid for recipients delivering in the third month of the new contract period..
   - After the third month, 100% of the global fee will be paid.

c. For patients in their third trimester, a startup exemption may be granted if their physician is not participating with the new Primary Contractor. Such exemptions must be received by the end of the contract period to a new Primary Contractor.

d. Incumbent Primary Contractors must submit a list of patients transitioning out no later than thirty days prior to new contract start date to Medicaid's Maternity Care Program Associate Director.

4.1 IMPLEMENTATION ACTIVITIES

Contractor's Requirements Meeting

A meeting may be held with all Contractors to ensure a understanding of program requirements.

Readiness Review

Prior to the implementation date Medicaid may elect to conduct a readiness review for any/all of the Primary Contractors to ensure that all program requirements are established. If this review is required it will be completed prior to the contract initiation. The purpose of the review will be to review administrative capability, provider subcontracts demonstrating the network, formal policies and procedures for patient care, a system of care coordination and optional home visits, review of education and outreach material, participation in the subcontractor training session and review of the quality assurance process. A checklist for the review will be provided prior to the review in order to allow the Primary Contractor time to prepare.

District Training Sessions

As part of the readiness review, the Primary Contractor will be required to hold a training session for subcontractors in its district. Advance notice of the date of the session shall be provided to Medicaid in writing. This session shall review all components of the program including, but not limited to, a review of billing procedures, procedure for protection of recipient choice, and quality assurance activities. Medicaid staff will attend but will not conduct these sessions.

Corrective Action Measures

In the event that a Primary Contractor fails to meet the requirements of the Contract during the readiness review, the Primary Contractor will be informed of its deficiencies in writing by Medicaid. Primary Contractor will be given a deadline by which time all identified deficiencies must be corrected to the satisfaction of Medicaid. Primary Contractor must respond within 48 hours of this notice of deficiencies with an acceptable corrective action plan.

In the event that a Primary Contractor fails to correct the deficiencies noted by Medicaid within the time frame specified by Medicaid approved corrective action plan, Primary Contractor will not be allowed to begin work. The geographic district covered by the deficient Primary Contractor shall not participate in the Maternity Care Program and Medicaid eligible recipients shall receive their services under a fee-for-service system for a period of no greater

than thirty calendar days. At the expiration of this thirty day period Primary Contractor's completion of the Medicaid corrective action plan will be evaluated.

If the Primary Contractor has not corrected the deficiencies noted by Medicaid, the Primary Contractor's contract with Medicaid will be terminated.

ITB10-X-2212639
Attachment A (To be completed upon award of contract)
Maternity Care Program

ALABAMA MEDICAID AGENCY

MATERNITY CARE PROGRAM CONTRACT

WHEREAS, Primary Contractor submitted a proposal to provide Medicaid Maternity Care Services in ***District XX*** for the Alabama Medicaid Agency at the rate of ***$XXXX.XX*** as a global fee per delivery, and;

WHEREAS, the Alabama Medicaid Agency has recommended to the State Finance Department Division of Purchasing that this proposal be accepted, and;

WHEREAS, the State Finance Department Division of Purchasing has notified Primary Contractor that it has been awarded the contract with the Alabama Medicaid Agency for Maternity Care Services for ***District XXX*** , and;

WHEREAS, Primary Contractor has satisfactorily passed all preliminary reviews and inspections required by the Alabama Medicaid Agency as a condition of starting work,

NOW, THEREFORE, the Alabama Medicaid Agency and Primary Contractor by their signatures on this contract agree to be bound by the terms, conditions, requirements, and authorities expressed in Maternity Care Invitation to Bid # 10-X-2193986. This contract specifically incorporates by reference the said Invitation to Bid, any attachments and amendments thereto, Contractor's bid response, including all attachments, and the Maternity Care Program Operational Manual dated January 2010.

This contract shall be effective January 1, 2010 and shall expire on December 31, 2012 unless sooner terminated in accordance with the provisions of the ITB.

Done this _____ day of _____, 2009.

Alabama Medicaid Agency	XXXXXXXXXXXXX
This contract has been reviewed for and is approved as to content.	
_____	_____
Carol H. Steckel, Commissioner	XXXXXXX, CEO
This contract has been reviewed for legal form and complies with all applicable laws, rules, and regulations of the state of Alabama governing these matters.	APPROVED
_____	_____
Medicaid Legal Counsel	Governor

ITB10-X-2212639
Attachment A (To be completed upon award of contract)
Maternity Care Program

ALABAMA MEDICAID AGENCY
BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum (this "Agreement") is made effective the _____ day of _____, 20____, by and between the Alabama Medicaid Agency ("Covered Entity"), an agency of the State of Alabama, and _____ ("Business Associate") (collectively the "Parties").

1. BACKGROUND

a. Covered Entity and Business Associate are parties to a contract entitled _____ (the "Contract"), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

b. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule (as defined below).

c. The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose protected health information to a business associate, and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. DEFINITIONS

Unless otherwise clearly indicated by the context, the following terms shall have the following meaning in this Agreement:

a. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

b. "Individual" shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

c. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

d. "Protected Health Information" (PHI) shall have the same meaning as the term "protected health information" in 45 CFR 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

e. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.501.

f. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his designee.

g. Unless otherwise defined in this Agreement, capitalized terms used herein shall have the same meaning as those terms have in the Privacy Rule.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

a. Use and Disclosure of PHI. Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as Required By Law.

b. Appropriate Safeguards. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement. The Business Associate agrees to take steps to safeguard, implement and maintain PHI in accordance with the HIPAA Privacy Rule.

c. Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

d. Report Unauthorized Use or Disclosure. Business Associate agrees to promptly report to Covered Entity any use or disclosure of PHI not provided for by this Agreement of which it becomes aware.

e. Applicability to Business Associate's Agents. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by the Business Associate on behalf of, Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information. The Business Associate agrees to have HIPAA-compliant Business Associate Agreements or equivalent contractual agreements with agents to whom the Business Associate discloses Covered Entity PHI.

f. Access. Upon receipt of a written request from Covered Entity, Business Associate agrees to provide Covered Entity, in order to allow Covered Entity to meet its requirements under 45 CFR 164.524, access to PHI maintained by Business Associate in a Designated Record Set within thirty (30) business days.

g. Amendments to PHI. Business Associate agrees to make any amendment(s) to PHI maintained by Business Associate in a Designated Record Set that Covered Entity directs or agrees to, pursuant to 45 CFR 164.526 at the request of Covered Entity, within thirty (30) calendar days after receiving a written request for amendment from Covered Entity.

h. Availability of Documents. Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, Covered Entity, available to Covered Entity or to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule, within five business days' after receipt of written notice.

i. Documentation of PHI Disclosures. Business Associate agrees to keep records of disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

j. Accounting of Disclosures. The Business Associate agrees to provide to Covered Entity, within 30 days of receipt of a written request from Covered Entity, information collected in accordance with the documentation of PHI disclosure of this Agreement, to permit Covered Entity to respond to a request by an Individual or an authorized representative for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

4. PERMITTED USES AND DISCLOSURES

Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity;

a. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

b. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that:

1) disclosures are Required By Law; or

2) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 42 CFR 164.504(e)(2)(i)(B).

d. Notwithstanding the foregoing provisions, Business Associate may not use or disclose PHI if the use or disclosure would violate any term of the Contract.

5. OBLIGATIONS OF COVERED ENTITY

a. Covered Entity shall notify the Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 CFR 164.520, to the extent that such limitation may affect Alabama Medicaid's use or disclosure of PHI.

b. Covered Entity shall notify the Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect the Business Associate's use or disclosure of PHI.

c. Covered Entity shall notify the Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

d. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

e. Covered Entity shall provide Business Associate with only that PHI which is minimally necessary for Business Associate to provide the services.

6. TERM AND TERMINATION

a. **Term**. The Term of this Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.

b. **Termination for Cause**. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:

1) Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

2) Immediately terminate this Agreement; or

3) If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

4) **Effect of Termination**.

Except as provided in paragraph (2) of this section or in the Contract, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from

Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

5) In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

7. GENERAL TERMS AND CONDITIONS

a. This Agreement amends and is part of the Contract.

b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.

c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

d. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

e. The Parties agree to take such action as is necessary to amend this Agreement from time to time for Covered Entity to comply with the requirements of the Privacy Rule and HIPAA.

IN WITNESS WHEREOF, Covered Entity and Business Associate have executed this Agreement effective on the date as stated above.

ALABAMA MEDICAID AGENCY

Signature: _____

Printed Name: Paul Brannan

Title: Privacy Officer

Date: _____

BUSINESS ASSOCIATE

Signature: _____

Printed Name: _____

Title: _____

Date: _____

ITB #10-X-2212639
Attachment C (To be completed upon contract award)

State of Alabama Disclosure Statement

(Required by Act 2001-955)

ENTITY COMPLETING FORM

ADDRESS

CITY, STATE, ZIP | TELEPHONE NUMBER (____)

STATE AGENCY/DEPARTMENT THAT WILL RECEIVE GOODS, SERVICES, OR IS RESPONSIBLE FOR GRANT AWARD
Alabama Medicaid Agency

ADDRESS
501 Dexter Avenue, Post Office Box 5624

CITY, STATE, ZIP | TELEPHONE NUMBER
Montgomery, Alabama 36103-5624 | (334) 242-5833

This form is provided with:
☐ Contract ☐ Proposal ☐ Request for Proposal ☐ Invitation to Bid ☐ Grant Proposal

Have you or any of your partners, divisions, or any related business units previously performed work or provided goods to any State Agency/Department in the current or last fiscal year?

☐ Yes ☐ No

If yes, identify below the State Agency/Department that received the goods or services, the type(s) of goods or services previously provided, and the amount received for the provision of such goods or services.

STATE AGENCY/DEPARTMENT	TYPE OF GOODS/SERVICES	AMOUNT RECEIVED

Have you or any of your partners, divisions, or any related business units previously applied and received any grants from any State Agency/Department in the current or last fiscal year?

☐ Yes ☐ No

If yes, identify the State Agency/Department that awarded the grant, the date such grant was awarded, and the amount of the grant.

STATE AGENCY/DEPARTMENT	DATE GRANT AWARDED	AMOUNT OF GRANT

1. List below the name(s) and address(es) of all public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF PUBLIC OFFICIAL/EMPLOYEE	ADDRESS	STATE DEPARTMENT/AGENCY

ITB #10-X-2212639

Attachment C (To be completed upon contract award)

2. List below the name(s) and address(es) of all family members of public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the public officials/public employees and State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF FAMILY MEMBER	ADDRESS	NAME OF PUBLIC OFFICIAL/ PUBLIC EMPLOYEE	STATE DEPARTMENT/ AGENCY WHERE EMPLOYED

If you identified individuals in items one and/or two above, describe in detail below the direct financial benefit to be gained by the public officials, public employees, and/or their family members as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

Describe in detail below any indirect financial benefits to be gained by any public official, public employee, and/or family members of the public official or public employee as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

List below the name(s) and address(es) of all paid consultants and/or lobbyists utilized to obtain the contract, proposal, request for proposal, invitation to bid, or grant proposal:

NAME OF PAID CONSULTANT/LOBBYIST	ADDRESS

By signing below, I certify under oath and penalty of perjury that all statements on or attached to this form are true and correct to the best of my knowledge. I further understand that a civil penalty of ten percent (10%) of the amount of the transaction, not to exceed $10,000.00, is applied for knowingly providing incorrect or misleading information.

Signature Date

Notary's Signature Date Date Notary Expires

Act 2001-955 requires the disclosure statement to be completed and filed with all proposals, bids, contracts, or grant proposals to the State of Alabama in excess of $5,000.

Evaluation Checklist

NOTICE TO VENDOR:

It is highly encouraged that the following checklist be used to verify completeness of Proposal content. It is not required to submit this checklist with your proposal.

Vendor Name

Project Director Review Date

☒ IF CORRECT	BASIC PROPOSAL REQUIREMENTS
☐	1. Vendor‘s original response received on time at correct location.
☐	2. Vendor submitted specified number of copies and in an electronic format.
☐	3. The response includes a completed and signed ITB Price Sheet.
☐	4. The response is a complete and independent document, with no references to external documents or resources.
☐	5. Vendor submitted signed acknowledgement of any and all addenda to ITB.
☐	6. The response includes written confirmation that the Vendor understands and shall comply with all of the provisions of the ITB.
☐	7. The response includes a corporate background.
☐	8. The response includes a detailed description of each element of the scope of work.
☐	9.

LETTER OF INTENT TO CONTRACT

The provider signing below is willing to enter into a contract with the __ (name of Primary Contractor) _____ as a subcontractor for the provision of covered services to Medicaid eligibles enrolled with the __(name of Primary Contractor)_____. This provider agrees to sign a contract with __ (name of Primary Contractor)_____, if said Primary Contractor is awarded a Medicaid contract beginning January 1, 2010 for __(district #)__ eligibles. Signing this letter of intent obligates the provider to sign a contract with __ (name of Primary Contractor)_____.

All subcontractors shall comply with Title VI of the Civil Rights Act of 1964 (42 USC §2000d, et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 USC §6101, et seq.), the Americans with Disabilities Act of 1990 (42 USC §2101, et seq.), and the regulations issued thereunder by the Department of Health and Human Services (45 CFR Parts 80, 84 and 90). No individual shall, on the ground of race, sex, color, creed, national origin, age or disability be excluded from participation in, be denied the benefits or, or be otherwise subjected to discrimination under any program of services.

The following information is furnished by the subcontracting provider:

1. Check all that apply: ____ DHCP ____ Prenatal Care Only
   ____ Other: specify: _____

2. Printed Name: _____ NPI: _____

3. Address: _____City _____ State _____ Zip _____
   (where services will be provided)

4. Telephone: _____ Fax: _____ Email: _____

5. Counties from which I will take patients: _____

6. If DHCP, hospital privileges held at: _____

7. Payment Arrangement: _____

_____ _____
Provider Signature Date Signed

_____ _____
Printed Name/Relation of Signer Office Contact

DHCP EXPECTATIONS OF THE PRIMARY CONTRACTOR

As a subcontracting Delivering HealthCare Professional (DHCP) in the Maternity Care Program, you should expect the following considerations from your Primary Contractor (PC). The relationship between the DHCP and the Primary Contractor is a contractual relationship and in many ways is not specifically governed by the Agency. Each DHCP will need to appoint a representative to participate in a bi-annual conference call with Agency staff to discuss the Maternity Care Program.

- A Negotiation of reimbursement dependent on the array of services performed (e.g. delivery only, prenatal and delivery, anesthesia, etc.);
- Annual open enrollment for subcontractors;
- An adequate network of subcontractors to meet patient needs;
- Timely payment once claims are submitted to the PC. Current standards are within 20 calendar days of Medicaid payment no later than 60 calendar days of delivery with the exception of TPL;
- Strict Compliance with HIPAA and patient confidentiality standards;
- Implementation and maintenance of Quality Assurance system by which access, outcome and processes are measured on both a program and provider specific basis;
- Patient choice of DHCP;
- Community based outreach program to ensure awareness of the Maternity Care Program;
- A provider education plan (what to expect, how the system works, etc.);
- To fully explain what services are included in their global payment as well as what services are included in your contractual payment. For example, lab services (other than hemoglobin, hematocrit and u/a) are billable fee-for-service; however cerclages are in the global fee paid to the PC and may or may not be included in your contractual payment;
- To have a Director to be available, accessible, and/or on-call for any medical or administrative problems which may arise;
- Prohibition of discrimination against any recipient based on their health status or need for health services;
- Toll-free telephone service for recipients to ask questions, enroll in the program, etc.;
- An established education plan for recipients to include healthy life styles, planning for the baby, self-care, family planning, appropriate use of the medical system, etc.;
- A grievance procedure for both subcontractors and recipients that is easily accessible and is explained to the recipients upon entry into care;
- A Care Coordinator assigned to each of your patients to assist with the Medicaid enrollment process, psychosocial issues, education and other needs that may arise;
- Patients that have completed the Medicaid enrollment process and if not, to have patients

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CHAPTER THIRTY-SEVEN

MANAGED CARE

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Chapter 37 - Managed Care

Rule No. 560-X-37-.01. General

(1) The Agency may, at its discretion, and in consultation with local communities, organize and develop area specific systems as part of an overall managed care system.

(a) Flexibility. Since community needs and resources differ from area to area, the Agency will maintain the flexibility to design plans which are consistent with local needs and resources.

(b) Waiver Programs. Plans may be either voluntary or mandatory pursuant to waiver(s) granted by the Centers for Medicare and Medicaid Services (CMS) or the Office of State Health Reform Demonstration. Some plans may start as voluntary and subsequently become mandatory. All required federal waivers must be obtained by Medicaid before any system or contract can become effective.

(c) State Plan Programs. Amendments to the state plan must be approved by CMS before any system or contract can become effective.

(d) Models. It is anticipated that managed care will be accomplished through a combination of primary care case management systems (PCCM), health maintenance organizations (HMO), managed care organizations (MCO) and prepaid Inpatient health plans.

(e) Purpose. The purposes of managed care are to:

(i) Ensure needed access to health care;

(ii) Provide health education;

(iii) Promote continuity of care;

(iv) Strengthen the patient/physician relationship;

and

(v) Achieve cost efficiencies.

(2) (a) Any managed care system established shall comply with the approved Alabama State Plan for Medical Assistance, Alabama Medicaid Administrative Code, ~~T~~the Alabama Medicaid Provider Manual and/or operational protocols, all other guidelines of Medicaid program areas, all state and federal laws and regulations, and any federally approved waivers in effect in the geographical areas of the State in which the system is operational and providing medical services to eligible Medicaid enrollees.

(b) The regulations of CMS at 42 CFR Parts 430, 432, 434, 438, 440, and 447, as promulgated in 67 Federal Register 40988 (June 14, 2002) and 68 Federal Register 3586 (January 24, 2003), and as may be subsequently amended, are adopted by reference. Copies of these regulations may be obtained from the US Government Printing Office, Washington, DC 20402 or at www.gpo.gov.su_docs/aces/aces140.html. Copies are also available from Medicaid at a cost of $7.00.

(3) Any managed care system or provider shall comply with all federal and state laws, rules and regulations relating to discrimination and equal employment opportunity, Titles VI and VII of the Civil Rights Act of 1964, as amended, the Federal Age Discrimination Act, Section 504 of the Rehabilitation Act of 1973, and Americans with Disabilities Act of 1990.

(4) The terminology and definitions in this chapter may be referenced in their entirety in 42 CFR 438.2. An abbreviated list follows:

(a) *Capitation payment* means a payment the state agency makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the state plan.

(b) *Capitated risk contract* means a risk contract that covers comprehensive services, that is, inpatient hospital services and any of the services listed in Rule 560-X-37-.03 (2).

(c) *Federally qualified HMO* means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

(d) *Health care professional* means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(e) *Health insuring organization (HIO)* means a county operated entity, that in exchange for capitation payments, covers services for recipients through payments to, or arrangements with, providers under a comprehensive risk contract with the state.

(f) *Managed care organization (MCO)* means an entity that has, or is seeking to qualify for, a comprehensive risk contract as defined in 42 CFR, Part 438, and that is a federally qualified HMO that meets the requirements of 42 CFR, Part 489, Subpart I.

(g) *Nonrisk contract* means a contract under which the contractor is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR, Section 447.362.

(h) *Prepaid ambulatory health plan (PAHP)* means an entity that provides medical services to enrollees under contract with the state agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

(i) *Prepaid inpatient health plan (PIHP)* means an entity that provides medical services to enrollees under contract with the state agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

(j) *Primary care* means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

(k) *Primary care case management* means a system under which a PCCM contracts with the state to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients.

(l) *Primary care case manager (PCCM)* means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services.

(m) *Primary medical provider (PMP)* means a family practitioner, general practitioner, internist, or pediatrician, an entity that provides or arranges for PMP coverage for services, consultation, or referrals 24 hours a day, seven days a week.

(n) *Risk contract* means a contract under which the contractor assumes risk for the cost of the services covered under the contract; and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

(5) The contract requirements in this chapter may be referenced in their entirety in 42 CFR 438.6. An abbreviated list follows:

(a) The CMS Regional Office must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in 438.806.

(b) Payments under risk contracts must be based on actuarially sound capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; and are appropriate for the populations to be covered, and the services to be furnished under the contract.

(c) All contracts in this chapter must comply with all applicable federal and state laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

(d) Physician incentive plans (PIP) do not apply to contracts in this chapter.

(e) All MCO and PIHP contracts must provide for compliance with the requirements of 422.128 for maintaining written policies and procedures for advance directives. The entity subject to this requirement must provide adult enrollees with written information on advance directives policies, and include a description of applicable state law.

(f) PCCM contracts must meet the following requirements:

(i) Provide for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.

(ii) Restrict enrollment to recipients who reside sufficiently near one of the manager's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation.

(iii) Provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

(iv) Prohibit discrimination in enrollment, disenrollment, and reenrollment, based on the recipient's health status or need for health care services.

(v) Provide that enrollees have the right to disenroll from their PCCM in accordance with 438.56 (c).

(6) The information requirements in this chapter may be referenced in their entirety in 42 CFR 438.10. An abbreviated list follows:

(a) *Enrollee* means a Medicaid recipient who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.

(b) *Potential enrollee* means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, or PCCM.

(c) Each state enrollment broker must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.

(d) The state must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.

(e) The state must establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the state. *Prevalent* means a non-English language spoken by a significant number of potential enrollees and enrollees in the state.

(f) The state and each managed care entity must make available written information in the prevalent non-English languages.

(g) The state must notify enrollees and potential enrollees and require each managed care entity to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages.

(7) The provider discrimination prohibitions in this chapter may be found in their entirety in 42 CFR 438.12. An abbreviated list follows:

(a) A managed care entity may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his license or certification under applicable state law, solely on the basis of that license or certification. If a managed care entity declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

(b) In all contracts with health care professionals, a managed care entity must comply with the requirements in 438.214.

(8) The enrollment requirements in this chapter may be found in their entirety in 42 CFR 438.50 through 438.66. An abbreviated list follows:

(a) A state plan that requires Medicaid recipients to enroll in managed care entities must comply with the provisions of this section, except when the state imposes the requirement as part of a demonstration project under section 1115 of the Act; or under a waiver granted under section 1915(b) of the Act.

(b) The state plan must specify the types of entities with which the state contracts; whether the payment method is fee for service or capitated; whether it contracts on a comprehensive risk basis; and the process the state uses to involve the public in both design and initial implementation of the program and the methods it uses to ensure ongoing public involvement once the state plan has been implemented.

(c) The plan must provide assurances that the state meets applicable requirements of section 1903(m) of the Act for MCOs; section 1905(t) of the Act for PCCMs; and section 1932(a)(1)(A) of the Act for the state's option to limit freedom of choice by requirring recipients to receive their benefits through managed care entities.

(d) The state must provide assurances that, in implementing the state plan managed care option, it will not require the following groups to enroll in an MCO or PCCM:

(i) Medicare eligible recipients;

(ii) Indians who are members of federally recognized tribes, except when the MCO or PCCM is the Indian Health Service or an Indian health program operated under a contract, grant, etc., with the Indian Health Service;

(iii) Children under 19 years of age who are eligible for SSI under title XVI; eligible under section 1902(e)(3) of the Act; in foster care or out of home placement; receiving foster care or adoption assistance; or receiving services through a community based care system.

(e) The state must have an enrollment system under which recipients already enrolled in an MCO or PCCM are given priority to continue that enrollment if the MCO or PCCM does not have the capacity accept all those seeking enrollment under the program.

(f) For recipients who do not choose an MCO or PCCM during their enrollment period, the state must have a default enrollment process for assigning those recipients to contracting MCOs and PCCMs.

(g) The process must seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients.

(h) An *existing provider-recipient relationship* is one in which the provider was the main source of Medicaid services for the recipient during the previous year.

(i) A provider is considered to have *traditionally served* Medicaid recipients if it has experience in serving the Medicaid population.

(9) The recipient choice requirements in this chapter may be found in their entirety in 42 CFR 438.52. An abbreviated list follows:

(a) A state that requires Medicaid recipients to enroll in an MCO, PIHP, PAHP or PCCM system must give those recipients a choice of at least two entities.

(b) A state may limit a rural area recipient to a single managed care entity with the exceptions noted in 438.52(b).

(c) A state may limit recipients to a single HIO if the recipient has a choice of at least two primary care providers within the entity.

(d) A state's limitation on an enrollee's freedom to change between primary care providers may be no more restrictive than the limitations on disrollment noted in 438.56.

(10) The disenrollment requirements and limitations in this chapter may be found in their entirety in 42 CFR 438.56. An abbreviated list follows:

(a) The provisions of this section apply to all managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with an MCO, a PIHP, a PAHP, or a PCCM.

(b) All contracts must specify the reasons for which the entity may request disenrollment of an enrollee.

(c) The entity may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

(d) All contracts must specify the methods by which the entity assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.

(e) All contracts must specify that a recipient may request disenrollment for cause at any time, or without cause at the following times:

(i) During the 90 days following the date of the recipient's initial enrollment with the entity or the date the state sends the recipient notice of the enrollment, whichever is later.

(ii) At least once every 12 months thereafter.

(iii) Upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

(f) Recipients (or their representatives) must submit oral or written requests for disenrollment to the state agency or the managed care entity (if the state permits the entity to process such requests).

(g) The following are cause for disenrollment:

(i) The enrollee moves out of the entity's service area.

(ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks.

(iii) The enrollee needs related services to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

(iv) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

(h) The state agency must complete the determination on the recipient's (or the entity's) request so that the effective date of disenrollment is no later than the first day of the second month following the month in which the recipient (or the entity) files the request.

(11) The state must have in effect safeguards against conflict of interest on the part of employees and agents of the state who have responsibilities relating to the managed care contracts. Medicaid employees must comply with the state ethics laws including, but not limited to, Code of Alabama (1975), Sections 36-25-5, -7, -8, -11, -12, and -13.

(12) The state must ensure that no payment is made to a provider other than the managed care entity for services available under the contract between the state and the entity. Medicaid ensures compliance with 438.60 through the systematic plan code determination at the detail level of a claim.

(13) The state must arrange for Medicaid services to be provided without delay to any Medicaid enrollee of a managed care entity whose contract is terminated and for any Medicaid enrollee who is disenrolled from an entity for any reason other than ineligibility for Medicaid.

(14) The state must have in effect procedures for monitoring the entity's operations, including at a minimum, operations related to the following:

(a) Recipient enrollment and disenrollment.
(b) Processing of grievances and appeals.
(c) Violations subject to intermediate sanctions.
(d) Violations of the conditions for FFP.
(e) All other conditions of the contract as appropriate.

(15) The enrollee rights in this chapter may be found in their entirety in 42 CFR 438.100. An abbreviated list follows:

(a) The state must ensure that each managed care entity has written policies regarding the enrollee rights specified in 438.100.

(b) Each entity shall comply with any applicable federal and state laws that pertain to enrollee rights and shall ensure that its staff and providers take those rights into account when furnishing services to enrollees.

(c) An enrollee of a managed care entity has the right to:

(i) Receive information in accordance with 438.10.

(ii) Be treated with respect and with due consideration for this or her dignity and privacy.

(iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

(iv) Participate in decisions regarding his or her health care.

(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

(vi) Request and receive a copy of his or her medical records, and request that they be amended or corrected.

(d) An enrollee of a managed care entity has the right to be furnished health care services in accordance with 438.206 through 438.210.

(e) The state must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the managed care entity and its providers treat the enrollee.

(f) The state must ensure that each entity complies with any other applicable federal and state laws.

(16) The provider-enrollee communications in this chapter may be found in their entirety in 42 CFR 438.102. An abbreviated list follows:

(a) A managed care entity may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is his or her patient, for the following:

(i) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

(ii) Any information the enrollee needs in order to decide among all relevant treatment options.

(iii) The risks, benefits, and consequences of treatment or nontreatment.

(iv) The enrollee's rights to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(17) The marketing activities described in this chapter may be found in their entirety in 42 CFR 438.104. An abbreviated list follows:

(a) *Cold-call marketing* means any unsolicited personal contact by the managed care entity for the purpose of marketing.

(b) *Marketing* means any communication from a managed care entity to a Medicaid recipient who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular entity's Medicaid product, or either to not enroll in, or to disenroll from, another entity's Medicaid product.

(c) Each contract with a managed care entity must provide that the entity does not distribute any marketing materials without first obtaining state approval.

(18) The rules concerning liability for payment may be found in their entirety in 42 CFR 438.106. An abbreviated list follows:

(a) Each managed care entity must provide that its Medicaid enrollees are not held liable for any of the following:

(i) The entity's debts in the event of insolvency.

(ii) Covered services provided to the enrollee for which the state does not pay the entity, or the state or the entity does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.

(iii) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the entity provided the services directly.

(19) All contracts must provide that any cost sharing imposed on Medicaid enrollees is in accordance with 447.50 through 447.60.

(20) The rules concerning emergency and poststabilization services may be found in their entirety in 42 CFR 438.114. An abbreviated list follows:

(a) *Emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent

layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(ii) Serious impairment to bodily functions.

(iii) Serious dysfunction of any bodily organ or part.

(b) *Emergency services* means covered inpatient and outpatient services that are as follows:

(i) Furnished by a provider that is qualified to furnish these services.

(ii) Needed to evaluate or stabilize an emergency medical condition.

(c) *Poststabilization care services* means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

(21) The solvency standards in this chapter may be found in their entirety in 42 CFR 438.116. An abbreviated list follows:

(a) Each MCO, PIHP, and PAHP that is not a federally qualified HMO must provide assurances to the state showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the managed care entity's debts if the entity becomes insolvent.

(b) Federally qualified HMOs are exempt from this requirement.

(22) The quality assessment and performance improvement standards in this chapter may be found in their entirety in 42 CFR, 438.200. An abbreviated list follows:

(a) The state must have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

(b) The state must obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it as final.

(c) The state must ensure that MCOs, PIHPs, and PAHPs comply with standards established by the state consistent with the regulations found in 42 CFR, Part 438.

(d) The state must conduct periodic reviews to evaluate the effectiveness of the strategy and update the strategy periodically as needed.

(e) The state must submit to CMS a copy of the initial strategy and the revised strategy whenever significant changes are made, as well as regular reports on the effectiveness of the strategy.

(23) The elements of state quality strategies in this chapter may be found in their entirety in 42 CFR 438.204. An abbreviated list follows:

(a) The contracts with MCOs and PIHPs must contain procedures that:

(i) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.

(ii) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. The state must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.

(iii) Regularly monitor and evaluate the MCO and PIHP compliance with the standards.

(iv) Arrange for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered.

(24) The rules concerning availability of services in this chapter may be found in their entirety in 42 CFR 438.206. An abbreviated list follows:

(a) The state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs and PAHPs.

(b) The state must ensure through its contracts that each entity, consistent with the entity's scope of contracted services, meets the following requirements:

(i) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.

(ii) Considers the anticipated Medicaid enrollment.

(iii) Considers the expected utilization of services, taking into account the characteristics and health care needs of specific Medicaid populations represented in the particular entity.

(iv) Considers the numbers and types of providers required to furnish the contracted Medicaid services.

(v) Considers the numbers of network providers who are not accepting new Medicaid patients.

(vi) Considers the geographic location of providers and enrollees.

(c) Each entity must do the following:

(i) Meet and require its providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services.

(ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service.

(iii) Make services included in the contract available 24 hours a day, seven days a week when medically necessary.

(iv) Establish mechanisms to ensure compliance by providers.

(v) Monitor providers regularly to determine compliance.

(vi) Take corrective action if there is a failure to comply.

(25) The assurances of adequate capacity and services in this chapter may be found in their entirety in 42 CFR 438.207 An abbreviated list follows:

(a) The state must ensure, through its contracts, that each entity gives assurances to the state and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state's standards for access to care.

(b) Each entity must submit documentation to the state, in a format specified by the state, to demonstrate that it complies with the following requirements:

(i) Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area.

(ii) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

(c) Each entity must submit the documentation to the state at the time it enters into a contract with Medicaid and at any time there has been a significant change in the entity's operations that would affect capacity and services.

(26) The requirements for coordination and continuity of care in this chapter may be found in their entirety in 42 CFR 438.208. An abbreviated list follows:

(a) Each managed care entity must implement procedures to deliver primary care and to coordinate health care service for all the entity's enrollees. These procedures must meet state requirements and must do the following:

(i) Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

(ii) Coordinate the services the entity furnishes to the enrollee with the services the enrollee receives from any other entity.

(iii) Share with other entities serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.

(iv) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with state and federal requirements to the extent that they are applicable.

(27) The requirements for coverage and authorization of services in this chapter may be found in their entirety in 42 CFR 438.210. An abbreviated list follows:

(a) Each contract with a managed care entity must identify, define, and specify the amount, duration, and scope of each service that the entity is required to offer.

(b) The services identified in each entity's contract must be furnished in the same manner that recipients receive under fee-for-service Medicaid.

(c) Each contract must ensure that the services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services were furnished.

(d) The entity may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of a diagnosis, type of illness, or condition of the beneficiary.

(28) The requirements for provider selection in this chapter may be found in their entirety in 42 CFR, 432.214. An abbreviated list follows:

(a) Medicaid must ensure through its contracts that each entity implements written policies and procedures for selection and retention of providers.

(b) Medicaid must establish a uniform credentialing and recredentialing policy that each entity must follow.

(c) Each entity must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the entity.

(d) The entity's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(e) The managed care entities may not employ or contract with providers excluded from participation in federal health care programs.

(f) Each entity must comply with any additional requirements established by Medicaid.

(29) The enrollee information requirements that the state must meet under the regulations in 438.10 constitute part of Medicaid's quality strategy at 438.204.

(30) Medicaid must ensure, through its contracts, for medical records and any other health and enrollment information that identifies any particular enrollee, each entity uses and discloses such information in accordance with applicable state and federal laws.

(31) Medicaid must ensure that each entity's contract complies with the enrollment and disenrollment requirements and limitations set forth in 438.56.

(32) Medicaid must ensure, through its contracts, that each entity has in effect a grievance system that meets the requirements of 438.400 through 438.424.

(33) The requirements concerning subcontractual relationships and delegation in this chapter may be found in their entirety in 42 CFR 438.230. An abbreviated list follows:

(a) Medicaid must ensure, through its contracts, that each entity oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.

(b) Before any delegation, each entity must evaluate the prospective subcontractor's ability to perform the activities to be delegated.

(c) A written agreement between the entity and the subcontractor must specify the activities and report responsibilities delegated to the subcontractor; and must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

(34) The requirements for practice guidelines in this chapter may be found in their entirety in 42 CFR 438.236. An abbreviated list follows:

(a) Medicaid must ensure, through its contracts, that each entity adopts practice guidelines that meet the following requirements:

(i) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(ii) Consider the needs of the entity's enrollees.

(iii) Are adopted in consultation with contracting health care professionals.

(iv) Are reviewed and updated periodically as appropriate.

(35) The requirements for quality assessment and performance improvement programs in this chapter may be found in their entirety in 42 CFR 438.240. An abbreviated list follows:

(a) Medicaid must require, through its contracts, that each entity has an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.

(b) At a minimum, Medicaid must require that each entity comply with the following requirements:

(i) Conduct performance improvement projects that are designed to achieve significant improvement in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

(ii) Submit performance measurement data to Medicaid annually.

(iii) Have in effect mechanisms to detect both underutilization and overutilization of services.

(iv) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

(36) The requirements for health information systems in this chapter may be found in their entirety in 42 CFR 438.242. An abbreviated list follows:

(a) Medicaid must ensure, through its contracts, that each entity maintains a health information system that collects, analyzes, integrates, and reports data.

(b) The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

(c) The entity must make all collected data available to Medicaid and upon request to CMS.

(37) The requirements for grievance systems in this chapter may be found in their entirety in 42 CFR 438.400. An abbreviated list follows:

(a) The Medicaid state plan provides an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(b) The Medicaid state plan provides for methods of administration that are necessary for the proper and efficient operation of the plan.

(c) Medicaid must require, through its contracts, that entities establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(d) In the case of an entity, *action* means:

(i) The denial or limited authorization of a requested service

(ii) The reduction, suspension, or termination of a previously authorized service.

(iii) The denial, in whole or in part, of payment for a service.

(iv) The failure to provide services in a timely manner as defined by the state.

(v) The failure of the entity to act within the timeframes provided in 438.408.

(e) *Appeal* means a request for review of an action, as "action" is defined above.

(f) *Grievance* means an expression of dissatisfaction about any matter other than an action, as "action" is defined above.

(38) The grievance system requirements in this chapter may be found in their entirety in 42 CFR 438.402. An abbreviated list follows:

(a) Each entity must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the state's fair hearing system.

(b) An enrollee, or a provider acting on behalf of the enrollee, may file an appeal, a grievance, or request a fair hearing.

(c) Medicaid will specify a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the entity's notice of action.

(39) The requirements for notice of action in this chapter may be found in their entirety in 42 CFR 438.404. An abbreviated list follows:

(a) The notice must be in writing and must meet the language and format requirements of 438.10(c) and (d) to ensure ease of understanding

(b) The notice must explain the following:

(i) The action the entity or its contractor has taken or intends to take.

(ii) The reasons for the action.

(iii) The enrollee's or the provider's right to file an appeal.

(iv) The enrollee's right to request a state fair hearing.

(v) The procedures for exercising the rights specified in this section.

(vi) The circumstances under which expedited resolution is available and how to request it.

(vii)The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(40) The requirements for the handling of grievances and appeals in this chapter may be found in their entirety in 42 CFR 438.406. An abbreviated list follows:

(a) In handling grievances and appeals, each entity must meet the following requirements:

(i) Give enrollees any reasonable assistance in completing forms and taking other procedural steps.

(ii) Acknowledge receipt of each grievance and appeal.

(iii) Ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making; or are health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease.

(41) The requirements for resolution and notification of grievances and appeals may be found in their entirety in 42 CFR 438.408. An abbreviated list follows:

(a) The managed care entity must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within the timeframes established by the state.

(b) The entity may extend the timeframes by up to 14 days if the enrollee requests the extension; or the entity demonstrates that there is need for additional information and how the delay is in the enrollee's interest.

(42) The requirements for expedited resolution of appeals in this chapter may be found in their entirety in 42 CFR 438.410. Each entity must establish and maintain an expedited review process for appeals, when the entity determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health.

(43) The managed care entity must provide the information specified at 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

(44) Medicaid must require, through its contracts, each entity to maintain records of grievances and appeals and must review the information as part of the state quality strategy.

(45) The requirements concerning continuation of benefits (while an appeal or fair hearing is pending) in this chapter may be found in their entirety in 42 CFR 438.420. The managed care entity must continue the enrollee's benefits if:

(a) The enrollee or the provider files the appeal timely.

(b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

(c) The services were ordered by an authorized provider.

(d) The original period covered by the original authorization has not expired.

(e) The enrollee requests extension of benefits.

(46) The requirements for effectuation of reversed appeal resolutions may be found in their entirety in 42 CFR 438.424.

(47) The requirements concerning fair hearings in this chapter may be found in their entirety in 42 CFR 431.200, et seq., and Chapter Three of this code. The Medicaid state plan must ensure that the regulations in these sections apply when a fair hearing is requested by an enrollee.

(48) The requirements concerning certifications and program integrity in this chapter may be found in their entirety in 42 CFR 438.600 through 438.610. An abbreviated list follows:

(a) When state payments to a managed care entity are based on data submitted by the entity, the state must require certification of the data as provided in 438.606.

(b) The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the state.

(c) The data submitted to the state must be certified by either the entity's chief executive officer, chief financial officer, or an individual who has been delegated the authority to sign for these officers.

(d) The certification must attest to the accuracy, completeness, and truthfulness of the submitted data.

(e) The entity must have procedures that are designed to guard against fraud and abuse.

(f) The entity must have written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable state and federal standards.

(g) The entity may not knowingly have a relationship with an individual who is debarred, suspended, or otherwise excluded from participation in state or federal health care programs.

(49) The requirements concerning sanctions in this chapter may be found in their entirety in 42 CFR 438.700 through 438.730. An abbreviated list follows:

(a) Medicaid must establish, through its contracts with managed care entities, intermediate provider sanctions that may be imposed upon the state's findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(b) Medicaid may impose sanctions that include the following:

(i) Civil money penalties.

(ii) Appointment of temporary management for the entity.

(iii) Granting enrollees the right to terminate enrollment without cause.

(iv) Suspension of all new enrollment after the effective date of the sanction.

(v) Suspension of payment for recipients enrolled after the effective date of the sanction.

(50) The requirements concerning federal financial participation (FFP) in this chapter may be found in their entirety in 42 CFR 438.602 through 438.812. An abbreviated list follows:

(a) FFP is not available in an MCO contract that does not have prior approval from CMS.

(b) Under a risk contract, the total amount Medicaid pays for carrying out the contract provisions is a medical assistance cost.

(c) Under a nonrisk contract, the amount Medicaid pays for the furnishing of medical services to eligible recipients is a medical assistance cost; and the amount paid for the contractor's performance of other functions is an administrative cost.

(51) The requirements for timely processing of claims and cost-sharing in this chapter may be found in their entirety in 42 CFR 447.45 through 447.60. An abbreviated list follows:

(a) A contract with a managed care entity must provide that the entity will meet the requirements of 447.45 and abide by those specifications.

(b) The managed care entity and its providers may, by mutual agreement, establish an alternative payment schedule, which must be stipulated in their contract.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: Alabama State Plan for Medical Assistance (hereinafter State Plan), Section 2.1(c), Attachment 2.1-A; Social Security Act, Title XI and Title XIX, Section 1903(m) (2) (B); 42 C.F.R Section 434.26, Section 434.6; Part 438; Civil Rights Act of 1964, Titles VI and VII, as amended. The Federal Age Discrimination Act. Rehabilitation Act of 1973. The Americans with Disabilities Act of 1990.
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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 one of the providers listed in (2) below.

(b) PCCM services may be offered by the state as a voluntary option under the Medicaid state plan; or on a mandatory basis under a 1915(b) waiver.

(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 or a group of physicians.

(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 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.

(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 period ends.)

(y) Provide the Agency within 30 days notice of PMP disenrollment or change in practice site. This will allow for an orderly reassignment of enrollees. Failure to provide 30 days 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 lock-in date to the PCCM program. Recipients have the ability to change PMPs on a monthly basis. Changes must be requested prior to the 20th of the month for the change to be effective the first of the following month.

(5) In order to participate in the PCCM system, a provider must sign an agreement with Medicaid that will detail the requirements of the PCCM 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 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 fess 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.

Author: Kim Davis-Allen, Director, Medical Services

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.
History: **New Rule:** Filed June 21, 2004; effective September 15, 2004

Rule No. 560-X-37-.03 Prepaid Inpatient Health Plan (PIHP)

(1) A prepaid inpatient health plan (PIHP) is one that provides services to enrolled recipients on a capitated basis but does not qualify as a HMO.

(2) Capitated PIHPs do not need to meet the requirements of §1903(m)(2)(A) of the Social Security Act if services are less than fully comprehensive. Comprehensive services are defined as:

(a) Inpatient hospital services and one or more services or groups of services as follows:

(i) Outpatient hospital services;
(ii) Laboratory and X-ray services;
(iii) Nursing facility (NF) services
(iv) Physician services;
(v) Home health services;
(vi) Rural health clinic services;
(vii)FQHC services;
(viii)Early and periodic screening, diagnostic, and treatment (EPSDT) services; and
(ix) Family planning services.

(b) No inpatient services, but three or more services or groups of services listed in Section (2)(a).

(3) If inpatient services are capitated, but none of the additional services listed in Section (2)(a) above are capitated, the entity may be considered a PIHP.

(4) The Partnership Hospital Program (PHP) is a non-comprehensive Prepaid Inpatient Health Plan (PIHP) operating under the Medicaid state plan. The following further describes the Partnership Hospital Program:

(a) It is an inpatient care program.

(b) It is mandatory for Medicaid recipients, with the exception of recipients with Part A Medicare coverage, SOBRA adults who are enrolled in and receive inpatient care through the Maternity Care program in counties covered by the PHP, and children certified through the Children's Health Insurance Program (CHIP).

(c) It is composed of prepaid inpatient health plans organized by districts in the State of Alabama.

(d) PIHPs operate under the authority granted in the Partnership Hospital Program, a state plan service as approved by CMS.

(e) Medicaid reimburses the prepaid inpatient health plans participating in the Partnership Hospital Program on a per member per month capitation basis.

(f) Prepaid inpatient health plans provide medically necessary inpatient care for covered Medicaid recipients including:

(i) Bed and board

(ii) Nursing services and other related services

(iii) Use of hospital facilities

(iv) Medical social services

(v) Drugs, biologicals, supplies, appliances and equipment

(vi) Certain other diagnostic and therapeutic services, and

(vii)Medical or surgical services provided by certain interns or residents-in-training.

(viii)Excluded are inpatient family planning services and inpatient emergency services.

(g) Prepaid inpatient health plans will assist the participant in gaining access to the health care system and will monitor on an inpatient basis the participant's condition, health care needs, and service delivery.

(h) Prepaid inpatient health plans are responsible for locating, coordinating, and monitoring all inpatient care in acute care hospitals within the state.

(i) Systems required of prepaid health plans, at a minimum, include:

(i) Quality assurance and utilization review systems

(ii) Grievance systems

(iii) Systems to furnish required services, including utilization review

(iv) Systems to prove financial capability

(v) Systems to pay providers of care

(5) The PIHP and Medicaid shall operate a quality assurance (QA) program sufficient to meet those quality review requirements of 42 CFR Part 438, Subpart D, applicable to PIHPs and their providers. The QA Program and any revisions must be approved in writing by Medicaid.

(a) The PIHP shall appoint a QA Committee to implement and supervise the QA Program. This committee shall consist of not less than three healthcare professionals, who may be members of the PIHP board, employees of providers or such other persons in the healthcare field as the PIHP believes will be required to oversee the creation and control of a successful QA Program for the PIHP.

(b) The QA Program shall be a written program specifying:

(i) Utilization control procedures for the on-going evaluation, on a sample basis, of the need for, and the quality and timeliness of care provided to Medicaid eligibles by the PIHP.

(ii) Review procedures by appropriate health professionals of the process, following the provision of health services.

(iii) Procedures for systematic data collection of performance and patient results.

(iv) Procedures for interpretation of these data to the provider.

(v) Procedures for making needed changes.

(c) The QA Committee shall employ a professional staff to obtain and analyze data from Medicaid information systems, the provider hospitals, and such other

sources as the staff deems necessary to carry out the QA Program. All costs of the QA Program shall be paid by the PIHP.

(d) PIHP member hospitals shall conduct continuing internal reviews of their own QA programs. The QA Committee staff shall be given all such assistance and direction by such provider QA programs and shall obtain such reasonable information from such providers as may be necessary to implement the PIHP QA Programs.

(e) The staff shall implement such focused medical reviews of the providers as may be required by Medicaid, required under the QA Program, or believed necessary the staff.

(f) Medicaid staff shall coordinate with the PIHP's QA Committee and staff on QA matters. Medicaid shall make such audits and surveys as it deems reasonably required, but shall do at least one annual medical audit on each PIHP and all of its providers. The PIHP shall provide all information, medical records, or assistance as may be reasonably required for Medicaid to conduct such audits.

(g) Medicaid QA personnel will make periodic on-site visits to review and monitor the QA Program and assess improvements in quality. The PIHP shall make certain all necessary information and records are available at such sites.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Part 434 and 438; State Plan Attachment 4.19-A(f)
History: Rule amended July 12, 1996. Emergency rule effective October 1, 1996. Amended January 14, 1997; January 12, 1998; June 16, 2003.
Amended: Filed April 7, 2004; effective July 16, 2004.

Rule No 560-X-37-.04 Health Maintenance Organizations (HMO)

(1) Health Maintenance Organizations (HMOs) means any entity or corporation that undertakes to provide or arrange for basic health care services through an organized system which combines the delivery and financing of health care to enrollees. The organization shall provide physician services directly through physician employees or under contractual arrangements with either individual physicians or a group of physicians. The organization shall provide basic health care services directly or under contractual arrangements. When reasonable and appropriate, the organization may provide physician services and basic health care services through other arrangements. The organization may provide, or arrange for, health care services on a prepayment or other financial basis.

(2) Covered services shall be provided to each eligible enrollee and will be reimbursed on a monthly capitation basis.

