Alabama Coordinated Health Network (ACHN) Quality Strategy

November 15, 2019

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Section I: Introduction

The Alabama Medicaid Agency (AMA) began operations on January 1, 1970, and is a State and federally-funded, implemented program that pays for medical and long-term care services for low-income pregnant women, children, certain people on Medicare, disabled individuals, Plan First recipients, and nursing home residents. These enrollees must meet certain income and other eligibility requirements to receive medical services and care.
At the close of Federal Fiscal Year 2017, the Alabama Medicaid program provided health care services to nearly 52% percent of children statewide and 25% percent of the State's population overall. In addition, the Medicaid program accounts for more than half of the births in the State. Recent growth in enrollment has led to an increase in total Alabama Medicaid program expenditures from approximately $4.4 billion in 2008 to approximately $6.5 billion in Fiscal Year 2017[1].

As the Medicaid population continues to grow in the State of Alabama, AMA has taken the initiative to create a more efficient and effective way to serve its Medicaid eligible individuals. AMA evaluated its managed care programs, currently acting in a standalone manner, and took the approach of creating and implementing a coordinated care network in order to better monitor, serve, and treat actively enrolled Medicaid participants, ultimately improving the quality of care.

In order to create a more effective managed care program with a defined purpose and improve the quality of care while reducing costs, it is important to understand the current managed care programs and the history associated with each before successfully creating a new method for serving the Medicaid population.

History of Managed Care in Alabama

The Agency currently operates statewide Maternity Care, Patient 1st, Health Home, and Plan First programs for Alabama's Medicaid Eligible Individuals (EIs). Care Coordination services are provided to EIs in each of these programs outlined below, linking EIs to appropriate services. The Agency submitted a plan to Centers for Medicare and Medicaid Services (CMS) and received approval to consolidate these separate Care Coordination programs into a single program that will allow the Agency and Providers a more effective platform for service delivery and improved quality. The background and history of the current programs is as follows:

Maternity Care Program

The Alabama Maternity Care program is a statewide program established in 1988 under the 1915(b) Waiver authority to serve Medicaid eligible pregnant women. The waiver was developed in an effort to address Alabama's high infant mortality rate, the high drop-in delivery rate and the lack of delivering healthcare professionals participation. The State is currently divided into 14 districts for the provision of maternity services. In 12 districts, the State contracts with Primary Contractors for each district. The Primary Contractors subcontract with healthcare providers for the provision of prenatal, delivery and postpartum care. Two districts are not under the District Plan and maternity services are paid fee-for-service (FFS) to the provider of the services. Primary Contractors are paid a capitated payment for each delivery. Some services

[1] Alabama Medicaid Agency FY 2017 Annual Report

are outside the capitated payment methodology and are paid fee-for-service such as inpatient care, routine and high-risk care provided by Teaching Physicians (University of Alabama at Birmingham and University of South Alabama, high-risk care provided by a perinatologist, outpatient emergency services, Screening, Brief Intervention, and Referral to Treatment (SBIRT), referral to specialists, and tobacco cessation counseling. The Maternity Program will end September 30, 2019. Care coordination services will be provided under the Alabama Coordinated Health Network Program. Medicaid covered services for prenatal, delivery and postpartum care will be reimbursed fee-for-service to the Medicaid enrolled provider of care.

AMA monitors the Maternity Care program through statewide quality measures, medical record reviews and administrative reviews. AMA has selected the following quality measures and benchmarks for the program:

Measure	Benchmark
Percentage of women with first doctor's visit less than 14 weeks gestation	75%
Percentage of low birth weight (LBW < 2500 grams) babies born to Medicaid mothers	11%
Percentage of very low birth weight (VLBW < 1500 grams) babies born to Medicaid mothers	2%
Percentage of women who completed a family planning visit prior to the 60th postpartum day	80%
Percentage of women who received the adequate number of prenatal visits containing all the required elements according to gestational age at entry into care	61% or greater
Percentage of very low birth weight babies born at appropriate facilities for high-risk deliveries and newborns	69%
Percentage of babies born prior to 37 weeks gestation	13%
Percentage of women who quit smoking while pregnant/number of smokers	25%
Percentage of diabetic women who have at least one session with a registered dietician	50%
Number of enrolled diabetic women per district Percentage of women identified as breast feeding at postpartum visit	25%
Percentage of women who received a Care Coordination visit after delivery prior to discharge from the hospital	88%
Percentage of women who completed a postpartum visit prior to the 60th postpartum day	85%

Patient 1st Program

The Patient 1st program is a Primary Care Case Management (PCCM) Program serving more than 600,000 participants. Since its launch in 2004, Patient 1st has expanded technology and tools to help doctors and other health professionals better manage the increasing cost of health care while promoting better care for Medicaid patients. Medicaid's Patient 1st program provides patient-centered, quality-focused care by creating a medical home for each Medicaid recipient. Each recipient has a primary medical provider (PMP) who provides or arranges the recipient's health care needs. The Patient 1st program will end September 30, 2019. Care coordination services will be provided under the Alabama Coordinated Health Network Program.

Health Home Program

The Health Home Program was established regionally in 2012 and expanded statewide April 1, 2015. AMA's Health Home Program is a Section 2703 approved Health Home Program that integrates and coordinates care for patients with certain chronic conditions to achieve improved health outcomes. The Health Home program adds additional support to Patient 1st PMPs by intensively coordinating care for patients who have or are at risk of having chronic conditions including:

- Asthma
- Diabetes
- Cancer
- COPD
- HIV
- Mental health conditions
- Substance use disorders
- Transplants
- Sickle cell disease
- BMI over 25
- Heart disease
- Hepatitis C

Health Homes connect patients with needed resources, teaching self-management skills, providing transitional care, and bridging medical and behavioral health services. The Health Home Program will end September 30, 2019. Care coordination services will be provided under the Alabama Coordinated Health Network Program.

2019 Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set)[2]

NQF #	Measure Steward	Measure Name	Data Collection Method
Core Set Measures			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	Administrative or EHR
0018	NCQA	Controlling High Blood Pressure (CBP-HH)	Administrative, hybrid, or EHR
0418/0418e	CMS	Screening for Depression and Follow-Up Plan (CDF-HH)	Administrative or EHR

[2] Medicaid.gov; https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/quality-reporting/index.html

0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH-HH)	Administrative
1768	NCQA	Plan All-Cause Readmissions (PCR-HH)	Administrative
NA	NCQA	Adult Body Mass Index Assessment (ABA-HH)	Administrative or hybrid
NA	AHRQ	Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)	Administrative
Utilization Measures			
NA	CMS	Admission to an Institution from the Community (AIF-HH)	Administrative
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)	Administrative
NA	CMS	Inpatient Utilization (IU-HH)	Administrative

AHRQ = Agency for Healthcare Research & Quality; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum

Plan First Program

The Plan First Program was implemented in 2000, based on the need for continued family planning services to individuals who would have otherwise lost Medicaid eligibility. Services under Plan First are designed to reduce unintended pregnancies and improve the well-being of children and families in Alabama by extending Medicaid eligibility for family planning services to eligible women (between the ages of 19 and 55 years old) and men (ages 21 and older) whose income is at or below 141% of the Federal Poverty Level (FPL). A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income. Services under Plan First include care coordination, various types of birth control methods, office visits, HIV counseling, labs and sterilizations. Males can receive a vasectomy, vasectomy related services, and vasectomy related care coordination. As of October 1, 2019, family planning services will still be provided by Alabama Department of Public Health (ADPH) or any other Plan First enrolled provider. The care coordination component of Plan First will now be provided by the Alabama Coordinated Health Network Program.

<u>Medicaid Transformation in Alabama</u>

While historical quality improvement programs, such as the Maternity Care, Patient 1st and Health Home, have made strides in addressing problems in Alabama's care delivery system, Alabama Medicaid has embarked and been granted CMS approval to implement a comprehensive managed care program to achieve more wide-scale reform through a coordinated care network.

Alabama Coordinated Care Network Program

Using lessons learned from the process to establish Regional Care Organization's (RCOs), the Maternity Care Program, the Patient 1st program, the Patient Care Networks of Alabama (PCNA), and the Health Homes Program, a new approach for improving healthcare outcomes has been designed. Improving healthcare outcomes through appropriate Care Coordination targeting high risk and/or high cost individuals has shown promise around the country. The Agency for Healthcare Research and Quality (AHRQ) has demonstrated that on average five percent (5%) of the population is associated with fifty percent (50%) of healthcare costs. By focusing on that five percent (5%) and other high-risk individuals, improvements can be made both in the quality and cost of healthcare for the Agency.

Alabama has room to improve:

- Maternity Outcomes in Alabama are less than optimal, and preterm birth rates and infant mortality are higher than the national average.
- Obesity is an issue across the country, but particular in Alabama.
- Substance Abuse is a national crisis and we have much work to do on this issue in Alabama.

The Agency proposes a system transformation that includes the establishment of a managed care system, combining Family Planning Care Coordination services, Patient 1st (State Plan Amendment (SPA)) Care Coordination services, Health Home (SPA) functions, and Maternity Care (1915(b) Waiver) functions into single, region specific Primary Care Case Management Entities (PCCM-E) throughout the state. Intended goals of the transformation include:

- Creation of a delivery system that allows for seamless Care Coordination across eligibility categories and incentivizes quality outcomes;
- Address statewide and regional health outcome goals;
- Conduct outcome-focused population management activities;
- Facilitate timeliness of key health activities (e.g., Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings, flu shots, early entry to prenatal care, care for substance use disorder);
- Reduce barriers impacting health outcomes; and
- Flexibility to address regional quality issues (e.g., asthma in a region due to environmental issues; substance abuse targeted in a local area where there is a high incidence of neonatal abstinence syndrome (NAS) infants).

The Agency is establishing the Alabama Coordinated Health Network (ACHN) statewide in 2019 to streamline and increase access to Care Coordination for Eligible Individuals (EIs). Seven Regions will be established as follows:

1. Central, which includes the following counties: Autauga, Butler, Chilton, Crenshaw, Dallas, Elmore, Lowndes, Marengo, Montgomery, Perry, and Wilcox.

2. East, which includes the following counties: Blount, Calhoun, Cherokee, Clay, Cleburne, Coosa, DeKalb, Etowah, Randolph, St. Clair, Talladega, and Tallapoosa.

3. Jefferson and Shelby, which includes the following counties: Jefferson and Shelby.

4. Northeast, which includes the following counties: Cullman, Jackson, Limestone, Madison, Marshall, and Morgan.

5. Northwest, which includes the following counties: Bibb, Colbert, Fayette, Franklin, Greene, Hale, Lamar, Lauderdale, Lawrence, Marion, Pickens, Sumter, Tuscaloosa, Walker, and Winston.

6. Southeast, which includes the following counties: Barbour, Bullock, Chambers, Coffee, Covington, Dale, Geneva, Henry, Houston, Lee, Macon, Pike, and Russell.

7. Southwest, which includes the following counties: Baldwin, Choctaw, Conecuh, Clarke, Escambia, Mobile, Monroe, and Washington.

Quality

In moving towards a system of coordinated care, Alabama is placing an emphasis on quality and quality initiatives. As with any other new program, Alabama's Medicaid Program faces significant challenges related to quality, access and cost of health care services. These challenges are heightened, in part, due to a lack of provider incentives to coordinate care across the continuum of physical and behavioral health. In offering incentives through a new payment model and by addressing these challenges, AMA in partnership with the ACHN Program can more effectively manage the total cost of care, improve health outcomes, and reduce avoidable hospital care. In addition, Alabama providers have limited means of sharing essential medical information through information technology. However, with the inception of this newly designed Program, the Agency is actively trying to ensure quality improvement, as providers are encouraged to not only adopt and implement electronic health record technology but to utilize the Agency's current Health Information Exchange (HIE), referred to as OneHealthRecord. The ACHN Networks are also responsible for creating their own health information management system (HIMS) to track and monitor patient progress.

Until the ACHN Program fully meets its potential, certain challenges will arise. It will be the Agency's goal to continue to assist and help the ACHNs overcome these challenges and adopt solutions that will allow eligible providers to meet quality outcomes.

