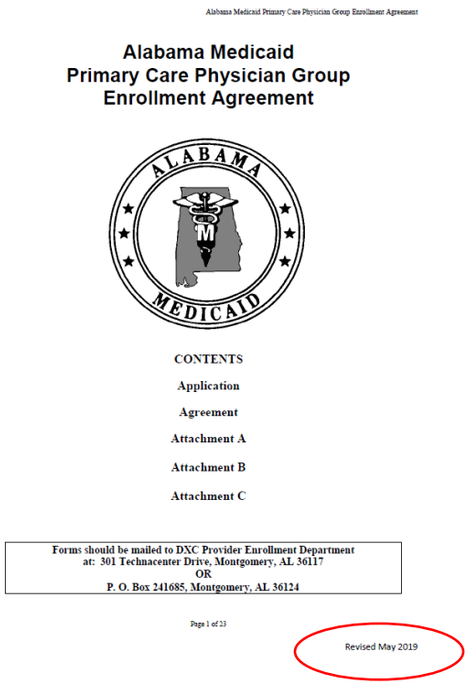
ALABAMA MEDICAID PRIMARY CARE PHYSICIAN GROUP APPLICATION CHECKLIST

☐ **Ensure that you are using the most current application that is listed on the Medicaid Agency's website. ALL pages must be from the current application on the website. There will be a revised date at the bottom right hand corner of the application (as shown below).**



Alabama Medicaid Primary Care Physician Group Enrollment Agreement

Alabama Medicaid
Primary Care Physician Group
Enrollment Agreement

CONTENTS

Application

Agreement

Attachment A

Attachment B

Attachment C

Forms should be mailed to DXC Provider Enrollment Department
at: 301 Technacenter Drive, Montgomery, AL 36117
OR
P. O. Box 241685, Montgomery, AL 36124

Page 1 of 23

Revised May 2019

(PAGE 2)

☐ **Ensure that you have selected "YES"** for **intent to participate in the Alabama Coordinated Health Network (ACHN) Program**. You must list at least one ACHN Entity on the line (i.e. *My Care Alabama Northwest, North Alabama Community Care, Alabama Care Network-Midstate, My Care Alabama Central, My Care Alabama East, Alabama Care Network Southeast, or Gulf Coast Total Care).*

☐ **Ensure that you have answered question, "Has this practice or anyone associated with this practice been terminated or sanctioned by Medicare or Medicaid?"**

☐ **Ensure that you have answered question, "Are you associated with an academic teaching facility?"**

☐ **Ensure that you have selected the appropriate SPECIALTY type for your GROUP:** You will need to select the specialty that your group is **currently** enrolled as with Alabama Medicaid. Please contact Provider Enrollment if assistance is needed with determining your specialty type or if your specialty type is not listed.

☐ **Ensure that you have indicated your GROUP/CLINIC NAME**: You will need to indicate the same name that your group is **currently** enrolled as with Alabama Medicaid.

☐ **Ensure that you have indicated your MEDICAID GROUP ID**: Your Medicaid Group ID is different from your NPI number and is unique for Alabama Medicaid Providers. The Medicaid Group ID can be found on your Alabama Medicaid Financial Remittance Advice (RA) or your Alabama Medicaid Welcome Letter. If further assistance is needed with determining your Medicaid Group ID, please contact Provider Enrollment at 1-888-223-3630.

☐ Ensure that you have indicated your **GROUP NPI**: Your NPI is different from your Medicaid Group ID. Your Group NPI is issued by CMS.

☐ Ensure that you have indicated your **GROUP TAX ID**: Your Group TAX ID is issued by the IRS.

☐ **Ensure that you have indicated your PHYSICAL ADDRESS** (PRIMARY LOCATION): You will need to indicate the same physical address that your group is **currently** enrolled as with Alabama Medicaid.

☐ Ensure that you have indicated your **MAILING ADDRESS:** This address will be used for all mail correspondence for the group. If this area is not complete, we will use the physical address listed for the mailing address.

