	Issue	Question	Response
1	General	Why is there not a general forum page for community-wide discussions? Why was the video link disabled to disallow comments?	The Agency has established a page on its website where questions and comments may be submitted. A link to subscribe for email updates is also available on this page. All questions and answers received by the Agency will be posted to this page. Additional communmity engagement activities will be announced as the program is developed.
2	Governing Board	How do physicians apply to be on the governing board of the ACHN entity and who decides on the selection of these members?	Each ACHN will be responsible for policies and procedures regarding the development of its governing board.
3	Governing Board	With regard to each ACHN's board, the PPT states that "hospitals can employ no more than one board physician per entity." How does this change the limit of two hospital-employed physicians per board?	The proposed board composition is intended to reflect several key components of the health care system. To have a qualifying board, both hospital positions would need to be filled. A. Hospital Positions: Hospitals can choose who fills the two hospital slots (administrator, physician, etc.) The two slots should represent more than one system if at all possible. B: Primary Care Physician positions: It is not required that hospitals employ any of the primary care physicians filling the primary care slots, but it is allowed for each hospital represented to employ one of the physicians filling a primary care slot. It is certainly allowable for the board to choose to increase their membership above the 12 minimum members; however, the ratios will need to be maintained. For example, doubling the number of hospital-associated slots would require a doubling of all the other slots on the board.
4	Governing Board	If an ACHN entity has three participating hosptals, can the board now have three hospital-employed physicians?	See above question
5	Governing Board	Alternatively, if an ACHN entity has only one participating hospital, is the PCCM entity limited to one hospital-employed physician?	See above question
6	Participation	According to Medicaid's program briefing, PMPs will now have the choice as to if they participate in the Pivot Program instead of being required as a condition of Patient 1st provider enrollment. Accordingly, providers that choose not to participate in the Pivot Program will only receive the current Medicaid FFS. Please provide information including requirements for PMP enrollment with Medicaid since the existing Patient 1st contact will be invalid.	In addition to the regular Medicaid provider enrollment form, Primary Care Physicians will also be required to complete a PCP Enrollment form. This enrollment form is still under development and will be released closer to implementation of the program. A separate agreement will be required between the PCP and the ACHN entity in order to quaify for bonus payments.
7	Participation	If there is no impact on FQHCs and RHCs, can they still participate with ACHN?	Yes, there will be an opportunity for bonus payments to PCPs based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region.
8	Participation	We currently have two pediatric board-certified specialists (neurology and pulmonology) who are receiving the enhanced bump rate as they meet the requirements. Will they be able to participate in the ACHN Entity and continue to receive the bump rate? If they are participating, what measures would they have to meet to obtain incentive payments as they do not provide check-ups, immunizations or BMI measures?	Yes. All physicians who meet the current requirements to receive "bump" payments AND actively participate with the ACHN Entity will be eligible to receive the ACHN Participation Rate (which replaces the "Bump" rate).
9	Participation	Do you have to be an FQHC to develop a PIVOT?	No. Any organization interested in participating in the ACHN program must comply with the organizational qualification requirements set by the Agency in the ACHN Program RFP to be issued in the near future.
10	Participation	How do you apply to be an ACHN Entity and what is the selection process?	Any interested organizations must respond to the Response for Proposal (RFP) to be issued in the near future.
11	Participation	Will practices operating under RHC status continue under their current status if the ACHN Project is approved or will RHCs be replaced?	The RHC will continue under their current status, but will also be encouraged to participate with the ACHN Entity for care coordination services and to be eligible for bonus payments.
12	Participation	Will PMPs employed by a group practice, outpatient clinic, hospital affiliated outpatient clinic, etc. be allowed to participate in the Pivot Program and be eligible for incentive payments?	Yes, there will be an opportunity for bonus payments to PCPs based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region.
13	Program Funding	Where is the funding coming from that will fund these care coodination entities. Who will receive the cuts that will be required to cover the cost of the program?	There is no additional funding for the ACHN. The Agency will be combining Patient 1st, Health Homes, Plan First, and the Maternity Program into a single care coordination delivery system with the goal of a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results.
14	Program Funding	It is great to identify regional factors that affect health in Alabama. Where will the funding come to address regional environmental factors (drug abuse, mental health, water pollution) once identified by regional entities? We are already aware of issues that have negative effects on patient health and areas of shortages of specific services such as mental health, but how will this plan improve this?	Each ACHN will have funded quality improvement projects (QIPs) focusing on population priorities, such as Substance Abuse, Infant Mortality, Obesity, and Obesity Prevention.
15	Program Structure	Given health centers role as medical homes and the overall aim of population health management to improve the outcomes of patients while improving efficiencies and reducing the total costs, please provide the rationale for excluding health center PMPs from the Pivot Performance Incentive Program.	There will be an opportunity for bonus payments to health center PCPs based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the Network Entity in their region.

16	Program Structure	We currently have some systems in place to identify cost-efficient Medicaid providers (Provider Profiles, reporting available via EHRs, Gold Standard Prescribers, etc.); have we considered utilizing/improving these systems that are already in place to incentivize providers/entities to provide better outcome-based and more cost-efficient care?	The new payment methodology does build on current systems to better recognize and reward outcome-based, cost-efficient care.
17	Program Structure	When will provider-specific meetings be held on this new program. Provider input during the planning phase could be a crucial component of program success.	Several provider-specific (OB/Gyn, Pediatrics, Family Medicine) meetings and presentations have already been conducted. More provider meetings, webinars and other activites are planned in the coming months. The Agency has also established a page on its website where questions and comments may be submitted. A link to subscribe for email updates is also available on this page. All questions and answers received by the Agency will be posted to this page. Additional communmity engagement activities will be announced as the program is developed.
18	Program Structure	Will there be a visit limit? If so, without patient panels, how will a provider know when a patient has used all of their visit? Many providers' billing is often delayed six months or more due to credentialing timeframes.	Today the same concerns about approaching the 14-visit limit for adults exist. Simply having a panel does not prevent recipients from accessing the ER which also counts toward the 14-visit limit for adults. It will be important for physicians to work with the ACHN entities to manage and educate patients regarding the visit limits.
19	Program Structure	Will Pediatric providers be able to dismiss Medicaid patients that choose to go to Urgent Care centers on a regular basis for illness, but use their Pediatric provider for behavior needs and EPSDT's?	The Primary Care Physician will determine dismissal of any recipient.
20	Program Structure	Will Pediatric providers be required to administer EPSDT's or will any "willing Medicaid provider" be able to administer these screenings?	EPSDT screenings may be provided by any EPSDT provider enrolled with Medicaid without regard to their enrollment status with the ACHN entity.
21	Program Structure	Can individual provider practices set up an ACHN Entity?	Any interested organizations must respond to the Response for Proposal (RFP) to be issued in the near future.
22	Program Structure	Will there be more than 1 ACHN in each region.	There will be only one ACHN entity per region.
23	Program Structure	Dr. Moon mentioned three organizations that they were talking with to help in the areas of infant mortality, substance abuse and obesity/obesity prevention. Can you share who those are? We (AL-AAP and ADPH) have an established opioid misuse in women task force – how can we connect with the pivot entities in the area of substance abuse?	Alabama Child Health Improvement Alliance (ACHIA) has agreed to work with ACHN to develop Quality Improvement Plans related to Obesity and Obesity Prevention. The Alabama Perinatal Quality Collaborative has agreed to work with ACHN to develop QIPs related to Infant Mortality. The Medicaid Agency is in discussions with the Alabama Department of Mental Health about working with ACHN to develop QIPs related to substance abuse. Other groups may want to reach out to these lead organizations regarding how they might contribute.
24	Program Structure	Do you see providers being able to provide the same continuity of care when patients will be given a broader freedom to walk in Urgent Care centers for their immediate need?	The ACHN is an outcome-focused effort. Consequently, providers will be incentivized for providing a medical home and for the quality of the care they provide. With the support of care coodinators, more patients will be encouraged to obtain care in an appropriate setting. The Agency does not now and currently has no plan to pay stand alone Urgent Care centers.
25	Program Structure	Dr. Moon reported that the Patient 1st Program will not continue and that patients, except for some maternity cases, will no longer be assigned to PMPs. Please provide information on Medicaid's rationale for discontinuing the process of assigning related Medicaid enrollees to a medical home. It seems that the basis of any Primary Care Case Management Program is patient assignment to a PMP/medical home that is responsible for managing patient needs; additionally, since Medicaid will now be making additional incentive payments to private physicians for "PCMH activities" but has severed the basic tenant of any care coordination system which is the establishment of a consistent medical home relationship. Medicaid's own data seems to demonstrate that the percentage of Medicaid enrollees requesting changes in their PMP assignments is low. What has prompted Medicaid to discontinue the process of assigning PMPs?	Most other payers in our state do not use assigned panels. The largest commercial payer (BCBS) uses an attribution methodology and some Medicare plans use an attribution methodology. Medicaid's move to an attribution methodology is consistent with the approach of other payers in our state.
26	Program Structure	Since patients will no longer be assigned to a Patient 1st PMP and may see any "Medicaid Primary Care Physician" they choose, please define "Medicaid Primary Care Physician."	Primary Care Physician (PCP) – A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) that practices in the specialty designation of family medicine, general internal medicine, pediatrics, and general medicine.
27	Reimbursement	Medicaid has determined that for purposes of its Primary Care Case Management Plan, "Pivot Plan", health centers are not "primary care providers" eligible for performance related payments. (Medicaid briefing, March 22, 2018). Health Centers:	Health center physicians will be eligible to participate in the performance-based incentive program to include PCMH activities, cost effectiveness, and quality.
28	Reimbursement	How will ACHN impact designated Rural Health Clinic Reimbursement?	It will not affect the current PPS reimbursement. However, there will be an opportunity for bonus payments based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region.
29	Reimbursement	How will FQHCs andRHCs be impacted by ACHN? Will the current reimbursement structure change and/or will these provider types be eligible for incentives?	It will not affect the current PPS reimbursement. However, there will be an opportunity for bonus payments based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region.
30	Reimbursement	What will be the global OB (59400) fee schedule for pivot program recipients? Urban vs. rural fee schedules? Is it based on patient address?	The global fee schedule will change. Medicaid will make separate bonus payments for one prenatal visits made in the first trimester and one post partum visits. There will be an urban and rural rate. The rural rate will be paid based on the address of the billing DHCP.

31	Reimbursement	"ACHN Participation Payment": I understand that this will take the place of what we now know to be the "bump" increase. How have you determined this to be measured and accounted for?	Only Primary Care Physicians will be eligible for the ACHN Participation Rate. They will need to: 1) qualify for the Bump payment with Medicaid, 2) sign a PCP agreement with Medicaid and a Network Entity, and 3) meet participation requirements with a Network Entity. To qualify for Medicaid "bump" certification, a physician must be 1) Board-certified in family medicine, general internal medicine or pediatrics and must actually practice in their specialty; or 2) if non-board certified, must practice in the field of family medicine, general internal medicine or pediatrics or be a subspecialist under one of these specialities if the doctor can attest that 60% of paid Medicaid procedures billed are for certain E&M codes and Vaccines for Children administration codes during the most recently completed calendar year, or for newly eligible physicians, the prior month. Additionally, they must actively participate with the network entity by working with the entity in the development of individualized and comprehensive care plans, participating in the entity's Multi-Disciplinary Care Team (MCT), participating in program initiatives centered around quality measures, reviewing data provided by the ACHN entity to help achieve Agency and region quality goals and participating in person in at least two (2) quarterly Medical Management Meetings and one webinar/facilitation exercise with the ACHN entity's Medical Director over a twelve (12) month period.
32	Reimbursement	"Patient-Centered Medical Home Activities": Will there be opportunity for credit given to all recognized levels? If so, will this be increased/decreased depending on the level? We are currently Level 2.	In year one, all Primary Care Physicians working toward PCMH recognition will receive a bonus payment. In year two, all Primary Care Physicians who have achieved PCMH recognition ***at any level*** will continue to receive the bonus payment.
33	Reimbursement	"Cost Effectiveness": How will this be measured? Similar to Blue Cross?	Cost effectiveness bonus rates are calculated to reward providers who control costs. Bonus participation is based on the risk adjusted, average monthly cost of members attributed to the provider group when compared to other similar provider groups. Members who do not receive services are excluded from the calculation.
34	Reimbursement	"Quality Metric Performance": How will this be measured? Similar to Blue Cross?	The quality component of the provider bonus payment will be earned by a provider based on their previous calendar year's performance on the Agency's set of quality metrics, to be announced later. The Agency will also publish measure specifications, current baselines and regional targets for each year.
35	Reimbursement	When will you have more details on the patient attribution process (how a pt will be attributed to that provider)?	Attribution Process: Review a two year history of primary care utilization for each member; preventative and regular office visits will be identified along with prescriptions for chronic care; a score will be calculated for each member/provider combination; more recent claims and preventative visits will receive higher values; and the provider with the highest score for the member is attributed the member. Attribution will be updated quarterly.
36	Reimbursement	Once the ACHN entities start (whether it is November 1, December 1, or January 1), how will providers be reimbursed at the outset before data has been collected – for the cost effectiveness and quality metric categories? Will it be based on data from the previous year (pre-pivot)?	In the first year of the program, bonus payments for Quality Measures, Cost Effectiveness, and PCMH recognition will be distributed to the practice based on the number of patients attributed to the practice. In subsequent years, the bonus payments will be determined by data generated since the start of the new program.
37	Reimbursement	When we (AL-AAP, AAFP and MASA) met with you all a couple of months when you had the series of stakeholder meetings, did you provide us with any more details on the three "buckets" of enhanced payments? I can't remember if there was a slide that had more detail than the slide in Dr. Moon's presentation yesterday. If so, can you share that with me? Just wondered if you all had more details to share RE the three categories.	Other than what is described above, There is no additional detail at this time.
38	Contracting	When will the RFP be released?	Agency Requests for Proposal are released pursuant state rules and regulation. Please continue to monitor the Agency website for RFP releases. Also, potential bidders are encouraged to register with STAARS to recieve RFP release notifications.
39	Contracting	Will there be a separate RFP for each Region?	Agency Requests for Proposal are released pursuant state rules and regulation. Please continue to monitor the Agency website for RFP releases. Also, potential bidders are encouraged to register with STAARS to recieve RFP release notifications.
40	Contracting	What is the time period for bidders to respond?	Agency Requests for Proposal are released pursuant state rules and regulation. Please continue to monitor the Agency website for RFP releases. Also, potential bidders are encouraged to register with STAARS to recieve RFP release notifications.
41	Contracting	What is the time period for Agency review and Award?	Agency Requests for Proposal are released pursuant state rules and regulation. Please continue to monitor the Agency website for RFP releases. Also, potential bidders are encouraged to register with STAARS to recieve RFP release notifications.
42	Program Operation	What is the current status of CMS' review and approval of the Plan?	The Waiver is currently being prepared for submission to CMS.
43	Program Operation	How will CMS' review and approval affect the proposed implementation timeline.	We are working closely with CMS and following their guidance and guidelines. At this point, the Agency is confident our process is consistent with CMS guidelines.

