Provider Insider

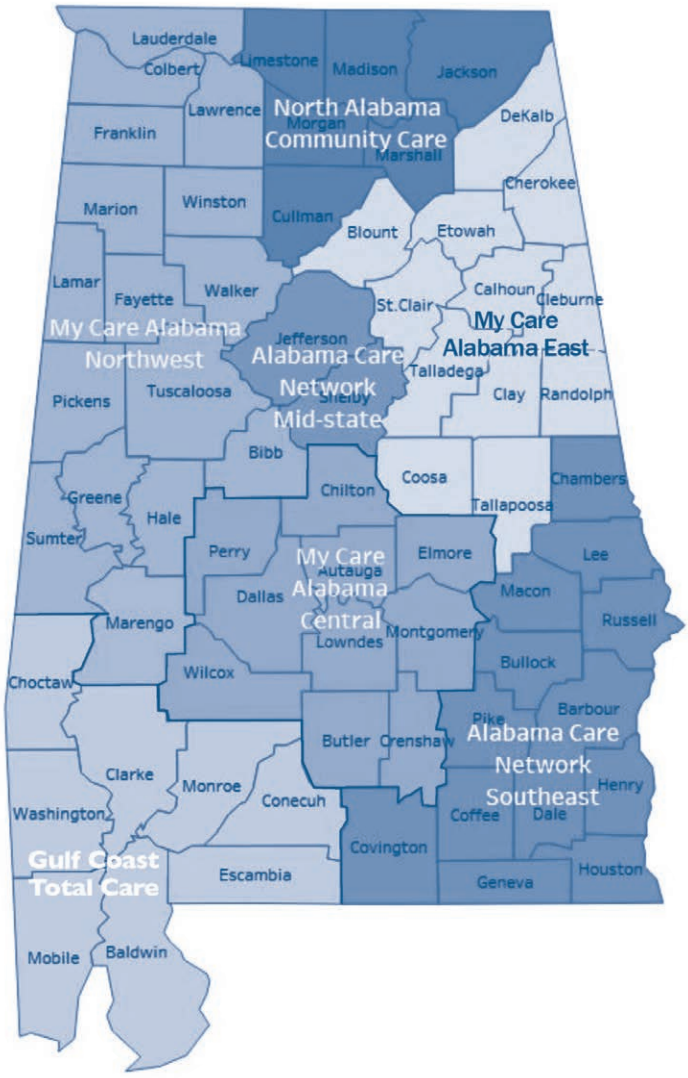
Alabama Medicaid Special Edition **September 2019**

OVERVIEW OF THE ALABAMA COORDINATED HEALTH NETWORK

ALABAMA COORDINATED HEALTH NETWORK (ACHN)

The Alabama Coordinated Health Network (ACHN) Program will go live on October 1, 2019. Medicaid received approval of a 1915(b) waiver from the Centers for Medicare and Medicaid Services (CMS) on June 14, 2019, that authorizes Medicaid to implement the program. The Networks will provide a single care coordination delivery system combining Health Homes, the Maternity Program, and Plan First.

The ACHN Program will effectively link patients, providers and community resources in each of seven newly-defined regions to improve health outcomes for Medicaid recipients. A map describing the breakout of the regions is shown below:



In this special edition of Provider Insider, detailed information is provided for Primary Care Physicians (PCPs) and Delivering Healthcare Professionals (DHCPs).

ACHN PARTICIPANTS

The ACHN Program will affect current Patient 1st recipients, current/former foster children, Medicaid-eligible maternity care recipients, and Plan First participants (women age 19-55 and men 21 and older).

In This Issue

Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ❒ Office Manager
- ❒ Billing Department
- ❒ Medical/Clinical Professionals
- ❒ Other _____

The information contained within is subject to change. Please review your Provider Manual and all Provider Alerts for the most up-to-date information.

ACHN CARE COORDINATION SERVICES

The ACHN will provide Care Coordination services beginning November 1, 2019. PCPs will no longer manage a panel, but they will partner with licensed social workers and nurses from the ACHN who will provide care coordination services. Medicaid is moving to a system of attribution instead of panels. Refer to the Administrative Code, Rule No. 560-X-37-.09 for details on attribution. PCPs should continue to see patients on their panels, especially those that have not been seen in the previous two years, to ensure these services provided are considered when patients are attributed in October 2019.