Quality Challenges

While there is ample opportunity for Alabama to improve its health care status, doing so will require systemic change at the delivery system level. Looking at the entire population of Alabama, the State performs below the national average for several health status indicators, as shown in Table 1 below.

Table 1: Alabama Quality Data

Condition (Health Status Measure)	Alabama	National
Heart (Heart Disease Deaths per 100,000)	223.2	165
Mental Health (Percent of Adults with Poor Mental Health)	37.7	35.6
Diabetes (Percent of Adults who Ever Had Diabetes)	14.1	10.8
Cardiovascular Disease (Percent of Adults with Cardiovascular Disease)	8.7	6.4
Asthma Prevalence (Percent of Adults with Self-Reported Asthma)	10.9	9.1
Smoking (Percent of Adults who Smoke)	20.9	16.4
Body Mass Index (BMI)		
(Percent of Adults who are Overweight or Obese)	70.2	65.4
(Percent of Overweight or Obese Children, Ages 10-17)	33.2	30.7
Cancer (Cancer Deaths per 100,000)	170.0	152.5
Maternity		
(Teen Birth Rate per 1,000)	27.0	18.8
(Infant Mortality Rate per 1,000)*2016 data, 2017 data unavailable)	9.0	5.9

Source: Kaiser Family Foundation State Health Status Data (2017)

Access Challenges

Alabama is a largely rural and poor state, which has led to challenges recruiting and retaining health care providers to participate in the Medicaid program. Alabama has fewer Medicaid physicians per population compared to the national average. Fewer providers can result in the

postponement of care and higher rates of avoidable emergency department usage or preventable admissions and readmissions.

Fewer providers can result in poorer health outcomes. The State experiences higher than average inpatient admissions and emergency department visits. In addition, the State has fewer office (outpatient) visits compared to the national average. This suggests a need to re-evaluate where recipients receive care, focusing on primary care coordination, care transition management and post-acute care follow-up and management strategies an opportunity to address health needs outside of the emergency department (see Table 2 below).

Table 2: Alabama Access Data

Kaiser Measure	Alabama	National
Hospital Admissions per 1,000 Population	129	105
Hospital Emergency Department Visits per 1,000 Population	479	445
Hospital Outpatient Visits per 1,000 Population	1,908	2,352
Percent of Adults Reporting Not Seeing a Doctor in the Past 12 Months Because of Cost	16.5	13.5
Percent of Adults Reporting Not Having a Personal Doctor	20.8	22.5
Percent of Adults Reporting Any Mental Illness in the Past Year (2016-2017)	19.6	18.2
Percent of Individuals Reporting Alcohol Dependence or Abuse in the Past Year (2016-2017) Adults Age 18+	4.7	5.7
Percent of Individuals Reporting Illicit Drug Dependence or Abuse in the Past Year (2016-2017) Adults Age 18+	2.8	2.7
Opioid Overdose Deaths as a Percent of All Drug Overdose Deaths	51%	68%

Source: Kaiser Family Foundation State Health Status Data (2017)

Cost Challenges

Although Alabama has one of the lowest costs per Medicaid eligible in the nation, largely due to a limited benefit package, the State is challenged to sustain its Medicaid program. As the fourth poorest state in the country, nearly 19 percent of Alabama residents live at or below the Federal

Poverty Level (FPL) compared to 15.4 percent in the nation.[3, 5] This has led to an increase in Medicaid enrollment from 750,000 in 2008 to over one million in 2017. In addition, Alabama Medicaid expenditures are growing. Enrollment and associated expenditures have led to growth in total Alabama Medicaid program expenditures from approximately $4.4 billion in 2008 to an estimated $6.5 billion in 2017. This is leading to an unsustainable rate of health care costs in Alabama.

3 24/7 Wall St., based on state data on income, health insurance coverage, employment by industry, food stamp recipients, poverty, and income inequality from the U.S. Census Bureau's 2013 American Community Survey and annual average unemployment data from the Bureau of Labor Statistics for 2012 and 2013. "America's Richest (and Poorest) States." September 18, 2014. Available at: http://247wallst.com/special-report/2014/09/18/americas-richest-and-poorest-states-2/#ixzz3MfbE8F2I.

Section II: Goals and Objectives for Continuous Quality Improvement

AMA is contracting with ACHNs, which will be responsible for managing the quality of Medicaid services and related care coordination for defined populations. We are proposing to use ACHNs to foster and encourage innovation, improvement, and clinical transformation at the care delivery level. We believe that incentivizing change at the delivery system level will create the impetus for sustainable health reform and clinical transformation that will, ultimately, benefit all patients in the State.

Through the ACHN Program, AMA aims to accomplish the following objectives:

- Improve care coordination and reduce fragmentation in the State's delivery system
- Create aligned incentives to improve beneficiary clinical outcomes
- Improve access to health care providers
- Reduce the rate of growth of Medicaid expenditures

The ongoing use of care coordination tenets that are central to the ACHN Program will drive quality improvements and decrease the rate of expenditure growth for Medicaid in the long term. The Agency expects these efforts to reduce costs related to preventable admissions, readmissions and emergency department (ED) utilization and rationalize care delivery to the most efficient and appropriate care setting. In addition, an ACHN will work to align all members a PCP and will administer care coordination services for their members to ensure all EIs have a medical home while monitoring these EIs to improve health outcomes.

The ACHN Program utilizes a value-based purchasing (VBP) strategy that aligns incentives for the State, ACHN, providers and enrollees to achieve the Program's overarching program objectives.

Quality Incentive Payment Methodology

1) Overview

   a) Ensuring quality outcomes for Medicaid recipients is one of the primary goals of the ACHN Program. Quality efforts should reflect a partnership between the ACHN, the Providers, and the Agency. To promote quality improvement within the ACHN Program, the Agency has implemented a Quality Incentive Payment, whereby the ACHN may earn an incentive payment up to ten percent (10%) of the total revenues received in the quality metrics evaluation year if the ACHN meets quality targets set by the Agency.

   b) Beginning in year one (1) of the ACHN Program, the ACHN will have the opportunity to participate in an incentive program based upon the achievement of Agency determined benchmarks for each of the Quality Measures. If the ACHN achieves the minimum necessary of the annual benchmarks, it will be eligible to receive up to a ten percent (10%) incentive payment. For details related to incentive payments see Table 1 below.

2) Key Features

a) The Agency will select ten (10) incentive measures to assess the ACHN quality performance. Each of the ten (10) measures will be equally weighted when assessing the ACHN's performance. If any measure has any sub-components, the total of the sub-components will equal any one incentive measure. The measures are listed in Table 4.

b) Any ACHN that fails to submit the required performance reports to facilitate a related measure calculation or is in a sanctioned status that the Agency determines would preclude the ACHN from obtaining the Quality Incentive Payment, the ACHN will be ineligible to participate in the Quality Incentive Program.

c) Starting in FY21 and going forward, the Agency will distribute earned incentive funds based on the ACHN's performance for the incentive measures of the previous calendar year (CY). For the first year of implementation, if the ACHN is operational for a minimum of ten (10) months or more, the ACHN's performance will be evaluated on the full calendar year's outcomes.

3) Methodology

a) Setting Final Rate and Annual Improvement Targets. The Agency will identify ten (10) incentive measures. The Agency will calculate baseline rates using CY13-17 data in each Region. The average of the rates over these five (5) years will be used as the baseline for each Region. The Agency will determine a final rate and Annual Improvement Targets for each measure as follows:

i) Final Rate Target: The regional and State baselines will be compared to national benchmarks where they exist, and the Agency will select an appropriate Final Rate Target for the State that reflects an achievable and meaningful level of quality for the measure. For measures where baseline rates cannot be calculated, the Agency will select a Final Rate Target for the State that reflects an achievable and meaningful level of quality for the measure.

ii) Annual Improvement Target: Beginning in CY20, Annual Improvement Targets for each ACHN and each measure will be based on a linear improvement in each measure from the regional baseline to the Final Rate Target with each ACHN projected to meet or exceed the Final Rate Target by CY24.

b) Calculating the Quality Incentive Score. Each of the ten (10) incentive measures will be worth ten (10) points, for a maximum quality incentive score of one hundred (100) points. As described above, for each measure, the Agency will set a Final Rate Target and an Annual Improvement Target. If the ACHN's rate meets the Final Rate Target, the ACHN will earn ten (10) points for the measure. If the ACHN fails to meet the Final Rate Target, the ACHN will still earn ten (10) points for the measure if it achieves the Annual Improvement Target. If the ACHN fails to meet either target, it will receive zero (0) points for the measure.

c) Composite Measures. Some of the incentive measures may be composite measures. Composite measures are measures that consist of two (2) or more components (i.e., sub-measures). For example, the Child Access to Care measure is one incentive measure

that consists of four (4) components: 1) Child Access to Care 12 -24 months old, 2) Child Access to Care 25 months to 6 years old, 3) Child Access to Care 7 – 11 years, and 4) Child Access to Care 12 – 19 years. The Agency will divide composite measures into equally weighted components. For example, a composite incentive measure with two (2) components will have two (2) rate targets and two (2) Annual Improvement Targets. Each component will be worth five (5) points, and the maximum points for the composite incentive measure will be ten (10) points.

The Agency will sum the points from all ten (10) incentive measures to calculate a total Quality Incentive Payment score for the ACHN. The Agency will distribute the earned withhold funds as follows:

Table 3: Quality Incentive Payment Methodology

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

4) Ongoing Monitoring and Performance Improvement Activities. At the end of each FY, the ACHN must meet with the Agency to review the quality measures and share best practices. Additionally, the Agency will meet at least quarterly with each ACHN to review preliminary data, review measure specifications, plan for data gathering, and share early successes and challenges.

As described in the methodology above, the ACHN will have 10 quality measures available for reporting while the provider or provider group will have 8 quality measures. The measures are closely related yet not identical and are listed below.

ACHN Quality Measures

Table 4: ACHN Quality Incentive Program Measures

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

Provider Quality Measures

Due to CMS constraint, the ACHN and Provider Quality measures are not duplicative. However, in an effort for consistency, the Agency decided to align the quality measures for both the ACHN and the PCP/PCP group as closely as possible without replicating measures. It was the Agency's attempt to improve health outcomes by having a similar (but not identical) standard quality measure set that allows both the ACHN and PCP/PCP group to benefit the Medicaid recipient population.

If an actively participating PCP/PCP group is successful in meeting the below quality measures than the PCP/PCP group can quality for a PCP Bones Payment as described in the methodology above.

Table 5: PCP Quality Measures

PROVIDER MEASURES				
Measure		**Measure Description**	**State-wide Baseline**	**Benchmark**
1	W34-CH	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	**61.1%**	**66.7%**
2	AWC-CH	Adolescent Well-Care Visits	**43.0%**	**45.0%**
3	CIS-CH	Childhood Immunization Status (Combo 3)	**70.5%**	**74.0%**
4	IMA-CH	Immunizations for Adolescents (Combo 2)	**20.4%**	**24.6%**
5	AMM-AD	Antidepressant Medication Management (Continuation Phase)	**29.6%**	**37.1%**
6	HA1C-AD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	**73.4%**	**83.3%**
7	FUA-AD	Follow-Up after Emergency Department Visit for Alcohol and other Drug Abuse or Dependence (30 days)	**11.4%**	**12.4%**
8	CHL-AD	Chlamydia Screening in Women Ages 21 – 24	**9.7%**	**54.3%**

Benchmarks represent varying percentiles of national performance rates. Generally the Agency chose either the 25th or 50th percentiles, whichever was the next target compared to current Alabama performance baselines

Quality Improvement Projects

In addition to having an Improvement Plan, the ACHNs are required to submit and implement Quality Improvement Projects (QIPS) that address at minimum the prevention of childhood obesity, infant mortality and/or adverse birth outcomes, and substance use disorders. Each QIP must be completed within the timeframes established by AMA and make available all information regarding the success of the QIP through ongoing reporting and review. AMA reserves the right to require additional QIPs if it identifies deficiencies in an ACHN's performance.