44	Program Operation	Will Readiness Assessment be conducted before CMS' approval of the plan?	The Agency will make every effort to stay within the timeline set forth within the RFP regardless of CMS approval of the waiver.
45	Contracting	Will the Agency award the RFP without CMS' approval of the Plan?	Yes, the Agency will consider awarding the RFP without CMS' final approval.
46	Program Funding	What is the current FY2019 budget allocated for the Pivot Plan?	The Agency will be combining Patient 1st, Health Homes, Plan First , and the Maternity Program into a single care coordination delivery system with the goal of a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results.
47	Program Funding	What is the expected budget allocation for FY2020 and 2021?	Budgets for FY 2020 and FY 2021 have not yet been submitted.
48	Reimbursement	What is the anticipated reimbursement model for the Pivot vendors?	Specific Information will be included in the RFP.
49	Reimbursement	When will the specific reimbursement rates be determined?	Specific Information will be included in the RFP.
50	Reimbursement	In regards to the maternity program, anesthesiologists are paid a flat rate for epidurals for deliveries. Will this continue?	Under the ACHN, anesthesiologists will bill Medicaid fee-for-service on a medical claim form. When regional anesthesia (i.e., nerve block) is administered by the attending physician during a delivery or procedure, the physician's fee for administration of the anesthesia is billed at one-half the established rate for a comparable service when performed by an anesthesiologist. When regional anesthesia is administered by the attending obstetrician during delivery (i.e., saddle block or continuous caudal), the obstetrician's fee for administration of the anesthesia will be billed at one-half the established rate for a comparable service performed by an anesthesiologist. When regional anesthesia is administered by an anesthesiologist during delivery or other procedure, the anesthesiologist's fee will be covered and should be billed separately.
51	Governing Board	Can one hospital serve on multiple boards in different regions?	No. They may only serve on a board in the region in which they are located.
52	Program Operation	The patient 1st program is going to be done away with. So they can see whoever without getting a referral except for some Specialist. I work for a OBGYN office. We don't have to get referrals for out patients. But if a patient sees our NP for anything but pregnancy it requires a referral. Is this something is gonna change? Are we still gonna need to get a referral for only NP?	The referral process will not change. There will continue to be a referral requirement for Nurse Practitioners.
53	General	I was trying to locate to dates, time and location for the meeting. However I'm not being successful at locating this. Could you please email this info to me? Thanks in advance.	Future public meetings regarding the ACHN Program and will be posted to the Agency's Website at http://www.medicaid.alabama.gov/content/2.0_Newsroom/2.7_Special_Initiatives/2.7.6_ACHN.aspx
54	General	I just learned of this new program. Are yall going to have meetings in the different regions so providers can learn more about these? When is the current expected implementation/go live date?	Information regarding the ACHN can be found on the Agency's website at http://www.medicaid.alabama.gov/content/2.0_Newsroom/2.7_Special_Initiatives/2.7.6_ACHN.aspx Future public meetings regarding the ACHN will also be posted at the same location.
55	Governing Board	Please provide clarification on the governance allowance that allows up to 2 of the primary care physicians to be employed by a hospital. Why is this allowance limited to hospital employed primary care physicians?	The goal in constructing the ACHN boards is to reflect the impact various provider groups have on the populations included in the ACHN. Physicians and hospitals are major provider groups, both in terms of large numbers of individuals served and in terms of agency budgetary impact. Other critical groups are also included on the ACHN boards: Federally Qualified Health Centers, Community Mental Health Centers, Substance Abuse Treatment Facilities, and Consumers. In order to maintain a judicious board size, but to also reflect the relative impact on Medicaid's recipients and budget, the decision was made to allow only hospitals to, in addition to their two hospital positions, employ two of the primary care physicians filling the primary care board positions.
56	Program Structure	What type of legal entity must be formed to qualify as an ACHN entity?	The entity must be an Alabama nonprofit entity with an office located in the region, and registered as an Alabama domicile with the Secretary of State.
57	Program Structure	What are the requirements for ownership of an ACHN entity? We understand that providers must serve on the board of directors, but do providers also have to be owners of the entity?	There are currently no requirements for ownership.
58	Program Structure	Will there be some limitations as to the number of times a maternity patient can change OB providers during the course of a pregnancy? Frequent patient movement especially in urban areas is a concern in such a time limited treatment span such as pregnancy and the potential impact it will have on overall outcome of care and provider ability to meet set care parameters/benchmarks in order to be eligible for the incentive monies.	The maternity patient must be allowed to change a DHCP once without cause within the first 90 Calendar Days of selecting a DHCP and at any time for just cause, which is defined as a valid complaint submitted orally or in writing to the PCCM-E.
59	Governing Board	Can the medical director for the ACHN serve on the ACHN board?	Yes.
60	Governing Board	For the ACHN board, may the FQHC representative be a physician who also satisfies one of the required primary care board positions? If so, can the board have fewer than 12 members/directors?	No. The FQHC representative cannot satisfy the required primary care board position. The minimum number for the board is 12 members.

61	General	I was recently made aware of the innovative plan for the Alabama Coordinated Health Network and would like to speak with someone about this initiative for "pivot entities".	Information on the ACHNs (formerly known as Pivot Entities) can be found at http://www.medicaid.alabama.gov/content/2.0_Newsroom/2.7_Special_Initiatives/2.7.6_ACHN.aspx An email address is also provided at the website to submit any questions regarding the new program.
62	Governing Board	Can a medical director be a medical director in two different regions?	No. The Medical Director must practice medicine in the region they serve. If the Medical Director practices in more than one region, they will only be eligible to serve (as Medical Director) in the region of their main practice site.
63	Participation	When can we register to be a part of this program?	DHCPs will contract with the ACHN entities when the contract is awarded.
64	Program Structure	For an entity to be eligible to respond to the ACHN, must a final determination letter regarding 501(c)(3) status be obtained, or will the Agency accept either the entity's nonprofit status or the entity's submission of the 501(c)(3) application?	The ACHNs will not be required to obtain 501(c)(3) status. The ACHN must be an Alabama nonprofit organization.
65	Program Operation	If the ACHN would like to use the RMEDE software, will there be a charge to use the software?	The ACHNs will fund their case management system from the funds they receive through the provision of services. Unless the ACHN develops its own system, they will need to contract with someone. The terms of that agreement will be between the case management system provider and the ACHN.
66	General	Will the Medicaid Portal go away? If so, will there be something to replace it?	No. The Medicaid Provider Portal will remain in place.
67	General	As of 8/30/18, has the 1915b waiver been submitted to CMS? If so, will the waiver be posted to the ACHN page on Medicaid?	The Waiver was submitted to CMS on August 2, 2018 and has been posted to the website.
68	General	When will these changes happen?	The Agency plans to implement the ACHNs in 2019.
69	General	Will meetings be held in each region?	Several provider-specific (OB/Gyn, Pediatrics, Family Medicine) meetings and presentations have already been conducted. More provider meetings, webinars and other activites are planned in the coming months. The Agency has also established a page on its website where questions and comments may be submitted. A link to subscribe for email updates is also available on this page. All questions and answers received by the Agency will be posted to this page. Additional communmity engagement activities will be announced as the program is developed.
70	Participation	How will this plan affect physicians working through an FQHC?	Physicians working in an FQHC will have an opportunity to receive bonus payments based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region and actively participate with the ACHN Entity.
71	Participation	Does every provider have to attend the three meetings or can a provider rep attend?	A representative from the group practice must attend, who may be a physician, nurse practitioner, or physician's assistant.
72	Participation	Am I to understand correctly, if you are a solo practioner with no np or assistants, the physician themselves must attend the meeting and cannot send office managers or charge nurses in their place?	This is correct. In order to participate with an ACHN, a PCP, nurse practitioner, or physician assistant must attend at least two Quarterly Medical Management Meetings and participate in a webinar.
73	Participation	How will this plan affect physicians working through an FQHC?	Physicians working in an FQHC will have an opportunity to receive bonus payments based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region.
74	Participation	Does every provider have to attend the three meetings or can a provider rep attend?	A representative from the group practice must attend, who may be a physician, nurse practitioner, or physician's assistant.
75	Participation	Am I to understand correctly, if you are a solo practioner with no np or assistants, the physician themselves must attend the meeting and cannot send office managers or charge nurses in their place?	This is correct. In order to participate with an ACHN, a PCP, nurse practitioner, or physician assistant must attend at least two Quarterly Medical Management Meetings and participate in a webinar.
76	Program Operation	Will the Medicaid Portal go away? If so, will there be something to replace it?	No. The Medicaid Provider Portal will remain in place.
77	Program Operation	How transparent are we going to be to give data feed back to PCPS?	It will be similar to the current data the Health Homes provide.
78	Program Operation	Are there limited amount of visits annually?	Yes. The Agency will continue to limit visits to 14 annually for adults. However, with correct coding of EPSDT screening and follow-up visits, additional visits for care to treat medical issues may be covered for children.
79	Program Operation	I am understanding that a Medicaid patient may be seen in our office, and then go to another office and then return to our office and during all of this, the patient doesn't have to be assigned to our PCP?	This is correct. The Agency will no longer assign patients, and the patient will be able to visit any PCP they choose.
80	Program Operation	How transparent are we going to be to give data feed back to PCPS?	It will be similar to the current data the Health Homes provide.
81	Program Operation	Are there limited amount of visits annually?	Yes. The Agency will continue to limit visits to 14 annually for adults. However, with correct coding of EPSDT screening and follow-up visits, additional visits for care to treat medical issues may be covered for children.
82	Program Operation	I am understanding that a Medicaid patient may be seen in our office, and then go to another office and then return to our office and during all of this, the patient doesn't have to be assigned to our PCP?	This is correct. The Agency will no longer assign patients, and the patient will be able to visit any PCP they choose.
83	Program Structure	Will the panels be eliminated prior to the implementation of the full program?	No. The panels will be eliminated when the ACHNs are implemented.
84	Program Structure	How will this program affect non PCP providers like radiology and pathology?	Radiologists and pathologists do not qualify to participate in the ACHN program, and will continue to receive referrals and payments as they do today.

85	Program Structure	Is there a way to reduce the risk of cherry picking patients-- physicians discharging patients who don't fill their maintenance medications, for instance, if those physicians are not getting their maximum amount of payment and are trying to obtain it?	The Agency recognizes that some patients are more time and resource intensive. The ACHN bonus system will factor that in by risk adjusting for these patients in the cost-effectiveness calculation. At the same time, the ACHN will be incentivized to provide additional care coordination services to encourage recipients to be more compliant.
86	Program Structure	How can we prevent recipients from Dr shopping? Since they don't need referral.	Currently in Patient 1st, recipients can change PMPs as often as they choose. Reducing referrals or removing panels will not increase the number of times a recipient changes PMPs. Instead, we believe this will result in a more streamlined system for providers and recipients. The advantage of the ACHN system is that a patient who appears to be "doctor shopping" can be identified and referred to the ACHN for care coordination.
87	Program Structure	If you do not participate with ACHN, will you still have a Patient 1st panel or are you doing away with Patient 1st?	Patient 1st will end with the implementation of the ACHNs. Physicians will no longer have panels.
88	Program Structure	When there is no longer a panel, will we still be able to limit the number of new Medicaid recipients attributed to our practice?	Physicians may continue to limit the number of Medicaid recipients using some of the same office procedures they use to limit other types of payers.
89	Program Structure	How would you budget Networks and also incentivizing networks ?	There is no additional funding for the ACHN. The Agency will be combining Patient 1st, Health Homes, Plan First, and the Maternity programs into a single care coordination delivery system with the goal of a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results.
90	Program Structure	Does ACHN encourage Patient homes?	The Agency values Patient-Centered Medical Homes which is why PCMH recognition is incentivized in the ACHN program.
91	Program Structure	We currently have a panel limit and we are not currently taking new medicaid patients, will our Physicians be required to accept new patients?	No. Physicians may continue to limit the number of Medicaid recipients using some of the same office procedures they use to limit other types of payers.
92	Program Structure	So, under this program, as a PCP, if you see a new Medicaid patient, you will no longer have to get a referral from the PCP the patient is currently assigned to?	This is correct. The patient will no longer need a referral to see a new PCP.
93	Program Structure	Will the panels be eliminated prior to the implementation of the full program?	No. The panels will be eliminated when the ACHNs are implemented.
94	Program Structure	How will this program affect non PCP providers like radiology and pathology?	Radiologists and pathologists do not qualify to participate in the ACHN program, and will continue to receive referrals and payments as they do today.
95	Program Structure	Is there a way to reduce the risk of cherry picking patients-- physicians discharging patients who don't fill their maintenance medications, for instance, if those physicians are not getting their maximum amount of payment and are trying to obtain it?	The Agency recognizes that some patients are more time and resource intensive. The ACHN bonus system will factor that in by risk adjusting for these patients in the cost-effectiveness calculation. At the same time, the ACHN will be incentivized to provide additional care coordination services to encourage recipients to be more compliant.
96	Program Structure	How can we prevent recipients from Dr shopping? Since they don't need referral.	Currently in Patient 1st, recipients can change PMPs as often as they choose. Reducing referrals or removing panels will not increase the number of times a recipient changes PMPs. Instead, we believe this will result in a more streamlined system for providers and recipients. The advantage of the ACHN system is that a patient who appears to be "doctor shopping" can be identified and referred to the ACHN for care coordination.
97	Program Structure	If you do not participate with ACHN, will you still have a Patient 1st panel or are you doing away with Patient 1st?	Patient 1st will end with the implementation of the ACHNs. Physicians will no longer have panels.
98	Program Structure	When there is no longer a panel, will we still be able to limit the number of new Medicaid recipients attributed to our practice?	Physicians may continue to limit the number of Medicaid recipients using some of the same office procedures they use to limit other types of payers.
99	Program Structure	How would you budget Networks and also incentivizing networks ?	There is no additional funding for the ACHN. The Agency will be combining Patient 1st, Health Homes, Plan First, and the Maternity programs into a single care coordination delivery system with the goal of a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results.
100	Program Structure	Does ACHN encourage Patient homes?	The Agency values Patient-Centered Medical Homes which is why PCMH recognition is incentivized in the ACHN program.
101	Program Structure	We currently have a panel limit and we are not currently taking new medicaid patients, will our Physicians be required to accept new patients?	No. Physicians may continue to limit the number of Medicaid recipients using some of the same office procedures they use to limit other types of payers.
102	Program Structure	So, under this program, as a PCP, if you see a new Medicaid patient, you will no longer have to get a referral from the PCP the patient is currently assigned to?	This is correct. The patient will no longer need a referral to see a new PCP.
103	Reimbursement	If you are part of an alternative payment model (Teaching Physician/FQHC/Etc) are you still eligible to participate in the PCMH and Quality incentives?	Physicians working in FQHCs or RHCs, or physicians who are part of a state university's medical faculty, will have an opportunity to receive bonus payments based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region.
104	Reimbursement	Is Bump/enhanced rate included with claim payment or paid quarterly?	The bump/enhanced rate will be renamed the participation rate and will be included in the claims payment received twice monthly.
105	Reimbursement	Is midlevel activity included when calculating incentive payments?	Yes. Midlevel activity by nurse practitioners and physician assistants working in a participating group is included in the calculation of bonus payments.
106	Reimbursement	If you are not PCMH can you still achieve Quality or Cost incentive payments?	Yes. Providers may receive Quality or Cost Effective bonus payments and not participate in PCMH recognition. Each bonus payment is independent from the other bonus payments.