(3) The HMO is required to obtain a Certificate of Authority to operate as a HMO in the State of Alabama, issued by the Department of Insurance prior to providing services. HMOs must obtain a Certificate of Need (CON) or a letter of non-reviewability from the State Health Planning Agency. When applicable, the HMO may also be required to participate in an Invitation to Bid process as directed by the Medicaid Agency.

(4) The HMO shall make adequate provisions against the risk of insolvency as contained in the Code of Alabama Section 27-21A-12 and as specified in the contract between the HMO and Medicaid. The HMO must ensure that individuals eligible for benefits are never held liable for debts of the plan.

(5) HMOs desiring to participate as a managed care provider should contact the Medical Services Division at Medicaid. HMOs must submit written documentation for approval which includes, but is not limited to, the following:

(a) Description of services to be provided
(b) Marketing Plan and any marketing materials to be used by the plan
(c) Quality Assurance Plan
(d) Enrollment Plan
(e) Education Plan
(f) Copy of Certificate of Authority
(g) Copy of Certificate of Need or letter of non-reviewability
(h) Examples of subcontracts to be utilized by the plan
(i) Proposed enrollment sites
(j) Enrollment area
(k) Grievance procedures

All of the above information must be sent before the review can be completed.

(6) The HMO must ensure contracted health services required by the enrollees are available and accessible through a system that arranges for primary and preventive care provided by and coordinated through a Medicaid enrolled Primary Care Physician (PCP).

(7) Enrollment

(a) In geographical areas that are served by a freedom-of-choice waiver, enrollment in an approved HMO is mandatory for those recipients included in the waiver. Recipients will have the opportunity to voluntarily enroll in an HMO during the open enrollment period, if applicable.

(b) In the event that a recipient who resides in an area that has a freedom-of-choice waiver does not select an HMO, Medicaid will mandatorily assign that recipient to an HMO. In an area where only one HMO is operational under an approved 1115 waiver, the recipient will be required to select a PCP within the HMO's network or be assigned. This will be done according to a formula which meets the needs of the State and the recipients and which is communicated to all health plans in advance. This formula may consist of rotation among the HMOs. Medicaid will notify the HMO of the recipients mandatorily enrolled in their plan via computer compatible media. Recipients that have been mandatorily assigned will also be notified by Medicaid. The effective date of enrollment generally will be the first day of the month following a full calendar month after assignment to an HMO. It is the HMO's responsibility to send to Medicaid

monthly, on computer compatible media, all current enrollees, new enrollees and disenrollments.

(8) Disenrollment

(a) When an enrollee becomes ineligible for Medicaid benefits, is deceased, moves out of the service area, or is changed to a non-covered aid category; the effective date of disenrollment will be the first day of the month following documentation of the change on the Managed Care File.

(b) Any enrollee may elect to disenroll from an HMO, with or without cause, and enroll in another where multiple HMOs participate in the Medicaid program in that area. Recipients are required to submit a written disenrollment request to the HMO with a reason documented in the patient file and on the monthly enrollment information. Disenrollment is effective the first day of the month following a full calendar month after receipt of the disenrollment on the monthly enrollment information.

(c) Unless otherwise specified in an approved waiver, an HMO may disenroll an enrollee whose behavior is disruptive, unruly, abusive, or uncooperative, and not caused by a medical condition, to the extent that his membership in the HMO seriously impairs the HMO's ability to furnish services to that enrollee or other members of the HMO. The HMO is required to provide at least one verbal and one written warning to the enrollee regarding the implication of his actions. No member can be involuntarily disenrolled without the prior written approval of Medicaid.

(d) Unacceptable reasons for an HMO to disenroll an enrollee include pre-existing medical conditions, changes in health status, and periodic missed appointments.

(e) Enrollees may be disenrolled for knowingly committing fraud or permitting abuse of their Medicaid card. Disenrollment of this nature must be promptly reported to Medicaid and must be prior authorized by Medicaid.

(f) The HMO's responsibility for all disenrollments includes supplying disenrollment forms to enrollees desiring to disenroll; ensuring that completed disenrollment forms are maintained in an identifiable enrollee record; ensuring that disenrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so; and ensuring that disenrollees receive written notification of the effective date of and reason for disenrollment. HMOs must submit voluntary disenrollments on the first electronic submission sent to Medicaid after the request is received by the HMO.

(9) Marketing

(a) The Medicaid Agency may elect to enroll recipients through contracted enrollment vendors. If the State chooses to use vendors, HMOs will not be allowed to enroll or recruit patients through marketing representatives.

(b) The HMO shall submit the written marketing plan, procedures, and materials to Medicaid for approval prior to implementation. Enrollment of recipients may not begin until the marketing plan has been approved by Medicaid.

(c) The HMO shall not engage in marketing practices that mislead, confuse, or defraud enrollees, providers, or Medicaid. Mailings, gifts of a material nature, telecommunication and door-to-door marketing are subject to prior approval by the Alabama Medicaid Agency.

(d) Accurate, clear, readable, and concise information shall be made available to eligible recipients and providers in the area serviced by the HMO. Such information shall include, but not be limited to: covered services, location, telephone number, hours of service, enrollment, disenrollment, grievance procedures, and what to do in case of an emergency.

(e) No more than fifty percent (50%) of a marketing representative's total annual compensation, including salary, benefits, bonuses and commission, shall come from commissions.

(10) Grievance Procedures

(a) The HMO shall have a written internal grievance procedure that is approved by Medicaid.

(b) The HMO must have written procedures for prompt and effective resolution of written enrollee grievances.

(c) The HMO must include a description of the grievance system including the right to appeal decisions.

(d) The HMO must maintain records of all oral complaints and written grievances in a log (hard copy or automated).

(e) The HMO must make provisions to accept and resolve grievances filed by individuals other than enrollees.

(11) Quality Assurance

(a) The HMO's Quality Assurance Plan (QAP) must objectively and systematically monitor and evaluate the quality and age appropriateness of care and services through quality of care studies and related activities by following written guidelines predicated on the Quality Assurance Reform Initiative (QARI) which must include:

(i) Goals and objectives;
(ii) Scope;
(iii) Specific activities;
(iv) Continuous activities;
(v) Provider review; and
(vi) Focus on health outcomes.

(b) The Governing Body of the HMO must be responsible for, or designate an accountable entity within the organization to be responsible for, oversight of the QAP.

(c) Each HMO must designate a committee responsible for the performance of QA functions accountable to the Governing Body.

(d) The QAP must objectively and systematically monitor and evaluate the quality and appropriateness of care and service through quality of care studies and related activities.

(e) Each HMO must designate a senior executive to be responsible for QAP implementation and the Medical Director must have subsequent involvement in QAP activities.

(f) The QA Committee must have, as members HMO providers representative of the composition of all providers of service.

(g) The QAP must include provisions for credentialing and recredentialing of health care professionals who are licensed by the State.

(h) HMOs shall allow Medicaid's authorized representative, on an annual basis, to conduct an external independent quality review to analyze the quality of services furnished by the HMO to ensure adequate delivery of care. The results of the review shall be made available to Medicaid, and upon request, to the Secretary of HHS, the Inspector General, and the Comptroller General.

(12) Records

(a) An appropriate record system shall be maintained for all services (including ancillary services) provided to all enrollees. Such records shall be stored in a safe manner to prevent damage and unauthorized use. Records will be reasonably accessible for review.

(b) Entries on medical records shall be authenticated and written legibly in ink or typewritten.

(c) Records must contain all pertinent information relating to the medical management of each enrollee reflecting all aspects of patient care in a detailed, organized and comprehensive manner consistent with medical practice standards.

(d) The HMO shall make available at no cost to Medicaid, the Department of Health and Human Services, and to their designees, any records of the provider and/or subcontractors which relate to the HMO's ability to bear risks for the services performed, amounts paid for benefits, quality review, and any other requested documentation.

(13) Reporting

(a) The HMO shall furnish any information from its records to HHS, the Comptroller General, and/or their agents which may be required to administer the contract. At a minimum, the HMO shall furnish to Medicaid, and to authorized representatives, in a manner and form specified by Medicaid:

(i) Business transactions to include:

a. Any sale, exchange or lease of any property between the HMO and a party in interest;

b. Any lending of money or other extension of credit between the HMO and a party in interest; and

c. Any furnishing for consideration of goods, services (including management services) or facilities between the Plan and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The information which must be disclosed in the transactions listed above between an HMO and a party in interest includes the name of the party in interest for each transaction, a description of each transaction and the quality of units involved, the accrued dollar value of each transaction during the fiscal year and justification of the reasonableness of each transaction.

(ii) Proposed changes to the marketing plan, procedures or materials;

(iii) Monthly enrollment data to include name, Medicaid number, payee number, and PCP assignment number;

(iv) Utilization data concerning enrollees in the Plan as required by contract;

(v) Summaries of all complaints and all grievances received by the HMO under this contract and actions taken to resolve complaints and grievances quarterly and annually.

(vi) Summaries of amounts recovered from third parties for services rendered to enrollees under the HMO;

(vii)A list of payments made by the HMO during the past month for services purchased through referral and subcontracted providers;

(viii)Encounter data claims submitted directly to Medicaid's fiscal agent for all services paid for or provided by the HMO to enrollees in previous months; and

(x) All other reports as specified and defined in the Managed Care Provider Manual/Operational Protocol and contract.

(b) The HMO will keep and make available to Medicaid, HHS, the Comptroller General, and their agents or authorized representatives, any of the HMO's records which are necessary to fully disclose and substantiate the nature, quality, cost, and extent of items and services provided to enrollees. The HMO shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of five years from the date of the last payment made by Medicaid to the HMO under this contract. However, when audit, litigation, or other action involving records is initiated prior to the end of the five (5) years period, records shall be maintained for a period of five (5) years following the completion of such action and the resolution of all actions which arise from it. Plans shall fully complete and submit to Medicaid quarterly financial statements. Quarterly reports are due for periods ending March 31, June 30, September 30, and December 31 and must be submitted within 45 days of the end of the reporting period or the HMO shall pay a penalty of $100.00 for each day the financial report is delinquent. In addition, the National Association of Insurance Commissioner's Annual Statement Blank, must be fully completed by Contractor annually and submitted to Medicaid. The HMO's annual report must be submitted no later than March 1 or Contractor shall pay to Medicaid a penalty of $100.00 for each day the annual report is delinquent. However, the Commissioner of Medicaid shall have the option to waive the penalty with shown proof by the HMO of good cause for the delay. In addition, the HMO must submit an audited financial statement to Medicaid covering the fiscal year within 90 days of the end of its fiscal year. Contractor shall also promptly submit any and all other financial information requested by Medicaid, HHS, or the Comptroller General.

(14) Payment

(a) Capitation payments to the HMO for all eligible enrollees shall be made monthly.

(b) The HMO shall accept the capitation fees as payment in full for Medicaid benefits provided and shall require its providers to accept payments in full for Medicaid benefits provided.

(c) Neither managed care enrollees nor Medicaid shall be held liable for debts of the HMO in the event of the organization's insolvency.

(d) In-plan covered services must be provided by the HMO chosen by the recipient. These services can be provided directly, through subcontract providers, or by non-contract out-of-plan providers when appropriately referred.

(e) If an enrollee utilizes a non-contract provider for in-plan service, other than emergency services, family planning services, and services provided by a Federally Qualified Health Center (FQHC), the HMO, to the extent allowed by law, may not be held liable for the cost of such utilization unless the HMO referred the enrollee to the non-contract provider or authorized the out-of-plan utilization. Payment by the referring HMO for properly documented claims shall not exceed the maximum fee-for-service rates applicable for the provider for similar services rendered under the Alabama Medicaid Program, unless otherwise agreed upon by the HMO and the non-contract provider. No reimbursement shall be available directly from Medicaid for in-plan services provided by non-contract providers. If there is an FQHC in the geographical area being served by a HMO that contracts with one or more HMO's, an enrollee may elect to join the HMO contracting with the FQHC in order to receive the services offered by the FQHC. If no FQHC in the area agrees to contract with any of the HMOs, the HMOs are obligated to reimburse the FQHC if an enrollee elects to receive services from this entity.

(15) Compliance Review Committee

(a) Alabama Medicaid shall establish a Compliance Review Committee (CRC). The purpose of the CRC is to facilitate resolution of issues related to compliance with the requirements of the contract between the HMO and Medicaid.

(b) Administrative sanctions are reserved for managed care program abuses. Sanctions may be imposed by the Agency for failure to comply with Agency program requirements.

(c) In all cases of HMO abuse, restitution of improper payments or monetary sanctions may be pursued in addition to any administrative sanctions imposed. Administrative sanctions include, but are not limited too, probation. During probation, an HMO may have the number of enrollees it serves limited to a fixed number by the Agency for a set period of time. The HMO will be notified if probation has been authorized for a specific period of time and at the termination of the probation, the HMO will be subject to a follow-up review of its Medicaid Managed Care practice.

(d) The decision as to the sanction(s) to be imposed shall be at the discretion of the Medicaid Commissioner based on the recommendation(s) of the staff of the Managed Care Division, the CRC or other appropriate program review personnel.

(e) The following factors shall be considered in determining the sanctions to be imposed:

(i) Seriousness of the offense(s)

(ii) Extent of violations and history of prior violations

(iii) Prior imposition of sanctions

(iv) Actions taken or recommended by Peer Review Organizations or licensing boards

(v) Effect on health care delivery in the area

When an HMO is reviewed for administrative sanctions, the Agency shall notify the HMO of its final decision and the HMO's entitlement to a hearing in accordance with the Alabama Administrative Procedure Act.

(16) Childrens Health Insurance Program (CHIP)

Children eligible as CHIP children, aged up to 19, who reside in counties in which HMO coverage is available may be included in the program.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: Alabama State Plan for Medical Assistance (hereinafter State Plan), Section 2.1(c), Attachment 2.1-A; Attachment 4.18-A; Social Security Act, Title XI and Title XIX, Section 1903(m); 42 C.F.R. Section 434 et seq.; Civil Rights Act of 1964, Titles VI and VII, as amended. Code of Alabama 1975, Section 22-21-20, et seq., Section 27-21A-1, et seq., and 41-22-1, et seq. The Federal Age Discrimination Act. Rehabilitation Act of 1973. The Americans with Disabilities act of 1990.
History: Effective date is July 12, 1996. Amended January 12, 1998. **Amended**: Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-37-.05 Medicare Health Maintenance Organizations (MHMOs) and Competitive Medical Plans (CMPs)

(1) A Medicare Health Maintenance Organizations (MHMO) and Competitive Medical Plans (CMP) are organizations which may contract with the Health Care Financing Administration (HCFA) to enroll Medicare beneficiaries and other individuals and groups to deliver a specified comprehensive range of high quality services efficiently, effectively, and economically to its Medicare enrollees. An HMO or CMP must be organized under the laws of the State and must meet HCFA's qualifying criteria, as specified in 42 C.F.R. §417.410-.418, in order to enter into a contract with HCFA to enroll Medicare beneficiaries.

A Competitive Medical Plan, as defined in 42 C.F.R. §417.407(c), is a legal entity, which provides to its enrollees at least the following services: services performed by physicians; laboratory, x-ray, emergency, and preventive services; out-of-area coverage; and inpatient hospital services. The entity receives compensation by Medicaid for the health care services it provides to enrollees on a periodic, prepaid capitation basis regardless of the frequency, extent, or kind of services provided to any enrollee. The entity provides physician services primarily through physicians who are employees or partners of the entity or physicians or groups of physicians (organized on a group or individual practice basis) under contract with the entity to provide physician services. The entity assumes full financial risk on a prospective basis for provision of health care services, but may obtain insurance or make other arrangements as specified in 42 C.F.R. §417.120 and .407. The entity must provide adequately against the risk of insolvency by meeting the fiscal and administrative requirements of 42 C.F.R. §417.120(a)(1)(i) through (a)(1)(iv) and 417.122(a).

(2) The Alabama Medicaid Agency may reimburse a fixed per member per month (PMPM) capitated payment established by Medicaid to HMOs and CMPs which have an approved Medicare risk contract with the Health Care Financing Administration for beneficiaries who enroll in a Medicare HMO or CMP for which Medicaid is responsible for payment of medical cost sharing. Medicare beneficiaries must receive Part A or Parts A&B coverage to be eligible for this program. This PMPM payment will cover, in full, any premiums or cost sharing required from the Medicare Plan. The PMPM payment will be established based on historical costs and negotiations.

(3) Medicare HMOs and CMPs may enroll with the Medicaid Agency to receive capitated payments for beneficiary premiums and cost sharing by executing a Memorandum Of Understanding with the Medicaid Agency. To enroll the following must be submitted to Medicaid:

(a) A copy of HCFA approval for a Medicare risk contract to enroll Medicare beneficiaries;

(b) A copy of the HMO or the CMP's member services handbook; and

(c) A copy of Certificate of Authority (COA) from the Alabama Insurance Department and appropriate approvals for a material modification to a COA.

(4) All services covered by Medicare shall be covered by the HMO or CMP at no cost to the beneficiary. In addition, the HMO or CMP may offer additional services to the beneficiary (e.g. hearing exams, annual physical exam, eye exams, etc.). The HMO or CMP must notify the Alabama Medicaid Agency prior to adding additional services (identified by procedure code) available to the beneficiary through the Plan. Services covered directly by Medicaid which are not covered by Medicare are not included in the Plan.

(5) The beneficiary will be given freedom of choice in selecting a primary care provider through the Medicare HMO or CMP.

(6) The Medicare HMO or CMP is required to submit a monthly electronic enrollment listing to Medicaid in a format specified by Medicaid.

Authority: State Plan 3.2(a)(10)(E)(i). Social Security Act §1905(p)(1). 42 C.F.R. Section 434.20, Section 434.26, Section 434.23, Section 434.29, Section 434.38, Section 434.6. Effective date is July 12, 1996.

Rule No. 560-X-37-.06 - Family Planning Waiver

(1) The Family Planning Waiver program operates under an approved Section 1115(a) Research and Demonstration Waiver, which extends Medicaid eligibility for family planning services to all women of childbearing age (19 through 44), with incomes at or below 133% of the federal poverty level who would not otherwise qualify for Medicaid. The waiver has been approved for five (5) years and may be renewed with HCFA's approval.

(2) The program represents a collaborative effort between the Alabama Medicaid Agency and the Alabama Department of Public Health.

(3) The Family Planning Waiver Program is officially known as the "Plan First Program."

(4) Enrolled Medicaid providers are eligible to provide family planning services but must also enroll as a network provider by completing a Plan First agreement. Upon receipt of the signed agreement, Medicaid's fiscal agent will add the Plan First provider specialty code to the provider's existing record. Those providers that only do tubal ligations do not have to enroll as a Plan First provider nor do anesthesia providers for these procedures. There are no changes to current provider eligibility policies due to this waiver.

(5) The following are the eligible groups for the Family Planning Waiver:

(a) Women age 19 through 44 who have SOBRA eligible children will become automatically eligible for family planning without a separate eligibility determination. Women who are not citizens and are payees of SOBRA Medicaid children will be sent a letter along with an application telling them how to apply for the Plan First Program.

(b) SOBRA poverty level pregnant women age 19 through 44 will receive automatic eligibility for family planning services at the expiration of their 60 days postpartum without separate eligibility determination.

(c) Other women age 19 through 44 who are not pregnant and are not applying for a child may apply for family planning services using a simplified shortened application.

(d) SOBRA females who are turning age 19 and would ordinarily be terminated from Medicaid.

Newly awarded family planning recipients will receive a Medicaid plastic card based on the same criteria as other Medicaid recipients. Providers will be informed at the time of eligibility verification that services are limited to family planning only. If a recipient has received a plastic card in the recent past, another card will be sent only upon request.

(6) In order to be eligible for Family Planning Services a woman must:

(a) Furnish a Social Security number or proof they have applied for one

(b) Be a female resident of Alabama age 19 through 44

(c) Meet citizenship and alienage requirements

(d) Have family income at or below 133% of the federal poverty level

(e) Cooperate in establishing third party medical benefits, and apply for all benefits to which she may be entitled

(7) Once determined eligible, a woman will remain eligible for benefits until the termination of the waiver unless she disenrolls or is terminated from the waiver for one of the following reasons:

(a) The recipient's gross countable family income exceeds 133% of the federal poverty level

(b) The recipient does not reside in Alabama

(c) The recipient is deceased

(d) The recipient has received a sterilization procedure

(e) The recipient requests her family planning benefits be terminated

(f) The recipient is outside the family planning age limit of 19 through 44

(g) The recipient is eligible for Medicare benefits

(h) The recipient becomes eligible for another Medicaid program

(i) The recipient fails to cooperate with the Medicaid Agency in the eligibility process, receipt of services or Medicaid Quality Control Review

(j) The recipient is determined ineligible due to fraud, misrepresentation of facts, or incorrect information

(8) Medical services covered for the extended eligibles are limited to birth control services and supplies only. This includes:

(a) All currently covered family planning methods

(b) Outpatient tubal ligation

(c) Doctor/clinic visits (for family planning only)

(d) HIV pre and post test counseling visits

(9) Eligible participants have freedom of choice in the selection of an enrolled network provider. Oral contraceptives must be received from an in-network provider, not from a pharmacy. Network providers may dispense only those oral contraceptives that are on the Alabama Department of Public Health's formulary. Requests from providers for oral contraceptives not on the Health Department's formulary will be reviewed and a decision will be made based on medical necessity of an alternate oral contraceptive.

(10) Oral contraceptives that are dispensed by network providers must be ordered from the Alabama Department of Public Health and must be dispensed only to waiver participants. Stock for waiver participants should be maintained separately from sample stock. Orders should be placed using the "Oral Contraceptives Order Form" provided to network providers and orders should be placed for a three (3) month period and re-ordered when the provider is down to a 30-day supply. Orders will be processed by the Alabama Department of Public Health within five (5) working days of receipt of order form. Order forms will be accepted by general mail or fax.

(11) Under this waiver, Medicaid also reimburses for care coordination activities provided by licensed social workers or registered nurses associated with the Alabama Department of Public Health who have received training on the Family Planning Program. Services are available to all women, regardless of the care site. Care coordination will be reimbursed on a per hour basis in 5 minute increments. Enrolled providers must refer participants to the Health Department to initiate care coordination.

(12) Family Planning Care Coordination will only be available for women eligible through the Family Planning Waiver. Recipients eligible for other Medicaid eligibility programs will be eligible for the regular benefit packages established for those programs and will not be eligible for the enhanced family planning care coordination services.

(13) The Family Planning Waiver program operates under approved Terms and Conditions as specified in the waiver and the Operational Protocol Manual.

Author: Kim Davis-Allen, Director, Medical Services Division.
Statutory Authority: Section 1115(a): Sections 1902(a) (10) (b), (e) (5) and (6) of the Social Security Act.
History: New Emergency Rule filed: August 28, 2000; effective October 1, 2000. Amended: Filed September 21, 2000, effective December 11, 2000. Amended: Filed September 21, 2001, effective December 14, 2001.

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Chapter 45 Maternity Care Program

Rule No. 560-X-45-.01 Authority and Purpose

(1) Pregnancy related care for Medicaid eligible women provided through the Maternity Care Program (MCP) is provided pursuant to the Alabama State Plan as approved by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) and the approved 1915(b) Waiver. The purpose of the program is to provide a comprehensive, coordinated system of obstetrical care to pregnant recipients.

(2) Coverage for the MCP includes the provisions of the Balanced Budget Act of 1997 and the subparts of the BBA Medicaid Managed Care regulation at 42 CFR Part 438.

(3) Program specifics are delineated in the Invitation to Bid (ITB) that is utilized for selection of Primary Contractors for the program.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.02 Eligibility

(1) Pregnant women participating in the program are determined Medicaid eligible by Medicaid and/or other approved certifying agencies through the normal eligibility process. Persons eligible for the MCP are women deemed pregnant through medical examination and/or laboratory tests.

(2) Recipients eligible for both Medicare and Medicaid shall not be enrolled.

(3) Providers shall access eligibility information through the Medicaid Automated Voice Response System or the appropriate electronic software for specific information on the county of residence and the pregnancy restriction to a Primary Contractor.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.03 Primary Contractor Standards
Primary Contractors must comply with the provisions of the executed contract, its amendments and referenced materials, the approved 1915(b) Waiver, and all other state and federal regulations governing the Medicaid program. The following outlines the standards for the Primary Contractor.

(1) Demonstrate the capability to serve all of the pregnant Medicaid eligible population in the designated geographical area.

(2) Designate a Director or other designee to be available, accessible, and/or on call at all times for any administrative and/or or medical problems which may arise.

(3) Require subcontractors providing direct care to be on call or make provisions for medical problems 24-hours per day, seven days per week.

(4) Require that all persons including employees, agents, subcontractors acting for or on behalf of the Primary Contractor, be properly licensed under applicable state laws and/or regulations.

(5) Comply with certification and licensing laws and regulations applicable to the Primary Contractor's practice, profession or business. The Primary Contractor agrees to perform services consistent with the customary standards of practice and ethics in the profession. The Primary Contractor agrees not to knowingly employ or subcontract with any health professional whose participation in the Medicaid and/or Medicare Program is currently suspended or has been terminated by Medicaid and/or Medicare.

(6) Require that network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider only serves Medicaid recipients as required at 42 CFR 438.206(c)(1)(i).

(7) Establish mechanisms to ensure that the network providers comply with timely access requirements. The primary contractor shall monitor regularly to determine compliance and shall take corrective action if there is a failure to comply. Access requirements are further defined at 42 CFR 438.206(c)(1)(iv)(v)(vi).

(8) Comply with all State and Federal regulations regarding family planning services and sterilizations, including no restriction on utilization of services.

(9) Require all subcontractors providing direct services to meet the requirements of and enroll as Medicaid providers as applicable

(10) Require accurate completion and submission of hospital encounter data claims to support the validity of data used for statistical capitation purposes.

(11) Cooperate with external review agents who have been selected by the State

to review the Program.

(12) Report suspected fraud and abuse to the Alabama Medicaid Agency. In addition, these policies and procedures must comply with all mandatory State guidelines and federal guidelines as specified at 42 CFR 438.608(b)(1).

(13) Prohibit discrimination against recipients based on their health status or need for health services as specified at 42 CFR 438.6(d)(3)(4).

(14) Ensure that medical records and any other health and enrollment information that identifies any individual enrollee must be handled in such a manner as to meet confidentiality requirements as specified in 42 CFR 438.224. Each Primary Contractor must establish and implement procedures consistent with confidentiality requirements as specified in 42 CFR 438.224.

(15) The Primary Contractor is not required to provide, reimburse payment, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds in accordance with 42 CFR 438.102(a)(b). If the Primary Contractor elects not to provide the service, then it must provide the related information to the State so that it can be provided to the recipient.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.04 Primary Contractor Functions/Responsibilities

(1) Provide the pregnant Medicaid eligible population obstetrical care through a comprehensive system of quality care. The care can be provided directly or through subcontracts.

(2) Implement and maintain the Medicaid approved quality assurance system by which access, process and outcomes are measured.

(3) Utilize proper tools and service planning for women assessed to be medically or psychosocially at risk.

(4) Provide recipient choice among Delivering Healthcare Professionals in their network.

(5) Meet all requirements of the Provider Network including maintaining

written subcontracts with providers to be used on a routine basis including but not limited to, delivering physicians including obstetricians, family practitioners, general practitioners, etc., anesthesiologists, hospitals, and care coordinators. After contract award and for the 1st 30 days of each succeeding contract year, the Primary Contractor must offer opportunities for participation to all interested potential subcontractors.

The Primary Contractor must notify the Agency, in writing, of changes in the subcontractor base including the subcontractor's name, specialty, address, telephone number, fax number and Medicaid provider number.

(6) Maintain a toll-free line and designated staff to enroll recipients and provide program information.

(7) Require subcontractors to comply with advance directives requirements.

(8) Develop, implement and maintain an extensive recipient education plan covering subjects, such as appropriate use of the medical care system, purpose of care coordination, healthy lifestyles, planning for baby, self-care, etc. All materials shall be available in English and the prevalent non-English language in the particular service area. The Primary Contractor is required to participate in the Agency's efforts to promote the delivery of services in a culturally competent manner including to those with limited English proficiency and with diverse cultural and ethnic backgrounds. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight and/or speech impairments.

(9) Develop, implement, and maintain a provider education plan, covering subjects such as minimum program guidelines, billing issues, updates from Medicaid, etc. Provide support and assistance to subcontractors to include at minimum program guidelines, billing issues, updates from Medicaid, etc.

(10) Develop, implement and maintain an effective outreach plan to make providers, recipients and the community aware of the purpose of the Alabama Medicaid Agency MCP and the services it offers. The Primary Contractor is refrained from marketing activities as specified in Administrative Code 560-X-37-.01(17) and as further defined in 42 CFR 438.104(a) and 438.104(b)(1) et al.

(11) Develop, implement and maintain an educational program explaining how to access the MCP including service locations. Materials shall provide information about recipient rights and responsibilities, provisions for after-hours and emergency care, referral policies, notification of change of benefits, procedures for appealing adverse decisions, procedures for changing DHCP, exemption procedures and grievance procedures. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight and/or speech impairments.

(12) Develop, implement and maintain a grievance procedure that is easily accessible and that is explained to recipients upon entry into the system.

(13) Develop, implement and maintain a system for handling billing inquiries from recipients and subcontractors so that inquiries are handled in a timely manner.

(14) Develop, implement and maintain a computer based data system that collects, integrates, analyzes and reports. Minimum capabilities include recipient tracking, billing and reimbursement, data analysis and the generation of reports regarding recipient services and utilization.

(15) Give Medicaid immediate notification, by telephone and followed in writing, of any action or suit filed and prompt notice of any claim made against the Primary Contractor by any subcontractor which may result in litigation related in any way to the subject matter of this Contract. In the event of the filing of a petition of bankruptcy by or against any subcontractor or the insolvency of any subcontractor, the Primary Contractor must ensure that all tasks related to any subcontractor are performed in accordance with the executed office.

(16) Maintain a complete record for each enrolled recipient, at one location, of all services and identify by recipient name, recipient number, date of service, and services provided prior to making payment to that provider of provided. The Primary Contractor must obtain such information from all providers of services service. It is acceptable to maintain one medical record and one administrative record (e.g. care coordination billing, etc.).

(17) Perform claims review prior to submission to Medicaid for Administrative Review.

(18) Advise recipients of services that may be covered by Medicaid that are not covered through the MCP.

(19) Promptly provide to Medicaid all information necessary for the reimbursement of outstanding claims in the event of insolvency.

(20) Coordinate care from out-of-network providers to ensure that there is no added cost to the enrollee.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Wavier.
History: New ruled filed: August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.05 Payment to Primary Contractors

(1) Primary Contractors shall be reimbursed at a rate per global delivery as established through the open and competitive bid process.

(2) Claims shall be submitted to Medicaid's Fiscal Agent for payment of the established rate through normal claim submission procedures.

(3) Payment for the delivery of the infant(s) and all pregnancy care is payment in full for all services provided that are covered by the MCP.

(4) Primary Contractors are not allowed to operate Physician Incentive Plans (PIPs) as explained in 42 CFR 422.208, 422.210 and 438.6(h) and 1903(m)(2)(A)(x) of the Social Security Act.

(5) Primary Contractors cannot hold the enrollee liable for covered services in the event of the entity's insolvency, non-payment by the State, or excess payments as specified at 1932 (b)(6) of the Social Security Act and 42 CFR 438.106, 438.6, 438.230 and 438.204.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Wavier.
History: New ruled filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.06 Covered Services

(1) Primary Contractor Contractors shall have or arrange for a comprehensive system of maternity care that includes all services specified in the ITB used for selection of contractors. Detailed information regarding specific services covered by the MCP is provided in the ITB as well as the MCP Operational Manual

(2) Excluded services shall be covered fee for service by Medicaid. Any fee for service payment is made according to the benefit limits and coverage limitations applicable for the eligibility classification.

Author: Gloria S. Luster, Associate Director, Maternity Care Program.
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.07 Complaints and Grievances

(1) Each Primary Contractor shall implement an approved written grievance system that meets the requirements of 42 CFR 431.201 including, but not limited to:

(a) Designation of a responsible Grievance Committee.

(b) Two levels of review for the resolution of grievances. The time frame for these reviews shall be based on the nature of the grievance and the immediacy or urgency of the health care needs of the Medicaid recipient.

(c) The primary entry level for complaints shall be a designated responsible representative of each Primary Contractor.

(d) Resolution of grievances of an immediate or urgent nature (life threatening situations, perceived harm, etc.) shall not exceed a forty-eight hour review within the Primary Contractor's review process, which includes subcontractor's review. The Grievance Committee's decision shall be binding unless the Medicaid recipient files a written appeal.

(e) If the Medicaid recipient is not satisfied with the findings of the Grievance Committee, the Medicaid recipient may appeal to the Medicaid Agency for an administrative fair hearing.

(f) All grievances shall be maintained in a log as specified in the MCP Manual.

(2) Handling of Grievance and Appeals. The Primary Contractor must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State established timeframes and as specified in CFR 438.408, 438.410, 438.416, 438.420 and 438.424, including but not limited to:

(a) General Requirements. In handling grievances and appeals, the following requirements must be met:

1. Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing numbers that have adequate TTY/TTD and interpreter capability.

2. Acknowledge receipt of each grievance and appeal.

3. Ensure that the individuals who make decisions on grievances and appeals are individuals-

(i) Who were not involved in any previous level of review or decision making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(I) An appeal of a denial that is based on lack of medical necessity.

(II) A grievance regarding denial of expedited resolution of an appeal.

(III) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

1. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

2. Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The Primary

Contractor must inform the enrollee of the limited time available for this in the case of expedited resolution.)

3. Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

4. Include, as parties to the appeal-

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's estate.

(3) Service Authorizations and Notice of Action

(a) An action is defined as the Primary Contractor

1. denying or limiting authorization of a requested service including the type or level of service;

2. reduction, suspension or termination of a previously authorized service;

3. the denial, in whole or part, of payment for a service;

4. the failure to provide services in a timely manner;

5. the failure to act within specified timeframes

(b) Adverse actions taken by the Primary Contractor must meet the requirements of 42 CFR 438.10, 438.12, 438.404 and 438.210-214.

(c) A service authorization is defined as an enrollee's request for the provision of a service.

(d) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must meet the requirements of 42 CFR 438.210.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.08 District Designation and Selection of Primary Contractors

(1) The number of Primary Contractors shall be restricted to one in each of the geographic districts within the State. Geographic districts are based on county designation and are generally comprised of multiple counties. Counties for specific districts shall be identified during the open and competitive bid process for a specified time period as per the ITB.

(2) Primary Contractors shall be selected through evaluation of the ability of the provider's ability to provide required components of the MCP submitted by prospective entities during the competitive bid process as more fully described in the MCP ITB specifications.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.09 Quality Improvement

(1) Each Primary Contractor shall provide an internal quality assurance (QA) system that meets all applicable state and federal guidelines and all quality requirements specified in the procurement document used in the bid process.

(2) Each Primary Contractor's Quality Assurance system shall include an ongoing quality assessment and performance improvement program as specified in 42 CFR 438.20 and a minimum of the following:

(a) Utilization control procedures for the on-going evaluation, on a sample basis, of the quality and accessibility of care provided to program participants

(b) Provide for review by appropriate health professionals of the process followed for providing health services

(c) Provide for systematic data collection of performance and patient results

(d) Provide for interpretation of this data

(e) Provide for making needed changes

(3) Primary Contractors shall have a structured and active Quality Assurance Committee, which shall:

(a) Be composed of, at a minimum, Program Director or designee, a board certified OB/GYN physician, a registered nurse with obstetrical experience, a licensed social worker, and hospital representation

(b) Meet at least quarterly, but more often as needed, to demonstrate that the Committee is following up on all findings and required actions .

(c) Operates under the following parameters:

1. Information shall be treated as confidential in accordance with Medicaid rules and regulations and HIPAA - Health Insurance Portability and Accountability Act standards;

2. Committee shall identify actual and potential problems;

3. Committee shall develop appropriate recommendations for corrective action;

4. Committee shall perform follow-up on the recommendations to assure implementation of actions and continued monitoring, if necessary;

5. Committee shall collect data and analyze data;

6. Committee shall include utilization in quality assurance activities;

7. Committee shall include grievances in quality assurance activities;

8. Committee shall document all activities

(4) Each Primary Contractor shall have a written Quality Assurance (QA) Program description including:

(a) A scope of work which addresses both the quality and clinical care as well as non-clinical care.

(b) A written Quality Management plan which documents activities including: policies/procedures for performing chart reviews, utilization of provider and enrollee surveys, policies and procedures for analysis of data, procedures for analysis of administrative data and procedures for implementation of corrective action.

(c) A methodology for measurement which includes all demographic groups.

(d) Continuous performance of the activities to be tracked and the timeframes for reporting

(e) Feedback to health professionals regarding performance and patient results.

(f) Identification of individuals/organizations responsible for implementation of the QA plan.

(g) Identification of relevant and measurable standards of care (minimum requirements are contained in the MCP Operational Manual).

(h) Demonstration of measurable improvement of services being received through benchmarks (minimum requirements) are contained in the MCP Operational Manual).

(5) The Primary Contractor shall include in all subcontractor contracts and employment agreements a requirement securing cooperation with the Quality Assurance Program including access to records and responsible parties.

(6) Beneficiary survey results must be made available to the State upon request.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended**: Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.10 High Risk Protocols

(1) Each recipient entering the MCP shall be assessed for high risk pregnancy and if indicated referred to a Delivering Health Care Professional qualified to provide

high risk care. The recipient may be exempted from the MCP if it is determined that she will require high-risk care throughout antepartum and delivery. Reimbursement shall be fee-for-service if the recipient is exempted from the MCP.

(2) A high-risk assessment tool approved by the Medicaid Agency shall be utilized in performing risk assessments.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended**: Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.11 Care Coordination

(1) Each Primary Contractor shall ensure that each woman enrolled in the program receives care coordination. Care coordination is the mechanism for linking and coordinating segments of the service delivery system and assuring that the recipient care needs are met and provided at the appropriate level of care. Care Coordination is a resource that ensures that the care received in the program is augmented with appropriate psychosocial support.

(2) Care coordination requirements are delineated in the bid specification and MCP Operational Manual and include, but are not limited to:

(a) Performing the initial encounter requirements
(b) Psychosocial risk assessment
(c) Assessing medical and social needs
(d) Developing service plans
(e) Providing information and education
(f) Patient tracking
(g) Encounters as specified throughout the course of the pregnancy.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended**: Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.12 Health Care Professional Panel

(1) Primary Contractors shall have a delivery system that meets Medicaid standards as defined in the bid. The Primary Contractor shall ensure that there are sufficient health care professionals and hospitals to perform the required duties as specified in the ITB and contract with Medicaid.

(2) Participation opportunities for Delivering Health Care Professionals shall be offered as specified in the ITB.

(3) Primary Contractors shall continually monitor the health care panel to assure adequate access to care for program recipients. Services shall be available to the recipients within the 50-mile/50 minute standard as required by Medicaid.

(4) Primary Contractors shall utilize in-state providers if time/distance or medical necessity is not a factor.

(5) Primary Contractor shall notify Medicaid within one working day of any unexpected changes that would impair the network or create access to care issues.

(6) All subcontracts must meet the requirements of 42 CFR 438.6.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended**: Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.13 Recipient Choice

(1) Women participating in the MCP shall be allowed to select the Delivering Health Care Professional of their choice from within the participating Delivering Health Care Professionals of the Primary Contractor. They may change professionals for cause at any time or without cause within 90 days of enrollment.

(2) Recipients who refuse to select a Delivering Health Care Professional shall be assigned one by the Primary Contractor who must follow assignment procedures specified in the MCP ITB.

(3) Lists of Delivering Health Care Professionals shall be maintained and utilized in the selection process.

(4) Recipients shall be provided all pertinent information about Delivering Health Care Professional as needed to make an informed selection. A toll free number must be available to recipients for use in selection of Delivering Health Care Professionals as well as for other questions/information.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.

History: New rule filed: February 19, 1999; effective May 1, 1999. Amended: Filed August 22, 2005; effective November 16, 2005.

day of the following month, the child's presumptive eligibility will end on that last day; and

(B) If a Medicaid application on behalf of the child is filed by the last day of the following month, the child's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and

(v) For children determined not to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate—

(A) Of the reason for the determination; and

(B) That he or she may file an application for Medicaid on the child's behalf with the Medicaid agency; and

(3) Provide all services covered under the plan, including EPSDT.

(4) Allow determinations of presumptive eligibility to be made by qualified entities on a Statewide basis.

(c) The agency must adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame.

PART 438—MANAGED CARE

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Subpart A—General Provisions

§438.1 Basis and scope.

(a) *Statutory basis.* This part is based on sections 1902(a)(4), 1903(m), 1905(t), and 1932 of the Act.

(1) Section 1902(a)(4) requires that States provide for methods of administration that the Secretary finds necessary for proper and efficient operation of the State plan. The application of the requirements of this part to PIHPs and PAHPs that do not meet the statutory definition of an MCO or a PCCM is under the authority in section 1902(a)(4).

(2) Section 1903(m) contains requirements that apply to comprehensive risk contracts.

(3) Section 1903(m)(2)(H) provides that an enrollee who loses Medicaid eligibility for not more than 2 months may be enrolled in the succeeding month in the same MCO or PCCM if that MCO or PCCM still has a contract with the State.

(4) Section 1905(t) contains requirements that apply to PCCMs.

(5) Section 1932—

(i) Provides that, with specified exceptions, a State may require Medicaid recipients to enroll in MCOs or PCCMs;

(ii) Establishes the rules that MCOs, PCCMs, the State, and the contracts between the State and those entities must meet, including compliance with requirements in sections 1903(m) and 1905(t) of the Act that are implemented in this part;

(iii) Establishes protections for enrollees of MCOs and PCCMs;

(iv) Requires States to develop a quality assessment and performance improvement strategy;

(v) Specifies certain prohibitions aimed at the prevention of fraud and abuse;

(vi) Provides that a State may not enter into contracts with MCOs unless it has established intermediate sanctions that it may impose on an MCO that fails to comply with specified requirements; and

(vii) Makes other minor changes in the Medicaid program.

(b) *Scope.* This part sets forth requirements, prohibitions, and procedures for the provision of Medicaid services through MCOs, PIHPs, PAHPs, and PCCMs. Requirements vary depending on the type of entity and on the authority under which the State contracts with the entity. Provisions that apply only when the contract is under a mandatory managed care program authorized by section 1932(a)(1)(A) of the Act are identified as such.

§ 438.2 Definitions.

As used in this part—

Capitation payment means a payment the State agency makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular recipient receives services during the period covered by the payment.

Comprehensive risk contract means a risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

(1) Outpatient hospital services.

(2) Rural health clinic services.

(3) FQHC services.

(4) Other laboratory and X-ray services.

(5) Nursing facility (NF) services.

(6) Early and periodic screening, diagnostic, and treatment (EPSDT) services.

(7) Family planning services.

(8) Physician services.

(9) Home health services.

Federally qualified HMO means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

Health care professional means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Health insuring organization (HIO) means a county operated entity, that in exchange for capitation payments, covers services for recipients—

(1) Through payments to, or arrangements with, providers;

(2) Under a comprehensive risk contract with the State; and

(3) Meets the following criteria—

(i) First became operational prior to January 1, 1986; or

(ii) Is described in section 9517(e)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990).

Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is—

(1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or

(2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:

(i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity.

(ii) Meets the solvency standards of § 438.116.

Nonrisk contract means a contract under which the contractor—

(1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in § 447.362 of this chapter; and

(2) May be reimbursed by the State at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

Prepaid ambulatory health plan (PAHP) means an entity that—

(1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;

(2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and

(3) Does not have a comprehensive risk contract.

Prepaid inpatient health plan (PIHP) means an entity that—

(1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;

(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and

(3) Does not have a comprehensive risk contract.

Primary care means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary care case management means a system under which a PCCM contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients.

Primary care case manager (PCCM) means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services or, at State option, any of the following:

(1) A physician assistant.

(2) A nurse practitioner.

(3) A certified nurse-midwife.

Risk contract means a contract under which the contractor—

(1) Assumes risk for the cost of the services covered under the contract; and

(2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

§ 438.6 Contract requirements.

(a) *Regional office review.* The CMS Regional Office must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in § 438.806.

(b) *Entities eligible for comprehensive risk contracts.* A State agency may enter into a comprehensive risk contract only with the following:

(1) An MCO.

(2) The entities identified in section 1903(m)(2)(B)(i), (ii), and (iii) of the Act.

(3) Community, Migrant, and Appalachian Health Centers identified in section 1903(m)(2)(G) of the Act. Unless they qualify for a total exemption under section 1903(m)(2)(B) of the Act, these entities are subject to the regulations governing MCOs under this part.

(4) An HIO that arranges for services and became operational before January 1986.

(5) An HIO described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as added by section 4734(2) of the Omnibus Budget Reconciliation Act of 1990).

(c) *Payments under risk contracts.*

(1) *Terminology.* As used in this paragraph, the following terms have the indicated meanings:

(i) *Actuarially sound capitation rates* means capitation rates that—

(A) Have been developed in accordance with generally accepted actuarial principles and practices;

(B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; and

(C) Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

(ii) *Adjustments to smooth data* means adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

(iii) *Cost neutral* means that the mechanism used to smooth data, share risk, or adjust for risk will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.

(iv) *Incentive arrangement* means any payment mechanism under which a contractor may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract.

(v) *Risk corridor* means a risk sharing mechanism in which States and contractors share in both profits and losses under the contract outside of predetermined threshold amount, so that after an initial corridor in which the contractor is responsible for all losses or retains all profits, the State

contributes a portion toward any additional losses, and receives a portion of any additional profits.

(2) *Basic requirements.* (i) All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound.

(ii) The contract must specify the payment rates and any risk-sharing mechanisms, and the actuarial basis for computation of those rates and mechanisms.

(3) *Requirements for actuarially sound rates.* In setting actuarially sound capitation rates, the State must apply the following elements, or explain why they are not applicable:

(i) Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population.

(ii) Adjustments made to smooth data and adjustments to account for factors such as medical trend inflation, incomplete data, MCO, PIHP, or PAHP administration (subject to the limits in paragraph (c)(4)(ii) of this section), and utilization;

(iii) Rate cells specific to the enrolled population, by—

(A) Eligibility category;

(B) Age;

(C) Gender;

(D) Locality/region; and

(E) Risk adjustments based on diagnosis or health status (if used).

(iv) Other payment mechanisms and utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk sharing, or other appropriate cost-neutral methods.

(4) *Documentation.* The State must provide the following documentation:

(i) The actuarial certification of the capitation rates.

(ii) An assurance (in accordance with paragraph (c)(3) of this section) that all payment rates are—

(A) Based only upon services covered under the State plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).

(B) Provided under the contract to Medicaid-eligible individuals.

(iii) The State's projection of expenditures under its previous year's contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract.

(iv) An explanation of any incentive arrangements, or stop-loss, reinsurance, or any other risk-sharing methodologies under the contract.

(5) *Special contract provisions.* (i) Contract provisions for reinsurance, stop-loss limits or other risk-sharing methodologies must be computed on an actuarially sound basis.

(ii) If risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments will not be considered actuarially sound to the extent that they result in total payments that exceed the amount Medicaid would have paid, on a fee-for-service basis, for the State plan services actually furnished to enrolled individuals, plus an amount for MCO, PIHP, or PAHP administrative costs directly related to the provision of these services.

(iii) Contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered to be actuarially sound.

(iv) For all incentive arrangements, the contract must provide that the arrangement is—

(A) For a fixed period of time;

(B) Not to be renewed automatically;

(C) Made available to both public and private contractors;

(D) Not conditioned on intergovernmental transfer agreements; and

(E) Necessary for the specified activities and targets.

(v) If a State makes payments to providers for graduate medical education (GME) costs under an approved State plan, the State must adjust the actuarially sound capitation rates to account for the GME payments to be made on behalf of enrollees covered under the contract, not to exceed the aggregate amount that would have been paid under the approved State

plan for FFS. States must first establish actuarially sound capitation rates prior to making adjustments for GME.

(d) *Enrollment discrimination prohibited.* Contracts with MCOs, PIHPs, PAHPs, and PCCMs must provide as follows:

(1) The MCO, PIHP, PAHP, or PCCM accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by the Regional Administrator), up to the limits set under the contract.

(2) Enrollment is voluntary, except in the case of mandatory enrollment programs that meet the conditions set forth in §438.50(a).