It is at the ACHN's discretion to develop QIPs that best address the needs of their organization and enrollees. Each plan must be organized and thoroughly researched and developed. AMAs External Quality Review Organization (EQRO) will review and approve each ACHN's QIPs.

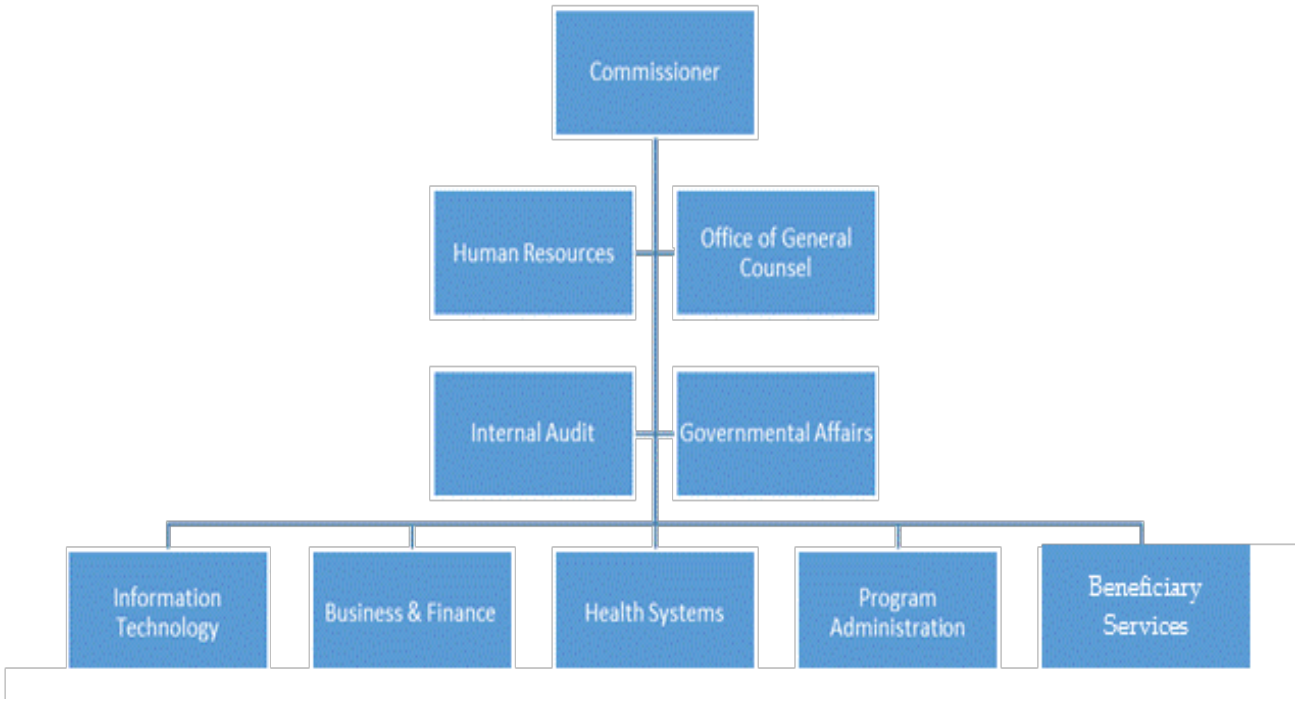
As mentioned above, the Agency has determined that the following three QIPs will be the starting focus for each participating ACHN: childhood obesity, infant mortality and/or adverse

birth outcomes, and substance use disorders. With quality being the primary focus of the ACHN Program, a budget has been established for the ACHN program to positively impact health outcomes. Three agencies or organizations will be collaborating with the ACHNs in developing, implementing, and monitoring their QIPs. These agencies or organizations are the Alabama Child Health Improvement Alliance (ACHIA), Alabama Perinatal Quality Collaborative (ALPQC), and the Department of Mental Health.

Section III: Alabama Medicaid Agency Infrastructure and Organizational Support

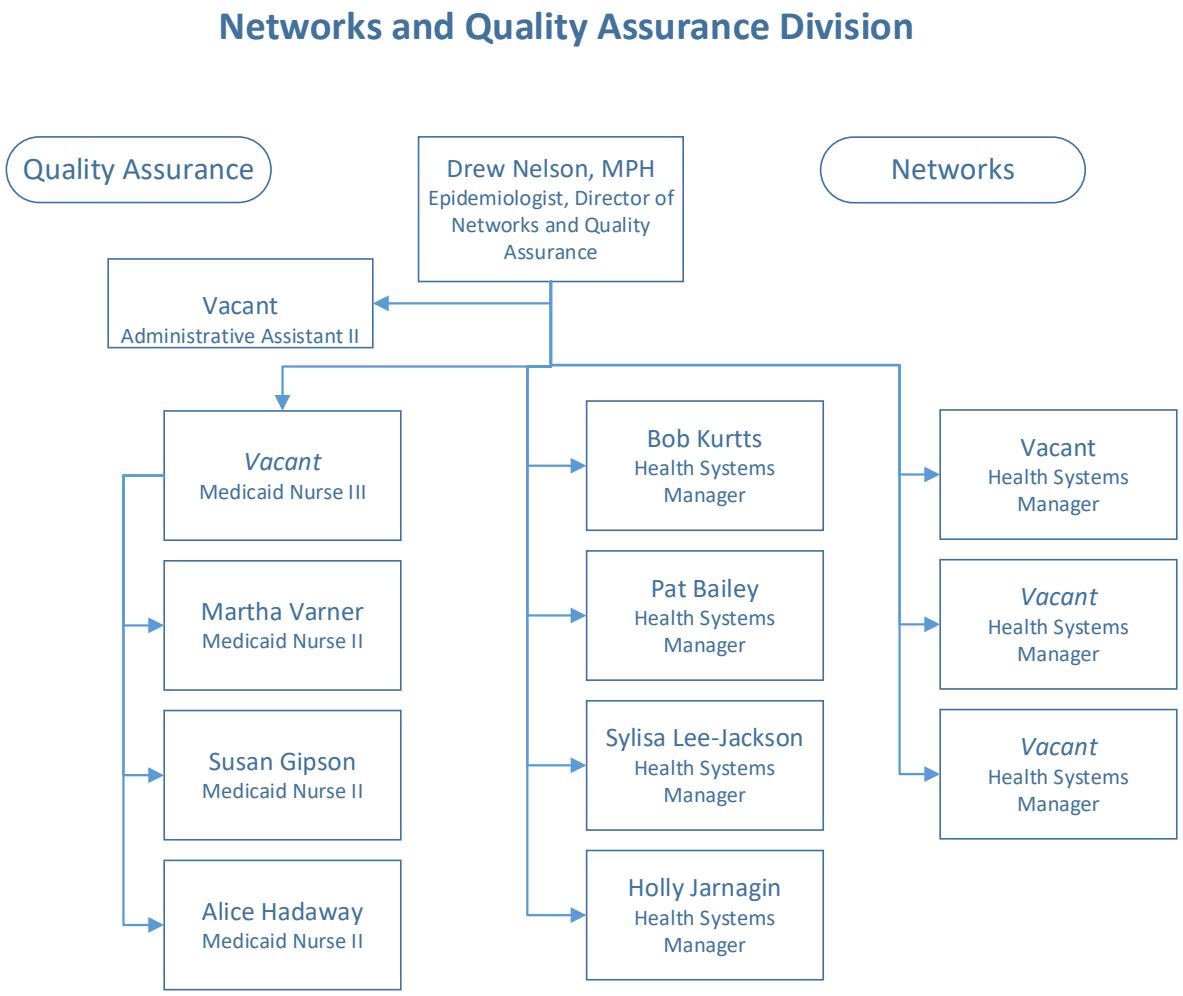
AMA is responsible for all Medicaid programs and structured to administer, monitor and strategize across various functional areas, overseen by the Medicaid Commissioner. This organizational structure will support the State's and ACHN's quality improvement efforts by assigning dedicated staff to each program and identifying inter-agency and ACHN quality improvement subject matter experts (SMEs). AMA is composed of the following functional departments:

Figure 1. Alabama Medicaid Agency Organizational Structure



AMA is charged with overseeing and monitoring ACHN operations. While all functional departments have a role in supporting the quality monitoring, oversight and program integrity of the ACHN program, the Health Systems Department and, more specifically, the Networks and Quality Assurance Division is primarily responsible for ACHN oversight. See Figure 2 for the Networks and Quality Assurance Division organizational structure as of May 2019. It reflects modifications that AMA has made or will be making to its organizational structure to support the needs of its new managed care operations, as opposed to the fee-for-service operating environment.

Figure 2. Network and Quality Assurance Division Structure



Networks and Quality Assurance Division

Previously, AMA had a specific Quality Division headed by the Deputy Commissioner and Assistant Medical Director. Now, with increased reporting required by CMS on AMA-wide quality initiatives and evaluation, AMA has created a Quality Assurance (QA) Division. By combining the responsibilities of monitoring and reporting of the various programs, waiver-specific quality initiatives and the quality of services provided by AMA, AMA will be able to more efficiently respond to all inquiries by sister state agencies, the Alabama Legislature, and CMS. The QA Division will coordinate all quality and reporting activities for the managed care programs, the Maternity Program, Home and Community-Based Services and other long-term care programs. Additionally, the QA Division will oversee contracted quality activities including annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and External Quality Review Organization (EQRO) activities. As the ACHN Program was being implemented, the Program was moved to the newly renamed, Networks and Quality Assurance Division to reflect the Agency's view that the ACHN Program is principally a quality program built on a care

coordination infrastructure. The Networks side of the Division is tasked with the day to day oversight and monitoring of the ACHNs with each Health System Manager assigned a Region and ACHN to supervise while also providing technical assistance for a particular area to all ACHNs. The Quality Assurance side of the Division provides oversight and guidance for the ACHN Quality Program including Quality Measures, QIPs, and Quality Plan.

Internal ACHN Quality Forum

Intra-Agency collaboration is evidenced in AMA's Internal ACHN Quality Forum. This Forum is a collaboration between different Divisions within the Agency, the Quality and Key Leadership of the ACHNs, and other stakeholders in the State focused on aligned goals of the ACHN Program. The Forum provides a setting for ACHNs and the Agency to pose questions, share ideas and best practices, discuss new evidence-based research and initiatives, as well as request expert training for issues that arise through their daily work.

External Quality-Related Committees

In addition to internal quality oversight, AMA has implemented various external committees and task forces that are charged with supporting quality management activities. These include the Quality Assurance Committees (QAC) and Citizen's Advisory Committees.

Quarterly Quality Collaborative – The ACHN must participate in the agency-led ACHN Quality Collaborative that is composed of the Agency, ACHN Programs in each Region, and other State agency representatives when appropriate. This collaborative will meet quarterly, at minimum, to develop and refine program measures, utilization and management reports, innovative health care and utilization management strategies, quality improvement goals and measures, QIP progress and evaluation, and opportunity for shared program operations and support.

Regional Medical Management Committee – The ACHN must establish and is responsible for a Region Medical Management Committee that is chaired by the Medical Director and composed of all participating Providers who must have at least one representative (PCP, Physician Assistant, or Nurse Practitioner) from its medical practice to participate over a twelve month period in at least two quarterly Medical Management meetings in person and one webinar/facilitation exercise with the Network(s) Medical Director. The purpose of the Region Medical Management Committee is to implement and supervise program initiatives centered around quality measures, review utilization data with PCPs as needed to achieve quality goals of the ACHN, review and assist the ACHN in implementing and evaluating QIPs, and discuss and when appropriate, resolve any issues with the PCPs or the ACHN encounter in providing Care Coordination services to their EIs.

Consumer Advisory Committee (CAC)- Each ACHN is required by administrative rule to develop a Consumer Advisory Committee that will meet at least once in the first quarter and at least once in the third quarter. The ACHN will be responsible for engaging the CAC to advise the ACHN on ways it can be more efficient in providing quality care to its enrollees, in addition to other functions and duties assigned by the organization and approved by AMA. In terms of membership, the CAC must have at least six members and with at least 20% of the committee must be compromised of Medicaid recipients or parent/care takers of the EIs enrolled in the ACHN and reflect the racial, gender, geographic, urban/rural, and economic diversity of the State The Committee must also include members who are representatives of patient or low-income advocacy organizations and only include persons who live in the Region the ACHN plans to serve.