107	Reimbursement	Will the BUMP payment be in addition to the Capitation payment we are currently receiving?	No. There will not be a capitation payment in the new program. There will be a participation rate, which replaces the current Bump rates, as well as the opportunity for quarterly bonus payments.
108	Reimbursement	Will the quarterly payments for quality and cost effectiveness be paid at the beginning of the quarter or the end of the quarter?	The quarterly payment for bonuses will be paid at the beginning of the quarter.
109	Reimbursement	Do we have a set budget for these payments for quality and cost effectiveness?	There is no additional funding for the ACHN. The Agency will be combining Patient 1st, Health Homes, Plan First, and the Maternity programs into a single care coordination delivery system with the goal of creating a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results. The quality and cost effectiveness bonus payments are included in this pool of funds.
110	Reimbursement	Will incentive payments be at risk if the legislative budget is short?	There is no additional funding for the ACHN. The Agency will be combining Patient 1st, Health Homes, Plan First, and the Maternity programs into a single care coordination delivery system with the goal of a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results.
111	Reimbursement	If a patient presents and is out of authorized visits, does the provider still get paid?	No. When the patient has exhausted his/her visits, no payment will be made to the physician.
112	Reimbursement	Is Bump/enhanced rate included with claim payment or paid quarterly?	The enhanced rate will be included in the claims payment received twice monthly.
113	Reimbursement	Is midlevel activity included when calculating incentive payments?	Yes. Midlevel activity by nurse practitioners and physician assistants working in a participating group is included in the calculation of bonus payments.
114	Reimbursement	If you are not PCMH can you still achieve Quality or Cost incentive payments?	Yes. Providers may receive Quality or Cost Effective bonus payments and not participate in PCMH recognition. Each bonus payment is independent from the other bonus payments.
115	Reimbursement	Will the BUMP payment be in addition to the Capitation payment we are currently receiving?	No. There will not be a capitation payment in the new program. There will be a participation rate, which replaces the current Bump rates, as well as the opportunity for quarterly bonus payments.
116	Reimbursement	Will the quarterly payments for quality and cost effectiveness be paid at the beginning of the quarter or the end of the quarter?	The quarterly payment for bonuses will be paid at the beginning of the quarter.
117	Reimbursement	Do we have a set budget for these payments for quality and cost effectiveness?	There is no additional funding for the ACHN. The Agency will be combining Patient 1st, Health Homes, Plan First, and the Maternity programs into a single care coordination delivery system with the goal of creating a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results. The quality and cost effectiveness bonus payments are included in this pool of funds.
118	Reimbursement	Will incentive payments be at risk if the legislative budget is short?	There is no additional funding for the ACHN. The Agency will be combining Patient 1st, Health Homes, Plan First, and the Maternity programs into a single care coordination delivery system with the goal of a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results.
119	Reimbursement	If a patient presents and is out of authorized visits, does the provider still get paid?	No. When the patient has exhausted his/her visits, no payment will be made to the physician.
120	Reimbursement	If you are part of an alternative payment model (Teaching Physician/FQHC/Etc) are you still eligible to participate in the PCMH and Quality incentives?	Physicians working in FQHCs or RHCs, or physicians who are part of a state university's medical faculty, will have an opportunity to receive bonus payments based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region.
121	Contracting	In the AL-AAP webinar on 09/05, the Agency stated that they would wait for CMS approval of the waiver before setting a schedule. 1.) Does that mean that the Agency will wait for CMS wavier approval before releasing an RFP? 2.) If so, to assist potential bidders in their scheduling and planning in progress for proposal responses, when does the Agency anticipate the waiver will be submitted and/or approved?	The 1915 (b) ACHN waiver was formally submitted to CMS on August 2, 2018 and has been posted to the AMA website. The Agency anticipates releasing the RFP in early January 2019.
122	General	Will the Agency provide an open comment period for the waiver prior to submitting to CMS for approval?	The 1915 (b) ACHN waiver was formally submitted to CMS on August 2, 2018 and has been posted to the AMA website. If you have any questions concerning the waiver, you may submit them to the ACHN e-mail address.
123	Participation	Right now, if a provider has a patient assigned to them, the provider must see that patient until/unless they discharge them. Since the program moves to an attribution model instead of assignment model, will we have an increase in patients, especially older children, who cannot find a physician to accept them? What will we do if patients have a card and no available PCP? This could be a risk to the program should a provider choose not to see more patients if they are incentive payout is at risk if they add more patients.	Physicians may continue to choose how many new Medicaid recipients they accept. If the recipient does not currently have a PCP, a care coordinator with the ACHN may assist the recipient in choosing a PCP.
124	Program Operation	How will we able to identify if a recipient needs an EPSDT(since we will not have provider panels at the point of care)	The Agency will be sending quarterly a list of recipients attributed to the Group Practice. The EPSDT program will have the same relationship with the attributed Provider as it does today with the Patient 1st Provider.
125	Program Operation	Will that "attribution" list be available on a quarterly basis?	Yes. It will be available on a quarterly basis.

126	Program Operation	At the start of the program, and periodically thereafter, will Medicaid provide providers a list of patients attributed to them using Medicaid's methodology?	Yes. The Agency will be sending quarterly a list of recipients attributed to the Group Practice.
127	Program Operation	How can the visits be tracked if there is no panel. A provider won't know what diagnosis was included on the EPSDT if done at another clinic. If a patient sees provider one week and uses their last visit, then comes to another provider the following week, how will I know that all the visits have been exhausted?	The provider will continue to check eligibility to determine if visits are exhausted. Please refer to Appendix A in the Provider Manual for correct coding of EPSDT.
128	Program Structure	Will providers be required to complete LOIs or ACHN agreements to participate in the incentive structure?	Yes. Providers must enter agreements with the ACHN entity in the region in which they practice to be eligible for bonus payments and the participation rates.
129	Program Structure	When will ACHN entities be required to contract with providers – Prior to go-live or during the 1-year "look back" period prior to incentive payout?	The ACHN entities will need to contract with providers prior to implementation in order for the providers to receive their first quarter bonus payments and participation rates. However, providers may also contract with an ACHN entity at anytime, but would not receive participation payment rates or bonus payments prior to contract.
130	Program Structure	Will the Agency provide the ACHN entity with specific quality data that identifies providers who are not meeting quality metrics? If so, how often and in what format will that reporting occur?	Yes, the Agency will provide summary data on a monthly basis to the ACHN entities on the performance of quality measures.
131	Program Structure	Will the Agency require ACHNs to use the RMEDE system for documentation of care coordination activities? If so, please provide the latest technical specifications and an updated user manual for RMEDE, so that potential ACHNs can understand its capabilities as they formulate their concept of operations for the proposal.	No. Technical specifications will be detailed in the RFP.
132	Program Structure	Is it possible for the Entity to contract with current ADPH Care Coordinators? Could these Care Coordinators continue to be housed in the ADPH Clinics? With the above scenario, would these Care Coordinators have to be direct employees of the Entity and not ADPH employees?	The PCCM-E may choose to contract with an organization or agency to provide Care Coordination. The PCCM-E will determine where the Care Coordinators will be located. The Care Coordinators would not have to be direct employees of the Entity.
133	Quality	In the AL-AAP webinar on 09/05, the Agency outlined several quality measures that will be tracked as part of the ACHN incentive program. Where does the data come from that will be used to report on these quality measures? How often will the ACHN entity receive this data? Will the ACHN entity receive combined data reports (such as currently received by the Health Homes via ESD tables) or will the ACHN entity have access to the raw claims data to do their own analysis?	All quality measures will be calculated from administrative data. It is the intention of the Agency to provide data on a monthly basis as summarized reports.
134	Quality	Quality Measure: Immunization status child/adolescent • Will we have access to IMPRINT? • What if immunization is obtained via public health/school vs PCP	Specifics on the exact quality measures and their specifications will be released at a future time.
135	Quality	Quality Measure: Antidepressant medication management • What drugs are included in this measure? • Does this measure line up with a specific HEDIS measure? If so, please specify which and any changes the Agency may have made to the measure specific for this population.	Specifics on the exact quality measures and their specifications will be released at a future time.
136	Quality	Quality Measure: HbA1c Test for Diabetic patients • Will the requirement be yearly or every six months? • Does this measure evaluate the actual lab values or only if the test was completed or not?	Specifics on the exact quality measures and their specifications will be released at a future time.
137	Quality	Quality Measure: Follow-up after ER visit for alcohol or other drugs • What is the time frame for follow-up. • Does this measure line up with a specific HEDIS measure? If so, please specify which and any changes the Agency may have made to the measure specific for this population	Specifics on the exact quality measures and their specifications will be released at a future time.
138	Quality	The quality measures selected measure patient adherence, not physician action. Any time a patient adherence factor is included in quality measures, then "cherry picking" will happen. This ultimately hurts the recipients who need the most help and frustrates physicians, possibly reducing their participation rates. It is not my experience that patients who fail to adhere to maintenance treatment do not come to the office. They do come, because they are not doing well. Would Medicaid substitute measures that tie provider performance back to the incentive program instead of patient adherence? Examples may be rx being received by the pharmacy even if not ever picked up by patient or counting lab orders, instead of whether a patient goes to lab. Also, provide a mechanism for providers to submit evidence of scheduled EPSDTs, whether or not patients show up, because no shows not only hurt due to missed fees but now can affect performance pay.	The ACHN will be incentivized to care coordinate with PCP's input that will encourage recipients to be more compliant. Regarding the other possible options for quality measures, these would not be possible for the Agency to calculate since it does not have access to those data sources.
139	Quality	Given that the quality measures are tied to patient adherence instead of provider performance, how does the Agency propose to prevent Providers from cherry picking "healthy" recipients and/or refusing to take "unhealthy" recipients?	By allowing patients to see the PCP of their choice, the Agency believes this will dissuade providers from cherry picking patients that they want to see. In addition, if a PCP chooses to have a narrow panel, this does not necessarily benefit them on meeting quality metrics, as they must have an appropriate panel size that includes a population that would allow them to have enough patients to qualify for the measures they are being evaluated on. Small panel sizes may be easy to achieve benchmarks but they may also easily hurt their performance.
140	Quality	Will the Agency be providing interim reporting to Providers on their progress to achieving their incentive bonus? In other words, if the Agency is publishing full reports quarterly, will a provider be able to know at any time prior to that report where they stand on meeting incentive payout?	Quality measures will be reported to providers annually. Cost effectiveness reports will be provided quarterly to the providers.

141	Reimbursement	Do you anticipate the bonus / incentive payments will be equal to / less than or greater than the current capitation payment	By implementing ACHNs, the Agency's primary goal is to spend money differently to achieve better results and keep providers whole. The ACHN effort differs from the Patient 1st program in that payments to PCPs will focus on activity as opposed to panel size. During the transition to the this new system, PCPs will receive full payment for quality and cost-effectiveness based on attribution. After that transition period, bonus payments will be made to participating PCPs based on actual performance.
142	Reimbursement	Will there be an appeals process for attribution and quality/cost scoring?	Details of a reconsideration process regarding attribution or quality scoring will be contained in the provider's contract with the Agency.
143	Reimbursement	When there are multiple providers' services by FQHC medical visits "FQHC service" and private physicians levels same date of service – who receive payment 1st if office visit limit is exceeded?	The first provider to submit a claim will receive the payment.
144	Reimbursement	Will FQHC providers be reimbursed on the same day when and/or if services are also provided by private providers?	The first provider to submit a claim will receive the payment.
145	Reimbursement	After listening to the webinar with Dr. Moon today, I learned that FQHCs, rural clinics and other similar entities will keep their current enhanced rates. Currently Jefferson County Department of Health receives an enhanced public health rate. Will this rate continue with the ACHN?	Medicaid is not aware of any changes to public health rates with the implementation of the ACHN.
146	Contracting	Any update on the date of the release of the RFP?	The Agency plans to release the RFP January 2019.
147	Program Structure	Are there any granular statistics that show the challenges for the high-risk individuals in the 5% for each region?	AHRQ is a very well established federal research entity and their statistics on the high utilization and high cost recipients has been shown to also be demonstrated in the Alabama Medicaid population. Additional demographic and summary data will be available for responders after the RFP is released.
148	Program Structure	Will there be increased Substance Abuse providers for Medicaid recipients in order to participate in S/A quality improvement projects?	It is not the Agency's intention for the entity to hire or increase the number of substance abuse providers for Medicaid recipients. The Agency expects through the QIP implementation, that the entity will address the prevention and outcomes for those with substance abuse disorders through community outreach, provider education, and care coordination of it's recipients. Please see the following link of Substance Abuse providers that are currently certified by DMH. This list is updated monthly by DMH. http://www.mh.alabama.gov/downloads/SA/SASDProgramDirectory.pdf
149	Quality	Does the BMI metric follow the HEDIS measure, which measures whether or not a BMI is documented yearly? Please confirm that the Providers will be coding in a claim for the BMI quality measure, and the PCCM-E will not be responsible for gathering this data.	Specifics on the exact quality measures and their specifications will be released at a future time. The majority of the quality measures will be CMS Core Quality Measures and as such are HEDIS Measures with minor modifications for age categories.
150	Program Structure	Please describe the process the Agency will utilize to assist the PCCM-E in verifying appropriate modes of transportation that will be paid by the Agency.	The PCCM-E Care Coordinators will be assisting recipients in navigating the Agency's Non Emergency Transportation (NET) program as well as local resources.
151	Program Structure	Please confirm that the PCCM-E will not be required to pay for or provide (i.e.: contracts with transportation providers) non-emergency transportation.	This is correct, the PCCM-E will not be required to pay for or provide non-emergency transportation services.
152	Reimbursement	Is the payment model based on activities completed within a calendar month (ie: 1st – 31st)? Will payments be received the following calendar month (ie: payment for September activity is received in October)?	Specific Information will be included in the RFP.
153	Program Structure	For these bonus payments, where will the evaluated data originate, RMEDE?	These bonus payments will be paid by Medicaid based on meeting criteria. The data used to calculate the measures will originate from submitted claims.
154	Program Structure	Please define the oversight provided between the PCCM-E and the Agency.	Specific Information will be included in the RFP.
155	Program Structure	Will the PCCM-E be required to conduct SBIRT training for Providers and certify the Provider's completion of such training?	No, SBIRT training will continue to be done by the Department of Mental Health as it is today.
156	Participation	Will Urgent Care facilities and their providers be allowed to participate in the ACHN?	Urgent Care facilities may enroll as a physician group and may participate in the ACHN as a PCP provider.
157	Program Structure	Please provide the Agency standards for the case to staff ratios expected for ACHN.	Specific Information will be included in the RFP.
158	Program Structure	Please confirm that this requirement is for recipients in an "active case management" status, and not the total regional population.	This requirement is for recipients currently receiving care coordination services. This does not preclude the PCCM-E from identifying and engaging with other individuals who would benefit from care coordination.
159	Program Structure	Please confirm that emergency rooms will be required to report discharges to the Agency in real time, and that reporting will be immediately available to the PCCM-E.	The PCCM-Es will need to coordinate with the hospitals in their region to provide services in a timely manner, as the Health Homes do today.
160	Program Structure	Please confirm that the Agency will maintain responsibility for publishing and issuing a Provider Directory to recipients.	The Agency will maintain a Provider Directory for recipients.
161	Program Structure	Please provide any requirements the Agency has for the referral process the PCCM-E is to create.	Specific Information will be included in the RFP.

162	Program Structure	If enrollees are seeing multiple providers, how do PCCM-E's determine the PCP for the purpose of medication reconciliation and discharge follow-up?	The PCCM-E will follow up with the PCP of the recipient's choice.
163	Program Structure	Will the Agency require the use of RMEDE for case management documentation in this regional case management approach? If not, are there any requirements which need to be followed to exchange information between regional case management systems should a recipient move from one region to another?	The ACHNs will fund their case management system from the funds they receive through the provision of services. Unless the ACHN develops its own system, they will need to contract for that capability. The terms of that agreement will be between the case management system provider and the ACHN. Specific information related to patient transfers will be included in the RFP.
164	Program Structure	Please confirm that the Agency will define the business requirements/guidelines for the transfer process instead of each PCCM-E individually working out those details among regions.	Specific Information will be included in the RFP.
165	Program Structure	How will continuity of care be measured if enrollees are allowed to see any Medicaid provider? For example: If a member is seeing multiple providers, who does the PCCM-E coordinate the plan of care with and provide follow up with post discharge or ER visit?	The PCCM-E will follow up with the PCP of the recipient's choice. Medicaid encourages PCCM-Es to work closely with the recipient to seek a single PCP for the purpose of continuity of care.
166	Program Structure	Please confirm that "implementation date" is the expected go-live date of the program, and does not include the implementation and readiness period prior to go-live.	The implementation date is the expected go-live date.
167	Program Structure	Please define the process for submitting disenrollment to the Agency for review and approval.	Specific Information will be included in the RFP.
168	Program Structure	How will the grievance data be made available to the PCCM-E? Will the Agency consider monthly reporting, so that the PCCM-E can work with a member to stop any issues/concerns in a timely manner?	Specific Information will be included in the RFP.
169	Program Structure	Please confirm it is the Agency's expectation that each PCCM-E will self-report on their case management activity for which they get paid. If so, how will the Agency ensure that each PCCM-E is defining all elements the same and providing accurate information?	Specific Information will be included in the RFP addressing requirements for these issues.
170	Program Structure	How will the PCCM-E receive data on Non-Authorized Specialist requests?	The Agency will provide quality and utilization summary data to the PCCM-Es on a monthly basis. The Agency will also provide a monthly list of recipients to be screened by the entity. Prior authorization data would be included if determined it would be necessary and used by the PCCM-Es.
171	Program Structure	Will the utilization information and data be similar to the current ESD tables used by the Health Homes (i.e.; The current Touch Report)?	The Agency will provide quality and utilization summary data to the PCCM-Es on a monthly basis. The Agency will also provide a monthly list of recipients to be screened by the entity. Prior authorization data would be included if determined it would be necessary and used by the PCCM-Es.
172	Program Structure	If every PCCM-E is allowed to use its own case management system, what is the system of truth the Agency will use to validate the touches that determine payment?	The Alabama Medicaid Management Information System (MMIS) is the system of truth and the Agency will use this system to validate the touches that determine payment.
173	Program Structure	Please define the requirements to be paid for the following activities within the General Population: "Intensely Managed", "Moderately Managed" and "Monitoring – Medical Review".	Specific Information will be included in the RFP.
174	Program Structure	On what date did the initial 90-day period start? Have there been any additional requests from CMS extending this period?	The initial 90-day period began on August 2, 2018. The current 90-day period has been paused pending CMS's request for additional information.
175	Program Structure	How will PCPs know if recipients have exceeded their 14 visits or not?	PCPs may check the eligibility file for exceeded visits the same way as they do today.
176	Program Structure	Will visit information be available that info on their verification Portal? Will it be real-time?	Visit information is available on the provider's verification portal. This information is not real-time, but is updated as claims are paid.
177	Program Structure	Will Medicaid continue to use the current quality scorecard system available through the Medicaid Provider Portal?	Medicaid is reviewing the current quality scorecard system to determine future changes.
178	Program Structure	How will I know if my attributed patient happened to have gone elsewhere and gotten an EPSDT(say for instance they could not get an appointment with me in a timely manner and needed the Epsdt sooner than I could do)??? Or say even a New Patient that is transferring to our clinic. Will the agency website have last EPSDT date on the website??	A PCP may view the 'date of last screening' on the eligibility file the same way as they do today.
179	Program Structure	Will the Pharmacy and Provider Lock-In process remain the same in the ACHN model? If yes, if a recipient is in lock-in and the assigned Provider refuses to see the recipient, will they be allowed to switch to another Provider	The pharmacy and provider lock in will remain in the ACHN model. The recipient will be assigned to a provider and will not be allowed to change. If the provider refuses to see the patient, the physician, the patient, or the PCCM-E may contact Medicaid to assist in assigning a different lock-in provider.
180	Program Operation	Will there be a listing available to know if a patient is due a screening? As is now we are able to pull list based on our panel to cross reference our own records.	The Providers will continue to have access to all EPSDT reports as they do today. A PCP may view the 'date of last screening' on the eligibility file as is the process today.
181	Program Structure	We'd like to get a better understanding of the technical capabilities of RMEDE as we're preparing for ACHN. We're finalizing our operational ConOps, and as you know, RMEDE will play a key role.	All requirements for the Health Information Management Systems (HIMS) will be provided in the ACHN RFP.
		Specifically, I was wondering if all of the care coordination activities (maternity, health home, etc.) would live under one interface, or will they be silo'd? We're particularly interested in whether there is a referral process that includes maternity?	
		Also, would you be able to send us a copy of the Technical Specs?	