(3) The MCO, PIHP, PAHP, or PCCM will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.

(4) The MCO, PIHP, PAHP, or PCCM will not discriminate against individuals eligible to enroll on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

(e) *Services that may be covered.* An MCO, PIHP, or PAHP contract may cover, for enrollees, services that are in addition to those covered under the State plan, although the cost of these services cannot be included when determining the payment rates under §438.6(c).

(f) *Compliance with contracting rules.* All contracts under this subpart must:

(1) Comply with all applicable Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education 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; and

(2) Meet all the requirements of this section.

(g) *Inspection and audit of financial records.* Risk contracts must provide that the State agency and the Department may inspect and audit any financial records of the entity or its subcontractors.

(h) *Physician incentive plans.* (1) MCO, PIHP, and PAHP contracts must provide for compliance with the requirements set forth in §§422.208 and 422.210 of this chapter.

(2) In applying the provisions of §§422.208 and 422.210 of this chapter, references to "M+C organization", "CMS", and "Medicare beneficiaries" must be read as references to "MCO, PIHP, or PAHP", "State agency" and "Medicaid recipients", respectively.

(i) *Advance directives.* (1) All MCO and PIHP contracts must provide for compliance with the requirements of §422.128 of this chapter for maintaining written policies and procedures for advance directives.

(2) All PAHP contracts must provide for compliance with the requirements of §422.128 of this chapter for maintaining written policies and procedures for advance directives if the PAHP includes, in its network, any of those providers listed in §489.102(a) of this chapter.

(3) The MCO, PIHP, or PAHP subject to this requirement must provide adult enrollees with written information on advance directives policies, and include a description of applicable State law.

(4) The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

(j) *Special rules for certain HIOs.* Contracts with HIOs that began operating on or after January 1, 1986, and that the statute does not explicitly exempt from requirements in section 1903(m) of the Act, are subject to all the requirements of this part that apply to MCOs and contracts with MCOs. These HIOs may enter into comprehensive risk contracts only if they meet the criteria of paragraph (a) of this section.

(k) *Additional rules for contracts with PCCMs.* A PCCM contract must meet the following requirements:

(1) Provide for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.

(2) Restrict enrollment to recipients who reside sufficiently near one of the manager's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation.

(3) Provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

(4) Prohibit discrimination in enrollment, disenrollment, and re-enrollment, based on the recipient's health status or need for health care services.

(5) Provide that enrollees have the right to disenroll from their PCCM in accordance with § 438.56(c).

(l) *Subcontracts.* All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

(m) *Choice of health professional.* The contract must allow each enrollee to choose his or her health professional to the extent possible and appropriate.

§ 438.8 Provisions that apply to PIHPs and PAHPs.

(a) The following requirements and options apply to PIHPs, PIHP contracts, and States with respect to PIHPs, to the same extent that they apply to MCOs, MCO contracts, and States for MCOs.

(1) The contract requirements of § 438.6, except for requirements that pertain to HIOs.

(2) The information requirements in § 438.10.

(3) The provision against provider discrimination in § 438.12.

(4) The State responsibility provisions of subpart B of this part except § 438.50.

(5) The enrollee rights and protection provisions in subpart C of this part.

(6) The quality assessment and performance improvement provisions in subpart D of this part to the extent that they are applicable to services furnished by the PIHP.

(7) The grievance system provisions in subpart F of this part.

(8) The certification and program integrity protection provisions set forth in subpart H of this part.

(b) The following requirements and options for PAHPs apply to PAHPs, PAHP contracts, and States.

(1) The contract requirements of § 438.6, except requirements for—

(i) HIOs.

(ii) Advance directives (unless the PAHP includes any of the providers listed in § 489.102) of this chapter.

(2) All applicable portions of the information requirements in § 438.10.

(3) The provision against provider discrimination in § 438.12.

(4) The State responsibility provisions of subpart B of this part except § 438.50.

(5) The provisions on enrollee rights and protections in subpart C of this part.

(6) Designated portions of subpart D of this part.

(7) An enrollee's right to a State fair hearing under subpart E of part 431 of this chapter.

(8) Prohibitions against affiliations with individuals debarred by Federal agencies in § 438.610.

[67 FR 41095, June 14, 2002, as amended at 67 FR 65505, Oct. 25, 2002]

§ 438.10 Information requirements.

(a) *Terminology.* As used in this section, the following terms have the indicated meanings:

Enrollee means a Medicaid recipient who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.

Potential enrollee means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, or PCCM.

(b) *Basic rules.* (1) Each State, enrollment broker, MCO, PIHP, PAHP, and PCCM must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.

(2) The State must have in place a mechanism to help enrollees and potential enrollees understand the State's managed care program.

(3) Each MCO and PIHP must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.

(c) *Language.* The State must do the following:

(1) Establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State. "Prevalent" means a non-English language spoken by a significant number or percentage of potential enrollees and enrollees in the State.

(2) Make available written information in each prevalent non-English language.

(3) Require each MCO, PIHP, PAHP, and PCCM to make its written information available in the prevalent non-English languages in its particular service area.

(4) Make oral interpretation services available and require each MCO, PIHP, PAHP, and PCCM to make those services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.

(5) Notify enrollees and potential enrollees, and require each MCO, PIHP, PAHP, and PCCM to notify its enrollees—

(i) That oral interpretation is available for any language and written information is available in prevalent languages; and

(ii) How to access those services.

(d) *Format.* (1) Written material must—

(i) Use easily understood language and format; and

(ii) Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

(2) All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

(e) *Information for potential enrollees.* (1) The State or its contracted representative must provide the information specified in paragraph (e)(2) of this section to each potential enrollee as follows:

(i) At the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program.

(ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHPs, PAHPs, or PCCMs.

(2) The information for potential enrollees must include the following:

(i) General information about—

(A) The basic features of managed care;

(B) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; and

(C) MCO, PIHP, PAHP, and PCCM responsibilities for coordination of enrollee care;

(ii) Information specific to each MCO, PIHP, PAHP, or PCCM program operating in potential enrollee's service area. A summary of the following information is sufficient, but the State must provide more detailed information upon request:

(A) Benefits covered.

(B) Cost sharing, if any.

(C) Service area.

(D) Names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs, this includes at a minimum information on primary care physicians, specialists, and hospitals.

(E) Benefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service.

(f) *General information for all enrollees of MCOs, PIHPs, PAHPs, and PCCMs.* Information must be furnished to MCO, PIHP, PAHP, and PCCM enrollees as follows:

(1) The State must notify all enrollees of their disenrollment rights, at a minimum, annually. For States that choose to restrict disenrollment for periods of 90 days or more, States must

send the notice no less than 60 days before the start of each enrollment period.

(2) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must notify all enrollees of their right to request and obtain the information listed in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least once a year.

(3) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must furnish to each of its enrollees the information specified in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, within a reasonable time after the MCO, PIHP, PAHP, or PCCM receives, from the State or its contracted representative, notice of the recipient's enrollment.

(4) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must give each enrollee written notice of any change (that the State defines as "significant") in the information specified in paragraphs (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least 30 days before the intended effective date of the change.

(5) The MCO, PIHP, and, when appropriate, the PAHP or PCCM, must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

(6) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must provide the following information to all enrollees:

(i) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs this includes, at a minimum, information on primary care physicians, specialists, and hospitals.

(ii) Any restrictions on the enrollee's freedom of choice among network providers.

(iii) Enrollee rights and protections, as specified in § 438.100.

(iv) Information on grievance and fair hearing procedures, and for MCO and PIHP enrollees, the information specified in § 438.10(g)(1), and for PAHP enrollees, the information specified in § 438.10(h)(1).

(v) The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.

(vi) Procedures for obtaining benefits, including authorization requirements.

(vii) The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers.

(viii) The extent to which, and how, after-hours and emergency coverage are provided, including:

(A) What constitutes emergency medical condition, emergency services, and poststabilization services, with reference to the definitions in § 438.114(a).

(B) The fact that prior authorization is not required for emergency services.

(C) The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.

(D) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services covered under the contract.

(E) The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.

(ix) The poststabilization care services rules set forth at § 422.113(c) of this chapter.

(x) Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.

(xi) Cost sharing, if any.

(xii) How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the MCO, PIHP,

PAHP, or PCCM need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service.

(g) *Specific information requirements for enrollees of MCOs and PIHPs.* In addition to the requirements in §438.10(f), the State, its contracted representative, or the MCO and PIHP must provide the following information to their enrollees:

(1) Grievance, appeal, and fair hearing procedures and timeframes, as provided in §§438.400 through 438.424, in a State-developed or State-approved description, that must include the following:

(i) For State fair hearing—

(A) The right to hearing;

(B) The method for obtaining a hearing; and

(C) The rules that govern representation at the hearing.

(ii) The right to file grievances and appeals.

(iii) The requirements and timeframes for filing a grievance or appeal.

(iv) The availability of assistance in the filing process.

(v) The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.

(vi) The fact that, when requested by the enrollee—

(A) Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and

(B) The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.

(vii) Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.

(2) Advance directives, as set forth in §438.6(i)(2).

(3) Additional information that is available upon request, including the following:

(i) Information on the structure and operation of the MCO or PIHP.

(ii) Physician incentive plans as set forth in §438.6(h) of this chapter.

(h) *Specific information for PAHPs.* The State, its contracted representative, or the PAHP must provide the following information to their enrollees:

(1) The right to a State fair hearing, including the following:

(i) The right to a hearing.

(ii) The method for obtaining a hearing.

(iii) The rules that govern representation.

(2) Advance directives, as set forth in §438.6(i)(2), to the extent that the PAHP includes any of the providers listed in §489.102(a) of this chapter.

(3) Upon request, physician incentive plans as set forth in §438.6(h).

(i) *Special rules: States with mandatory enrollment under State plan authority*—(1) *Basic rule.* If the State plan provides for mandatory enrollment under §438.50, the State or its contracted representative must provide information on MCOs and PCCMs (as specified in paragraph (i)(3) of this section), either directly or through the MCO or PCCM.

(2) *When and how the information must be furnished.* The information must be furnished as follows:

(i) For potential enrollees, within the timeframe specified in §438.10(e)(1).

(ii) For enrollees, annually and upon request.

(iii) In a comparative, chart-like format.

(3) *Required information.* Some of the information is the same as the information required for potential enrollees under paragraph (e) of this section and for enrollees under paragraph (f) of this section. However, all of the information in this paragraph is subject to the timeframe and format requirements of paragraph (i)(2) of this section, and includes the following for each contracting MCO or PCCM in the potential enrollees and enrollee's service area:

(i) The MCO's or PCCM's service area.

(ii) The benefits covered under the contract.

(iii) Any cost sharing imposed by the MCO or PCCM.

(iv) To the extent available, quality and performance indicators, including enrollee satisfaction.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

§ 438.12 Provider discrimination prohibited.

(a) *General rules.* (1) An MCO, PIHP, or PAHP may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If an MCO, PIHP, or PAHP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

(2) In all contracts with health care professionals, an MCO, PIHP, or PAHP must comply with the requirements specified in § 438.214.

(b) *Construction.* Paragraph (a) of this section may not be construed to—

(1) Require the MCO, PIHP, or PAHP to contract with providers beyond the number necessary to meet the needs of its enrollees;

(2) Preclude the MCO, PIHP, or PAHP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

(3) Preclude the MCO, PIHP, or PAHP from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

Subpart B—State Responsibilities

§ 438.50 State Plan requirements.

(a) *General rule.* A State plan that requires Medicaid recipients to enroll in managed care entities must comply with the provisions of this section, except when the State imposes the requirement—

(1) As part of a demonstration project under section 1115 of the Act; or

(2) Under a waiver granted under section 1915(b) of the Act.

(b) *State plan information.* The plan must specify—

(1) The types of entities with which the State contracts;

(2) The payment method it uses (for example, whether fee-for-service or capitation);

(3) Whether it contracts on a comprehensive risk basis; and

(4) The process the State uses to involve the public in both design and initial implementation of the program and the methods it uses to ensure ongoing public involvement once the State plan has been implemented.

(c) *State plan assurances.* The plan must provide assurances that the State meets applicable requirements of the following statute and regulations:

(1) Section 1903(m) of the Act, for MCOs and MCO contracts.

(2) Section 1905(t) of the Act, for PCCMs and PCCM contracts.

(3) Section 1932(a)(1)(A) of the Act, for the State's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities.

(4) This part, for MCOs and PCCMs.

(5) Part 434 of this chapter, for all contracts.

(6) Section 438.6(c), for payments under any risk contracts, and § 447.362 of this chapter for payments under any nonrisk contracts.

(d) *Limitations on enrollment.* The State must provide assurances that, in implementing the State plan managed care option, it will not require the following groups to enroll in an MCO or PCCM:

(1) Recipients who are also eligible for Medicare.

(2) Indians who are members of Federally recognized tribes, except when the MCO or PCCM is—

(i) The Indian Health Service; or

(ii) An Indian health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.

(3) Children under 19 years of age who are—

(i) Eligible for SSI under title XVI;

(ii) Eligible under section 1902(e)(3) of the Act;

(iii) In foster care or other out-of-home placement;

(iv) Receiving foster care or adoption assistance; or

(v) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the State in terms

of either program participation or special health care needs.

(e) *Priority for enrollment.* The State must have an enrollment system under which recipients already enrolled in an MCO or PCCM are given priority to continue that enrollment if the MCO or PCCM does not have the capacity to accept all those seeking enrollment under the program.

(f) *Enrollment by default.* (1) For recipients who do not choose an MCO or PCCM during their enrollment period, the State must have a default enrollment process for assigning those recipients to contracting MCOs and PCCMs.

(2) The process must seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients. If that is not possible, the State must distribute the recipients equitably among qualified MCOs and PCCMs available to enroll them, excluding those that are subject to the intermediate sanction described in § 438.702(a)(4).

(3) An "existing provider-recipient relationship" is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through State records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

(4) A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

§ 438.52 Choice of MCOs, PIHPs, PAHPs, and PCCMs.

(a) *General rule.* Except as specified in paragraphs (b) and (c) of this section, a State that requires Medicaid recipients to enroll in an MCO, PIHP, PAHP, or PCCM must give those recipients a choice of at least two entities.

(b) *Exception for rural area residents.* (1) Under any of the following programs, and subject to the requirements of paragraph (b)(2) of this section, a State may limit a rural area resident to a single MCO, PIHP, PAHP, or PCCM system:

(i) A program authorized by a plan amendment under section 1932(a) of the Act.

(ii) A waiver under section 1115 of the Act.

(iii) A waiver under section 1915(b) of the Act.

(2) A State that elects the option provided under paragraph (b)(1) of this section, must permit the recipient—

(i) To choose from at least two physicians or case managers; and

(ii) To obtain services from any other provider under any of the following circumstances:

(A) The service or type of provider (in terms of training, experience, and specialization) is not available within the MCO, PIHP, PAHP, or PCCM network.

(B) The provider is not part of the network, but is the main source of a service to the recipient, provided that—

(*1*) The provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO, PIHP, PAHP, or PCCM network as other network providers of that type.

(*2*) If the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the enrollee will be transitioned to a participating provider within 60 days (after being given an opportunity to select a provider who participates).

(C) The only plan or provider available to the recipient does not, because of moral or religious objections, provide the service the enrollee seeks.

(D) The recipient's primary care provider or other provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.

(E) The State determines that other circumstances warrant out-of-network treatment.

(3) As used in this paragraph, "rural area" is any area other than an "urban area" as defined in § 412.62(f)(1)(ii) of this chapter.

(c) *Exception for certain health insuring organizations (HIOs).* The State may limit recipients to a single HIO if—

(1) The HIO is one of those described in section 1932(a)(3)(C) of the Act; and

(2) The recipient who enrolls in the HIO has a choice of at least two primary care providers within the entity.

(d) *Limitations on changes between primary care providers.* For an enrollee of a single MCO, PIHP, PAHP, or HIO under paragraph (b) or (c) of this section, any limitation the State imposes on his or her freedom to change between primary care providers may be no more restrictive than the limitations on disenrollment under § 438.56(c).

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

§ 438.56 Disenrollment: Requirements and limitations.

(a) *Applicability.* The provisions of this section apply to all managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with an MCO, a PIHP, a PAHP, or a PCCM.

(b) *Disenrollment requested by the MCO, PIHP, PAHP, or PCCM.* All MCO, PIHP, PAHP, and PCCM contracts must—(1) Specify the reasons for which the MCO, PIHP, PAHP, or PCCM may request disenrollment of an enrollee;

(2) Provide that the MCO, PIHP, PAHP, or PCCM may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, or PCCM seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees); and

(3) Specify the methods by which the MCO, PIHP, PAHP, or PCCM assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.

(c) *Disenrollment requested by the enrollee.* If the State chooses to limit disenrollment, its MCO, PIHP, PAHP, and PCCM contracts must provide that a recipient may request disenrollment as follows:

(1) For cause, at any time.

(2) Without cause, at the following times:

(i) During the 90 days following the date of the recipient's initial enrollment with the MCO, PIHP, PAHP, or PCCM, or the date the State sends the recipient notice of the enrollment, whichever is later.

(ii) At least once every 12 months thereafter.

(iii) Upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

(iv) When the State imposes the intermediate sanction specified in § 438.702(a)(3).

(d) *Procedures for disenrollment*— (1) *Request for disenrollment.* The recipient (or his or her representative) must submit an oral or written request—

(i) To the State agency (or its agent); or

(ii) To the MCO, PIHP, PAHP, or PCCM, if the State permits MCOs, PIHP, PAHPs, and PCCMs to process disenrollment requests.

(2) *Cause for disenrollment.* The following are cause for disenrollment:

(i) The enrollee moves out of the MCO's, PIHP's, PAHP's, or PCCM's service area.

(ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks.

(iii) The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

(iv) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

(3) *MCO, PIHP, PAHP, or PCCM action on request.* (i) An MCO, PIHP, PAHP, or PCCM may either approve a request for disenrollment or refer the request to the State.

(ii) If the MCO, PIHP, PAHP, PCCM, or State agency (whichever is responsible) fails to make a disenrollment determination so that the recipient can be disenrolled within the timeframes

specified in paragraph (e)(1) of this section, the disenrollment is considered approved.

(4) *State agency action on request.* For a request received directly from the recipient, or one referred by the MCO, PIHP, PAHP, or PCCM, the State agency must take action to approve or disapprove the request based on the following:

(i) Reasons cited in the request.

(ii) Information provided by the MCO, PIHP, PAHP, or PCCM at the agency's request.

(iii) Any of the reasons specified in paragraph (d)(2) of this section.

(5) *Use of the MCO, PIHP, PAHP, or PCCM grievance procedures.* (i) The State agency may require that the enrollee seek redress through the MCO, PIHP, PAHP, or PCCM's grievance system before making a determination on the enrollee's request.

(ii) The grievance process, if used, must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in §438.56(e)(1).

(iii) If, as a result of the grievance process, the MCO, PIHP, PAHP, or PCCM approves the disenrollment, the State agency is not required to make a determination.

(e) *Timeframe for disenrollment determinations.* (1) Regardless of the procedures followed, 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 enrollee or the MCO, PIHP, PAHP, or PCCM files the request.

(2) If the MCO, PIHP, PAHP, or PCCM or the State agency (whichever is responsible) fails to make the determination within the timeframes specified in paragraph (e)(1) of this section, the disenrollment is considered approved.

(f) *Notice and appeals.* A State that restricts disenrollment under this section must take the following actions:

(1) Provide that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period.

(2) Ensure access to State fair hearing for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment.

(g) *Automatic reenrollment: Contract requirement.* If the State plan so specifies, the contract must provide for automatic reenrollment of a recipient who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

§438.58 Conflict of interest safeguards.

(a) As a condition for contracting with MCOs, PIHPs, or PAHPs, a State must have in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or the default enrollment process specified in §438.50(f).

(b) These safeguards must be at least as effective as the safeguards specified in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

§438.60 Limit on payment to other providers.

The State agency must ensure that no payment is made to a provider other than the MCO, PIHP, or PAHP for services available under the contract between the State and the MCO, PIHP, or PAHP, except when these payments are provided for in title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract, in accordance with §438.6(c)(5)(v), to make payments for graduate medical education.

§438.62 Continued services to recipients.

The State agency must arrange for Medicaid services to be provided without delay to any Medicaid enrollee of an MCO, PIHP, PAHP, or PCCM whose contract is terminated and for any Medicaid enrollee who is disenrolled from an MCO, PIHP, PAHP, or PCCM for any reason other than ineligibility for Medicaid.

§438.66 Monitoring procedures.

The State agency must have in effect procedures for monitoring the MCO's, PIHP's, or PAHP's operations, including, at a minimum, operations related to the following:

(a) Recipient enrollment and disenrollment.

(b) Processing of grievances and appeals.

(c) Violations subject to intermediate sanctions, as set forth in subpart I of this part.

(d) Violations of the conditions for FFP, as set forth in subpart J of this part.

(e) All other provisions of the contract, as appropriate.

Subpart C—Enrollee Rights and Protections

§ 438.100 Enrollee rights.

(a) *General rule.* The State must ensure that—

(1) Each MCO and PIHP has written policies regarding the enrollee rights specified in this section; and

(2) Each MCO, PIHP, PAHP, and PCCM complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees.

(b) *Specific rights*— (1) *Basic requirement.* The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (b)(3) of this section.

(2) An enrollee of an MCO, PIHP, PAHP, or PCCM has the following rights: The right to—

(i) Receive information in accordance with § 438.10.

(ii) Be treated with respect and with due consideration for his or her dignity and privacy.

(iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in § 438.10(f)(6)(xii).)

(iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.

(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

(vi) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and 164.526.

(3) An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with §§ 438.206 through 438.210.

(c) *Free exercise of rights.* The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, or PCCM and its providers or the State agency treat the enrollee.

(d) *Compliance with other Federal and State laws.* The State must ensure that each MCO, PIHP, PAHP, and PCCM complies with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

§ 438.102 Provider-enrollee communications.

(a) *General rules.* (1) An MCO, PIHP, or PAHP may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following:

(i) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

(ii) Any information the enrollee needs in order to decide among all relevant treatment options.

(iii) The risks, benefits, and consequences of treatment or nontreatment.

(iv) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(2) Subject to the information requirements of paragraph (b) of this section, an MCO, PIHP, or PAHP that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement in paragraph (a)(1) of this section is not required to do so if the MCO, PIHP, or PAHP objects to the service on moral or religious grounds.

(b) *Information requirements: MCO, PIHP, and PAHP responsibility.* (1) An MCO, PIHP, or PAHP that elects the option provided in paragraph (a)(2) of this section must furnish information about the services it does not cover as follows:

(i) To the State—

(A) With its application for a Medicaid contract; and

(B) Whenever it adopts the policy during the term of the contract.

(ii) Consistent with the provisions of §438.10—

(A) To potential enrollees, before and during enrollment; and

(B) To enrollees, within 90 days after adopting the policy with respect to any particular service. (Although this timeframe would be sufficient to entitle the MCO, PIHP, or PAHP to the option provided in paragraph (a)(2) of this section, the overriding rule in §438.10(f)(4) requires the State, its contracted representative, or MCO, PIHP, or PAHP to furnish the information at least 30 days before the effective date of the policy.)

(2) As specified in §438.10, paragraphs (e) and (f), the information that MCOs, PIHPs, and PAHPs must furnish to enrollees and potential enrollees does not include how and where to obtain the service excluded under paragraph (a)(2) of this section.

(c) *Information requirements: State responsibility.* For each service excluded by an MCO, PIHP, or PAHP under paragraph (a)(2) of this section, the State must provide information on how and where to obtain the service, as specified in §438.10, paragraphs (e)(2)(ii)(E) and (f)(6)(xii).

(d) *Sanction.* An MCO that violates the prohibition of paragraph (a)(1) of this section is subject to intermediate sanctions under subpart I of this part.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

§438.104 Marketing activities.

(a) *Terminology.* As used in this section, the following terms have the indicated meanings:

Cold-call marketing means any unsolicited personal contact by the MCO, PIHP, PAHP, or PCCM with a potential enrollee for the purpose of marketing as defined in this paragraph.

Marketing means any communication, from an MCO, PIHP, PAHP, or PCCM to a Medicaid recipient who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular MCO's, PIHP's, PAHP's, or PCCM's Medicaid product, or either to not enroll in, or to disenroll from, another MCO's, PIHP's, PAHP's, or PCCM's Medicaid product.

Marketing materials means materials that—

(1) Are produced in any medium, by or on behalf of an MCO, PIHP, PAHP, or PCCM; and

(2) Can reasonably be interpreted as intended to market to potential enrollees.

MCO, PIHP, PAHP, or PCCM include any of the entity's employees, affiliated providers, agents, or contractors.

(b) *Contract requirements.* Each contract with an MCO, PIHP, PAHP, or PCCM must comply with the following requirements:

(1) Provide that the entity—

(i) Does not distribute any marketing materials without first obtaining State approval;

(ii) Distributes the materials to its entire service area as indicated in the contract;

(iii) Complies with the information requirements of §438.10 to ensure that, before enrolling, the recipient receives, from the entity or the State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll;

(iv) Does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and

(v) Does not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

(2) Specify the methods by which the entity assures the State agency that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients or the State agency. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that—

(i) The recipient must enroll in the MCO, PIHP, PAHP, or PCCM in order to obtain benefits or in order to not lose benefits; or

(ii) The MCO, PIHP, PAHP, or PCCM is endorsed by CMS, the Federal or State government, or similar entity.

(c) *State agency review.* In reviewing the marketing materials submitted by the entity, the State must consult with the Medical Care Advisory Committee established under § 431.12 of this chapter or an advisory committee with similar membership.

§ 438.106 Liability for payment.

Each MCO, PIHP, and PAHP must provide that its Medicaid enrollees are not held liable for any of the following:

(a) The MCO's, PIHP's, or PAHP's debts, in the event of the entity's insolvency.

(b) Covered services provided to the enrollee, for which—

(1) The State does not pay the MCO, PIHP, or PAHP; or

(2) The State, or the MCO, PIHP, or PAHP does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.

(c) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the MCO, PIHP, or PAHP provided the services directly.

§ 438.108 Cost sharing.

The contract must provide that any cost sharing imposed on Medicaid enrollees is in accordance with §§ 447.50 through 447.60 of this chapter.

§ 438.114 Emergency and poststabilization services.

(a) *Definitions.* As used in this section—

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are as follows:

(1) Furnished by a provider that is qualified to furnish these services under this title.

(2) Needed to evaluate or stabilize an emergency medical condition.

Poststabilization care services means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition.

(b) *Coverage and payment: General rule.* The following entities are responsible for coverage and payment of emergency services and poststabilization care services.

(1) The MCO, PIHP, or PAHP.

(2) The PCCM that has a risk contract that covers these services.

(3) The State, in the case of a PCCM that has a fee-for-service contract.

(c) *Coverage and payment: Emergency services.* (1) The entities identified in paragraph (b) of this section—

(i) Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO, PIHP, PAHP, or PCCM; and

(ii) May not deny payment for treatment obtained under either of the following circumstances:

(A) An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of *emergency medical condition* in paragraph (a) of this section.

(B) A representative of the MCO, PIHP, PAHP, or PCCM instructs the enrollee to seek emergency services.

(2) A PCCM must—

(i) Allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnishes the services; and

(ii) Pay for the services if the manager's contract is a risk contract that covers those services.

(d) *Additional rules for emergency services.* (1) The entities specified in paragraph (b) of this section may not—

(i) Limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms; and

(ii) Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, PIHP, PAHP or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

(2) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

(3) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment.

(e) *Coverage and payment: Poststabilization care services.* Poststabilization care services are covered and paid for in accordance with provisions set forth at §422.113(c) of this chapter. In applying those provisions, reference to "M+C organization" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section.

(f) *Applicability to PIHPs and PAHPs.* To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the PIHP or PAHP is responsible, the rules under this section apply.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

§438.116 Solvency standards.

(a) *Requirement for assurances* (1) Each MCO, PIHP, and PAHP that is not a Federally qualified HMO (as defined in section 1310 of the Public Health Service Act) must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the MCO's, PIHP's, or PAHP's debts if the entity becomes insolvent.

(2) Federally qualified HMOs, as defined in section 1310 of the Public Health Service Act, are exempt from this requirement.

(b) *Other requirements*—(1) *General rule.* Except as provided in paragraph (b)(2) of this section, an MCO or PIHP, must meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity.

(2) *Exception.* Paragraph (b)(1) of this section does not apply to an MCO or PIHP, that meets any of the following conditions:

(i) Does not provide both inpatient hospital services and physician services.

(ii) Is a public entity.

(iii) Is (or is controlled by) one or more Federally qualified health centers and meets the solvency standards established by the State for those centers.

(iv) Has its solvency guaranteed by the State.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

Subpart D—Quality Assessment and Performance Improvement

§ 438.200 Scope.

This subpart implements section 1932(c)(1) of the Act and sets forth specifications for quality assessment and performance improvement strategies that States must implement to ensure the delivery of quality health care by all MCOs, PIHPs, and PAHPs. It also establishes standards that States, MCOs, PIHPs, and PAHPs must meet.

§ 438.202 State responsibilities.

Each State contracting with an MCO or PIHP must do the following:

(a) Have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

(b) Obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final.

(c) Ensure that MCOs, PIHPs, and PAHPs comply with standards established by the State, consistent with this subpart.

(d) Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy periodically, as needed.

(e) Submit to CMS the following:

(1) A copy of the initial strategy, and a copy of the revised strategy whenever significant changes are made.

(2) Regular reports on the implementation and effectiveness of the strategy.

§ 438.204 Elements of State quality strategies.

At a minimum, State strategies must include the following:

(a) The MCO and PIHP contract provisions that incorporate the standards specified in this subpart.

(b) Procedures that—

(1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.

(2) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.

(3) Regularly monitor and evaluate the MCO and PIHP compliance with the standards.

(c) For MCOs and PIHPs, any national performance measures and levels that may be identified and developed by CMS in consultation with States and other relevant stakeholders.

(d) Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO and PIHP contract.

(e) For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.

(f) An information system that supports initial and ongoing operation and review of the State's quality strategy.

(g) Standards, at least as stringent as those in the following sections of this subpart, for access to care, structure and operations, and quality measurement and improvement.

ACCESS STANDARDS

§ 438.206 Availability of services.

(a) *Basic rule.* Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs.

(b) *Delivery network.* The State must ensure, through its contracts, that each MCO, and each PIHP and PAHP consistent with the scope of the PIHP's or PAHP's contracted services, meets the following requirements:

(1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO, PIHP, and PAHP must consider the following:

(i) The anticipated Medicaid enrollment.

(ii) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO, PIHP, and PAHP.

(iii) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.

(iv) The numbers of network providers who are not accepting new Medicaid patients.

(v) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

(2) Provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

(3) Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.

(4) If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, or PAHP must adequately and timely cover these services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP is unable to provide them.

(5) Requires out-of-network providers to coordinate with the MCO or PIHP with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.

(6) Demonstrates that its providers are credentialed as required by §438.214.

(c) *Furnishing of services.* The State must ensure that each MCO, PIHP, and PAHP contract complies with the requirements of this paragraph.

(1) *Timely access.* Each MCO, PIHP, and PAHP must do the following:

(i) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.

(ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

(iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

(iv) Establish mechanisms to ensure compliance by providers.

(v) Monitor providers regularly to determine compliance.

(vi) Take corrective action if there is a failure to comply.

(2) *Cultural considerations.* Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

§438.207 Assurances of adequate capacity and services.

(a) *Basic rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this subpart.

(b) *Nature of supporting documentation.* Each MCO, PIHP, and PAHP must submit documentation to the State, in a format specified by the State to demonstrate that it complies with the following requirements:

(1) Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area.

(2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

(c) *Timing of documentation.* Each MCO, PIHP, and PAHP must submit the documentation described in paragraph (b) of this section as specified by the State, but no less frequently than the following:

(1) At the time it enters into a contract with the State.

(2) At any time there has been a significant change (as defined by the

State) in the MCO's, PIHP's, or PAHP's operations that would affect adequate capacity and services, including—

(i) Changes in MCO, PIHP, or PAHP services, benefits, geographic service area or payments; or

(ii) Enrollment of a new population in the MCO, PIHP, or PAHP.

(d) *State review and certification to CMS.* After the State reviews the documentation submitted by the MCO, PIHP, or PAHP, the State must certify to CMS that the MCO, PIHP, or PAHP has complied with the State's requirements for availability of services, as set forth in § 438.206.

(e) *CMS' right to inspect documentation.* The State must make available to CMS, upon request, all documentation collected by the State from the MCO, PIHP, or PAHP.

§ 438.208 Coordination and continuity of care.

(a) *Basic requirement*—(1) *General rule.* Except as specified in paragraphs (a)(2) and (a)(3) of this section, the State must ensure through its contracts, that each MCO, PIHP, and PAHP complies with the requirements of this section.

(2) *PIHP and PAHP exception.* For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to—

(i) Meet the primary care requirement of paragraph (b)(1) of this section; and

(ii) Implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in paragraph (c) of this section.

(3) *Exception for MCOs that serve dually eligible enrollees.* (i) For each MCO that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare+Choice plan, the State determines to what extent the MCO must meet the primary care coordination, identification, assessment, and treatment planning provisions of paragraphs (b) and (c) of this section with respect to dually eligible individuals.

(ii) The State bases its determination on the services it requires the MCO to furnish to dually eligible enrollees.

(b) *Primary care and coordination of health care services for all MCO, PIHP, and PAHP enrollees.* Each MCO, PIHP, and PAHP must implement procedures to deliver primary care to and coordinate health care service for all MCO, PIHP, and PAHP enrollees. These procedures must meet State requirements and must do the following:

(1) Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

(2) Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP, or PAHP.

(3) Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.

(4) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

(c) *Additional services for enrollees with special health care needs*—(1) *Identification.* The State must implement mechanisms to identify persons with special health care needs to MCOs, PIHPs and PAHPs, as those persons are defined by the State. These identification mechanisms—

(i) Must be specified in the State's quality improvement strategy in § 438.202; and

(ii) May use State staff, the State's enrollment broker, or the State's MCOs,

PIHPs and PAHPs.

(2) *Assessment.* Each MCO, PIHP, and PAHP must implement mechanisms to assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph (c)(1) of this section) and identified to the MCO, PIHP, and PAHP by the State as having special health care needs in order

to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

(3) *Treatment plans.* If the State requires MCOs, PIHPs, and PAHPs to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be—

(i) Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;

(ii) Approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO, PIHP, or PAHP; and

(iii) In accord with any applicable State quality assurance and utilization review standards.

(4) *Direct access to specialists.* For enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with §438.208(c)(2)) to need a course of treatment or regular care monitoring, each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

§438.210 Coverage and authorization of services.

(a) *Coverage.* Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in §440.230.

(3) Provide that the MCO, PIHP, or PAHP—

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service—

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes "medically necessary services" in a manner that—

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require—

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP—

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in

treating the enrollee's condition or disease.

(c) *Notice of adverse action.* Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of § 438.404, except that the notice to the provider need not be in writing.

(d) *Timeframe for decisions.* Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—

(i) The enrollee, or the provider, requests extension; or

(ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(2) *Expedited authorization decisions.* (i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.

(ii) The MCO, PIHP, or PAHP may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(e) *Compensation for utilization management activities.* Each contract must provide that, consistent with § 438.6(h), and § 422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

STRUCTURE AND OPERATION STANDARDS

§ 438.214 Provider selection.

(a) *General rules.* The State must ensure, through its contracts, that each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of providers and that those policies and procedures include, at a minimum, the requirements of this section.

(b) *Credentialing and recredentialing requirements.* (1) Each State must establish a uniform credentialing and recredentialing policy that each MCO, PIHP, and PAHP must follow.

(2) Each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO, PIHP, or PAHP.

(c) *Nondiscrimination.* MCO, PIHP, and PAHP provider selection policies and procedures, consistent with § 438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(d) *Excluded providers.* MCOs, PIHPs, and PAHPs may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

(e) *State requirements.* Each MCO, PIHP, and PAHP must comply with any additional requirements established by the State.

[67 FR 41095, June 14, 2002; 67 FR 54532, Aug. 22, 2002]

§ 438.218 Enrollee information.

The requirements that States must meet under § 438.10 constitute part of the State's quality strategy at § 438.204.

§ 438.224 Confidentiality.

The State must ensure, through its contracts, that (consistent with subpart F of part 431 of this chapter), for

medical records and any other health and enrollment information that identifies a particular enrollee, each MCO, PIHP, and PAHP uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.

§ 438.226 Enrollment and disenrollment.

The State must ensure that each MCO, PIHP, and PAHP contract complies with the enrollment and disenrollment requirements and limitations set forth in § 438.56.

§ 438.228 Grievance systems.

(a) The State must ensure, through its contracts, that each MCO and PIHP has in effect a grievance system that meets the requirements of subpart F of this part.

(b) If the State delegates to the MCO or PIHP responsibility for notice of action under subpart E of part 431 of this chapter, the State must conduct random reviews of each delegated MCO or PIHP and its providers and subcontractors to ensure that they are notifying enrollees in a timely manner.

§ 438.230 Subcontractual relationships and delegation.

(a) *General rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP—

(1) Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor; and

(2) Meets the conditions of paragraph (b) of this section.

(b) *Specific conditions.* (1) Before any delegation, each MCO, PIHP, and PAHP evaluates the prospective subcontractor's ability to perform the activities to be delegated.

(2) There is a written agreement that—

(i) Specifies the activities and report responsibilities delegated to the subcontractor; and

(ii) Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

(3) The MCO, PIHP, or PAHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.

(4) If any MCO, PIHP, or PAHP identifies deficiencies or areas for improvement, the MCO, PIHP, or PAHP and the subcontractor take corrective action.

MEASUREMENT AND IMPROVEMENT STANDARDS

§ 438.236 Practice guidelines.

(a) *Basic rule:* The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) *Adoption of practice guidelines.* Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) *Dissemination of guidelines.* Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) *Application of guidelines.* Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

§ 438.240 Quality assessment and performance improvement program.

(a) *General rules.* (1) The State must require, through its contracts, that each MCO and PIHP have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.

(2) CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to

be required by States in their contracts with MCOs and PIHPs.

(b) *Basic elements of MCO and PIHP quality assessment and performance improvement programs.* At a minimum, the State must require that each MCO and PIHP comply with the following requirements:

(1) Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

(2) Submit performance measurement data as described in paragraph (c) of this section.

(3) Have in effect mechanisms to detect both underutilization and overutilization of services.

(4) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

(c) *Performance measurement.* Annually each MCO and PIHP must—

(1) Measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements of § 438.204(c) and § 438.240(a)(2);

(2) Submit to the State, data specified by the State, that enables the State to measure the MCO's or PIHP's performance; or

(3) Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section.

(d) *Performance improvement projects.* (1) MCOs and PIHPs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following:

(i) Measurement of performance using objective quality indicators.

(ii) Implementation of system interventions to achieve improvement in quality.

(iii) Evaluation of the effectiveness of the interventions.

(iv) Planning and initiation of activities for increasing or sustaining improvement.

(2) Each MCO and PIHP must report the status and results of each project to the State as requested, including those that incorporate the requirements of § 438.240(a)(2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

(e) *Program review by the State.* (1) The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's quality assessment and performance improvement program. The review must include—

(i) The MCO's and PIHP's performance on the standard measures on which it is required to report; and

(ii) The results of each MCO's and PIHP's performance improvement projects.

(2) The State may require that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.

§ 438.242 Health information systems.

(a) *General rule.* The State must ensure, through its contracts, that each MCO and PIHP maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

(b) *Basic elements of a health information system.* The State must require, at a minimum, that each MCO and PIHP comply with the following:

(1) Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.

(2) Ensure that data received from providers is accurate and complete by—

(i) Verifying the accuracy and timeliness of reported data;

(ii) Screening the data for completeness, logic, and consistency; and

(iii) Collecting service information in standardized formats to the extent feasible and appropriate.

(3) Make all collected data available to the State and upon request to CMS, as required in this subpart.

Subpart E—External Quality Review

SOURCE: 68 FR 3635, Jan. 24, 2003, unless otherwise noted.

§438.310 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart is based on sections 1932(c)(2), 1903(a)(3)(C)(ii), and 1902(a)(4) of the Act.

(b) *Scope.* This subpart sets forth requirements for annual external quality reviews of each contracting managed care organization (MCO) and prepaid inpatient health plan (PIHP), including—

(1) Criteria that States must use in selecting entities to perform the reviews;

(2) Specifications for the activities related to external quality review;

(3) Circumstances under which external quality review may use the results of Medicare quality reviews or private accreditation reviews; and

(4) Standards for making available the results of the reviews.

(c) *Applicability.* The provisions of this subpart apply to MCOs, PIHPs, and to health insuring organizations (HIOs) that began on or after January 1, 1986 that the statute does not explicitly exempt from requirements in section 1903(m) of the Act.

§438.320 Definitions.

As used in this subpart—

EQR stands for external quality review.

EQRO stands for external quality review organization.

External quality review means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their contractors furnish to Medicaid recipients.

External quality review organization means an organization that meets the competence and independence requirements set forth in §438.354, and performs external quality review, other EQR-related activities as set forth in §438.358, or both.

Financial relationship means—

(1) A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or

(2) A compensation arrangement with an entity.

Quality, as it pertains to external quality review, means the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Validation means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

§438.350 State responsibilities.

Each State that contracts with MCOs or PIHPs must ensure that—

(a) Except as provided in §438.362, a qualified EQRO performs an annual EQR for each contracting MCO or PIHP;

(b) The EQRO has sufficient information to use in performing the review;

(c) The information used to carry out the review must be obtained from the EQR-related activities described in §438.358.

(d) For each EQR-related activity, the information must include the elements described in §438.364(a)(1)(i) through (a)(1)(iv);

(e) The information provided to the EQRO in accordance with paragraph (c) of this section is obtained through methods consistent with the protocols established under §438.352; and

(f) The results of the reviews are made available as specified in §438.364.

§ 438.352 External quality review protocols.

Each protocol must specify—

(a) The data to be gathered;

(b) The sources of the data;

(c) The activities and steps to be followed in collecting the data to promote its accuracy, validity, and reliability;

(d) The proposed method or methods for validly analyzing and interpreting the data once obtained; and

(e) Instructions, guidelines, worksheets, and other documents or tools necessary for implementing the protocol.

§ 438.354 Qualifications of external quality review organizations.

(a) *General rule.* The State must ensure that an EQRO meets the requirements of this section.

(b) *Competence.* The EQRO must have at a minimum the following:

(1) Staff with demonstrated experience and knowledge of—

(i) Medicaid recipients, policies, data systems, and processes;

(ii) Managed care delivery systems, organizations, and financing;

(iii) Quality assessment and improvement methods; and

(iv) Research design and methodology, including statistical analysis.

(2) Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities.

(3) Other clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractors.

(c) *Independence.* The EQRO and its subcontractors are independent from the State Medicaid agency and from the MCOs or PIHPs that they review. To qualify as "independent"—

(1) A State agency, department, university, or other State entity may not have Medicaid purchasing or managed care licensing authority; and

(2) A State agency, department, university, or other State entity must be governed by a Board or similar body the majority of whose members are not government employees.

(3) An EQRO may not—

(i) Review a particular MCO or PIHP if either the EQRO or the MCO or PIHP exerts control over the other (as used in this paragraph, "control" has the meaning given the term in 48 CFR 19.101) through—

(A) Stock ownership;

(B) Stock options and convertible debentures;

(C) Voting trusts;

(D) Common management, including interlocking management; and

(E) Contractual relationships.

(ii) Deliver any health care services to Medicaid recipients;

(iii) Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO or PIHP services, except for the related activities specified in § 438.358; or

(iv) Have a present, or known future, direct or indirect financial relationship with an MCO or PIHP that it will review as an EQRO.

§ 438.356 State contract options.

(a) The State—

(1) Must contract with one EQRO to conduct either EQR alone or EQR and other EQR-related activities; and

(2) May contract with additional EQROs to conduct EQR-related activities as set forth in § 438.358.

(b) Each EQRO must meet the competence requirements as specified in § 438.354(b).

(c) Each EQRO is permitted to use subcontractors. The EQRO is accountable for, and must oversee, all subcontractor functions.

(d) Each EQRO and its subcontractors performing EQR or EQR-related activities must meet the requirements for independence, as specified in § 438.354(c).

(e) For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.

§ 438.358 Activities related to external quality review.

(a) *General rule.* The State, its agent that is not an MCO or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities in this section.

(b) *Mandatory activities.* For each MCO and PIHP, the EQR must use information from the following activities:

(1) Validation of performance improvement projects required by the State to comply with requirements set forth in §438.240(b)(1) and that were underway during the preceding 12 months.

(2) Validation of MCO or PIHP performance measures reported (as required by the State) or MCO or PIHP performance measure calculated by the State during the preceding 12 months to comply with requirements set forth in §438.240(b)(2).

(3) A review, conducted within the previous 3-year period, to determine the MCO's or PIHP's compliance with standards (except with respect to standards under §§438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) established by the State to comply with the requirements of §438.204(g).

(c) *Optional activities.* The EQR may also use information derived during the preceding 12 months from the following optional activities:

(1) Validation of encounter data reported by an MCO or PIHP.

(2) Administration or validation of consumer or provider surveys of quality of care.

(3) Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO.

(4) Conduct of performance improvement projects in addition to those conducted by an MCO or PIHP and validated by an EQRO.

(5) Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

(d) *Technical assistance.* The EQRO may, at the State's direction, provide technical guidance to groups of MCOs or PIHPs to assist them in conducting activities related to the mandatory and optional activities that provide information for the EQR.

§438.360 Nonduplication of mandatory activities.

(a) *General rule.* To avoid duplication, the State may use, in place of a Medicaid review by the State, its agent, or EQRO, information about the MCO or PIHP obtained from a Medicare or private accreditation review to provide information otherwise obtained from the mandatory activities specified in §438.358 if the conditions of paragraph (b) or paragraph (c) of this section are met.

(b) *MCOs or PIHPs reviewed by Medicare or private accrediting organizations.* For information about an MCO's or PIHP's compliance with one or more standards required under §438.204(g), (except with respect to standards under §§438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) the following conditions must be met:

(1) The MCO or PIHP is in compliance with standards established by CMS for Medicare+Choice or a national accrediting organization. The CMS or national accreditation standards are comparable to standards established by the State to comply with §438.204(g) and the EQR-related activity under §438.358(b)(3).

(2) Compliance with the standards is determined either by—

(i) CMS or its contractor for Medicare; or

(ii) A private national accrediting organization that CMS has approved as applying standards at least as stringent as Medicare under the procedures in §422.158.

(3) The MCO or PIHP provides to the State all the reports, findings, and other results of the Medicare or private accreditation review applicable to the standards provided for in §438.204(g); and the State provides the information to the EQRO.

(4) In its quality strategy, the State identifies the standards for which the EQR will use information from Medicare or private accreditation reviews, and explains its rationale for why the standards are duplicative.

(c) *Additional provisions for MCOs or PIHPs serving only dually eligibles.* The State may use information obtained from the Medicare program in place of

information produced by the State, its agent, or EQRO with respect to the mandatory activities specified in § 438.358 (b)(1) and (b)(2) if the following conditions are met:

(1) The MCO or PIHP serves only individuals who receive both Medicare and Medicaid benefits.

(2) The Medicare review activities are substantially comparable to the State-specified mandatory activities in § 438.358(b)(1) and (b)(2).

(3) The MCO or PIHP provides to the State all the reports, findings, and other results of the Medicare review from the activities specified under § 438.358(b)(1) and (b)(2) and the State provides the information to the EQRO.

(4) In its quality strategy, the State identifies the mandatory activities for which it has exercised this option and explains its rationale for why these activities are duplicative.

§ 438.362 Exemption from external quality review.

(a) *Basis for exemption.* The State may exempt an MCO or PIHP from EQR if the following conditions are met:

(1) The MCO or PIHP has a current Medicare contract under part C of title XVIII or under section 1876 of the Act, and a current Medicaid contract under section 1903(m) of the Act.

(2) The two contracts cover all or part of the same geographic area within the State.

(3) The Medicaid contract has been in effect for at least 2 consecutive years before the effective date of the exemption and during those 2 years the MCO or PIHP has been subject to EQR under this part, and found to be performing acceptably with respect to the quality, timeliness, and access to health care services it provides to Medicaid recipients.