NOTE: *The mailing address indicated above will be applied to the file of the provider for which this application is completed.*

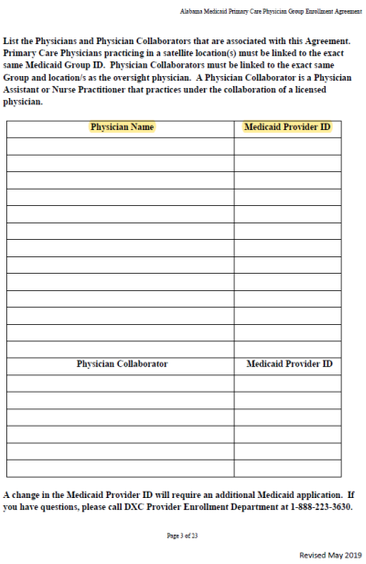
☐ **Ensure that you have indicated your CREDENTIALING CONTACT NAME/TELEPHONE NUMBER/EMAIL ADDRESS:** This will be the person that will be contacted if there are issues with enrollment.

ALABAMA MEDICAID PRIMARY CARE PHYSICIAN GROUP APPLICATION CHECKLIST

(PAGE 3)

☐ **Ensure that you have indicated ALL Primary Care Physician's that intend to participate with the ACHN and are enrolled under your group.**
Note: *The provider must be currently enrolled* ***AND*** *active with Alabama Medicaid. Pending enrollments should* ***NOT*** *be listed on the application.*

- The participating PCPs **must** be listed under the *physician* section on page 2 (see highlighted area below).



Alabama Medicaid Primary Care Physician Group Enrollment Agreement

List the Physicians and Physician Collaborators that are associated with this Agreement. Primary Care Physicians practicing in a satellite location(s) must be linked to the exact same Medicaid Group ID. Physician Collaborators must be linked to the exact same Group and location/s as the oversight physician. A Physician Collaborator is a Physician Assistant or Nurse Practitioner that practices under the collaboration of a licensed physician.

Physician Name	Medicaid Provider ID
Physician Collaborator	Medicaid Provider ID

A change in the Medicaid Provider ID will require an additional Medicaid application. If you have questions, please call DXC Provider Enrollment Department at 1-888-223-3630.

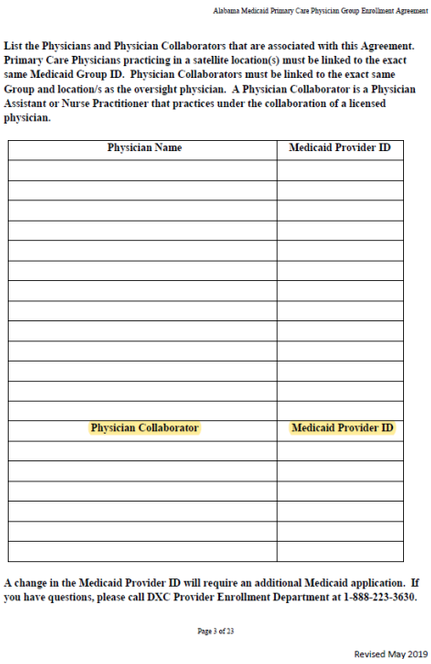
Page 3 of 23

Revised May 2019

- **Provide ALL the PHYSICIAN'S NAMES & the MEDICAID PROVIDER IDs (not NPI)** that were issued by the Alabama Medicaid Agency.
- The provider must be enrolled with the Group that is applying for enrollment. The provider must be enrolled under the same TAX ID and NPI as the Group that is applying for enrollment.
- Primary Care Physicians practicing in a satellite location(s) must be linked to the exact same Medicaid Group ID.

☐ **Ensure that you have listed all mid-levels (nurse practitioners & physician assistants) under the section titled "physician collaborators."** *A Physician Collaborator is a Physician Assistant or Nurse Practitioner that practices under the collaboration of a licensed physician.* **Also list their MEDICAID PROVIDER IDs (not NPI)** that were issued by the Alabama Medicaid Agency.
NOTE: *The physician collaborator must be currently enrolled* ***AND*** *active with Alabama Medicaid. Pending enrollments should* ***NOT*** *be listed on the application.*

- The physician collaborators **must** be listed under the *physician collaborator* section on page 2 (see highlighted area below).



Alabama Medicaid Primary Care Physician Group Enrollment Agreement

List the Physicians and Physician Collaborators that are associated with this Agreement. Primary Care Physicians practicing in a satellite location(s) must be linked to the exact same Medicaid Group ID. Physician Collaborators must be linked to the exact same Group and location/s as the oversight physician. A Physician Collaborator is a Physician Assistant or Nurse Practitioner that practices under the collaboration of a licensed physician.

Physician Name	Medicaid Provider ID
Physician Collaborator	Medicaid Provider ID

A change in the Medicaid Provider ID will require an additional Medicaid application. If you have questions, please call DXC Provider Enrollment Department at 1-888-223-3630.

