

Alabama Coordinated Health Networks: History, Development, and Overview



Presented to North Dakota Medicaid Stakeholder
Taskforce
February 19, 2020

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How Alabama went FFS to MCO to Hybrid?

- Alabama Medicaid Agency began in 1970
- Fiscal Year 2017, the Alabama Medicaid covered:
 - Nearly 52% percent of children statewide
 - 25% percent of the State's population overall
 - Accounts for more than half of the births in the State.
 - Recent growth in enrollment had led to an increase in total Alabama Medicaid program expenditures from approximately \$4.4 billion in 2008 to approximately \$6.5 billion in Fiscal Year 2017
- October 2012 – Governor Bentley established a Medicaid Advisory Commission to review other states and propose recommendations to curb the growth trajectory of the Medicaid program and improve the quality and types of care provided to Medicaid enrollees.
- 2013 – 2017 Alabama Medicaid began a transformation to full Managed Care through 1115 Waiver Authority to implement the Regional Care Organizations (RCO)
- July 2017 – Due to new Federal regulations, funding considerations, and the intent to develop more flexibility in the State, the Agency ended the RCO implementation

How Alabama went FFS to MCO to Hybrid?



- Alabama has a long history of care coordination in the State:
 - 1915 (b) Waiver (PAHP) – Maternity Contractors
 - PCCM – Patient 1st Medical Home Program
 - Health Homes – PCNA Pilot in 2012 and expanded statewide April 2015
 - 1115 Family Planning Waiver – care coordination provided by Public Health staff
- Providers were used to care coordination and supported the model
 - Provider engagement and feedback is critical for any implementation success
- RCO Pivot was an expansion on the care coordination model while also incorporating lessons learned through the full MCO implementation

Hybrid Model: Alabama Coordinated Health Networks



- 2015 CMS Managed Care Final Rule lays out many models or types of Managed Care

FFS > PCCM > PCCM-E > PAHP/PIHP > MCO

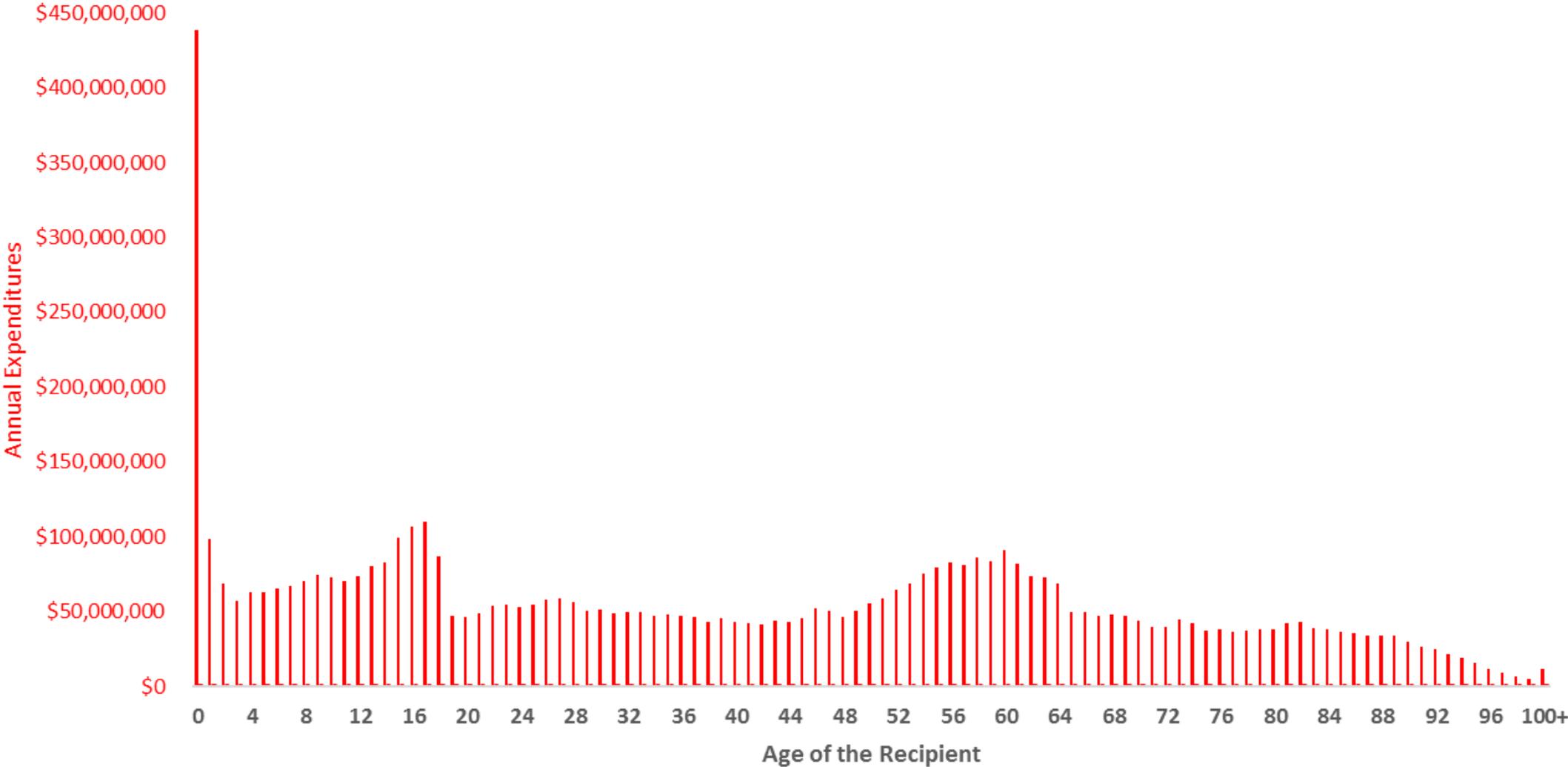
- Alabama's Model: PCCM-E
 - Patient Centered Case Management Entity
 - FFS for medical services with care coordination through managed care overlay
 - "Managed Fee for Service"
 - Expands on Alabama strengths but in a model that providers can accept while also allowing for improvement of health outcomes