(b) *Information on exempted MCOs or PIHPs.* When the State exercises this option, the State must obtain either of the following:

(1) *Information on Medicare review findings.* Each year, the State must obtain from each MCO or PIHP that it exempts from EQR the most recent Medicare review findings reported on the MCO or PIHP including—

(i) All data, correspondence, information, and findings pertaining to the MCO's or PIHP's compliance with Medicare standards for access, quality assessment and performance improvement, health services, or delegation of these activities;

(ii) All measures of the MCO's or PIHP's performance; and

(iii) The findings and results of all performance improvement projects pertaining to Medicare enrollees.

(2) *Medicare information from a private, national accrediting organization that CMS approves and recognizes for Medicare+Choice deeming.*

(i) If an exempted MCO or PIHP has been reviewed by a private accrediting organization, the State must require the MCO or PIHP to provide the State with a copy of all findings pertaining to its most recent accreditation review if that review has been used for either of the following purposes:

(A) To fulfill certain requirements for Medicare external review under subpart D of part 422 of this chapter.

(B) To deem compliance with Medicare requirements, as provided in § 422.156 of this chapter.

(ii) These findings must include, but need not be limited to, accreditation review results of evaluation of compliance with individual accreditation standards, noted deficiencies, corrective action plans, and summaries of unmet accreditation requirements.

§ 438.364 External quality review results.

(a) *Information that must be produced.* The State must ensure that the EQR produces at least the following information:

(1) A detailed technical report that describes the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP. The report must also include the following for each activity conducted in accordance with § 438.358:

(i) Objectives.

(ii) Technical methods of data collection and analysis.

(iii) Description of data obtained.

(iv) Conclusions drawn from the data.

(2) An assessment of each MCO's or PIHP's strengths and weaknesses with

respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients.

(3) Recommendations for improving the quality of health care services furnished by each MCO or PIHP.

(4) As the State determines, methodologically appropriate, comparative information about all MCOs and PIHPs.

(5) An assessment of the degree to which each MCO or PIHP has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

(b) *Availability of information.* The State must provide copies of the information specified in paragraph (a) of this section, upon request, through print or electronic media, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO or PIHP, recipient advocacy groups, and members of the general public. The State must make this information available in alternative formats for persons with sensory impairments, when requested.

(c) *Safeguarding patient identity.* The information released under paragraph (b) of this section may not disclose the identity of any patient.

§438.370 Federal financial participation.

(a) FFP at the 75 percent rate is available in expenditures for EQR (including the production of EQR results) and EQR-related activities set forth in §438.358 conducted by EQROs and their subcontractors.

(b) FFP at the 50 percent rate is available in expenditures for EQR-related activities conducted by any entity that does not qualify as an EQRO.

Subpart F—Grievance System

§438.400 Statutory basis and definitions.

(a) *Statutory basis.* This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) *Definitions.* As used in this subpart, the following terms have the indicated meanings:

Action means—

In the case of an MCO or PIHP—

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service;

(4) The failure to provide services in a timely manner, as defined by the State;

(5) The failure of an MCO or PIHP to act within the timeframes provided in §438.408(b); or

(6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

Appeal means a request for review of an action, as "action" is defined in this section.

Grievance means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

§438.402 General requirements.

(a) *The grievance system.* Each MCO and PIHP must have a system in place for enrollees that includes a grievance

process, an appeal process, and access to the State's fair hearing system.

(b) *Filing requirements*—(1) *Authority to file.* (i) An enrollee may file a grievance and an MCO or PIHP level appeal, and may request a State fair hearing.

(ii) A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.

(2) *Timing.* The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the MCO's or PIHP's notice of action. Within that timeframe—

(i) The enrollee or the provider may file an appeal; and

(ii) In a State that does not require exhaustion of MCO and PIHP level appeals, the enrollee may request a State fair hearing.

(3) *Procedures.* (i) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO or the PIHP.

(ii) The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.

§ 438.404 Notice of action.

(a) *Language and format requirements.* The notice must be in writing and must meet the language and format requirements of § 438.10(c) and (d) to ensure ease of understanding.

(b) *Content of notice.* The notice must explain the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take.

(2) The reasons for the action.

(3) The enrollee's or the provider's right to file an MCO or PIHP appeal.

(4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.

(5) The procedures for exercising the rights specified in this paragraph.

(6) The circumstances under which expedited resolution is available and how to request it.

(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(c) *Timing of notice.* The MCO or PIHP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§ 431.211, 431.213, and 431.214 of this chapter.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in § 438.210(d)(1).

(4) If the MCO or PIHP extends the timeframe in accordance with § 438.210(d)(1), it must—

(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in § 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in § 438.210(d).

§ 438.406 Handling of grievances and appeals.

(a) *General requirements.* In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals—

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(b) *Special requirements for appeals.* The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal—

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's estate.

§ 438.408 Resolution and notification: Grievances and appeals.

(a) *Basic rule.* The MCO or PIHP must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.

(b) *Specific timeframes*—(1) *Standard disposition of grievances.* For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 days from the day the MCO or PIHP receives the grievance.

(2) *Standard resolution of appeals.* For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(3) *Expedited resolution of appeals.* For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(c) *Extension of timeframes*—(1) The MCO or PIHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—

(i) The enrollee requests the extension; or

(ii) The MCO or PIHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.

(2) *Requirements following extension.* If the MCO or PIHP extends the timeframes, it must—for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.

(d) *Format of notice*— (1) *Grievances.* The State must establish the method MCOs and PIHPs will use to notify an enrollee of the disposition of a grievance.

(2) *Appeals.* (i) For all appeals, the MCO or PIHP must provide written notice of disposition.

(ii) For notice of an expedited resolution, the MCO or PIHP must also make reasonable efforts to provide oral notice.

(e) *Content of notice of appeal resolution.* The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the enrollees—

(i) The right to request a State fair hearing, and how to do so;

(ii) The right to request to receive benefits while the hearing is pending, and how to make the request; and

(iii) That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the MCO's or PIHP's action.

(f) *Requirements for State fair hearings*—(1) *Availability.* The State must permit the enrollee to request a State fair hearing within a reasonable time period specified by the State, but not less than 20 or in excess of 90 days from whichever of the following dates applies—

(i) If the State requires exhaustion of the MCO or PIHP level appeal procedures, from the date of the MCO's or PIHP's notice of resolution; or

(ii) If the State does not require exhaustion of the MCO or PIHP level appeal procedures and the enrollee appeals directly to the State for a fair hearing, from the date on the MCO's or PIHP's notice of action.

(2) *Parties.* The parties to the State fair hearing include the MCO or PIHP as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

§ 438.410 Expedited resolution of appeals.

(a) *General rule.* Each MCO and PIHP must establish and maintain an expedited review process for appeals, when the MCO or PIHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

(b) *Punitive action.* The MCO or PIHP must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(c) *Action following denial of a request for expedited resolution.* If the MCO or PIHP denies a request for expedited resolution of an appeal, it must—

(1) Transfer the appeal to the timeframe for standard resolution in accordance with § 438.408(b)(2);

(2) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.

§ 438.414 Information about the grievance system to providers and subcontractors.

The MCO or PIHP must provide the information specified at § 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

§ 438.416 Recordkeeping and reporting requirements.

The State must require MCOs and PIHPs to maintain records of grievances and appeals and must review the information as part of the State quality strategy.

§ 438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending.

(a) *Terminology.* As used in this section, "timely" filing means filing on or before the later of the following:

(1) Within ten days of the MCO or PIHP mailing the notice of action.

(2) The intended effective date of the MCO's or PIHP's proposed action.

(b) *Continuation of benefits.* The MCO or PIHP must continue the enrollee's benefits if—

(1) The enrollee or the provider files the appeal timely;

(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(3) The services were ordered by an authorized provider;

(4) The original period covered by the original authorization has not expired; and

(5) The enrollee requests extension of benefits.

(c) *Duration of continued or reinstated benefits.* If, at the enrollee's request, the MCO or PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

(1) The enrollee withdraws the appeal.

(2) Ten days pass after the MCO or PIHP mails the notice, providing the

resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.

(3) A State fair hearing Office issues a hearing decision adverse to the enrollee.

(4) The time period or service limits of a previously authorized service has been met.

(d) *Enrollee responsibility for services furnished while the appeal is pending.* If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in §431.230(b) of this chapter.

§438.424 Effectuation of reversed appeal resolutions.

(a) *Services not furnished while the appeal is pending.* If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO or PIHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

(b) *Services furnished while the appeal is pending.* If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the PIHP or the State must pay for those services, in accordance with State policy and regulations.

Subpart G [Reserved]

Subpart H—Certifications and Program Integrity

§438.600 Statutory basis.

This subpart is based on sections 1902(a)(4), 1902(a)(19), 1903(m), and 1932(d)(1) of the Act.

(a) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(b) Section 1902(a)(19) requires that the State plan provide the safeguards necessary to ensure that eligibility is determined and services are provided in a manner consistent with simplicity of administration and the best interests of the recipients.

(c) Section 1903(m) establishes conditions for payments to the State with respect to contracts with MCOs.

(d) Section 1932(d)(1) prohibits MCOs and PCCMs from knowingly having certain types of relationships with individuals excluded under Federal regulations from participating in specified activities, or with affiliates of those individuals.

§438.602 Basic rule.

As a condition for receiving payment under the Medicaid managed care program, an MCO, PCCM, PIHP, or PAHP must comply with the applicable certification, program integrity and prohibited affiliation requirements of this subpart.

§438.604 Data that must be certified.

(a) *Data certifications.* When State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP, the State must require certification of the data as provided in §438.606. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals, and related documents.

(b) *Additional certifications.* Certification is required, as provided in §438.606, for all documents specified by the State.

§438.606 Source, content, and timing of certification.

(a) *Source of certification.* For the data specified in §438.604, the data the MCO or PIHP submits to the State must be certified by one of the following:

(1) The MCO's or PIHP's Chief Executive Officer.

(2) The MCO's or PIHP's Chief Financial Officer.

(3) An individual who has delegated authority to sign for, and who reports directly to, the MCO's or PIHP's Chief Executive Officer or Chief Financial Officer.

(b) *Content of certification.* The certification must attest, based on best knowledge, information, and belief, as follows:

(1) To the accuracy, completeness and truthfulness of the data.

(2) To the accuracy, completeness and truthfulness of the documents specified by the State.

(c) *Timing of certification.* The MCO or PIHP must submit the certification concurrently with the certified data.

§ 438.608 Program integrity requirements.

(a) *General requirement.* The MCO or PIHP must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

(b) *Specific requirements.* The arrangements or procedures must include the following:

(1) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.

(2) The designation of a compliance officer and a compliance committee that are accountable to senior management.

(3) Effective training and education for the compliance officer and the organization's employees.

(4) Effective lines of communication between the compliance officer and the organization's employees.

(5) Enforcement of standards through well-publicized disciplinary guidelines.

(6) Provision for internal monitoring and auditing.

(7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's or PIHP's contract.

§ 438.610 Prohibited affiliations with individuals debarred by Federal agencies.

(a) *General requirement.* An MCO, PCCM, PIHP, or PAHP may not knowingly have a relationship of the type described in paragraph (b) of this section 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 nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.

(b) *Specific requirements.* The relationships described in this paragraph are as follow:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP.

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity.

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

(c) *Effect of Noncompliance.* If a State finds that an MCO, PCCM, PIHP, or PAHP is not in compliance with paragraphs (a) and (b) of this section, the State:

(1) Must notify the Secretary of the noncompliance.

(2) May continue an existing agreement with the MCO, PCCM, PIHP, or PAHP unless the Secretary directs otherwise.

(3) May not renew or otherwise extend the duration of an existing agreement with the MCO, PCCM, PIHP, or PAHP unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

(d) *Consultation with the Inspector General.* Any action by the Secretary described in paragraphs (c)(2) or (c)(3) of this section is taken in consultation with the Inspector General.

Subpart I—Sanctions

§438.700 Basis for imposition of sanctions.

(a) Each State that contracts with an MCO must, and each State that contracts with a PCCM may, establish intermediate sanctions, as specified in §438.702, that it may impose if it makes any of the determinations specified in paragraphs (b) through (d) of this section. The State may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(b) A State determines whether an MCO acts or fails to act as follows:

(1) Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.

(2) Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

(3) Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a recipient, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services.

(4) Misrepresents or falsifies information that it furnishes to CMS or to the State.

(5) Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.

(6) Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in §§422.208 and 422.210 of this chapter.

(c) A State determines whether an MCO, PIHP, PAHP or PCCM has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

(d) A State determines whether—

(1) An MCO has violated any of the other requirements of sections1903(m) or 1932 of the Act, and any implementing regulations;

(2) A PCCM has violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act and any implementing regulations;

(3) For any of the violations under paragraphs (d)(1) and (d)(2) of this section, only the sanctions specified in §438.702, paragraphs (a)(3), (a)(4), and (a)(5) may be imposed.

§438.702 Types of intermediate sanctions.

(a) The types of intermediate sanctions that a State may impose under this subpart include the following:

(1) Civil money penalties in the amounts specified in §438.704.

(2) Appointment of temporary management for an MCO as provided in §438.706.

(3) Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll.

(4) Suspension of all new enrollment, including default enrollment, after the effective date of the sanction.

(5) Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

(b) State agencies retain authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in §438.700, as well as additional areas of noncompliance. Nothing in this subpart prevents State agencies from exercising that authority.

§438.704 Amounts of civil money penalties.

(a) *General rule.* The limit on, or the maximum civil money penalty the State may impose varies depending on the nature of the MCO's or PCCM's action or failure to act, as provided in this section.

(b) *Specific limits.* (1) The limit is $25,000 for each determination under the following paragraphs of §438.700:

(i) Paragraph (b)(1) (Failure to provide services).

(ii) Paragraph (b)(5) (Misrepresentation or false statements to enrollees, potential enrollees, or health care providers).

(iii) Paragraph (b)(6) (Failure to comply with physician incentive plan requirements).

(iv) Paragraph (c) (Marketing violations).

(2) The limit is $100,000 for each determination under paragraph (b)(3) (discrimination) or (b)(4) (Misrepresentation or false statements to CMS or the State) of § 438.700.

(3) The limit is $15,000 for each recipient the State determines was not enrolled because of a discriminatory practice under paragraph (b)(3) of § 438.700. (This is subject to the overall limit of $100,000 under paragraph (b)(2) of this section).

(c) *Specific amount.* For premiums or charges in excess of the amounts permitted under the Medicaid program, the maximum amount of the penalty is $25,000 or double the amount of the excess charges, whichever is greater. The State must deduct from the penalty the amount of overcharge and return it to the affected enrollees.

§ 438.706 Special rules for temporary management.

(a) *Optional imposition of sanction.* The State may impose temporary management only if it finds (through onsite survey, enrollee complaints, financial audits, or any other means) that—

(1) There is continued egregious behavior by the MCO, including but not limited to behavior that is described in § 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or

(2) There is substantial risk to enrollees' health; or

(3) The sanction is necessary to ensure the health of the MCO's enrollees—

(i) While improvements are made to remedy violations under § 438.700; or

(ii) Until there is an orderly termination or reorganization of the MCO.

(b) *Required imposition of sanction.* The State must impose temporary management (regardless of any other sanction that may be imposed) if it finds that an MCO has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Act, or this subpart. The State must also grant enrollees the right to terminate enrollment without cause, as described in § 438.702(a)(3), and must notify the affected enrollees of their right to terminate enrollment.

(c) *Hearing.* The State may not delay imposition of temporary management to provide a hearing before imposing this sanction.

(d) *Duration of sanction.* The State may not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not recur.

§ 438.708 Termination of an MCO or PCCM contract.

A State has the authority to terminate an MCO or PCCM contract and enroll that entity's enrollees in other MCOs or PCCMs, or provide their Medicaid benefits through other options included in the State plan, if the State determines that the MCO or PCCM has failed to do either of the following:

(a) Carry out the substantive terms of its contract; or

(b) Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Act.

§ 438.710 Due process: Notice of sanction and pre-termination hearing.

(a) *Notice of sanction.* Except as provided in § 438.706(c), before imposing any of the intermediate sanctions specified in this subpart, the State must give the affected entity timely written notice that explains the following:

(1) The basis and nature of the sanction.

(2) Any other due process protections that the State elects to provide.

(b) *Pre-termination hearing*—(1) *General rule.* Before terminating an MCO or PCCM contract under § 438.708, the State must provide the entity a pre-termination hearing.

(2) *Procedures.* The State must do the following:

(i) Give the MCO or PCCM written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;

(ii) After the hearing, give the entity written notice of the decision affirming or reversing the proposed termination

of the contract and, for an affirming decision, the effective date of termination; and

(iii) For an affirming decision, give enrollees of the MCO or PCCM notice of the termination and information, consistent with §438.10, on their options for receiving Medicaid services following the effective date of termination.

§438.722 Disenrollment during termination hearing process.

After a State notifies an MCO or PCCM that it intends to terminate the contract, the State may do the following:

(a) Give the entity's enrollees written notice of the State's intent to terminate the contract.

(b) Allow enrollees to disenroll immediately without cause.

§438.724 Notice to CMS.

(a) The State must give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in §438.700.

(b) The notice must—

(1) Be given no later than 30 days after the State imposes or lifts a sanction; and

(2) Specify the affected MCO, the kind of sanction, and the reason for the State's decision to impose or lift a sanction.

§438.726 State plan requirement.

(a) The State plan must include a plan to monitor for violations that involve the actions and failures to act specified in this part and to implement the provisions of this part.

(b) A contract with an MCO must provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under section 438.730(e).

§438.730 Sanction by CMS: Special rules for MCOs

(a) *Basis for sanction.* (1) A State agency may recommend that CMS impose the denial of payment sanction specified in paragraph (e) of this section on an MCO with a contract under this part if the agency determines that the MCO acts or fails to act as specified in §438.700(b)(1) through (b)(6).

(b) *Effect of an Agency Determination.* (1) The State agency's determination becomes CMS's determination for purposes of section 1903(m)(5)(A) of the Act unless CMS reverses or modifies it within 15 days.

(2) When the agency decides to recommend imposing the sanction described in paragraph (e) of this section, this recommendation becomes CMS's decision, for purposes of section 1903(m)(5)(B)(ii) of the Act, unless CMS rejects this recommendation within 15 days.

(c) *Notice of sanction.* If the State agency's determination becomes CMS's determination under section (b)(2), the State agency takes the following actions:

(1) Gives the MCO written notice of the nature and basis of the proposed sanction;

(2) Allows the MCO 15 days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommended sanction;

(3) May extend the initial 15-day period for an additional 15 days if—

(i) the MCO submits a written request that includes a credible explanation of why it needs additional time;

(ii) the request is received by CMS before the end of the initial period; and

(iii) CMS has not determined that the MCO's conduct poses a threat to an enrollee's health or safety.

(d) *Informal reconsideration.* (1) If the MCO submits a timely response to the notice of sanction, the State agency—

(i) Conducts an informal reconsideration that includes review of the evidence by a State agency official who did not participate in the original recommendation;

(ii) Gives the MCO a concise written decision setting forth the factual and legal basis for the decision; and

(iii) Forwards the decision to CMS.

(2) The agency decision under paragraph (d)(1)(ii) of this section becomes CMS's decision unless CMS reverses or modifies the decision within 15 days from date of receipt by CMS.

(3) If CMS reverses or modifies the State agency decision, the agency

sends the MCO a copy of CMS's decision.

(e) *Denial of payment.* (1) CMS, based upon the recommendation of the agency, may deny payment to the State for new enrollees of the HMO under section 1903(m)(5)(B)(ii) of the Act in the following situations:

(i) If a CMS determination that an MCO has acted or failed to act, as described in paragraphs (b)(1) through (b)(6) of § 438.700, is affirmed on review under paragraph (d) of this section.

(ii) If the CMS determination is not timely contested by the MCO under paragraph (c) of this section.

(2) Under § 438.726(b), CMS's denial of payment for new enrollees automatically results in a denial of agency payments to the HMO for the same enrollees. (A new enrollee is an enrollee that applies for enrollment after the effective date in paragraph (f)(1) of this section.)

(f) *Effective date of sanction.* (1) If the MCO does not seek reconsideration, a sanction is effective 15 days after the date the MCO is notified under paragraph (b) of this section of the decision to impose the sanction.

(2) If the MCO seeks reconsideration, the following rules apply:

(i) Except as specified in paragraph (d)(2)(ii) of this section, the sanction is effective on the date specified in CMS's reconsideration notice.

(ii) If CMS, in consultation with the State agency, determines that the MCO's conduct poses a serious threat to an enrollee's health or safety, the sanction may be made effective earlier than the date of the agency's reconsideration decision under paragraph (c)(1)(ii) of this section.

(g) *CMS's role.* (1) CMS retains the right to independently perform the functions assigned to the State agency under paragraphs (a) through (d) of this section.

(2) At the same time that the agency sends notice to the MCO under paragraph (c)(1)(i) of this section, CMS forwards a copy of the notice to the OIG.

(3) CMS conveys the determination described in paragraph (b) of this section to the OIG for consideration of possible imposition of civil money penalties under section 1903(m)(5)(A) of the Act and part 1003 of this title. In accordance with the provisions of part 1003, the OIG may impose civil money penalties on the MCO in addition to, or in place of, the sanctions that may be imposed under this section.

Subpart J—Conditions for Federal Financial Participation

§ 438.802 Basic requirements.

FFP is available in expenditures for payments under an MCO contract only for the periods during which the contract—

(a) Meets the requirements of this part; and

(b) Is in effect.

§ 438.806 Prior approval.

(a) *Comprehensive risk contracts.* FFP is available under a comprehensive risk contract only if—

(1) The Regional Office has confirmed that the contractor meets the definition of an MCO or is one of the entities described in paragraphs (b)(2) through (b)(5) of § 438.6; and

(2) The contract meets all the requirements of section 1903(m)(2)(A) of the Act, the applicable requirements of section 1932 of the Act, and the implementing regulations in this part.

(b) *MCO contracts.* Prior approval by CMS is a condition for FFP under any MCO contract that extends for less than one full year or that has a value equal to, or greater than, the following threshold amounts:

(1) For 1998, the threshold is $1,000,000.

(2) For subsequent years, the amount is increased by the percentage increase in the consumer price index for all urban consumers.

(c) FFP is not available in an MCO contract that does not have prior approval from CMS under paragraph (b) of this section.

§ 438.808 Exclusion of entities.

(a) *General rule.* FFP is available in payments under MCO contracts only if the State excludes from the contracts any entities described in paragraph (b) of this section.

(b) *Entities that must be excluded.* (1) An entity that could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual.

(2) An entity that has a substantial contractual relationship as defined in §431.55(h)(3) of this chapter, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act.

(3) An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

(i) Any individual or entity excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

(ii) Any entity that would provide those services through an excluded individual or entity.

§438.810 Expenditures for enrollment broker services.

(a) *Terminology.* As used in this section—

Choice counseling means activities such as answering questions and providing information (in an unbiased manner) on available MCO, PIHP, PAHP, or PCCM delivery system options, and advising on what factors to consider when choosing among them and in selecting a primary care provider;

Enrollment activities means activities such as distributing, collecting, and processing enrollment materials and taking enrollments by phone or in person;

Enrollment broker means an individual or entity that performs choice counseling or enrollment activities, or both, and;

Enrollment services means choice counseling, or enrollment activities, or both.

(b) *Conditions that enrollment brokers must meet.* State expenditures for the use of enrollment brokers are considered necessary for the proper and efficient operation of the State plan and thus eligible for FFP only if the broker and its subcontractors meet the following conditions:

(1) *Independence.* The broker and its subcontractors are independent of any MCO, PIHP, PAHP, PCCM, or other health care provider in the State in which they provide enrollment services. A broker or subcontractor is not considered "independent" if it—

(i) Is an MCO, PIHP, PAHP, PCCM or other health care provider in the State;

(ii) Is owned or controlled by an MCO, PIHP, PAHP, PCCM, or other health care provider in the State; or

(iii) Owns or controls an MCO, PIHP, PAHP, PCCM or other health care provider in the State.

(2) *Freedom from conflict of interest.* The broker and its subcontractor are free from conflict of interest. A broker or subcontractor is not considered free from conflict of interest if any person who is the owner, employee, or consultant of the broker or subcontractor or has any contract with them—

(i) Has any direct or indirect financial interest in any entity or health care provider that furnishes services in the State in which the broker or subcontractor provides enrollment services;

(ii) Has been excluded from participation under title XVIII or XIX of the Act;

(iii) Has been debarred by any Federal agency; or

(iv) Has been, or is now, subject to civil money penalties under the Act.

(3) *Approval.* The initial contract or memorandum of agreement (MOA) for services performed by the broker has been reviewed and approved by CMS.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

§438.812 Costs under risk and nonrisk contracts.

(a) Under a risk contract, the total amount the State agency pays for carrying out the contract provisions is a medical assistance cost.

(b) Under a nonrisk contract—

(1) The amount the State agency pays for the furnishing of medical services to eligible recipients is a medical assistance cost; and

(2) The amount the State agency pays for the contractor's performance of other functions is an administrative cost.

c. For crossover claims the allowable payment to the provider is determined not by the Alabama Medicaid Agency but by Medicare. The Alabama Medicaid Agency will pay no more than the part of the allowable payment not paid by Medicare and other insurers who are obligated to pay part of the claim.

3. Physicians and Other Practitioners

Effective Date: 02/01/05

a. A statewide maximum payment will be calculated for each service designated by a procedure code recognized by the Alabama Medicaid Agency as designating a covered service . To determine payments for procedures codes without an established Medicaid rate, the Alabama Medicaid Agency will base rates on 1) Medicare, if not available then 2) commercial rate, or if not available 3) a percent of the charge. Payment rates are the same for both public and private providers except as noted below.

1. In order to increase provider participation and improve access to care, providers of all specialties, both public and private, in rural counties will be paid an enhanced rate for office visits and hospital visits. Providers in rural counties whose specialty is OB/GYN, Family Practice, General Practice or Pediatrics, will be paid an enhanced rate for global delivery codes and delivery only codes.

2. Physician Access Payments: In order to maintain adequate access to specialty faculty physician (all specialties except general practice, family practice, and general pediatrics) services as required by 42 USC 1396(a)(30) and 42 CFR 447.204, enhanced rates will be paid to teaching physicians who enter into an agreement with the Alabama Medicaid Agency to guarantee access to teaching physician services for Medicaid recipients. These rates, in the aggregate, will not exceed the state's average commercial rate. Teaching physicians are defined as doctors of medicine or osteopathy employed by or under contract with (a) a medical school that is part of the public university system (The University of Alabama at Birmingham and The University of South Alabama) or (b) a children's hospital healthcare system which meets the criteria and receives funding under Section 340E(a) of the U.S. Public Health Service Act (42 USC 256e), and which operates and maintains a state license for specialty pediatric beds.

In order to establish the rates for teaching physicians, the rates paid by the top five commercial insurance companies in Alabama were obtained. The State calculated the average commercial rate for each procedure code and determined the total expenditures the State would have made during a twelve-month period using the average rates. Then the State calculated total expenditures the State would have made during the same period using rates equal to 134.5% of Medicare rates. Since total expenditures using 134.5% of Medicare were less than the expenditures using the average commercial rates, the State will pay enhanced rates equal to 134.5% of Medicare to teaching physicians. Calculated reimbursement rates for all numeric procedure codes will be rounded to the nearest dollar. Rates for procedure codes starting with an alphabetic character will be rounded to the nearest penny. Procedure codes not recognized by Medicare are ineligible for the enhanced payment.

Effective Date: 04/01/90

b. For Medicare crossover claims, refer to item 19 in this attachment.

Effective Date: 07/01/87

c. Medicaid recipients are required to pay and providers are required to collect designated copayments for services, supplies, appliances, and equipment, except for the designated exemptions. The allowable copayment amount shall be credited against the Medicaid payment to the providers according to the copayment table in Attachment 4.18-A. Designated exemptions include services provided for pregnancy, nursing home residents, inpatient hospital visits, recipients under 18 years of age, emergencies, surgery fees, physical therapy, and family planning.

Effective Date: 06/01/90

d. Payment to Certified Registered Nurse Anesthetists will not exceed 85% of the maximum allowable rate paid to physicians for providing the same service.

Effective Date: 04/01/98

e. Payment to physician-employed Physician Assistants and Certified Registered Nurse Practitioners will not exceed 85% of the maximum allowable rate paid to physicians for providing the same service except for injectables and laboratory procedure. Injectable and Laboratory procedures are reimbursed at 100% of the amount paid to physicians.

MATERNITY CARE PROGRAM OPERATIONAL MANUAL

JANUARY 2010

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OPERATIONAL MANUAL

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I. OVERVIEW

The Maternity Care Program Operational Manual is provided as a resource tool. For questions or clarification of program policy or requirements, you may contact the Maternity Care Program Associate Director.

A. Maternity Care Program Authority

The program is also governed by the existing State Plan, Alabama Medicaid Agency Administrative Code, Alabama Medicaid Provider Billing Manual and the CFR. It is the responsibility of the Primary Contractor to be aware of and maintain copies of all governing materials.

B. Districts

Primary Contractors for all districts are required to provide maternity care services to all women eligible for the program.

DISTRICT	COUNTIES
1	Colbert, Franklin, Lauderdale, Marion
2	Jackson, Lawrence, Limestone, Madison, Marshall, Morgan
3	Calhoun, Cherokee, Cleburne, DeKalb, Etowah
4	Bibb, Fayette, Lamar, Pickens, Tuscaloosa
5	Blount, Chilton, Cullman, Jefferson, Shelby, St. Clair, Walker, Winston
6	Clay, Coosa, Randolph, Talladega, Tallapoosa
7	Greene & Hale
8	Choctaw, Marengo, Sumter
9	Dallas, Wilcox, Perry
10	Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, Pike
11	Barbour, Chambers, Lee, Macon, Russell
12	Baldwin, Clark, Conecuh, Covington, Escambia, Monroe, Washington
13	Coffee, Dale, Geneva, Henry, Houston
14	Mobile

C. Recipients to be Served

1. The following recipients who are pregnant are required to participate and must be enrolled by the district where the recipient resides:
   a. Recipients certified through the SOBRA (Sixth Omnibus Budget Reconciliation Act) program with the exception of Department of Youth Services recipients with County Code 69
   b. Recipients certified through the Medicaid for Low Income Families Program
   c. Refugees
   d. Supplemental Security Income (SSI) eligible women

2. The following recipients are not required to participate in the Maternity Care Program:
   a. Dual eligible recipients (Medicare/Medicaid)
   b. Individuals granted emergency Medicaid due to their illegal status

3. Primary Contractor must follow non-discriminatory standards of care for all recipients regardless of eligibility category.
   a. Ensuring that no person shall, on the grounds of race, color, creed, national origin, age, health status or handicap, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program of services provided by Medicaid.
   b. Compliance with Federal Civil Rights and Rehabilitation Acts is required of providers participating in the Alabama Medicaid Agency.

II. DEFINITIONS

Anesthesia

Any sensory and/or motor paralysis for the relief of pain including but not limited to; epidural, saddle-block, pudendal block, inhalation central anesthesia, endotracheal anesthesia, or other, which is not medically contraindicated.

Antenatal Care

All usual prenatal services including, but not limited to, the initial visit at the time pregnancy is diagnosed, initial and subsequent histories, Care Coordination, risk assessments, physical exams, recordings of weight and blood pressure, fetal heart tones and rates, lab work appropriate to the level of care including hematocrit and chemical urinalysis, and any additional services required for high-risk women.

Application Assisters

Individuals trained by the Medicaid Agency to assist recipients in completing Medicaid Applications.

Benchmark

A benchmark is a standard by which requirements can be measured or judged.

Recipients

Pregnant women, who reside in Alabama, are certified for Medicaid and receive pregnancy related services under the Maternity Care Program.

Care Coordination

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

Clean Claim

A clean claim is one that can be processed without Medicaid obtaining additional information from the provider of service or a third party insurance carrier.

CMS

Centers for Medicare and Medicaid Services, a division of the U.S.

Department of Health and Human Services.

Continuity of Care

Uninterrupted continual care of the Medicaid recipient that is coordinated to address the health care needs among practitioners and across organizations and time.

Contract Services

See "covered services".

Convicted

A judgment of conviction that has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

Covered Services

Health care services, as designated in Section 5, to be delivered by a Primary Contractor or through subcontracts.

Days

Calendar days unless otherwise specified.

Debarment

Debarment is exclusion from participation as a Medicare/Medicaid provider.

Delivery

Delivery is the birth of an infant via vaginal birth canal (with or without episiotomy and with or without forceps), or cesarean section delivery.

Delivering Healthcare Professional (DHCP)

A licensed physician or nurse midwife who is qualified to perform deliveries, prenatal and postpartum care.

Disclosing Entity

The entity is a Medicaid provider or a fiscal agent.

Districts

Districts are geographic divisions of the State of Alabama as defined by the Alabama Medicaid Agency which comprise the entire state divided into fourteen districts.

Dropouts

A recipient who begins care in the district of her residence but does

not deliver her infant within that district's network is considered a dropout. An example of dropout may include someone who moves to another district or miscarries prior to 21 weeks.

Eligible

A person certified as eligible to receive Medicaid benefits and who has been issued a Medicaid identification number.

Eligibility

A process of determination of eligibility for medical assistance performed by Medicaid.

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy or serious impairment of bodily functions; or serious dysfunction of any bodily organ or part.

Enrollee

An enrollee is a Medicaid recipient who is currently enrolled in the Maternity Care Program via her district of residence.

Fee for Service

A method of Medicaid reimbursement based upon payment to providers for services rendered to Medicaid recipients subsequent to, and specifically for, the rendering of those services. Those services that are payable outside the global fees.

Fiscal Agent

The company designated by Medicaid, through contract, to maintain the Medicaid claims processing system.

Fiscal Year

Defined as October 1 through September 30.

Global Fee

The reimbursement fee paid following delivery to the Primary Contractor for recipients who meet the requirements of the Medicaid Maternity Care Program. This fee is a global amount paid to the Primary Contractor who, in turn, pays subcontractors

who provided services to the particular recipient. The amount paid to each subcontractor is a negotiated amount between the Primary Contractor and the subcontractor, with Medicaid minimums established for Delivering Health Care Professionals.

Grievance

A grievance is a written expression of dissatisfaction about any matter.

Indicator

An indicator is a measurable dimension of care (e.g., a medical event, diagnosis, or outcome) to reflect aspects of care, the importance of which is gauged by frequency, severity, or cost.

Material Omission

A fact, data or other information excluded from a report, contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.

Maternity Care

Primary Contractor

A person or organization agreeing through a direct contract with the Alabama Medicaid Agency to provide those goods and services specified by contract in conformance with the requirements of the bid and state and federal laws and regulations.

Medicaid

A Federal/State program authorized by Title XIX of the Social Security Act, as amended, which provides Federal matching funds for a medical assistance program for recipients of federally aided public assistance and SSI benefits and other specified groups. Certain minimal populations and services shall be included.

Medically Necessary

Appropriate and necessary services as determined by health care practitioners according to national or community standards

Medical Record

The document that records all of the medical treatment and services provided to the Medicaid recipient.

Party of Interest

A person or organization with an ownership interest with the Primary Contractor of five percent or more or in which the Primary Contractor has ownership interest of five percent or more.

Performance Measure

A consistent measurement of service, practice, and governance of a health care organization. Measurements shall produce solid, statistically-based measurement of critical processes that in turn shall permit the organization to make solid decisions about improvements.

Postpartum Care

Postpartum care includes inpatient hospital visits, office visits and/or home visits by a physician, midwife or registered nurse following delivery for routine care through the end of the month of the 60-day postpartum period (e.g. whether the 60th day is on September 2nd or September 16th, the eligibility continues through the end of the month.)

Potential Enrollee

A Medicaid recipient who is subject to mandatory or voluntary enrollment, but is not yet enrolled.

Pre-Term Delivery

Deliveries occurring prior to 37 weeks gestation.

Program Exemption

A recipient who has an exemption is not required to receive care from the Primary Contractor's network. This is generally as a result of medical necessity, travel hardship or for individuals enrolled in a private Health Maintenance Organization (HMO). The claims for exempted recipients are paid fee for service if provided by an authorized Alabama Medicaid provider.

Quality Assurance

An objective and systematic process that evaluates the quality and appropriateness of services provided.

Remittance Advice

An explanation of the check writes payment. It lists the paid, denied, adjusted and recouped claims. Remittance Advice was previously called the Explanation of Payment.

Risk Assessment

Medical and psycho-social assessment performed to determine the perinatal risk status of pregnant women. The purpose of the assessment is to determine the presence of any medical and/or social risk factors.

SOBRA

SOBRA is an eligibility category for children and pregnant women. SOBRA is further defined as maternity services for a woman who is eligible for pregnancy only related care, postpartum and family planning services. These women are maternity eligible until the end of the month in which the 60th postpartum day falls. After SOBRA ends the women are covered by family planning services. These women are also identified as poverty level women.

Subcontract

A subcontract is any written agreement between the Primary Contractor and another party for any services necessary to fulfill the requirements of the Medicaid Maternity Care Program contract

Third Party Liability (TPL)

Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for covered services furnished to enrollees. The recipient is still restricted to receiving care through the Primary Contractor unless the TPL is a HMO/Managed Care Plan with a restricted provider network, and then a program exemption shall be requested. Primary Contractor is responsible for collecting all third party payments prior to submitting a claim to Medicaid for payment.

Utilization Review

Prospective, concurrent and retrospective review and analysis of data related to utilization of health care resources in terms of cost effectiveness, efficiency, control, quality, and medical necessity.

III. ADMINISTRATIVE REQUIREMENTS

A. Standards for Primary Contractor

The Primary Contractor must comply with all the provisions of the executed contract, its amendments and referenced materials and shall act in good faith in the performance of the provisions of said contract. The following is a listing of the standards for the Primary Contractor:

1. Demonstrate the capability to serve all of the pregnant Medicaid eligible population in the designated geographical area whether the Medicaid eligible has or has not enrolled in your district.

2. Procure a network of providers within a maximum of 50 miles travel for all areas of their district.

3. Designate a Director or other designee to be available, accessible, or on call at all times for any administrative or medical problems which may arise.

4. Require subcontractors providing direct medical care to be on call or make provisions for maternity call coverage 24-hours per day, seven days per week.

5. Require that all persons, including employees, agents, and subcontractors acting for or on behalf of the Primary Contractor, be properly licensed under applicable state laws and/or regulations. Any Delivering Health Care Professional must have hospital privileges at a participating hospital within the Maternity Care program district. Some providers may elect to provide prenatal care only; another provider would provide delivery and postpartum care. In this case there would not be a requirement for the prenatal provider to have hospital privileges.

6. Comply with certification and licensing laws and regulations applicable to the Primary Contractor's practice, profession or business. The Primary Contractor agrees to perform services consistent with the customary standards of practice and ethics in the profession. The Primary Contractor agrees not to knowingly employ or subcontract with any health professional whose participation in the Medicaid or Medicare Program is currently suspended or has been terminated by Medicare or Medicaid.

7. Must require that network providers offer hours of operation that Are not less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service.

8. Comply with all state and federal regulations regarding family planning services, including no restriction on utilization of services. The Plan First Program Manager can provide information on available contraception. The sterilization consent form is available on the Medicaid web site.

9. Require all subcontractors providing direct services to meet the requirements of and enroll as Medicaid providers as applicable. This will include any professionals that provide on-call coverage for the network provider.

10. Cooperate with external review agents who have been selected by the State to review the program.

11. Report suspected fraud and abuse to the Medicaid Agency. The Primary Contractor must have policies, procedures, a mandatory compliance plan, a compliance officer, compliance committee and training education for all of its employees. These policies and procedures must comply with all mandatory state guidelines and federal guidelines as specified in 42 CFR 438.608(b) (1).

12. Prohibit discrimination against recipients based on their health status or need for health services as specified at 42 CFR 438.6 (d) (3).

13. Ensure that medical records and any other health and enrollment information that identifies any individual enrollee must be handled in such a manner as to meet confidentiality requirements as specified in 42 CFR 438.224. Develop and implement procedures consistent with confidentiality requirements as specified in 42 CFR 438.224.

14. The Primary Contractor is not required to reimburse payment, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds in accordance with 42 CFR 438.102 (a)(2). If the Primary Contractor elects not to provide the service, then if must provide the related information to Medicaid so that it can be provided to the recipient.

B. Functions/Responsibilities

The Primary Contractor must comply with all the provisions of the executed contract, its amendments and referenced materials and must act in good faith in the performance of the provisions of said contract. The following is a listing of the functions and/or responsibilities of the Primary Contractor:

1. Provide the pregnant Medicaid eligible population obstetrical care through a comprehensive system of quality prenatal care, physician or midwife

delivery care, and postpartum care. The care can be provided directly or through subcontracts. The successful bidder's delivery system will not include the hospital component. The care can be provided directly or through subcontracts.

2. Implement and maintain the Medicaid approved quality assurance system by which access, process and outcomes are measured.

3. Provide Application Assister services to Medicaid recipients. (Refer to the information in Attachment 5 for details on Application Assisters.)

4. Utilize proper tools and service planning for women assessed to be at risk medically or psychosocially.

5. Provide recipient choice among Delivery Health Care Professionals in its network.

6. Meet all requirements of the provider network including maintaining written subcontracts with providers to be used on a routine basis, including but not limited to, obstetricians, and general practitioners, nurse midwives, anesthesiologists, radiologists and Care Coordinators. The Primary Contractor must notify Medicaid, in writing, of changes in the subcontractor base including the subcontractor's name, specialty, address, telephone number, fax number and Medicaid provider number.

7. Maintain a toll-free line and designated staff to enroll recipients and provide program information.

8. Develop, implement and maintain an extensive recipient education plan covering subjects, such as appropriate use of the medical care system, purpose of care coordination, healthy lifestyles, planning for baby, self-care, etc. All materials shall be available in English and in the prevalent non-English language in the particular service area. The Primary Contractor is required to participate in Medicaid's efforts to promote the delivery of services in a culturally competent manner including those with limited English proficiency and with diverse cultural and ethnic backgrounds. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight or speech impairments. The Primary Contractor must make oral interpretation services available for all non-English languages free of charge to each enrollee and potential enrollee.

9. Develop, implement, and maintain a provider education plan, covering subjects such as minimum program guidelines, billing issues, updates from Medicaid, etc. Provide support and assistance to subcontractors to include at minimum program guidelines, billing issues, updates from

Medicaid, etc. At a minimum such education shall be provided semi-annually. Records of education programs including providers' attendance, date, length of session, topics covered, and presenter(s) information shall be maintained for Administrative Audits.

10. Develop, implement and maintain an effective outreach plan to make providers, recipients and the community aware of the purpose of Medicaid Maternity Care Program and the services it offers. The Primary Contractor is refrained from marketing activities as specified in Administrative Code 560-X-37-.01(17).

11. Develop, implement and maintain a recipient educational program explaining how to access the Maternity Care Program including service locations. Materials shall provide information about recipient rights and duties, provisions for after-hours and emergency care, referral policies, notification of change of benefits, procedures for appealing adverse decisions, procedures for changing Delivering Health Care Professionals, exemption procedures and grievance procedures. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight or speech impairments. The Primary Contractor must inform all enrollees and potential enrollees who have special needs that the information is available in alternative formats. All materials shall be available in English and in the prevalent non-English language in the particular service area. The Primary Contractor is required to participate in Medicaid's efforts to promote the delivery of services in a culturally competent manner including those with limited English proficiency and with diverse cultural and ethnic backgrounds. The Primary Contractor must make oral interpretation services available for all non-English languages free of charge to each enrollee and potential enrollee. This applies to all non-English languages not just those that the State identifies as prevalent. Each entity must notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services.

12. Develop, implement and maintain a grievance procedure including an appeal process that is easily accessible and that is explained to recipients upon entry into the system.

13. Develop a system to ensure that all written materials are drafted in an easily understood language and format. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that the information is available in alternative formats and how to access those formats.

14. Develop, implement and maintain a system for handling billing inquiries from recipients and subcontractors so that inquiries are handled in a timely manner.

15. Develop, implement and maintain a computer based data system that collects, integrates, analyzes and reports with recipient information.

16. Give Medicaid immediate notification, by telephone and followed in writing, of any action or suit filed and prompt notice of any claim made against the Primary Contractor by any subcontractor which may result in litigation related in any way to the subject matter of this Contract. In the event of the filing of a petition of bankruptcy by or against any subcontractor or the insolvency of any subcontractor, the Primary Contractor must ensure that all tasks related to any subcontractor are performed in accordance with the terms of the contract.

17. Maintain a complete record, including Care Coordination notes, for each enrolled recipient, at one location, of all services and identify by recipient name, Medicaid number, date of service, and services provided prior to making payment. Any record requested by Medicaid shall be provided free of charge.

18. Perform claims review prior to submission to Medicaid for administrative review.

19. Advise recipients of services that may be covered by Medicaid that are not covered through the Maternity Care Program.

20. Promptly provide to Medicaid all information necessary for the reimbursement of outstanding claims in the event of insolvency.

21. Coordinate care from out-of-network providers to ensure that there is no added cost to the enrollee.

C. General

1. The Primary Contractor is responsible for the management of comprehensive obstetrical care. The success of the Maternity Care Program is contingent upon the Primary Contractors' provision of a network of quality caregivers, which considers the needs of the enrollees and enables each pregnant woman served to receive comprehensive obstetrical care.

2. The Primary Contractor must utilize resources such as American College of Obstetrics and Gynecologists Standards (ACOG), established community

practice standards, etc. in the development of program guidelines, which are reviewed and updated periodically as appropriate. The Primary Contractor must disseminate the program guidelines to all affected providers and upon request to enrollees and potential enrollees.

3. Primary Contractor must ensure that decisions for utilization management, enrollee education, and coverage of services are consistent with the program guidelines.

4. It is unlikely that a Primary Contractor will be able to provide all of the necessary resources to participate in the program. Subcontracts must be developed with other providers capable of providing the requisite services. Primary Contractors must have sufficient resources and personnel with necessary education and experience or training to perform the requisite duties and responsibilities.

5. The Primary Contractor must use the Medicaid Web Service Database for reporting program demographics and other elements related to the pregnancy.

D. Program Director

Each Maternity Care Primary Contractor must have a full time Director. This person shall have the following minimum qualifications:

1. A BS or BA degree from an accredited college or university or a minimum of three years of management experience in a managed health care.

2. Experience in working with low-income populations.

The Program Director must have the authority to make decisions and implement program policy. Any changes in the Director's position must be approved by Medicaid. Medicaid must be notified in writing prior to the effective date of the change.

E. Computer System

Primary Contractors must maintain a HIPAA compliant computer system that collects, integrates, analyzes and reports. Minimum capabilities include:

1. Analysis of data and generation of reports including but not limited to utilization and financial services.

2. Database functionality that includes, but is not limited to storage, analysis, and retrieval of information.

3. The ability to produce provider profiles including current overall recipient counts and the number of Medicaid recipients.

4. An automated tracking system that includes at a minimum the following information:
   a. Recipient name
   b. Medicaid number
   c. Date of birth
   d. Address
   e. Estimated Date of Confinement
   f. Telephone number
   g. Delivering Health Care Professional Chosen
   h. Care Coordinator Assigned
   i. Risk status; including medical and psychosocial.

F. Provider Network

Primary Contractors must have a delivery system that meets Medicaid standards. Primary Contractors shall ensure that this delivery system promotes continuity of care and quality care. Primary Contractors must provide all medically necessary services as covered services following Medicaid policies and procedures.

1. For the first 30 days after contract award, the Primary Contractor must offer opportunities for participation to all interested potential subcontractors. The potential subcontractors must meet requirements and be willing to participate as providers according to the guidelines of the Medicaid Maternity Care Program.

   Thereafter, a yearly open enrollment period is required during the first month of each succeeding contract year. Subcontractors must be willing to adhere to program requirements and accept offered reimbursement for services provided.

2. Primary Contractor must offer all willing subcontractors the opportunity to participate at a reimbursement level consistent with other like subcontractors.

3. Each Primary Contractor must have written policies and procedures for the selection and retention, credentialing and re-credentialing requirements and non-discrimination of subcontractors as specified at 42 CFR 438.214

4. Primary Contractors not required to offer participation to potential subcontractors who do not agree to adhere to program requirements nor to those who have been disqualified from participation in any federal program, nor any person convicted of an offense involving Medicaid or Medicare programs.

5. Providers who are willing to adhere to program requirements and who otherwise qualify must be given equal and fair participation opportunities. Complaints of discrimination will be investigated by Medicaid.

