Health Home Agreement between Alabama Care Plan and Patient 1st Primary Medical Provider

THIS AGREEMENT is entered into as of _____(effective date) between Alabama Care Plan whose principal office is located in the City of Birmingham, County of Jefferson, State of Alabama, hereinafter referred to as the "Health Home" and Patient 1st Primary Medical Provider _____ located in the City of_____, County of _____, State of Alabama, hereinafter referred to as the "Participant".

WHEREAS, the Health Home has entered into an agreement with the Alabama Medicaid Agency to provide case management services for the Health Home Program (as defined below); and

WHEREAS, The Health Home Program is a program that is designed to build on Patient 1st by assisting local providers to develop organized care systems that coordinate the full continuum of care with processes to influence cost and quality of care; and

WHEREAS, the Health Home will provide staffing to the Health Home Program to support the Participant with care coordination; and

WHEREAS, the Participant has direct responsibility to provide comprehensive care management services and coordination to Health Home Program recipients with a team of health care professionals; and

WHEREAS, the Health Home Program provides services to all eligible health home individuals who meet criteria set forth by the Alabama Medicaid Agency; and

WHEREAS, the Participant employs or contracts for the services of health care providers duly licensed in the State of Alabama and wishes to participate and cooperate with the Health Home in the development and implementation of Medicaid care management initiatives that will positively impact the quality and cost of providing health care to Medicaid recipients.

NOW, THEREFORE, it is agreed between the Health Home and the Participant, as follows:

Section 1 – General Statement of Purpose and Intent

The Health Home Program is a program that will involve building care management support systems, and implementing network development efforts. Providers are expected to actively participate in network meetings and initiatives. The Health Home Program is expected to demonstrate the capacity to do the following for enrolled Medicaid recipients:

- develop a care management plan to meet budget, utilization, and performance targets;
- develop the care management systems needed to manage enrollee services;
- promote improved care management strategies, such as: disease management, authorization and referral processes, after hours protocols, and targeted care management;
- implement quality improvement initiatives (QI) and participate in program-wide QI activities;
- focus on high cost and high risk Medicaid enrollees;
- provide primary care, referral and authorization of Medicaid services through a network of Alabama Patient 1st providers; and,
- assure the appropriate expenditure of the enhanced care management fees

This Agreement describes the terms and conditions under which the agreement is made and the responsibilities of the parties thereto. Nothing in this Agreement directly or indirectly restricts the Participant from performing work for any other organization that has been awarded a contract for Health Home Program services by the Alabama Medicaid Agency.

Section 2 – General Statement of the Law

Alabama Patient 1st is a community-based care management plan implemented in accordance with Title XIX of the Social Security Act, and is subject to the provisions of Alabama Statutes and Alabama Administrative Regulations.

Section 3 – Functions and Duties of the Participant

The Participant agrees to do the following:

3.1 Cooperate with the Health Home Program in the development and utilization of care management systems and tools for managing the care of Medicaid enrollees. Such cooperation shall include: attending meetings detailing initiatives, expectations, and performance, as requested by the Health Home; assist in the development of a transitional care program; and the provision of clinical information necessary to establish effective care management processes for the provision of cost-effective and quality health care (subject to all applicable requirements regarding confidential medical information). At least one physician from a practice must attend a medical management meeting at least quarterly.

3.2 Comply with the policies and procedures developed by the Health Home Program's Medical Management Committee and / or Steering Committee that aim to effectively manage the quality, utilization, and cost of services, including but not limited to the following:

- Inpatient admissions;
- Emergency room visits;
- Specialty and ancillary referrals;
- Early detection and health promotion;

- Chronic and high cost diseases;
- At risk patients; and
- Pharmacy prescribing patterns.

3.3 Cooperate with the Health Home Program's patient risk assessment process to identify and track those Medicaid recipients that would most benefit from enhanced care coordination and disease management activities**.** Participate, as requested by the Health Home, in interdisciplinary teams to help manage and optimize patient care of those enrollees at highest risk and cost.

3.4 Authorize and coordinate with the Health Home Program care coordinators in carrying out the enhanced care coordination activities targeting Health Home Program recipients enrolled with the Participant.

3.5 Participate in the implementation of Health Home approved care coordination plans for Health Home Program recipients.

3.6 Participant will maintain an integrated medical record and will allow the Health Home access in order to coordinate patient care.

3.7 Participant will identify high risk individuals and refer to the Health Home Program where enhanced care management is part of the comprehensive health care plan.

3.8 Participant will work with Health Home Program to plan and communicate with other primary and specialty care providers regarding a patient's care including but not limited to the following; sharing of reports regarding diagnosis, medication, test results and psychosocial evaluations.

3.9 The Participant will review data provided by the Health Home Program as part of the quality improvement program.

3.10 The Participant will develop a comprehensive health plan informed by the patient integrating care across systems (Mental Health, Substance Abuse, primary care, etc.).