182	Program Structure	Are FQHCs allowed to bill FFS for SBIRT?	In the 1915(b) Waiver, SBIRT (screening, brief intervention and referral to treatment) services are (b)(3) services that may be billed by enrolled providers who have been certified by DMH. SBIRT-certified physicians employed by FQHCs may bill these services FFS.
183	Program Structure	IP Question 2. In general, the current requirement for a referral from the primary care provider in order to see a specialist has many pros. One exception is when a patient has an orthopedic injury already evaluated in a urgent care setting. These patients should be able to see an orthopedic specialist without having to make an extra visit to a primary care provider. Modifier Question For the convenience of the family, chronic conditions are often assessed at the EPSDT visit and in some cases involve complex adjustments to the treatment plan. Other payers allow for a modifier to be added to the well visit when significant modifications are required. Could reimbursement be revised to include this modifier?	Yes, we understand these issues and we are in the process of actively looking at the billing procedures associated with the EPSDT program to address the issues you have raised.
184	Program Structure	Alabama Arise has a vested interest in the success of Medicaid transformation. We have been actively involved in the current reform process from its beginnings in 2012. The 2013 RCO law and 2015 ICN law were exemplary in their provisions for consumer oversight via governing board representation and advisory committees. Now that those two laws are no longer applicable, we are concerned that robust consumer oversight is no longer guaranteed. We applaud Alabama Select for maintaining – and even strengthening – the ICN consumer oversight provisions in the new environment. However, the current plan for governance of Alabama Coordinated Health Networks (ACHNs) falls short of the RCO benchmark. We have raised this issue numerous times and have yet to see meaningful movement from the state. We continue to believe that the ACHN plan cannot achieve its goals of better care, better outcomes and lower cost without robust consumer involvement in Medicaid policymaking. For more detail, we offer the following observations and recommendations: • The RCO consumer advisory structure, while uneven and often frustrating or absent altogether, offers important lessons for the ACHNs. The best examples (such as a transportation forum prompted by consumer representatives in the Viva Region B RCO) illustrate that consumer input can help shape Medicaid policy priorities. • A statutory provision that limited RCO consumer representatives to direct Medicaid beneficiaries was a serious hindrance to effective consumer engagement. The inclusion of parents and caregivers as potential consumer representatives for the ACHNs is a major breakthrough that vastly increases the pool of willing and capable participants. • We feel one consumer representative on each ACHN board is inadequate. We strongly recommend at least two consumer representatives. Peer support is vital for consumer representatives at policy tables dominated by health care and business professionals. In response to our previous appeals, Medicaid and ACHN officials have responded that adding another consumer representative to the board would throw the membership formula out of balance, prompting	Thank you for your feedback regarding consumer representation with the Alabama Coordinated Health Networks (ACHN). We learned from the RCOs and ICNs and believe that consumers and other stakeholders such as FQHCs, Community Mental Health Centers, and Substance Abuse treatment facilities, are all vital to the program. Therefore, the ACHNs are required to have a Consumer Advisory Committee (CAC) in which 20% of the Committee must be consumers. The consumer representative may be a recipient, parent/caretaker or an advocacy organization representative. The ACHNs have a requirement for the Governing Boards to receive a verbal report from the CAC at each meeting. The Agency will permit teleconferencing of the ACHN's CAC and Board Meetings.
185	Reimbursement	My company is researching the upcoming Alabama Coordinated Health Network to consider becoming a Pivot Entity. We have a question about the global fees paid to OBs. I have gone through all of the questions, but that answers are a little contradictory. It says, "The OB providers will be paid Fee-for-Service.", but then it states, "The global fee schedule will remain the same." I need some clarification on that. Will the OB fee for all service still be the same as the current fee schedule, but each doctor will only be paid for the service he or she performs? If memory serves me correctly, currently, the doctor who performs the delivery gets the entire amount of the global fee. I am just trying to get clarification on how this has changed.	OB-GYNs and other delivering healthcare professionals who are contracted with the proposed networks will receive one set rate for prenatal, delivery, and postpartum services. In addition to the set rate, there will be fee-for-service payments available for services, such as ultrasound, laboratory, and anesthesia. OB-GYNs and other delivering healthcare professionals who are contracted with the proposed networks will also be eligible to receive two bonus payments, one for an office visit in the first trimester, and a postpartum office visit.
186	Reimbursement	What is the number of providers participating in the current 4 programs that will be eligible for bonus payments?	Providers eligible to receive bonus payments for patients in the general population include primary care physicians, as well as primary care physicians who are employed in FQHCs, RHCs, and PTFs and choose to actively participate with the PCCM-Es. Maternity care providers are also eligible for certain bonus payments as well.
187	Reimbursement	This section of the waiver does not include an "x", however the information is filled in. Please confirm that this is intended to be the PMPM payments given to the PCCM-E to cover initial administrative costs and Key Personnel.	The PMPM payment is for quality improvement projects; however we recognize that administrative costs and key personnel will be necessary to implement the program. Therefore the PMPM payment is also intended to be used for these expenses.

188	Participation	Under the current system, referrals may be made for conditions reviewed at the EPSDT visit. For complex patients with chronic conditions, referrals are typically made/renewed at the annual EPSDT visit. When a condition necessitating a referral is identified outside of the EPSDT visit, an inter-periodic visit is required. Currently the standard reimbursement for an inter-periodic visit is less than the reimbursement for most office visits and does not take into account the complexity of the visit. IP Question 1. In the proposed system, it is possible for a medically complex patient to go to Practice A for the most complicated care, elect to go to Practice B for just the EPSDT visit (even if Practice A is willing/able to see the patient in a timely fashion), and then return to Practice A to continue management and coordination of the complex conditions. Given the current reimbursement structure for the inter-periodic visit, Practice A would have a financial challenge to continue managing complex patients who elect to obtain the EPSDT elsewhere. I know that both the practices and the networks will stress the importance of continuity of care. In addition, could reimbursement for inter-periodic visits be revised to mirror office and follow-up visits?	Yes, we understand these issues and we are in the process of actively looking at the billing procedures associated with the EPSDT program to address the issues you have raised.
189	Program Structure	Please confirm the Managed Care division within the Agency, and not the PCCM-E, will complete this activity.	The Managed Care Division will be responsible for confirming eligibility for PCMH recognition bonus payments based on information submitted by
190	Program Structure	If quality bonus payments are not calculated until May/June for the previous year, when will Providers receive the payments?	For at least four quarters, all practice groups will automatically receive a full quality bonus payment at the first of each quarter. In the future,
191	Program Structure	Will the PCCM-E be part of the process to calculate the measure and will the PCCM-E receive any prior interim reporting to measure progress towards goals?	For the bonus payment to the providers, the PCCM-E will not be part of the calculation of the measures but will be expected to work with providers to help improve their performance. To assist with this collaboration, the Agency will provide monthly quality reports on all of its population. For the PCCM-E quality incentive payments, the calculations of the quality measures will be performed by the Agency but the Agency will send monthly quality reports to assist the PCCM-E with monitoring its performance.
192	Program Structure	Given this timeline, will the Agency continue to make bonus payments after the waiver's 2 year demonstration period is over?	It is the intent of the Agency to renew the waiver after the initial two year period.
193	Program Structure	Does this pool include bonus payments to both the PCCM-Es and the providers?	The designated $15.0 million is for bonus payments to actively participating primary care physicians.
194	Program Structure	In previous FAQs, the Agency stated that ACHNs must be 501(c)3 non-profits. An entity can be a non-profit without filing for a 501(c)3 designation with the IRS. By requiring an ACHN entity to obtain a 501(c)3 IRS status, the Agency is also requiring an ACHN's Governing Board members and officers to publicly disclose all of their personal income and investments. This is a risk to any entity proposing to become an ACHN and could inhibit the ACHN's ability to secure interested candidates on its Governing Board. Please confirm that the Agency intends for ACHNs to (1) have a non-profit legal status under Alabama law and (2) file as a 501(c)3 entity with the IRS.	The ACHN must be an Alabama nonprofit organization but will not be required to apply for a 501(c)(3) designation with the IRS.
195	Participation	Will there be a separate RFP for each Region?	Only one RFP will be released, although Vendors may submit a proposal on a region by region basis.
196	Participation	When will the RFP be released?	The Agency plans to release the RFP January 2019.

197	Participation	If you are part of an alternative payment model (Teaching Physician/FQHC/Etc) are you still eligible to participate in the PCMH and Quality incentives?	Physicians working in FQHCs or RHCs, or physicians who are part of a state university's medical faculty, will have an opportunity to receive bonus payments based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region and actively participate with the ACHN Entity.
198	Program Structure	What is the current status of CMS' review and approval of the Plan?	The Agency has submitted the Waiver to CMS and expects an approval before the end of 2018 or early 2019.
199	Program Structure	Will Readiness Assessment be conducted before CMS' approval of the plan?	The Agnecy has submitted the Waiver to CMS and expects an approval before the end of 2018 or early 2019.
200	Program Structure	Will the Agency award the RFP without CMS' approval of the Plan?	The Agency has submitted the Waiver to CMS and expects an approval before the end of 2018 or early 2019.
201	Program Structure	Is there a meeting we need to attend to sign up for the new program?	Information regarding the ACHN can be found on the Agency's website at http://www.medicaid.alabama.gov/content/2.0_Newsroom/2.7_Special_Initiatives/2.7.6_ACHN.aspx Future public meetings regarding the ACHN are posted at the same location.

202	Program Structure	Do we have a date on when we can enroll?	DHCPs will contract with the ACHN entities when the contract is awarded.
203	Program Structure	Our office currently participates in the Maternity program for Medicaid participants. We have received information for the ACHN program as it relates to OB care for Jefferson & Shelby counties. Where can I find information for the entities that will be providing care coordination for Walker and Cullman counties?	The Agency current intends to issue the contract award notification on April 17, 2019. The notification will be posted on the Alabama Medicaid Agency website.

204	Providers	Our facilities are currently credentialed with Alabama Medicaid PID 158165. I would like to see if we are in network with ACHN at this time, or if we need to apply and what that process is if so. I have a letter of intent with our pertinent information listed.	The providers who will be participating in the ACHN are Primary Care Physicians and Delivering Healthcare Professionals. Laboratories will continue to provide services to Medicaid recipients as they do today. There will be no additional required agreements or letters of intent..
205	Program Operation	Thank you for your response. My understanding of the "PCP" attribution process is that the patient will be attributed to a PCP retroactively and this will update quarterly. I am unclear on how a PCP can effectively work with a coordinator on a panel of retroactively attributed patients. Under the current system, once we get a patient assigned to our panel, we begin immediately to educate and monitor for appropriate utilization. I look forward to hearing the plan for coverage beyond the 14 visits as this will help us in our preparation for the changes.	Although attribution is calculated based on historic utilization, a provider will still be able to effectively manage his/her patients. By working with the care coordinator for the health of the patient, we anticipate a more lasting bond between the provider and patient which increases the likelihood of a patient staying with that provider. At the current time, there is no plan to change the 14 visit limit.
206	Program Operation	Please advise how the BCBS –Medicaid Contract may affect hospital facility providers.	Under the ACHN program there is no impact on hospital providers, unless they are enrolled as a primary care provider. If a provider is a Maternal Fetal Medicine specialist or OB/GYN employed by a hospital then the following would apply based on information in Chapter 28 (Physicians) of the provider billing manual: "A hospital-based physician who is a physician employed by and paid by a hospital may not bill Medicaid for services performed therein and for which the hospital is reimbursed."
207	Participation	Please confirm whether the new enrollment agreement applies to our group as we are an FQHC.	Yes. FQHCs are allowed to participate in the ACHN program; however, FQHC's will continue to receive the current PPS rates. Under the ACHN program, the FQHC must sign a Participation Agreement with the ACHN and a PCP Group Agreement with the Agency to be eligible to receive bonus payments.
208	Participation	As obstetrical providers, are we supposed to enroll with the ACHN or is that only for primary care physicians?	Yes. The DHCP must sign a Participation Agreement with the ACHN and participate in the selection referral process in order to be reimbursed for services provided to a Medicaid Recipient. If the DHCP chooses to participate as a PCP, they must also sign a PCP Participation Agreement.
209	General	Will there be protocols in place to prescribe certain drugs to Medicaid recipients? I am assuming there will be a focus on cost containment, aka using the lowest-cost/generic drugs, but are there some instances where providers might be incentivized to prescribe higher-cost drugs for their proven efficacy?	The Agency utilizes various programs and criteria to ensure cost-effective prescribing, such as the Preferred Drug Program, Prescription Limit, DAW edits, etc. More information can be found on the Agency website under the Pharmacy link below. If you have questions on a specific program, we can hold a discussion with your staff and Medicaid pharmacy staff at an upcoming meeting.
210	Participation	What is the process for Specialists in regards to ACHN Participation? Are they required to complete new applications?	There are no new requirements related to non-primary care specialists within the ACHN program. However, some non-primary care specialty providers will need to continue to obtain a referral from a PCP.
211	Reimbursement	1. Are the PCP Participation Rates posted on the website for a physician? Is there a separate rate for nurse practitioners? 2. What is the anticipated incentive payment for PCHM's?	The PCP participation rates are posted on the AMA website. However, NPs who collaborate with participtating PCP groups will be reimbursed at 80% of the PCP participation rate. If the participating group achieves or demonstrates appropriate progress towards achieving PCMH Recognition, then the group will receive a bonus payment. The dollar amount of the bonus will be dependent on the number of groups that achieve recognition and the number of attributed recipients to the group.
212	Reimbursement	Our Doctor is a specialist and needs a PCP referral with a current EPSDT date for payment of services. Does the ending of this program effect any of the current process of our referrals?	No. The ending of the Patient 1st program will not affect the current process for specialty referrals.
213	Reimbursement	Two of the quality measures for incentive payments are related to well care visits. Where will this information be obtained? The periodic screening/rescreening lists from the Medicaid Management Information System is horribly inaccurate. Apparently, the system doesn't recognize when a patient had their yearly well visit with a previous Medicaid number. We have numerous patients on our list that should not be there.	The information will continue to be obtained from the MMIS. However, the Agency is working to resolve the current issue with duplicate Medicaid IDs. These corrections to the system will be made prior to go-live on 10/1/2019.