Medical Care Advisory Committee (MCAC)- In accordance with 42 CFR 431.12, the State established an advisory committee to the AMA Commissioner to advise on policy development and program administration, including recipient participation in the Alabama Medicaid Program. The MCAC meets semi-annually and at the request of the Commissioner. The committee includes 22 members representing state agencies, medical associations, health and medical care professionals, and consumers. At MCAC semi-annual meetings, representatives from the Networks and Quality Assurance Division provide updates on the ACHN program, including quality improvement.

ACHN Oversight

The Health Systems Department is led by the Agency's Deputy Commissioner and Chief Medical Officer, who oversees the policies and structure of the Networks and Quality Assurance Division and Managed Care Operations Division within the Health Systems Department. The Networks and Quality Assurance and Managed Care Operations organizational structure is composed of:

- ***One Division Manager:*** Responsible for oversight of performance of all ACHNs.
- ***Seven Health Systems Managers:*** Oversee the contract compliance and operational effectiveness of a specific region; will be responsible for day-to-day relationship management with ACHNs.
- ***Managed Care Operations Support Team:*** The Operations, Quality and Clinical Management Leads works with the ACHN Managers in assigning various tasks, as illustrated in Table 3 below, to members of the Support Team and ensuring that all tasks are completed on time. The Support Team is responsible for determining whether the ACHNs are meeting agreed upon performance requirements within their designated areas of expertise – including Operations, Quality and Clinical Management. The primary responsibilities of the Support Team members within each of these areas are described below.

Table 6. Primary Responsibilities of Support Team Areas

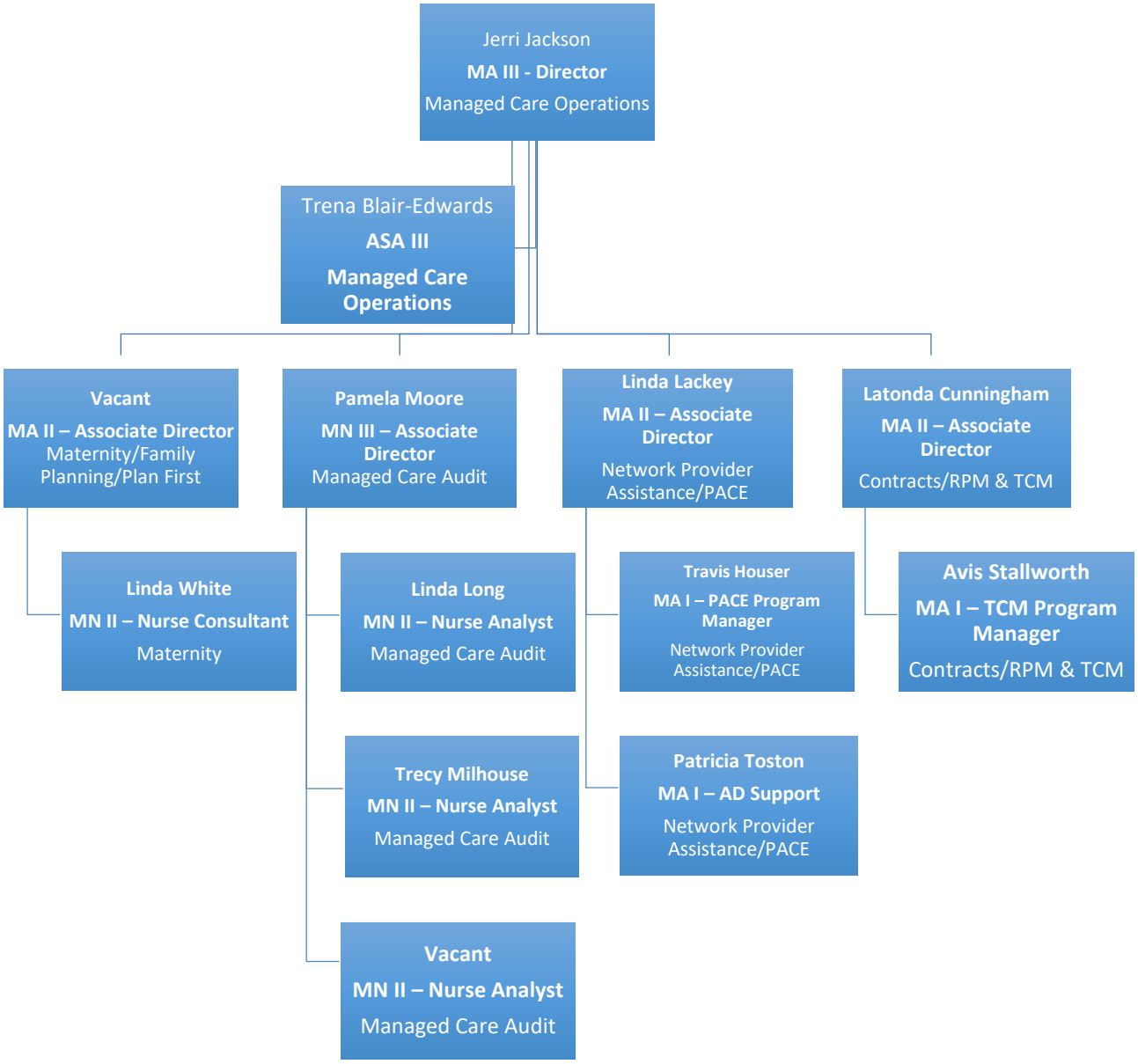
Support Team Area	Primary Responsibilities
Operations	Responsible for evaluating the ACHNs' overall operations and structure by: • Monitoring the ACHNs' provider and enrollee call center statistic reports, appeals reports, and other operational reports as outlined in the ACHNACHN contract • Approving the ACHNs' provider or enrollee outreach materials, staffing and organizational structures, governing board, and provider and ACHNACHN contracts (along with other departments such as the Office of General Counsel) • Monitoring the ACHNs' compliance with network adequacy and access standards through various reports
Quality	Responsible for evaluating the quality of medical care and services that ACHNs provide by:

Support Team Area	Primary Responsibilities
	• Reviewing the ACHNs' quality of care using measures selected by the Quality Assurance Committee (QAC) and analyzing the ACHNs' Quality Management program • Administering the Quality Withhold Program • Monitoring IPS programs and related performance measure reporting and progress • Coordinating the activities of the QAC • Overseeing and coordinating EQRO contract and functions • Coordinating and implementing performance improvement projects • Reviewing quality metric reports, enrollee surveys, complaints and grievance procedures and logs, quality improvement activities reports and other reports required by federal regulations
Clinical Management	Responsible for monitoring the ACHNs' care coordination and case management services by: • Approving the ACHNs' clinical policies and procedures • Performing chart reviews, as necessary • Analyzing the ACHNs' utilization and case management protocols and statistics • Monitoring the ACHNs' denial of services log, as requested
Finance	Housed within the Business and Finance Department, the Finance Support Team area is responsible for monitoring the ACHNs' financial stability and overall performance from a cost perspective by: • Reviewing the ACHNs' audited annual financial statements, unaudited monthly/quarterly financial statements, and the results of the ACHNs' audited compliance plans to evaluate the ACHNs' financial performance • Analyzing the financials and operational effectiveness of the ACHNs' subcontractors • Working with actuaries in setting capitation rates • Reviewing cost and utilization data, to analyze trends and provide guidance to ACHNs related to reducing costs and improving overall performance • Calculating the withhold amounts due back to ACHNs through the Quality Withhold Program • Contributing to financial oversight of QIPs

The Managed Care Operations Division, refer to Figure 3, is structured to regularly coordinate with other SMEs to enhance monitoring and oversight functions, including staff from Finance, Program Integrity, Third Party Liability, Communications, the Analytics Unit and Systems and Encounter Data Monitoring.

The ACHN Managers and Support Team will work with AMA leadership and SMEs to develop and deliver learning collaboratives for ACHNs to enhance the quality of services they provide to enrollees and the value they provide to the ACHN program.

Figure 3. Managed Care Operations Division Structure



Section IV: Development and Review of Quality Strategy

The development of the Quality Strategy first began with Alabama's multi-stakeholder Medicaid Advisory Commission, which was charged with providing recommendations for developing a Medicaid reform plan. This Commission consisted of state government and insurance company representatives and medical providers, as well as professional organizations that represented hospitals to rural health clinics to nursing homes.

In addition to the Medicaid Advisory Commission, the Agency's history with CMS Quality Measure Reporting and previous quality initiatives have played a large role in the development of the quality measurement approach for the ACHN Program, which is an essential component of this Quality Strategy.

AMA published the Draft ACHN Quality Strategy to the Agency website and provided it to Poarch Band of Creek Indians in November 2019 to obtain input from a variety of stakeholders. The draft ACHN Quality Strategy was sent to CMS on November 15, 2019, and made available for public comment on the Agency's website. At the end of the comment period, the Agency received feedback from three entities and reviewed all recommendations. Upon revision of the ACHN Quality Strategy, AMA submitted a final version to CMS for review and approval on January 8, 2020. The final version of the ACHN Quality Strategy will be published to the Agency website upon final approval from CMS.

The State will continue to update the Quality Strategy and as the ACHN Program matures to reflect AMA priorities. Every three years, AMA will conduct a formal review of the Quality Strategy and make the updated Strategy available for public comment and submit to CMS for review and comment. The revised Strategy will include an evaluation of the effectiveness of the Quality Strategy and summarize changes AMA made to the Strategy. Additionally, AMA will make the Strategy available for public comment when significant changes are made to the Strategy outside of the 3-year review cycle. Significant change is defined as either

- Significant change is defined as a federal or state statutory or regulatory change in the ACHN Program that would have an effect on the operation or administration of the ACHN or ICN programs in Alabama; or

- Significant change is defined as a material change in the following:

    - Achievement of goals and priorities

    - ACHN performance based on reporting data, grievance and appeals reports, annual compliance audit or surveys

    - Quality standards resulting from regulatory authority or legislation at the state or federal level
    - Structure of Alabama Medicaid including enrollee demographics, provider networks or Medicaid funding

    - Stakeholder feedback and input

Section V: ACHN Readiness, Ongoing Monitoring and Performance

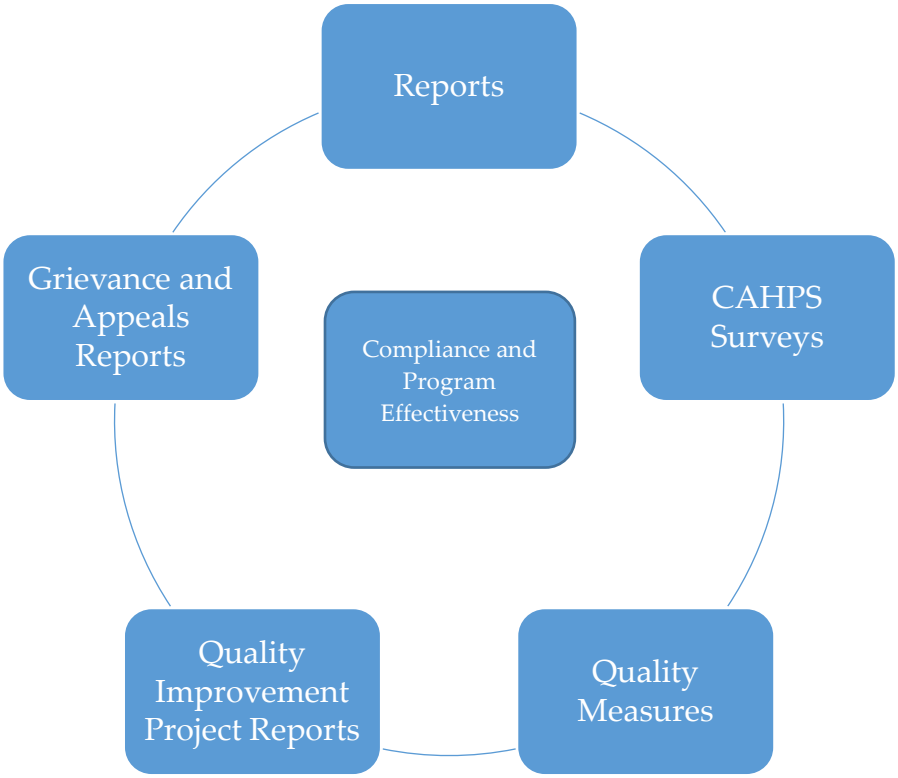
Successful quality improvement will require innovation and collaboration among AMA, the Networks and Quality Assurance and Managed Care Operations Divisions, ACHNs (including external committees), providers, enrollees, other state agencies, and advocacy groups. AMA will have informal touch points with the ACHNs throughout the quality improvement cycle and will provide feedback to ACHNs on a regular basis. This feedback may include discussions between AMA and ACHN representatives about trends in the organization's submitted reports, feedback from providers or enrollees, or focused dialogue regarding critical issues.