Page 3 of 23

Revised May 2019

- **Provide ALL the PHYSICIAN COLLABORATOR'S NAMES & the MEDICAID PROVIDER IDs** that were issued by the Alabama Medicaid Agency.

- The physician collaborator must be enrolled with the Group that is applying for enrollment. The physician collaborator must be enrolled under the same TAX ID and NPI as the Group that is applying for enrollment.
- Physician Collaborators practicing in a satellite location(s) must be linked to the exact same Medicaid Group ID.
- Physician Collaborators must be collaborating with a physician that is listed on the enrollment agreement. The physician collaborator must be enrolled at the same location with his/her collaborating physician. That collaborating physician must be currently enrolled and active with Alabama Medicaid.
- If the physician collaborator does not have a collaborating physician listed in our records or if the collaborating physician does not match our records, you will need to send a request to update the collaborating physician. The collaborating physician must be updated before the physician collaborator can be enrolled.

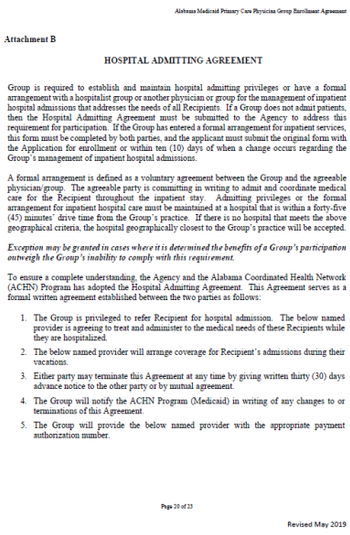
(PAGE 4)

ADMITTING PRIVILEGES

☐ **Ensure that you have answered and completed the *Admitting Privileges* section.**

- If you select **YES,** you must indicate the hospital(s) where you will be admitting your patients**.**
- If you select **NO,** Attachment B must be signed and completed **by the physician that will be admitting patients on your behalf.**
- Attachment B can be found on pages 20-21 of the application (see below).

THIS PAGE MUST BE COMPLETED & SIGNED BY THE GROUP/PHYSICIAN THAT WILL BE ADMITTING PATIENTS ON YOUR BEHALF.



Alabama Medicaid Primary Care Physician Group Enrollment Agreement

Attachment B

HOSPITAL ADMITTING AGREEMENT

Group is required to establish and maintain hospital admitting privileges or have a formal arrangement with a hospitalist group or another physician or group for the management of inpatient hospital admissions that addresses the needs of all Recipients. If a Group does not admit patients, then the Hospital Admitting Agreement must be submitted to the Agency to address this requirement for participation. If the Group has entered a formal arrangement for inpatient services, this form must be completed by both parties, and the applicant must submit the original form with the Application for enrollment or within ten (10) days of when a change occurs regarding the Group's management of inpatient hospital admissions.

A formal arrangement is defined as a voluntary agreement between the Group and the agreeable physician/group. The agreeable party is committing in writing to admit and coordinate medical care for the Recipient throughout the inpatient stay. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a forty-five (45) minutes' drive time from the Group's practice. If there is no hospital that meets the above geographical criteria, the hospital geographically closest to the Group's practice will be accepted.

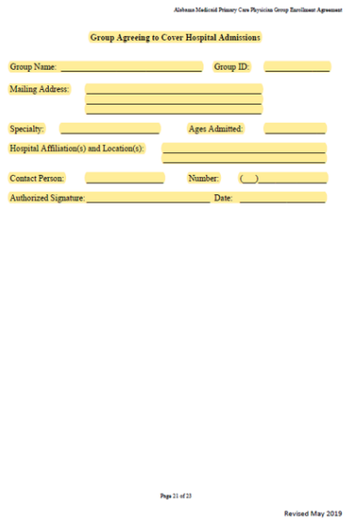
Exception may be granted in cases where it is determined the benefits of a Group's participation outweigh the Group's inability to comply with this requirement.

To ensure a complete understanding, the Agency and the Alabama Coordinated Health Network (ACHN) Program has adopted the Hospital Admitting Agreement. This Agreement serves as a formal written agreement established between the two parties as follows:

1. The Group is privileged to refer Recipient for hospital admission. The below named provider is agreeing to treat and administer to the medical needs of these Recipients while they are hospitalized.
2. The below named provider will arrange coverage for Recipient's admissions during their vacations.
3. Either party may terminate this Agreement at any time by giving written thirty (30) days advance notice to the other party or by mutual agreement.
4. The Group will notify the ACHN Program (Medicaid) in writing of any changes to or terminations of this Agreement.
5. The Group will provide the below named provider with the appropriate payment authorization number.

