
# Alabama Care Network Mid-state
# Medical Management Meeting
# September 12th and September 18th

# Welcome and Introductions

**Presenters**

- Jim Hotten, Executive Director
- Melissa O'Brien, LICSW Manager of Care Management
- Dr. Peily Soong, MD – Medical Director
  - Pediatrician, Pediatrics East
- Nicole Reed, MSHA, MSHQS - Quality Manager

# Agenda

- Medicaid Updates
- ACHN Updates
- Medical Management Meeting Requirements
- ACHN Quality Improvement Programs

# Medicaid updates- Medicaid Alerts

- Recent Medicaid (MCD) Provider Alerts
  - 6/23/25 Alert: EPSDT Rate increase from $70 to $80
  - 7/8/25 Alert: Clarification on documentation needed for diaper/incontinence supply coverage for 3 years and older.
    - If ambulatory, documentation needed “How the cognitive, developmental, or behavioral diagnosis/disability affects or inhibits independent toileting” and stating has had “caregiver led toilet training **OR** therapy led toilet training.”
  - 7/11/25 Alert: Changes to Respiratory Panel Coverage
    - Outpatient only coverage for up to 5 antigen panel PCR testing (87631-87633).
    - Cannot do molecular rapid tests + respiratory panel in same facility
    - Can do in-house rapid molecular testing + lab send out for 87633.

# Medicaid updates- Medicaid Alerts

- Upcoming Medicaid Changes
  - For provider quality measure regarding Chlamydia screening, MCD will look at issue with UPT testing done before surgical procedures.
  - Will be looking at Pediatric Bed Policy (e.g., Cubby Beds)
  - **10/1/2025: Increase Payments**
    - **ACHN Bump Payment increase**
    - **Dental rate increases**
  - 10/1/2025: Policy on hysterectomy changes. Will have provider webinar 9/17 explaining changes.
  - 10/1/2025: Presumptive Eligibility for Pregnant Women
    - 60 day coverage with ambulatory PNC visits. Not full MCD coverage.
  - Appendix A in the Provider manual will have significant changes on 10/1/2025 including:
    - Alignment with Bright Futures including recommendations for 3-5 day newborn visits and 30 month check up visits.
  - MCD coverage for vaccines will follow ACIP recommendations. Any future changes will have to be made by a request from AL MCD to CMS.

# Medicaid Updates

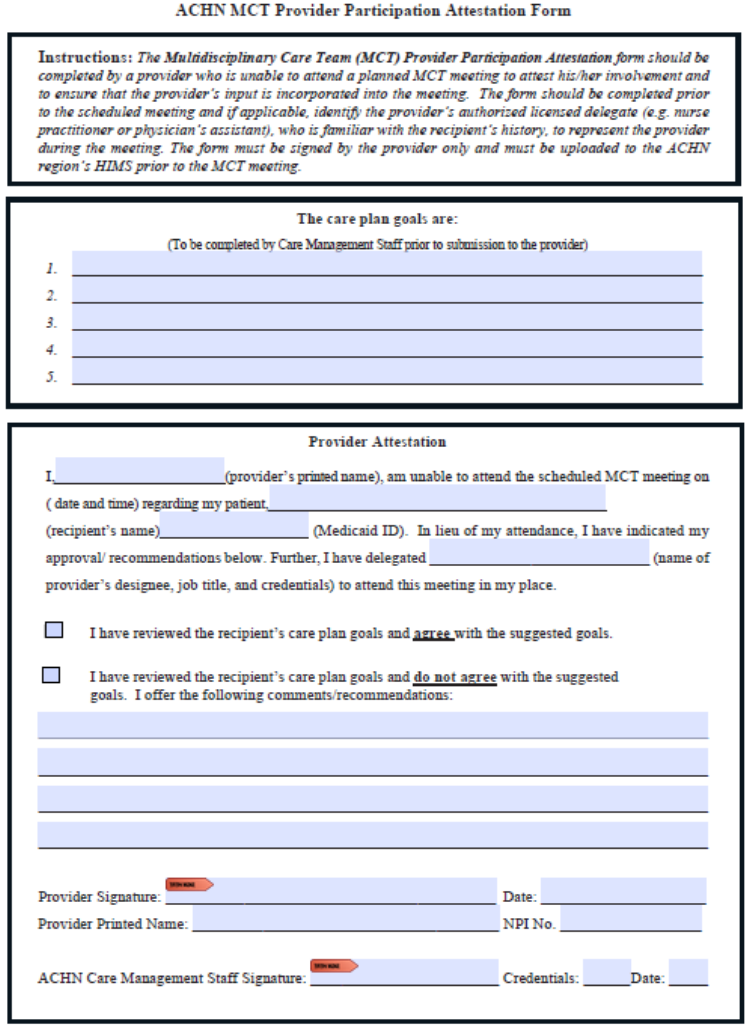
- Patient Centered Medical Home
  - Fiscal Year (FY) 2026 (October 1, 2025-September 30, 2026) Patient-Centered Medical Home (PCMH) Attestation Form deadline is 10/1/25. If you have any questions, please contact Medicaid.
  - Email: ACHN@medicaid.alabama.gov or Fax: 334-353-3856