PCPs should inform their patients that no care coordination services will be provided by the ACHN in October; these services will be provided by the ACHN beginning November 1, 2019. Care Coordination referrals may be requested by providers, recipients, or community sources. The ACHN care coordinators can, among other things:

- Provide services in a setting of the recipient's choice, including a provider office, a hospital, the ACHN office in their region, a public location, or in the recipient's home
- Help manage complex or non-compliant patients
- Perform a screening and assessment of the recipient's 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 versus Emergency Room)
- Facilitate communication between the patient and care providers
- Help recipients locate needed community services

Recipients with abnormal lead levels, newborn metabolic screenings, and newborn hearing screenings will continue to receive care coordination from the Alabama Department of Public Health.

PRIMARY CARE PHYSICIAN (PCP)

AGREEMENTS FOR PRIMARY CARE PHYSICIANS (PCP)

Primary Care Physicians (PCPs) who want to receive Bonus Payments and ACHN Participation Rates in conjunction with the state's ACHN Program must sign **two** agreements beyond their Medicaid Enrollment. A PCP Group Enrollment Agreement with Medicaid and one agreement with the ACHN is required. The PCP must be enrolled with Medicaid as a Medicaid provider. Send both agreements in as soon as possible to prevent delay of payments.

1. To download the PCP Group Enrollment Agreement with Alabama Medicaid Agency:
   https://medicaid.alabama.gov/documents/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers/5.1.3_PCP_Group_Enrollment_Agreement_with_Medicaid_5-10-19.pdf

2. To obtain the PCP Group Agreement with the ACHN, email the ACHN Regional contact at the following link:
   https://medicaid.alabama.gov/documents/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers/5.1.3_ACHN%20_Regional_Map_Contacts_Revised_9-3-19.pdf

Family Practitioners, General Practitioners, Pediatricians, Internists, OB/GYNs, FQHCs, and RHCs are eligible to participate with an ACHN as a PCP.

When in the best interest of a patient, a nontraditional PCP may choose to enroll as a PCP with Medicaid. Other physician types may be considered for PCP participation if willing to meet all contractual and participation requirements.

In the absence of these agreements, PCPs will not be eligible to receive enhanced Participation Rates or Bonus Payments for Quality, Cost Effectiveness, and Patient Centered Medical Home (PCMH) recognition. If a provider chooses not to participate, they will receive regular fee-for-service rates or current BUMP rates if eligible.

REQUIREMENTS FOR BMI DIAGNOSIS

Obesity is a chronic disease with complex psychological, environmental (social and cultural), genetic, physiological, and metabolic causes and consequences. Childhood obesity is an area of focus for the ACHN Program. A Childhood Obesity initiative is one Quality Improvement Project the Networks are required to implement.

Beginning October 1, 2019, Primary Care Physicians (PCPs), nurse practitioners, physician assistants, PCP groups with a PCP Enrollment Agreement on file with Medicaid, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Public Health Departments, and Teaching Facilities that bill procedure codes 99201-99205, 99211-99215, and 99241-99245 must include a BMI diagnosis on the claim or the claim will be denied.

The table below provides a description of procedure codes and ICD-10 codes that require a percentile on the CMS 1500 claim form for **recipients age 3 up to age 20:**

Procedure Code Description		ICD-10 Diagnosis Code Description for Age 3 up to age 20	
99201	Office/Outpatient Visit New		
99202	Office/Outpatient Visit New	Z6851	BMI Pediatric, Less Than 5th Percentile for Age
99203	Office/Outpatient Visit New	Z6852	BMI Pediatric, 5th Percentile to Less Than 85% for Age
99204	Office/Outpatient Visit New	Z6853	BMI Pediatric, 85% To Less Than 95th Percentile for Age
99205	Office/Outpatient Visit New	Z6854	BMI Pediatric, Greater Than or Equal To 95% for Age
99211	Office/Outpatient Visit Est		
99212	Office/Outpatient Visit Est		
99213	Office/Outpatient Visit Est		
99214	Office/Outpatient Visit Est		
99215	Office/Outpatient Visit Est		
99241	Office Consultation		
99242	Office Consultation		
99243	Office Consultation		
99244	Office Consultation		
99245	Office Consultation		