Page 20 of 23

Revised May 2019



Alabama Medicaid Primary Care Physician Group Enrollment Agreement

Group Agreeing to Cover Hospital Admissions

Group Name: _____ Group ID: _____

Mailing Address: _____

Specialty: _____ Ages Admitted: _____

Hospital Affiliation(s) and Location(s): _____

Contact Person: _____ Number: (___)_____

Authorized Signature: _____ Date: _____

Page 21 of 23

Revised May 2019

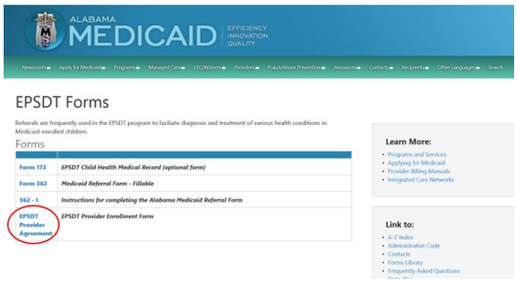
EPSDT

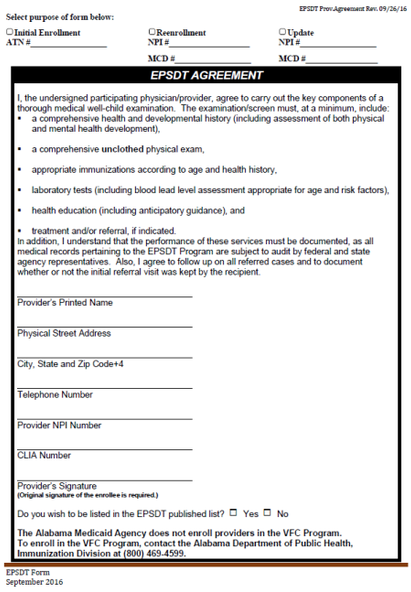
☐ **Ensure that you have answered and completed the *EPSDT* section.**

Note: If you only see adult patients (ages 21 and older), EPSDT enrollment is not required. You will need to submit a signed letter on your company's letterhead informing the Alabama Medicaid Agency that you only accept adult patients and would not like to enroll in EPSDT.

- *Are you currently enrolled in the EPSDT program?*
  - If you select **YES, no other action is required. The Alabama Medicaid Agency with verify that you are currently enrolled with EPSDT.**

- If you select **NO,** you **must** answer the following question on the application:
  If you are not currently enrolled, will you be doing your own EPSDT screenings?
  - If you select **YES to the question above,** you must complete and sign an EPSDT agreement and submit a copy of your current CLIA certificate. The EPDST agreement can be accessed from the Medicaid Agency's website with the following link: https://www.medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.5_EPSDT_Forms.aspx
    (Please note the EPSDT Agreement is different from the Attachment C form in this application. You must access the EPSDT Agreement from the website if you would like to enroll as an EPSDT provider. See below).




EPSDT Prov Agreement Rev. 09/26/16

Select purpose of form below:

☐ Initial Enrollment ATN # _____ ☐ Reenrollment NPI # _____ MCD # _____ ☐ Update NPI # _____ MCD # _____

EPSDT AGREEMENT

I, the undersigned participating physician/provider, agree to carry out the key components of a thorough medical well-child examination. The examination/screen must, at a minimum, include:

- a comprehensive health and developmental history (including assessment of both physical and mental health development),
- a comprehensive **unclothed** physical exam,
- appropriate immunizations according to age and health history,
- laboratory tests (including blood lead level assessment appropriate for age and risk factors),
- health education (including anticipatory guidance), and
- treatment and/or referral, if indicated.

In addition, I understand that the performance of these services must be documented, as all medical records pertaining to the EPSDT Program are subject to audit by federal and state agency representatives. Also, I agree to follow up on all referred cases and to document whether or not the initial referral visit was kept by the recipient.

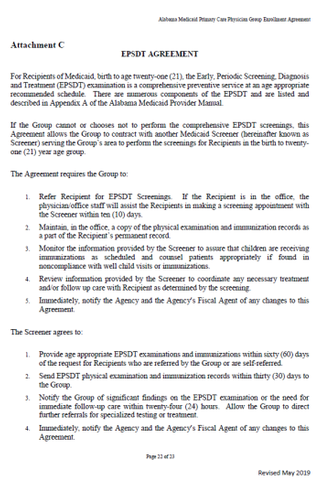
Provider's Printed Name _____
Physical Street Address _____
City, State and Zip Code+4 _____
Telephone Number _____
Provider NPI Number _____
CLIA Number _____
Provider's Signature _____
(Original signature of the enrollee is required.)