A new direction... ACHNs

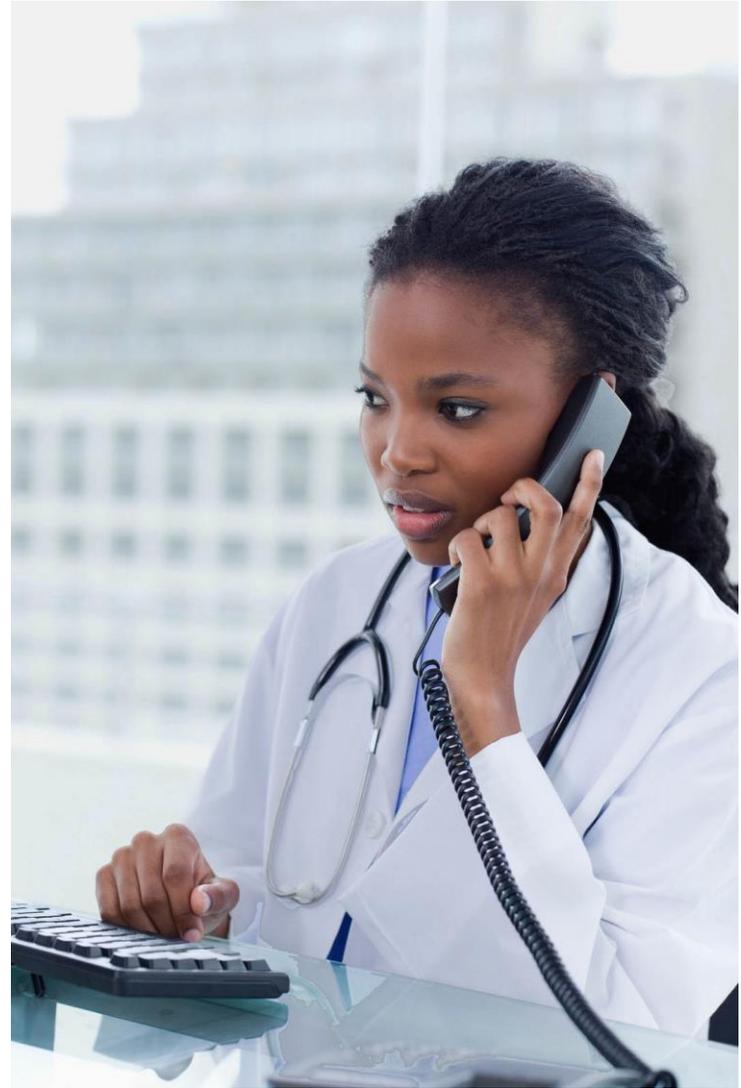


- Single care coordination delivery system combining Health Homes, Maternity Program, and Plan First
- Replaces silos in current care coordination efforts
- Care coordination services provided by regional Primary Care Case Management Entities (PCCM-Es), or the ACHN Networks
- Seven newly defined regions; primary care physicians practicing in district comprise at least half of board
- A system that works holistically with a Medicaid recipient to address issues impacting health can make a positive difference

Alabama Medicaid Agency
Expenditures for Medical and Support Services
Fiscal Year 2017
By Age at the Date of Service



ACHN Operation



ACHN Operation



- Statewide operation, one entity in each of seven pre-defined regions
- Each network will be responsible for creating a care coordination delivery system within the region
- Care coordination will be provided based on a recipient's county of residence
- ACHN entities will not make payments to physicians
- Statewide system will manage care coordination services now provided by 12 maternity programs, six health home programs, and ADPH staff in 67 counties
- Regional entities will be incentivized along with primary care providers to achieve better health outcomes and to provide a higher volume of care coordination services

ACHN Governing Board



- 50% of the Governing Board must be primary care physicians (including at least one OB-GYN) who practice in the Region and engage in Active Participation with the Entity. Up to two of these primary care physicians can be employed by a hospital
- At least 2 representatives of In-Region hospitals representing more than one system, if more than one system exists in a Region
- At least 1 representative of a Community Mental Health Center located in the Region
- At least 1 representative of a Substance Abuse Treatment Facility located in the Region
- At least 1 Consumer Representative (e.g., EI, Parent of EI or advocacy organization representative) who lives in the Region
- At least 1 representative of a FQHC located in the Region

Consumer Advisory Committee



- Organization must have a Consumer Advisory Committee (CAC) comprised as follows:
 - Must have at least six members
 - Must meet at least once in the first quarter, and at least once in the third quarter
 - 20% of the members must be eligible individuals or parent/caretakers of eligible individuals served by the network
- Several CACs have parents or guardians of a recipient on their Committee
- CAC required to provide verbal report at each governing board meeting

ACHN Regions



Based on:

- Existing patterns of care
- Access to care
- Ability to ensure financial viability of regional ACHN entities



Alabama Coordinated Health Network – Regional Contacts for Providers



Region	ACHN	Phone Number (Recipients)	Phone Number (Providers)	Contact Name	Email Address
Central	My Care Alabama Central	1-855-288-8360	1-855-288-8361	Casey Wylie	casey_wylie@MyCareAlabama.org
East	My Care Alabama East	1-855-288-8364	1-855-288-8366	Donna Oliver	donna.oliver@MyCareAlabama.org
Jefferson/Shelby	Alabama Care Network Mid-State	1-833-296-5245	1-833-296-5245	Michael Battle	mbattle@uabmc.edu
Northeast	North Alabama Community Care	1-855-640-8827	1-855-640-8827	Dana Garrard Stout	dana.garrard@alabamacomunitycare.org
Northwest	My Care Alabama Northwest	1-855-200-9471	1-855-500-9470	Stacey Copeland	stacy.copeland@MyCareAlabama.org
Southeast	Alabama Care Network Southeast	1-833-296-5246	1-833-296-5246	Kim Eason	keason@uabmc.edu
Southwest	Gulf Coast Total Care	1-833-296-5247	1-833-296-5247	Sylvia Brown	sbrown@uabmc.edu