The table below provides a description of procedure codes and ICD-10 diagnosis codes for BMI that is required on the CMS 1500 claim form for **recipients age 20 years of age and older**:

Procedure Code Description		ICD-10 Diagnosis Code Description for Ages 20 and Older	
99201	Office/Outpatient Visit New	Z681	Body Mass Index (BMI) 19 Or Less, Adult
99202	Office/Outpatient Visit New	Z6820	Body Mass Index (BMI) 20.0-20.9, Adult
99203	Office/Outpatient Visit New	Z6821	Body Mass Index (BMI) 21.0-21.9, Adult
99204	Office/Outpatient Visit New	Z6822	Body Mass Index (BMI) 22.0-22.9, Adult
99205	Office/Outpatient Visit New	Z6823	Body Mass Index (BMI) 23.0-23.9, Adult
		Z6824	Body Mass Index (BMI) 24.0-24.9, Adult
99211	Office/Outpatient Visit Est	Z6825	Body Mass Index (BMI) 25.0-25.9, Adult
99212	Office/Outpatient Visit Est	Z6826	Body Mass Index (BMI) 26.0-26.9, Adult
99213	Office/Outpatient Visit Est	Z6827	Body Mass Index (BMI) 27.0-27.9, Adult
99214	Office/Outpatient Visit Est	Z6828	Body Mass Index (BMI) 28.0-28.9, Adult
99215	Office/Outpatient Visit Est	Z6829	Body Mass Index (BMI) 29.0-29.9, Adult
		Z6830	Body Mass Index (BMI) 30.0-30.9, Adult
99241	Office Consultation	Z6831	Body Mass Index (BMI) 31.0-31.9, Adult
99242	Office Consultation	Z6832	Body Mass Index (BMI) 32.0-32.9, Adult
99243	Office Consultation	Z6833	Body Mass Index (BMI) 33.0-33.9, Adult
99244	Office Consultation	Z6834	Body Mass Index (BMI) 34.0-34.9, Adult
99245	Office Consultation	Z6835	Body Mass Index (BMI) 35.0-35.9, Adult
		Z6836	Body Mass Index (BMI) 36.0-36.9, Adult
		Z6837	Body Mass Index (BMI) 37.0-37.9, Adult
		Z6838	Body Mass Index (BMI) 38.0-38.9, Adult
		Z6839	Body Mass Index (BMI) 39.0-39.9, Adult
		Z6841	Body Mass Index (BMI) 40.0-44.9, Adult
		Z6842	Body Mass Index (BMI) 45.0-49.9, Adult
		Z6843	Body Mass Index (BMI) 50-59.9, Adult
		Z6844	Body Mass Index (BMI) 60.0-69.9, Adult
		Z6845	Body Mass Index (BMI) 70 or Greater, Adult

REFERRAL REQUIREMENTS FOR PRIMARY CARE PHYSICIANS (PCPS)

Unlike the Patient 1st Program, in the new ACHN Program recipients will not be assigned to specific PCPs but will be attributed to a PCP based on historical claims data. PCP to PCP referrals will no longer be required. For most specialty services, a referral from a PCP is required. EPSDT referrals will continue to be required with the implementation of ACHN. Recipient eligibility screens will display the date of the last screening and the attributed provider for the recipient. Referral requirements may apply to Professional and Outpatient claims.

NOTE: Referrals to specialists/consultants can also be authorized by Physician extenders (e.g., Nurse Practitioners and Physician Assistants).

Referral Form - All referrals must be documented on the revised (10/1/2019) Alabama Medicaid Referral Form (Form 362).

- Hard copy referrals require the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee. This means that a signature signed by the physician's designee, must be a complete signature, not initials
- For electronic referrals, an electronic or digital signature is required

Referral authorization from the PCP must be given prior to patient treatment. If given verbally, a written or electronic referral form, from the PCP to the consultant, must follow within 72 hours of the verbal authorization.

Referral Process for PCP to Specialist/Consultant. Coordination of care is an important part of the PCP referral process. PCPs may refer a patient to any practitioner that can best meet the patient's needs. However, every effort should be made to refer patients to Medicaid enrolled physicians that are reasonably geographically accessible for the patient.