ACHN Questions and Answers - Updated 1/23/19

	Issue	Question	Response
1	Contracting	Will there be a separate RFP for each Region?	Agency Requests for Proposal are released pursuant state rules and regulation. Please continue to monitor the Agency website for RFP releases. Also, potential bidders are encouraged to register with STAARS to recieve RFP release notifications.
2	Contracting	What is the time period for bidders to respond?	Agency Requests for Proposal are released pursuant state rules and regulation. Please continue to monitor the Agency website for RFP releases. Also, potential bidders are encouraged to register with STAARS to recieve RFP release notifications.
3	Contracting	What is the time period for Agency review and Award?	Agency Requests for Proposal are released pursuant state rules and regulation. Please continue to monitor the Agency website for RFP releases. Also, potential bidders are encouraged to register with STAARS to recieve RFP release notifications.
4	Contracting	Will the Agency award the RFP without CMS' approval of the Plan?	Yes, the Agency will consider awarding the RFP without CMS' final approval.
5	Contracting	When will the RFP be released?	Agency Requests for Proposal are released pursuant state rules and regulation. Please continue to monitor the Agency website for RFP releases. Also, potential bidders are encouraged to register with STAARS to recieve RFP release notifications.

6	Contracting	In the AL-AAP webinar on 09/05, the Agency stated that they would wait for CMS approval of the waiver before setting a schedule. 1.) Does that mean that the Agency will wait for CMS wavier approval before releasing an RFP? 2.) If so, to assist potential bidders in their scheduling and planning in progress for proposal responses, when does the Agency anticipate the waiver will be submitted and/or approved?	The 1915 (b) ACHN waiver was formally submitted to CMS on August 2, 2018 and has been posted to the AMA website. The Agency anticipates releasing the RFP in early January 2019.
7	Contracting	Any update on the date of the release of the RFP?	The Agency plans to release the RFP January 2019.

ACHN Questions and Answers - Updated 6/21/19

	Issue	Question	Response
1	General	Why is there not a general forum page for community-wide discussions? Why was the video link disabled to disallow comments?	The Agency has established a page on its website where questions and comments may be submitted. A link to subscribe for email updates is also available on this page. All questions and answers received by the Agency will be posted to this page. Additional communmity engagement activities will be announced as the program is developed.
2	General	I just learned of this new program. Are yall going to have meetings in the different regions so providers can learn more about these? When is the current expected implementation/go live date?	Future public meetings regarding the ACHN Program and will be posted to the Agency's Website at http://www.medicaid.alabama.gov/content/2.0_Newsroom/2.7_Special_Initiatives/2.7.6_ACHN.aspx
3	General	I was trying to locate to dates, time and location for the meeting. However I'm not being successful at locating this. Could you please email this info to me? Thanks in advance.	The Agency has established a page on its website where questions and comments may be submitted. A link to subscribe for email updates is also available on this page. All questions and answers received by the Agency will be posted to this page. Additional communmity engagement activities will be announced as the program is developed.
4	General	I was recently made aware of the innovative plan for the Alabama Coordinated Health Network and would like to speak with someone about this initiative for "pivot entities".	Information on the ACHNs (formerly known as Pivot Entities) can be found at http://www.medicaid.alabama.gov/content/2.0_Newsroom/2.7_Special_Initiatives/2.7.6_ACHN.aspx An email address is also provided at the website to submit any questions regarding the new program.
5	General	As of 8/30/18, has the 1915b waiver been submitted to CMS? If so, will the waiver be posted to the ACHN page on Medicaid?	The Waiver was submitted to CMS on August 2, 2018 and has been posted to the website.
6	General	When will these changes happen?	The Agency plans to implement the ACHNs in 2019.

7	General	Will meetings be held in each region?	Several provider-specific (OB/Gyn, Pediatrics, Family Medicine) meetings and presentations have already been conducted. More provider meetings, webinars and other activites are planned in the coming months. The Agency has also established a page on its website where questions and comments may be submitted. A link to subscribe for email updates is also available on this page. All questions and answers received by the Agency will be posted to this page. Additional communmity engagement activities will be announced as the program is developed.
8	General	Will the Agency provide an open comment period for the waiver prior to submitting to CMS for approval?	The 1915 (b) ACHN waiver was formally submitted to CMS on August 2, 2018 and has been posted to the AMA website. If you have any questions concerning the waiver, you may submit them to the ACHN e-mail address.
9	General	Will there be protocols in place to prescribe certain drugs to Medicaid recipients? I am assuming there will be a focus on cost containment, aka using the lowest-cost/generic drugs, but are there some instances where providers might be incentivized to prescribe higher-cost drugs for their proven efficacy?	The Agency utilizes various programs and criteria to ensure cost-effective prescribing, such as the Preferred Drug Program, Prescription Limit, DAW edits, etc. More information can be found on the Agency website under the Pharmacy link below. If you have questions on a specific program, we can hold a discussion with your staff and Medicaid pharmacy staff at an upcoming meeting.

ACHN Questions and Answers - Updated 10/3/18

	Issue	Question	Response
1	Governing Board	How do physicians apply to be on the governing board of the ACHN entity and who decides on the selection of these members?	Each ACHN will be responsible for policies and procedures regarding the development of its governing board.
2	Governing Board	With regard to each ACHN's board, the PPT states that "hospitals can employ no more than one board physician per entity." How does this change the limit of two hospital-employed physicians per board?	The proposed board composition is intended to reflect several key components of the health care system. To have a qualifying board, both hospital positions would need to be filled. A. Hospital Positions: Hospitals can choose who fills the two hospital slots (administrator, physician, etc.) The two slots should represent more than one system if at all possible. B: Primary Care Physician positions: It is not required that hospitals employ any of the primary care physicians filling the primary care slots, but it is allowed for each hospital represented to employ one of the physicians filling a primary care slot. It is certainly allowable for the board to choose to increase their membership above the 12 minimum members; however, the ratios will need to be maintained. For example, doubling the number of hospital-associated slots would require a doubling of all the other slots on the board.
3	Governing Board	If an ACHN entity has three participating hosptals, can the board now have three hospital-employed physicians?	See above question
4	Governing Board	Alternatively, if an ACHN entity has only one participating hospital, is the PCCM entity limited to one hospital-employed physician?	See above question
5	Governing Board	Can one hospital serve on multiple boards in different regions?	No. They may only serve on a board in the region in which they are located.

6	Governing B	Please provide clarification on the governance allowance that allows up to 2 of the primary care physicians to be employed by a hospital. Why is this allowance limited to hospital employed primary care physicians?	The goal in constructing the ACHN boards is to reflect the impact various provider groups have on the populations included in the ACHN. Physicians and hospitals are major provider groups, both in terms of large numbers of individuals served and in terms of agency budgetary impact. Other critical groups are also included on the ACHN boards: Federally Qualified Health Centers, Community Mental Health Centers, Substance Abuse Treatment Facilities, and Consumers. In order to maintain a judicious board size, but to also reflect the relative impact on Medicaid's recipients and budget, the decision was made to allow only hospitals to, in addition to their two hospital positions, employ two of the primary care physicians filling the primary care board positions.
7	Governing Board	Can the medical director for the ACHN serve on the ACHN board?	Yes.
8	Governing Board	For the ACHN board, may the FQHC representative be a physician who also satisfies one of the required primary care board positions? If so, can the board have fewer than 12 members/directors?	No. The FQHC representative cannot satisfy the required primary care board position. The minimum number for the board is 12 members.
9	Governing Board	Can a medical director be a medical director in two different regions?	No. The Medical Director must practice medicine in the region they serve. If the Medical Director practices in more than one region, they will only be eligible to serve (as Medical Director) in the region of their main practice site.

ACHN Questions and Answers - Updated 6/21/19

	Issue	Question	Response
1	Participation	According to Medicaid's program briefing, PMPs will now have the choice as to if they participate in the Pivot Program instead of being required as a condition of Patient 1st provider enrollment. Accordingly, providers that choose not to participate in the Pivot Program will only receive the current Medicaid FFS. Please provide information including requirements for PMP enrollment with Medicaid since the existing Patient 1st contact will be invalid.	In addition to the regular Medicaid provider enrollment form, Primary Care Physicians will also be required to complete a PCP Enrollment form. This enrollment form is still under development and will be released closer to implementation of the program. A separate agreement will be required between the PCP and the ACHN entity in order to quaify for bonus payments.
2	Participation	If there is no impact on FQHCs and RHCs, can they still participate with ACHN?	Yes, there will be an opportunity for bonus payments to PCPs based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region.
3	Participation	We currently have two pediatric board-certified specialists (neurology and pulmonology) who are receiving the enhanced bump rate as they meet the requirements. Will they be able to participate in the ACHN Entity and continue to receive the bump rate? If they are participating, what measures would they have to meet to obtain incentive payments as they do not provide check-ups, immunizations or BMI measures?	Yes. All physicians who meet the current requirements to receive "bump" payments AND actively participate with the ACHN Entity will be eligible to receive the ACHN Participation Rate (which replaces the "Bump" rate).
4	Participation	Do you have to be an FQHC to develop a PIVOT?	No. Any organization interested in participating in the ACHN program must comply with the organizational qualification requirements set by the Agency in the ACHN Program RFP to be issued in the near future.
5	Participation	How do you apply to be an ACHN Entity and what is the selection process?	Any interested organizations must respond to the Response for Proposal (RFP) to be issued in the near future.

6	Participation	Will practices operating under RHC status continue under their current status if the ACHN Project is approved or will RHCs be replaced?	The RHC will continue under their current status, but will also be encouraged to participate with the ACHN Entity for care coordination services and to be eligible for bonus payments.
7	Participation	Will PMPs employed by a group practice, outpatient clinic, hospital affiliated outpatient clinic, etc. be allowed to participate in the Pivot Program and be eligible for incentive payments?	Yes, there will be an opportunity for bonus payments to PCPs based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region.
8	Participation	When can we register to be a part of this program?	DHCPs will contract with the ACHN entities when the contract is awarded.
9	Participation	How will this plan affect physicians working through an FQHC?	Physicians working in an FQHC will have an opportunity to receive bonus payments based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region and actively participate with the ACHN Entity.
10	Participation	Does every provider have to attend the three meetings or can a provider rep attend?	A representative from the group practice must attend, who may be a physician, nurse practitioner, or physician's assistant.
11	Participation	Am I to understand correctly, if you are a solo practioner with no np or assistants, the physician themselves must attend the meeting and cannot send office managers or charge nurses in their place?	This is correct. In order to participate with an ACHN, a PCP, nurse practitioner, or physician assistant must attend at least two Quarterly Medical Management Meetings and participate in a webinar.

12	Participation	Right now, if a provider has a patient assigned to them, the provider must see that patient until/unless they discharge them. Since the program moves to an attribution model instead of assignment model, will we have an increase in patients, especially older children, who cannot find a physician to accept them? What will we do if patients have a card and no available PCP? This could be a risk to the program should a provider choose not to see more patients if they are incentive payout is at risk if they add more patients.	Physicians may continue to choose how many new Medicaid recipients they accept. If the recipient does not currently have a PCP, a care coordinator with the ACHN may assist the recipient in choosing a PCP.

13	Participation	Under the current system, referrals may be made for conditions reviewed at the EPSDT visit. For complex patients with chronic conditions, referrals are typically made/renewed at the annual EPSDT visit. When a condition necessitating a referral is identified outside of the EPSDT visit, an inter-periodic visit is required. Currently the standard reimbursement for an inter-periodic visit is less than the reimbursement for most office visits and does not take into account the complexity of the visit. IP Question 1. In the proposed system, it is possible for a medically complex patient to go to Practice A for the most complicated care, elect to go to Practice B for just the EPSDT visit (even if Practice A is willing/able to see the patient in a timely fashion), and then return to Practice A to continue management and coordination of the complex conditions. Given the current reimbursement structure for the inter-periodic visit, Practice A would have a financial challenge to continue managing complex patients who elect to obtain the EPSDT elsewhere. I know that both the practices and the networks will stress the importance of continuity of care. In addition, could reimbursement for inter-periodic visits be revised to mirror office and follow-up visits?	Yes, we understand these issues and we are in the process of actively looking at the billing procedures associated with the EPSDT program to address the issues you have raised.
14	Participation	Will Urgent Care facilities and their providers be allowed to participate in the ACHN?	Urgent Care facilities may enroll as a physician group and may participate in the ACHN as a PCP provider.
15	Participation	Will there be a separate RFP for each Region?	Only one RFP will be released, although Vendors may submit a proposal on a region by region basis.
16	Participation	When will the RFP be released?	The Agency plans to release the RFP January 2019.

17	Participation	If you are part of an alternative payment model (Teaching Physician/FQHC/Etc) are you still eligible to participate in the PCMH and Quality incentives?	Physicians working in FQHCs or RHCs, or physicians who are part of a state university's medical faculty, will have an opportunity to receive bonus payments based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region and actively participate with the ACHN Entity.
18	Participation	Please confirm whether the new enrollment agreement applies to our group as we are an FQHC.	Yes. FQHCs are allowed to participate in the ACHN program; however, FQHC's will continue to receive the current PPS rates. Under the ACHN program, the FQHC must sign a Participation Agreement with the ACHN and a PCP Group Agreement with the Agency to be eligible to receive bonus payments.
19	Participation	As obstetrical providers, are we supposed to enroll with the ACHN or is that only for primary care physicians?	Yes. The DHCP must sign a Participation Agreement with the ACHN and participate in the selection referral process in order to be reimbursed for services provided to a Medicaid Recipient. If the DHCP chooses to participate as a PCP, they must also sign a PCP Participation Agreement.
20	Participation	What is the process for Specialists in regards to ACHN Participation? Are they required to complete new applications?	There are no new requirements related to non-primary care specialists within the ACHN program. However, some non-primary care specialty providers will need to continue to obtain a referral from a PCP.

ACHN Questions and Answers - Updated 10/3/18

	Issue	Question	Response
1	Program Funding	What is the current FY2019 budget allocated for the Pivot Plan?	The Agency will be combining Patient 1st, Health Homes, Plan First , and the Maternity Program into a single care coordination delivery system with the goal of a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results.
2	Program Funding	What is the expected budget allocation for FY2020 and 2021?	Budgets for FY 2020 and FY 2021 have not yet been submitted.
3	Program Funding	Where is the funding coming from that will fund these care coodination entities. Who will receive the cuts that will be required to cover the cost of the program?	There is no additional funding for the ACHN. The Agency will be combining Patient 1st, Health Homes, Plan First, and the Maternity Program into a single care coordination delivery system with the goal of a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results.
4	Program Funding	It is great to identify regional factors that affect health in Alabama. Where will the funding come to address regional environmental factors (drug abuse, mental health, water pollution) once identified by regional entities? We are already aware of issues that have negative effects on patient health and areas of shortages of specific services such as mental health, but how will this plan improve this?	Each ACHN will have funded quality improvement projects (QIPs) focusing on population priorities, such as Substance Abuse, Infant Mortaility, Obesity, and Obesity Prevention.