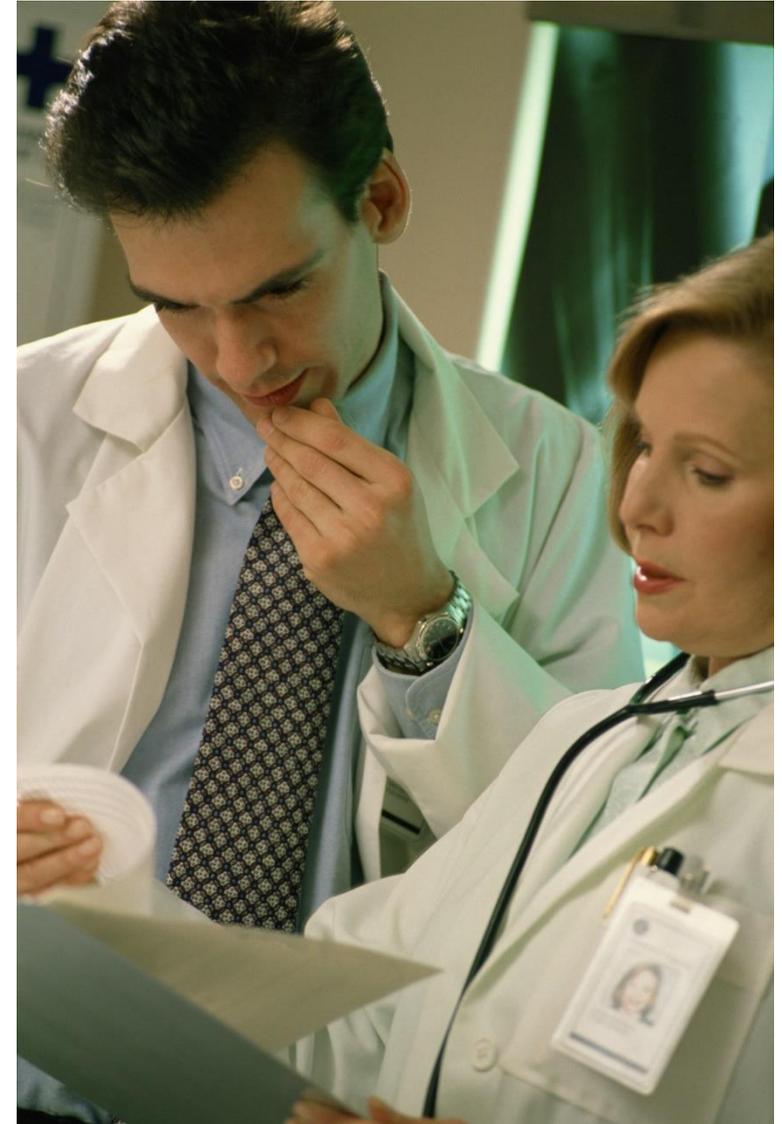
Region	Counties
Central	Autauga, Butler, Chilton, Crenshaw, Dallas, Elmore, Lowndes, Marengo, Montgomery, Perry, and Wilcox counties
East	Blount, Calhoun, Cherokee, Clay, Cleburne, Coosa, DeKalb, Etowah, Randolph, Talladega, Tallapoosa, and St. Clair counties
Jefferson/Shelby	Jefferson, and Shelby counties
Northeast	Cullman, Jackson, Limestone, Madison, Marshall, and Morgan counties
Northwest	Bibb, Colbert, Fayette, Franklin, Greene, Hale, Lamar, Lauderdale, Lawrence, Marion, Pickens, Sumter, Tuscaloosa, Walker, and Winston counties
Southeast	Barbour, Bullock, Chambers, Coffee, Covington, Dale, Geneva, Henry, Houston, Lee, Macon, Pike, and Russell counties
Southwest	Baldwin, Choctaw, Clarke, Conecuh, Escambia, Mobile, Monroe, and Washington counties

ACHN Participants



- General Population – Current Patient 1st recipients, plus current/former foster children
- Medicaid-eligible maternity care recipients
- Plan First – Women ages 19-55 and men age 21 and over

Care Coordination Services



Care Coordination Services



- Care Coordination referrals may be requested by providers, recipients, or community sources
- Care Coordination services provided in a setting of recipient's choice, to include provider offices, hospitals, ACHN entity office, public location, or in the recipient's home
- Screening and assessment of recipient needs
- Assist recipients in obtaining transportation or applying for Medicaid
- Help recipients with appointments or appointment reminders
- Coordinate and facilitate referrals
- Educate or assist recipients with medication or treatment plans
- Help recipients seek care in the most appropriate setting (e.g. office verses ER)
- Help recipients locate needed community services

Care Coordination Program - Maternity Population



Care coordination services provided by the ACHN for the maternity population include

- Face-to-Face eligibility assistance
- First Face-to-Face encounter
- Face-to-Face follow-up encounter
- Inpatient Face-to-Face delivery encounter
- In Home Face-to-Face postpartum encounter

Care Coordination - CMC



- Children with Medical Complexity (CMC) require the highest level of intensity of care and frequently numerous pediatric specialists are required to care for their conditions. The medical and social care for these children is typically more extensive than other members of the general population.
- These children are frequently medically fragile with congenital/acquired multi-system disease. Many require medical technology to sustain their activities of daily living.
 - They also must have a qualifying diagnosis/condition and/or social assessment to meet CMC criteria for this program.
- The PCP, in concurrence with the ACHN Medical Director, may also identify additional EIs for this group.