In some cases, the PCP may choose to authorize a service retroactively. All referrals, including services authorized retroactively, are at the discretion of the PCP. Some services do not require referral (e.g., administration of allergy injections, ambulance services, certified emergencies, radiology services, laboratory services). Some provider types also do not require a referral including county health departments, Children's Rehab Services (CRS), hospitals, independent radiologists, pathologists, and dermatologists.

For a complete list of services and provider types not requiring a referral, please see Chapter 40 of the Provider Billing Manual (October 1, 2019).

Referral Process from an ACHN for Billing Purposes only. An "ACHN Billing Referral" to a specialist/consultant may be needed in certain instances such as when a recipient has been referred by an emergency room physician to a specialist/consultant and the recipient does not have a PCP. In these instances, the ACHN must be contacted by the specialist for an "ACHN Billing Referral." The ACHN will document on Medicaid's Referral Form 362 "For Billing Purposes Only" in the space provided under REFERRAL VALID FOR. The ACHN will encourage the recipient to enroll into active care coordination to ensure the recipient finds a PCP as quickly as possible.

REIMBURSEMENTS AND PAYMENTS TO PCPs

With the implementation of the ACHN, PCPs will no longer receive case management fees but will be eligible to earn higher payments for 15 Evaluation & Management (E&M) codes if they participate with the ACHNs. This higher payment is called the ACHN Participation Rate and includes the following E&M codes: 99201-99205, 99211-99215, and 99241-99245. Nurse Practitioners and Physician Assistants who are enrolled in the PCP Group will receive 80% of the physician rate for these E&M codes. FQHCs and RHCs are excluded from this payment, as they will continue to receive encounter rates.

All PCPs (including FQHCs and RHCs) participating with the ACHN will initially qualify to receive Bonus Payments for meeting Quality, Cost Effectiveness, and Patient Centered Medical Home (PCMH) recognition.

Current BUMP Rate. Requirements for the BUMP rates are unchanged and include:

- Must be Board certified with a specialty or subspecialty designation in family medicine, general internal medicine, or pediatrics that is recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA), and must actually practice in their specialty.
- A NON-board certified provider who practices in the field of family medicine, general internal medicine, or pediatrics or a subspecialty under one of these specialties, is eligible if he/she can attest that sixty percent of their paid Medicaid procedures billed are for certain specified procedure codes for E&M services and certain Vaccines for Children (VFC) vaccine administration codes during the most recently completed Calendar Year or, for newly eligible physicians, the prior month.

Definitions for Different Rates PCPs may earn:

Fee-For-Service Rates. This is the base fee-for-service rate a physician will receive for E&M codes if he/she chooses not to participate with the ACHN.

BUMP Rates. PCPs must qualify for the BUMP rates as described above and follow the same attestation process as currently exists.

Participation Rates. Participation Rates are higher than BUMP rates and will be paid to providers that participate with the ACHN. FQHCs and RHCs will not receive these rates, however, they will continue to receive encounter rates.

Bonus Payments. These payments will be made to all participating providers (including FQHCs and RHCs) during the start-up phase of the program and will be based on the attribution of recipients to providers. After the start-up phase, bonuses will be based on performance.

The table below shows four different scenarios for PCP payments:

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

The table below further describes the four different PCP payment scenarios listed above:

* EXAMPLES *
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, FFS Rates for all other codes, and Bonus Payments
PCP Scenario 3 Example: Receive Bump Rates only (no Participation Rates or Bonus Payments)
PCP Scenario 4 Example: Receive PR for the fifteen E&M codes, Bump Rates for all other codes, and Bonus Payments

Payment Types and Payment Cycles are described in the table below:

Type of Payment	When Paid
Fee-For-Service	Every checkwrite
ACHN Participation Rate	Every checkwrite
Bonus Payment	Beginning with the first checkwrite in November, the next payment will be made the first checkwrite in January 2020 and quarterly thereafter
BUMP Payments	Every checkwrite

BUMP Rates vs. ACHN Participation Rates are described in the table below:

Procedure	Procedure Description	BUMP Rate	ACHN Participation Rate	Amount Increase
99201	OFFICE/OUTPATIENT VISIT NEW	$40.04	$42.00	$1.96
99202	OFFICE/OUTPATIENT VISIT NEW	$69.27	$73.00	$3.73
99203	OFFICE/OUTPATIENT VISIT NEW	$100.52	$107.00	$6.48
99204	OFFICE/OUTPATIENT VISIT NEW	$155.25	$166.00	$10.75
99205	OFFICE/OUTPATIENT VISIT NEW	$194.18	$210.00	$15.82
99211	OFFICE/OUTPATIENT VISIT EST.	$18.46	$19.00	$0.54
99212	OFFICE/OUTPATIENT VISIT EST.	$40.36	$41.00	$0.64
99213	OFFICE/OUTPATIENT VISIT EST.	$68.17	$72.00	$3.83
99214	OFFICE/OUTPATIENT VISIT EST.	$100.91	$108.00	$7.09
99215	OFFICE/OUTPATIENT VISIT EST.	$135.59	$146.00	$10.41
99241	OFFICE CONSULTATION	$45.45	$46.00	$0.55
99242	OFFICE CONSULTATION	$85.87	$88.00	$2.13
99243	OFFICE CONSULTATION	$117.58	$122.00	$4.42
99244	OFFICE CONSULTATION	$175.38	$184.00	$8.62
99245	OFFICE CONSULTATION	$214.62	$226.00	$11.38

URBAN/RURAL COUNTIES FOR PROVIDERS

A map showing urban and rural counties for providers may be accessed on the Medicaid website at www.medicaid.alabama.gov, then select the ACHN tab, ACHN Providers, Medicaid's Designated Urban and Rural Map.

REQUIREMENTS FOR PCP PARTICIPATION WITH THE ACHN

PCP participation requirements for engaging with one of the seven ACHNs are described below:

- In person attendance over a 12-month period to at least two quarterly medical management meetings and one webinar/facilitation exercise with the ACHN's medical director (one PCP or nurse practitioner/physician assistant from the group may attend to meet attendance requirements)
- Engagement in ACHN initiatives centered around Quality Measures
- Data review with the ACHN to help achieve Agency and ACHN Quality goals
- Engagement as appropriate in the ACHN's multidisciplinary care team and the development of an individualized and comprehensive care plan

If a PCP stops participating or terminates their agreement with the ACHN they signed the original agreement with, then the PCP Group must sign another agreement to actively participate with a different ACHN to continue receiving Participation Rates and Bonus payments.

Agency Monitoring: Participation requirements will be monitored monthly by the Agency and the ACHN. The Agency will remove a PCP or PCP Group from the ACHN for not meeting requirements. Before a PCP Group is removed from ACHN participation, the Agency will confirm with the ACHN and the PCP Group that the Group did not meet the requirements.

ATTRIBUTION

Under the ACHN Program, Medicaid recipients will be attributed to PCP Groups based on historical claims data utilization. Reference Rule No. 560-X-37-.09, "Attribution under the Alabama Coordinated Health Network Program." PCPs are encouraged to continue seeing patients as medically necessary in order to ensure their provided services are considered when patients are attributed in October 2019. Attribution is the process that will be used to associate a Medicaid recipient to the PCP Group that provides primary care to that recipient. Attribution is a critical factor in determining distribution of Bonus Payments among eligible providers. On a quarterly basis, the Medicaid Agency will determine attribution for each Medicaid recipient under the ACHN Program in accordance with the following process:

- The Medicaid Agency will review the previous two-year history of face-to-face provider visit utilization for each Medicaid recipient. Utilization will consider both preventive visits and regular office visits.
- The Medicaid Agency will review the previous 12-month history of filled prescriptions for chronic care conditions for each Medicaid recipient.
- The point values described below associated with the visits and prescriptions will be assigned to the individual doctor that performed the service. The individual PCP scores will be combined to form the PCP Group's total point score for each patient.
    - o Preventive visits will receive a higher point value. Visits that have occurred more recently will receive a higher point value. Visits with a PCP will receive a higher point value than visits with a specialist.
    - o PCP Groups will receive points based on the number of filled prescriptions for chronic care conditions prescribed by members of the group for the past year.
- The PCP Group with the highest number of points will have the Medicaid recipient attributed to that PCP Group. The Medicaid recipient must have met criteria for the ACHN Program for three out of the previous 24 months to be attributed.
- If a specialist group has the highest number of points, then the specialist group will be attributed the Medicaid recipient.