Do you wish to be listed in the EPSDT published list? ☐ Yes ☐ No

The Alabama Medicaid Agency does not enroll providers in the VFC Program. To enroll in the VFC Program, contact the Alabama Department of Public Health, Immunization Division at (800) 469-4599.

EPSDT Form
September 2016

  - If you select **NO** to the question above, you must designate an EPSDT enrolled provider to conduct your screenings for you. The provider you designate to conduct your EPSDT screenings **must** complete and sign Attachment C of the application. Attachment C can be found on pages 22-23 of the application (see below).


Alabama Medicaid Primary Care Physician Group Enrollment Agreement

Attachment C

EPSDT AGREEMENT

For Recipients of Medicaid, birth to age twenty-one (21), the Early, Periodic Screening, Diagnosis and Treatment (EPSDT) examination is a comprehensive preventive service at an age appropriate recommended schedule. There are numerous components of the EPSDT and are listed and described in Appendix A of the Alabama Medicaid Provider Manual.

If the Group cannot or chooses not to perform the comprehensive EPSDT screenings, this Agreement allows the Group to contract with another Medicaid Screener (hereinafter known as Screener) serving the Group's area to perform the screenings for Recipients in the birth to twenty-one (21) year age group.

The Agreement requires the Group to:

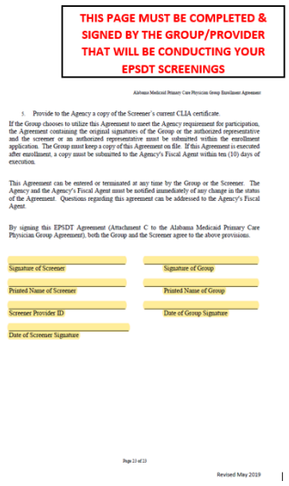
1. Refer Recipient for EPSDT Screenings. If the Recipient is in the office, the physician/office staff will assist the Recipients in making a screening appointment with the Screener within ten (10) days.
2. Maintain, in the office, a copy of the physical examination and immunization records as a part of the Recipient's permanent record.
3. Monitor the information provided by the Screener to assure that children are receiving immunizations as scheduled and counsel patients appropriately if found in noncompliance with well child visits or immunizations.
4. Review information provided by the Screener to coordinate any necessary treatment and/or follow up care with Recipient as determined by the screening.
5. Immediately, notify the Agency and the Agency's Fiscal Agent of any changes to this Agreement.

The Screener agrees to:

1. Provide age appropriate EPSDT examinations and immunizations within sixty (60) days of the request for Recipients who are referred by the Group or are self-referred.
2. Send EPSDT physical examination and immunization records within thirty (30) days to the Group.
3. Notify the Group of significant findings on the EPSDT examination or the need for immediate follow-up care within twenty-four (24) hours. Allow the Group to direct further referrals for specialized testing or treatment.
4. Immediately, notify the Agency and the Agency's Fiscal Agent of any changes to this Agreement.

Page 22 of 23

Revised May 2019


THIS PAGE MUST BE COMPLETED & SIGNED BY THE GROUP/PROVIDER THAT WILL BE CONDUCTING YOUR EPSDT SCREENINGS

Alabama Medicaid Primary Care Physician Group Enrollment Agreement

1. Provide to the Agency a copy of the Screener's current CLIA certificate.

If the Group chooses to utilize this Agreement to meet the Agency requirement for participation, the Agreement containing the original signatures of the Group or the authorized representative and the screener or an authorized representative must be submitted within the enrollment application. The Group must keep a copy of this Agreement on file. If this Agreement is executed after enrollment, a copy must be submitted to the Agency's Fiscal Agent within ten (10) days of execution.

This Agreement can be entered or terminated at any time by the Group or the Screener. The Agency and the Agency's Fiscal Agent must be notified immediately of any change in the status of the Agreement. Questions regarding this agreement can be addressed to the Agency's Fiscal Agent.

By signing this EPSDT Agreement (Attachment C to the Alabama Medicaid Primary Care Physician Group Agreement), both the Group and the Screener agree to the above provisions.