CMC Staffing Requirements



- The PCCM-E must have staff with pediatric experience to provide training to general Care Coordination staff in the care and linking of services for children with medical complexity.
 - Pediatric Nurse: Must have a BSN with a minimum of two (2) years complex pediatric nursing experience or an ADN with a minimum of five (5) years complex pediatric nursing experience. Preferred experience settings include acute hospital, intensive care, Children's Rehabilitation, Children's Specialty Clinic, or a pediatric practice.
 - Social Worker: A Licensed Independent Clinical Social Worker (LICSW) (preferred) or a Licensed Master Social Worker (LMSW) with experience in a pediatric environment. Preferred experience settings include acute hospital, intensive care, Children's Rehabilitation, Children's Specialty Clinic, Children's Mental Health, or pediatric clinic.
 - Pharmacist: A Pharm D is required with pediatric experience preferred

Quality Improvement



Quality and the ACHN Program



- Although the ACHN Program is creating a single coordinated system to provide care coordination for:
 - General Population – old Patient 1st and Health Homes
 - Maternity Population – old Maternity Contractors
 - Family Planning Population – Plan First
- The Agency believes the ACHN Program is primarily a Quality Assurance Program
 - By providing a single entity that is responsible for the needs of recipients throughout their life and the different stages of their life, the health outcomes of all recipients will be improved
- Quality Care for Medicaid recipients will always be the #1 priority

Collaboration is Critical for Success



- Quarterly Quality Collaborative
 - Used to discuss programmatic issues
 - Agency and ACHN concerns
 - Discussion of best practices
- Quarterly Medical Management Meetings
 - Implement and supervise program initiatives centered around quality measures
 - Review utilization data with PCPs as needed to achieve quality goals of the ACHN
 - Review and assist the ACHN in implementing and evaluating its QIPs
 - Discuss, and when appropriate, resolve any issues the PCPs or the ACHN encounter in providing Care Coordination services to their EIs

Quality Measures



- Measure and report to the Agency on its performance, using the Quality Measures required by the Agency; or
- Submit data, specified by the Agency, which enables the Agency to calculate the PCCM-E's performance using the Quality Measures identified by the Agency
- Data Sources:
 - Administrative Claims, including Recipient 3 Yr. History provided by the Agency
 - CAHPS Patient Satisfaction Surveys
 - Other Sources of data, i.e. Maternity data, Substance Use Data

ACHN Quality Incentive Program Measures

CMS Measure Designation		ACHN Measure Description
1	W15-CH	Well-Child Visits in the First 15 Months of Life
2	ABA-AD	Adult BMI Check
3	WCC-CH	Child BMI
4	CCS-AD	Cervical Cancer Screen
5a	AMR-CH	Asthma Medication Ratio (Child Measure)
5b	AMR-AD	Asthma Medication Ratio (Adult Measure)
6	AMM-AD	Antidepressant Medication Management
7	LBW-AD	Live Births less than 2500
8a	CAP-CH	CAP-CH 12-24 months
8b		CAP-CH 25-mos - 6-years
8c		Child Access to Care 7-years to 11-years
8d		Child Access to Care 12-years to 19-years
9	PPC-CH	Prenatal and Postpartum: Timeliness of Prenatal Care
10	IET-AD	Initiation and Engagement of Treatment for AOD [Initiation]
		Initiation and Engagement of Treatment for AOD [Continuation]



Quality Incentive Program

- Beginning in year one (1) of the ACHN Program, the ACHN will have the opportunity to participate in an Incentive Program based upon the achievement of Agency determined benchmarks for each of the Quality Measures
- If the ACHN achieves the minimum necessary of the annual benchmarks, it will be eligible to receive up to a ten percent (10%) incentive payment. See Exhibit P of the RFP, Table 1 for more information on the qualifications and awarding of the Quality Incentive Payment, and see Exhibit Q for the list of Quality Measures
- See [Baseline and Targets Chart](#)

Total Quality Incentive Program Score	Percentage of Incentive Earned
Less than 20 points	0%
Between 20 points and 30 points	25%
Between 31 points and 50 points	50%
Between 51 points and less than 80 points	75%
80 or more points	100%

Quality Improvement Projects



- The goal of the ACHN QIPs is to truly invest in the implementation of projects that will lead to true improvement of health outcomes related to:
 - Prevention of Childhood Obesity
 - Infant Mortality
 - Substance Use Disorders
- The Agency has chosen 3 Lead Technical Assistance Organizations to provide guidance and support in the development of the QIPs
- QIP Development
 - Mid-September there will be an introductory call for ACHN and Lead TA Organizations to provide overview and information about the topics
 - October 2019 – Initial Submission of the QIPs
 - Ongoing Quarterly calls with EQRO to provide feedback and evaluation on the implementation of the QIPs

What is expected for an ACHN QIP?



- Quality Improvement Projects (QIPs) comprise one component of the overall PCCM-E Quality Improvement Program
- The purpose of a QIP is to focus on and improve the processes and outcomes of health outcomes of the PCCM-E
 - Annually, the PCCM-E must submit for the Agency's approval, a description of its QIPs which it has chosen to implement to address each of the topic categories chosen by the Agency.
 - Prevention of Childhood Obesity
 - Infant mortality and/or adverse birth outcomes
 - Substance Use Disorders