Redetermination of Attribution. A PCP Group may request the attribution calculation for any Medicaid recipient who has received care from the group. If a PCP Group believes the Medicaid Agency has not properly attributed one or more Medicaid recipients to the PCP Group, it may request the Medicaid Agency reconsider its attribution calculation.

- A request for reconsideration must be submitted to the Medicaid Agency in writing and within seven business days of the quarterly attribution notification. The written request for reconsideration must contain:
    - o the period of attribution
    - o the name(s) of the Medicaid recipient(s) that the PCP Group believes was/were not properly attributed
    - o supporting information and/or documentation demonstrating that the Medicaid Agency either failed to or improperly considered information which had a material impact on the result of the attribution

- The PCP Group that has been attributed the Medicaid recipient(s) subject to the request for reconsideration shall be notified by the Medicaid Agency of the request and be permitted to submit information for Medicaid Agency consideration within three business days of the notice. If the PCP Group that has been attributed the Medicaid recipients subject to the request for reconsideration does not respond to Medicaid within the three-day time frame, Medicaid will continue the review without additional information from the attributed group.
- The Medicaid Agency will review all relevant information and complete any adjustments to the PCP Group's Medicaid recipient attribution within seven business days of receipt of the request for reconsideration.

Contact information will be included in the quarterly attribution information.

BONUS PAYMENTS FOR QUALITY, COST EFFECTIVENESS, and PCMH RECOGNITION

This is a Bonus pool in the amount of $15 million annually to fund three Bonus payments for Participating PCP groups. The Bonus Payment pool is allotted as follows:

- 50% for Quality
- 45% for Cost Effectiveness
- 5% for PCMH Recognition

The first quarterly payment will be made on the first checkwrite in November 2019. Subsequent payments will be made on a quarterly basis beginning in January 2020.

Quality Bonus Payments. PCP groups will be eligible for a Bonus Payment if the PCP group meets the requirements described below:

- For the first seven quarters of the program, all practice groups will automatically receive a Quality Bonus Payment that is based solely on the number of attributed patients
- Beginning July 2021, the group must achieve annual Bonus benchmarks determined by the Agency
- Benchmarks will be posted at www.medicaid.alabama.gov, will be updated annually (Click the ACHN tab/Provider), and are statewide.

PCP Quality Measures are listed below:

- Well-child visits for children, ages 3-6
- Adolescent well care visits
- Immunization status—Child
- Immunization status—Adolescent
- Antidepressant medication management
- HbA1c test for diabetic patients
- Follow-up after ER visit for alcohol or other drugs
- Chlamydia screening in women

Quality Bonus Payment Schedule

QUARTER 1 FALL 2019	QUARTER 2 WINTER 2020	QUARTER 3 SPRING 2020	QUARTER 4 SUMMER 2020	QUARTER 5 FALL 2020	QUARTER 6 WINTER 2021	QUARTER 7 SPRING 2021	QUARTER 8 SUMMER 2021
FULL	FULL	FULL	FULL	FULL	FULL	FULL	CALCULATED

Cost Effectiveness Bonus Payments. For at least five quarters, ACHN participating PCP groups will receive a Cost Effectiveness Bonus Payment based on the number of Medicaid recipients attributed to the PCP group for the prior quarterly period. PCPs are encouraged to see their patients prior to October 1, 2019, to ensure attribution.

After the first four quarters, PCP Groups will be eligible for a Bonus payment if the PCP group meets or exceeds the Cost Effectiveness criteria established by the Agency. Payments will be distributed to each PCP group that has met criteria. The Cost Effectiveness Bonus calculation that will begin with the January 2021 payment is described below:

- Compares a 12-month per member per month (PMPM) to a risk-adjusted expected PMPM based on the costs of similar PCP groups that treat Medicaid recipients
- Groups ranked by an efficiency score that is derived from actual PMPM versus the expected PMPM
- Bonus payment is paid for PCP groups at or below the median efficiency score (i.e., more efficient)
- Calculation occurs three months after the previous 12 month's performance has been derived. For example, the quarterly payments made in January 2021 will be based on the actual Cost Effectiveness calculated for the period between October 1, 2019, and September 30, 2020, providing three months of claims payment completion. Likewise, the quarterly payments made in April 2021 will be based on the actual cost effectiveness calculated for the period between January 1, 2020 and December 31, 2020, to allow for three months of claims payment completion.