In addition, AMA will meet with ACHNs on a quarterly basis to discuss operations issues, share performance results, and identify opportunities for improvement based on data and reporting. (In the initial states of ACHN Program, AMA may meet with the organizations on a more frequent basis.) These meetings will promote transparency of ACHN performance, foster shared learning, and create a space to discuss program trends and leading practices. The quarterly meetings will have standing agenda items on important program topics and provide the opportunity to discuss new issues that may impact multiple ACHNs or the Program overall. AMA may also invite other stakeholders to participate in these meetings, depending on the topics to be covered. The informal touch points between AMA and the ACHNs will help inform the agenda topics for these quarterly meetings.

AMA will conduct data analysis and baseline measurements of ACHN Quality Measures and of other leading indicators provided in regularly submitted performance reports. Initially, AMA will use FFS data to understand performance on ACHN Quality Measures by ACHN region. However, over time, AMA will also incorporate case management data and other feedback forums to identify performance gaps. Based on the data analysis results, the Networks and Quality Assurance Division will collaborate with ACHNs to identify specific areas for improvement, set improvement goals, implement interventions, conduct measurements, and adapt interventions or corrective action plans as necessary. AMA's ACHN Quality Incentive Program incentivizes ACHNs to successfully implement quality improvement activities that advance AMA's overall program objectives.

AMA will employ a number of monitoring approaches, including review and analysis of regular reports submitted by ACHNs, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, Quality Measure performance, Quality Improvement Project reporting, and grievance and appeals reporting.

Figure 4. Mechanisms for Monitoring Compliance and Program Effectiveness



On a monthly and quarterly basis, AMA will analyze all available quality reporting to monitor program performance. AMA will evaluate reports not only for compliance with contractual requirements, but also for progress towards achieving AMA's program effectiveness goals. Many reporting elements serve as leading indicators for overall program effectiveness. For example, if an ACHN's reporting of grievances and appeals indicates that enrollees are not able to make timely appointments with PCPs, this may be an indicator that the program is not on target to increase primary care and prevention visits or reduce the rate of unnecessary emergency department visits, two of AMA's program effectiveness measures.

While AMA's first step will be to provide technical assistance and learning collaborative opportunities for the ACHNs, AMA will implement sanctions or corrective action plans to remedy any non-compliance, when necessary.

To provide stakeholders with information about the programs, AMA will publicly report summaries at the ACHN\level on quality measures, costs, outcomes and other information.

ACHN Readiness Assessment

The Agency shall conduct readiness assessments as required by 42 C.F.R § 438.66 and in accordance with Alabama Medicaid Administrative Code Chapter 37 to determine the ACHN's readiness and ability to provide services to its EIs and resolve any identified operational deficiencies. The Agency may require the ACHN to develop and implement corrective action plans (CAPs) acceptable to the Agency demonstrating the ACHN's readiness to satisfy the

requirements of this RFP. The ACHN must cooperate with the Agency in the Agency's readiness assessments, including but not limited to:

a. Providing all information, data, policies, procedures and reports the Agency requires or requests that are within the scope of the readiness assessments; and

b. Allowing the Agency reasonable access to the ACHN's facilities, staff, and leadership.

As briefly mentioned above, the Agency is responsible for completing a readiness assessment that evaluates the ACHN's ability to successfully meet the ACHN RFP requirements. This includes evaluating policies and procedures as well as seeing demonstrations required to evaluate the functionality of the proposed health information management system (HIMS) to be implemented by the ACHN either in person or via webinar. A thorough review was conducted on all mentioned aspects to ensure successful implementation was obtainable.

The ACHN acknowledges and understands that it shall neither provide services to EIs nor be paid until the Agency has determined, in its sole discretion, that the ACHN has demonstrated readiness to satisfy the requirements of this RFP and until the effective date. The Agency will provide a written notice to the ACHN when the ACHN has met all requirements of the RFP to provide services. Therefore, the readiness assessment was critical to each ACHN and, by passing, ensured a "go-live" decision or a start date for a single, coordinated care program within the Medicaid population.

ACHN Ongoing Monitoring and Performance

The Agency shall conduct ongoing monitoring and supervision as required by 42 C.F.R. § 438.66 to determine the ACHN's ability to provide services to EIs and resolve any identified operational deficiencies. The Agency may require the ACHN to develop and implement CAPs acceptable to the Agency demonstrating the ACHN's ability to satisfy the requirements of this RFP.

The ACHN must cooperate with the Agency in the ongoing monitoring and supervision, including but not limited to:

a. Providing all information, data, or reports the Agency requires or requests under the Contract, including but not limited to the Agency's annual report to the Centers for Medicare and Medicaid Services (CMS) on the ACHN as required by 42 C.F.R. § 438.66(e)(1); and

b. Allowing the Agency reasonable access to the ACHN's facilities, staff, and leadership.

Review of Regular Reports Submitted by ACHNs

ACHNs are contractually required to submit a variety of reports to AMA on a regular basis, as illustrated in Table 4 below. These reports cover many topics including enrollee services, provider availability and accessibility, care coordination, quality management, utilization management (including underutilization of care), finance and solvency, grievances and appeals, among others. In addition, ACHNs are required to submit accurate and complete case

management data on a monthly basis. AMA will use the case management data in its monitoring activities as well as for capitation rate development.

Table 5. ACHN Reporting Requirements

ACHN Report Title	Frequency	RFP Location (Page #)
Care Coordination Data	As required	58
Cash Flow Flash Report	Monthly	45
Financial	Quarterly and Annually	45
Fraud and Abuse Activities	As required	66
Grievances Log	Quarterly	47, 57
Medical Management Committee Minutes	Quarterly and Annually	41, 57
Outreach and Education Activities	Quarterly	62
PCP and DHCP List	Monthly	62
Performance Reports	Quarterly	142
Pharmacy	Quarterly	57, 132
Quality Improvement	Quarterly	115

To help confirm that ACHNs submit reports to AMA that are meaningful and comparable across ACHNs, AMA developed a Reporting Manual that will be made available to the ACHNs. This Reporting Manual defines the specifications and formats that ACHNs must use when developing and submitting reports to AMA. When reviewing the ACHN reports, the Health System Managers and members of the Managed Care Operations Support Team will use standard operating procedures to collect, analyze and summarize findings for each report. Health System Managers will also compile report findings across ACHN and regions to identify areas of opportunity for discussion at ACHN quarterly meetings and learning collaboratives.

CAHPS Survey

Starting November 2016, AMA has contracted with the University of Alabama at Birmingham (UAB) to collect and analyze the results of CAHPS survey data. UAB administers the CAHPS Health Plan 5.0 Survey to assess beneficiaries' experience with care. The survey will be administered statewide and stratified to compare the experiences between the ACHN regions. UAB will survey ACHN and non-ACHN participants using CAHPS on a quarterly basis. Beginning in January 2016, UAB will administer a quarterly survey with a valid sample of at least 300 complete surveys for each ACHN, the non-ACHN population and 35 highlighted populations groups. The Agency has 3 years of baseline data to compare ACHNs performance to previous recipients' satisfaction of care. The Agency will also analyze the satisfaction of care coordination for ACHN recipients as well as the experience of care for Children with Medical Complexity to ensure the transition is smooth and outcomes are improved.

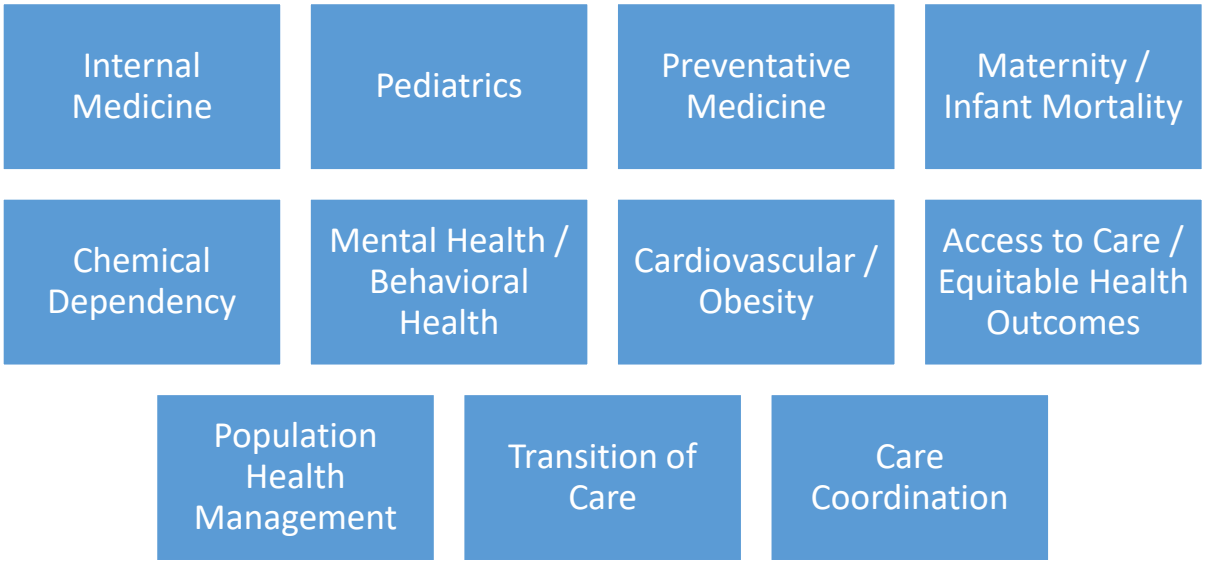
Site Visits

As part of the ongoing monitoring phase, each Health Systems Manager for his or her respective area will be required to conduct an onsite visit to ensure the entity is meeting the RFP or other contractual obligations in addition to efficiently and effectively serving the Medicaid population and improving health outcomes. These visits will be performed on a quarterly basis after the initial startup period. During the initial or first few months of operation, a site visit may occur more frequently in order to avoid any potential issues or address unexpected problems. These visits will provide an insight on day-to-day operations and allow the Health Systems Manager to visually see and experience workflows and processes that might not be witnessed while offsite.

ACHN Quality Measure Performance

The Agency assembled an internal team with the goal of identifying objective outcome and quality measures, including measures for ambulatory care, preventative care, chemical dependency and mental health treatment, and population health management, provided by the ACHNs.

The ACHN QA team meets at least annually to review the ACHN outcome and quality measure data for the past year and possibly adjust targets for the upcoming calendar year. In November 2018, the ACHN QA team adopted 10 quality measures, listed in Attachment B, to evaluate the performance of the ACHNs. The 10 measures are grouped into the following twelve domains:



ACHN Incentive Measures

The ACHN QA team also proposed that these measures would be tied to financial incentives. Ten measures were selected by AMA with input from Agency leadership.

AMA used the Kepner-Tregoe Analysis, a process of weighing alternatives and assigning numerical weights to a series of valuates in the attempt to select the most appropriate options.