ACHN QIP Outcome Measures



Area of Focus	ACHN Incentive Measures	Physician Bonus Measures	QIP Outcome Measure
Prevention of Childhood Obesity	Well-Child Visits in the First 15 Months of Life	Well-Child Visits for Children 3 to 6 years of age	Child BMI Assessment
	Adult BMI Assessment		
	Child BMI Assessment	Adolescent Well Care Visits	
	Live Birth Weighing Less than 2500 grams		
	Child Access to Care: 12-24 months	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	
	Child Access to Care: 25 months to 6 years		
	Child Access to Care: 7 -11 years		
	Child Access to Care: 12 – 19 years		
Infant Mortality	Live Birth Weighing Less than 2500 grams	Chlamydia Screening in Women	Reduction in Infant Mortality
	Prenatal and Postpartum Care: Timeliness of Prenatal Care		
	Contraceptive Care – Postpartum Women Ages 21–44		
Substance Use Disorders	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Follow-Up After ED Visit for Alcohol or Other Drug Related Diagnosis	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment



Quality Improvement

- The areas of focus for the Quality Improvement Program are:
 - Reduction of Infant Mortality
 - Substance Use Disorders
 - Prevention of Childhood Obesity
- DHCPs can positively impact quality by
 - Performing a prenatal visit in the first trimester
 - Performing a postpartum visit (21-56 days)
 - Participating in Quality Improvement projects with the ACHN

PCP Quality Measures



8 Provider Quality Measures

4 Child Quality Measures

W34-CH: Well-Child Visits in the 3rd, 4th, 5th, and 6th years of Life

AWC-CH: Adolescent Well-Care Visits

CIS-CH: Childhood Immunization Status - Combination 3

IMA-CH: Immunization For Adolescents - Combination 2

4 Adult Quality Measures

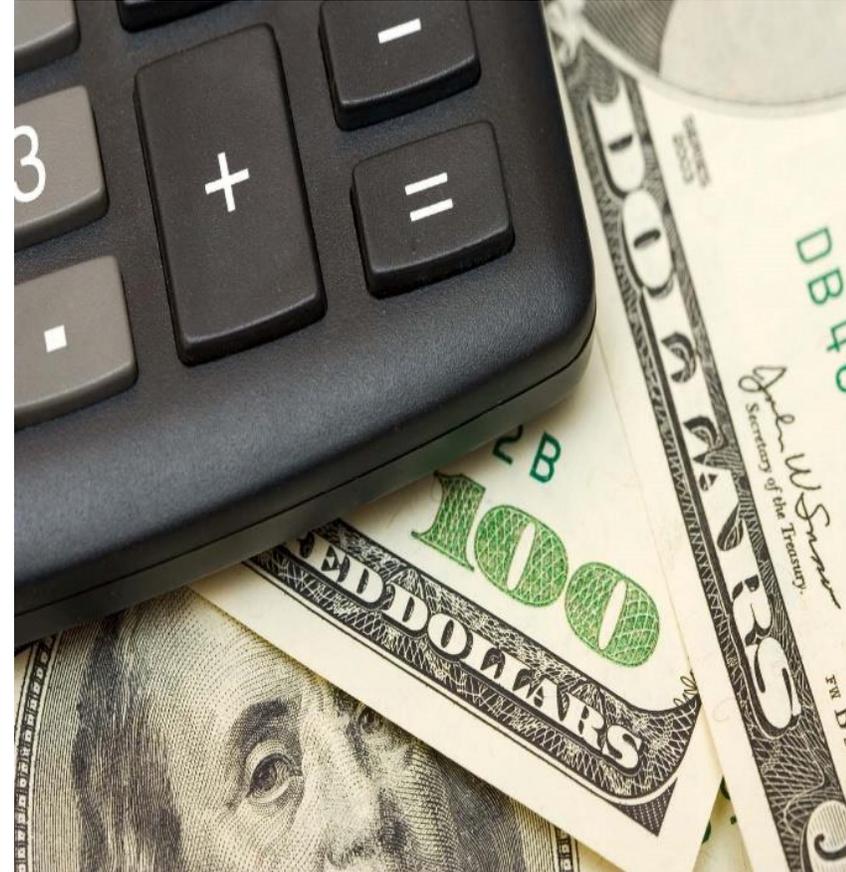
AMM-AD: Antidepressant Medication Management - Continuation Phase

HA1C-AD: Comprehensive Diabetes Care: Hemoglobin A1C (HBA1C) Testing

FUA-AD: Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

CHL-AD: Chlamydia Screening in Women Ages 21–24

ACHN Payment Model



Bonus / Incentive Payments



- Goals aligned for physician, ACHN and Medicaid
- Networks incentivized to meet quality goals
- Payments made quarterly
- Structured to keep PCPs whole during transition

ACHN Payments



- ACHNs are paid through three (3) distinct payments:
 - PMPM for Administrative costs and QIPs – about \$1 per recipient
 - Case Management Payment for Activities – about \$4.5 million annual cap
 - Quality Bonus for meeting or succeeding quality measure targets – up to 10% of total income
- Care Coordination payment model is novel in that it only pays for activities completed by the ACHNs
- ACHNs each have a HIMS (Health Information Management System) that submits at a minimum monthly, all care coordination activities completed
 - MMIS processes activities similar to claims from providers
 - Maternity and Family Planning are paid per activity
 - General Population CC are paid based on total month's activities that then determined based on level of contacts: Intensely Managed, Moderately Managed or Medical Monitoring