The Cost Effectiveness calculation includes a PMPM calculation for the ACHN population. The Cost Effectiveness calculation excludes the most recent 3 months of data, hospital access payments, entity case management costs, other Bonus Payments in the waiver, and drug rebates.

Cost Effectiveness Bonus Payment Schedule

QUARTER 1 FALL 2019	QUARTER 2 WINTER 2020	QUARTER 3 SPRING 2020	QUARTER 4 SUMMER 2020	QUARTER 5 FALL 2020	QUARTER 6 WINTER 2021	QUARTER 7 SPRING 2021
FULL	FULL	FULL	FULL	FULL	CALCULATED	CALCULATED

Patient Centered Medical Home (PCMH) Recognition Bonus Payments. The purpose of the PCMH recognition Bonus payment is to incentivize providers to attain PCMH recognition ensuring Medicaid recipients are receiving care through a nationally recognized medical home model. Participating PCP groups can obtain PCMH recognition or certification through nationally recognized entities such as National Committee for Quality Assurance (NCQA) or the Joint Commission (among others). Details from NCQA can be found at https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/?utm_source=ncqa&utm_medium=homepage-link&utm_campaign=pcmh&utm_content=left. Details from the Joint Commission can be found at https://www.jointcommission.org/certification/primary_care_medical_home_certification.aspx.

For at least four quarters, all practice groups will automatically receive a PCMH Bonus Payment. The Agency will review attestation on an annual basis thereafter. More details of this annual review will be forthcoming in June/July 2020.

PCMH Bonus Payments

QUARTER 1 FALL 2019	QUARTER 2 WINTER 2020	QUARTER 3 SPRING 2020	QUARTER 4 SUMMER 2020	QUARTER 5 FALL 2020	QUARTER 6 WINTER 2021
FULL	FULL	FULL	FULL	CALCULATED	CALCULATED

DELIVERING HEALTHCARE PROFESSIONAL (DHCP)

ENROLLMENT REQUIREMENTS FOR DHCPs

Delivering Healthcare Professionals (DHCPs) who want to receive reimbursement and Bonus Payments for providing services to maternity patients must sign a new agreement to participate with an ACHN. In the absence of this agreement, DHCPs will not be eligible for reimbursement for maternity services and will not receive Bonus Payments for performing first trimester and post-partum visits. This agreement replaces the current Maternity Contractor agreements and is between the ACHN and the individual DHCP practitioner or DHCP group.

To obtain the DHCP Group Agreement with the ACHN, email the ACHN Regional contact at the following link:
https://medicaid.alabama.gov/documents/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers/5.1.3_ACHN%20_Regional_Map_Contacts_Revised_9-3-19.pdf

If you are a DHCP and choose not to participate, you will NOT receive reimbursement for maternity global services identified in the DHCP reimbursement table below or Bonus Payments.

QUALITY

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

DHCPs will not be reimbursed for maternity global services identified in the DHCP reimbursement table below if they choose not to participate with the ACHN.

ACHN PARTICIPATION FOR DHCPs

Active participation for DHCPs is defined as:

- Providing data to the ACHN
- Engaging in the development of the recipient's care plan
- Engaging in the DHCP selection and referral process

Monitoring. ACHNs will send a monthly list to the Agency to report which DHCPs have signed agreements and engaged with the ACHN to provide maternity services. DHCPs who fail to meet requirements will no longer receive referrals from the ACHN and will not be paid to provide maternity services to the ACHN population.