AMA selected the top 10 measures based on internal AMA staff votes and set weighted variables based on the following principles and goals:

Guiding Principles of the ACHNs	Clinical Goals of the ACHNs	Guiding Principles of the ACHN QA Team
• Improved access to providers and Medicaid Services • Improved clinical quality measures and member experience • Increased access to quality care coordination and case management services, considering actions needed for a smooth transition from current programs	• Better birth outcomes • Reduce childhood obesity • Improve substance abuse initiation and continuation of treatment	• Readily available data • National benchmarks • Sufficient denominator population • ACHN has abilit to impact oucome

These ten measures can be found in of this document.

ACHN Quality Incentive Program Measures

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

Quality Improvement Program

The ACHN must implement a Quality Improvement Program to improve health outcomes by systematic data analysis to target EIs with chronic/behavioral health conditions and Providers for outreach, education, and intervention; monitoring access to care, services, and treatment including linkage to a Medical Home; monitoring quality and effectiveness of interventions; facilitating quality improvement activities that educate, support, and monitor Providers regarding evidence-based care for best practices; and implementing clinical management initiatives identified as priorities by the Agency and the Quality Assurance Committee (QAC).

In accordance with 42 CFR §438 Subparts D and E and the Alabama Medicaid Administrative Code Chapter 560-X-37, ACHNs must have an ongoing Quality Assessment and Performance Improvement Program that executes a Quality Improvement Plan to systematically monitor and evaluate the quality and appropriateness of care and services rendered to enrollees and promote and improve quality of care and patient outcomes for its EIs.

The ACHN must develop, implement and maintain written policies and procedures which address components of effective health care management including but not limited to anticipation, identification, monitoring, measurement and evaluation of EI's health care needs, and effective action to promote quality of care.

As part of the Quality Improvement Program, the ACHN must develop and submit a written Quality Improvement Plan (herein "Improvement Plan") to the Agency within thirty (30) Calendar Days from execution of the Contract and resubmit it to the Agency annually by October 1st of each year for written approval. The Improvement Plan must annually measure and report to the Agency on its performance, using the Quality Measures required by the Agency or submit data, specified by the Agency, which enables the Agency to calculate the ACHN's performance using the Quality Measures identified by the Agency. The Improvement Plan must include processes for the investigation and resolution of individual performance or quality of care issues whether identified by the ACHN or the Agency that:

a. Allow for the tracking and trending of issues on an aggregate basis pertaining to problematic patterns of care;

b. Collect and submit performance measurement data in accordance with 42 C.F.R. § 438.330(c);

c. Implement mechanisms to detect both underutilization and overutilization of services;
d. Monitor the delivery of Care Coordination services provided, including but not limited to, an assessment of care between care settings;

e. An Assessment of the level of Care Coordination provided; and

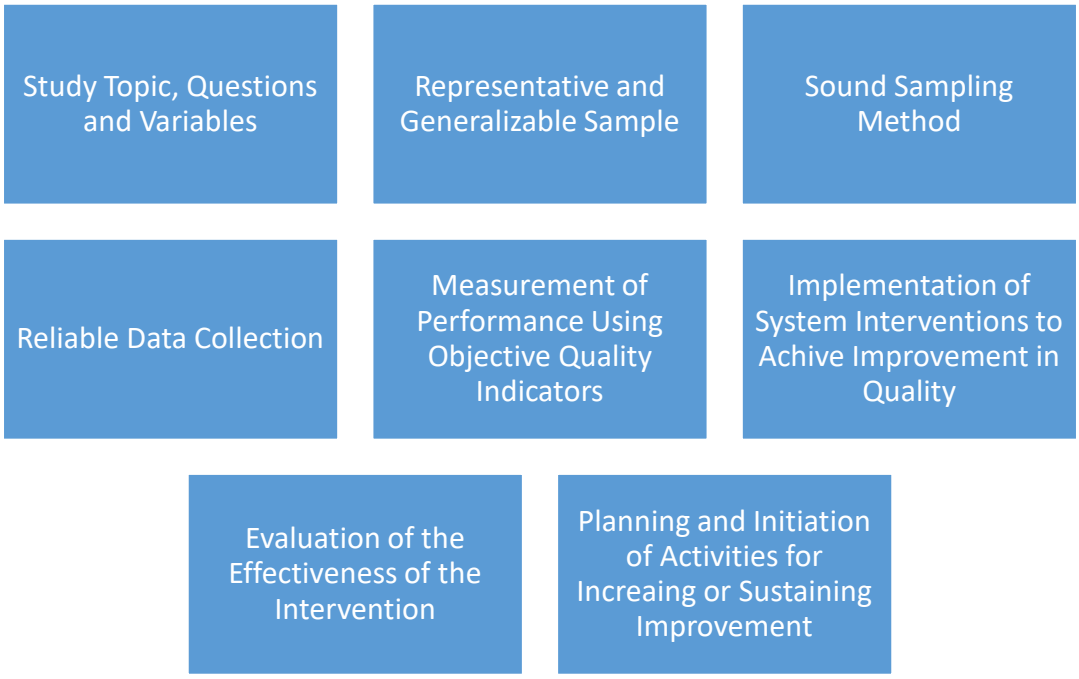
f. Health outcomes of the EIs.

In addition to having an Improvement Plan, the ACHNs are required to submit and implement Quality Improvement Projects (QIPS) that address at minimum the prevention of childhood obesity, infant mortality and/or adverse birth outcomes, and substance use disorders. Each QIP must be completed within the timeframes established by AMA and make available all

information regarding the success of the QIP through ongoing reporting and review. AMA reserves the right to require additional QIPs if it identifies deficiencies in an ACHN's performance.

It is at the ACHN's discretion to develop QIPs that best address the needs of their organization and enrollees. Each plan must be organized and thoroughly researched and developed. AMAs External Quality Review Organization (EQRO) will review and approve each ACHN's QIPs.

QIPs must include the following sections:



As mentioned above, the Agency has determined that the following three QIPs will be the starting focus for each participating ACHN: childhood obesity, infant mortality and/or adverse birth outcomes, and substance use disorders. With quality being the primary focus of the ACHN Program, the Agency has invested significant resources and time has been dedicated to the ACHNs to positively influence the State using quality. Three agencies or organizations will be collaborating with the ACHNs in developing, implementing, and monitoring their QIPs. These agencies or organizations are the Alabama Child Health Improvement Alliance (ACHIA), Alabama Perinatal Quality Collaborative (ALPQC), and the Department of Mental Health.

Grievance and Dispute Resolution

ACHNs are required to have a grievance process in place, submit a quarterly grievance log to AMA, and have a dispute resolution process in place in the event an EI would like to appeal a decision that adversely affects their services. AMA will monitor these reports to identify specific program areas that may require attention. For example, if an ACHN receives a large volume of grievances about availability of primary medical providers, AMA would conduct further investigation to confirm that the ACHN complies with provider network requirements. Close

attention to grievance and appeal reporting, particularly in the initial years of the ACHN program, is an important component of AMA's quality monitoring strategy.

Agency Intervention

If a problem is identified by the Agency regarding the quality of services received, the Agency will intervene as indicated below:

1. Provide education and informal mailings to EIs and ACHNs;
2. Initiate telephone and/or mail inquiries and follow-up;
3. Request ACHN's response to identified problems;
4. Refer to program staff for further investigation;
5. Send warning letters to ACHNs;
6. Refer to State's medical staff for investigation; or
7. Institute corrective action plans and follow-up.

Section VI: Identifying Long-Term Care and Special Health Care Needs

AMA defines Special Health Care Needs as individuals who have high health care needs, multiple chronic conditions, mental illness, or substance use disorders and either 1) have functional disabilities, or 2) live with health or social conditions that place them at risk of developing functional disabilities which may include serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care. Special Health Care Needs also includes pregnancy.

ACHNs are required to conduct health risk screenings and health and psychosocial assessments, as described below.

ACHN Screening Process

The health risk screening is used as a data collection tool to identify and stratify all new enrollees in need of Care Coordination services into appropriate risk categories. The ACHNs will stratify non-pregnant enrollees into one of three levels (low, medium or high risk) or a monitoring categories based on the severity of their disease or chronic illness. The screening tool will take into account prior utilization data such as frequent emergency room visits or hospitalizations, large gaps in provider or EPSDT visits and changes in pharmacy claims. Enrollees identified as medium or high risk will also receive a health and psychosocial assessment conducted face-to-face within 21 calendar days of the initial health risk screening. The assessment must include the following domains:

Family and social support

Enrollee's general perception of health

Medical equipment in the home

Health assessment

Social issues/needs

Behavioral health history (mental health and substance use)

Ability to perform activities of daily living

Cognitive development/impairment

Motor impairment

Functional impairment

Caregiver ability

Sensory deficits

Referral source

Maternal Health Screening

All pregnant ACHN enrollees are required to receive a maternal health screening. Screening must be completed by telephone or face-to-face within five business days of notification of a pregnant woman's enrollment. The screening will determine if the enrollee is appropriate for Maternal Health Care Coordination services. ACHNs must conduct a health risk and psychosocial assessment for all pregnant enrollees. The health risk and psychological

assessment covers the items listed under ACHN Screening process above, as well as additional items specific to pregnancy issues.

CMC Screening Process

Care Coordination for Children with Medical Complexity

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

The ACHN must have on staff, a nurse and a social worker with pediatric experience to provide training to general Care Coordination staff in the care and linking of services for children with medical complexity. A designated pharmacist will also receive training for this population. The requirements for all positions are described below:

- Pediatric Nurse: Must have a BSN with a minimum of two (2) years complex pediatric nursing experience or an ADN with a minimum of five (5) years complex pediatric nursing experience. Preferred experience settings include acute hospital, intensive care, Children's Rehabilitation, Children's Specialty Clinic, or a pediatric practice.

- Social Worker: A Licensed Independent Clinical Social Worker (LICSW) (preferred) or a Licensed Master Social Worker (LMSW) with experience in a pediatric environment. Preferred experience settings include acute hospital, intensive care, Children's Rehabilitation, Children's Specialty Clinic, Children's Mental Health, or pediatric clinic.

- Pharmacist: A Pharm D is required with pediatric experience preferred.

Section VII: Transition of Care Policy

AMA requires ACHNs to have a transitional plan in placing during the implementation stage of the program as well as a transitional plan in place in the event an EI transitions in between ACHNs or an ACHN contract is terminated or expires. The below outlines each required transitional process.

Transitional Plan for ACHN during the Implementation stage:

- General Care Coordination. The Transitional Plan for ACHN during the implementation stage ensures that the process focuses on continuity of care for EIs moving from one of the ending Care Coordination programs to the ACHN's Care Coordination services. The ACHN must develop, implement, and maintain policies and procedures, subject to Agency approval, to ensure continuity of care for all EIs upon initial enrollment with the ACHN as follows:
    - The ACHN is assigned or referred a new EI for management of care; and
    - The ACHN requests information from the previous organization (i.e., Health Home, ADPH) for all EIs receiving Care Coordination services. Information would include all documentation in the HIMS, demographic information and the EI's Care Plan.
- Maternity Care Coordination:
    - The continuity of care process must include a focus on the EI's Care Coordination to and from services and programs outside of the ACHN's program.
    - The ACHN must develop, implement, and maintain policies and procedures, subject to Agency approval, to ensure continuity of care for all EIs upon initial placement with the ACHN as follows:
        - The ACHN is assigned a new EI for management of care;
        - The ACHN requests transfer information from the previous Maternity Contractor for all EIs receiving Care Coordination services. Information would include all documentation regarding Care Coordination services;
        - The ACHN must contact the EI within five (5) Business Days to initiate services and provide a referral to the transitioning maternity Provider, if indicated.

Transition of EIs between ACHN's

- When an EI, who is currently receiving Care Coordination services, moves out of the Region and is assigned to a new ACHN, the previous ACHN must submit within ten (10) Business Days information regarding the EI's Care Coordination services to the new ACHN.

- The continuity of care process must include a focus on the EI's Care Coordination to and from services and programs outside of the ACHN's program.