CMA Activity Table



Current CODE	Description	Case Management Type			Benefit Plan						Staff Requirements
		General	Mat	FP	TXIX	SBRW	PLNF	Non-Citizens	Other non-Duals (NO Part A or B)	DUALS	
A0001	Case Management Not Successful Contact	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Reject	
A0002	Chart Audit	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Reject	
A0003	Chart Note	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Reject	
A0004	Claims Review	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Reject	
A0005	Correspondence with PCP	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Reject	
A0006	Correspondence w EI	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Reject	
A0007	Medication List	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Reject	
A0008	Medication Reconciliation Follow-Up	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Reject	
A0009	Medication Review	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Reject	
A0010	Pharmacist Note	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Reject	
A0011	Receipt of Referral	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Reject	
A0012	Medication Reconciliation	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Inform	Reject	
G0001	Face to Face Assessment / Reassessment	Accept	Reject	Reject	Accept	Accept	Inform	Inform	Inform	Reject	SW, RN
G0002	Face To Face Practice Encounter w EI	Accept	Reject	Reject	Accept	Accept	Inform	Inform	Inform	Reject	SW, RN
G0003	Face to Face Hospital Transition Contact w EI	Accept	Reject	Reject	Accept	Accept	Inform	Inform	Inform	Reject	SW, RN
G0004	Face to Face In Home Visit	Accept	Reject	Reject	Accept	Accept	Inform	Inform	Inform	Reject	SW, RN
G0005	Face to Face Non-Home Visit	Accept	Reject	Reject	Accept	Accept	Inform	Inform	Inform	Reject	SW, RN
G0006	Phone call - Successful	Accept	Reject	Reject	Accept	Accept	Inform	Inform	Inform	Reject	SW, RN
G0007	Community Resources Assistance	Accept	Reject	Reject	Accept	Accept	Inform	Inform	Inform	Reject	SW, RN
G0008	Other Professional Encounter	Accept	Reject	Reject	Accept	Accept	Inform	Inform	Inform	Reject	SW, RN
G0009	Professional Encounter with PCP	Accept	Reject	Reject	Accept	Accept	Inform	Inform	Inform	Reject	SW, RN
G0010	Transportation Request	Accept	Reject	Reject	Accept	Accept	Inform	Inform	Inform	Reject	any staff
G0011	Multi-disciplinary Care Team Meeting	Accept	Reject	Reject	Accept	Accept	Inform	Inform	Inform	Reject	SW, RN
G0012	Case Review - Clinical Monitoring	Accept	Reject	Reject	Accept	Accept	Inform	Inform	Inform	Reject	RN

CMA Activity Table (cont.)