3.11 The Participant will work with the network pharmacist to help manage patient pharmaceutical issues by responding to Health Home Program clinical pharmacist's assessment of any problems with medications prescribed versus medications filled/taken.

3.12 The Participant will work with the Health Home Program's quality care manager to implement the chronic care improvement program within the practice and enhance the coordination of patient care.

3.13 The Participant will ensure appropriate access to care by providing timely follow-up appointments and ensuring appropriate referral process and communications with specialists are in place.

3.14 Work in concert with the Health Home Program to do the following:

- develop specific strategies to address special needs of the Medicaid population;
- develop local referral processes and communications with specialists;
- promote Health Home Program recipient's ability and confidence in their self management of chronic illness(es);
- develop plans to meet the Health Home Program utilization and budget targets;
- evaluate and implement appropriate changes in service utilization; and,

- develop and refine Health Home Program measures, utilization reports, management reports, quality improvement goals, and care management initiatives.

3.15 Nothing in this Agreement shall interfere with or supersede Participant's obligation to provide health care services to Medicaid recipients under separate agreement with the Alabama Medicaid Agency.

Section Four – Duties and Responsibilities of the Health Home

The Health Home agrees to do the following:

4.1 Provide training and technical assistance regarding the Health Home Program when required.

4.2 Work with the Participant to:

- Provide the Participant with periodic utilization and cost reports.
- Gather and analyze data relating to service utilization by Health Home recipients to determine whether program measures are met.

4.3 Provide integration and coordination of services for individuals with mental health or substance abuse.

4.4 Maintain relationships with Community Mental Health Centers and Substance Abuse Providers. The Health Home Program will serve as a representative of the Participant with these providers through coordinating Mental Health and Substance Abuse services between Mental Health and Substance Abuse agencies, care managers, and the Participant.

4.5 Work with providers to clarify and communicate patient's preference to all involved providers and to ensure the timely delivery of services.

4.6 Suggest to the Participant that a patient be referred to in home monitoring when it would be beneficial to the patient's comprehensive health plan.

4.7 Screen and assess referrals from the Participant for possible care management.

4.8 Assist the Participants with Health Home Program recipient's long term care support and services.

4.9 Establish a board/steering committee, a medical management committee, and oversee care management activities in concert with Participant.

4.10 Provide clinical and administrative leadership and technical support in collaboration with the Health Home Program to design, develop, and implement new clinical and care management initiatives.

4.11 Establish an ongoing process with community providers and other community agencies to coordinate the planning and provision of care management and other support services for enrollees needing those services.

4.12 Work with the Alabama Medicaid Agency, and other resources to pilot new approaches in managing the care of Medicaid recipients.

Section Five – General Terms and Conditions

5.1 Audit: The Health Home and the Alabama Medicaid Agency retain the right to periodically audit the Participant's information and records as may reasonably be necessary to review Participant performance relative to the Health Home Program's goals and objectives, and other reasonable, necessary and appropriate purposes during the term of this Agreement and in accordance with state and federal law.

5.2 Non-Discrimination: The Participant shall comply with all applicable federal and state laws which prohibit discrimination on the grounds of race, creed, sex, religion, national origin, or physical or mental handicap.

5.3 Transfer of Agreement: This Agreement may not be transferred.

5.4 Contract Termination: This Agreement may be terminated under the following conditions:

5.41 Automatically upon Participant's suspension or termination from the Patient 1st Program or upon Medicaid's discontinuance of the Health Home Program; or

5.42 Upon the Participant's failure to comply with the Health Home Program policies and procedures; or

5.43 By either party, with cause, upon at least thirty (30) days' notice, in writing, and delivered by registered mail with return receipt requested or in person, except that a Participant may terminate participation effective only on the first day of each month; or

5.44 As to any health care provider employed or under contract by Participant, immediately upon a revocation of such employee's or contractor's license to practice medicine in the State of Alabama, a revocation of such employee's or contractor's enrollment as a participating provider under Title XIX (Medicaid) of the Social Security Act, and / or cancellation of such employee's or contractor's Liability Insurance; or

5.45 By mutual consent of both parties; or

5.46 By either party for any reason upon ninety (90) days written notice to the other party.

5.5 Supplements: No supplements, modifications or amendments of this Agreement will be binding unless executed in writing by both parties.

Section Six – Effective Date and Duration

This Agreement shall become effective on the date listed above and remain in effect until amended or terminated pursuant to the terms of this Agreement.

Section Seven – Signatories

Alabama Care Plan

_____
(Signature – Authorized Official)

_____
(Title)

_____
(Date)

Participant

_____
(Signature – Authorized Official)

_____
(Title)

_____
(Date)

_____

_____
(Mailing Address)

_____
(Alabama Medicaid Provider Number)

_____
National Provider Identifier (NPI)