6. Primary Contractor must contract with subcontractors who are geographically appropriate (50 miles) to recipients within the district. If there are no in-district providers that would ensure that every recipient meets the 50 miles requirement, the Primary Contractor is responsible for establishing a network of providers and may have to pursue contracts with out of district providers.

7. Primary Contractor must continually monitor the provider network to ensure that the capacity is sufficient to meet the needs of all Medicaid recipients in the district and that availability and accessibility are not hindered.

8. Primary Contractor must monitor and evaluate provider performance of all subcontractors to ensure that Medicaid and Primary Contractor standards are met. Such monitoring and evaluation system must include a corrective action system.

9. Primary Contractor must notify Medicaid within one working day of any unexpected changes that would impair its provider network. This notification shall include:

   a. Information as to how the change shall affect the delivery of covered services,
   b. Primary Contractor's plans for maintaining the quality of member care if the provider network change is likely to result in deficient delivery of covered services.

10. Primary Contractor must not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. This includes providers that serve high-risk populations or specialize in conditions that require costly treatment. If a Primary Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This should not be construed to require the Primary Contractor to contract with providers beyond the number necessary to meet the needs of its enrollees, preclude the Primary Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or preclude the Primary Contractor from establishing measures that are designed to

maintain quality of services and control costs and is consistent with its responsibilities to the enrollee.

11. The Primary Contractor must make a good faith effort to give a written notification of the termination of a contracted provider within fifteen days of the receipt or issuance of the termination notice to each recipient who was being seen on a regular basis by that subcontractor.

12. Delivering Health Care Professionals shall have the option of establishing a limited number of Medicaid recipients that he/she shall accept.

G. Subcontractor Requirements

Subcontracts executed for the purposes of meeting program requirements must meet the following requirements:

1. Be in writing;

2. Require provider to comply with accepted medical Standards of Care;

3. Require provider to comply with other terms and conditions contained in this bid;

4. Contain provider reimbursement provisions;

5. Contain a provision specifying that provider must agree that under no circumstances (including, but not limited to, situations involving non-payment by the Primary Contractor, insolvency of the Primary Contractor, or breach of agreement) shall the provider bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against Medicaid recipients, or persons acting on their behalf, for **covered** services, rendered during the term of provider's agreement or subcontract with the Primary Contractor. A provider may charge for non-covered services delivered on a fee-for-service basis to Medicaid recipients;

6. Contain a provision that states "payment for maternity-related services, not covered by the Maternity Care Program, does not make the recipient responsible for all of her maternity care";

7. Cover the same time period as the Primary Contractors' contract with Medicaid;

8. Contain a provision indicating that subcontracts may only be terminated for cause.

H. Annual Verification Requirements

The Primary Contractor must annually verify the following:

1. That the subcontractor possesses a current Alabama Medical License or certification and licensure as a Certified Nurse Midwife or other appropriate licensure requirements.

2. That the subcontractor is enrolled as a Medicaid provider.

3. That the subcontractor has current hospital privileges (as applicable), in good standing, at a Medicaid participating hospital within the Maternity Care Program district.

4. That the subcontractor is not currently debarred from participation from Medicare/Medicaid. Primary Contractor is required to notify Medicaid within two business days of the time of occurrence when a disbarred provider is identified. The quarterly sanctions report that is distributed by Medicaid as well as the Debarred Provider List that is maintained at the federal level shall be monitored on an ongoing basis to identify these individuals.

I. Outreach

Primary Contractor is responsible for implementing and maintaining a Medicaid approved outreach program to inform and educate Medicaid recipients and the community on the Maternity Care Program availability and services. The goal is to have all Medicaid eligible women enter care in their first trimester. The program components include, but are not limited to:

1. Medicaid approved printed material available at a sixth grade literacy level explaining program specifics. Outreach materials must include at a minimum explanations of how to access the Maternity Care Program.

2. Medicaid must approve all outreach and educational material prior to actual usage.

3. Easily accessible program information available at sites such as hospitals, physician offices, Social Security offices, DHR offices, health departments, community resource centers, tax refund offices, family planning centers, or other community areas.

4. Coordination with local communities, other agencies, and service providers to ensure awareness of the program and to identify other services available to meet the needs of the Medicaid recipient.

5. A system for recipients to receive information and ask questions regarding the Maternity Care Program.

6. Review of the Primary Contractors' outreach materials will be done during the annual evaluation.

J. Recipient Education

Maternity Care Primary Contractor is responsible for implementing and maintaining a Medicaid approved education program to inform and educate Medicaid recipients on the Maternity Care Program. The program components include, but are not limited to:

1. Basic education, such as importance of early and continuous pregnancy care and the importance of following physician's instructions, and expectations of pregnancy and delivery.

2. Education regarding danger signs (e.g., spotting or bleeding, gush of fluid from vagina, etc.) during the pre and post natal period which includes information on when to seek medical care in an emergency situation.

3. Education on where and how to seek emergency care.

4. Education regarding nutrition and other components of a healthy lifestyle that are necessary for a good pregnancy outcome. Education regarding availability of newborn care classes, information about the Patient 1st Program and immunization schedules.

5. Education regarding importance of family planning along with written and oral instructions regarding all forms of birth control. The Family Planning PT+3 materials are provided by Medicaid free of charge. The patient must also be made aware of and referred to the Plan First Program.

6. Discuss that over the counter and any other medicines must be approved by the Delivering Health Care Professional, avoidance of smoking cigarettes, and the importance of avoiding use of drugs and alcohol.

K. Subcontractor Education

Primary Contractor must provide a structured educational component for each subcontractor that participates in the program which includes, but is not limited to:

1. Program requirements

2. Billing procedures/claims resolution

3. Quality management protocols

4. Training sessions or provider meetings at least bi-annually or more often as needed to address problems and/or provide updated information

L. Billing Inquires/Claims Resolution

Primary Contractor is responsible for implementing a system for responding to billing inquiries from recipients and subcontractors. Primary Contractor shall only refer claim inquiries to Medicaid that require an administrative review.

IV. ENROLLMENT REQUIREMENTS

A. Recipient Choice

Recipients must be allowed to select the Delivering Health Care Professional of their choice at the time of entry (enrollment) into the care system. Primary Contractor must accept all women covered by the program and must not disenroll women from the program except through the exemption process (refer to Section V.D.). Primary Contractor must comply with the requirements set forth at 42 CFR 438.56 regarding recipient disenrollment (Attachment 12). If disenrollment is approved pursuant to section V.D., 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 enrollee files the request. If the Primary Contractor fails to make a disenrollment determination within this timeframe, the disenrollment is approved.

Primary Contractor must have written policies and procedures governing recipient enrollment. The following guidelines apply:

B. List Requirements

1. A Delivering Health Care Professional List must be available for use in the selection process.

2. Current Delivering Health Care Professionals provider listings must be maintained. (NOTE: All listings, forms, etc. must be approved by the Agency prior to use).

   a. The list must include Delivering Health Care Professional choices available through the provider network listed alphabetically and must be provided to the enrollees. The list shall include: Address and telephone number; any physician extenders such as nurse midwives, nurse practitioners, residents in training, or physician assistants;

   b. Hospital where the Delivering Health Care Professionals deliver; all sites where the Delivering Health Care Professionals see recipients i.e., office, Health Department, satellite clinic; and all sites where prenatal care is provided.

   c. Any limitations on services, for example, some Delivering Health Care Professionals do not perform sterilizations. This would be significant if the recipient states that she wants sterilization prior to discharge from the hospital when the delivery occurs.

3. A weekly updated Delivering Health Care Provider list is required during the initial award period and up to 30 days after implementation date and during the yearly open enrollment. Otherwise, the list shall be updated as changes are made and sent to the Maternity Care Program Associate Director.

C. Recipient Choice Requirements

1. The recipient will have to indicate on the 'Agreement to Receive Care' (Attachment 2) her choice of Delivering Health Care Professionals and a copy of the form must be provided to her.

2. A recipient enrolled in the Patient 1st Program may select the same Primary Medical Provider (PMP) if he/she is a subcontractor for the Maternity Care Program.

3. A staffed toll-free line is required to enroll recipients into the Maternity Care Program and to provide requested information. The toll-free line must be staffed at minimum during the hours of 8-5 weekdays with an answering machine for after hours.

4. All enrollment material must be provided in a manner and format that may be easily understood in compliance with 42 CFR 438.10(b) (1).

The recipient should be asked whether she is a Medicaid recipient. If not, ask if she submitted an eligibility application and whether she needs assistance. If assistance is needed, an immediate referral to the Care Coordinator should be arranged to get the application process started.

D. Delivering Health Care Professional Selection Process

Recipients must be advised of the process that is to be used in selecting a Delivering Health Care Professional. This process shall include:

1. Recipient is to select the Delivering Health Care Professional of her choice for Maternity Care services from a list of network providers.

2. Advise the recipient of medical professionals who shall be involved in her care, e.g. nurse midwives, nurse practitioners, on-call physicians, etc. Provide this information in writing.

3. Patients may not in any way be influenced when selecting a Delivering Health Care Professional.

4. If the Delivering Health Care Professional has no slots available, staff must work with recipients to have a Delivering Health Care Professional selected within two working days.

5. If the recipient does not want to choose a Delivering Health Care Professional on the day of enrollment, then she shall be informed that she must call back within five working days to choose a Delivering Health Care Professional, or the Primary Contractor shall assign a Delivering Health Care Professional to her on a rotation basis between other Delivering Health Care Professionals on the panel. Recipients shall also be notified of the Delivering Health Care Professional with whom they have been assigned.

6. In the event the recipient refuses to choose a Delivering Health Care Professional or fails to choose a Delivering Health Care Professional within the designated time frame, the Primary Contractor must assign her to a Delivering Health Care Professional based on equivalent distribution among the Delivering Health Care Professionals, with available openings to serve additional recipients. This process must include consideration of the distance the recipient lives from the provider and prior relationships, if the Primary Contractor has access to this information.

E. Delivering Health Care Professional Notification

1. Each recipient's selected Delivering Health Care Professional must be notified within five working days of the recipient's enrollment.

2. A monthly listing of Medicaid recipients electing to enroll with each Delivering Health Care Professional shall be provided to the Delivering Health Care Professional. This list must be provided prior to the first day of each month.

F. Changes in Selection of Delivering Health Care Professionals

Guidelines for change of Delivering Health Care Professional must include:

1. Allowing recipients to change Delivering Health Care Professionals, without cause, once within the first 90 days of enrolling.

2. Establishing internal policies and procedures for changing Delivering Health Care Professionals.

3. Allowing recipient to change Delivering Health Care Professionals after the first 90 days with cause, which is defined as a valid complaint submitted to the Primary Contractor in writing explaining the reason the recipient wishes to change her Delivering Health Care Professional.

4. Tracking of changes in Delivering Health Care Professionals with grievance procedure timeframes being met.

G. Program Enrollment

The following guidelines apply when processing a woman's enrollment into the program:

1. Recipients must be provided with all required information regarding rights and responsibilities, grievance process and fair hearing process, and telephone numbers, at the time of enrollment.

2. The person enrolling the recipient into the program must ascertain if the woman has third party liability. If TPL is available, obtain the name of the insurance company, the name on the policy (insured), recipient relationship to the insured, address, phone number and policy number. If possible, ascertain from the recipient what type of coverage the policy provides. Verify the information with the insurance company or Medicaid and record all information in the file. Some of this information may be available through the online eligibility systems maintained by Medicaid's Fiscal Agent. The recipient should be informed of coverage limits of pregnancy related illness through SOBRA and allowed to make an informed choice regarding continued coverage of any previous insurance coverage. **It is vital that this type of information be collected at the beginning of prenatal care.**

3. Enrollment is defined as the date that the form, Agreement to Receive Prenatal Care, is signed by the recipient. If the delivery has occurred there is no reason to enroll the recipient.

4. Advise the recipient of her ability to change Delivering Health Care Professionals, without cause, within 90 days of enrollment or at any time, with cause. Continuity of care shall be stressed at the time of enrollment to encourage the recipient to select a Delivering Health Care Professional with whom she is comfortable.

V. SERVICES

A. General

1. All maternity care services offered under the contract must be in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under fee-for-service Medicaid. The Primary Contractor may not arbitrarily deny or reduce these services for any reason including the diagnosis, health status, type of illness, or condition. The Primary Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity, or for utilization control, provided the services furnished can be expected to achieve their purpose as defined in 42 CFR 438.210(a).

2. The Alabama Medicaid Administrative Code Rule 560-X-1-.07 states: "Providers who agree to accept Medicaid payment shall agree to do so for all medically necessary services rendered during a particular visit. For example, if pain management services are provided to Medicaid recipients during labor and delivery, these services are considered by Medicaid to be medically necessary when provided in accordance with accepted standards of medical care in the community. These services are covered by, and billable to Medicaid. Providers may not bill Medicaid recipients they have accepted as recipients for covered labor and delivery related pain management services."

3. The Primary Contractor shall require that provisions be made available for a second opinion (if either the recipient or health care professional deems it necessary) from a qualified health care professional within the network, or arrange for a second opinion outside the network at no cost to the recipient as specified in 42 CFR 438.206(b)(3) and (4).

4. Out of network providers must coordinate with the Primary Contractor with respect to payment as specified in 42 CFR 438.206(b)(5).

5. Enrollees with special needs shall be allowed direct access to specialists as specified in 42 CFR 438.208(c) (4).

6. The Primary Contractor must have a mechanism in place to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular monitoring. The assessment must use appropriate health care professionals. The Primary Contractor must maintain a treatment plan for enrollees determined as having special care needs. The treatment plan must be developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee and must be reviewed and approved by the Primary

Contractor within a timely manner. The treatment plan must be developed in accordance with applicable quality assurance and utilization review standards.

7. Recipients must use in-network providers.

B. Services Included in the Global Fee

1. The Primary Contractor will be responsible for implementation and coordination of a comprehensive maternity care delivery system with the exception of the inpatient hospital component that meets the needs of the Medicaid recipients. The time span of responsibility begins the date that pregnancy is determined and ends the last day of the month in which the 60th postpartum day falls.

2. Primary Contractor and their Delivering Health Care Professionals are responsible for identification and referral of high risk recipients to the appropriate high risk referral site.

3. The fee shall include all usual prenatal services appropriate to the risk level of the woman including the initial visit at the time pregnancy is diagnosed.

4. Covered services must be medically necessary and encompass maternity related services as well as those that might otherwise complicate or exacerbate the pregnancy.

5. The Primary Contractor shall receive a fee upon pregnancy outcome (delivery or termination by miscarriage or stillbirth at 21 weeks or later).

6. Fees paid by Medicaid to the Primary Contractor represent payment in full.

7. Recipients cannot be billed for any service that is included in the Maternity Care Program.

8. Chapter 28 of the Alabama Medicaid Provider Manual provides additional details on the billing of services.

9. Services to be provided through the Primary Contractor network and which are reimbursed as part of the global are listed in Attachment Three and described below. If there is a question whether a service is covered, please contact Medicaid.

   a. Prenatal Visits

      Visits to the Delivering Health Care Professional include the initial prenatal visit as well as any revisits. The components of the initial

prenatal visit and revisits are defined by ACOG.

b. Ultrasounds
Maternity ultrasounds are unlimited in number and are a component of the global fee. The global fee includes both the professional and technical components of **all** medically necessary ultrasounds. A Primary Contractor may develop an evidence-based prior authorization process to manage the number of ultrasounds performed.

c. Delivery
The global fee includes vaginal delivery or cesarean section delivery. No more than one fee may be billed for a multiple birth delivery.

d. Postpartum
Postpartum care includes inpatient hospital visits, office visits and home visits following delivery for postpartum care through the end of the month of the 60-day postpartum period. The postpartum Delivering Health Care Professional exam shall be accomplished between days 21 to 60 after delivery.

e. Assistant Surgeon Fees
The global fee includes assistant surgeon fees for cesarean-section deliveries.

f. Associated Services
The global fee includes all services associated with treatment of the pregnancy during the antenatal delivery and postpartum period listed in Attachment Three.

g. Laboratory Fees
The global fee includes routine chemical urinalysis, hemoglobin and hematocrit tests as listed in Attachment Three. Other laboratory tests may be billed to Medicaid's fiscal agent fee-for-service. EXCEPTION: urinalysis, hemoglobin and hematocrit provided in conjunction with an emergency room visit are billable fee-for-service.

h. Anesthesia Services
The global fee includes anesthesia services, performed by either an anesthesiologist, nurse anesthetist, or the Delivering Health Care Professional, which are not medically contraindicated. The Primary Contractor shall provide for payment of anesthesia for Medicaid recipients to the same extent and under the same conditions as available to the general public. Attachment Three lists the anesthesia codes which are included in the global fee.

i. Care Coordination Services
The global fee includes Care Coordination which is detailed in Section VI.

j. Postpartum Home Visit
Home visits are optional. It is the opinion of the Alabama Medicaid Agency that home visits improve outcomes. Refer to Section VII for specific details related to home visits.

C. Excluded Services—Covered Fee-For-Service

A general description of those services outside the scope of the global fee is listed below. For these services, the provider of service shall bill using the appropriate CPT code and their regular provider Medicaid number. All claims for these services shall be sent directly to Medicaid's Fiscal Agent. Services that can be billed fee for service include:

1. Inpatient Hospital Care
All hospital care will be billed fee for service and will include applicable limitations of 16 inpatient days per calendar year.

2. Drugs
Medications prescribed for a pregnant woman are covered if the drug is covered through the Medicaid Pharmacy Program. The medication must be prescribed by the Delivering Health Care Professional or specialty physician and presented to an active Medicaid pharmacy provider. The prescribed drug will be subject to all applicable Medicaid policies. Pharmacy providers should dispense the drug at no cost to the recipient.

Drugs which are administered in an in-patient setting or ambulatory surgical center setting are included in the global fee.

3. Durable Medical Equipment/Supplies
Pregnant women with Type I, Type II or gestational diabetes are eligible to receive diabetic equipment/supplies from an active Medicaid Equipment (DME) Supplier. Not all pharmacies are DME suppliers. In order to locate a DME supplier, you may contact the Alabama Medicaid Policy Advisory Unit at 334-353-4753.

4. Lab Services
All lab services except hemoglobin, hematocrit, and chemical urinalysis may be billed fee-for-service. Pregnancy tests can be billed fee-for-service.

5. Radiology
Radiology services are billed fee-for-service with the exception of maternity ultrasounds. NOTE: a stress test is considered to be a maternity service; therefore, this procedure is included in the global fee.

6. Dental
   Dental services are covered for eligible recipients certified as children under age 21.

7. Physician
   Physician fees for family planning procedures, circumcision code, routine newborn care code, standby and infant resuscitation code may be billed fee for service. Claims for circumcision, routine newborn care, standby and infant resuscitation may be billed under the mother's name and number.

8. Family Planning Services
   Claims for physician services with a family planning procedure code or indicator may be billed fee-for- service.

9. Outpatient Emergency Room Services
   Outpatient emergency room service claims containing a facility fee charge of 99281-99285 and associated physician charges 99281– 99288, may be billed fee-for-service. This includes outpatient observation. The Maternity Care Program does not restrict access to emergency services.

10. Transportation
    Transportation as allowed by Medicaid's State Plan may be billed fee for service. The Medicaid Non Emergency Transportation (NET) Program covers non-emergency transportation. The Medicaid Agency is developing a process which will accommodate an electronic submission of the Non Emergency Transport form. Final details will be provided upon contract award.

11. Fees for Dropout/Miscarriages
    a. Claims for miscarriages must include the appropriate diagnosis code from the following range; 630-635, 637-639. Claims using these diagnosis codes may be billed directly to EDS.
    b. If a woman begins care with any district's program, and subsequently moves out of district or miscarries (prior to 21 weeks), she is considered a dropout.
    c. The Primary Contractor shall be paid a dropout fee for recipients that have a miscarriage prior to 21 weeks gestation.
    d. Services for drop-outs may be billed fee-for-service.
    e. In order for the claims to process for a dropout, subcontractors must send all claims to the Primary Contractor. The Primary Contractor must complete the Administrative Review Form and forward the claims to Medicaid for action.
    f. The Primary Contractor can bill the dropout fee directly to EDS (Medicaid's fiscal agent liaison).

12. Mental Health
    Visits for the purpose of **outpatient** mental health services may be billed fee for service. Effective with this contract Screening, Brief Intervention and Referral to Treatment (SBIRT) codes for pregnant women may be billed by delivering health care professionals who have completed a training program and have had a specialty provider indicator added to the provider file. These services include alcohol and/or drug screening and/or brief intervention.

13. Referral to Specialists
    Office or in-hospital visits provided by non-OB specialty physicians for problems complicated or exacerbated by pregnancy may be billed fee-for-service.

14. Program Exemptions
    Claims for women who are granted a program exemption must be billed fee-for-service. Refer to D below for details on the exemption process.

15. Non-Pregnancy Related Care
    Services provided that are not pregnancy-related are the responsibility of the recipient unless she is eligible for regular Medicaid benefits.

16. High-Risk
    Each recipient entering the care system must be assessed for high-risk pregnancy status and referred to a Delivering Health Care Professional qualified to provide high-risk care if the assessment reflects a condition that cannot be appropriately handled in routine prenatal care sites. Referrals for high-risk care are the responsibility of the Maternity Care Primary Contractor. The following guidelines apply.

a. **High Risk Exempt** – For patients meeting the exemption criteria described in the Operation Manual, Section V.D, care is provided fee for service and the primary Contractor will be reimbursed a drop out-fee.

b. **Care Provided at Teaching Facility** – For any service provided by a physician associated with a teaching facility, as defined in Attachment 4.19-B of the State Plan, the service is excluded from the global.

Primary Contractor must clearly describe the way the program will manage high-risk pregnancies, including: a process for identifying high-risk cases, a method to denote high-risk status and the reason for high risk-status, a network for care, policy and procedures for monitoring referrals and services to be provided to high-risk women.

D. Program Exemptions

1. Purpose
   The purpose of the program exemption is to allow recipients to receive care outside of their established Maternity Care districts. There must be policies and procedures developed by the Primary Contractor describing how the exemption will be handled including application of criteria.

   Recipients residing in district Five will not require and will not be granted medical exemptions for care being provided at UAB Hospital and/or UAB Maternal and Fetal Medicine. For high risk care being provided at another facility, an exemption can be requested.

2. Criteria for Exemptions
   a. Medical Necessity
      If the recipient has a high risk pregnancy that the subcontracting physician believes cannot or should not be treated by the Primary Contractor network and determines the continuous obstetrical specialty care is needed by an out of plan provider, a medical exemption can be requested. A letter from the referring physician or accepting physician shall accompany the request or the referring or accepting physician can sign the exemption form (Attachment 12). **Transfers at the time of delivery are not eligible for exemptions.**

      The exemption request shall be based on the severity of the condition necessitating the request. Lists of conditions that shall be considered for medical necessity exemptions are listed below. This list is not all-inclusive and medical justification for additional diagnoses shall be reviewed for consideration of exemption status.

      1. Seizure disorder (recurrent or repetitive)
      2. Diabetes—Poorly controlled; complicating pregnancy, maternal diabetic neuropathy
      3. Heart disease
      4. Pulmonary edema
      5. Systemic Lupus Erythematosus—decompensated
      6. AIDS
      7. Tuberculosis, active
      8. Asthma, severe
      9. Sickle Cell Disease
      10. Antiphospholipid Syndrome
      11. Cancer/Leukemia
      12. ABO blood incompatibility requiring in utero fetal blood transfusion

If the medical report is for a condition/diagnosis other than the ones listed above, then medical records may be requested by Medicaid.

When the referral to the specialty provider is for one or two visits and the recipient returns to a subcontractor in the Primary Contractor network, the medical necessity exemption shall not be granted. The services provided will be covered in the global fee.

b. Medicaid Eligibility Granted Late in Pregnancy
When the recipient applies for and receives Medicaid eligibility late in her pregnancy (third trimester which begins at 27 weeks gestation through delivery) or after delivery and has been receiving continuous care through a non-subcontracted provider, she may be eligible for a program exemption. The Primary Contractor must maintain documentation demonstrating a significant and unexpected financial change occurring after 27 weeks (e.g. loss of insurance or loss of job). The Primary Contractor must confirm the date of application.

c. Private Managed Care/HMO
If a recipient has insurance or a managed care plan, the Primary Contractor must maintain a copy of the policy or a letter from the insurer indicating the scope of coverage or that the recipient must use a prescribed provider network.

d. Change in Health Status
The Primary Contractor cannot request disenrollment because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

E. Services for Illegal Aliens

Services provided to illegal aliens are not part of the Maternity Care Program. The following is provided for information only:
"Certification is done through the Medicaid out-stationed eligibility worker. Only the actual provider of service is reimbursed in these cases. For a pregnant woman, only the delivery is covered. If you are contacted by an illegal alien, or someone who is helping an illegal alien, refer them to the out-stationed eligibility worker. All payments for this eligibility category are processed outside the Maternity Care Program through emergency services."

VI. CARE COORDINATION

A. Overview

An integral part of the medical care delivered through the Maternity Care Program is Care Coordination. Care Coordination is the mechanism for linking and coordinating segments of a service delivery system to ensure the most comprehensive program meeting the clients' needs for care. It may involve one person or a team that has responsibility for managing, assessing, planning, procuring or delivering, monitoring and evaluating services to meet the identified needs of the client. The approach to Care Coordination shall vary from case to case. The needs of the patient should dictate when services are provided and the number of visits that are needed.

1. Care Coordination can be generally defined in one of three ways:
   a. A system of activities to link the service system to a recipient;
   b. A balanced system of services; or
   c. A process of ensuring that the recipient moves sequentially through a continuum of services.

2. Stratification of Case Management
   a. Visit flexibility to meet the needs of the recipient is allowed. Minimums are established, but, beyond the minimum, the total number of visits should be dictated by the needs of the patient. The Care Coordinator will be required to assess the patient face to face at a minimum of two visits. The Care Coordinator will have flexibility to determine how to best improve outcomes.
   b. If the medical or psychosocial status of the recipient changes, the Care Coordinator is responsible for adjusting the service plan and proceeding accordingly.
   c. It is up to the Delivering Health Care Professional and Care Coordinator to decide and develop a service plan that meets the patient's needs.

B. Requirements for Maternity Care Coordinators

1. Social workers licensed and/or license-eligible for Alabama practice with a BSW or an MSW from a school accredited by the Council on Social Work Education (license – eligible social worker(s) must obtain license within12 months of date of employment to function as a Care Coordinator;

2. Licensed Registered Nurse(s) with a minimum of one year's obstetrical experience in counseling, accessing resources, and coordinating care with low-income populations;

3. Licensed Practical Nurse(s) with at least two years obstetrical experience and one year experience in counseling, accessing resources and coordinating care with low-income populations;
4. Registered Nurses with no obstetrical or counseling experience who have successfully completed a Care Coordinator training course provided by the Primary Contractor and who must be under the supervision of an experienced Care Coordinator for at least six months. Where supervision is required, documentation must indicate the Care Coordinator is being monitored/audited for compliance.
5. The Primary Contractor has flexibility in determining how to perform the Application Assister function. Care coordinators are not required to be Application Assisters; however, the Application Assister function is required to be performed by the Primary Contractor. The Primary Contractor may choose to use a Care Coordinator for this function, while others may choose to have other staff provide this function. Application assister training is provided free of charge by Medicaid Agency staff (Attachment Five).

6. Care Coordination is a professional skill and must be supported from within the Primary Contractor system. Skills and functions employed by the Care Coordinator include:

   a. Care Coordinator's responsibilities include, but are not limited to, performing the initial encounter requirements, performing the psychosocial risk assessment, assessing the medical and social needs, developing service plans, providing information and education, making appropriate referrals, and tracking recipients throughout their pregnancy and postpartum period.

   b. Community orientations, including the ability to locate, augment, and develop resources including information on services offered by other agencies.

   c. The Primary Contractor must advise all subcontractors of Care Coordinators services and must require that the subcontractors refer all Medicaid recipients to enroll in the program with the Primary Contractor within ten days of the first visit.

   d. The Care Coordinator shall provide the recipient with a business card that provides location and telephone number where the recipient can get in touch with the Care Coordinator should any questions arise.

   e. Care Coordinators must be located in an area, which provides adequate recipient access and maintains recipient confidentiality. Private offices are preferred.

   f. Telephones must be available for use in recipient contacts.

g. Primary Contractor must have a training plan for initial and on-going care coordination. These plans must at a minimum support the requirements of this document and include training specific to the maternity program and/or related topics on an on-going basis. Educational materials must include obtaining TPL information, importance of keeping appointments with both the Care Coordinator and the DHCP, exemption candidates, current proper sleeping positions for the infant, domestic abuse, breast feeding, smoking & alcohol or other substance cessation, nutrition, and bonding for mother and infant. The effectiveness of the training plans will be monitored per quality outcome measures.

h. Care Coordinators or other Primary Contractor staff will enroll the recipient in the Maternity Care Program and start the Medicaid application process.

i. Primary Contractor must have a system for verification of current license for each Care Coordinator. This shall be reported to the Medicaid Agency annually.

j. Care Coordinator's responsibilities include, but are not limited to, performing the initial encounter requirements, performing the psychosocial risk assessment, assessing the medical and social needs, developing service plans, providing information and education, making appropriate referrals, and tracking recipients throughout their pregnancy and postpartum period.

C. Initial Encounter

Time frame: Entry into care

- ✓ Enrolled 0-6 weeks gestation - this encounter should be no later than 21 days after enrollment date
- ✓ Enrolled 7-14 weeks gestation - this encounter should be no later than 14 days after enrollment date.
- ✓ Enrolled 15 weeks gestation or more - this encounter should be no later than 7 days after enrollment date.

1. Intake form- The Care Coordinator will prepare the intake form for enrollment into the Maternity Care Program. Minimum elements to be included on the intake form of your choice are: Recipient Name; Date of Birth; Address; County of Residence; Social Security Number; Medicaid Number if they have one; if no Medicaid number make a note to assist with application as appropriate; Delivering Health Care Professional choice; Date Delivering Health Care Professional notified; and psychosocial risk status. A sample form is included as Attachment 22. This form will be faxed to the office of the Delivering Health Care Professional of choice within five calendar days of the

recipient's first Delivering Health Care Professional's health visit. If the recipient does not have Medicaid financial eligibility, the Primary Contractor is responsible for immediately providing Application Assister services to aid the patient in completing the application process.

2. The following forms must be completed at the initial encounter:
   a. Psychosocial/medical risk assessment.
   b. Agreement to Receive Care/Release of Information (Attachment Two)
   c. Recipient rights and duties as described in Attachment Seven and required by 42 CFR 438.100
   d. Maternity Fact Sheet (Attachment Four)

3. Information about facility location, hours of operation, services available, etc. should be shared. Explain your role as Care Coordinator and how you will be assisting the recipient during her pregnancy and postpartum period. Encourage the recipient to contact you as needed for assistance.

4. Explain to the recipient the benefits and services provided through the Maternity Care Program. Explain that all pregnancy related care including prenatal, delivery and postpartum is available through the Primary Contractor network. Stress the importance of pre-natal and post partum visits. Stress that birth control is frequently arranged at the post partum visit. Explain that Medicaid also offers assistance with transportation to medical appointments, emergency ambulance coverage, family planning and pediatric services.

5. Provide written and oral education about the grievance process and explain to the recipient that it is designed for her. Ensure that the recipient understands the process and the procedures for filing a grievance, an appeal and/or fair hearing.

6. Explain to the recipient the importance of early and continuous prenatal care. Help her understand that she can play a key role in shaping the birth outcome. Explain that if she encounters barriers such as transportation, medication, childcare, etc., she should contact the Care Coordinator for assistance.

7. Develop and document a service plan for coordinating total obstetrical care based on medical and psychosocial risk status that will best suit the needs of the recipient.

8. Screen the patient for partner abuse utilizing the screening tool in Attachment Eight. Be cognizant of verbal and non-verbal clues when assessing the patient.

9. Encourage breast feeding. Explain the benefits such as better infant tolerance, better immunity from childhood viruses and illnesses. Explain that pumping can be done and the milk stored for times when the mother will be away, and that nursing the infant and avoiding any artificial nipples will produce more mother's milk. The Care Coordinator should utilize the most effective teaching methods for increasing the rate of breast feeding.

10. Explain that the recipient may be receiving a home visit. Inform her of the positive aspects of the visit and what can be accomplished.

11. Ask if the recipient is a smoker. Encourage smoking cessation. Discuss the effects of smoking on the infant to include: increased risk of prematurity, low birth weight, infant mortality, and a sicker infant. Use the most effective evidence-based method suitable to your area to assist moms to stop smoking. Encourage the use of the Alabama Department of Public Health Quitline for counseling and ask her to discuss with her doctor the possibility of obtaining a prescription to help her stop smoking.

D. Subsequent Encounters

Care Coordinators will be required to assess face to face at a minimum of two encounters. One of the required encounters is the Initial Encounter defined above. The other encounter must occur while the mother is still in the hospital after delivery. Other encounters will be at the discretion of the Care Coordinator based on the level of complexity of the recipient needs either medical or psychosocial. The encounters should be scheduled in order to help obtain the best outcomes.

1. Update the psychosocial assessment and service plan based on client interview and any other available information.

2. Encourage continuous compliance with prenatal care, reviewing the recipient's medical high-risk factors and explaining the importance of continued prenatal care.

3. Assess for understanding of medical conditions as well as the plan for managing it as outlined by medical staff. Assist in arranging further counseling by medical staff as needed.

4. Provide the recipient with the information about the various family planning services available. Counsel about the effects of each method and assist the recipient with consent forms as appropriate.

5. Ask about status of Medicaid eligibility. Assist with resolving the delay of approval, if possible.

6. Screen the patient for partner abuse utilizing the screening tool in Attachment Eight. Be cognizant of verbal and non-verbal clues when assessing the patient.

7. Determine the need for any third party exemptions.

8. Ensure that the recipient knows which hospital will be used for delivery. If Medicaid coverage is established, complete hospital preadmission for the hospital of choice.

9. Discuss the labor and delivery process. Begin talking with the recipient about what to expect and what to do at the onset of labor, etc.

10. Re-emphasize and encourage breast feeding.

11. Explain that the patient may meet the criteria for a home visit. Re-emphasize the purpose and the positive aspects.

12. Review smoking cessation with women who smoke. Utilize the most appropriate evidence based methods. Encourage to cut down and quit. Explain harmful effects to the fetus. If she states that she has quit or cut down on the number of cigarettes that she smokes, praise her efforts.

13. Ask the recipient if she has considered who will provide pediatric care. If needed provide a list of Medicaid pediatric care providers. If she has not thought about a pediatric care provider, encourage her to do so. Provide information and services available for the newborn through the first year of life including Medicaid Patient 1st and EPSDT (Early Periodic Screening and Developmental Testing). Assist the patient in completing the Patient 1st Newborn Choice Form (Attachment 10). A copy of the hospital information and the Medicaid Patient 1st Newborn Choice Form should be faxed to the selected health care professional at the time of the hospital visit.

14. Ensure that the patient is prepared for childbirth. If preadmission has not been completed, assist recipient in choosing hospital for delivery and completing preadmission. Assess transportation needs to the scheduled hospital.

15. Ensure home preparation, assistance with newborn and mother in immediate postpartum period, availability of an infant car seat, etc.

16. Verify that the recipient and father of the baby (if he is involved) have made preparations for the infant's arrival and that they have a bed and a space designated for the new infant.

17. Educate the recipient regarding SIDS and current methods of placement of the infant for sleep.

18. Explain to the recipient the need to contact the SOBRA outstation eligibility worker/DHR worker/Social Security worker with information about the baby's birth to ensure a Medicaid number for the baby.

19. Explain to the recipient that in cases of early hospital discharge where the Care Coordinator or designee does not get to visit with her in the hospital, **a home visit will be made to the recipient's home**. Explain the need for the visit and what services will be offered. Encourage the recipient to use this time for education.

20. Emphasize the importance of keeping the post-partum Delivering Health Care Professional check-up appointment. If it has not been scheduled then screen for any barriers, e.g. transportation, childcare, etc. Assist the recipient as necessary in scheduling the postpartum exam.

21. Explain to the recipient that you or someone from the Primary Contractor's staff will make a visit to the recipient during the hospitalization after delivery.

22. Re-emphasize the positive aspects of the home visit if it is decided by the Care Coordinator that a home visit is necessary. Obtain numbers where the recipient can be located. Ask where she will be staying when she takes the infant home from the hospital. Assure her that this visit is to help her in caring for herself and the infant.

23. Stress the importance of preventive dental care for the infant. Utilize Medicaid's Smile Alabama educational material available via Medicaid's website.

24. Review the importance of effective family planning methods and availability of family planning services. Verify that the recipient has chosen birth control pills or any other method (condoms, injection contraception, etc.) of family planning and explain that this must be discussed with the Delivering Health Care Professional during the hospitalization. A prescription may be necessary in order to obtain the chosen method. Make referrals to the Plan 1st and Patient 1st Programs.

25. Emphasize that the recipient can become pregnant while breast feeding if she is not using any contraception.

G. Missed Encounters

At least two attempts on the required initial and hospital encounters must be made to reschedule/perform required Care Coordination encounters or home visits. The attempts must be **documented** in the recipient's medical record. Attempt action must be commensurate to the recipient and the required encounter. If the second encounter visit which is required in the hospital is missed, a home visit must be done.

H. Tracking of Care Coordinator Visits

In an effort to ensure standard tracking of Care Coordination services provided, the following codes have been established for use by the Primary Contractor for internal tracking. **These codes cannot be billed separately to Medicaid.**

T1016 - U1	1ST encounter
T1016 – U2	2ND encounter
T1016 – U3	3RD encounter
T1016 – U4	4TH encounter
T1016 – U5	5TH encounter

I. Oversight of Care Coordinator Activities

Primary Contractor has the responsibility of maintaining oversight activities regarding the provision of Care Coordination services.

VII. HOME VISITS

A. Purpose

Home visits are optional, unless the required visit in the hospital is missed. **If the hospital face to face encounter visit is missed, a home visit must be made.** It is the opinion of the Alabama Medicaid Agency that home visits improve outcomes. Improved outcomes increase eligibility of the Primary Contractor for bonus payments. The Primary Contractor may develop criteria within their respective district for the purpose of home visits. The home visit criteria must be submitted for review by the Medicaid Agency with the ITB response.

The following are recommendations for consideration of home visit criteria development.

1. Under 16 Years of Age
   - At time of conception
   - Late entry into care (20 weeks gestation and over)
   - Not residing in home with parents or significant other
   - Grossly overweight or underweight
   - Not in school
   - Use of tobacco and/or alcohol and/or drugs
   - Transportation issues
   - Lack of support from family or father of baby
   - Any triggers that indicate a need for follow-up after delivery

2. Drug and Alcohol Abuse
   - Self reported
   - Psychosocial assessment
   - Odor of alcohol
   - Observations of track marks and/or bruises from needle use
   - Unexplained late entry into care 20 weeks gestation and over
   - At risk lifestyle (i.e., multiple sex partners)
   - Suspicious behavior such as incessant talking, drug seeking behavior (i.e., narcotics for various pains) glazed eyes, lying, sedated, short attention span, etc.

3. Mental illness
   - Postpartum depression (it is expected that these women may require a series of visits)
   - Long term history of mental illness
   - Taking psychotropic drugs for mental illness (ex. Mellaril, Haldol, Lithium, etc.)

- Taking anti-depressants and exhibiting outward signs of depression (i.e., flat affect depressed mood and thought process, lack of interest in personal appearance, lack of interest in planning for baby's arrival, etc.)

4. Birth weight 2500 grams or less
   - Lack of prenatal care
   - Previous birth outcomes including low birth weight births
   - Mom or others in the household are smokers
   - Whether the infant is enrolled in a hospital follow-up program

5. Partner Abuse (Attachment Eight)
   - Reported by the recipient
   - Unexplained visible injuries
   - Fear of partner & his uncontrollable temper
   - Reports of partner's threats to harm or kill recipient
   - Reports of extreme partner jealousy and/or being possessive
   - Reports of verbal abuse; yelling, cursing, name-calling, isolation
   - Other—Care Coordinator or Delivering Heath Care Professional judgment

B. Documentation

Medical records must be maintained that support the need or lack of need and the outcome of home visits. Refer to Attachment 6.

C. Tracking Of Home Visits

The following codes have been established to assist the Primary Contractor in tracking home visits. These are not separately billable codes but codes to be used for internal tracking systems and may be expanded dependent upon your district specific criteria.

H001 – under 16 years of age
H002 – Drug & Alcohol Abuse
H003 – Mental Illness
H004 – Low Birth-weight
H005 – Partner Abuse
H006 – Missed Inpatient Encounter
H007 – Other

VIII. PAYMENT FOR SERVICES

A. Global Fee

The following procedure codes must be billed when the recipient has received total obstetrical care through your program. Global fee codes to be used are:
59400 – Vaginal birth
59510 – Cesarean section birth

The following procedure codes must be billed for delivery or C-section only:
59410 – Vaginal Delivery and Postpartum Care Only
59515 - Cesarean Delivery and Postpartum Care Only

B. Dropout Fee

This fee must be billed when the recipient begins care in your program but does not deliver. In order to bill this service the woman must have been enrolled prior to delivery. The procedure code is **99199.**

C. Subcontractor Reimbursement

The Primary Contractor must have a HIPAA- compliant automated reimbursement system for payments to subcontractors and out-of-plan providers. Payments to subcontractors should be made within 20 calendar days of Medicaid payment and in all cases within 60 calendar days of date of delivery. Payments to out-of-plan providers must be made within 90 calendar days. The only exception is when TPL is involved or when payment is under appeal. Medicaid payment is defined as the date the check-write is deposited in to the provider's account.

Delivering Health Care Professionals, except for those associated with a teaching facility as defined in Attachment 4.19-B of the State plan, must be paid at a rate no less than the Medicaid fee-for-service urban rate for delivery only. The current urban fee-for-service rate is $1,000 for delivery only. Nurse midwives are paid at 80% of that rate. The physician teaching facility rate for delivery only is $1,161 and caesarean delivery only is $1,383.

D. Services Billed as TPL

Primary Contractor is responsible for collecting all third party payments prior to submitting a claim to Medicaid for payment. Recipients with third party coverage are required to follow all program guidelines. Global claims must reflect the total payments by the third party carrier. Primary Contractor cannot

ask maternity recipients to pay any part of the co-pay/deductible. TPL requirements are:

1. TPL Maternity Coverage
   a. Primary Contractor is responsible for collecting all TPL information before submitting a request to Medicaid for payment.

   b. Subcontractors shall file with the other insurer and report amount collected to the Primary Contractor. If the TPL amount collected is more than the rate agreed on between the subcontractor and the Primary Contractor, then the Primary Contractor shall report the TPL amount that has been agreed on between the Primary Contractor and the subcontractor on the global claim.

   c. Primary Contractor's claim shall reflect the total payments as outlined in b above or a documented denial from the TPL insurer.

   d. Denials must be submitted only when the entire claim is denied. If there is a TPL payment on any part of the claim, that amount shall be listed on the claim and no denial submitted. If denials are submitted and there is also a payment, the claim may not process correctly.

   e. Primary Contractor is responsible for notifying Medicaid's TPL Division by telephone or by mail using the form in Attachment 20 if they identify that the recipient has TPL insurance, and it is not listed on the Medicaid file. Primary Contractor must review eligibility for current TPL information prior to submitting claims.

   f. Medicaid shall grant a program exemption for TPL carrier only if recipient is enrolled in an HMO. An HMO is defined as a TPL carrier, which requires the individual to utilize a limited network of providers. In many cases these providers do not accept Medicaid.

2. Recipients with TPL Coverage, Excluding Maternity
   a. Primary Contractor may notify Medicaid's TPL Division if the recipient has TPL but the contract does not provide maternity coverage or maternity coverage is not provided for dependents. (If maternity coverage is not available due to a waiting period, deductible hasn't been met, etc.; Medicaid cannot update its records. The provider must obtain a denial and submit it with the claim.)

   b. This information may be provided by phone directly to Medicaid's TPL Division or may be mailed to Medicaid's TPL Division using the form in Attachment 20.

c. The phone number for Medicaid's TPL Division is based on the recipient's last name. **If the last name of the recipient begins with A-G, call (334) 242-5280; H-P call (334) 242-5254; and Q-Z call (334) 242-5279**. If the worker is not available, Primary Contractor may leave information on voice mail. Information which must be left includes: name of caller and phone number, recipient's name and Medicaid number, the name of the insurance company, and the message that the contract does not cover maternity or that recipient is a dependent and dependent maternity benefits are not available.

d. Once this information is loaded into Medicaid's TPL file, Primary Contractor may submit claims without having to attach TPL denial.

3. Recipients with TPL coverage that has lapsed.

a. Primary Contractor must notify Medicaid's TPL Division of the actual month, date, and year the policy lapsed.

b. This information may be provided by phone directly to Medicaid's TPL Division or may be mailed to Medicaid's TPL Division using the form in Attachment 20.

c. The phone numbers are the same as listed in 2.c. above.

4. The Administrative Review

The Administrative Review Process is designed as a mechanism for subcontractors to submit claims, through the Primary Contractor, for consideration of payment. The following guidelines apply:

a. Claims that are received by the Agency from subcontractors will be returned to the Primary Contractor for follow up.

b. When claims are sent through the Administrative Review Process, the Primary Contractor should review the claims to ensure that the claim meets requirements.

c. The Administrative Review Form (Attachment 11) must be completed by the Primary Contractor and utilized in order for these requests to be processed.

d. Any claim past the time filing limit must have a detailed explanation of why time filing limits were not met.

e. The claim must be submitted to Medicaid <u>within 5 calendar days of receipt of claims</u> from the sub-contractor.

5. Billing for Other Districts
   a. When a recipient moves to another county outside of the district for which she is eligible and does not change her county code, the billing district will bill the global using their own global rate. The billing district will keep $100 for its time (administrative fee) and send the remaining global and all claims due to the district in which the patient resides. **You may not bill a drop out and use this policy.**

   b. It is the responsibility of every provider to check the recipients' eligibility and county code each time services are provided.

6. High Risk Payments

Each recipient entering the care system must be assessed for high-risk pregnancy status and referred to a Delivering Health Care Professional qualified to provide high-risk care if the assessment reflects a condition that cannot be appropriately handled in routine prenatal care sites. Referrals for high-risk care are the responsibility of the Maternity Care Primary Contractor. This includes procedure codes 99241-99245

a. **High Risk Exempt** – For patients meeting the exemption criteria described in the Operation Manual, Section V.D., care is provided fee for service and the primary Contractor will be reimbursed a drop out-fee.

b. **Care Provided at Teaching Facility** – For any service provided by a physician associated with a teaching facility, as defined in Attachment 4.19-B of the State Plan, the service is excluded from the global.

IX. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Quality Assurance and Performance Improvement (QAPI) is an integral part of the Maternity Care Program addressing both clinical and nonclinical areas. This section outlines the requirements of the program and the responsibilities of the Primary Contractor and Medicaid. Within the Medicaid Agency the Office of Quality Improvement and Standards Division reviews program initiatives and makes recommendations based on national standards to the program areas. The oversight of quality assurance and performance improvement is the responsibility of the Maternity Care Program Associate Director. Each facet of the Quality Assurance and Performance Improvement process has its own unique roles and responsibilities.

A. Primary Contractor Requirements

1. Overall Plan
   a. Is written, clear, and concise and addresses all program requirements including outcomes and processes;

   b. Has defined processes for the collection, analyzing of and reporting of data;

   c. Identifies areas of concern and allows for implementation of corrective action;

   d. Corrects significant systemic problems that may be identified through internal surveillance (monitoring and evaluation), complaints, or other mechanisms;

   e. Uses clinical care and practice standards that
      1. Are based on reasonable scientific evidence and are reviewed by plan providers;
      2. Focus on the process and outcomes of health care delivery, as well as access to care;
      3. Are included in provider manuals developed for use by providers/subcontractors or otherwise disseminated to providers as they are adopted;
      4. Addresses preventive health education services;
      5. Are developed for the full spectrum of populations enrolled in the plan, and for which a mechanism is in place for continuously updating the standards/guidelines.

   f. Has sufficient material resources and staff with the necessary education, experience, and training, to effectively carry out its specified activities.