ACHN Questions and Answers - Updated 10/3/18

	Issue	Question	Response
1	Program Operation	What is the current status of CMS' review and approval of the Plan?	The Waiver is currently being prepared for submission to CMS.
2	Program Operation	How will CMS' review and approval affect the proposed implementation timeline.	We are working closely with CMS and following their guidance and guidelines. At this point, the Agency is confident our process is consistent with CMS guidelines.
3	Program Operation	Will Readiness Assessment be conducted before CMS' approval of the plan?	The Agency will make every effort to stay within the timeline set forth within the RFP regardless of CMS approval of the waiver.
4	Program Operation	The patient 1st program is going to be done away with. So they can see whoever without getting a referral except for some Specialist. I work for a OBGYN office. We don't have to get referrals for out patients. But if a patient sees our NP for anything but pregnancy it requires a referral. Is this something is gonna change? Are we still gonna need to get a referral for only NP?	The referral process will not change. There will continue to be a referral requirement for Nurse Practitioners.
5	Program Operation	If the ACHN would like to use the RMEDE software, will there be a charge to use the software?	The ACHNs will fund their case management system from the funds they receive through the provision of services. Unless the ACHN develops its own system, they will need to contract with someone. The terms of that agreement will be between the case management system provider and the ACHN.
6	Program Operation	Will the Medicaid Portal go away? If so, will there be something to replace it?	No. The Medicaid Provider Portal will remain in place.
7	Program Operation	How transparent are we going to be to give data feed back to PCPS?	It will be similar to the current data the Health Homes provide.

8	Program Operation	Are there limited amount of visits annually?	Yes. The Agency will continue to limit visits to 14 annually for adults. However, with correct coding of EPSDT screening and follow-up visits, additional visits for care to treat medical issues may be covered for children.
9	Program Operation	I am understanding that a Medicaid patient may be seen in our office, and then go to another office and then return to our office and during all of this, the patient doesn't have to be assigned to our PCP?	This is correct. The Agency will no longer assign patients, and the patient will be able to visit any PCP they choose.
10	Program Operation	How transparent are we going to be to give data feedback to PCPS?	It will be similar to the current data the Health Homes provide.
11	Program Operation	How will we able to identify if a recipient needs an EPSDT(since we will not have provider panels at the point of care)	The Agency will be sending quarterly a list of recipients attributed to the Group Practice. The EPSDT program will have the same relationship with the attributed Provider as it does today with the Patient 1st Provider.
12	Program Operation	Will that "attribution" list be available on a quarterly basis?	Yes. It will be available on a quarterly basis.
13	Program Operation	At the start of the program, and periodically thereafter, will Medicaid provide providers a list of patients attributed to them using Medicaid's methodology?	Yes. The Agency will be sending quarterly a list of recipients attributed to the Group Practice.
14	Program Operation	How can the visits be tracked if there is no panel. A provider won't know what diagnosis was included on the EPSDT if done at another clinic. If a patient sees provider one week and uses their last visit, then comes to another provider the following week, how will I know that all the visits have been exhausted?	The provider will continue to check eligibility to determine if visits are exhausted. Please refer to Appendix A in the Provider Manual for correct coding of EPSDT.

15	Program Operation	Thank you for your response. My understanding of the "PCP" attribution process is that the patient will be attributed to a PCP retroactively and this will update quarterly. I am unclear on how a PCP can effectively work with a coordinator on a panel of retroactively attributed patients. Under the current system, once we get a patient assigned to our panel, we begin immediately to educate and monitor for appropriate utilization. I look forward to hearing the plan for coverage beyond the 14 visits as this will help us in our preparation for the changes.	Although attribution is calculated based on historic utilization, a provider will still be able to effectively manage his/her patients. By working with the care coordinator for the health of the patient, we anticipate a more lasting bond between the provider and patient which increases the likelihood of a patient staying with that provider. At the current time, there is no plan to change the 14 visit limit.
16	Program Operation	Please advise how the BCBS –Medicaid Contract may affect hospital facility providers.	Under the ACHN program there is no impact on hospital providers, unless they are enrolled as a primary care provider. If a provider is a Maternal Fetal Medicine specialist or OB/GYN employed by a hospital then the following would apply based on information in Chapter 28 (Physicians) of the provider billing manual: "A hospital-based physician who is a physician employed by and paid by a hospital may not bill Medicaid for services performed therein and for which the hospital is reimbursed."

ACHN Questions and Answers - Updated 3/14/19

	Issue	Question	Response
1	Program Structure	Given health centers role as medical homes and the overall aim of population health management to improve the outcomes of patients while improving efficiencies and reducing the total costs, please provide the rationale for excluding health center PMPs from the Pivot Performance Incentive Program.	There will be an opportunity for bonus payments to health center PCPs based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the Network Entity in their region.
2	Program Structure	We currently have some systems in place to identify cost-efficient Medicaid providers (Provider Profiles, reporting available via EHRs, Gold Standard Prescribers, etc.); have we considered utilizing/improving these systems that are already in place to incentivize providers/entities to provide better outcome-based and more cost-efficient care?	The new payment methodology does build on current systems to better recognize and reward outcome-based, cost-efficient care.
3	Program Structure	When will provider-specific meetings be held on this new program. Provider input during the planning phase could be a crucial component of program success.	Several provider-specific (OB/Gyn, Pediatrics, Family Medicine) meetings and presentations have already been conducted. More provider meetings, webinars and other activites are planned in the coming months. The Agency has also established a page on its website where questions and comments may be submitted. A link to subscribe for email updates is also available on this page. All questions and answers received by the Agency will be posted to this page. Additional communmity engagement activities will be announced as the program is developed.

4	Program Structure	Will there be a visit limit? If so, without patient panels, how will a provider know when a patient has used all of their visit? Many providers' billing is often delayed six months or more due to credentialing timeframes.	Today the same concerns about approaching the 14-visit limit for adults exist. Simply having a panel does not prevent recipients from accessing the ER which also counts toward the 14-visit limit for adults. It will be important for physicians to work with the ACHN entities to manage and educate patients regarding the visit limits.
5	Program Structure	Will Pediatric providers be able to dismiss Medicaid patients that choose to go to Urgent Care centers on a regular basis for illness, but use their Pediatric provider for behavior needs and EPSDT's?	The Primary Care Physician will determine dismissal of any recipient.
6	Program Structure	Will Pediatric providers be required to administer EPSDT's or will any "willing Medicaid provider" be able to administer these screenings?	EPSDT screenings may be provided by any EPSDT provider enrolled with Medicaid without regard to their enrollment status with the ACHN entity.
7	Program Structure	Can individual provider practices set up an ACHN Entity?	Any interested organizations must respond to the Response for Proposal (RFP) to be issued in the near future.
8	Program Structure	Will there be more than 1 ACHN in each region.	There will be only one ACHN entity per region.

9	Program Structure	Dr. Moon mentioned three organizations that they were talking with to help in the areas of infant mortality, substance abuse and obesity/obesity prevention. Can you share who those are? We (AL-AAP and ADPH) have an established opioid misuse in women task force – how can we connect with the pivot entities in the area of substance abuse?	Alabama Child Health Improvement Alliance (ACHIA) has agreed to work with ACHN to develop Quality Improvement Plans related to Obesity and Obesity Prevention. The Alabama Perinatal Quality Collaborative has agreed to work with ACHN to develop QIPs related to Infant Mortality. The Medicaid Agency is in discussions with the Alabama Department of Mental Health about working with ACHN to develop QIPs related to substance abuse. Other groups may want to reach out to these lead organizations regarding how they might contribute.
10	Program Structure	Do you see providers being able to provide the same continuity of care when patients will be given a broader freedom to walk in Urgent Care centers for their immediate need?	The ACHN is an outcome-focused effort. Consequently, providers will be incentivized for providing a medical home and for the quality of the care they provide. With the support of care coodinators, more patients will be encouraged to obtain care in an appropriate setting. The Agency does not now and currently has no plan to pay stand alone Urgent Care centers.

11	Program Structure	Dr. Moon reported that the Patient 1st Program will not continue and that patients, except for some maternity cases, will no longer be assigned to PMPs. Please provide information on Medicaid's rationale for discontinuing the process of assigning related Medicaid enrollees to a medical home. It seems that the basis of any Primary Care Case Management Program is patient assignment to a PMP/medical home that is responsible for managing patient needs; additionally, since Medicaid will now be making additional incentive payments to private physicians for "PCMH activities" but has severed the basic tenant of any care coordination system which is the establishment of a consistent medical home relationship. Medicaid's own data seems to demonstrate that the percentage of Medicaid enrollees requesting changes in their PMP assignments is low. What has prompted Medicaid to discontinue the process of assigning PMPs?	Most other payers in our state do not use assigned panels. The largest commercial payer (BCBS) uses an attribution methodology and some Medicare plans use an attribution methodology. Medicaid's move to an attribution methodology is consistent with the approach of other payers in our state.
12	Program Structure	Since patients will no longer be assigned to a Patient 1st PMP and may see any "Medicaid Primary Care Physician" they choose, please define "Medicaid Primary Care Physician."	Primary Care Physician (PCP) – A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) that practices in the specialty designation of family medicine, general internal medicine, pediatrics, and general medicine.
13	Program Structure	What type of legal entity must be formed to qualify as an ACHN entity?	The entity must be an Alabama nonprofit entity with an office located in the region, and registered as an Alabama domicile with the Secretary of State.
14	Program Structure	What are the requirements for ownership of an ACHN entity? We understand that providers must serve on the board of directors, but do providers also have to be owners of the entity?	There are currently no requirements for ownership.

15	Program Structure	Will there be some limitations as to the number of times a maternity patient can change OB providers during the course of a pregnancy? Frequent patient movement especially in urban areas is a concern in such a time limited treatment span such as pregnancy and the potential impact it will have on overall outcome of care and provider ability to meet set care parameters/benchmarks in order to be eligible for the incentive monies.	The maternity patient must be allowed to change a DHCP once without cause within the first 90 Calendar Days of selecting a DHCP and at any time for just cause, which is defined as a valid complaint submitted orally or in writing to the PCCM-E.
16	Program Structure	Does ACHN encourage Patient homes?	The Agency values Patient-Centered Medical Homes which is why PCMH recognition is incentivized in the ACHN program.
17	Program Structure	For an entity to be eligible to respond to the ACHN, must a final determination letter regarding 501(c)(3) status be obtained, or will the Agency accept either the entity's nonprofit status or the entity's submission of the 501(c)(3) application?	The ACHNs will not be required to obtain 501(c)(3) status. The ACHN must be an Alabama nonprofit organization.
18	Program Structure	How can we prevent recipients from Dr shopping? Since they don't need referral.	Currently in Patient 1st, recipients can change PMPs as often as they choose. Reducing referrals or removing panels will not increase the number of times a recipient changes PMPs. Instead, we believe this will result in a more streamlined system for providers and recipients. The advantage of the ACHN system is that a patient who appears to be "doctor shopping" can be identified and referred to the ACHN for care coordination.
19	Program Structure	How will this program affect non PCP providers like radiology and pathology?	Radiologists and pathologists do not qualify to participate in the ACHN program, and will continue to receive referrals and payments as they do today.

20	Program Structure	How would you budget Networks and also incentivizing networks ?	There is no additional funding for the ACHN. The Agency will be combining Patient 1st, Health Homes, Plan First, and the Maternity programs into a single care coordination delivery system with the goal of a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results.
21	Program Structure	If you do not participate with ACHN, will you still have a Patient 1st panel or are you doing away with Patient 1st?	Patient 1st will end with the implementation of the ACHNs. Physicians will no longer have panels.
22	Program Structure	Is there a way to reduce the risk of cherry picking patients-- physicians discharging patients who don't fill their maintenance medications, for instance, if those physicians are not getting their maximum amount of payment and are trying to obtain it?	The Agency recognizes that some patients are more time and resource intensive. The ACHN bonus system will factor that in by risk adjusting for these patients in the cost-effectiveness calculation. At the same time, the ACHN will be incentivized to provide additional care coordination services to encourage recipients to be more compliant.
23	Program Structure	So, under this program, as a PCP, if you see a new Medicaid patient, you will no longer have to get a referral from the PCP the patient is currently assigned to?	This is correct. The patient will no longer need a referral to see a new PCP.
24	Program Structure	We currently have a panel limit and we are not currently taking new medicaid patients, will our Physicians be required to accept new patients?	No. Physicians may continue to limit the number of Medicaid recipients using some of the same office procedures they use to limit other types of payers.
25	Program Structure	When there is no longer a panel, will we still be able to limit the number of new Medicaid recipients attributed to our practice?	Physicians may continue to limit the number of Medicaid recipients using some of the same office procedures they use to limit other types of payers.
26	Program Structure	Will the panels be eliminated prior to the implementation of the full program?	No. The panels will be eliminated when the ACHNs are implemented.

27	Program Structure	Will there be some limitations as to the number of times a maternity patient can change OB providers during the course of a pregnancy? Frequent patient movement especially in urban areas is a concern in such a time limited treatment span such as pregnancy and the potential impact it will have on overall outcome of care and provider ability to meet set care parameters/benchmarks in order to be eligible for the incentive monies.	The maternity patient must be allowed to change a DHCP once without cause within the first 90 Calendar Days of selecting a DHCP and at any time for just cause, which is defined as a valid complaint submitted orally or in writing to the PCCM-E.
28	Program Structure	When will ACHN entities be required to contract with providers – Prior to go-live or during the 1-year "look back" period prior to incentive payout?	The ACHN entities will need to contract with providers prior to implementation in order for the providers to receive their first quarter bonus payments and participation rates. However, providers may also contract with an ACHN entity at anytime, but would not receive participation payment rates or bonus payments prior to contract.
29	Program Structure	Will the Agency provide the ACHN entity with specific quality data that identifies providers who are not meeting quality metrics? If so, how often and in what format will that reporting occur?	Yes, the Agency will provide summary data on a monthly basis to the ACHN entities on the performance of quality measures.
30	Program Structure	Will the Agency require ACHNs to use the RMEDE system for documentation of care coordination activities? If so, please provide the latest technical specifications and an updated user manual for RMEDE, so that potential ACHNs can understand its capabilities as they formulate their concept of operations for the proposal.	No. Technical specifications will be detailed in the RFP.
31	Program Structure	Is it possible for the Entity to contract with current ADPH Care Coordinators? Could these Care Coordinators continue to be housed in the ADPH Clinics? With the above scenario, would these Care Coordinators have to be direct employees of the Entity and not ADPH employees?	The PCCM-E may choose to contract with an organization or agency to provide Care Coordination. The PCCM-E will determine where the Care Coordinators will be located. The Care Coordinators would not have to be direct employees of the Entity.

32	Program Structure	Will there be increased Substance Abuse providers for Medicaid recipients in order to participate in S/A quality improvement projects?	It is not the Agency's intention for the entity to hire or increase the number of substance abuse providers for Medicaid recipients. The Agency expects through the QIP implementation, that the entity will address the prevention and outcomes for those with substance abuse disorders through community outreach, provider education, and care coordination of it's recipients. Please see the following link of Substance Abuse providers that are currently certified by DMH. This list is updated monthly by DMH. http://www.mh.alabama.gov/downloads/SA/SASDProgramDirectory.pdf
33	Program Structure	Are there any granular statistics that show the challenges for the high-risk individuals in the 5% for each region?	AHRQ is a very well established federal research entity and their statistics on the high utilization and high cost recipients has been shown to also be demonstrated in the Alabama Medicaid population. Additional demographic and summary data will be available for responders after the RFP is released.
34	Program Structure	Please describe the process the Agency will utilize to assist the PCCM-E in verifying appropriate modes of transportation that will be paid by the Agency.	The PCCM-E Care Coordinators will be assisting recipients in navigating the Agency's Non Emergency Transportation (NET) program as well as local resources.
35	Program Structure	Please confirm that the PCCM-E will not be required to pay for or provide (i.e.: contracts with transportation providers) non-emergency transportation.	This is correct, the PCCM-E will not be required to pay for or provide non-emergency transportation services.

36	Program Structure	For these bonus payments, where will the evaluated data originate, RMEDE?	These bonus payments will be paid by Medicaid based on meeting criteria. The data used to calculate the measures will originate from submitted claims.
37	Program Structure	Please define the oversight provided between the PCCM-E and the Agency.	Specific Information will be included in the RFP.
38	Program Structure	Will the PCCM-E be required to conduct SBIRT training for Providers and certify the Provider's completion of such training?	No, SBIRT training will continue to be done by the Department of Mental Health as it is today.
39	Program Structure	Please provide the Agency standards for the case to staff ratios expected for ACHN.	Specific Information will be included in the RFP.
40	Program Structure	Please confirm that this requirement is for recipients in an "active case management" status, and not the total regional population.	This requirement is for recipients currently receiving care coordination services. This does not preclude the PCCM-E from identifying and engaging with other individuals who would benefit from care coordination.
41	Program Structure	Please confirm that emergency rooms will be required to report discharges to the Agency in real time, and that reporting will be immediately available to the PCCM-E.	The PCCM-Es will need to coordinate with the hospitals in their region to provide services in a timely manner, as the Health Homes do today.
42	Program Structure	Please confirm that the Agency will maintain responsibility for publishing and issuing a Provider Directory to recipients.	The Agency will maintain a Provider Directory for recipients.
43	Program Structure	Please provide any requirements the Agency has for the referral process the PCCM-E is to create.	Specific Information will be included in the RFP.
44	Program Structure	If enrollees are seeing multiple providers, how do PCCM-E's determine the PCP for the purpose of medication reconciliation and discharge follow-up?	The PCCM-E will follow up with the PCP of the recipient's choice.