REIMBURSEMENT AND PAYMENTS TO DHCPs

The following DHCP reimbursement table conveys current Medicaid delivery rates and future ACHN delivery rates (effective 10/1/2019) for rural and urban delivery procedure codes:

Proc Code	Description	Current Rural	ACHN Rural	Current Urban	ACHN Urban
59400	Global Vaginal	$1,700	$1,790	$1,300	$1,390
59510	Global Cesarean	$1,700	$1,790	$1,300	$1,390
59409	Vaginal Delivery - Only	$1,250	$1,340	$950	$1,040
59514	Cesarean Delivery - Only	$1,250	$1,340	$950	$1,040
59410	Vaginal Delivery: Including Post-Partum Care	$1,300	$1,390	$1,000	$1,090
59515	Cesarean Delivery: Including Post-Partum Care	$1,300	$1,390	$1,000	$1,090
59610	Global Vaginal: After previous Cesarean Delivery	$1,700	$1,790	$1,300	$1,390

NOTE: FQHCs and RHCs are reimbursed their Prospective Payment System (PPS) rate for maternity services provided in the ACHN Program. Nurse Midwives will be reimbursed 80% of the physician rate.

Rural rates apply to the county location of the DHCP's offices. A map showing urban and rural counties for providers may be accessed on the Medicaid website at www.medicaid.alabama.gov, then select the ACHN tab, ACHN Providers, Medicaid's Designated Urban and Rural Map.

Bonus Payments for DHCPs. Medicaid will pay $100.00 for each Bonus Payment and the following procedure codes must be submitted on a separate claim:

- Initial Prenatal Visit – H1000 (if made during the first trimester)
- Postpartum visit – G9357 (if made between 21 and 56 days of delivery)

Nurse Practitioners, Physician Assistants, and Nurse Midwives will receive 80% of the physician rate for these Bonus Payments. These Bonus Payments also apply to FQHCs and RHCs.

DHCP SELECTION REFERRAL REQUIREMENTS

DHCP Selection Referral Requirements. Services to maternity recipients with dates of service in October will not require a DHCP selection referral number. Beginning November 1, 2019, all maternity claims must have a DHCP selection referral number from the ACHN to receive payment from Medicaid. Although DHCPs will already have the ACHN NPI number, it is the responsibility of the DHCP to ensure a referral is in the medical record and that contact has been made with the ACHN. This ensures proper payment is made to DHCPs for maternity services.

Sample ACHN DHCP Referral Form

Alabama Coordinated Health Network

Delivering Healthcare Professional Selection Referral Form

ACHN's Name: _____ ACHN's NPI Number: _____

Date: _____

Type of Referral: □ Initial □ Change of DHCP □ High-Risk/Specialty □ Other _____

Medicaid Eligible Individual (EI) Information

Name:

Last _____ First _____ MI _____

Medicaid Number: _____ DOB: _____

Address: _____

Telephone Number (with area code): _____

ULTRASOUNDS

Ultrasounds. DHCPs must perform medically necessary ultrasounds and submit fee for service claims to DXC for payment. The details regarding ultrasounds are found in the Provider Billing Manual Chapter 28.

WHERE DO I FIND MORE INFORMATION?

The Alabama Medicaid Agency has more information about the ACHN Program on the website:
https://medicaid.alabama.gov/content/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers.aspx

The following is a link to Medicaid's PCP presentation:
https://www.youtube.com/watch?v=o2CcVmWBZ54&feature=youtu.be

The following is a link to Medicaid's DHCP presentation:
https://southalabama.tegrity.com/#/recording/34615b56-35e2-4ab0-8612-7aac906ebc5d?playbackToken=2NV222VPQIM6A

For more information related to the PCP agreement with Medicaid please contact DXC Provider Enrollment at 1-888-223-3630; select option one.

To obtain the PCP Group Agreement or the DHCP Agreement with the ACHN, email the ACHN Regional contact at the following link:
https://medicaid.alabama.gov/documents/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers/5.1.3_ACHN%20_Regional_Map_Contacts_Revised_9-3-19.pdf

Check Write Schedule Reminder:

01/04/19	03/01/19	05/03/19	07/05/19	09/06/19	11/01/19	01/03/20
01/18/19	03/15/19	05/17/19	07/19/19	09/13/19	11/15/19	01/17/20
02/01/19	04/05/19	06/07/19	08/02/19	10/04/19	12/06/19	02/07/20
02/15/19	04/19/19	06/21/19	08/16/19	10/18/19	12/13/19	02/21/20

The release of funds is normally the second Monday after the check write (remittance advice) date. Please verify direct deposit status with your bank. As always, the release of direct deposit and checks depends on the availability of funds.

Alabama Medicaid Bulletin

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