2. Quality Assurance Committee
   Each Primary Contractor shall have a Quality Assurance Committee that delineates an identifiable structure responsible for performing Quality Assurance functions. This committee or structure has:

   a. Regular meetings – The committee meets on a regular basis at a specified frequency (at a minimum quarterly) to oversee Quality Assurance and Performance Improvement activities. This frequency must be sufficient to demonstrate that the structure/committee is following up on all findings and required actions, with sufficient documentation that is reported to Medicaid quarterly.

   b. Established parameters for operating – The role, structure, and function of the structure/committee are specified.

   c. Documentation – There are records documenting the structure and the committee's activities, findings, recommendations, and actions. Attachment 15 is to be used in documenting quarterly Committee meetings for reporting to Medicaid.

   d. Accountability – The committee is accountable to the Primary Contractor and reports to it (or its designee) on a quarterly scheduled basis on activities, findings, recommendations and actions.

   e. Membership – There is active participation in the committee from subcontractors who are representative of the health plan's providers. At a minimum, it is composed of the Program Director or designee, an OB/GYN physician or a delivering physician who practices as a Family Physician or a delivering physician who practices as a General Practitioner, a registered nurse with obstetrical experience, and a licensed social worker. A Medicaid consumer should be included in the meetings. Documentation must support the Primary Contractor efforts for inclusion.

3. Minimum Elements
   Each Primary Contractor has the ability to structure its individual Quality Assurance Performance Improvement process to meet the needs of its service and program requirements. See Attachments 16A and 16B for examples. The following are the minimum elements that must be present:
   a. Mechanism to evaluate the enrollment and referral process.

   b. Have a system in place for enrollees that include a grievance process, an appeal process, and access to the State's fair hearing system.

   c. Provides for quarterly and annual reporting of Quality Assurance Performance Improvement activities.

d. Allows for the collection and inputting of service specific information into the Service Database. Refer to C. Service Database, of this section for information on the Service Database.

e. Utilizes information obtained from Medicaid's record reviews to incorporate relevant information into their Quality Assurance Performance Improvement process and reports best practices to Medicaid.

f. Conducts ongoing performance improvement projects that focus on clinical and non clinical areas. Refer to F of this section.

g. Conducts Delivering Health Care Professional medical record reviews on deliveries collecting and reporting, via report card format, the Delivering Health Care Professional measures indicated in D of this section.

h. Detects both under and over utilization of services by subcontractors and recipients.

i. Addresses the findings of the Delivering Health Care Professional report cards in the overall Quality Assurance Performance Improvement process.

B. State Requirements

To ensure that the Primary Contractor is meeting program requirements and that the program is achieving its intended outcome, Medicaid must also have a formal Quality Assurance Performance Improvement strategy.

1. Overall Plan
   a. Have a written strategy formulated with the input of stakeholders and formally approved.

   b. Identifies areas of concern and allows for implementation of corrective action.

   c. Corrects significant systemic problems that may be identified through internal surveillance, (monitoring and evaluation), complaints, or other mechanisms.

   d. Provides for feedback to the Primary Contractor and other stakeholders.

2. Minimum State QAPI Elements
   The State will conduct the following minimal activities with the assistance of

the Primary Contractor.

a. Perform medical record reviews to collect data.

b. Create and maintain a Service Database (Refer to C of this section) to collect service characteristics and outcome information.

c. Create Primary Contractor Profiles reflecting the elements in E of this section.

d. Review and provide a disposition of Grievances reported to the Agency.

e. Provide oversight of Primary Contractor Quality Assurance Performance Improvement Projects.

f. Conduct recipient surveys.

g. Review utilization and outcome data.

h. Perform On-site reviews to ensure compliance with program standards. Refer to Section XI. of this manual for details on the administrative review process and elements.

i. Provide an annual report of Maternity Care Program activities.

3. State Quality Assurance Performance Improvement Activities
As described herein and further in Sections X and XI of this Manual, the State will conduct Quality Assurance and oversight activities through a combination of data analyses, Primary Contractor reporting, and onsite reviews. All of these activities will be interwoven to present a complete and accurate reflection of the work that is being accomplished. From these various activities the State will produce an annual report showcasing the impact of the Maternity Care Program to improve birth outcomes.

C. Service Database

1. Description and Purpose
The Agency will create and maintain a web based database. Primary Contractor will be required to enter certain data elements into the database on each delivery occurring in their program for which they bill a global fee. The purpose of the database will be to collect information on 100% of deliveries so that an accurate reflection of program impact can be obtained. The data will also be the basis of the information for compilation of the Primary Contractor Performance Measures on the Profile. Data input will be directly into the database via a form view. Attachment 14 contains the form delineating the database elements.

1. The database is designed so that Primary Contractor can enter data upon patient enrollment continuing through the postpartum period. All data entry on a patient must be completed within 60 days of the delivery date.

   The database will be password protected and Primary Contractor will only be able to view information on their patients. Upon contract award additional passwords and training will be provided.

2. Reports
   In addition to the Primary Contractor Profiles described below, the Agency will utilize the information from the database to analyze program demographics, care trends, potential quality issues as well as outcome factors.

D. Delivering Healthcare Professional Report Cards

Report cards are just one tool that will be used by the State to gauge program effectiveness in addition to the information provided through the performance improvement projects and recipient surveys. Performance measures will be adjusted each contract year. Any changes will be communicated to Primary Contractor 60 days prior to effective date.

1. Delivering Health Care Professional Report Card Measures
   Every six months each Primary Contractor will be required to create a report card on each individual Delivering Health Care Professional and Delivering Health Care Professional group reporting the following measures:
   a. Percentage of medical records containing documentation of DHCP visits which contain the following elements: blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery.
   b. Percentage of women who have had a determination of blood group (ABO) and negative D (Rh) by the second prenatal care visit.
   c. Percentage of Rh negative women with no antibodies who receive Rhogam between 26-32 weeks gestation.
   d. Percentage of women who have had glucose tolerance testing performed.
   e. Percentage of women who have a cervical cytology smear performed during twelve months prior to onset of care or by the second prenatal care visit.
   f. Percentage of women who have at least one urine test to screen for asymptomatic bacteriuria.
   g. Percentage of Low Birth Weight (LBW < 2500 grams) babies born to Medicaid Mothers.
   h. Percentage of Very Low Birth Weight (VLBW < 1500 grams) babies born to Medicaid Mothers.

i. Percentage of women who delivered at less than 37 weeks.
j. Percentage of women (who do not opt out of the test) screened for HIV infection during the first or second prenatal care visit.

2. Definition of Data Elements

Primary Contractor must use the following definitions when applying the measures. This will ensure that all Delivering Health Care Professionals are being measured consistently and that all Primary Contractors are reporting the measures consistently.

a. Blood Group Determination – documentation of the test(s) being ordered.
b. Rhogam Injection – notation in the prenatal chart that Rhogam (or equivalent) was given to medically eligible women between 26-32 weeks gestation. NOTE: This measure can only be applied to those women who entered care by 32 weeks gestation and have not been sensitized by a prior pregnancy.
c. Glucose Tolerance Testing or other Diabetic Screening – notation in the prenatal chart of one of the following tests: glucose tolerance test; 1 hour glucose screen; two hour random blood sugar after a meal or a fasting blood sugar. Testing is not necessary for patients with pre-existing diabetes.
d. Cytology Smear – notation in the prenatal record of a cervical screening done 12 months prior to the onset of care OR notation of a screening being accomplished by the second prenatal visit.
e. Asymptomatic Bacteriuria Screening – notation of the results in the prenatal record.
f. Low Birth Weight – self-explanatory.
g. Very Low Birth Weight – self-explanatory.
h. Delivered less than 37 weeks – self-explanatory.
i. HIV Screening – notation in the prenatal record of the results. Must be measured against the number of women who declined testing.

3. Measurement Standards

Measure	**Benchmark**
Prenatal Visit Elements	98%
Blood Group Determination	95%
Rhogam Injection	99%
Glucose Tolerance Testing	90%
Cytology Smear	95%
Asymptomatic Bacteriuria Screening	95%
Low Birth Weight	*
Very Low Birth Weight	*
Delivered Less than 37 Weeks	Not established**
HIV Screening	95%

*Benchmark will be the three year historical average for the District in which the Delivering Health Care Professionals are delivering and being reported.
** A benchmark has not been established. Data will be collected beginning 10/1/2010 and a benchmark set within the 1st contract year.

4. Delivering Health Care Professionals Sampling Methodology
   A listing of all deliveries by Delivering Health Care Professionals for which a global fee was billed must first be compiled. Next, the listings of deliveries for each Delivering Health Care Professionals are separately alphabetized (ordered) to be used in the selection of a representative sample for medical record reviews. Samples will be drawn using the following chart indicating the sequence of record selection (every ninth name). The resulting sample from deliveries will be used by the Primary Contractor for reporting the above measures. The Primary Contractor must maintain documentation of records identified as part of the sample pulled. Medicaid's QI division will use the same sampling methodology for their reviews.

Sample Size	Number Of Charts	Sequence of Records Pulled for Sample
> 200	65	Pull first ordered record, skip the next 2 records
191 - 200	67	Pull first ordered record, skip the next 2 records
181 - 190	66	Pull first ordered record, skip the next 2 records
171 - 180	65	Pull first ordered record, skip the next 2 records
161 - 170	63	Pull first two ordered records, skip the next 3 records
151 - 160	62	Pull first two ordered records, skip the next 3 records
141 - 150	60	Pull first two ordered records, skip the next 3 records
131 - 140	59	Pull first two ordered records, skip the next 3 records
121 - 130	57	Pull first two ordered records, skip the next 3 records
111 - 120	55	Pull first ordered record, skip the next 1 record
101 - 110	53	Pull first ordered record, skip the next 1 record
91 - 100	51	Pull first ordered record, skip the next 1 record
81 - 90	48	Pull first two ordered records, skip the next 1 records
71 - 80	45	Pull first two ordered records, skip the next 1 records
61 - 70	42	Pull first two ordered records, skip the next 1 records
51 - 60	38	Pull first three ordered records, skip the next 1 records
41 - 50	34	Pull first four ordered records, skip the next 1 records
31 - 40	29	Pull first six ordered records, skip the next record
21 - 30	23	Pull all records
11 - 20	17	Pull all records
1 - 10	10	Pull all records

5. Delivering Health Care Professionals Review and Reporting Periods
   To accommodate program implementation and in order for the review to be

reflective of program efforts, a three month phase-in period will be allowed before Primary Contractors are required to collect and report Delivering Health Care Professionals measures. Within the District, Primary Contractor should develop a review schedule among their Delivering Health Care Professionals to ensure that the prescribed numbers of records are reviewed.

Delivery Date of Service	Review Period	Report Card Due
Apr – Jun 10	July - August	Sept 4, 2010
July – December 10	January - February	March 5, 2011
Jan – Jun 11	July - August	September 3, 2011
July – December 11	January - February	March 5, 2012
And so forth . . .		

6. Delivering Health Care Professional Report Card Format
Primary Contractor must use the following format in reporting Delivering Health Care Professionals measures. For those Delivering Health Care Professionals in group practices, defined as three or more physicians, the measures are to be reported per Delivering Health Care Professionals and per Group.

Primary Contractor is required to develop a system to mask their individual Delivering Health Care Professionals so that results from all districts Delivering Health Care Professionals can be provided. The algorithm used to mask providers should contain logic that links providers within a group to allow for further analyses of the data that may be necessary.

Measure	**Bench-mark**	**District Average**	**DELIVERING HEALTH CARE PROFESSIONAL (DHCP)**	**DHCP Group**	**DHCP #1**
Prenatal Visit Elements					
Blood Group Determination					
Rhogam Injection					
Glucose Tolerance Testing					
Cytology Smear					
Asymptomatic Bacteria Screening					
LBW					
VLBW					
Delivered Less than 37 Weeks					
HIV Screening					

E. Primary Contractor Profile Measures

1. Source of Data
   Medicaid will use the Service Database, Grievance Log and results from the recipient surveys to create the Primary Contractor Profile.

   a. Web Elements
      Medicaid, based on information obtained through the Service Database, will produce biannual Primary Contractor Profiles reflecting data on 100% of all deliveries. In addition to program demographics, the following elements will be measured and reported.
      1. Percentage of women with first doctor's visit less than 14 weeks gestation.
      2. Percentage of low birth weight (LBW < 2500 grams) babies born to Medicaid mothers.
      3. Percentage of very low birth weight (VLBW < 1500 grams) babies born to Medicaid mothers.
      4. Percentage of women who complete a family planning/post partum visit between days 21-60.
      5. Number of prenatal visits that contain all of the prenatal elements/number of paid deliveries.
      6. Percentage of very low birth weight babies born at appropriate facilities for high-risk deliveries and newborns.
      7. Percentage of babies born prior to 37 weeks gestation
      8. Number of women who quit smoking while pregnant/number of smokers
      9. Percentage of diabetic women who have at least one session with a registered dietician
      10. Percentage of women identified as breast feeding at post partum visit.
      11. Percentage of women who received a Care Coordination visit after delivery prior to discharge from the hospital.

   b. Grievances and Appeals
      Grievances and appeals as reported by category on the quarterly grievance log. Refer to H of this section for details on the grievance system.

   c. Recipient Surveys
      Refer to I of this section for details on the Recipient Explanation of Medicaid Benefits process.

2. Definition of Primary Contractor Data Elements
   a. Percentage of women with first doctor's visit less than 14 weeks gestation.
   b. Percent of Low Birth Weight – self-explanatory.
   c. Percent of Very Low Birth Weight – self-explanatory.
   d. Percent of family planning/postpartum visits completed day 21-60– defined as documented visit in prenatal record.
   e. Number of prenatal visits that contain all the prenatal elements.
   f. Percent of Very Low Birth Weight at high-risk facilities – Facilities as defined by the Alabama Department of Health as being as Level A or B hospital. **Level A**: USA, UAB; **Level B**: Huntsville Hospital, DCH-Tuscaloosa, DCH-Northport, Brook Wood, Cooper Green, Princeton, Regional Medical Center (Birmingham), St. Vincent's East (Shelby County), St. Vincent's, Trinity Medical Center, Montgomery Baptist South, and Montgomery Baptist East.
   g. Percentage of babies born prior to 37 weeks gestation – defined as 36 and 6/7ths weeks or earlier.
   h. Number of women-who quit smoking while pregnant – self-explanatory.
   i. Percentage of diabetic women who have at least one session with a registered dietician – self-explanatory.
   j. Percentage of women identified as breast feeding at post partum visit– self-explanatory.
   k. Care coordination.

3. Primary Contractor Reporting Periods
   Primary Contractor is encouraged to enter information on an ongoing basis.

Delivery Date of Service	Profile Issued
04/10-6/30/10	09/10
7/10 – 9/30/10	12/10
10/10-12/31/10	3/11
01/11-3/31/11	6/11
4/11 – 6/30/11	9/11
7/11-9/30/11	12/11

5. Primary Contractor Profile Formats
   The final Profile format will be released prior to contract implementation.

F. Performance Improvement Projects (PIPS)

The purpose of conducting a Performance Improvement Project is to improve relevant areas of clinical and non-clinical care that significantly impact enrollee health, function, and satisfaction in the Maternity Care Program. One Performance Improvement Project will be required by Medicaid per year unless otherwise directed. The first Performance Improvement Project will be specified at a later date.

G. Quality Improvement Activity Summary (QIAS)

In addition to specific Performance Improvement Projects described above, each Primary Contractor must have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. The Quality Improvement Activity Summary allows the Primary Contractor to have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. Attachment 9 contains the reporting format. Attachment 21 is an example of a completed project.

The Quality Improvement Activity Summary records quality assessment and performance, providing an overview of activity, why activity is relevant, and opportunities for improvement and interventions for the District. This form is maintained by the Primary Contractor and sent to Medicaid on a quarterly basis.

Quality improvement activities must focus on clinical and nonclinical areas and involve the following:

1. Measurement of performance using objective quality indicators.

2. Implementation of system interventions to achieve improvement in quality.

3. Evaluation of the effectiveness of the interventions in improving birth outcomes.

4. Planning and initiation of activities for increasing or sustaining improvement.

H. Grievance and Appeal System

Each Primary Contractor must implement and maintain a grievance and appeal system that includes a grievance process, an appeal process and access to Medicaid's fair hearing process. The Primary Contractor is required to send a notice of any adverse action to the enrollee and such notice must meet the notice requirements set forth in 42 CFR 431, Subpart E. The regulations as specified at 42 CFR 438.228 and 438.400 et al. must also be followed. The following is a general summation of the requirements.

1. General
   a. A grievance is defined as an expression of dissatisfaction about any matter other than an action.
   b. An action is the denial or limitation of a requested service, the reduction, suspension or termination of a previously authorized service, the denial of payment for a service or the refusal of the Primary Contractor or subcontractor to act in a timeframe specified.
   c. An appeal is defined as the request for review of an action.

d. Medicaid and the Primary Contractor must have a process in place to receive and resolve grievances.
e. The Primary Contractor must provide grievance and appeal procedures to all recipients and subcontractors, including recipients' right to a fair hearing.
f. The Primary Contractor must have written policies that document and outline the grievance and appeal process.
g. Primary Contractor must accept grievances either orally or in writing.
h. Primary Contractor must notify subcontractors and recipients in writing of the disposition of the grievance at each level.
i. The Primary Contractor must maintain records of grievances and appeals. On a quarterly basis, the Primary Contractor must submit to Medicaid the Grievance Log as defined in Attachment 17.
j. Medicaid will report any grievances received directly to the Primary Contractor. It is the responsibility of the Primary Contractor to handle the grievance as if it was received directly.

2. Primary Contractor Grievance System
The Primary Contractor must:
a. Give recipients participating in the program reasonable assistance in completing forms and other procedural steps including but not limited to providing interpreter services and toll-free numbers with TY/TDD and interpreter capability.
b. Acknowledge receipt of each grievance and appeal.
c. Ensure that grievances and appeals are handled in an objective and fair manner.
d. Make specific policies and procedures available addressing the grievance system including recipient rights; timeframes; assistance availability and the toll-free number to file oral grievances and appeals.

3. Grievance Process
Each Primary Contractor should have a designated individual who can receive the grievance and act to resolve the grievance on behalf of the recipient. These type grievances should be resolved within ten working days of receipt. If the grievance is of an urgent or immediate action, then it should be acted on within 48 hours. If an enrollee seeks disenrollment, the grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in 42 CFR 438.56(e).

If a grievance cannot be resolved at this level, then the grievance should be referred to the Primary Contractor's Grievance Committee. At this point the grievance becomes an appeal.

4. Appeal Process
Each Primary Contractor should have specific procedures for handling

appeals based on the requirements found at 42 CFR 438.400 et al. Below is a general summation of the requirements.

a. A recipient or a provider acting on behalf of the recipient can file an appeal to the Primary Contractor.
b. The appeal must be filed within 45 calendar days from the date of the action.
c. An appeal can be filed orally but must be followed with a timely written, signed appeal.
d. The Primary Contractor must have written policies governing appeals.
e. Appeals must be resolved within 45 calendar days of receipt. Extensions may be granted if requested by the enrollee.
f. The Primary Contractor must have a documented process for expedited appeals.

5. State Fair Hearing Process
If a recipient is not satisfied with the resolution of her appeal by the Primary Contractor, she may request a fair hearing from Medicaid. Fair Hearings are governed by Chapter Three of the Alabama Medicaid Administrative Code. The Primary Contractor must make available to recipients the right to a fair hearing, the method for obtaining a fair hearing and the rules that govern representation. The same information must be available to subcontractors and recipients.

I. Recipient Explanation of Medicaid Benefits (REOMBs)

The Agency, through its fiscal agent liaison, sends a recipient survey to those women delivering through the Maternity Care Program. The purpose of the survey is to solicit the patient's input on the care received through the program. It is also intended to gauge whether program requirements are being met and the patient's overall perception of program impact.

The surveys are distributed on a monthly basis to two percent of women delivering three months prior to the requesting month. The REOMBs schedule is established on a quarterly basis. Example:

1st Quarter 2010
January 2010-requested April 2010
February 2010-requested May 2010
March 2010-requested June 2010
Results would be reported July 2010

Medicaid will provide each Primary Contractor with the results from the women within their districts. Primary Contractor is required to share these findings with their subcontractors.

In addition, findings from the REOMBs will be reported on the Primary Contractor Profile comparing each district results.

J. Delegation of Quality Assurance Performance Improvement Activities

The Primary Contractor remains accountable for all Quality Assurance Performance Improvement functions, even if certain functions are delegated to other entities. If the Primary Contractor delegates any Quality Assurance Performance Improvement activities to contractors:

1. There must be written description of: the delegated activities; the delegate's accountability for these activities; and the frequency of reporting to the managed care organization.

2. The Primary Contractor must have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

3. There must be evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and review of regular specified reports.

K. Coordination of Quality Assurance Activity with Other Management Activity

The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of Quality Assurance Performance Improvement activity, are documented and reported to appropriate individuals within the organization and through established channels.

1. Quality Assurance Project information is used in re-credentialing, re-contracting, and for annual performance evaluations.
2. Activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances.
3. There is a linkage between Quality Assurance and the other management functions of the health plan such as:
   a. network changes
   b. benefits redesign
   c. medical management systems (e.g. pre-certification)
   d. practice feedback to physicians
   e. recipient education

L. Performance Incentive Measures

A bonus of up to 5% of the payments for that contract year may be awarded to the Primary Contractor based on performance of specific outcome and process measures on an annual basis. The bonus payments will be calculated within six months of the end of the annual contract date and are contingent upon the availability of funds. The following is a list of the specific measures and process of review:

a. Medical record documentation must support that the district has 5% of the total number of smoking mothers who enroll for care during the first year of the contract period to quit smoking while pregnant and continue to cease from smoking until the postpartum visit. This information will be monitored through the Agency web data base (Real-time Electronic Medical Data) and through medical record reviews performed by Agency staff. The Primary Contractor will qualify for 1% of the possible 5% bonus incentive if this measure is found to be supported per review by Agency staff.

b. The establishment and/or maintenance of at least one Centering Pregnancy site for the entire year per district. The Primary Contractor will be required to submit written documentation upon the establishment of such site to the Maternity Care Program. Agency Staff may provide an on-site visit to the site. The Primary Contractor will qualify for 0.5% of the possible 5% bonus incentive if this measure is found to be supported per review by Agency staff.

c. Medical record documentation must support that 50% of all diabetic women enrolled for care in the district have at least one session with a registered dietician by the end of the second trimester of the pregnancy. This information will be monitored through Real-time Medical Electronic Data Exchange and through medical record reviews performed by Agency staff. The Primary Contractor will qualify for 0.5% of the possible 5% bonus incentive if this measure is found to be supported per review by Agency staff.

d. Medical record documentation must support that 85% of all delivering women served by the district complete a family planning visit between postpartum day 21 and 60. This information will be monitored through Agency web data base and through medical record reviews performed by Agency staff. The Primary Contractor will qualify for 1% of the possible 5% bonus incentive if this measure is found to be supported per review by Agency staff.

e. Medical record documentation must support an average minimum of eleven prenatal visits per total number of paid deliveries. This information will be monitored through Real-time Electronic Medical Data Exchange and through medical record reviews performed by Agency staff. The Primary Contractor will qualify for 0.5% of the possible 5% bonus incentive if this measure is found to be supported as per review by Agency staff.

f. Medical record documentation must support that a minimum of 25% of the total number of deliveries served are identified as breast feeding mothers at their post partum visit. This information will be monitored through Real-time Medical Electronic Data Exchange and through medical record reviews performed by Agency staff. The Primary Contractor will qualify for 0.5% of the possible 5% bonus incentive if this measure is found to be supported as per review by Agency staff.

g. Medical record documentation must support that 75% of the number of deliveries in the district annually complete the first doctor's visit at <14 weeks gestation. This information will be monitored through REMEDE and through medical record reviews performed by Agency staff. The Primary Contractor will qualify for 1% of the possible 5% bonus incentive if this measure is found to be supported as per review by Agency staff.

In order to qualify for 100% of the bonus incentives the primary contractor must meet all of the above measures. The Contractor may qualify for any one of the measures if the medical record documentation supports compliance with the individual measure. The percentage each measure supports of the total amount is referenced at the end of each measure above and is as follows:

- Measure a = 1%
- Measure b =.5%
- Measure c = .5%
- Measure d = 1%
- Measure e = .5%
- Measure f = .5%
- Measure g = 1%

Example: if the total annual fees paid to the Primary Contractor are $500,000.00, then the Primary Contractor will be eligible for a 5% incentive of $50,000.00 annually.

X. RECORDS AND REPORTS

A. Record Requirements

1. Records
   The Primary Contractor must maintain books, records, documents, and other evidence pertaining to the costs and expenses of this contract (hereinafter collectively called the "records") to the extent and in such detail as must properly reflect all net costs for which payment is made under the provisions of any contract of which this contract is a part by reference or inclusion.

   In accordance with 45 CFR §74.164, and 42 CFR 438.6(g), Primary Contractor shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of three years from the date of the final payment made by Medicaid to Contractor under the contract. However, if audit, litigation, or other legal action by or on behalf of Medicaid or the Federal Government has begun but is not completed at the end of the three year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the three year period, the records shall be retained until resolution. Subsequent to the contract term, documents shall be returned to Medicaid within three working days following expiration or termination of the contract. Micro-media copies of source documents for storage may be used in lieu of paper source documents subject to Medicaid approval.

   Primary Contractor/Subcontractors agrees that representatives of the Comptroller General, Health Human Services, the General Accounting Office, the Alabama Department of Examiners of Public Accounts, and Medicaid and their authorized representatives shall have the right during business hours to inspect and copy Primary Contractor's/Subcontractors books and records pertaining to contract performance and costs thereof. Primary Contractor/Subcontractor shall cooperate fully with requests from any of the agencies listed above and shall furnish **free of charge** copies of all requested records. Primary Contractor/Subcontractor may require that a receipt be given for any original record removed from Primary Contractor's premises.

   A file and report retention schedule must be developed by the Primary Contractor and approved by Medicaid. Primary Contractor must maintain and Medicaid shall approve the retention schedule and all changes.

2. Substitution of Records
   The Primary Contractor may in fulfillment of its obligation to retain its records as required by this article, substitute clear and legible

photographs, microphotographs or other authentic reproductions of such records, after the expiration of three (3) years following the last day of the fiscal year in which payment to the Primary Contractor was made, unless a shorter period is authorized by Medicaid. The State Records Commission approves records retention schedules.

3. Medical Records
   Primary Contractor and subcontractors shall ensure that a medical record system is maintained within the State of Alabama in accordance with §2091.3 and §2087.8 of the State Medicaid Manual which makes available to appropriate health professionals all pertinent information relating to the medical management of each recipient. All entries on medical records must be written in ink or typewritten and authenticated by the signature or initials of the health care professional.

B. Reporting Requirements

1. Report Submission
   a. Reports are to be submitted as specified in the description of reports (#2 below).

   b. Primary Contractor must be responsible for timeliness, accuracy, and completeness of reports as defined below:

      1. Timeliness – Reports or other required data must be received on or before scheduled due dates.

      2. Accuracy – Reports or other required data must be prepared in conformity with appropriate authoritative sources and/or Medicaid defined standards.

      3. Completeness – All required information must be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.

      4. Primary Contractor must agree to be responsible for continued reporting beyond the term of the contract. For example, processing claims and reporting encounter data must likely continue beyond the term of the contract because of lag time in filing source documents by subcontractors.

      5. Medicaid requirements regarding reports, report content and frequency of submission of reports are subject to change at any time during the terms of the contract. Primary Contractor must comply with all changes specified by Medicaid.

6. Reporting requirements are based on calendar dates.

7. The "to" contained in the subsequent chart indicates to where the report should be submitted. Maternity Care Program refers to the Associate Director, Maternity Care Program. Specific email addresses will be provided prior to contract implementation.

2. Reports
The following are the reports that are required on a routine basis. Details on specific reporting requirements may have been contained in other sections of the Operational Manual and referred to below. Failure to deliver reports in the manner and timeframe specified may result in penalties.

Report Name	To	Media	Format	Timeframe	Due
Service Database	n/a	Web-based	n/a	Data must be entered within 60 days of the delivery	Refer to timeframe column
Global Summary Report	MCP	Email	Excel	Quarterly	Within 45 days of the end of the quarter being reported
Organizational Structure	MCP	Paper or E-mail	Word	Annual and upon change	January 1st and/or within 5 days of occurrence
Provider Network	MCP	e-mail	Excel	Annual and upon change	January 1st and/or within 5 days of occurrence (exception: due weekly for 30 days after contract award)
QI Activity Report	MCP	e-mail	Word	Quarterly	Within 45 days of the end of the quarter being reported
Grievance Log	MCP	e-mail	Word	Quarterly	Within 45 days of the end of the quarter being reported
QI Meeting Minutes	MCP	e-mail	Word	Quarterly	Within 45 days of the end of the

					quarter being reported
Sale, Exchange, Lease of Property	MCP	Paper	Word	Occurrence	Within 5 days of occurrence
Loans and/or Extension of Credit	MCP	Paper	Word	Occurrence	Within 5 days of occurrence
Furnishing for Consideration of Goods & Services	MCP	Paper	Word	Occurrence	Within 5 days of occurrence

Medicaid will confirm **receipt of reports via e-mail within 3 working days.**

3. Report Details

a. Service Database

The purpose of this report is to collect specifics on each delivery for which the Primary Contractor receives payment. Because the Primary Contractor is paid through a single procedure code, details on services and outcomes are not captured. Information will be entered via a web-based database as described in Section IX.C.

b. Global Summary Report:

The purpose of this report is to collect specifics on amounts paid to subcontractors for services reimbursed through the global fee. The format and instructions are included in Attachment 18.

c. Organizational Structure

This report indicates for Medicaid the individuals involved in the Primary Contractors' organization. Significant changes must be reported within 5 days of occurrence in a word format.

d. Provider Network

This report must be reflective of all subcontractors in the Primary Contractors' network. Complete demographic information must be included, the service offered and the providers NPI number. The format and instructions are included in Attachment 19.

e. Quality Improvement Activity

This report must summarize the Primary Contractors' Quality Improvement Activity Summary activities for the quarter. Details are contained in Section IX.G.

f. Grievance Log
This report allows Medicaid to track issues as they arise as well as assure that each issue is resolved. Details are contained in Section IX.H.

g. Quality Improvement Meeting Minutes
This report allows the Quality Assurance Division to focus on quality concerns in individual districts and how the concerns are being resolved. Details are contained in Section IX.A.

h. Sale, Exchange, Lease or Property;
These reports are Centers for Medicare and Medicaid Services required for Managed Care Organizations and are required in a word format.

i. Loans or Extension of Credit
These reports are centers for Medicare and Medicaid Services requirements for Managed Care Organizations and are required in a word format.

j. Furnishing for Consideration of Goods and Services
These reports are centers for Medicare and Medicaid Services requirements for Managed Care Organizations and are required in a word format.

XI. MEDICAID OVERSIGHT

A. General

Medicaid shall monitor Primary Contractor performance through a combination of performance measures, medical record reviews and administrative reviews. The purpose of oversight activities is to ensure that contract requirements are being met; standards of care are being implemented and enforced.

B. Administrative Reviews

1. Purpose
   To measure performance, each Primary Contractor will be visited annually on-site to ensure compliance with program requirements.

2. Elements

Valid Subcontracts
Delivering Health Care Professionals have hospital privileges at a facility that provides delivery services
Claim payment within timeframes
Staff knowledge of billing/reimbursement policies
Training (Subcontractor and Care Coordinator) as required
Application Assister
Delivering Health Care Professional Choice Requirements

3. Standards
   If after the Administrative review, the Primary Contractor is found to not be meeting the requirements, then the following penalties will be imposed. As indicated, corrective action will be allowed for some program elements with imposition of penalties as a final act.

Measure	**Penalty**
Subcontractor Not Enrolled with Medicaid	1st occurrence: Corrective Action, 2nd occurrence: $500 fine per provider not enrolled
Valid Subcontracts	1st occurrence: Corrective Action, 2nd occurrence: $500 fine per subcontract not meeting requirements
DHCP have hospital privileges	1st occurrence: Corrective Action 2nd occurrence: $500 fine per DHCP not having hospital

	privileges
Claim payment within timeframes	95% of claims paid within timeframes, $100 per incident for payments not meeting timeframes
Staff knowledge of billing/reimbursement policies	1st occurrence:, Staff re-training 2nd occurrence: $100 fine per incident thereafter.
Training (Subcontractor and Care Coordinator) as required	$500 training session not completed
Application Assister services	$500 per week that there is no Application Assister in all counties; Primary Contractor must submit a list of counties and names of assigned Application Assisters monthly
Delivering Health Care Professional Choice Requirements	1st occurrence: Corrective Action 2nd occurrence: $500 per choice requirements not being met

C. Medical Record Reviews

1. Purpose
   The purpose of the Medical Record Reviews is to ensure that each Primary Contractor is providing quality maternity care to their recipients. This will be accomplished by conducting periodic reviews to evaluate the effectiveness and adequacy of postpartum home visits, care coordination, and smoking cessation efforts. Medical Record Reviews will be performed in addition to the elements that are measured from the Web Database as described in Section IX.C.

2. Sample Size/Process
   Reviews will be conducted on a semi-annual basis. Samples will be based on the methodology explained in Section IX.D.4.

   The sample number of records will be chosen randomly from a DSS Query generated for a specific period of time prior to the review but in no case reflective of less than three months prior to the review month. A request for recipient records will be sent to the subcontracting provider requesting that patient records be sent back to the Medicaid Maternity Care Program for review. The subcontractor or the Primary Contractor cannot charge for these records.

3. Findings
   After the review is completed and all data compiled, Primary Contractor will be provided a summary of the findings.

Statewide statistical reports will be generated after all District reviews are completed. The Statewide statistical averages are computed by using weighted District averages to present a more accurate measurement due to the variation in the volume of deliveries per District. Further review and/or a request for a corrective action plan may be necessary dependant on Medical Record review findings.

4. Elements

Measure	What it is	Expectation
Care Coordination Encounters	The percentage of patients in which a care coordination encounter was done. If no encounter was done, were two attempts made to contact patient so that the encounter could be accomplished?	90% of patients receive an encounter. If no encounter was done, was there documentation present that two attempts were made to contact patient.
Content of Care Coordination	That required encounters met the guidelines specified in Section VI of the Operational Manual. For example: were risks identified? Were referrals made that addressed identified risk(s)? Were appropriate forms completed?	90% of the encounters meet the required guidelines.

5. Standards

If program requirements are not met, corrective action will be requested. Districts will implement a Plan of Correction and submit to the Medicaid Maternity Care Program for approval. The Primary Contractor assures follow-up on identified issues to ensure that actions for improvement have been effective. A written report of findings is to be submitted to the Medicaid Maternity Care Program six months after the Corrective Action Plan has been implemented. If improvement is not noted on the second incident, further actions may be taken including the penalties described below:

Measure	Penalty
Care Coordination Encounters	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark with no improvement noted, $500 per recipient
Content of Care Coordination	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark with no improvement noted, $500 per recipient

D. Corrective Action

The following standards will apply when the need for corrective action is identified:

1. There must be a written, defined corrective action plan.
2. The plan must be approved by all parties.
3. The plan must include:
   a. Specification of the types of problems requiring remedial/corrective action
   b. Specification of the person(s) or body responsible for making the final determinations regarding quality problems
   c. Specific actions to be taken
   d. Provision of feedback to appropriate health professional, providers and staff
   e. The schedule and accountability for implementing corrective actions
   f. The approach to modifying the corrective action if improvements do not occur
   g. Procedures for terminating the affiliation with the physician or other health professional or provider

4. There must be an assessment of effectiveness of corrective actions
   a. As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.
   b. Primary Contractor assures follow-up on identified issues to ensure that actions for improvement have been effective.

Imposition of these penalties may be in addition to other contract remedies and does not waive Medicaid's rights to terminate the contract

MEDICAID MATERNITY CARE PROGRAM

EXTENDED DAYS NOTIFICATION FORM

To be completed for those recipients who have exhausted their 16 inpatient days and are being admitted for delivery. Prior authorization is required for hospital payment.

_____ _____ ____ _____ _____
Recipient Last Name First Name MI DOB

_____ _____ _____
Medicaid # District Delivery Date

List below the dates (dd/mm/yy) **of days paid by the Primary Contractor and hospital name.**

Day	Date	Hospital		Day	Date	Hospital
1				9		
2				10		
3				11		
4				12		
5				13		
6				14		
7				15		
8				16		

Please include copies of paid claims for the first 16 in-patient days.

_____

Please list the days approved in the PA request (up to 8)

Day	Date		Day	Date
1			5	
2			6	
3			7	
4			8	

- PLEASE INCLUDE A HARD COPY CLAIM IN RED DROP-OUT INK FOR EXTENDED DAYS
- PLEASE NOTE THAT THE DAY OF DISCHARGE FROM THE HOSPITAL MAY NOT BE INCLUDED IN THE TOTALS FOR THE ABOVE.

Send this form and all information to the District Director of the recipient's residence.

AGREEMENT TO RECEIVE CARE/RELEASE OF INFORMATION

I want to have good health while I am pregnant. I will try to do all things to help my baby to be born healthy.

I have been told that I can choose who will give me prenatal care.

I have chosen _____ (Doctor, midwife, clinic)

His/her address is _____. I want my baby to be delivered at

_____.

I have been told that I can change my mind about this choice within 90 days for any reason.
I have been told that I have the right to change my mind about who gives me care at any time there is a good reason.
I agree to go to doctors, clinics, hospitals and other places for care that are set up for me while I am pregnant and after my baby is born.
I agree to follow the plan of care that has been set up for me by my doctor, midwife or other person who provides my care.
I have been told that a real emergency is when I have a health problem that can cause death or lasting injury to my unborn baby or to me.
I have been told what my rights and responsibilities are under the Medicaid Maternity Care Program.
I have been told what I need to do if I have a problem that I cannot solve on my own.
I have reported other insurance that I have.
I have had the chance to ask questions about anything that I did not understand and to have my questions answered in a manner in which I understand.

I give my permission to _____ and any and all subcontractors, to perform tests and procedures necessary for my maternity care unless I have a religious or moral belief that prevents me from giving my permission. I give my permission for the release of my health information to providers for treatment purposes or to help with my care. I give my permission for the release of any information including medical records acquired in the course of my enrollment, treatment, or examination to the Alabama Medicaid Agency, my insurance company, or other entities as is necessary for reimbursement purposes.

I have been given a copy of:
____**Recipient Rights and Duties**
____**Agreement to Receive Care/Release of Information**
____**Enrollment Form (if different)**
____**Maternity Care Fact Sheet**
____**Care Coordinator Business Card with her name and telephone number**

Name_____ **Medicaid #** _____ **DOB** _____

Signature_____ **Date Signed** _____

Global Associated Codes

The following services are considered associated codes and are included in the global fee:

Procedure Code	Description
00842	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; amniocentesis
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium)
00942	Anesthesia for colpotomy, vaginectomy, colporrhaphy, and open urethral procedures)
00948	Anesthesia for cervical cerclage & other ob procedures
00950	Anesthesia for culdoscopy)
00952	Anesthesia for hysteroscopy and/or hysterosalpingography
01958	Anesthesia for external cephalic version procedure
01960	Anesthesia for; vaginal delivery only
01961	Anesthesia for; cesarean delivery only
01965	Anesthesia for incomplete or missed abortions
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery
01968	Anesthesia for c-section delivery following Neuraxial labor . . .
01996	Daily hospital management of continuous epidural
10140	Incision and drainage of hematoma, seroma, or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst
10180	Incision and drainage, complex, postoperative wound infection
56405	Incision and drainage of vulva or perineal abscess
56420	Incision and drainage of Bartholin's gland abscess
56440	Marsupialization of Bartholin's gland cyst
56441	Lysis of labial adhesions (lesions)
56820	Coloscopy of the vulva
56821	Coloscopy of the vulva with biopsy
57000	Colpotomy; with exploration
57010	Colpotomy with drainage of pelvic abcess
57020	Colpocentesis (separate procedure)
57022	Incision and drainage of vaginal hematoma; obstetrical/postpartum
57150	Irrigation of vagina and/or application of medicament for treatment of disease
57400	Dilation of vagina under anesthesia (other than local)
57410	Pelvic examination under anesthesia (other than local)
57460	Colposcopy of the cervix including upper/adjacent vagina
59000	Amniocentesis, any method (diagnostic)
59001	Therapeutic amniotic fluid reduction
59012	Cordocentesis (intrauterine), any method
59020	Fetal contraction stress test
59025	Fetal non-stress test
59030	Fetal scalp blood sampling

Procedure Code	Description
59100	Hysterotomy for hydatidiform mole (abdominal)
59120	Surgical treatment of ectopic pregnancy
59130	Excision abdominal pregnancy
59150	Removal of ectopic pregnancy
59160	Curettage, postpartum (D&C after delivery)
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin)
59300	Episiotomy or vaginal repair by other than attending physician
59320	Cerclage of cervix, during pregnancy (vaginal)
59325	Repair after delivery via abdomen
59350	Hysterorrhaphy of ruptured uterus
59400	Routine obstetric care includes antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care
59409	Vaginal delivery only with or without episotomy with or without forceps
59410	Vaginal delivery only (with or without episiotomy and/or forceps), including postpartum care
59412	Delivery; external Cephalic
59414	Delivery of placenta following delivery of infant outside of hospital
59425	Antepartum care only (4 to 6 visits)
59426	Antepartum care only (7 or more visits)
59430	Postpartum care only (separate procedure)
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59514	Cesarean delivery only
59515	Cesarean delivery only; including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59620	Cesarean delivery only , following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care
59871	Removal of cerclage suture under anesthesia (except local)
59870	Removal of hydatidiform mole
59899	Unlisted procedure, maternity care and delivery
76801	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation (first trimester)
76802	Ultrasound, pregnant uterus, real time image documentation, with

Procedure Code	Description
	fetal and maternal evaluation (first trimester)
76805	Ultrasound, pregnant uterus, B-scan and/or real time with imagine documentation; complete; fetal and maternal evaluation after first trimester
76810	Ultrasound, complete, multiple gestation, after the first trimester
76811	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76812	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, Transabdominal or transvaginal approach single or first gestation
76814	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal.
76815	Ultrasound, limited (fetal size, heartbeat, placental location, fetal position, or emergency in the delivery room)
76816	Ultrasound, follow-up or repeat
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76818	Fetal biophysical profile with non-stress testing
76819	Fetal biophysical profile; without non-stress testing
76820	Doppler velcocimetry, fetal, umbilical artery
76821	Doppler velocimetry, fetal, middle cerebral artery
76825	Echocardiography, fetal
76826	Echocardiography, fetal, follow-up or repeat study
76827	Doppler echocardiography, fetal
76828	Doppler echocardiography, fetal, follow-up or repeat study
81000	Urinalysis, by dipstick or tablet reagent
81001	Urinalysis, automated, with microscopy
81002	Urinalysis, non-automated, without microscopy
81003	Urinalysis, automated, without microscopy
81005	Urinalysis; qualitative or semi quantitative, except immunoassays
81007	Urinalysis; bacteriuria screen, except by culture or dip stick
81015	Urinalysis; microscopic only
81020	Urinalysis; two or three glass test
83026	Hemoglobin, by copper sulfate method, non-automated
83036	Hemoglobin, glycated (A1C)
85013	Spun micro-hematocrit
85014	Blood count; other than spun hematocrit
85018	Blood count; hemoglobin
99058	Office services provided on an emergency basis
99201	Office or other out patient visit for E&M new patient
99202	Office or other out patient visit for E&M new patient
99203	Office or other out patient visit for E&M new patient

Procedure Code	Description
99204	Office or other out patient visit for E&M new patient
99205	Office or other out patient visit for E&M new patient
99211	Office or other out patient visit for E&M established patient
99212	Office or other out patient visit for E&M established patient
99213	Office or other out patient visit for E&M established patient
99214	Office or other out patient visit for E&M established patient
99215	Office or other out patient visit for E&M established patient
99217	Observation care discharge day management
99218	Initial observation care, per day, for E&M detailed or comprehensive
99219	Initial observation care, per day, for E&M comprehensive
99220	Initial observation care, per day comprehensive

*Note all ultrasounds professional and technical components are covered in the global fee paid to the Primary Contractors.

MATERNITY CARE PROGRAM FACT SHEET

1. To enroll in the Maternity Care Program you must apply for Medicaid. You must be eligible for Medicaid to participate in the Maternity Care Program.

2. You must live in one of these counties: (list counties of your district)

3. You may only go to doctors, nurse midwives, clinics, hospitals and other maternity providers that are a part of the the name of your program goes here. Example, Viva, Alabama Baby Care) Program.

4. Medicaid will not pay for any of your maternity care if you go to any medical provider that you are not enrolled with or one who is not part of the Maternity Care Program where you live. If you do this and it is not an emergency you will have to be responsible for paying the bill.

5. Tell your Care Coordinator if: you change your address or phone number; you move to another county or state; you miss a doctor's appointment; you go to the emergency room at a hospital for any reason; you have a question about your pregnancy or you need help with something.

6. You should follow all instructions given to you by your care coordinator and doctor or nurse midwife you have chosen.

7. If you change your mind about your choice of doctor or nurse midwife or hospital where you want your baby to be delivered tell your Care Coordinator.

8. Keep the card that has the name and information about your Care Coordinator on it and your Medicaid card. You will be asked to show both of these cards during your pregnancy.

Application Assisters

Application Assisters are individuals that have been trained to assist an individual with the Medicaid application process. Primary Contractors are required to provide Application Assister services to Medicaid recipients. The intent is to address barriers that may prevent the individual from becoming Medicaid eligible in a timely manner and more importantly, beginning her prenatal care as soon as possible.

Application Assisters should understand that their functions are limited to initial processing activities and that Medicaid employees continue to make all eligibility determinations.

Application Assisters will conduct themselves in a manner so as to avoid any conflicts of interests. The Application Assisters will not process applications for relatives, friends, or any other persons for whom doing so could reasonably be perceived as constituting a conflict of interest. The Application Assisters will refer any questionable cases to Medicaid for handling.

Primary Contractor Responsibilities

The Primary Contractor will ensure that Application Assister services are provided to Medicaid recipients.

The Primary Contractor will ensure that the Application Assister understands that functions are limited to assisting applicants in these ways:

- Taking/accepting applications
- Completing the Medicaid eligibility application #291, preferably online at www.insurealabama.org.
- Use of online applications is preferred, however, if a paper application is used, the Contractor will forward all completed #291 applications to the designated Medicaid eligibility contact person.
- Providing information and referral on related programs and services.
- Obtaining required documentation needed to complete processing of the application.
- Assuring completeness of the information contained on the application.
- Conducting interviews.

Training

Medicaid shall provide training to the Application Assisters. Each Application Assister will be required to attend an initial training prior to assisting with the application process. Medicaid will provide further training on an “as needed” basis or when new programs or changes in the current program are made. The training will cover all requirements under initial processing functions.