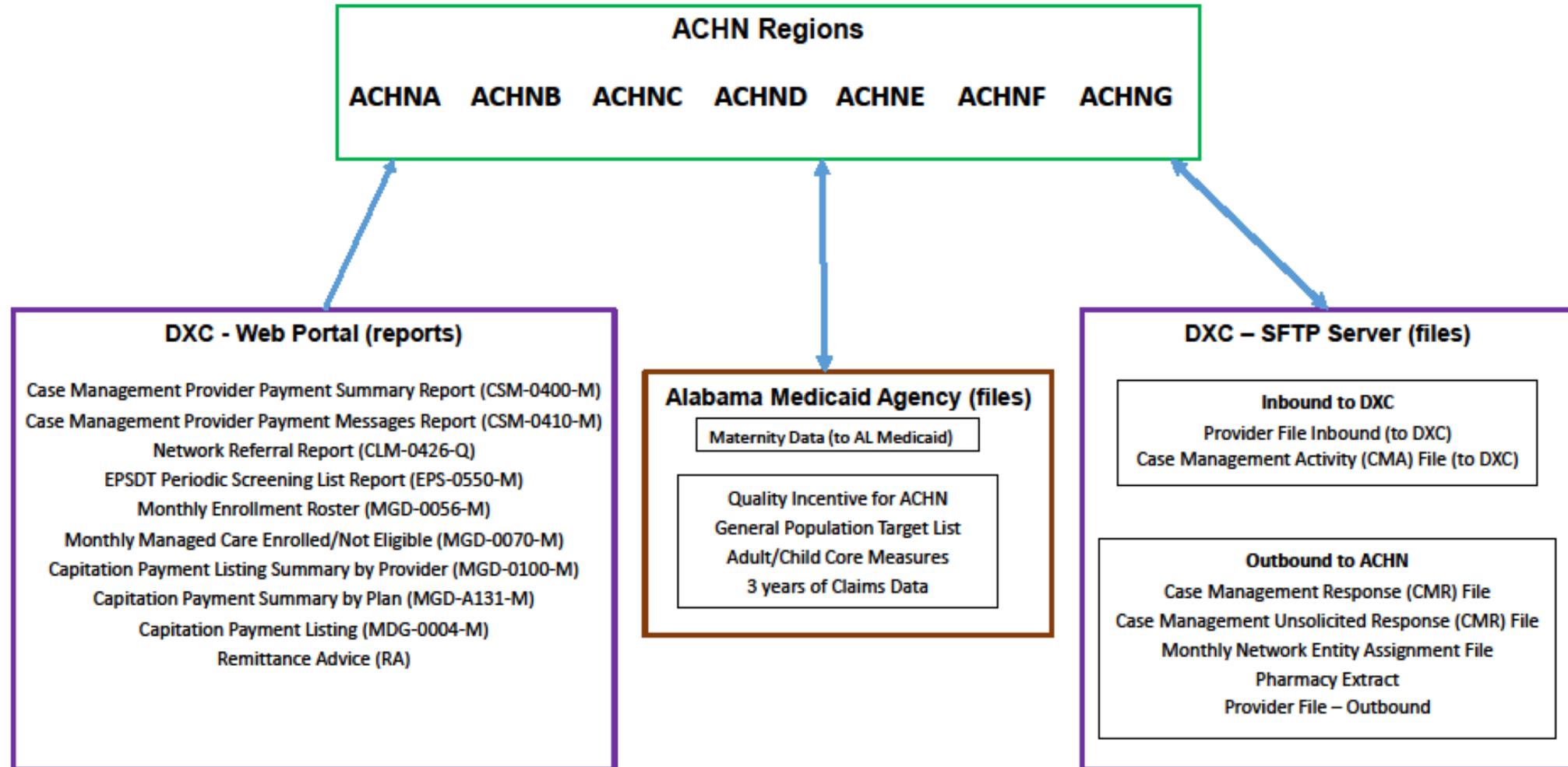


Current CODE	Description	Case Management Type			Benefit Plan						Staff Requirements
		General	Mat	FP	TXIX	SBRW	PLNF	Non-Citizens	Other non-Duals (NO Part A or B)	DUAL S	
M0001	Maternity Face to Face Eligibility Assistance	Reject	Accept	Reject	Reject	Accept	Susp	Inform	Reject	Reject	SW, RN, LPN
M0002	Maternity Face to Face Screening and Assessment	Reject	Accept	Reject	Accept	Accept	Susp	Inform	Accept	Reject	SW, RN, LPN
M0003	Maternity Face to Face Case Management Visit	Reject	Accept	Reject	Accept	Accept	Inform	Inform	Accept	Reject	SW, RN, LPN
M0004	Maternity Face to Face Delivery Encounter	Reject	Accept	Reject	Accept	Accept	Inform	Accept	Accept	Reject	SW, RN, LPN
M0005	Maternity Face to Face Post-Partum Home Visit	Reject	Accept	Reject	Accept	Accept	Inform	Inform	Accept	Reject	SW, RN, LPN
M0006	One-time transfer payment	Reject	Accept	Reject	Accept	Accept	Reject	Reject	Accept	Reject	SW, RN, LPN
F0001	FP Face to Face Case Care Coordination	Reject	Reject	Accept	Accept	Accept	Accept	Inform	Inform	Reject	SW, RN, BSN
F0002	FP Face to Face Risk Screening	Reject	Reject	Accept	Accept	Accept	Accept	Inform	Inform	Reject	SW, RN, BSN
F0003	FP Phone Care Coordination	Reject	Reject	Accept	Accept	Accept	Accept	Inform	Inform	Reject	SW, RN, BSN

HIMS Data Feeds



ACHN Interface File Flows



Payments and Rates for PCPs contracted with the ACHN



Agreements Required



- Alabama Medicaid Provider Agreement
- Alabama Medicaid Primary Care Physician Group Agreement
- Agreement between ACHN entity and the PCP group
- Only necessary to sign the one ACHN agreement; may participate with any region

ACHN Participation Requirements



Physician groups must also meet the following criteria for participation:

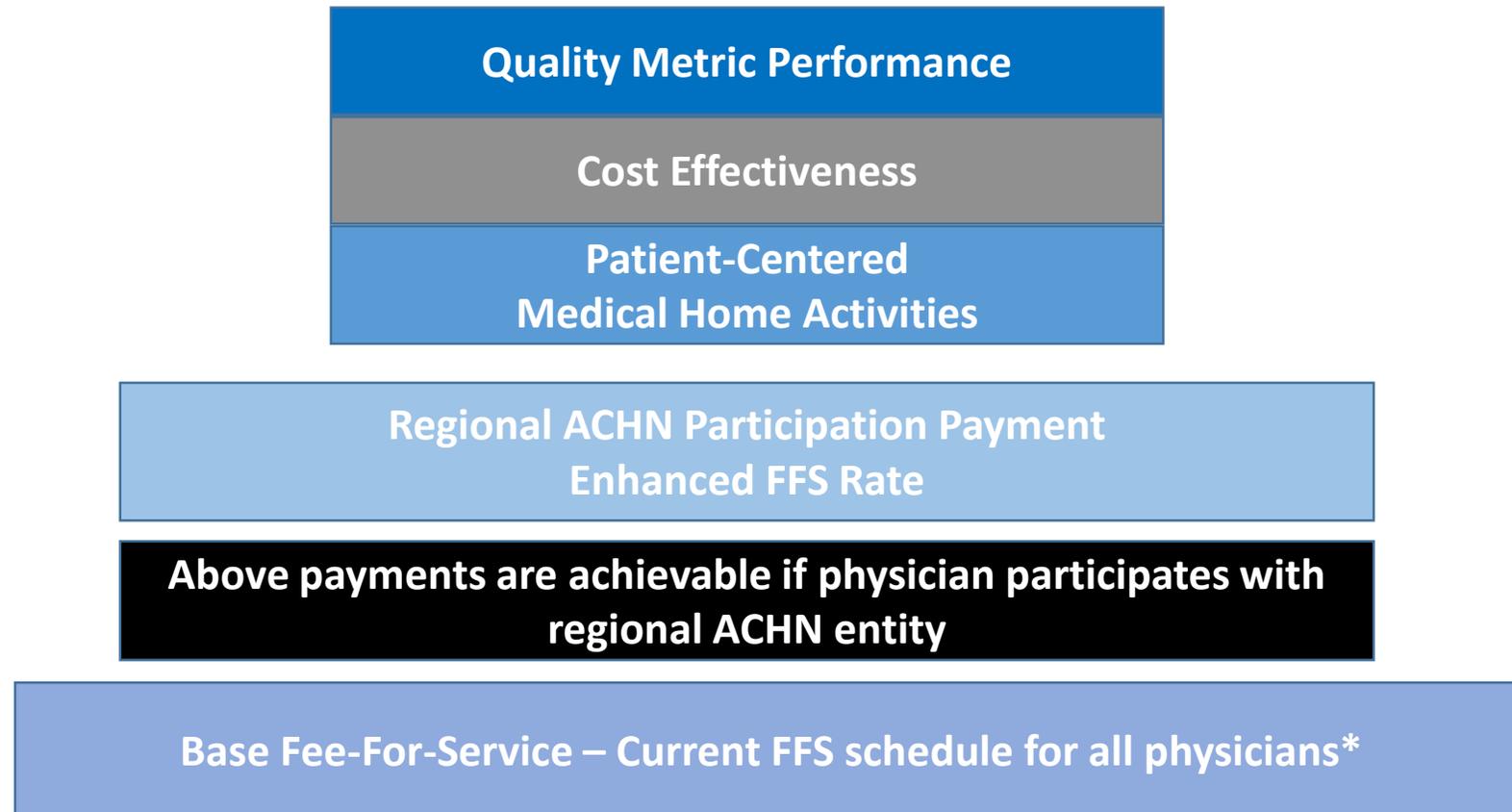
- Actively work with the ACHN entity to review recipient care plans
- Participate as needed in ACHN Multi-Disciplinary Care Team (MCT)
- Participate in ACHN initiatives centered around quality measures
- Participate in at least two quarterly Medical Management Meetings and one webinar/facilitation exercise with the regional ACHN medical director over a 12-month period
 - NPs and PAs may attend for PCP
- Review data provided by the ACHN to help achieve regional and state Medicaid goals