45	Program Structure	Will the Agency require the use of RMEDE for case management documentation in this regional case management approach? If not, are there any requirements which need to be followed to exchange information between regional case management systems should a recipient move from one region to another?	The ACHNs will fund their case management system from the funds they receive through the provision of services. Unless the ACHN develops its own system, they will need to contract for that capability. The terms of that agreement will be between the case management system provider and the ACHN. Specific information related to patient transfers will be included in the RFP.
46	Program Structure	Please confirm that the Agency will define the business requirements/guidelines for the transfer process instead of each PCCM-E individually working out those details among regions.	Specific Information will be included in the RFP.
47	Program Structure	How will continuity of care be measured if enrollees are allowed to see any Medicaid provider? For example: If a member is seeing multiple providers, who does the PCCM-E coordinate the plan of care with and provide follow up with post discharge or ER visit?	The PCCM-E will follow up with the PCP of the recipient's choice. Medicaid encourages PCCM-Es to work closely with the recipient to seek a single PCP for the purpose of continuity of care.
48	Program Structure	Please confirm that “implementation date” is the expected go-live date of the program, and does not include the implementation and readiness period prior to go-live.	The implementation date is the expected go-live date.
49	Program Structure	Please define the process for submitting disenrollment to the Agency for review and approval.	Specific Information will be included in the RFP.
50	Program Structure	How will the grievance data be made available to the PCCM-E? Will the Agency consider monthly reporting, so that the PCCM-E can work with a member to stop any issues/concerns in a timely manner?	Specific Information will be included in the RFP.
51	Program Structure	Please confirm it is the Agency’s expectation that each PCCM-E will self-report on their case management activity for which they get paid. If so, how will the Agency ensure that each PCCM-E is defining all elements the same and providing accurate information?	Specific Information will be included in the RFP addressing requirements for these issues.

52	Program Structure	How will the PCCM-E receive data on Non-Authorized Specialist requests?	The Agency will provide quality and utilization summary data to the PCCM-Es on a monthly basis. The Agency will also provide a monthly list of recipients to be screened by the entity. Prior authorization data would be included if determined it would be necessary and used by the PCCM-Es.
53	Program Structure	Will the utilization information and data be similar to the current ESD tables used by the Health Homes (i.e.; The current Touch Report)?	The Agency will provide quality and utilization summary data to the PCCM-Es on a monthly basis. The Agency will also provide a monthly list of recipients to be screened by the entity. Prior authorization data would be included if determined it would be necessary and used by the PCCM-Es.
54	Program Structure	If every PCCM-E is allowed to use its own case management system, what is the system of truth the Agency will use to validate the touches that determine payment?	The Alabama Medicaid Management Information System (MMIS) is the system of truth and the Agency will use this system to validate the touches that determine payment.
55	Program Structure	Please define the requirements to be paid for the following activities within the General Population: “Intensely Managed”, “Moderately Managed” and “Monitoring – Medical Review”.	Specific Information will be included in the RFP.
56	Program Structure	On what date did the initial 90-day period start? Have there been any additional requests from CMS extending this period?	The initial 90-day period began on August 2, 2018. The current 90-day period has been paused pending CMS's request for additional information.
57	Program Structure	How will PCPs know if recipients have exceeded their 14 visits or not?	PCPs may check the eligibility file for exceeded visits the same way as they do today.

58	Program Structure	Will visit information be available that info on their verification Portal? Will it be real-time?	Visit information is available on the provider's verification portal. This information is not real-time, but is updated as claims are paid.
59	Program Structure	Will Medicaid continue to use the current quality scorecard system available through the Medicaid Provider Portal?	Medicaid is reviewing the current quality scorecard system to determine future changes.
60	Program Structure	How will I know if my attributed patient happened to have gone elsewhere and gotten an EPSDT(say for instance they could not get an appointment with me in a timely manner and needed the Epsdt sooner than I could do)??? Or say even a New Patient that is transferring to our clinic. Will the agency website have last EPSDT date on the website??	A PCP may view the 'date of last screening' on the eligibility file the same way as they do today.
61	Program Structure	Will the Pharmacy and Provider Lock-In process remain the same in the ACHN model? If yes, if a recipient is in lock-in and the assigned Provider refuses to see the recipient, will they be allowed to switch to another Provider	The pharmacy and provider lock in will remain in the ACHN model. The recipient will be assigned to a provider and will not be allowed to change. If the provider refuses to see the patient, the physician, the patient, or the PCCM-E may contact Medicaid to assist in assigning a different lock-in provider.
62	Program Structure	We'd like to get a better understanding of the technical capabilities of RMEDE as we're preparing for ACHN. We're finalizing our operational ConOps, and as you know, RMEDE will play a key role.	All requirements for the Health Information Management Systems (HIMS) will be provided in the ACHN RFP.
63		Specifically, I was wondering if all of the care coordination activities (maternity, health home, etc.) would live under one interface, or will they be silo'd? We're particularly interested in whether there is a referral process that includes maternity?	
64		Also, would you be able to send us a copy of the Technical Specs?	

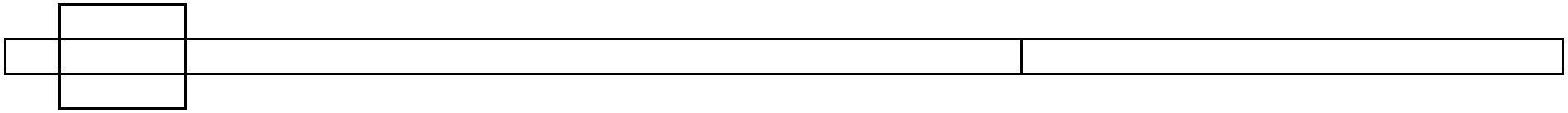
65	Program Structure	Are FQHCs allowed to bill FFS for SBIRT?	In the 1915(b) Waiver, SBIRT (screening, brief intervention and referral to treatment) services are (b)(3) services that may be billed by enrolled providers who have been certified by DMH. SBIRT-certified physicians employed by FQHCs may bill these services FFS.
66	Program Structure	IP Question 2. In general, the current requirement for a referral from the primary care provider in order to see a specialist has many pros. One exception is when a patient has an orthopedic injury already evaluated in a urgent care setting. These patients should be able to see an orthopedic specialist without having to make an extra visit to a primary care provider. Modifier Question For the convenience of the family, chronic conditions are often assessed at the EPSDT visit and in some cases involve complex adjustments to the treatment plan. Other payers allow for a modifier to be added to the well visit when significant modifications are required. Could reimbursement be revised to include this modifier?	Yes, we understand these issues and we are in the process of actively looking at the billing procedures associated with the EPSDT program to address the issues you have raised.
67	Program Structure	Alabama Arise has a vested interest in the success of Medicaid transformation. We have been actively involved in the current reform process from its beginnings in 2012. The 2013 RCO law and 2015 ICN law were exemplary in their provisions for consumer oversight via governing board representation and advisory committees. Now that those two laws are no longer applicable, we are concerned that robust consumer oversight is no longer guaranteed.governance of Alabama Coordinated Health Networks (ACHNs) falls short of the RCO benchmark.	representation with the Alabama Coordinated Health Networks (ACHN). We learned from the RCOs and ICNs and believe that consumers and other stakeholders such as FQHCs, Community Mental Health Centers, and Substance Abuse treatment facilities, are all vital to the program.
		We applaud Alabama Select for maintaining – and even strengthening – the ICN consumer oversight provisions in the new environment. However, the current plan for	

		We have raised this issue numerous times and have yet to see meaningful movement from the state. We continue to believe that the ACHN plan cannot achieve its goals of better care, better outcomes and lower cost without robust consumer involvement in Medicaid policymaking. For more detail, we offer the following observations and recommendations:	
		• The RCO consumer advisory structure, while uneven and often frustrating or absent altogether, offers important lessons for the ACHNs. The best examples (such as a transportation forum prompted by consumer representatives in the Viva Region B RCO) illustrate that consumer input can help shape Medicaid policy priorities. 1) The RCO consumer advisory structure, while uneven and often frustrating or absent altogether, offers important lessons for the ACHNs. The best examples (such as a transportation forum prompted by consumer representatives in the Viva	Therefore, the ACHNs are required to have a Consumer Advisory Committee (CAC) in which 20% of the Committee must be consumers. The consumer representative may be a recipient, parent/caretaker or an advocacy organization representative.
		• A statutory provision that limited RCO consumer representatives to direct Medicaid beneficiaries was a serious hindrance to effective consumer engagement. The inclusion of parents and caregivers as potential consumer representatives for the ACHNs is a major breakthrough that vastly increases	
		• We feel one consumer representative on each ACHN board is inadequate. We strongly recommend at least two consumer representatives. Peer support is vital for consumer representatives at policy tables dominated by health care and business professionals. In response to our previous appeals, Medicaid and ACHN officials have responded that adding another consumer representative to the board would throw the membership formula out of balance, prompting requests for additional members by other stakeholders. We urge you to consider that Medicaid beneficiaries are not a stakeholder type, comparable to hospitals or community mental health centers, but rather a stakeholder class, comparable only to risk-bearing providers and non-risk-bearing providers. By this measure, the addition of one consumer representative would enhance the stakeholder balance, not upset it.	

		• Medicaid plans to retain the Citizens' Advisory Committee (CAC) model, perhaps under the name Consumer Advisory Council. One of the frustrations in the RCO context was a frequent lack of coordination/communication between the CACs and the boards. Too often, the CAC member appointed to the board was not regarded as a true consumer liaison by the board and the RCO. Consumer concerns often didn't receive adequate attention on the board agenda. We strongly recommend making consumer engagement (for example, as spelled out in the RCO statutory provision for the CACs) an explicit responsibility of the boards. A standing high-level agenda item for consumer concerns at every ACHN board meeting would be another good measure.	The ACHNs have a requirement for the Governing Boards to receive a verbal report from the CAC at each meeting
		• Arise is working to identify "community contacts" around each region who can serve as local liaisons for the formal consumer advisors and representatives. We think this network will provide a level of support that	
		• We recommend the use of teleconferencing and other remote meeting capacities to accommodate the financial, mobility and other limitations of consumer representatives.	The Agency will permit teleconferencing of the ACHN's CAC and Board Meetings
		In summary, we urge you to support a strong consumer voice in Medicaid transformation by asking Medicaid to include the following provisions in its waiver request for the ACHN plan:	
		• Each ACHN board will have at least two consumer representatives (the CAC chair and co-chair).	
		• Each ACHN board meeting will include an opportunity for a report from the CAC.	
		We believe effective engagement of consumer representatives is a key to the success of the Alabama Coordinated Health Networks. Thank you for considering our concerns.	
68	Program Structure	Please confirm the Managed Care division within the Agency, and not the PCCM-E, will complete this activity.	The Managed Care Division will be responsible for confirming eligibility for PCMH recognition
69	Program Structure	If quality bonus payments are not calculated until May/June for the previous year, when will Providers receive the payments?	For at least four quarters, all practice groups will automatically receive a full quality bonus

70	Program Structure	Will the PCCM-E be part of the process to calculate the measure and will the PCCM-E receive any prior interim reporting to measure progress towards goals?	For the bonus payment to the providers, the PCCM-E will not be part of the calculation of the measures but will be expected to work with providers to help improve their performance. To assist with this collaboration, the Agency will provide monthly quality reports on all of its population. For the PCCM-E quality incentive payments, the calculations of the quality measures will be performed by the Agency but the Agency will send monthly quality reports to assist the PCCM-E with monitoring its performance.
71	Program Structure	Given this timeline, will the Agency continue to make bonus payments after the waiver's 2 year demonstration period is over?	It is the intent of the Agency to renew the waiver after the initial two year period.
72	Program Structure	Does this pool include bonus payments to both the PCCM-Es and the providers?	The designated $15.0 million is for bonus payments to actively participating primary care
73	Program Structure	In previous FAQs, the Agency stated that ACHNs must be 501(c)3 non-profits. An entity can be a non-profit without filing for a 501(c)3 designation with the IRS. By requiring an ACHN entity to obtain a 501(c)3 IRS status, the Agency is also requiring an ACHN's Governing Board members and officers to publicly disclose all of their personal income and investments. This is a risk to any entity proposing to become an ACHN and could inhibit the ACHN's ability to secure interested candidates on its Governing Board. Please confirm that the Agency intends for ACHNs to (1) have a non-profit legal status under Alabama law and (2) file as a 501(c)3 entity with the IRS.	The ACHN must be an Alabama nonprofit organization but will not be required to apply for a 501(c)(3) designation with the IRS.

74	Program Structure	What is the current status of CMS' review and approval of the Plan?	The Agency has submitted the Waiver to CMS and expects an approval before the end of 2018 or early 2019.
75	Program Structure	Will Readiness Assessment be conducted before CMS' approval of the plan?	The Agnecy has submitted the Waiver to CMS and expects an approval before the end of 2018 or early 2019.
76	Program Structure	Will the Agency award the RFP without CMS' approval of the Plan?	The Agency has submitted the Waiver to CMS and expects an approval before the end of 2018 or early 2019.
77	Program Structure	Is there a meeting we need to attend to sign up for the new program?	Information regarding the ACHN can be found on the Agency's website at http://www.medicaid.alabama.gov/content/2.0_Newsroom/2.7_Special_Initiatives/2.7.6_ACHN.aspx Future public meetings regarding the ACHN are posted at the same location.
78	Program Structure	Do we have a date on when we can enroll?	DHCPs will contract with the ACHN entities when the contract is awarded.
79	Program Structure	Our office currently participates in the Maternity program for Medicaid participants. We have received information for the ACHN program as it relates to OB care for Jefferson & Shelby counties. Where can I find information for the entities that will be providing care coordination for Walker and Cullman counties?	The Agency current intends to issue the contract award notification on April 17, 2019. The notification will be posted on the Alabama Medicaid Agency website.



ACHN Questions and Answers - Updated 11/30/18

	Issue	Question	Response
1	Quality	In the AL-AAP webinar on 09/05, the Agency outlined several quality measures that will be tracked as part of the ACHN incentive program. Where does the data come from that will be used to report on these quality measures? How often will the ACHN entity receive this data? Will the ACHN entity receive combined data reports (such as currently received by the Health Homes via ESD tables) or will the ACHN entity have access to the raw claims data to do their own analysis?	All quality measures will be calculated from administrative data. It is the intention of the Agency to provide data on a monthly basis as summarized reports.
2	Quality	Quality Measure: Immunization status child/adolescent • Will we have access to IMPRINT? • What if immunization is obtained via public health/school vs PCP	Specifics on the exact quality measures and their specifications will be released at a future time.
3	Quality	Quality Measure: Antidepressant medication management • What drugs are included in this measure? • Does this measure line up with a specific HEDIS measure? If so, please specify which and any changes the Agency may have made to the measure specific for this population.	Specifics on the exact quality measures and their specifications will be released at a future time.
4	Quality	Quality Measure: HbA1c Test for Diabetic patients • Will the requirement be yearly or every six months? • Does this measure evaluate the actual lab values or only if the test was completed or not?	Specifics on the exact quality measures and their specifications will be released at a future time.