Signature of Screener | Signature of Group
Printed Name of Screener | Printed Name of Group
Screener Provider ID | Date of Group Signature
Date of Screener Signature

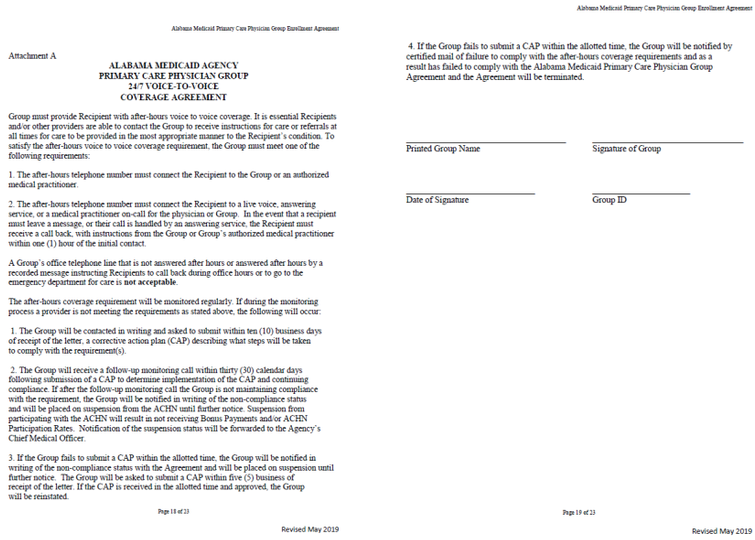
Page 23 of 23

Revised May 2019

☐ **<u>24 Hours/7 Days Telephone Coverage: Complete Attachment A (pages 18-19)</u>**
Ensure that you have answered and completed the *24 Hours/7 Days Telephone Coverage* section.

- **Ensure that you have indicated a telephone number where patients can reach you outside of your normal business hours.**
- **Provide a brief description of how you will satisfy the 24/7 coverage requirement.**
- **The telephone number can be an answering service or a voicemail. In either situation, the patient must be contacted within one (1) hour. Advising patients to go to the emergency room is <u>NOT</u>** acceptable.
- **Ensure that Attachment A (pages 18-19) is completed and signed. ATTACHMENT A IS REQUIRED WITH ALL APPLICATIONS (see below).**

ALABAMA MEDICAID PRIMARY CARE PHYSICIAN GROUP APPLICATION CHECKLIST



Alabama Medicaid Primary Care Physician Group Enrollment Agreement

Attachment A

ALABAMA MEDICAID AGENCY
PRIMARY CARE PHYSICIAN GROUP
24/7 VOICE-TO-VOICE
COVERAGE AGREEMENT

Group must provide Recipient with after-hours voice to voice coverage. It is essential Recipients and/or other providers are able to contact the Group to receive instructions for care or referrals at all times for care to be provided in the most appropriate manner to the Recipient's condition. To satisfy the after-hours voice to voice coverage requirement, the Group must meet one of the following requirements:

1. The after-hours telephone number must connect the Recipient to the Group or an authorized medical practitioner.

2. The after-hours telephone number must connect the Recipient to a live voice, answering service, or a medical practitioner on-call for the physician or Group. In the event that a recipient must leave a message, or their call is handled by an answering service, the Recipient must receive a call back, with instructions from the Group or Group's authorized medical practitioner within one (1) hour of the initial contact.

A Group's office telephone line that is not answered after hours or answered after hours by a recorded message instructing Recipients to call back during office hours or to go to the emergency department for care is **not acceptable**.

The after-hours coverage requirement will be monitored regularly. If during the monitoring process a provider is not meeting the requirements as stated above, the following will occur:

1. The Group will be contacted in writing and asked to submit within ten (10) business days of receipt of the letter, a corrective action plan (CAP) describing what steps will be taken to comply with the requirement(s).

2. The Group will receive a follow-up monitoring call within thirty (30) calendar days following submission of a CAP to determine implementation of the CAP and continuing compliance. If after the follow-up monitoring call the Group is not maintaining compliance with the requirement, the Group will be notified in writing of the non-compliance status and will be placed on suspension from the ACHN until further notice. Suspension from participating with the ACHN will result in not receiving Bonus Payments and/or ACHN Participation Rates. Notification of the suspension status will be forwarded to the Agency's Chief Medical Officer.

3. If the Group fails to submit a CAP within the allotted time, the Group will be notified in writing of the non-compliance status with the Agreement and will be placed on suspension until further notice. The Group will be asked to submit a CAP within five (5) business of receipt of the letter. If the CAP is received in the allotted time and approved, the Group will be reinstated.