# ACHN-Midstate Updates

- MCTs
  - Meeting with PCP and other providers (as needed) with ACHN team (Case Manager, Behavioral Health Nurse, and Pharmacist) and recipient to discuss recipient's needs and goals.
  - Recipients stratified high risk.
  - Medicaid asks for PCP and recipient attendance in meetings
    - Meeting for provider can be in person at ACHN office or virtual through zoom link.

# ACHN-Midstate Updates

- Medicaid has provided form in Provider absence
  - Recipient care plan and ACHN MCT Provider Participation Attestation Form will be sent for every recipient who is scheduled for MCT- by fax or email at least 10 days before scheduled MCT.
  - Care plan must be reviewed and ACHN MCT Provider Participation Attestation Form filled out and returned before MCT date for this to count in provider absence.
  - After MCT, documentation with summary notes from MCT meeting will be sent to provider to close loop.
  - Who is a good contact for your office?



**ACHN MCT Provider Participation Attestation Form**

**Instructions:** *The Multidisciplinary Care Team (MCT) Provider Participation Attestation form should be completed by a provider who is unable to attend a planned MCT meeting to attest his/her involvement and to ensure that the provider's input is incorporated into the meeting. The form should be completed prior to the scheduled meeting and if applicable, identify the provider's authorized licensed delegate (e.g. nurse practitioner or physician's assistant), who is familiar with the recipient's history, to represent the provider during the meeting. The form must be signed by the provider only and must be uploaded to the ACHN region's HIMS prior to the MCT meeting.*

**The care plan goals are:**

(To be completed by Care Management Staff prior to submission to the provider)

1. _____
2. _____
3. _____
4. _____
5. _____

**Provider Attestation**

I,_____(provider's printed name), am unable to attend the scheduled MCT meeting on ( date and time) regarding my patient,_____ (recipient's name)_____ (Medicaid ID). In lieu of my attendance, I have indicated my approval/ recommendations below. Further, I have delegated _____ (name of provider's designee, job title, and credentials) to attend this meeting in my place.

☐ I have reviewed the recipient's care plan goals and **agree** with the suggested goals.

☐ I have reviewed the recipient's care plan goals and **do not agree** with the suggested goals. I offer the following comments/recommendations:

_____

_____

_____

_____

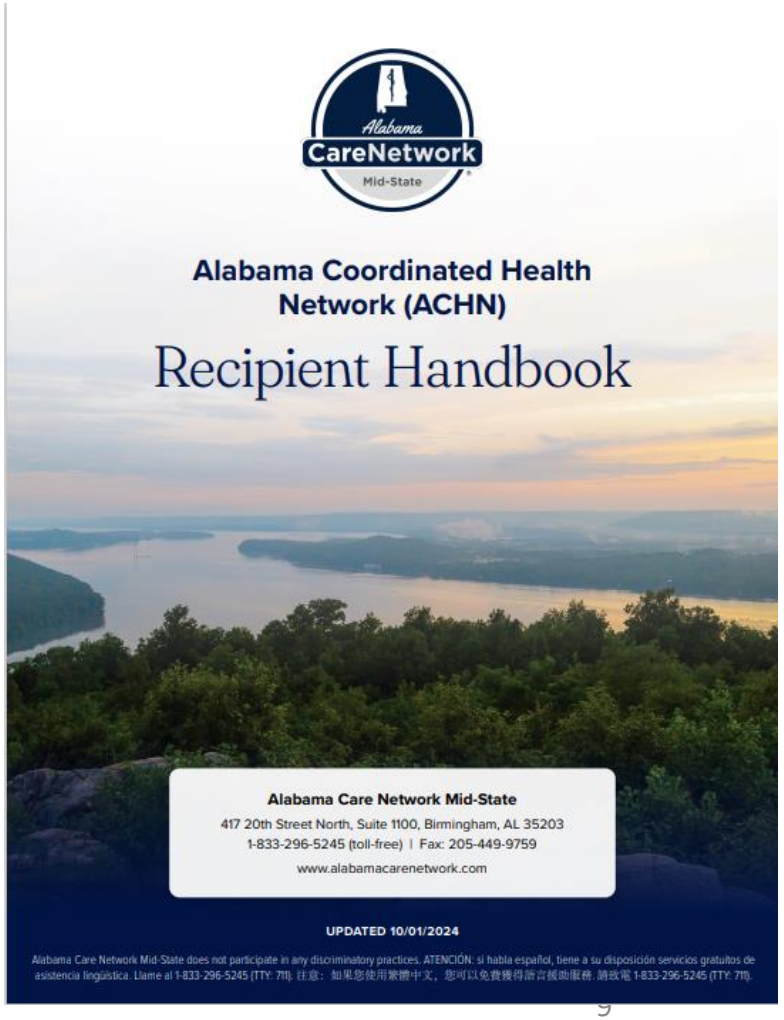
Provider Signature: _____ Date: _____

Provider Printed Name: _____ NPI No. _____

ACHN Care Management Staff Signature: _____ Credentials: _____ Date: _____

# ACHN Midstate Updates

- New QR Code for Recipients
  - Link to ACHN Midstate website with recipient handbook and updated program information.



# Medical Management Meeting Requirements

- Reminder
  - A PCP or physician extender (NP or PA) from each contracted clinic must attend 3 of 4 yearly Medical Management Meetings to remain in compliance.
  - An average of 2-3 meetings are held per quarter

# Quality Improvement Programs

Nicole Reed, MSHA, MSHQS - Quality Manager

# ACHN Quality Improvement Programs

- Substance Use Disorder
- Childhood Obesity
- Infant Mortality

# ACHN Quality Improvement Programs

- General QIP topics have been provided by Medicaid, but the ACHN does have the autonomy to select others of their interest.
- Data reviewed quarterly by Medicaid and IPRO to determine progress, track trends and make adjustments as needed.
- Each topic addressed once at quarterly Medicaid Quality Collaborative meetings held in Montgomery. All ACHN regions present to report out on current progress, successes and challenges.

# Substance Use Disorder

- Outreach to those with claims of substance use disorders
- Challenge to all regions in the state
- On going review with Medicaid to increase success
- Mid-State barriers
  - Access to up-to-date contact information
  - Limited buy in from recipients
  - Stigma associated with substance use
  - Limited resources
  - Lack of referrals to RRC

# Substance Use Disorder

- Increasing success
  - Partnership with the Recovery Resource Center (John Bayles)
  - Outreach calls through UAB Psych for those who have SUD follow up appts
  - One Case Manager with previous work experience in SUD devoted to outreach and placed at SUD program at Cahaba.
  - Training for providers and case managers through UAB to reduce stigma associated with SUD.