POSTPARTUM HOME VISIT SUMMARY

MOTHER'S INFORMATION

Patient Name:	Medicaid #:	DOB:	Age:	Race:
Delivery Date:	Type of Delivery:	Delivery Time:	Gest Age @ Delivery:	Hospital D/C Date:
Address:			County:	
Phone Number:		Alternate Phone Number:		
Directions to Home:				

REASON FOR HOME VISIT

(Check all that apply)

___Under 16 years of age ___ Birth weight
___Drugs and Alcohol ___Other: (specify)
___Missed hospital encounter ___ Partner Abuse
___Mental Illness ___ No Home Visit Needed

VISIT ATTEMPTS

Date	Type of Attempt

PSYCHOSOCIAL ASSESSMENT

Problems/Issues	YES	NO	Comments
Poor previous parenting experience			
Poor support system			
Literate			
Areas of anxiety noted			
Drugs, Alcohol, Tobacco Usage			
Conflict/ Violence noted in home			
Appropriate newborn/mother attachment			
Support systems present			
Mother able/willing to provide needed infant care			
Father able/willing to provide needed infant care			
Emotional status (Tearful, moody, anxious, depressed)			
Fatigue/Exhaustion			
Sleep disturbances			
Adequate living arrangements			
Other areas of need			
Referrals made			

PHYSICAL ASSESSMENT

Temperature:	BP:		Pulse:	Respirations:
Problems	Yes	No	Comments	
Breasts				
Perineum				
Lochia				
Abdomen (fundus)				
Incision site (signs of infection)				
Edema (location)				
Respiratory status				
Pain				
Appetite/Fluid intake				
Bladder/Bowel Function				

EDUCATION/COUNSELING

Teaching (Check areas discussed/or pamphlets given)

___Breast Care ___Breast Feeding ___Perineum Care ___Hygiene ___Nutrition ___Incision Care ___Bathing

___Family Planning/Birth Control ___Sexual Relations ___Educational Materials/Pamphlets provided ___Other
Comments:

SAFETY ASSESSMENT

___Workable Smoke Detector ___Car Seat Available/Used ___Inside Pets ___Crib Safety ___Telephone ___ Refrigeration ___Adequate Cooling ____ Adequate Heating ___ Vermin infestation
Comments:

Visiting Nurse Signature:	Date of Visit:

POSTPARTUM HOME VISIT SUMMARY

INFANT INFORMATION			
Infant name:		___Male ___Female	Birth complications:
Birth weight:	Current weight:	___Bottle fed ___Breast fed	___Tolerates Feedings
Formula: ___Ounces every ____Hour ___ Ounces Water per day ___ Wet Diapers per day ___Stools per day			
Medications:			
Pediatric Provider:			

INFANT PHYSICAL ASSESSMENT

Temperature:	Heart rate:	Respiratory rate:

Problems		Yes	No	Comments
Skin: membranes	Pink nail beds/Mucous			
	Jaundice			
	Rash			
	Other			
Neurological:	Lethargic			
	Hyper/Hypotonic			
	Crying (high pitched, non-consoling)			
	Symmetrical eye movement			
	Other			
Cardiovascular:	Tachycardia/Bradycardia			
	Irregular heart rate			
	Other			
Respiratory:	Rales/Rhonchi			
	Cough (dry, productive, etc.)			
	Nasal drainage (color, consistency)			
	Other			
Gastrological:	Abdominal distention			
	Other			
Genitourinary:	Abnormal genitalia			
	Circumcision			
	Other			
Extremities:	Adequate bilateral hand grasp			
	Hip click (right or left)			
	Other			

EDUCATION COUNSELING

Teaching: (Check areas discussed or pamphlets provided)			
___General Infant Care (bathing, diapering, napping/sleeping position, holding) ___Danger signs		___Colic	___Thermometer use
___Basic Home Safety	___When to call the Doctor	___Normal Growth and Development	___Day Care

Mother's Post Partum Appointment/Date and Time:	Location:	Mother aware:
Infant's next Pediatric Provider Appointment:	Location:	Mother aware:
Other Appointments/Referrals Mother or infant:		

Comments/Address Reason for Home Visit:_____

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Visiting Nurse Signature:	Date of Visit

POSTPARTUM HOME VISIT SUMMARY

MOTHER'S INFORMATION

Patient Name:	Medicaid #:	DOB:	Age:	Race:
Delivery Date:	Type of Delivery:	Delivery Time:	Gest Age @ Delivery:	Hospital D/C Date:
Address:			County:	
Phone Number:		Alternate Phone Number:		
Directions to Home:				

REASON FOR HOME VISIT

(Check all that apply)

___Under 16 years of age ___ Birth weight
___Drugs and Alcohol ___Other: (specify)
___Missed hospital encounter ___ Partner Abuse
___Mental Illness ___ No Home Visit Needed

VISIT ATTEMPTS

Date	Type of Attempt

PSYCHOSOCIAL ASSESSMENT

Problems/Issues	YES	NO	Comments
Poor previous parenting experience			
Poor support system			
Literate			
Areas of anxiety noted			
Drugs, Alcohol, Tobacco Usage			
Conflict/ Violence noted in home			
Appropriate newborn/mother attachment			
Support systems present			
Mother able/willing to provide needed infant care			
Father able/willing to provide needed infant care			
Emotional status (Tearful, moody, anxious, depressed)			
Fatigue/Exhaustion			
Sleep disturbances			
Adequate living arrangements			
Other areas of need			
Referrals made			

PHYSICAL ASSESSMENT

Temperature:	BP:		Pulse:	Respirations:
Problems	Yes	No	Comments	
Breasts				
Perineum				
Lochia				
Abdomen (fundus)				
Incision site (signs of infection)				
Edema (location)				
Respiratory status				
Pain				
Appetite/Fluid intake				
Bladder/Bowel Function				

EDUCATION/COUNSELING

Teaching (Check areas discussed/or pamphlets given)

___Breast Care ___Breast Feeding ___Perineum Care ___Hygiene ___Nutrition ___Incision Care ___Bathing

___Family Planning/Birth Control ___Sexual Relations ___Educational Materials/Pamphlets provided ___Other
Comments:

SAFETY ASSESSMENT

___Workable Smoke Detector ___Car Seat Available/Used ___Inside Pets ___Crib Safety ___Telephone ___ Refrigeration ___Adequate Cooling ____ Adequate Heating ___ Vermin infestation
Comments:

Visiting Nurse Signature:	Date of Visit:

POSTPARTUM HOME VISIT SUMMARY

INFANT INFORMATION			
Infant name:		___Male ___Female	Birth complications:
Birth weight:	Current weight:	___Bottle fed ___Breast fed	___Tolerates Feedings
Formula: ___Ounces every ____Hour ___ Ounces Water per day ___ Wet Diapers per day ___Stools per day			
Medications:			
Pediatric Provider:			

INFANT PHYSICAL ASSESSMENT

Temperature:	Heart rate:	Respiratory rate:

Problems		Yes	No	Comments
Skin: membranes	Pink nail beds/Mucous			
	Jaundice			
	Rash			
	Other			
Neurological:	Lethargic			
	Hyper/Hypotonic			
	Crying (high pitched, non-consoling)			
	Symmetrical eye movement			
	Other			
Cardiovascular:	Tachycardia/Bradycardia			
	Irregular heart rate			
	Other			
Respiratory:	Rales/Rhonchi			
	Cough (dry, productive, etc.)			
	Nasal drainage (color, consistency)			
	Other			
Gastrological:	Abdominal distention			
	Other			
Genitourinary:	Abnormal genitalia			
	Circumcision			
	Other			
Extremities:	Adequate bilateral hand grasp			
	Hip click (right or left)			
	Other			

EDUCATION COUNSELING

Teaching: (Check areas discussed or pamphlets provided)			
___General Infant Care (bathing, diapering, napping/sleeping position, holding) ___Danger signs		___Colic	___Thermometer use
___Basic Home Safety	___When to call the Doctor	___Normal Growth and Development	___Day Care

Mother's Post Partum Appointment/Date and Time:	Location:	Mother aware:
Infant's next Pediatric Provider Appointment:	Location:	Mother aware:
Other Appointments/Referrals Mother or infant:		

Comments/Address Reason for Home Visit:_____

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Visiting Nurse Signature:	Date of Visit

MEDICAID MATERNITY CARE PROGRAM
RECIPIENT RIGHTS AND DUTIES

You have the following rights and duties when you agree to be a part of the Maternity Care Program.

You have the right:

- To get good medical care for your pregnancy close to where you live.
- To get care during your pregnancy regardless of your overall health, your past medical history or any health problems you have now.
- To have care or treatments explained to you ahead of time and to refuse any care or treatment you do not want or that goes against your religious or personal beliefs.
- To decide about the care you get during your pregnancy and to give your permission before the start of treatment or surgery.
- To be told about any treatments that are proper for your condition in a way that you can understand.
- To know about all of the people who will be taking care of you during your pregnancy.
- To get care that is free of any restraint or action that is meant to force you to do something, punish you, or to get even with you.
- To get emergency care from **any hospital** if you have a **real emergency.** A real emergency is when you have a health problem that can cause lasting injury or death to you or your unborn baby.
- To choose where you want to get medical care for your baby.
- To choose what kind of birth control you want and where you want to get it.
- To be treated with respect, dignity and privacy.
- To have your medical records kept private.
- To get a copy of your medical record and to ask that the record be changed if it is not correct.
- To sign an Advance Directive saying what kind of care you want if you are too sick or hurt to decide about your care.
- To donate your organs if you die.
- To file a grievance or complaint if you are not satisfied with your care, how you were treated, or if your rights were not respected and you want action taken to solve the problem.

Filing a grievance:

✓ You have the right to have someone to talk with you about how you feel.
✓ Call the person who signed you up with the maternity care program or write a letter explaining why you are not pleased. Give the letter to that person or mail it to Medicaid, P.O. Box 5624, Montgomery Alabama 36103-5624.
✓ Medicaid will still pay for your pregnancy care if you were on Medicaid at the time you filed the grievance.
✓ If there is no action within 10 working days, you have the right to file an appeal to ask that someone else look into your complaint
✓ You have the right to an interpreter if you do not understand English or if you have any type of speaking or hearing disability
✓ If you need help to file a grievance, call your Care Coordinator or the toll free number for the district where you live.
✓ If your grievance is against the doctor that you picked, you may choose another doctor.

You have the duty:

- To go to doctors and hospitals in your area that you have agreed to see for pregnancy care. Your Care Coordinator will show you a list of all the doctors and hospitals in your area and you will choose a doctor and hospital.
- To go to all of your appointments. If you have a problem getting to your appointment, your Care Coordinator will help you with getting transportation.
- To follow the directions you get from your doctor or nurse for your pregnancy. You also have the duty to follow the plan of care that you and your Care Coordinator set up to help you have a healthy baby.
- To meet with your Care Coordinator and let her know if anything about you or your pregnancy changes.
- To report to the Care Coordinator if you move, if your Medicaid changes, or if you miscarry the baby.
- To take only the medicine that your doctor has told you to take. This includes over the counter medicine like aspirin, Tylenol, Tums, etc.
- To have a healthy lifestyle and to eat right.
- Not to smoke cigarettes or use drugs.

PROTOCOLS FOR SCREENING PREGNANT WOMEN FOR PARTNER ABUSE

All pregnant women shall be asked routine questions regarding domestic violence issues in their lives. A sample of questions that may be used is listed below:

- Is your partner excited about the baby?
- How is your family reacting to this?
- How are you and your partner getting along? Is he helping you to complete tasks that you are unable to do?
- How are things at home?
- Is anything preventing you from coming to the clinic?
- Since your pregnancy began, have you been kicked, slapped, or otherwise physically hurt by someone?
- Within the last year has anyone forced you to engage in sexual activities that made you feel uncomfortable?
- Do you feel that you are being stalked by anyone?
- Has your partner ever destroyed things that you cared about?
- We all disagree at times at home. What happens when you or your partner fight or disagree?
- Has your partner ever prevented you from leaving the house, seeing friends, getting a job or continuing your education?
- Is your partner jealous of the time you spend with your family or friends?

If yes to any of the above:

- Would you like help with any of this now?
- Would you like us to send a copy of this form to your DHCP?

The following indicators require timely follow-up:

- Late and/or sporadic access to prenatal care
- Injury to the breast(s) and/or the abdomen
- Divorce or separation during pregnancy
- Vaginal bleeding
- Self-induced or attempted abortion
- Increased alcohol or drug use
- Miscarriage
- Multiple abuse injury sites
- Low maternal weight gain
- Short inter-pregnancy interval
- Poor nutrition
- Premature labor
- Depression or less happiness about the pregnancy
- Suicidal ideation
- Frequent clinic/visits for somatic complaints (insomnia, hyperventilation, etc.)
- Recurrent STDs, pelvic infections or HIV
- Evidence of noncompliance with treatment/care plan

If a case of domestic violence is identified and the woman is willing, the referral process shall be implemented. Alabama has shelters statewide that can provide counseling support for victims of domestic violence. The statewide hotline number is **1-800-650-6522.** If a woman is not willing to call the shelter, the case manager should encourage the completion of a safety plan. The plan can help the woman better prepare for her safety when a violent situation arises.

Attachment Nine
MCP Operational Manual

District:

Quality Improvement Activity Form

Activity Number **Initial Submission:** **Continued:** **Discontinued:**	**Activity Name:**	**By Whom or How was issue / concern identified:**
Overview of Activity:		

Numerator	**Denominator**	**Baseline**	**Benchmark:**	**Measurement Period:**

Description of Population:	**Sample Size:**	**Sampling Methodology:**	**Data Collection Method** ☐ Administrative ☐ MRR ☐ Claims ☐ Other, explain

Why is Activity Relevant?

Opportunities for Improvement	**Barriers**

Interventions	**Timeline**	**Outcome**

Plan:

Analysis Conducted by:	**Responsible Party:**

Updated 3/08

(To print from website and FAX)

Alabama Medicaid Agency
Newborn Assignment Form

Please assign the newborn

FOR: (Mother's Name) _____

(Mother's Medicaid Number) _____

TO: Physician _____
First MI Last

Physician/Clinic's Medicaid Provider number (if known) _____

Physician Address _____

The Unborn/Medicaid Number of the baby is _____

Baby's Name _____

Address _____

City _____ Zip _____ Phone Number (_____) _____
Area Code

I have been told that I can choose which Patient 1st doctor I want to care for my baby.

Signature of Parent/Guardian _____ Date _____

Name of Person Completing Form _____

Phone Number (_____) _____ FAX Number (_____) _____
Area Code Area Code

Remember: If you send this form in, you do not need to call Medicaid!

What you need to do:

1) For future access, save this form to your computer using the File-Save command.
2) Fill in all of the blanks on this form. Be sure to write neatly! Be sure to answer all the questions on this form. If we do not have all of the information, we cannot make the newborn assignment.
3) After you have completed the form, you may Fax it to 334-215-4140.

If you have questions or do not know what to do, call Medicaid toll-free at 1-800-362-1504.

MATERNITY CARE PROGRAM
ADMINISTRATIVE REVIEW REQUEST FORM

Please attach original red drop-out claim forms for the recipient listed. If the claim is not included, this form will be sent back to you. This will cause a delay in administrative review process and claim processing. Primary Contractors are required to forward claims received from subcontractors to Medicaid within 5 working days.

Recipient Name _____ DOB _____

Medicaid # _____ County Code ___ EDC _____

Type (check one) ____Dropout ____Outdated claim _____Other

Explanation for review request: _____

_____

_____

_____

Claims Attached:

- ☐ Physician
- ☐ Clinic Antepartum Provider ☐ Anesthesiology
- ☐ Radiology/Ultrasound ☐ Other

Date Dropout Fee Claim Filed?: ☐ Yes ☐ No Date:_____

Primary Contractor: _____ District: _____

Submitted By: _____ Phone No.: _____

Medicaid Use Only:

Date Reviewed: _____ Date Sent to EDS: _____ Date Returned to PC for add info: _____

Notes by Reviewer:

_____

_____

_____

MATERNITY CARE PROGRAM
EXEMPTION REQUEST FORM

MEDICAID RECIPIENT INFORMATION

NAME_____ DOB_____ EDC _____

ADDRESS _____ City_____

COUNTY _____ ZIP _____ DISTRICT _____

MEDICAID # _____ PRIMARY CONTRACTOR _____

DATE STARTED PRENATAL CARE: _____

Signature of Program Director _____ Date _____

REASON FOR EXEMPTION REQUEST

1. MEDICAL NECESSITY _____
Diagnosis/Condition _____

I am certifying that this recipient requires continuous prenatal care and delivery services from a facility that is certified to provide high risk delivery services.

_____
Signature DHCP _____ HIGH RISK PROVIDER _____

2. MEDICAID ELIGILBILTY GRANTED LATE IN PREGNANCY _____
Date of Medicaid application _____ (date must be verified)
Has the non-subcontracted provider agreed to continue pregnancy care and delivery for the recipient? _____

3. Other ___ Please attach documentation

4. HMO INSURANCE
Name of Insurance Company _____
Policy #_____ Effective Date _____

FOR MEDICAID USE ONLY
Date Returned _____ Approved_____ Denied_____
Reason_____
_____
_____
_____
_____

MCP Smoking Cessation

1. _____was smoking ____cigarettes per day at her first visit.
2. _____was not smoking at her first visit.
3. Smoking Cessation information given on _____.
4. Provided **Smoking Quitline number 1-800-Quit-Now (1-800-784-8669)** on_____.
5. Counseled on Smoking and Effects on Pregnancy on_____.
6. _____ was not smoking as per interview at postpartum visit.
7.

1st Encounter

Date	Smoking Status	Action Taken	Initials
	☐ Smoking ☐ Has Quit ☐ Using Patches	Counseled and ☐ Provided support ☐ Praised and provided support	

2nd Encounter

Date	Smoking Status	Action Taken	Initials
	☐ Smoking ☐ Has Quit ☐ Using Patches	Counseled and ☐ Provided support ☐ Praised and provided support	

Other Encounter

Date	Smoking Status	Action Taken	Initials
	☐ Smoking ☐ Has Quit ☐ Using Patches	☐ Counseled ☐ Praised	

Attachment Thirteen
MCP Operational Manual

Attachment Fourteen
MCP Operational Manual

Service Database Web Elements

Medicaid ID number
Social Security Number
Last Name, First Name
Date of Birth
Race
County Code
Prenatal Para/Gravida
Date of 1st Prenatal Visit
Weeks Gest. At 1st Visit
Total # PNC Visits
Total # Missed Appts
Medical Psychosocial Risk Status at time of enrollment
Date of last pregnancy
Previous Fetal Loss
Previous Preterm Births less than 37 weeks
Pregnancy Planned
Attended Childbirth Class
Pre maternal weight
Post maternal weight
Previously enrolled
Smoker or recent quitter
Delivery provider
Delivery hospital
Delivery induced reason
Gestational Age at Delivery Weeks
Gestational Age at Delivery Days
Type of Delivery
Pregnancy Outcome
Maternal Death
Maternal Death Date
Infant Number 1
Infant Weight # 1
Infant in NICU #1
Infant Number 2
Infant Weight #2
Infant in NICU #2
Infant Number #3
Infant Weight #3
Infant in NICU #3
Infant Number 4

Service Database Web Elements

Infant Weight #4
Infant in NICU #4
Infant Number 5
Infant Weight #5
Infant in NICU #5
Home Visit required
Home Visit Date
Postpartum Date
Care Coordination
Breastfeeding at hospital discharge
Breastfeeding at Postpartum Medical Visit
Birth control method
Status

RMEDE Maternity Care Form

Completion Instructions

POLICY: The form should be completed and submitted for all women who enter and deliver through the program. All data should be entered and submitted within 60 days of the date of delivery. Standard reports can be run based on the data including a status report of completed vs incomplete forms.

COMPLETION INSTRUCTIONS: The form is divided into six sections. Each section can be collapsed or expanded. Data entered into the form can be edited, even after submission. The submitted form should reflect the pregnancy at the end. For example, if the patient did change her DHCP, the submitted form should reflect the last DHCP on record. There is not a required format for fields that can vary in length, e.g. para.

Forms are created, filed and retrieved by the mother's 13-digit Medicaid number or the mother's SSN. If the mother has not received a Medicaid number at the time of enrollment, then enter the SSN. It is allowable, but not necessary, to enter both numbers.

Required fields are: all fields in Patient Information, Prenatal Provider, Gravida and Para. They are marked with the red asterisks below. https://www.rmede.net is the e-mail address for RMEDE. Report problems or make suggestions to Barbie Oliver at USA, boliver@usouthal.edu and copy me on the e-mail, Gloria.Luster@medicaid.alabama.gov.

Patient Information

- *Last Name: Enter the mother's last name as it appears on her Medicaid card. If at the time of enrollment, the mother has not received her Medicaid, then enter the name as given to the Medicaid worker.
- *First Name: As with last name.
- *Date of Birth: Mother's date of birth. The calendar function gives you 20 years at a time. When you click on the earliest year, 20 more years are populated.
- *County Code: Mother's county of residence at time of enrollment. NOTE: If at time of delivery the county code changes, this field should be changed as well. The county code should reflect the billing Primary Contractor's district.
- *Race: choices will be in a drop down box.

Prenatal Visit Information

- *Prenatal Provider Information: This is the 10-digit NPI of the provider from whom the women has chosen to receive prenatal care. This will be a drop down box based on the Primary Contractor's identified subcontractors. If the patient obtains prenatal care outside the district, then select other.
- *Gravida: self-explanatory
- *Para: self-explanatory
- First Prenatal Visit Date: Enter the date of the first confirmed prenatal visit whether or not the visit is within the network.
- Gestation at First Prenatal Visit: self-explanatory
- Total Prenatal Visits: self-explanatory

- Total Missed Appointments: This should be a total of confirmed missed appointments.

Enrollment Data

- Psychosocial Risk at Enrollment: Enter high or low.
- Medical Risk Status at Enrollment: Enter high or low.
- Date of Last Pregnancy: Regardless of outcome. Indicate date of infant's birth or pregnancy termination. Leave blank if this is the first pregnancy.
- Previous Fetal Loss: Self Explanatory
- Previous Pre-Term Births (less than 37 weeks): Self-explanatory.
- Attended Childbirth Class: Self Explanatory
- Pre and Post Pregnancy Weight Gain: Record in pounds. Round up or down.
- Received Services through Plan First?: If the patient was eligible and did receive at least one service through the Plan First Program.
- Smoker or recent Quitter (within the last 2 months)?: Self Explanatory

Delivery Information

- Delivering Provider ID: This is the 10 digit NPI of the provider who delivered the infant. This will be a drop down box based on the Primary Contractor's identified subcontractors.
- Delivery Hospital: 10 digit NPI. This will be a drop down box based on the Primary Contractor's identified subcontractors.
- Delivery Date: Self Explanatory
- Psychosocial Risk at Delivery: Self Explanatory
- Delivery Induced?: Indicate yes whether the inducement was at 39 weeks or earlier and whether it was patient requested or physician ordered. Augmented is the same as induced.
- Gestational Age at Delivery (weeks): Self Explanatory
- Type of Delivery: Self Explanatory ADD RC
- Pregnancy Outcome: Self Explanatory ADD Neonatal Demise
- Maternal Death: Self Explanatory
- Maternal Death Date: Self Explanatory

Infant Information

First

- Infant Number: Enter 1 for the first infant or if a single live-born
- Infant Weight (pounds): Enter the Weight in either pounds or ounces **OR** grams
- Infant Weight (oz):
- Infant Weight (grams):
- Infant in NICU?: Self Explanatory

Please select one: This is the subsequent infants of this birth

Second

Third

Fourth

Postpartum

- Home Visit Required: Self Explanatory
- Home Visit Completed: Self Explanatory
- Post Partum Visit Date: Only indicate if the exam was completed
- Breastfeeding?: Self Explanatory

This format is to be used to report meeting minutes to the Agency.

PRIMARY CONTRACTOR'S NAME
QUALITY ASSURANCE COMMITTEE MEETING MINUTES

District:
Date:
Quarter:
Location:

Members Required	Members Name	Present/Absent	Comments
Program Director			
OB/GYN or Family Practice/Delivering Physician			
RN w/ OB experience			
Licensed Social Worker			
Members Recommended			
Medicaid Consumer			
Other			

Call to Order:

Approval of Minutes:

Agenda:
(To include but not limited to)

I. Evaluation of Enrollment Process
II. Grievances
III. Internal and External QAPI activities
IV. Performance Improvement Project
V. Subcontractors and Recipients under and over utilization detection
VI. Utilization of Medical Record Review information
VII. Provider Network Issues

General Discussion:

Question and Answer:

Adjournment:

MATERNITY CARE PROGRAM
Non Clinical Performance Improvement Project
Example

1. Study Topic: Application Assisters

The purpose of this study is to determine if Application Assisters improve early entry into prenatal care. Early entry into care is defined as the beginning of prenatal care with a delivering health care professional (DHCP) that is less than 14.0 weeks of gestational age. Beginning of prenatal care is defined as the first visit with the health care professional. Medicaid recipient is defined as a person enrolled in Medicaid.

2. Study Questions:

Data will be collected from each patient delivering beginning------.

A. What date did patient enter prenatal care?
B. How many weeks gestation was patient upon entering care?
C. Is the patient an active Medicaid recipient?
D. Did patient require assistance from an Application Assister in applying for Medicaid?
E. Factors causing additional delay in entry into care.

- Entered care late
- Unable to obtain
- Loss of benefits
- Lack of knowledge
- Other

F. Did the assistance from an Application Assister improve early entry into care?

3. Study Indicators:

The answers to the above questions will be analyzed based on the indicators in 2.E.
Outcomes of Assistance:

- Seeking Medicaid services after 14.0 weeks of gestational age.
- Missing information required for Medicaid enrollment and unable to obtain.
- Loss of prenatal insurance coverage.
- Lack of knowledge regarding available Medicaid services.
- Other

4. Study Population

All women entering care between -----and -------.

5. Sampling Technique

The information will be collected from the medical record.

6. Data Collection:

Data Source	Collection Method	Collection Instrument	Responsible Party
1. Recipient Medical Record	Information obtained documented findings	Application Assister Questionnaire	Care Coordinator or Designee
2. Application Assister Questionnaire	Information obtained during interview	Excel spreadsheet	Care Coordinator or Designee

A. Care Coordinator or Designee shall obtain the gestational age at entry into prenatal care from the recipient's medical record. The earliest gestational age at entry into prenatal care, regardless of the provider, i.e., out-of-district provider or in-district provider shall be used.

B. Care Coordinator or Designee shall obtain date entered into care from the recipient's medical record. Information regarding need for assistance, Medicaid eligibility and factors causing additional delay will be obtained during interview and recorded on the Application Assister Questionnaire.

Data Analysis Plan:

A. Data will be collected on stated study population using sources, methods, and instruments stated above.

B. All findings from individual Questionnaires should be recorded accurately and clearly on the standardized Excel Spreadsheet.

C. Detailed findings will be retained by the Primary Contractor.
Aggregate information will be provided on the standardized Excel Spreadsheet and submitted to the Alabama Medicaid Agency: This will report percentages for each factors indicated as a reason for late entry into care. All parties should be cognizant that the outcomes of delivery may be multi-faceted.

7. Analyze Data and Interpret Study Results:

A. Findings will be utilized in establishing performance improvement activities and assessed for program's ability to remove barriers to decrease late entry into care percentages.
B. Action should be initiated to address those barriers or reasons which are within the District's realm of responsibility to impact. The action necessary will be appropriate to study findings. The State will be monitoring to ensure that findings are acted upon in upcoming QA activities.
C. Each Primary Contractor should take the findings of the Performance Improvement Project (PIP) and implement follow-up activities to address the findings. Keep in mind that the purpose of the PIP is to implement action(s) to affect a change and to measure the impact of the action.

8. Implement Intervention and Improvement Strategies:

A. Opportunities for Improvement are identified.

B. Reasonable interventions are undertaken to address causes/ barriers identified through data analysis and QI processes undertaken.
C. Identify barriers initial and repeated measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity.
D. Interpret the extent to which the PIP was successful and follow-up activities

9. Plan for Improvement:

A. Determine if improvement in performance has validity.
B. Information will be provided on the standardized Excel Spreadsheet and submitted to the Alabama Medicaid Agency:

The final report is due by ----------

PERFORMANCE IMPROVEMENT PROJECT
APPLICATION ASSISTERS SUMMARY
Date

Sample Size (Total Number of Women)					
General Study Questions		**YES**	**NO**		
Active Medicaid Recipient					
Assistance of an Application Assister					
Total					
Reasons for Additional Delay		**YES**	**NO**	**% of total**	
Entered Care Late					
Unable to Obtain					
Loss of benefits					
Lack of knowledge					
Other					
Total					

Written interpretation of findings:

Instructions for Completion of Grievance and Appeal Log

The Complaint and Grievance Log is a mechanism of documenting and tracking complaints/grievances submitted by recipients or providers. It is an at-a-glance record of complaints from registration until resolution. It is maintained by the Primary Contractor and is submitted to the Medicaid QI Division quarterly. After grievances are logged in on the grievance log, the Primary Contractor will e-mail the Maternity Care Associate Director within three working days of the grievance stating recipient name, Medicaid number, nature of grievance and disposition of grievance.

Document appeals process and fair hearing process discussed with recipient.

All appeal resolutions must be provided will be notified in writing to the recipient by the Primary Contractor.

Items to be recorded are identified by column headers and are self-explanatory. A more detailed explanation of the codes required follows:

Complaint Codes

A. **Staff** – can refer to problems or conflicts with staff in MD office, hospital, other medical facilities or care coordination.
B. **Medical/MD** – refers to concerns related to care provided by MD or other medical professionals.
C. **Environment** – refers to issues related to MD office, hospital or other facilities encountered by the recipient.
D. **Billing** – refers to coverage and payment issues encountered by the recipient
E. **Communication** – refers to any problems encountered by the recipient related to the timely transmission of information from those involved in providing prenatal care.
F. **Time** – refers to any issues the recipient has related to time spent waiting for MD or Care Coordinator, scheduling issues, etc.
G. **Transportation** – any difficulties related to transportation to MD visits, other health visits required due to pregnancy, etc.
H. **Other** – refers to any complaint or issue not identified in the above codes.

Resolution Codes

A. **Resolved:** issue resolved satisfactorily between recipient and those involved.
B. **Unresolved – additional action needed**: issue has not been resolved and may require referral to the Grievance Committee.
C. **Unresolved – appeal process**: issue has not been resolved satisfactorily by the Grievance Committee and the recipient appeals for further action.
D. **Unresolved – fair hearing:** the recipient does not accept issue resolution and requests a fair hearing with Medicaid.

Level Codes

A. **S – Standard:** resolved within 90 days.
B. **E – Expedited:** requires more immediate resolution within 48 hours.

PROVIDER AND RECIPIENT GRIEVANCE AND APPEAL LOG/SUMMARY REPORT

DISTRICT (SITE): QUARTER:
PRIMARY CONTRACTOR:
TOTAL GRIEVANCES _____
(ALL PATIENTS)

P-Provider R-Recipient	PATIENT/ PROVIDER NAME/ADDRESS	PATIENT MEDICAID NUMBER	DATE RECEIVED	DATE OF OCCURRENCE	COMPLAINT CODE	SITE	GRIEVANCE: BRIEF EXPLANATORY SUMMARY	RESOLU-LUTION CODE	RESOLU-TION SUMMARY	DATE RESOLVED	LEVEL OF GRIEVANCE

COMPLAINT CODES: A. Staff, B. Medical/MD, C. Environment, D. Billing, E. Communication, F. Time, G. Transportation, H. Other
RESOLUTION CODES: 1. Resolved 2. Unresolved--Additional action needed, 3. Unresolved--Appeal process, 4. Unresolved--Fair Hearing

LEVEL CODES: S - Standard, E - Expedited

GLOBAL SUMMARY REPORT

Quarter Being Reported:

1	Number of Deliveries	
2	$ for Phys Delivery Services	
3	$ for Phys Del and Other Services	
4	$ Other Services	
5	$ for Anesthesia	
6	# ultrasounds	
7	$ ultrasounds	
8	# home visits	
9	$ home visits	
10	$ associated costs	
11	$ admn	
12	$ admn and Other Services	
13	$ Care Coordinator total	
14	$ Post Partum total	
15	**Adjustments/recoups**	
	Total	
16	TPL Collected	
17	TPL Reported	

Definition of Elements:

ONLY REPORT COSTS IN ONE CATEGORY

1 Report number of deliveries for which you received a global payment, including those with TPL.
2 If your physician payment only includes delivery services, indicate total paid.
3 If your physician paymentincludes delivery and other services, indicate total paid.
4 If your hospital payment is for services other than inpatient , indicate total paid.
5 Total paid for anesthesia services.
6 Number of ultrasounds provided
7 Total paid for ultrasound services.
8 Number of completed home visits.
9 Total paid for completed home visits.
10 Total paid for other services not defined in another category
11 If your administrative costs is only for operating expenses, indicate total paid.
12 If your administrative costs includes other costs and operating expenses, indicate total paid.
13 Total paid for care coordination services
14 Total paid for home visits
15 The total dollar amount of monies recouped and/or adjusted this quarter
16 Total TPL collected from other payors
17 Total TPL amounts reported via claims

Provider Network

Subcontractor Last Name	Subcontractor First Name	Subcontractor Middle Initial	Group Name	Service	Street Address	City	State	Office Phone	Fax	Email	24-Hour Number	Contact
				DHCP								
				Anesthesia								
				Care Coordinator								
				Home Visit								
				Asst. Surgeon								
				Ultrasounds								

Maternity Care Program
Third Party Insurance Verification

To Whom It May Concern:

The following is a form seeking verification of health/medical insurance information – as required by Medicaid – for the following person. Please note that a release of information is included.

I, _____give permission for the _____
(patient's full name) (Insurance Company)
and/or Personnel Department of _____to release the following
(Work place of insurance holder)
information concerning my insurance coverage to _____.
(name of Primary Contractor)
Patient Signature:_____ Date:_____

PATIENT INFORMATION

Name _____Date of Birth_____
Address_____
City_____County_____State_____
Zip_____SS#_____
Name and Address of Insurance Company _____
_____Phone_____
Policyholder's Name_____
Relationship to Patient_____
Policy # _____
Other Pertinent Data_____

TO BE COMPLETED BY INSURANCE COMPANY/PERSONNEL DEPARTMENT

Does the above named person have maternity coverage? Yes____No____

When did coverage begin? Month____Day____End Date: Month____Day____Year____

Is Pre-Certification required? Yes_____No_____

Additional Comments: _____

Signed: _____

Where should claims be filed? _____

_____

Telephone Verification: Yes____No____Date_____ Made by:_____

Please return form within 30 days to: _____
_____
If you have any questions, please call_____
(If possible, please include copy of policy booklet or pertinent sections. Thank you for your assistance)

Attachment Twenty One
MCP Operational Manual

The following is an example of the form and format to be used when reporting a quality improvement activity.

District Quality Improvement Activity Form Example

Activity Number: 003 **Initial Submission: 2003 Q1** **Continued: Yes** **Discontinued:**	**Activity Name:** VLBW Deliveries at non high-risk facilities.	**By Whom or How was issue / concern identified:** QI Committee / Administration

Overview of Activity: The QI Committee reviewed statistics presented at the August 2002 committee meeting for FYI 2000 and FYI 2001 program data. It was noted at this time that an overall decrease in LBW and preterm deliveries had occurred from one year to the next, however the percentage of these deliveries being VLBW deliveries increased in both districts. The QI committee recommended requesting data from the state to determine if there was a statewide trend. Sue requested and received masked data from the other State programs, which confirmed a statewide trend for increased VLBW deliveries as a total percentage of LBW deliveries. This data comparison was presented at the November 2002 committee meeting and Sue expressed interest in conducting a focused review of the VLBW population, this idea was supported and quality indicators were identified. The plan at this time was to develop an auditing tool for presentation at the next quality committee meeting. This review would be conducted to evaluate trends in VLBW deliveries, in particular the site of delivery and determine intervention strategies, as determined appropriate.

Numerator **N/A** D0- LBW 2000 = 12% 2001 = 9.4% D0- VLBW 2000 = 13% OF LBW 2001 = 20% OF LBW	**Denominator** D0- LBW 2003 - 10.92% D0- VLBW 2003 - 13.67% of LBW D0 - 2003 HR Facility delivery of VLBW = 50%	**Baseline** **VLBW = 20% of LBW** **FYI 2001**VLBW 63% at HHS 10% at UAB = 73% at subspecialty care facility. FYI 2001VLBW 9% of the total program VLBW deliveries occurred outside of a high risk facility in D1 FYI 2003VLBW	**Benchmark:** Alabama Medicaid Agency = 15% of LBW population is VLBW. "VLBW neonates should be deliverer in a subspecialty care facility whenever possible." Perinatal Standards of Care Fifth Edition, Page 163	**Measurement Period:** April through June 2004. July-September 2004 October-December2004 Jan - Mar 2005 March 2005 – October 2005

Description of Population: Medicaid eligible women enrolled in the Program.	**Sample Size:** 100% of VLBW deliveries occurring outside of a recognized high-risk facility. (HHS or UAB)	**Sampling Methodology:** ☐ Medical Record reviews	**Data Collection Method** ☐ Administrative ☐ MRR ☐ Claims

			☐ Other, explain

Why is Activity Relevant? Medical Record Review of the VLBW deliveries occurring at non high-risk facility will determine if any trends exist. If trends are identifies these can be addressed, which could potentially contribute to an increase in the number of VLBW occurring at high-risk facilities. Increasing the number of VLBW deliveries occurring at subspecialty care facilities ensures optimal care delivery resulting in improving neonatal outcomes and decreased cost to the State of Alabama.	
Opportunities for Program / Activity Improvement See above (Why is Activity Relevant?)	**Barriers** 1. Timeliness of notification of VLBW deliveries. **2.** Access to medial records for out of network high risk services i.e. UAB.

Interventions (number each step)	**Timeline**	**Desired Outcome**
1. Develop a tool based on quality indicators presented at the November 2002 QI committee meeting for presentation at the next committee meeting.	1. QI meeting March 2003	1. Positive Committee feedback on the quality of the tool
2. Based on VLBW tool as proposed prior to the March QI meeting. Run statistics on the indicator data for 2001 VLBW deliveries.	2. QI meeting March 2003	2. That the data will help to identify trends, provide insight into what needs to be added to the review tool, contribute to the overall understanding of our VLBW population and stimulate interest in the project.
3. Present percentage of VLBW deliveries by hospital	3. QI meeting March 2003	3. That committee would have a baseline idea of the significance of the problem. Note: Committee members present at the March meeting were pleased that 73% of the VLBW deliveries had occurred at high-risk facilities.
4. Finalize the assessment tool based on feedback from the March 2003 QI committee meeting.	4. April – May 2003	4. Tool will be ready for identified VLBW deliveries beginning Quarter 2 2003
5. Review VLBW deliveries occurring outside of high-risk facilities using the tool as approved by the QI Committee.	5. Begin Quarter 2 2003 *(Variance reviews began quarter 3)* ** could not justify travel to review one record at each Site. Reviews are scheduled in conjunction with random and focused folic acid assessment reviews.	5. That potential VLBW deliveries are identified, that appropriate prenatal assessment is conducted, that plans are in place for delivery at a high-risk facility and that delivery occurs at a high-risk facility, when appropriate.
	6.Quarter 3 2003 (September 19th 2003) QI meeting	6. .Feedback on identified

6.Provide feedback on reviews to the QI committee		trends and recommended interventions. One VLBW delivery was reviewed for Quarter 1 2003 District 0. Time for transfer from hospital to high-risk facility noted. This was presented at the September meeting with the following recommendations:
7.Follow-up with hospital to assess level of care (OB and Neonatal), policies and procedures for: initial assessment and maternal and neonatal transfer .	7.Prior to next QI meeting Quarter 4 2003 **scheduled November 2003*	7. Care was provided according to recognized standards of care and in accordance with hospital policies and procedures based on the level of care provided at the hospital
8. Provide feedback on reviews to the QI committee for DHCP patients: 000 - delivered at ___ at 28 wks, baby transported to high risk hospital 5 days after delivery of IUGR 28 wk 2-6 baby, PROM. HX. PTD	8.Prior to next QI meeting Quarter 4 2003 November 14, 2004	8. Maternal transport occurs if appropriate
9. Establish a mechanism for review of records onsite to allow for more through examination of record. This will allow for review by Medical Director, as indicated.	9.Deadline: 01-2004	9. Provide a more comprehensive review that allows for MD oversight
10. Mail to office request for records for all VLBW deliveries that did not deliver at a high risk facility according to the Service Report data keyed into a database for statistical analysis...	10. Deadline: 02-2004	10. Complete medical record for evaluation by staff and Medical Director, as indicated
11. Review VLBW deliveries with the Medical Directors evaluation of those deliveries, which are questionable.	11.Deadline QI meeting 03-12-2004	11. Complete medical record for evaluation by staff and Medical Director, as indicated.
12. Run complete statistics for 2002 on this quality indicator and continue individualized reviews as the records are obtained from the offices	12.Deadline QI meeting 03-12-2004	12. To meet program goals for VLBW as percentage of LBW deliveries and determine areas of focused concentration.
13. Present a summary of the VLBW records reviewed at the QI committee meeting set for March 12, 2004	13. Deadline QI meeting 03-12-2004	13. To review 100% of the sample available through the program.
14. Request 2 outstanding records from 000 and 000.	14.Deadline 04-01-2004	14. To improve accurate recording of

		data on the Service Report to ensure appropriate sampling for VLBW deliveries occurring at non high-risk facilities.
15. Discuss with the Care Coordinators the significance of recording delivery site accurately	15. Deadline next Care Coordinator meeting - tentatively set for 05-14-2004	15. Awareness of the consequence of inaccurate recordings.
16. Develop a policy and procedure for medical record handling.	16. Deadline next QI Committee meeting 06-2004. Cancelled and rescheduled to 08-20-2004 per State approval.	16. Protection of PHI
17. Run statistics on VLBW deliveries by DHCP and site of delivery in addition to an overall statistical summary.	17. Next QI Committee meeting tentatively scheduled for 08-2004.	17. Assess for any statistical trends in delivery by DHCP for VLBW infants at non high-risk facilities
18. Determine QI Committee opinion on activity continuation.	18. QI meeting scheduled for 08-20-2004	18. Continue or discontinue activity.
19. Run statistics on VLBW deliveries by DCHP and site Of delivery. Continue to trend for 6 additional Months.	19. QI meeting December 3, 2004.	19. Assess trends. Continue to trend data. Report findings to QI Committee.
20. Run statistics on VLBW deliveries by DHCP and site Of delivery. Continue to trend for 3 months.	20. QI Committee Meeting March 11, 2005.	20. Continue to trend data for 3 months. Report findings to QI Committee. Request re-review of activity continuance.
21. Run statistics on VLBW deliveries by DHCP and site of delivery. Continue to trend for 3 months.	21. Present to QI Committee Meeting in October 2005 for recommendation	21. Continue to trend data for 3 months. Report findings to QI Committee. Request re-reviews of activity continuance.
22. Run statistics on VLBW deliveries by DHCP and site of delivery. Medicaid reported at Jam Session on 09/30/05 that this was now considered a known measure and should be reported, but not as a quality measure...	22. Present Medicaid's recommendation to QI Committee meeting in October 2005 and discuss closure of activity 003.	22. Continue to trend data awaiting final approval by QI Committee in October 2005 to discontinue activity.
23. Continue to run statistics of V LBW deliveries by DHCP and site of delivery. Taking the recommendations made by Medicaid, we will continue to gather	23. Re-evaluate trends at February 2006 QI Committee meeting and discuss closure of activity 003.	23. Continue to trend data awaiting approval by QI Committee in February 2006 to discontinue activity.

data but not for a quality measure. Dr. voiced concern over outliers and suggests that we continue to trend a while longer to also gather data, but not for a quality measure.		
24. Continue to run statistics by DHCP and site of delivery. Since Medicaid recommended this activity is a known measure, Medicaid and PC will continue to trend the data, but not for a quality measure. Recent trending analysis results revealed that from Jan. – Nov. 2005 revealed 23 VLBW babies born outside High Risk facilities. Of the 23, a rate of 26% belonging to DHCP 000.There were 2 sets of twins in which 1 baby fit the criteria and 1 did not, in both sets. The QI Committee voted to investigate the twins' records of DHCP 000 further before deciding whether to include them in the data gathered for final analysis.	24. Re-evaluate and present trends at May 2006 QI Committee meeting and discuss recommendations.	24 .Continue to trend and assess data. Report findings to QI Committee. Request review of activity continuance.
25. Seventeen prenatal and delivery records of VLBW were received for review. There were 2 records from District that were questionable as to whether the babies should have been transferred to a High Risk facility for delivery. We. Will continue to trend this activity but not for a quality measure. Presented the summaries at the May 2006 QI committee meeting.	25. Re-evaluate and present trends at August 2006 QI Committee meeting and discuss recommendations.	25. Continue to trend and assess data. Report findings to QI Committee. Request review of activity continuance.
26. Four prenatal / delivery records of patient's with VLBW were received for review from Districts. There was one VLBW delivery recorded from 000 in District. This record was reviewed by the QI Committee. There were no trends noted for confrontation with any DHCP's at this time. We will continue to trend this activity but not for a quality measure. Presented the summaries at the August 2006 QI committee meeting.	26. Re-evaluate and present trends at December 2006 QI Committee meeting and discuss recommendations.	26. Continue to trend and assess data. Report findings to QI Committee. Request review of activity continuance.
27. Four prenatal / delivery records of patient's with VLBW were received for review from District. Summaries of each patient were presented at the Dec. 2006 QI Meeting. The QI committee members reviewed the records. Although two of the VLBW records were from (000), OB/GYN and two were noted from (000) – Dr O., the QI members all agreed that the deliveries occurred abruptly and were monitored appropriately. The committee did not	27. Re-evaluate and present trends at March 2007 QI Committee meeting and discuss recommendations	27. Continue to trend and assess data. Report findings to QI Committee. Request review of activity continuance.

find anything inappropriate with the 4 VLBW deliveries. We will continue to trend this activity but not for a quality measure.		
28. Continue to run statistics by DHCP and site of delivery. Since Medicaid recommended this activity is a known measure, Medicaid and PC will continue to trend the data, but not for a quality measure. Recent trending analysis results revealed that from 09/06 – 10/06, 3 VLBW babies were born outside of high risk facilities in District. Summaries of each patient were reviewed at the March QI meeting by committee members. QI members agreed that all the deliveries were monitored appropriately. The committee did not find anything inappropriate with the 3 VLBW deliveries.	28. Re-evaluate and present trends at June 2007 QI Committee meeting and discuss recommendations.	28. Continue to trend and assess data. Report findings to QI Committee. Request review of activity continuance

Plan: Presented the summaries of the VLBW records received for review to the March 2007 QI Committee meeting. The committee voted to continue to trend this activity but not for a quality measure. Will continue to utilize the Medicaid database to run report on VLBW deliveries for each quarter. Continue to trend and gather data for those deliveries occurring outside high risk facilities. Present any trends at each QI Committee and Care Coordinator update meetings. Continue trending, analysis, and reporting indefinitely or until closure of	
Analysis Conducted by: Clinical Program Specialist	**Responsible Party:** Clinical Program Specialist

Purpose: To provide a summary of the affect of quality assurance activities undertaken in response to concerns identified by the Primary Contractor (PC). This form is to be completed for each activity undertaken prompted by the Medicaid's QI Program or the Primary Contractor's internal QA committee.

- In completing the Quality Improvement Activity Summary provide complete details of the activity undertaken.
- Noting the following:
- Was there improvement?
- Was the process by which improvement measured valid?
- Were data analyses appropriate?
- Were strong actions implemented?
- Were actions timely?
- Does this activity demonstrate meaningful improvement?
- Is there clarification as to why this activity has or has not demonstrated meaningful improvement?
- Is follow- up required? If so what is the Plan?