Page 18 of 23

Revised May 2019

Alabama Medicaid Primary Care Physician Group Enrollment Agreement

4. If the Group fails to submit a CAP within the allotted time, the Group will be notified by certified mail of failure to comply with the after-hours coverage requirements and as a result has failed to comply with the Alabama Medicaid Primary Care Physician Group Agreement and the Agreement will be terminated.

Printed Group Name

Signature of Group

Date of Signature

Group ID

Page 19 of 23

Revised May 2019

(PAGE 5)

☐ Ensure that you have indicated your Group's name at the top of page 5 of the *Alabama Medicaid Primary Care Physician Group Agreement.*

☐ Ensure that you have read and understand the entire agreement (pages 5-16).

(PAGE 16)

(Note: PCP Group Agreement applications processed prior to the onset date of the ACHN will be Effective 10/01/2019; this is the start date of the ACHN. Applications received after 10/01/2019, will have a future effective **date).**

☐ Ensure that you have indicated an effective date at the bottom of page 16.

(PAGE 17)- Alabama Medicaid Primary Care Physician Group Agreement (signature page)

☐ Ensure that page 17 is completed accurately. See below for instructions on completing page 17.

Alabama Medicaid Primary Care Physician Group Enrollment Agreement

Nothing goes here. Agency's use ONLY

Nothing goes here. Agency's use ONLY

Primary Care Physician Group

Alabama Medicaid Agency

PRINT Group's Name on this line

Nothing goes here. Agency's use ONLY

Printed Name of Group

Signature of Agency Representative

Sign (cursive) Group Representative's Name on this line

Nothing goes here. Agency's use ONLY

Signature of Group Representative

Date

Print the Group's NPI (not Medicaid Provider ID) on this line

Group NPI

Print the date that the application was signed on this line

Date

ALABAMA MEDICAID PRIMARY CARE PHYSICIAN GROUP APPLICATION CHECKLIST

(PAGE 19) Attachment A (signature page) 24/7 Coverage Agreement

☐ Ensure that page 19 is completed accurately. See below for instructions on completing page 19.

4. If the Group fails to submit a CAP within the allotted time, the Group will be notified by certified mail of failure to comply with the after-hours coverage requirements and as a result has failed to comply with the Alabama Medicaid Primary Care Physician Group Agreement and the Agreement will be terminated.