    UAB Office of Learning Technologies | UAB Office of Learning Technologies

# Childhood Obesity

- Focusing on children with BMIs> 85% and adults with BMIs > 25
- Previous contract used Healthy Lifestyle Kits
  - Currently researching other options with greater impact
- UAB Dietitian Services
  - Education on nutrition and healthy habits
  - Enhanced reporting: tracking referrals, sessions, follow-ups
  - Added collaboration with UAB Dietitians in late 2023
  - Started with 5 referrals each week for program, moved to 7 referrals each week in August 2024
  - Started for ages 3-18, later open to recipients of all ages
  - Services also expanded to maternity recipients August 2024

# Childhood Obesity

- Case Manager notifies Quality Manager of recipients interested and the QM completes referral to be sent to the dietitians.
  - Services conducted remotely
  - Incentives provided to recipients by dietitians

- Dietitian Schedule
  - Receives referral and schedules 1st consult
  - 2nd Consult 2 weeks later
  - 3rd Consult 3 weeks after 2nd visit
  - 4th Consult and later visits on monthly basis with goals to be achieve by 8 sessions together and then recipient continues to work independently

- Dietitian Referrals and Participants
  - 2024  119  total participants
  - 2025  167 so far

# Childhood Obesity

- Partnership with KidOne
  - Takes recipients to WIC and well child appointments
  - Midstate staff completing Kid One applications to help with faster services delivery
    - Q2 and Q3 Kid One applications completed- 56
    - 23 of the 56  completed have used the service

# Infant Mortality

- Goal to increase number of healthy and full term pregnancies

- Common barriers include
  - Low health literacy
  - Nutritional gaps in pregnancy
  - Lack of breastfeeding support
  - Co-occurring health concerns like DM and HTN

# Infant Mortality

- ACHN Initiatives
  - Blood pressure cuffs
    - Provided to women of childbearing ages (18-44). Can be provided at visit or mailed
      - Case Managers provide on-going support and education to address high blood pressure in pregnancy and post partum
        - » 117 BP cuffs provided in 2025
  - Sleep sacks
    - Provided at delivery visits to help promote safe sleep.
      - Education on safe sleep provided through case management duration and followed into post partum
        - » 1,463 sleep sacks provided in 2025

# Infant Mortality

- Diapers
  - Provided at post partum visits (classes and in home)
    - Has helped with increase success of follow up visits

- Breast Pumps
  - New initiative as of June 2025
    - Provides electric breast pumps (Medela) to those who qualify, making sure to not overlap with those who can receive breast pumps from WIC and/or hospitals. Also receives 5 storage bags for milk as starter.
    - To obtain breast pump, must agree to once a month follow up education and support for 6 months
      - » Q3- 6 breast pumps have been provided to recipients

# Infant Mortality

- Community Partnerships
  - UAB Dieticians
    - Providing education and support to those with nutritional needs, DM and HTN.
  - Nurse Family Partnership
    - Providing hands on skills and education to those with more intense needs
      - Referral criteria (pregnancy + SDOH + health risk factors)
      - Implemented Q3– early success
        - » 98 referred, 81 accepted  82.7%
  - Bundles of Hope
    - Provides diapers to those in need
    - Proven to increase successful post partum visits

# Blood Pressure Cuff Success Story

“You don’t always get to see the difference you make with our job but this time I did.

During a postpartum visit, a mom recently diagnosed with high blood pressure thanked me for the blood pressure monitor I’d given her at her delivery visit. She told me that shortly after going home, she started feeling “off,” so she checked her blood pressure. It was dangerously high. She went straight to the ER and was admitted for four days to get it under control.

She said she would have never known if it weren’t for the monitor and the education she received during her visit with me. She was convinced it had saved her from serious complications and maybe even her life.

Moments like this remind me why we do what we do and the difference we make. Even when we might not always see it.”

# Breast Feeding Success Story

"I had the first follow up during her 1st post partum visit. She states breastfeeding is going so well- she was only able to produce 1-2 ounces with the manual pump and now with this electric pump she is getting like 3-5 and baby latches to eat still as well! She states she is storing milk for future use or will donate. She was so thankful for the pump and is looking forward to our touch bases in the next few months!"

# ACHN Quality Improvement Programs

## How Can You Help?

- By Referring those with identified needs to our program for on-going education and support


Alabama
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Mid-State
THANK YOU!