ACHN Participation Requirements



- Alternate payment methodologies are used for these providers:
 - FQHCs and Rural Health Clinics
 - Physicians who are part of the medical faculty as determined by a state university

PCP Payment Structure



*** Providers currently eligible for BUMP Payments will still be able to receive BUMP rates if they choose to not participate with the ACHN but will *NOT* be eligible for Participation Rates or Bonus Payments.**

Patient Attribution for Quality and Cost Effectiveness



- Recipients will not be assigned to individual PCPs, but will be **attributed** at PCP group level
- Recipients will be **attributed** to PCP group based on where they received services
- Score will be calculated for each recipient/provider combination

Attribution Overview



- Attribution is the process that will be used to associate a Medicaid recipient to the PCP Group that provides primary care to that recipient.
 - PCP Groups must sign the two agreements (one with Medicaid, one with an ACHN entity) to participate.
- Under the ACHN Program, Medicaid recipients will be attributed to PCP Groups based on historical claims data utilization.
- PCPs are encouraged to continue seeing patients, as medically necessary, on a consistent basis to increase the likelihood of attribution.
- Attribution is a critical factor in determining distribution of bonus payments among eligible providers.

Guiding Principles of Attribution Methodology



- Consistency with ACHN's principles of paying for activity.
- Continued emphasis on care coordination and health outcomes with a focus on preventative care.
- Acknowledgement that some recipients require specialist care.
- Evaluation of activities at the group level.

Key Steps in Attribution



- Medicaid recipients that have met criteria for the ACHN Program for three out of the previous 24 months will be attributed. This does not have to be a continuous period.
- The previous two-year history of face-to-face provider visits:
 - Both preventive visits and regular office visits are scored.
 - Preventive visits receive a higher point value.
 - Recent visits are scored higher than older visits.
 - PCP visits receive a higher point value than specialist visits.
- The previous 12-month history of filled prescriptions for chronic care conditions are scored.

Attribution Process



On a quarterly basis, the Medicaid Agency will determine attribution for each Medicaid recipient under the ACHN Program in accordance to the following process:

- Point values for face-to-face visits will be assigned to the individual provider that performed the service.
- The individual PCP scores will be combined to form the PCP Group's total point score for each patient.
- The PCP Group with the highest number of points will have the Medicaid recipient attributed to that PCP Group.
 - If a specialist group has the highest number of points, then the specialist group will be attributed the Medicaid recipient.

ACHN Payment Summary



ACHN Primary Care Physician Payment Chart

Primary Care Physician Scenarios	Base FFS Rates	Bump Rates	Participation Rates	Bonus Payments
PCP Scenario 1: PCPs not eligible for Bump Rates & not participating with ACHN	✓	✗	✗	✗
PCP Scenario 2: PCPs not eligible for Bump Rates & participating with ACHN	✓	✗	✓	✓
PCP Scenario 3: PCPs eligible for Bump Rates & not participating with ACHN	✗	✓	✗	✗
PCP Scenario 4: PCPs eligible for Bump Rates & participating with ACHN	✗	✓	✓	✓

EXAMPLE

Participation Rate (PR) = Enhanced Rates for fifteen E & M codes

PCP Scenario 1 Example: Receive only Base FFS Rates for all codes, including the fifteen PR codes

PCP Scenario 2 Example: Receive PR for the fifteen E & M codes and Basic FFS Rates for all other codes

PCP Scenario 3 Example: Receive Bump Rates for all codes, including the fifteen PR codes

PCP Scenario 4 Example: Receive PR for the fifteen E & M codes and Bump Rates for all other codes

Payments and Rates for DHCPs contracted with the ACHN



If you are a Delivering Healthcare Provider (DHCP)



- Claims for maternity services will be reimbursed directly by Medicaid
- You will have the opportunity to receive the following bonus payments in addition to your FFS payment
 - An initial prenatal visit made in the first trimester
 - A postpartum visit (if provided 21-56 days postpartum)
- To receive payment for services, DHCP groups must sign an agreement and actively participate with the ACHN
 - Only one agreement needs to be signed for participation in all ACHNs



If you are a DHCP

- Currently, DHCPs either bill Medicaid directly for services or bill the Primary Contractor for services
- Current Medicaid global rates are between \$950 - \$1,300 for urban and between \$1,250 - \$1,700 for rural
- Primary Contractors pay physicians in different ways: Some include ultrasounds in a global rate, some do not include ultrasounds in the global rate
- The average global payment made by a Primary Contractor is between \$1,300 - \$2,273. Some Primary Contractors pay a different rate for urban and rural

ACHN Provider Summary



Current Program	ACHN
12 Maternity Districts	7 Networks/Regions
6 Health Homes in 5 Regions	7 Networks/Regions
ADPH Staff serving 67 Counties	7 Networks/Regions
Care Coordination programs are in silos	Care Coordination is combined into a single delivery system
Medical Management Meetings require Physician Attendance	Medical Management Meetings will allow a NP or PA to attend for the Physician
PMP to PMP Referral Required	PCP to PCP referral not required
PMP Agreement with Health Home is required for each Health Home the PCP is working with	Only <u>one</u> agreement will be required, but will cover all 7 Networks

Questions



- **Website: www.Medicaid.alabama.gov**
ACHN > ACHN Providers
- **[Direct Link to Frequently Asked Questions](#)**
- **Submit questions for official response to:**
ACHN@medicaid.alabama.gov