Print Group's (or Group Representative's) Name on this line

Printed Group Name

Sign (cursive) Group's (or Group Representative's) Name on this line

Signature of Group

Print the date that the application was signed on this line

Date of Signature

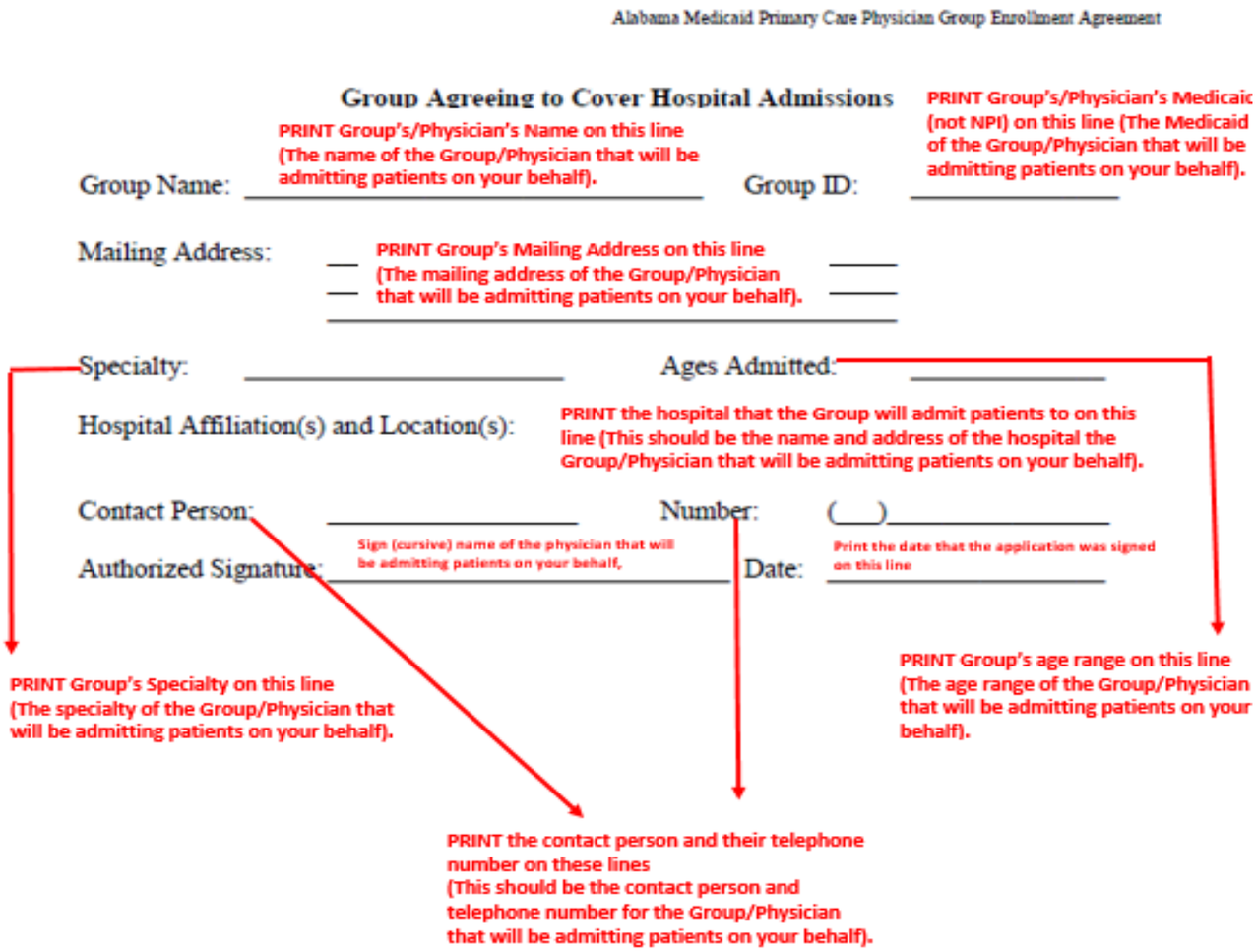
Print the Group's Medicaid ID (not NPI) on this line

Group ID

(PAGE 21) Attachment B (signature page) 24/7 Hospital Admitting Agreement

☐ Ensure that page 21 is completed accurately. See below for instructions on completing page 21.

Note: *page 21(Attachment B- Hospital Admitting Agreement) is only required if you are designating another Group/Physician to admit patients to a hospital on your behalf. This page* ***must*** *be completing by the Group/Physician that you have designated to admit patients on your behalf.*



(PAGE 23) Attachment C (signature page) EPSDT Agreement

☐ Ensure that page 23 is completed accurately. See below for instructions on completing page 23.

Note: *page 23(Attachment C- EPSDT Agreement) is only required if you are designating another Group/Physician to complete EPSDT screenings for recipients under the age of 21. This page* ***must*** *be completing by the Group/Physician that you have designated to complete EPSDT screenings on your behalf.*

5. Provide to the Agency a copy of the Screener's current CLIA certificate.

If the Group chooses to utilize this Agreement to meet the Agency requirement for participation, the Agreement containing the original signatures of the Group or the authorized representative and the screener or an authorized representative must be submitted within the enrollment application. The Group must keep a copy of this Agreement on file. If this Agreement is executed after enrollment, a copy must be submitted to the Agency's Fiscal Agent within ten (10) days of execution.

This Agreement can be entered or terminated at any time by the Group or the Screener. The Agency and the Agency's Fiscal Agent must be notified immediately of any change in the status of the Agreement. Questions regarding this agreement can be addressed to the Agency's Fiscal Agent.

By signing this EPSDT Agreement (Attachment C to the Alabama Medicaid Primary Care Physician Group Agreement), both the Group and the Screener agree to the above provisions.

Sign (cursive) name of the physician that will be completing EPSDT screenings on your behalf.

Signature of Screener

Print name of the physician that will be completing EPSDT screenings on your behalf.

Printed Name of Screener

Print Medicaid Provider ID (not NPI) of the physician that will be completing EPSDT screenings on your behalf.

Screener Provider ID

Print the date the physician that will be completing EPSDT screenings on your behalf signed the agreement.

Date of Screener Signature

Sign (cursive) name of the EPSDT screener's Group or Group Representative of that will be completing EPSDT screenings on your behalf.

Signature of Group

Print name of the EPSDT screener's Group or Group Representative of that will be completing EPSDT screenings on your behalf.

Printed Name of Group

Print the date the Group or Group Representative that will be completing EPSDT screenings on your behalf signed the agreement.

Date of Group Signature