Maternity Care Program Intake Form

Recipient Name_____

Date of Birth_____

Address_____

County of Residence_____

Social Security Number_____

Medicaid Number_____

If no assistance is required with Medicaid application, provide to eligibility ____
DHCP selected_____

Notified DHCP & 1st appointment obtained_____

Risk Status assigned_____

District Plan Code	Procedure Code & Description	Recipient County Code and Description	Undup Recip	Undup Claims	Paid Amount
P01	59400 - Obstet. Care	17 - Colbert	222	222	$863,892.50
Colbert		29 - Fayette	1	1	$4,134.00
Franklin		30 - Franklin	119	119	$467,811.50
Lauderdale		39 - Lauderdale	325	326	$1,255,744.69
Marion		40 - Lawrence	2	2	$8,268.00
		42 - Limestone	2	2	$8,268.00
		45 - Madison	1	1	$4,750.00
		47 - Marion	119	119	$463,191.03
		49 - Mobile	1	1	$4,134.00
		63 - Tuscaloosa	1	1	$4,134.00
		64 - Walker	1	1	$4,134.00
		67 - Winston	3	3	$12,402.00
	59400 - Obstet. Care	**PC Total**	**797**	**798**	**$3,100,863.72**
	59410 - Obstet. Care	17 - Colbert	10	10	$22,239.00
		29 - Fayette	1	1	$3,307.20
		30 - Franklin	5	5	$5,238.00
		39 - Lauderdale	16	16	$29,637.20
		47 - Marion	5	5	$16,536.00
	59410 - Obstet. Care	**PC Total**	**37**	**37**	**$76,957.40**
	59510 - Cesarean Del.	17 - Colbert	122	122	$458,250.95
		29 - Fayette	1	1	$4,134.00
		30 - Franklin	77	77	$304,665.09
		37 - Jefferson	1	1	$4,134.00
		39 - Lauderdale	159	159	$632,751.76
		40 - Lawrence	2	2	$8,268.00
		47 - Marion	75	75	$278,085.83
		67 - Winston	1	1	$614.00
	59510 - Cesarean Del.	**PC Total**	**438**	**438**	**$1,690,903.63**
	59515 - Cesarean Del.	17 - Colbert	1	1	$3,307.20

		30 - Franklin	3	3	$7,219.60
		39 - Lauderdale	4	4	$10,444.80
		47 - Marion	2	2	$6,614.40
	59515 - Cesarean Del.	**PC Total**	**10**	**10**	**$27,586.00**
P01		**District Total**	**1,282**	**1,283**	**$4,896,310.75**

P02	59400 - Obstet. Care	01 - Autauga	1	1	$4,750.00
Jackson		05 - Blount	3	3	$14,250.00
Lawrence		09 - Chambers	1	1	$4,750.00
Limestone		17 - Colbert	1	1	$4,750.00
Madison		20 - Covington	1	1	$4,750.00
Marshall		22 - Cullman	4	4	$18,383.94
Morgan		25 - Dekalb	1	1	$733.00
		28 - Etowah	1	1	$4,750.00
		30 - Franklin	1	1	$4,750.00
		31 - Geneva	1	1	$1,134.30
		35 - Houston	2	2	$5,717.00
		36 - Jackson	210	210	$961,590.31
		37 - Jefferson	2	2	$9,677.00
		39 - Lauderdale	1	1	$4,750.00
		40 - Lawrence	127	127	$573,868.34
		41 - Lee	1	1	$4,750.00
		42 - Limestone	250	250	$1,121,845.54
		45 - Madison	1,037	1,038	$4,622,351.81
		48 - Marshall	414	414	$1,866,728.53
		52 - Morgan	402	402	$1,816,041.11
		66 - Wilcox	1	1	$4,750.00
	59400 - Obstet. Care	**PC Total**	**2,462**	**2,463**	**$11,055,070.88**
	59410 - Obstet. Care	22 - Cullman	1	1	$590.00
		25 - Dekalb	1	1	$3,800.00
		30 - Franklin	1	1	$3,800.00

		36 - Jackson	7	7	$19,514.00
		37 - Jefferson	2	2	$7,600.00
		40 - Lawrence	11	11	$35,672.00
		42 - Limestone	3	3	$7,902.00
		45 - Madison	41	41	$136,888.21
		48 - Marshall	7	7	$23,090.00
		52 - Morgan	21	21	$63,850.00
		63 - Tuscaloosa	1	1	$3,800.00
	59410 - Obstet. Care	**PC Total**	**96**	**96**	**$306,506.21**
	59510 - Cesarean Del.	02 - Baldwin	1	1	$4,750.00
		16 - Coffee	1	1	$4,750.00
		22 - Cullman	2	2	$9,500.00
		25 - Dekalb	2	2	$9,500.00
		28 - Etowah	3	3	$10,170.00
		30 - Franklin	2	2	$9,500.00
		35 - Houston	1	1	$4,750.00
		36 - Jackson	90	90	$419,405.27
		40 - Lawrence	72	72	$334,440.00
		41 - Lee	1	1	$4,750.00
		42 - Limestone	114	114	$510,269.44
		45 - Madison	499	500	$2,243,513.14
		48 - Marshall	178	178	$793,985.26
		52 - Morgan	228	228	$974,116.14
	59510 - Cesarean Del.	**PC Total**	**1,194**	**1,195**	**$5,333,399.25**
	59515 - Cesarean Del.	28 - Etowah	1	1	$3,800.00
		36 - Jackson	2	2	$604.49
		37 - Jefferson	1	1	$3,800.00
		39 - Lauderdale	1	1	$3,800.00
		40 - Lawrence	5	5	$13,208.00
		42 - Limestone	6	6	$19,398.00
		45 - Madison	15	15	$57,000.00
		52 - Morgan	9	9	$27,780.00
	59515 - Cesarean Del.	**PC Total**	**40**	**40**	**$129,390.49**

P02		**District Total**	**3,792**	**3,794**	**$16,824,366.83**

P03	59400 - Obstet. Care	02 - Baldwin	2	2	$8,042.00
Calhoun		08 - Calhoun	621	623	$2,358,030.16
Cherokee		09 - Chambers	1	1	$4,021.00
Cleburne		10 - Cherokee	89	89	$328,239.07
Dekalb		14 - Clay	3	3	$12,063.00
Etowah		15 - Cleburne	78	78	$292,983.60
		20 - Covington	1	1	$4,021.00
		25 - Dekalb	314	315	$1,087,716.81
		26 - Elmore	1	1	$4,021.00
		28 - Etowah	431	431	$1,665,725.92
		31 - Geneva	1	1	$4,021.00
		36 - Jackson	2	2	$4,247.00
		37 - Jefferson	2	2	$8,042.00
		45 - Madison	1	1	$4,021.00
		48 - Marshall	4	4	$16,813.00
		51 - Montgomery	2	2	$4,592.00
		52 - Morgan	1	1	$4,021.00
		56 - Randolph	2	2	$8,042.00
		58 - St.Clair	2	2	$4,592.00
		61 - Talladega	4	4	$16,084.00
		63 - Tuscaloosa	1	1	$4,021.00
	59400 - Obstet. Care	**PC Total**	**1,563**	**1,566**	**$5,843,359.56**
	59410 - Obstet. Care	08 - Calhoun	15	15	$29,935.00
		10 - Cherokee	2	2	$3,434.00
		25 - Dekalb	12	12	$26,019.00
		28 - Etowah	16	16	$40,055.00
	59410 - Obstet. Care	**PC Total**	**45**	**45**	**$99,443.00**
	59510 - Cesarean Del.	05 - Blount	1	1	$4,021.00
		08 - Calhoun	266	266	$949,856.04

		10 - Cherokee	42	42	$157,842.00
		11 - Chilton	1	1	$4,021.00
		15 - Cleburne	33	33	$121,803.00
		25 - Dekalb	100	100	$356,299.88
		28 - Etowah	190	190	$710,068.63
		36 - Jackson	1	1	$4,750.00
		37 - Jefferson	2	2	$8,042.00
		58 - St.Clair	2	2	$8,042.00
		59 - Shelby	1	1	$4,021.00
		61 - Talladega	1	1	$4,021.00
	59510 - Cesarean Del.	**PC Total**	**640**	**640**	**$2,332,787.55**
	59515 - Cesarean Del.	08 - Calhoun	3	3	$3,491.00
		10 - Cherokee	1	1	$3,217.00
		25 - Dekalb	1	1	$3,217.00
		28 - Etowah	2	2	$6,434.00
	59515 - Cesarean Del.	**PC Total**	**7**	**7**	**$16,359.00**
P03		**District Total**	**2,255**	**2,258**	**$8,291,949.11**

P04	59400 - Obstet. Care	04 - Bibb	97	97	$366,235.61
Bibb		11 - Chilton	1	1	$3,998.00
Fayette		12 - Choctaw	1	1	$3,998.00
Lamar		16 - Coffee	1	1	$4,235.00
Pickens		24 - Dallas	1	1	$3,998.00
Tuscaloosa		29 - Fayette	70	70	$261,238.00
		33 - Hale	3	3	$11,994.00
		37 - Jefferson	8	8	$31,984.00
		38 - Lamar	64	64	$248,812.00
		45 - Madison	1	1	$3,998.00
		47 - Marion	2	2	$6,332.41
		49 - Mobile	2	2	$9,840.00
		51 - Montgomery	1	1	$3,998.00
		53 - Perry	2	2	$6,596.00

		54 - Pickens	88	88	$338,970.00
		59 - Shelby	1	1	$3,998.00
		63 - Tuscaloosa	731	731	$2,755,166.42
		64 - Walker	1	1	$3,998.00
	59400 - Obstet. Care	**PC Total**	**1,075**	**1,075**	**$4,069,389.44**
	59410 - Obstet. Care	29 - Fayette	1	1	$3,198.00
		33 - Hale	1	1	$3,198.00
		38 - Lamar	2	2	$3,366.00
		54 - Pickens	3	3	$9,594.00
		63 - Tuscaloosa	15	15	$45,190.00
	59410 - Obstet. Care	**PC Total**	**22**	**22**	**$64,546.00**
	59510 - Cesarean Del.	04 - Bibb	49	49	$186,053.98
		11 - Chilton	1	1	$3,998.00
		12 - Choctaw	1	1	$3,998.00
		29 - Fayette	46	46	$180,578.00
		37 - Jefferson	2	2	$7,996.00
		38 - Lamar	46	46	$180,578.00
		47 - Marion	2	2	$7,996.00
		54 - Pickens	52	52	$196,266.00
		60 - Sumter	1	1	$3,998.00
		61 - Talladega	1	1	$429.00
		63 - Tuscaloosa	342	342	$1,283,230.83
		67 - Winston	1	1	$1,979.68
	59510 - Cesarean Del.	**PC Total**	**544**	**544**	**$2,057,101.49**
	59515 - Cesarean Del.	04 - Bibb	1	1	$3,198.00
		29 - Fayette	1	1	$3,198.00
		38 - Lamar	1	1	$3,198.00
		63 - Tuscaloosa	10	10	$29,677.00
	59515 - Cesarean Del.	**PC Total**	**13**	**13**	**$39,271.00**
P04		**District Total**	**1,654**	**1,654**	**$6,230,307.93**

P05	59400 - Obstet. Care	01 - Autauga	3	3	$14,781.00
Blount Chilton Cullman		02 - Baldwin	2	2	$9,247.00

Jefferson St. Clair Shelby Walker Winston					
Chilton		04 - Bibb	2	2	$9,854.00
Cullman		05 - Blount	187	187	$869,679.16
Jefferson		08 - Calhoun	3	3	$14,781.00
St. Clair		11 - Chilton	187	187	$904,356.53
Shelby		19 - Coosa	1	1	$4,927.00
Walker		20 - Covington	2	2	$9,854.00
Winston		22 - Cullman	313	313	$1,432,945.46
		24 - Dallas	1	1	$4,927.00
		28 - Etowah	3	3	$14,781.00
		29 - Fayette	1	1	$4,927.00
		30 - Franklin	1	1	$4,927.00
		35 - Houston	1	1	$1,236.00
		37 - Jefferson	2,690	2,694	$12,963,749.33
		40 - Lawrence	1	1	$4,927.00
		44 - Macon	1	1	$4,765.00
		45 - Madison	4	4	$11,978.71
		46 - Marengo	1	1	$4,927.00
		47 - Marion	1	1	$4,927.00
		48 - Marshall	1	1	$4,927.00
		49 - Mobile	2	2	$9,847.00
		51 - Montgomery	1	1	$3,887.00
		52 - Morgan	2	2	$9,854.00
		57 - Russell	1	1	$4,927.00
		58 - St.Clair	333	334	$1,585,553.28
		59 - Shelby	323	323	$1,549,283.50
		60 - Sumter	1	1	$4,927.00

		61 - Talladega	3	3	$14,781.00
		62 - Tallapoosa	1	1	$4,927.00
		63 - Tuscaloosa	2	2	$9,854.00
		64 - Walker	325	326	$1,551,091.53
		66 - Wilcox	1	1	$4,927.00
		67 - Winston	92	92	$422,300.82
	59400 - Obstet. Care	**PC Total**	**4,493**	**4,499**	**$21,477,584.32**
	59410 - Obstet. Care	02 - Baldwin	1	1	$3,942.00
		05 - Blount	5	5	$19,710.00
		11 - Chilton	4	4	$10,019.00
		22 - Cullman	7	7	$18,273.00
		29 - Fayette	1	1	$975.00
		37 - Jefferson	78	78	$258,619.00
		48 - Marshall	1	1	$3,942.00
		52 - Morgan	2	2	$4,390.00
		58 - St.Clair	9	9	$32,511.00
		59 - Shelby	12	12	$44,337.00
		64 - Walker	8	8	$31,536.00
		67 - Winston	4	4	$15,768.00
	59410 - Obstet. Care	**PC Total**	**132**	**132**	**$444,022.00**
	59510 - Cesarean Del.	05 - Blount	77	77	$352,507.00
		07 - Butler	1	1	$4,927.00
		10 - Cherokee	1	1	$4,021.00
		11 - Chilton	74	74	$350,925.00
		17 - Colbert	1	1	$4,134.00
		22 - Cullman	138	138	$610,557.93
		27 - Escambia	2	2	$9,854.00
		28 - Etowah	2	2	$6,415.00
		33 - Hale	1	1	$4,927.00
		37 - Jefferson	1,089	1,089	$5,162,448.01
		40 - Lawrence	1	1	$4,927.00
		45 - Madison	2	2	$9,677.00
		48 - Marshall	1	1	$4,927.00

		49 - Mobile	2	2	$9,847.00
		52 - Morgan	1	1	$4,927.00
		58 - St.Clair	162	162	$764,493.69
		59 - Shelby	127	128	$610,772.59
		60 - Sumter	1	1	$4,927.00
		61 - Talladega	1	1	$4,927.00
		64 - Walker	126	126	$595,310.86
		67 - Winston	58	58	$271,002.00
	59510 - Cesarean Del.	**PC Total**	**1,868**	**1,869**	**$8,796,454.08**
	59515 - Cesarean Del.	05 - Blount	3	3	$8,719.00
		11 - Chilton	3	3	$8,859.00
		22 - Cullman	1	1	$3,942.00
		37 - Jefferson	21	21	$72,036.54
		51 - Montgomery	1	1	$3,942.00
		58 - St.Clair	2	2	$7,884.00
		59 - Shelby	3	3	$5,648.03
		61 - Talladega	1	1	$3,942.00
		64 - Walker	3	3	$8,139.00
		67 - Winston	5	5	$19,710.00
	59515 - Cesarean Del.	**PC Total**	**43**	**43**	**$142,821.57**
P05		**District Total**	**6,536**	**6,543**	**$30,860,881.97**

P06	59400 - Obstet. Care	08 - Calhoun	2	2	$8,798.00
		09 - Chambers	1	1	$4,399.00
		11 - Chilton	2	2	$5,078.00
		14 - Clay	40	41	$156,804.27
		15 - Cleburne	1	1	$4,399.00
		16 - Coffee	1	1	$4,399.00
		19 - Coosa	35	35	$136,229.88
		37 - Jefferson	2	2	$9,326.00
		41 - Lee	2	2	$8,798.00
		49 - Mobile	2	2	$9,840.00
		51 - Montgomery	1	1	$4,399.00

		53 - Perry	1	1	$3,989.00
		55 - Pike	1	1	$899.00
		56 - Randolph	84	85	$359,077.87
		58 - St.Clair	4	4	$17,596.00
		59 - Shelby	1	1	$4,399.00
		61 - Talladega	412	412	$1,652,232.31
		62 - Tallapoosa	130	130	$521,564.23
	59400 - Obstet. Care	**PC Total**	**722**	**724**	**$2,912,227.56**
	59410 - Obstet. Care	19 - Coosa	1	1	$3,519.00
		37 - Jefferson	1	1	$3,519.00
		56 - Randolph	6	6	$17,914.00
		61 - Talladega	16	16	$56,304.00
		62 - Tallapoosa	2	2	$7,038.00
	59410 - Obstet. Care	**PC Total**	**26**	**26**	**$88,294.00**
	59510 - Cesarean Del.	08 - Calhoun	1	1	$4,399.00
		14 - Clay	36	36	$142,484.00
		19 - Coosa	29	29	$115,967.09
		26 - Elmore	1	1	$4,399.00
		36 - Jackson	1	1	$4,399.00
		37 - Jefferson	1	1	$4,399.00
		41 - Lee	1	1	$4,399.00
		56 - Randolph	55	55	$233,865.30
		61 - Talladega	195	195	$799,169.31
		62 - Tallapoosa	140	140	$585,200.00
	59510 - Cesarean Del.	**PC Total**	**460**	**460**	**$1,898,680.70**
	59515 - Cesarean Del.	19 - Coosa	2	2	$3,838.00
		37 - Jefferson	1	1	$3,519.00
		56 - Randolph	1	1	$319.00
		61 - Talladega	6	6	$17,914.00
		62 - Tallapoosa	2	2	$7,038.00
	59515 - Cesarean Del.	**PC Total**	**12**	**12**	**$32,628.00**
P06		**District Total**	**1,220**	**1,222**	**$4,931,830.26**

P07	59400 - Obstet. Care	32 - Greene	50	51	$187,064.50

		33 - Hale	81	81	$293,380.00
		46 - Marengo	2	2	$7,560.00
		53 - Perry	1	1	$3,780.00
	59400 - Obstet. Care	**PC Total**	**134**	**135**	**$491,784.50**
	59410 - Obstet. Care	33 - Hale	3	3	$9,075.00
		63 - Tuscaloosa	1	1	$3,025.00
	59410 - Obstet. Care	**PC Total**	**4**	**4**	**$12,100.00**
	59510 - Cesarean Del.	32 - Greene	25	25	$91,300.00
		33 - Hale	48	48	$178,458.00
		63 - Tuscaloosa	1	1	$3,998.00
	59510 - Cesarean Del.	**PC Total**	**74**	**74**	**$273,756.00**
	59515 - Cesarean Del.	33 - Hale	1	1	$3,025.00
	59515 - Cesarean Del.	**PC Total**	**1**	**1**	**$3,025.00**
P07		**District Total**	**213**	**214**	**$780,665.50**

P08	59400 - Obstet. Care	12 - Choctaw	73	73	$270,240.00
		37 - Jefferson	1	1	$3,780.00
		46 - Marengo	107	107	$373,640.16
		60 - Sumter	69	69	$260,820.00
		63 - Tuscaloosa	1	1	$3,998.00
	59400 - Obstet. Care	**PC Total**	**251**	**251**	**$912,478.16**
	59410 - Obstet. Care	12 - Choctaw	1	1	$3,025.00
		41 - Lee	1	1	$3,025.00
		60 - Sumter	2	2	$6,050.00
	59410 - Obstet. Care	**PC Total**	**4**	**4**	**$12,100.00**
	59510 - Cesarean Del.	12 - Choctaw	29	29	$108,370.00
		24 - Dallas	1	1	$3,780.00
		37 - Jefferson	1	1	$3,658.20
		45 - Madison	1	1	$4,750.00
		46 - Marengo	59	59	$211,220.00
		53 - Perry	1	1	$3,780.00
		60 - Sumter	39	39	$146,539.70
		63 - Tuscaloosa	1	1	$1,221.95
	59510 - Cesarean Del.	**PC Total**	**132**	**132**	**$483,319.85**
	59515 - Cesarean Del.	46 - Marengo	2	2	$6,050.00

		60 - Sumter	4	4	$12,100.00
	59515 - Cesarean Del.	**PC Total**	**6**	**6**	**$18,150.00**
P08		**District Total**	**393**	**393**	**$1,426,048.01**

P09	59400 - Obstet. Care	02 - Baldwin	2	2	$7,978.00
		11 - Chilton	1	1	$3,989.00
		13 - Clarke	2	2	$8,309.00
		24 - Dallas	323	323	$1,220,504.61
		33 - Hale	1	1	$3,989.00
		43 - Lowndes	1	1	$3,989.00
		49 - Mobile	1	1	$4,920.00
		51 - Montgomery	2	2	$7,978.00
		53 - Perry	64	64	$244,287.00
		59 - Shelby	1	1	$3,989.00
		66 - Wilcox	69	70	$262,930.00
	59400 - Obstet. Care	**PC Total**	**467**	**468**	**$1,772,862.61**
	59410 - Obstet. Care	01 - Autauga	1	1	$3,191.00
		24 - Dallas	29	29	$86,539.00
		53 - Perry	8	8	$19,628.00
		66 - Wilcox	10	10	$31,910.00
	59410 - Obstet. Care	**PC Total**	**48**	**48**	**$141,268.00**
	59510 - Cesarean Del.	01 - Autauga	1	1	$3,989.00
		02 - Baldwin	1	1	$3,989.00
		24 - Dallas	169	169	$649,596.94
		37 - Jefferson	1	1	$3,989.00
		53 - Perry	42	42	$153,638.00
		66 - Wilcox	38	38	$147,882.00
	59510 - Cesarean Del.	**PC Total**	**252**	**252**	**$963,083.94**
	59515 - Cesarean Del.	24 - Dallas	4	4	$12,764.00
		53 - Perry	1	1	$3,191.00
		66 - Wilcox	1	1	$3,191.00
	59515 - Cesarean Del.	**PC Total**	**6**	**6**	**$19,146.00**
P09		**District Total**	**773**	**774**	**$2,896,360.55**

P10	59400 - Obstet. Care	01 - Autauga	228	228	$846,232.60
		02 - Baldwin	1	1	$3,887.00
		03 - Barbour	1	1	$3,887.00
		06 - Bullock	71	72	$267,630.50
		07 - Butler	144	144	$511,658.00
		11 - Chilton	2	2	$7,774.00
		18 - Conecuh	1	1	$3,887.00
		20 - Covington	1	1	$3,887.00
		21 - Crenshaw	73	73	$267,806.50
		24 - Dallas	1	1	$3,887.00
		26 - Elmore	268	268	$980,451.01
		27 - Escambia	1	1	$3,887.00
		35 - Houston	3	3	$11,661.00
		37 - Jefferson	2	2	$7,774.00
		41 - Lee	2	2	$8,652.00
		43 - Lowndes	72	73	$266,451.00
		44 - Macon	2	2	$7,774.00
		45 - Madison	2	2	$8,637.00
		49 - Mobile	1	1	$3,887.00
		50 - Monroe	1	1	$4,320.00
		51 - Montgomery	1,317	1,319	$4,940,555.82
		55 - Pike	148	148	$537,080.44
		57 - Russell	2	2	$7,774.00
		60 - Sumter	1	1	$3,887.00
		61 - Talladega	2	2	$7,774.00
		62 - Tallapoosa	3	3	$11,661.00
		63 - Tuscaloosa	1	1	$3,887.00
	59400 - Obstet. Care	**PC Total**	**2,351**	**2,355**	**$8,736,649.87**
	59410 - Obstet. Care	01 - Autauga	7	7	$21,770.00
		06 - Bullock	3	3	$9,330.00
		07 - Butler	1	1	$3,110.00
		21 - Crenshaw	1	1	$3,110.00
		24 - Dallas	2	2	$6,301.00

		26 - Elmore	15	15	$46,650.00
		43 - Lowndes	2	2	$6,220.00
		44 - Macon	1	1	$3,110.00
		51 - Montgomery	41	42	$121,720.00
		55 - Pike	5	5	$15,550.00
	59410 - Obstet. Care	**PC Total**	**78**	**79**	**$236,871.00**
	59510 - Cesarean Del.	01 - Autauga	74	74	$273,838.00
		02 - Baldwin	1	1	$3,887.00
		06 - Bullock	35	35	$126,905.84
		07 - Butler	53	53	$194,051.60
		16 - Coffee	1	1	$3,887.00
		21 - Crenshaw	29	29	$109,223.00
		24 - Dallas	1	1	$437.00
		26 - Elmore	117	117	$429,506.51
		27 - Escambia	1	1	$4,320.00
		35 - Houston	1	1	$3,887.00
		37 - Jefferson	1	1	$437.00
		43 - Lowndes	37	37	$140,369.00
		44 - Macon	1	1	$3,887.00
		46 - Marengo	1	1	$3,887.00
		49 - Mobile	1	1	$4,920.00
		51 - Montgomery	490	490	$1,751,698.42
		55 - Pike	81	81	$291,677.00
		59 - Shelby	1	1	$3,887.00
		62 - Tallapoosa	1	1	$3,887.00
		63 - Tuscaloosa	1	1	$3,998.00
		66 - Wilcox	1	1	$3,887.00
	59510 - Cesarean Del.	**PC Total**	**929**	**929**	**$3,362,477.37**
	59515 - Cesarean Del.	01 - Autauga	1	1	$3,110.00
		06 - Bullock	1	1	$3,110.00
		07 - Butler	1	1	$60.00
		13 - Clarke	1	1	$3,456.00
		26 - Elmore	5	5	$12,500.00

		43 - Lowndes	1	1	$3,110.00
		51 - Montgomery	18	18	$52,930.00
		55 - Pike	1	1	$3,110.00
	59515 - Cesarean Del.	**PC Total**	**29**	**29**	**$81,386.00**
P10		**District Total**	**3,387**	**3,392**	**$12,417,384.24**

P11	59400 - Obstet. Care	02 - Baldwin	1	1	$4,320.00
		03 - Barbour	99	99	$461,475.00
		09 - Chambers	163	163	$713,580.00
		26 - Elmore	1	1	$4,765.00
		41 - Lee	478	480	$2,174,884.00
		44 - Macon	104	105	$484,683.27
		50 - Monroe	1	1	$4,320.00
		51 - Montgomery	3	3	$14,295.00
		55 - Pike	1	1	$2,111.00
		56 - Randolph	2	2	$9,530.00
		57 - Russell	287	288	$1,347,978.00
		62 - Tallapoosa	2	2	$9,530.00
		63 - Tuscaloosa	1	1	$4,765.00
	59400 - Obstet. Care	**PC Total**	**1,143**	**1,147**	**$5,236,236.27**
	59410 - Obstet. Care	03 - Barbour	3	3	$11,436.00
		06 - Bullock	1	1	$3,812.00
		09 - Chambers	9	9	$30,833.00
		41 - Lee	11	11	$32,303.00
		44 - Macon	5	5	$18,053.00
		57 - Russell	16	16	$60,992.00
		62 - Tallapoosa	1	1	$3,812.00
	59410 - Obstet. Care	**PC Total**	**46**	**46**	**$161,241.00**
	59510 - Cesarean Del.	03 - Barbour	66	66	$314,490.00
		09 - Chambers	81	81	$363,017.00
		41 - Lee	182	182	$807,059.00
		44 - Macon	39	39	$181,258.00
		51 - Montgomery	1	1	$4,765.00

		57 - Russell	104	104	$488,752.00
		61 - Talladega	1	1	$4,765.00
		62 - Tallapoosa	3	3	$14,295.00
	59510 - Cesarean Del.	**PC Total**	**477**	**477**	**$2,178,401.00**
	59515 - Cesarean Del.	03 - Barbour	4	4	$15,248.00
		09 - Chambers	4	4	$15,248.00
		41 - Lee	7	7	$23,540.00
		57 - Russell	2	2	$7,624.00
	59515 - Cesarean Del.	**PC Total**	**17**	**17**	**$61,660.00**
P11		**District Total**	**1,683**	**1,687**	**$7,637,538.27**

P12	59400 - Obstet. Care	01 - Autauga	1	1	$4,320.00
		02 - Baldwin	671	672	$2,754,529.46
		07 - Butler	2	2	$8,640.00
		13 - Clarke	90	90	$372,723.00
		16 - Coffee	2	2	$8,555.00
		18 - Conecuh	58	59	$216,936.00
		20 - Covington	165	166	$685,989.96
		21 - Crenshaw	2	2	$8,640.00
		27 - Escambia	177	178	$735,584.04
		28 - Etowah	1	1	$4,320.00
		29 - Fayette	1	1	$4,320.00
		31 - Geneva	1	1	$4,320.00
		37 - Jefferson	3	3	$13,567.00
		45 - Madison	1	1	$4,320.00
		48 - Marshall	1	1	$4,320.00
		49 - Mobile	7	7	$29,071.34
		50 - Monroe	103	103	$401,028.00
		51 - Montgomery	2	2	$5,582.43
		55 - Pike	1	1	$4,320.00
		59 - Shelby	1	1	$4,320.00
		65 - Washington	43	43	$174,386.32
	59400 - Obstet. Care	**PC Total**	**1,333**	**1,337**	**$5,449,792.55**

	59410 - Obstet. Care	02 - Baldwin	13	13	$41,937.00
		13 - Clarke	3	3	$7,013.00
		18 - Conecuh	2	2	$6,912.00
		20 - Covington	3	3	$10,368.00
		27 - Escambia	2	2	$6,912.00
		50 - Monroe	3	3	$10,368.00
		65 - Washington	1	1	$3,456.00
	59410 - Obstet. Care	**PC Total**	**27**	**27**	**$86,966.00**
	59510 - Cesarean Del.	02 - Baldwin	265	265	$1,069,484.51
		08 - Calhoun	1	1	$4,320.00
		13 - Clarke	87	87	$355,053.21
		18 - Conecuh	49	49	$188,392.00
		20 - Covington	114	114	$436,239.14
		21 - Crenshaw	1	1	$4,320.00
		27 - Escambia	163	164	$667,947.03
		45 - Madison	1	1	$4,320.00
		49 - Mobile	1	1	$4,320.00
		50 - Monroe	85	85	$317,869.10
		65 - Washington	39	39	$160,750.00
		67 - Winston	1	1	$4,320.00
	59510 - Cesarean Del.	**PC Total**	**807**	**808**	**$3,217,334.99**
	59515 - Cesarean Del.	02 - Baldwin	5	5	$14,289.00
		13 - Clarke	1	1	$3,456.00
		20 - Covington	1	1	$365.80
		49 - Mobile	1	1	$3,456.00
		50 - Monroe	2	2	$6,912.00
		63 - Tuscaloosa	1	1	$3,456.00
		65 - Washington	2	2	$6,912.00
	59515 - Cesarean Del.	**PC Total**	**13**	**13**	**$38,846.80**
P12		**District Total**	**2,180**	**2,185**	**$8,792,940.34**

P13	59400 - Obstet. Care	03 - Barbour	2	2	$8,077.91
		16 - Coffee	172	172	$676,878.48
		20 - Covington	3	3	$12,705.00

		23 - Dale	210	210	$842,061.49
		30 - Franklin	1	1	$4,235.00
		31 - Geneva	149	149	$570,366.04
		34 - Henry	47	47	$195,777.00
		35 - Houston	470	470	$1,917,086.35
		37 - Jefferson	1	1	$4,235.00
		51 - Montgomery	1	1	$4,235.00
		58 - St.Clair	1	1	$4,235.00
		63 - Tuscaloosa	1	1	$3,998.00
	59400 - Obstet. Care	**PC Total**	**1,058**	**1,058**	**$4,243,890.27**
	59410 - Obstet. Care	16 - Coffee	3	3	$10,164.00
		23 - Dale	3	3	$10,164.00
		31 - Geneva	1	1	$3,388.00
		35 - Houston	21	21	$71,148.00
	59410 - Obstetrical Care	**PC Total**	**28**	**28**	**$94,864.00**
	59510 - Cesarean Del.	16 - Coffee	86	86	$340,674.61
		20 - Covington	1	1	$4,235.00
		23 - Dale	101	101	$406,111.02
		31 - Geneva	58	58	$226,620.92
		34 - Henry	26	26	$110,110.00
		35 - Houston	279	280	$1,138,049.10
		37 - Jefferson	2	2	$8,470.00
		55 - Pike	2	2	$2,253.72
	59510 - Cesarean Del.	**PC Total**	**555**	**556**	**$2,236,524.37**
	59515 - Cesarean Del.	16 - Coffee	1	1	$3,388.00
		23 - Dale	2	2	$6,776.00
		31 - Geneva	1	1	$345.46
		35 - Houston	6	6	$14,866.08
	59515 - Cesarean Del.	**PC Total**	**10**	**10**	**$25,375.54**
P13		**District Total**	**1,651**	**1,652**	**$6,600,654.18**

P14	59400 - Obstet. Care	02 - Baldwin	2	2	$9,240.00
		04 - Bibb	1	1	$4,920.00
		35 - Houston	1	1	$4,235.00

		37 - Jefferson	2	2	$9,840.00
		45 - Madison	1	1	$4,920.00
		49 - Mobile	2,401	2,405	$11,478,696.14
		51 - Montgomery	1	1	$4,920.00
		59 - Shelby	1	1	$4,927.00
	59400 - Obstet. Care	**PC Total**	**2,410**	**2,414**	**$11,521,698.14**
	59410 - Obstet. Care	13 - Clarke	1	1	$3,936.00
		49 - Mobile	43	44	$163,175.61
	59410 - Obstet. Care	**PC Total**	**44**	**45**	**$167,111.61**
	59510 - Cesarean Del.	02 - Baldwin	5	5	$19,775.00
		28 - Etowah	1	1	$4,021.00
		37 - Jefferson	1	1	$4,927.00
		49 - Mobile	1,079	1,080	$5,085,659.35
		52 - Morgan	1	1	$4,920.00
		65 - Washington	3	3	$14,760.00
	59510 - Cesarean Del.	**PC Total**	**1,090**	**1,091**	**$5,134,062.35**
	59515 - Cesarean Del.	02 - Baldwin	1	1	$3,936.00
		49 - Mobile	13	13	$51,168.00
		51 - Montgomery	1	1	$3,936.00
	59515 - Cesarean Del.	**PC Total**	**15**	**15**	**$59,040.00**
P14		**District Total**	**3,559**	**3,565**	**$16,881,912.10**

		Grand Total	**Undup 30,555**	**30,616**	**$129,469,150.04**

Amendment One To
ITB 10-X-2212639
Maternity Care Program

I hereby certify that I have received and read this Amendment. I understand that the changes contained herein are legally binding.

Name | District

Bidder Name | Date

Amendment One
ITB 10-X-2212639
Maternity Care Program

The above referenced Invitation to Bid (ITB), is amended as outlined below: Changes to text are characterized by quotation marks. **This Amendment must be signed and returned with the bid response.**

ITB Document

1. Page 26, Section 2.5 Healthcare Professional Panel, b., which states:

   Primary Contractor must offer participation opportunities for 30 days after contract award and for the first month of each succeeding contract year to all interested potential subcontractors within district boundaries. Subcontractors must be willing to abide by all program requirements and accept offered reimbursement for services provided. For purposes of offering and awarding subcontracts, Primary Contractor must offer the reimbursement level consistent with other like subcontractors.

   is amended to state:

   Primary Contractor must offer participation opportunities for "30 days prior to the contract start date" and for the first month of each succeeding contract year to all interested potential subcontractors within district boundaries. Subcontractors must be willing to abide by all program requirements and accept offered reimbursement for services provided. For purposes of offering and awarding subcontracts, Primary Contractor must offer the reimbursement level consistent with other like subcontractors.

2. Page 31, Section 2.6 Medical Care System, Excluded Services, q., which states:

   q. High-Risk consults (Procedure Codes 99241– 99245)

   is deleted

3. Page 33, Section 2.7 Payment for Services, under Reimbursement for Services, third paragraph which states:

For recipients who receive no prenatal care through the Primary Contractor's network, a delivery-only fee must be billed. The components of the delivery-only fee include those services provided from the time of delivery through the postpartum period..

is amended to state:

For recipients who receive no prenatal care through the Primary Contractor's network, a delivery-only fee must be billed. " The components of the delivery-only fee include those services provided from the time of the delivery through the postpartum period, including a hospital face to face encounter by the Care Coordinator."

Operational Manual (Attachment I)

1. Page 30, Section V. Services, C. Excluded Services – Covered Fee-For-Service, 2. Drugs, the last sentence which states:

Drugs which are administered in an in-patient setting or ambulatory surgical center setting are included in the global fee.

is deleted.

2. Page 43, Section VII. Home Visits, A. Purpose, first paragraph which states:

Home visits are optional, unless the required visit in the hospital is missed. **If the hospital face to face encounter visit is missed, a home visit must be made.** It is the opinion of the Alabama Medicaid Agency that home visits improve outcomes. Improved outcomes increase eligibility of the Primary Contractor for bonus payments. The Primary Contractor may develop criteria within their respective district for the purpose of home visits. The home visit criteria must be submitted for review by the Medicaid Agency with the ITB response.

is amended to state:

Home visits are optional, unless the required visit in the hospital is missed. "**If the hospital face to face encounter visit is missed, a home visit must be made within twenty days of the delivery date."** It is the opinion of the Alabama Medicaid Agency that home visits improve outcomes. Improved outcomes increase eligibility of the Primary Contractor for bonus payments. The Primary Contractor may develop criteria within their respective

district for the purpose of home visits. The home visit criteria must be submitted for review by the Medicaid Agency with the ITB response.

3. Page 53, Section IX. Quality Assurance and Performance Improvement, C. Service Database, 1. Description and Purpose, number 1 which states:

1. The database is designed so that Primary Contractor can enter data upon patient enrollment continuing through the postpartum period. All data entry on a patient must be completed within 60 days of the delivery date.

is amended to state:

1. The database is designed so that Primary Contractor can enter data upon patient enrollment continuing through the postpartum period. "All data entry on a patient must be completed within 90 days of the delivery date."

4. Page 55, D. Delivering Healthcare Professional Report Cards, Paragraph 4. Delivering Health Care Professionals Sampling Methodology which states:

4. Delivering Health Care Professionals Sampling Methodology

A listing of all deliveries by Delivering Health Care Professionals for which a global fee was billed must first be compiled. Next, the listings of deliveries for each Delivering Health Care Professionals are separately alphabetized (ordered) to be used in the selection of a representative sample for medical record reviews. Samples will be drawn using the following chart indicating the sequence of record selection (every ninth name). The resulting sample from deliveries will be used by the Primary Contractor for reporting the above measures. The Primary Contractor must maintain documentation of records identified as part of the sample pulled. Medicaid's QI division will use the same sampling methodology for their reviews.

Sample Size	**Number Of Charts**	**Sequence of Records Pulled for Sample**
> 200	65	Pull first ordered record, skip the next 2 records
191 - 200	67	Pull first ordered record, skip the next 2 records

181 - 190	66	Pull first ordered record, skip the next 2 records
171 - 180	65	Pull first ordered record, skip the next 2 records
161 - 170	63	Pull first two ordered records, skip the next 3 records
151 - 160	62	Pull first two ordered records, skip the next 3 records
141 - 150	60	Pull first two ordered records, skip the next 3 records
131 - 140	59	Pull first two ordered records, skip the next 3 records
121 - 130	57	Pull first two ordered records, skip the next 3 records
111 - 120	55	Pull first ordered record, skip the next 1 record
101 - 110	53	Pull first ordered record, skip the next 1 record
91 - 100	51	Pull first ordered record, skip the next 1 record
81 - 90	48	Pull first two ordered records, skip the next 1 records
71 - 80	45	Pull first two ordered records, skip the next 1 records
61 - 70	42	Pull first two ordered records, skip the next 1 records
51 - 60	38	Pull first three ordered records, skip the next 1 records
41 - 50	34	Pull first four ordered records, skip the next 1 records
31 - 40	29	Pull first six ordered records, skip the next record
21 - 30	23	Pull all records
11 - 20	17	Pull all records
1 - 10	10	Pull all records

is amended to delete this chart and the narrative is amended to state:

4. Delivering Health Care Professionals Sampling Methodology

"The Primary Contractor must perform a minimum of a 5% random sampling of each DHCP every 6 months for measurement of the required elements and the development of professional report cards."

5. Page 57, IX. Quality Assurance and Performance Improvement, E. Primary Contractor Profile Measures, 1. Source of Date, a. Web Elements, 4. which states:

4. Percentage of women who complete a family planning/post partum visit between days 21-60.

is amended to state:

4. Percentage of women who complete a family planning/post partum visit "prior to the 60th post partum day."

6. Page 63, IX. Quality Assurance and Performance Improvement, L. Performance Incentive Measures, d. which states:

d. Medical record documentation must support that 85% of all delivering women served by the district complete a family planning visit between postpartum day 21 and 60. This information will be monitored through Agency web data base and through medical record reviews performed by Agency staff. The Primary Contractor will qualify for 1% of the possible 5% bonus incentive if this measure is found to be supported per review by Agency Staff.

is amended to state:

d. Medical record documentation must support that 85% of all delivering women served by the district complete a family planning visit " by the 60th postpartum day." This information will be monitored through Agency web data base and through medical record reviews performed by Agency staff. The Primary Contractor will qualify for 1% of the possible 5% bonus incentive if this measure is found to be supported per review by Agency Staff.

7. Page 64, IX. Quality Assurance and Performance Improvement, L. Performance Incentive Measures, the example provided at the end of page 64 which states:

Example: if the total annual fees paid to the Primary Contractor are $500,000.00, then the Primary Contractor will be eligible for a 5% incentive of $50,000.00 annually.

is amended to state:

Example: if the total annual fees paid to the Primary Contractor are $500,000.00, then the Primary Contractor will be eligible for a 5% incentive of "$25,000.00 annually."

8. Page 70/71, XI. Medicaid Oversight, B. Administrative Reviews, 3. Standards, which states:

> If after the Administrative review, the Primary Contractor is found to not be meeting the requirements, then the following penalties will be imposed. As indicated, corrective action will be allowed for some program elements with imposition of penalties as a final act.

Measure	**Penalty**
Subcontractor Not Enrolled with Medicaid	1st occurrence: Corrective Action, 2nd occurrence: $500 fine per provider not enrolled
Valid Subcontracts	1st occurrence: Corrective Action, 2nd occurrence: $500 fine per subcontract not meeting requirements
DHCP have hospital privileges	1st occurrence: Corrective Action 2nd occurrence: $500 fine per DHCP not having hospital privileges
Claim payment within timeframes	95% of claims paid within timeframes, $100 per incident for payments not meeting timeframes
Staff knowledge of billing/reimbursement policies	1st occurrence:, Staff re-training 2nd occurrence: $100 fine per incident thereafter.
Training (Subcontractor and Care Coordinator) as required	$500 training session not completed
Application Assister services	$500 per week that there is no Application Assister in all counties; Primary Contractor must submit a list of counties and names of assigned Application Assisters monthly
Delivering Health Care Professional Choice Requirements	1st occurrence: Corrective Action 2nd occurrence: $500 per choice

	requirements not being met

is amended to state:

If after the Administrative review, the Primary Contractor is found to not be meeting the requirements, then the following penalties will be imposed. As indicated, corrective action will be allowed for some program elements with imposition of penalties as a final act.

Measure	**Penalty**
Subcontractor Not Enrolled with Medicaid	1st occurrence: Corrective Action, 2nd occurrence: $500 fine per provider not enrolled
Valid Subcontracts	1st occurrence: Corrective Action, 2nd occurrence: $500 fine per subcontract not meeting requirements
DHCP have hospital privileges	1st occurrence: Corrective Action 2nd occurrence: $500 fine per DHCP not having hospital privileges
Claim payment within timeframes	95% of claims paid within timeframes, $100 per incident for payments not meeting timeframes
Staff knowledge of billing/reimbursement policies	1st occurrence:, Staff re-training 2nd occurrence: $100 fine per incident thereafter.
Training (Subcontractor and Care Coordinator) as required	$500 training session not completed
Application Assister services	**"**$500 per week in which there is no access to an Application Assister for all counties in the district; Primary Contractor must submit a list of

	counties and names of assigned Application Assisters monthly **“’**
Delivering Health Care Professional Choice Requirements	1st occurrence: Corrective Action 2nd occurrence: $500 per choice requirements not being met

9. Attachment 3, Global Associated Codes, Operational Manual, which currently states:

The following services are considered associated codes and are included in the global fee.

is amended as follows:

“Procedure codes:
59025 Fetal non-stress test
59120 Surgical treatment of ectopic pregnancy
59130 Excision abdominal pregnancy

are deleted from the global associated code list.”

Amendment Two To
ITB 10-X-2212639
Maternity Care Program

I hereby certify that I have received and read this Amendment. I understand that the changes contained herein are legally binding.

Name	District
Bidder Name	Date

Amendment Two
ITB 10-X-2212639
Maternity Care Program

The above referenced Invitation to Bid (ITB), is amended as outlined below: Changes to text are characterized by quotation marks. **This Amendment must be signed and returned with the bid response.**

ITB Document

1. Page 23/24, Section 2.4, Maternity Care Program Administration, Standards for Primary Contractors, is being amended by adding a new Section r. to state as follows:

> "r. Primary Contractor must comply with the provisions of the American Recovery and Reinvestment Act of 2009, Section 5006, regarding the protections for Indians receiving Medicaid benefits. "

2. Page 25, Section 2.4., Maternity Care Program Administration, Functions /Responsibilities of Primary Contractors, Section p. which states:

> p. Maintain for each recipient a complete record at one location of all services provided. The Primary Contractor shall obtain such information from all providers of services and identify by recipient name, recipient number, date of service, and services provided prior to making payment to that provider of service.

is amended to state:

> p. Maintain for each recipient a complete record at one location of all services provided. The Primary Contractor shall obtain such information from all providers of services and identify by recipient name, recipient number, date of service, and services provided prior to making payment to that provider of service.
> "Primary Contractor must comply with the applicable provisions of the utilization control requirements of 42 C.F.R. 456, Subpart C. "

3. Page 24, Section 2.4., Maternity Care Program Administration, Functions /Responsibilities of Primary Contractors, Section g. which states:

> g. Maintain a toll-free line and designated staff to enroll recipients and provide program information.

is amended to state:

g. Maintain a toll-free line and maintain adequate staff to enroll recipients and provide program information. "If the Primary Contractor, all subcontractors and recipients are within the local calling distance area a toll –free line is not necessary."

4. Page 33, Section 2.7 Payment for Services, Subcontractor Reimbursement System, Section b. which states:

b. In all cases payments to subcontractors must be within 60 calendar days of the date of delivery.

is amended to state:

b. In all cases "except where third party insurance billing is required by the DHCP," payments to subcontractors must be made within 60 calendar days of the date of delivery.

5. Page 37, Section 2.9 Medicaid Oversight, b. Medical Record Reviews, (2) Sample Size/Process, the first sentence which states:

Reviews will be conducted on an annual basis.

is amended to state:

"Reviews will be conducted on a semi-annual basis."

Operational Manual (Attachment I)

1. Page 54, Section IX. Quality Assurance and Performance Improvement, D. Delivering Healthcare Professional Report Cards, 2. Definition of Date Elements which states:

2. Definition of Data Elements

Primary Contractor must use the following definitions when applying the measures. This will ensure that all Delivering Health Care Professionals are being measured consistently and that all Primary Contractors are reporting the measures consistently.

a. Blood Group Determination – documentation of the test(s) being ordered.
b. Rhogam Injection – notation in the prenatal chart that Rhogam (or equivalent) was given to medically eligible women between 26-32 weeks gestation. NOTE: This measure can only be applied to those women who entered care by 32 weeks gestation and have not been sensitized by a prior pregnancy.
c. Glucose Tolerance Testing or other Diabetic Screening – notation in the prenatal chart of one of the following tests: glucose tolerance test; 1 hour glucose screen; two

hour random blood sugar after a meal or a fasting blood sugar. Testing is not necessary for patients with pre-existing diabetes.

d. Cytology Smear – notation in the prenatal record of a cervical screening done 12 months prior to the onset of care OR notation of a screening being accomplished by the second prenatal visit.
e. Asymptomatic Bacteriuria Screening – notation of the results in the prenatal record.
f. Low Birth Weight – self-explanatory.
g. Very Low Birth Weight – self-explanatory.
h. Delivered less than 37 weeks – self-explanatory.
i. HIV Screening – notation in the prenatal record of the results. Must be measured against the number of women who declined testing.

is amended to state:

"a. Prenatal Visit Elements- DHCP records must contain at a minimum the following: blood pressure, weight, urine protein, uterine size, fetal heart tones and estimated date of delivery at each visit."
b. Blood Group Determination – documentation of the test(s) being ordered.
c. Rhogam Injection – notation in the prenatal chart that Rhogam (or equivalent) was given to medically eligible women between 26-32 weeks gestation. NOTE: This measure can only be applied to those women who entered care by 32 weeks gestation and have not been sensitized by a prior pregnancy.
d. Glucose Tolerance Testing or other Diabetic Screening – notation in the prenatal chart of one of the following tests: glucose tolerance test; 1 hour glucose screen; two hour random blood sugar after a meal or a fasting blood sugar. Testing is not necessary for patients with pre-existing diabetes.
e. Cytology Smear – notation in the prenatal record of a cervical screening done 12 months prior to the onset of care OR notation of a screening being accomplished by the second prenatal visit.
f. Asymptomatic Bacteriuria Screening – notation of the results in the prenatal record.
g. Low Birth Weight – self-explanatory.
h. Very Low Birth Weight – self-explanatory.
i. Delivered less than 37 weeks – self-explanatory.
j. HIV Screening – notation in the prenatal record of the results. Must be measured against the number of women who declined testing.

2. Page 62, Section IX. Quality Assurance and Performance Improvement, J. Delegation of Quality Assurance Performance Improvement Activities, Section 1. which states:

1. There must be written description of: the delegated activities; the delegate's accountability for these activities; and the frequency of reporting to the managed care organization.

is amended to state:

1. There must be written description of: the delegated activities; the delegate's accountability for these activities; and the frequency of reporting to the "primary contractor."

3. Attachment Three of the Operational Manual, Global Associated Codes which currently states:

The following codes are considered associated codes and are included in the global fee.

is amended as follows:

"Procedure Codes:
59870 Removal of hydatidiform mole
59100 Hysterotomy for hydatidiform mole (abdominal)

are deleted from the global associated code list."