5	Quality	Quality Measure: Follow-up after ER visit for alcohol or other drugs • What is the time frame for follow-up. • Does this measure line up with a specific HEDIS measure? If so, please specify which and any changes the Agency may have made to the measure specific for this population	Specifics on the exact quality measures and their specifications will be released at a future time.
6	Quality	The quality measures selected measure patient adherence, not physician action. Any time a patient adherence factor is included in quality measures, then “cherry picking” will happen. This ultimately hurts the recipients who need the most help and frustrates physicians, possibly reducing their participation rates. It is not my experience that patients who fail to adhere to maintenance treatment do not come to the office. They do come, because they are not doing well. Would Medicaid substitute measures that tie provider performance back to the incentive program instead of patient adherence? Examples may be rx being received by the pharmacy even if not ever picked up by patient or counting lab orders, instead of whether a patient goes to lab. Also, provide a mechanism for providers to submit evidence of scheduled EPSDTs, whether or not patients show up, because no shows not only hurt due to missed fees but now can affect performance pay.	The ACHN will be incentivized to care coordinate with PCP's input that will encourage recipients to be more compliant. Regarding the other possible options for quality measures, these would not be possible for the Agency to calculate since it does not have access to those data sources.

7	Quality	Given that the quality measures are tied to patient adherence instead of provider performance, how does the Agency propose to prevent Providers from cherry picking "healthy" recipients and/or refusing to take "unhealthy" recipients?	By allowing patients to see the PCP of their choice, the Agency believes this will dissuade providers from cherry picking patients that they want to see. In addition, if a PCP chooses to have a narrow panel, this does not necessarily benefit them on meeting quality metrics, as they must have an appropriate panel size that includes a population that would allow them to have enough patients to qualify for the measures they are being evaluated on. Small panel sizes may be easy to achieve benchmarks but they may also easily hurt their performance.
8	Quality	Will the Agency be providing interim reporting to Providers on their progress to achieving their incentive bonus? In other words, if the Agency is publishing full reports quarterly, will a provider be able to know at any time prior to that report where they stand on meeting incentive payout?	Quality measures will be reported to providers annually. Cost effectiveness reports will be provided quarterly to the providers.
9	Quality	Does the BMI metric follow the HEDIS measure, which measures whether or not a BMI is documented yearly? Please confirm that the Providers will be coding in a claim for the BMI quality measure, and the PCCM-E will not be responsible for gathering this data.	Specifics on the exact quality measures and their specifications will be released at a future time. The majority of the quality measures will be CMS Core Quality Measures and as such are HEDIS Measures with minor modifications for age categories.

ACHN Questions and Answers - Updated 7/19/19

	Issue	Question	Response
1	Reimbursement	Medicaid has determined that for purposes of its Primary Care Case Management Plan, "Pivot Plan", health centers are not "primary care providers" eligible for performance related payments. (Medicaid briefing, March 22, 2018). Health Centers:	Health center physicians will be eligible to participate in the performance-based incentive program to include PCMH activities, cost effectiveness, and quality.
2	Reimbursement	How will ACHN impact designated Rural Health Clinic Reimbursement?	It will not affect the current PPS reimbursement. However, there will be an opportunity for bonus payments based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region.
3	Reimbursement	How will FQHCs andRHCs be impacted by ACHN? Will the current reimbursement structure change and/or will these provider types be eligible for incentives?	It will not affect the current PPS reimbursement. However, there will be an opportunity for bonus payments based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region.
4	Reimbursement	What will be the global OB (59400) fee schedule for pivot program recipients? Urban vs. rural fee schedules? Is it based on patient address?	The global fee schedule will change. Medicaid will make separate bonus payments for one prenatal visits made in the first trimester and one post partum visits. There will be an urban and rural rate. The rural rate will be paid based on the address of the billing DHCP.

5	Reimbursement	"ACHN Participation Payment": I understand that this will take the place of what we now know to be the "bump" increase. How have you determined this to be measured and accounted for?	Only Primary Care Physicians will be eligible for the ACHN Participation Rate. They will need to: 1) qualify for the Bump payment with Medicaid, 2) sign a PCP agreement with Medicaid and a Network Entity, and 3) meet participation requirements with a Network Entity. To qualify for Medicaid "bump" certification, a physician must be 1) Board-certified in family medicine, general internal medicine or pediatrics and must actually practice in their specialty; or 2) if non-board certified, must practice in the field of family medicine, general internal medicine or pediatrics or be a subspecialist under one of these specialities if the doctor can attest that 60% of paid Medicaid procedures billed are for certain E&M codes and Vaccines for Children administration codes during the most recently completed calendar year, or for newly eligible physicians, the prior month. Additionally, they must actively participate with the network entity by working with the entity in the development of individualized and comprehensive care plans, participating in the entity's Multi-Disciplinary Care Team (MCT), participating in program initiatives centered around quality measures, reviewing data provided by the ACHN entity to help achieve Agency and region quality goals and participating in person in at least two (2) quarterly Medical Management Meetings and one webinar/facilitation exercise with the ACHN entity's Medical Director over a twelve (12) month period.
6	Reimbursement	"Patient-Centered Medical Home Activities": Will there be opportunity for credit given to all recognized levels? If so, will this be increased/decreased depending on the level? We are currently Level 2.	In year one, all Primary Care Physicians working toward PCMH recognition will receive a bonus payment. In year two, all Primary Care Physicians who have achieved PCMH recognition ***at any level*** will continue to receive the bonus payment.

7	Reimbursement	"Cost Effectiveness": How will this be measured? Similar to Blue Cross?	Cost effectiveness bonus rates are calculated to reward providers who control costs. Bonus participation is based on the risk adjusted, average monthly cost of members attributed to the provider group when compared to other similar provider groups. Members who do not receive services are excluded from the calculation.
8	Reimbursement	"Quality Metric Performance": How will this be measured? Similar to Blue Cross?	The quality component of the provider bonus payment will be earned by a provider based on their previous calendar year's performance on the Agency's set of quality metrics, to be announced later. The Agency will also publish measure specifications, current baselines and regional targets for each year.
9	Reimbursement	When will you have more details on the patient attribution process (how a pt will be attributed to that provider)?	Attribution Process: Review a two year history of primary care utilization for each member; preventative and regular office visits will be identified along with prescriptions for chronic care; a score will be calculated for each member/provider combination; more recent claims and preventative visits will receive higher values; and the provider with the highest score for the member is attributed the member. Attribution will be updated quarterly.
10	Reimbursement	Once the ACHN entities start (whether it is November 1, December 1, or January 1), how will providers be reimbursed at the outset before data has been collected – for the cost effectiveness and quality metric categories? Will it be based on data from the previous year (pre-pivot)?	In the first year of the program, bonus payments for Quality Measures, Cost Effectiveness, and PCMH recognition will be distributed to the practice based on the number of patients attributed to the practice. In subsequent years, the bonus payments will be determined by data generated since the start of the new program.

11	Reimbursement	When we (AL-AAP, AAFP and MASA) met with you all a couple of months when you had the series of stakeholder meetings, did you provide us with any more details on the three “buckets” of enhanced payments? I can’t remember if there was a slide that had more detail than the slide in Dr. Moon’s presentation yesterday. If so, can you share that with me? Just wondered if you all had more details to share RE the three categories.	Other than what is described above, There is no additional detail at this time.
12	Reimbursement	What is the anticipated reimbursement model for the Pivot vendors?	Specific Information will be included in the RFP.
13	Reimbursement	When will the specific reimbursement rates be determined?	Specific Information will be included in the RFP.
14	Reimbursement	In regards to the maternity program, anesthesiologists are paid a flat rate for epidurals for deliveries. Will this continue?	Under the ACHN, anesthesiologists will bill Medicaid fee-for-service on a medical claim form. When regional anesthesia (i.e., nerve block) is administered by the attending physician during a delivery or procedure, the physician's fee for administration of the anesthesia is billed at one-half the established rate for a comparable service when performed by an anesthesiologist. When regional anesthesia is administered by the attending obstetrician during delivery (i.e., saddle block or continuous caudal), the obstetrician's fee for administration of the anesthesia will be billed at one-half the established rate for a comparable service performed by an anesthesiologist. When regional anesthesia is administered by an anesthesiologist during delivery or other procedure, the anesthesiologist's fee will be covered and should be billed separately.

15	Reimbursement	Is Bump/enhanced rate included with claim payment or paid quarterly?	The bump/enhanced rate will be renamed the participation rate and will be included in the claims payment received twice monthly.
16	Reimbursement	Is midlevel activity included when calculating incentive payments?	Yes. Midlevel activity by nurse practitioners and physician assistants working in a participating group is included in the calculation of bonus payments.
17	Reimbursement	If you are not PCMH can you still achieve Quality or Cost incentive payments?	Yes. Providers may receive Quality or Cost Effective bonus payments and not participate in PCMH recognition. Each bonus payment is independent from the other bonus payments.
18	Reimbursement	Will the BUMP payment be in addition to the Capitation payment we are currently receiving?	No. There will not be a capitation payment in the new program. There will be a participation rate, which replaces the current Bump rates, as well as the opportunity for quarterly bonus payments.
19	Reimbursement	Will the quarterly payments for quality and cost effectiveness be paid at the beginning of the quarter or the end of the quarter?	The quarterly payment for bonuses will be paid at the beginning of the quarter.
20	Reimbursement	Do we have a set budget for these payments for quality and cost effectiveness?	There is no additional funding for the ACHN. The Agency will be combining Patient 1st, Health Homes, Plan First, and the Maternity programs into a single care coordination delivery system with the goal of creating a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results. The quality and cost effectiveness bonus payments are included in this pool of funds.
21	Reimbursement	Will incentive payments be at risk if the legislative budget is short?	There is no additional funding for the ACHN. The Agency will be combining Patient 1st, Health Homes, Plan First, and the Maternity programs into a single care coordination delivery system with the goal of a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results.
22	Reimbursement	If a patient presents and is out of authorized visits, does the provider still get paid?	No. When the patient has exhausted his/her visits, no payment will be made to the physician.

23	Reimbursement	Is Bump/enhanced rate included with claim payment or paid quarterly?	The bump/enhanced rate will be renamed the participation rate and will be included in the claims payment received twice monthly.
24	Reimbursement	Is midlevel activity included when calculating incentive payments?	Yes. Midlevel activity by nurse practitioners and physician assistants working in a participating group is included in the calculation of bonus payments.
25	Reimbursement	If you are not PCMH can you still achieve Quality or Cost incentive payments?	Yes. Providers may receive Quality or Cost Effective bonus payments and not participate in PCMH recognition. Each bonus payment is independent from the other bonus payments.
26	Reimbursement	Will the BUMP payment be in addition to the Capitation payment we are currently receiving?	No. There will not be a capitation payment in the new program. There will be a participation rate, which replaces the current Bump rates, as well as the opportunity for quarterly bonus payments.
27	Reimbursement	Will the quarterly payments for quality and cost effectiveness be paid at the beginning of the quarter or the end of the quarter?	The quarterly payment for bonuses will be paid at the beginning of the quarter.
28	Reimbursement	Do we have a set budget for these payments for quality and cost effectiveness?	There is no additional funding for the ACHN. The Agency will be combining Patient 1st, Health Homes, Plan First, and the Maternity programs into a single care coordination delivery system with the goal of creating a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results. The quality and cost effectiveness bonus payments are included in this pool of funds.
29	Reimbursement	Will incentive payments be at risk if the legislative budget is short?	There is no additional funding for the ACHN. The Agency will be combining Patient 1st, Health Homes, Plan First, and the Maternity programs into a single care coordination delivery system with the goal of a more efficient care coordination system while achieving optimal health outcomes. The primary goal is to spend money differently to achieve better results.
30	Reimbursement	If a patient presents and is out of authorized visits, does the provider still get paid?	No. When the patient has exhausted his/her visits, no payment will be made to the physician.

31	Reimbursement	If you are part of an alternative payment model (Teaching Physician/FQHC/Etc) are you still eligible to participate in the PCMH and Quality incentives?	Physicians working in FQHCs or RHCs, or physicians who are part of a state university's medical faculty, will have an opportunity to receive bonus payments based on quality, cost effectiveness and Patient Centered Medical Home (PCMH) recognition if they contract with the ACHN Entity in their region.
32	Reimbursement	Do you anticipate the bonus / incentive payments will be equal to / less than or greater than the current capitation payment	By implementing ACHNs, the Agency's primary goal is to spend money differently to achieve better results and keep providers whole. The ACHN effort differs from the Patient 1st program in that payments to PCPs will focus on activity as opposed to panel size. During the transition to the this new system, PCPs will receive full payment for quality and cost-effectiveness based on attribution. After that transition period, bonus payments will be made to participating PCPs based on actual performance.
33	Reimbursement	Will there be an appeals process for attribution and quality/cost scoring?	Details of a reconsideration process regarding attribution or quality scoring will be contained in the provider's contract with the Agency.
34	Reimbursement	When there are multiple providers' services by FQHC medical visits "FQHC service" and private physicians levels same date of service – who receive payment 1st if office visit limit is exceeded?	The first provider to submit a claim will receive the payment.
35	Reimbursement	Will FQHC providers be reimbursed on the same day when and/or if services are also provided by private providers?	The first provider to submit a claim will receive the payment.
36	Reimbursement	After listening to the webinar with Dr. Moon today, I learned that FQHCs, rural clinics and other similar entities will keep their current enhanced rates. Currently Jefferson County Department of Health receives an enhanced public health rate. Will this rate continue with the ACHN?	Medicaid is not aware of any changes to public health rates with the implementation of the ACHN.

37	Reimbursement	My company is researching the upcoming Alabama Coordinated Health Network to consider becoming a Pivot Entity. We have a question about the global fees paid to OBs. I have gone through all of the questions, but that answers are a little contradictory. It says, "The OB providers will be paid Fee-for-Service.", but then it states, "The global fee schedule will remain the same." I need some clarification on that. Will the OB fee for all service still be the same as the current fee schedule, but each doctor will only be paid for the service he or she performs? If memory serves me correctly, currently, the doctor who performs the delivery gets the entire amount of the global fee. I am just trying to get clarification on how this has changed.	OB-GYNs and other delivering healthcare professionals who are contracted with the proposed networks will receive one set rate for prenatal, delivery, and postpartum services. In addition to the set rate, there will be fee-for-service payments available for services, such as ultrasound, laboratory, and anesthesia. OB-GYNs and other delivering healthcare professionals who are contracted with the proposed networks will also be eligible to receive two bonus payments, one for an office visit in the first trimester, and a postpartum office visit.
38	Reimbursement	What is the number of providers participating in the current 4 programs that will be eligible for bonus payments?	Providers eligible to receive bonus payments for patients in the general population include primary care physicians, as well as primary care physicians who are employed in FQHCs, RHCs, and PTFs and choose to actively participate with the PCCM-Es. Maternity care providers are also eligible for certain bonus payments as well.

39	Reimbursement	This section of the waiver does not include an "x", however the information is filled in. Please confirm that this is intended to be the PMPM payments given to the PCCM-E to cover initial administrative costs and Key Personnel.	The PMPM payment is for quality improvement projects; however we recognize that administrative costs and key personnel will be necessary to implement the program. Therefore the PMPM payment is also intended to be used for these expenses.
40	Reimbursement	Is the payment model based on activities completed within a calendar month (ie: 1st – 31st)? Will payments be received the following calendar month (ie: payment for September activity is received in October)?	Specific Information will be included in the RFP.
41	Reimbursement	1. Are the PCP Participation Rates posted on the website for a physician? Is there a separate rate for nurse practitioners? 2. What is the anticipated incentive payment for PCHM's?	The PCP participation rates are posted on the AMA website. However, NPs who collaborate with participtating PCP groups will be reimbursed at 80% of the PCP participation rate. If the participating group achieves or demonstrates appropriate progress towards achieving PCMH Recognition, then the group will receive a bonus payment. The dollar amount of the bonus will be dependent on the number of groups that achieve recognition and the number of attributed recipients to the group.
42	Reimbursement	Our Doctor is a specialist and needs a PCP referral with a current EPSDT date for payment of services. Does the ending of this program effect any of the current process of our referrals?	No. The ending of the Patient 1st program will not affect the current process for specialty referrals.

43	Reimbursement	Two of the quality measures for incentive payments are related to well care visits. Where will this information be obtained? The periodic screening/rescreening lists from the Medicaid Management Information System is horribly inaccurate. Apparently, the system doesn't recognize when a patient had their yearly well visit with a previous Medicaid number. We have numerous patients on our list that should not be there.	The information will continue to be obtained from the MMIS. However, the Agency is working to resolve the current issue with duplicate Medicaid IDs. These corrections to the system will be made prior to go-live on 10/1/2019.