- The ACHN must develop, implement, and maintain policies and procedures for Agency approval to ensure continuity of care for all EIs for the following:

    - When receiving a new EI for management of care; and/or

    - When requesting information from the previous ACHN for all EIs receiving Care Coordination services. Information would include all documentation in the HIMS.

- The receiving ACHN must contact the EI within five (5) Business Days to initiate services.

Transition at Expiration and/or Termination of Contract.

- The Agency may terminate the Contract, in accordance with the terms of RFP 2019-ACHN-01, Section 2.I.10, with the ACHN and place EIs into a different ACHN or provide Medicaid benefits through other state plan authority, if the Agency determines that the ACHN has failed to carry out the substantive terms of its contracts or meet the applicable requirements of sections 1932, 1903(m) or 1905(t) of the Act.

- A transition period shall begin in the event of termination of this Contract, prior to the end of the term of this Contract if the Agency and the ACHN do not execute a new contract or upon notice that the Agency does not intend to exercise an option to renew this Contract for any additional year.

- During the transition period, the ACHN must work cooperatively with the Agency and any organization with whom the Agency may contract for similar services to EIs in the Region.

- The Agency will specify a plan for the transferring ACHN to follow during this transition period. The length of the transition period shall be at the Agency's sole discretion. The costs relating to the transfer of materials and responsibilities must be paid by the transferring ACHN without additional compensation or reimbursement of expenses from the Agency. The transferring ACHN must be responsible for all necessary services during the transition period.

Section VIII: Network Adequacy

The ACHN Contract provide detailed language regarding network adequacy. The ACHNs are required to adhere to availability and timeliness standards defined by AMA and reflected in the respective contract.

The ACHN must demonstrate network adequacy to meet the medically necessary maternity needs of eligible individuals (EIs) in their contracted Region. The DHCP network shall include delivering obstetricians/gynecologists, or other physicians with credentials to perform prenatal, delivery, and postpartum care within fifty (50) miles of all areas of the contracted Region.

The ACHN must:

- Identify, develop, and maintain a Delivering Healthcare Professional (DHCP) Network report proving network adequacy to include the DHCP's delivering hospitals;
- Continually monitor the provider network to ensure capacity is sufficient to meet the needs of EIs, ensuring accessibility to maternity services are not hindered;
- Submit documentation to the Agency when there are changes in the provider network or changes in the provider's hospital delivering privileges.
- The ACHN must develop, implement, and maintain policies and procedures addressing network adequacy for the Agency's approval.

The ACHN shall:

- Comply with the network adequacy requirements;
- Submit a Network Adequacy Report to include the name of DHCP and group practice (if applicable),provider specialty, location of practice address, county of practice, telephone number, email address, fax number, and delivering hospital.
- Monitor participating providers regularly to determine compliance with the Participation Agreement and the requirements of this Contract; and
- Take corrective action if there is a failure to comply with this Contract.
- The ACHN must submit the documentation of network adequacy no less frequently than the following:

    a) At the time of Readiness;

    b) On an annual basis; and

    c) At any time there is a change in the ACHN's DHCP provider network

- The ACHN must continually monitor the Provider network to ensure that the capacity is sufficient to meet the needs of all EIs to ensure that availability and accessibility to services are not hindered. The ACHN must submit documentation to the Agency when there are changes in its maternity Provider network.

Section IX: Health Information Technology

Health Information Management System (HIMS)

As part of the ACHN Program, each entity is responsible for utilizing a case management system or Health Information Management Systems (HIMS) in order to improve the quality of care provided to Medicaid's population. It is in hopes that the use of a HIMS will not only improve the quality of care but be cost effective, reduce health disparities,

The below are requirements set forth by the ACHN RFP:

- Functional Requirements

  a) The Agency is requiring a case management system that includes Care Coordination documentation, maternity data and the ability to accept Admission/Discharge/Transfer (ADT) feeds. Failure to input Maternity data and/or Care Coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database will result in Sanctions (see Section II.M.2.i.).

  b) The ACHN shall submit complete and accurate maternity delivery data for each EI who delivery under the ACHN program. The data shall be submitted to Medicaid or Medicaid's designee in the format specified in the RFP. All delivery data must be completed within 90 days of the delivery date. The ACHN shall comply with this requirement and shall take corrective action if there is a failure to comply with this Contract requirement.

  c) The Agency will provide to the ACHN HIMS summary level reports for guiding quality improvement, supporting Providers, and general population health monitoring.

  d) The Agency will provide data about specific EIs in the ACHN Region.

  e) The ACHN may request ad-hoc research request from the Agency through the ACHN's primary contact with the Managed Care Division. Upon review, the Managed Care Division will forward to the Analytics Division for further review, scope development and prioritization.

- The ACHN must ensure all PHI data is protected per federal laws, state laws, and Business Associates Agreement.
- The ACHN must ensure that the HIMS is fully operational and tested by the ACHN, Agency, and/or Agency designee, prior to the completion of the Agency's readiness assessment pursuant to Section II.E. The ACHN must ensure prior to the completion of the Agency's readiness assessment that its HIMS be operational and have completed:
  - Design;
  - Testing; and
  - Training of staff on the HIMS.

- The ACHN HIMS must comply with the following:
    - The system must provide the Agency a monthly extract of data in the format prescribed by the Agency.
    - The system must use specifications from the Agency to document user information and case management (see Section II.B).
- The Agency, directly or through the HIMS, will provide to the ACHN the following data for EI's in the Region:
    - Paid claims data at least monthly or at most after each check write;
    - Pharmacy data daily;
    - Eligibility data;
    - Provider data; and
    - Reference data.
- The system will allow the Agency to have access to the system for reviewing case management data and to review security and management components.

ADT/OneHealthRecord

One Health Record®, Alabama's State Health Information Exchange, will provide services, including clinical provider accounts and clinical viewer, to the seven ACHN regions that serves the participating Medicaid members. These services will allow the regions to coordinate care management activities for their recipients, through the document queries, and HL7 ADT Admission, Discharge, and Transfer) alert notifications and direct secure messaging (DSM).

ADT's alert notifications are used to improve health care coordination when an event occurs with a member such as an admission to, or discharge from an emergency department or inpatient hospital setting, or during a transfer within the hospital or from one healthcare facility to another. ADT's will be sent to the DSM accounts to the regions in which the member resides. Members will be followed by zip code.

ADT's contain member's demographic data, insurance information, and encounter and diagnosis information. With each event, the ADT will reflect the most updated member information available, as the ADT's are real-time information.

Section X: External Quality Review

The Code of Federal Regulations (CFR), 42 Part 438, subpart E, provides that contracts with managed care organizations must conduct external quality review, using a third party External Quality Review Organization (EQRO). External quality review is defined by the CFR as "the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that [a] Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Management (PCCM) entity, or their Vendors furnish to Medicaid beneficiaries." (42 CFR § 438.320) A technical report is to be prepared annually by the EQRO defining methodologies used to evaluate MCOs, detailing the evaluation and its outcomes, and providing recommendations for improvement. The Agency is requesting proposals to provide external quality review for the seven ACHNs contracted to provide case management activities to Alabama Medicaid recipients.

On an annual basis, AMA EQR vendor will perform an external quality review (EQR). As of June 2019, AMA has begun the process of procuring an EQRO, which will be responsible for conducting two mandatory activities and one optional activity:

1. Review, within the previous three-year period, to determine ACHN compliance with State standards for access to care, structure and operations, and quality measurement and improvement.

2. Validation of performance measures.

3. Validation of Quality Improvement Projects (QIPs).

Section XI: Health Disparities

AMA has engaged in efforts and initiatives aimed at reducing disparities in health care. Two such initiatives are the State's Health Home Program (formerly named Patient Care Networks) and the Patient 1st Program. These programs create health homes and medical homes that provide population health management through education and outreach to recipients and providers. As a result of systematic data analysis targeted at monitoring access to care, provider capacity, and quality and effectiveness of interventions to the population, these programs provide care management for high risk, high acuity recipients. The care management programs promote the delivery of appropriate, evidence-based care and education about disease states and self-management. Both the Health Home and Patient 1st Programs have been incorporated into the ACHNs' responsibilities.

In addition, each ACHN must develop a Citizens' Advisory Committee. Each Committee will consist of Medicaid recipients and representatives from the Disabilities Leadership Coalition of Alabama or Alabama Arise, or their successor organizations and can have a role in identifying and developing solutions to address disparities. In addition, AMA will use quality reporting as a mechanism to identify racial disparities. The ACHNs will report quality measure data to AMA by race and ethnicity. The additional level of reporting will allow us to analyze and understand racial and ethnic disparities and identify approaches to reduce them.

Section XII: Intermediate Sanctions

In accordance with Alabama Medicaid Administrative Code Chapter 37, the Agency may impose Sanctions on the ACHN if the Agency determines, in its sole discretion, that the ACHN has violated any applicable federal or State law or regulation, the Alabama Medicaid State Plan, the RFP, any policies, procedures, written interpretations, or other guidance of the Agency, or for any other applicable reason described in 42 C.F.R. Part 438, Subpart I or Alabama Medicaid Administrative Code Chapter 37, including, but not limited to, a determination by the Agency that a ACHN acts or fails to act as follows:

a. Acts to discriminate among EIs on the basis of their health status or need for health care services (including termination of enrollment or refusal to reenroll an EI, except as permitted under the Alabama Medicaid program, or any practice that would reasonably be expected to discourage enrollment by EIs whose medical condition or history indicates probable need for substantial future medical services);

b. Misrepresents or falsifies information that it furnishes to Agency or to CMS;

c. Misrepresents or falsifies information that it furnishes to an EI, Potential EI, or health care Provider;

d. Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved in writing by the Agency or that contain false or materially misleading information;

e. Fails to submit a Corrective Action Plan (CAP) that is acceptable to the Agency within the time period specified by the Agency's written notice or does not implement or complete the corrective action within the established time period;

f. Violates, as determined by the Agency, any requirement of sections 1932 or 1905(t) of the Social Security Act or any implementing regulations; or

g. Violates, as determined by the Agency, any applicable requirement of the Alabama Code or the Alabama Medicaid Administrative Code.

h. Unauthorized use of information.

i. Failure to safeguard confidential information of Providers, EIs or the Medicaid program.

The Sanctions imposed by the Agency against the ACHN are as follows:

a. Requiring the ACHN to develop and implement a CAP that is acceptable to the Agency;

b. The intermediate Sanctions described in 42 U.S.C. § 1396u-2(e)(2) and 42 C.F.R. Part 438, Subpart I, including but not limited to civil monetary penalties up to the maximum amounts set forth in 42 C.F.R. § 438.704;

c. Grant EIs the right to disenroll without cause (the Agency may notify the affected EIs of their right to disenroll);

d. Suspend all new enrollment, including auto-assignment, after the date HHS or the Agency notifies the ACHN of a determination of a violation of any requirement under Sections 1932 or 1905(t) of the Social Security Act;

e. Suspend payment for EIs enrolled after the effective date of the Sanction until CMS or the Agency is satisfied that the reason for the imposition of the Sanction no longer exists and is not likely to recur;

f. For acts or omissions which are not addressed by 42 C.F.R. Part 438, Subpart I, other provisions of Alabama Medicaid Administrative Code Chapter 37, or the Contract, RFP, and appendices thereto, and which, in the opinion of the Agency, constitute willful, gross, or fraudulent misconduct, the assessment of a monetary penalty amount up to $100,000 per act or omission;

g. Any other Sanction available under federal or State law or regulation, including without limitation Alabama Medicaid Administrative Code Rule 560-X-37-.01;

h. Termination of the Contract, in accordance with Section IX.K. of this RFP; and

i. Any other Sanction reasonably designed to remedy noncompliance and/or compel future compliance with the Contract or federal or State law or regulation, pursuant to the Agency's authority under 42 C.F.R. § 438.702(b), including but not limited to:

Table 7. ACHN Sanctions

Contract Section	Performance Standard	Intermediate Sanction
Section II. M.1.e., II.M.1.f. and II.V.6.	● Distribution of unapproved marketing material or those that contain false or materially misleading information.	● Up to $25,000 for each determination
Section II. M.1.i.	● Unauthorized use of information	● Up to $25,000 for each determination
Section II. M.1.j.	● Failure to safeguard confidential information of Providers, EIs or the Medicaid program.	● Up to $25,000 for each determination
Section II. .M.1.d.	● Misrepresents or falsifies information furnished to the Agency or CMS.	● Up to $100,000 for each determination.
Section II.M.2.a.	● Failure to submit an acceptable CAP	● Up to $1,000 per instance

Section II.M.1.g.	● Failure to comply with the Agency approved CAP	● Up to $1,000 per instance
Section II.S.2.a., and Exhibit F.4.b.	● Failure to deliver quarterly reports as defined by the RFP by the date specified	● Up to $100 per day for each day delinquent per report or review
Section II.S.2.b.i.	● Failure to provide reports as required by the RFP regarding PCP and DHCP participation	● Up to $100 per day for each day delinquent
Section II. U.1.a.	● Failure to input Maternity Data for each EI with a 95% accuracy rate into the Health Information System/Database	● Up to $100 per instance
Section II. U.2.	● Failure to meet technical requirements	● Up to $1,000 per instance
Section II. I.1.f.	● Failure to maintain adequate case load levels necessary to perform the requirements of the Contract	● Up to $1,000 per instance
Section II. I.1.g.	● Insufficient or absence of Care Coordination documentation	● Up to $500 per instance
Section II.M.1.c. and II.O.1.	● Discriminate based on health status or need for health care services	● Up to $25,000 per instance
Section II.U.1.a.	● Failure to input Care Coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database	● Up to $100 per instance
Section II.V.	● Noncompliance with requirements for the EI services telephone line	● Up to $500 per instance

Section XIII: Conclusion

AMA has taken a comprehensive approach to monitoring and evaluating the quality and effectiveness of the ACHN Program as a transformative quality improvement and care coordination program. The Quality Strategy is an evolving plan that incorporates quality assurance monitoring and ongoing quality improvement processes to coordinate, assess, and continually improve the delivery of quality care and services to enrollees. The Quality Strategy will evolve as the program continues to grow, more data are available and AMA gathers additional feedback from stakeholders, beneficiaries, providers and State agencies. The ACHNs, and AMA are committed to appropriately updating the Quality Strategy as the program develops, and to using the Quality Strategy as an important tool and roadmap for continuous quality improvement.

Attachment A. PCP Quality Measures[4]

ACHN Provider Quality Measures

PROVIDER MEASURES				
Measure		**Measure Description**	**State-wide Baseline**	**Benchmark**
1	W34-CH	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	**61.1%**	**66.7%**
2	AWC-CH	Adolescent Well-Care Visits	**43.0%**	**45.0%**
3	CIS-CH	Childhood Immunization Status (Combo 3)	**70.5%**	**74.0%**
4	IMA-CH	Immunizations for Adolescents (Combo 2)	**20.4%**	**24.6%**
5	AMM-AD	Antidepressant Medication Management (Continuation Phase)	**29.6%**	**37.1%**
6	HA1C-AD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	**73.4%**	**83.3%**
7	FUA-AD	Follow-Up after Emergency Department Visit for Alcohol and other Drug Abuse or Dependence (30 days)	**11.4%**	**12.4%**
8	CHL-AD	Chlamydia Screening in Women Ages 21 - 24	**9.7%**	**54.3%**

4 https://medicaid.alabama.gov/documents/2.0_Newsroom/2.5_Media_Library/2.5.1_Slide_Presentations/2.5.1_ACHN-Related/2.5.1_Initial_Recommended_Quality_Measures_8-31-15.pdf

Attachment B. ACHN Quality Incentive Program Measures

Alabama Coordinated Health Networks Baselines

Measure	Region	Baseline 2013 - 2017	Baseline 2018	Annual Improvement Targets				Quality Target 2024	National Benchmark	Annual Improvement Needed
				2020	2021	2022	2023			
Well-Child Visits in the First 15 Months of Life	Central	60.3	N/A	60.6	60.9	61.2	61.5	61.8	Median	0.30
	East	*62.9*	N/A	*61.8*	*61.8*	*61.8*	*61.8*	*61.8*	Median	-0.22
	Jefferson / Shelby	50.3	N/A	52.6	54.9	57.2	59.5	61.8	Median	2.30
	Northeast	61.7	N/A	61.7	61.7	61.8	61.8	61.8	Median	0.02
	Northwest	53.2	N/A	54.9	56.6	58.4	60.1	61.8	Median	1.72
	Southeast	*64.2*	N/A	*61.8*	*61.8*	*61.8*	*61.8*	*61.8*	Median	-0.48
	Southwest	53.1	N/A	54.8	56.6	58.3	60.1	61.8	Median	1.74
	Statewide Avg	57.8	N/A	58.6	59.4	60.2	61.0	61.8	Median	0.80
Adult BMI Assessment	Central	22.8	N/A	33.5	44.2	55.0	65.7	76.4	Median	10.72
	East	28.8	N/A	38.3	47.8	57.4	66.9	76.4	Median	9.52
	Jefferson / Shelby	30.9	N/A	40.0	49.1	58.2	67.3	76.4	Median	9.10
	Northeast	28.4	N/A	38.0	47.6	57.2	66.8	76.4	Median	9.60
	Northwest	28.9	N/A	38.4	47.9	57.4	66.9	76.4	Median	9.50
	Southeast	38.8	N/A	46.3	53.8	61.4	68.9	76.4	Median	7.52
	Southwest	22.0	N/A	32.9	43.8	54.6	65.5	76.4	Median	10.88
	Statewide Avg	28.4	N/A	38.0	47.6	57.2	66.8	76.4	Median	9.60
Child BMI Assessment	Central	6.5	N/A	17.4	28.3	39.2	50.1	61.0	Median	10.90
	East	6.7	N/A	17.6	28.4	39.3	50.1	61.0	Median	10.86
	Jefferson / Shelby	8.6	N/A	19.1	29.6	40.0	50.5	61.0	Median	10.48
	Northeast	12.1	N/A	21.9	31.7	41.4	51.2	61.0	Median	9.78
	Northwest	4.4	N/A	15.7	27.0	38.4	49.7	61.0	Median	11.32
	Southeast	13.3	N/A	22.8	32.4	41.9	51.5	61.0	Median	9.54

	Southwest	5.8	N/A	16.8	27.9	38.9	50.0	61.0	Median	11.04
	Statewide Avg	8.2	N/A	18.8	29.3	39.9	50.4	61.0	Median	10.56
Cervical Cancer Screening	Central	43.4	N/A	44.3	45.2	46.2	47.1	48.0	25th %ile	0.92
	East	37.1	N/A	39.3	41.5	43.6	45.8	48.0	25th %ile	2.18
	Jefferson / Shelby	39.1	N/A	40.9	42.7	44.4	46.2	48.0	25th %ile	1.78
	Northeast	33.7	N/A	36.6	39.4	42.3	45.1	48.0	25th %ile	2.86
	Northwest	36.2	N/A	38.6	40.9	43.3	45.6	48.0	25th %ile	2.36
	Southeast	40.5	N/A	42.0	43.5	45.0	46.5	48.0	25th %ile	1.50
	Southwest	41.6	N/A	42.9	44.2	45.4	46.7	48.0	25th %ile	1.28
	Statewide Avg	39.5	N/A	41.2	42.9	44.6	46.3	48.0	25th %ile	1.70
Asthma Medication Ratio (Child)	Central	*85.2*	N/A	*74.4*	*74.4*	*74.4*	*74.4*	*74.4*	75th %ile	-2.16
	East	*82.6*	N/A	*74.4*	*74.4*	*74.4*	*74.4*	*74.4*	75th %ile	-1.64
	Jefferson / Shelby	*77.6*	N/A	*74.4*	*74.4*	*74.4*	*74.4*	*74.4*	75th %ile	-0.64
	Northeast	*79.2*	N/A	*74.4*	*74.4*	*74.4*	*74.4*	*74.4*	75th %ile	-0.96
	Northwest	*77.3*	N/A	*74.4*	*74.4*	*74.4*	*74.4*	*74.4*	75th %ile	-0.58
	Southeast	*83.2*	N/A	*74.4*	*74.4*	*74.4*	*74.4*	*74.4*	75th %ile	-1.76
	Southwest	70.9	N/A	71.6	72.3	73.0	73.7	74.4	75th %ile	0.70
	Statewide Avg	*79.9*	N/A	*74.4*	*74.4*	*74.4*	*74.4*	*74.4*	75th %ile	-1.10
Asthma Medication Ratio (Adult)	Central	*58.9*	N/A	*58.8*	*58.8*	*58.8*	*58.8*	*58.8*	75th %ile	-0.02
	East	56.8	N/A	57.2	57.6	58.0	58.4	58.8	75th %ile	0.40
	Jefferson / Shelby	52	N/A	53.4	54.7	56.1	57.4	58.8	75th %ile	1.36
	Northeast	57.4	N/A	57.7	58.0	58.2	58.5	58.8	75th %ile	0.28
	Northwest	58.2	N/A	58.3	58.4	58.6	58.7	58.8	75th %ile	0.12
	Southeast	*63.2*	N/A	*58.8*	*58.8*	*58.8*	*58.8*	*58.8*	75th %ile	-0.88
	Southwest	57.4	N/A	57.7	58.0	58.2	58.5	58.8	75th %ile	0.28
	Statewide Avg	57.6	N/A	57.8	58.1	58.3	58.6	58.8	75th %ile	0.24
	Central	24.5	N/A	27.0	29.5	32.1	34.6	37.1	Median	2.52
	East	32.7	N/A	33.6	34.5	35.3	36.2	37.1	Median	0.88

Antidepressant Medication Management	Jefferson / Shelby	27.4	N/A	29.3	31.3	33.2	35.2	37.1	Median	1.94
	Northeast	36.3	N/A	36.5	36.6	36.8	36.9	37.1	Median	0.16
	Northwest	30.9	N/A	32.1	33.4	34.6	35.9	37.1	Median	1.24
	Southeast	28.5	N/A	30.2	31.9	33.7	35.4	37.1	Median	1.72
	Southwest	26.7	N/A	28.8	30.9	32.9	35.0	37.1	Median	2.08
	Statewide Avg	30.1	N/A	31.5	32.9	34.3	35.7	37.1	Median	1.40
Live Births Less Than 2500 grams	Central	7.9	N/A	*8.6*	*8.6*	*8.6*	*8.6*	*8.6*	Median	0.14
	East	8.8	N/A	8.8	8.7	8.7	8.6	8.6	Median	-0.04
	Jefferson / Shelby	10.6	N/A	10.2	9.8	9.4	9.0	8.6	Median	-0.40
	Northeast	9.0	N/A	8.9	8.8	8.8	8.7	8.6	Median	-0.08
	Northwest	9.8	N/A	9.6	9.3	9.1	8.8	8.6	Median	-0.24
	Southeast	9.5	N/A	9.3	9.1	8.9	8.7	8.6	Median	-0.18
	Southwest	10.4	N/A	10.0	9.7	9.3	9.0	8.6	Median	-0.36
	Statewide Avg	9.5	N/A	9.3	9.1	9.0	8.8	8.6	Median	-0.18
Child Access to Care: 12 - 24 Months	Central	96.3	N/A	96.4	96.5	96.7	96.8	96.9	75th %ile	0.12
	East	*97.2*	N/A	*96.9*	*96.9*	*96.9*	*96.9*	*96.9*	75th %ile	-0.06
	Jefferson / Shelby	80.7	N/A	83.9	87.2	90.4	93.7	96.9	75th %ile	3.24
	Northeast	95.8	N/A	96.0	96.2	96.5	96.7	96.9	75th %ile	0.22
	Northwest	96.1	N/A	96.3	96.4	96.6	96.7	96.9	75th %ile	0.16
	Southeast	*97.1*	N/A	*96.9*	*96.9*	*96.9*	*96.9*	*96.9*	75th %ile	-0.04
	Southwest	95.3	N/A	95.6	95.9	96.3	96.6	96.9	75th %ile	0.32
	Statewide Avg	93.8	N/A	94.4	95.0	95.7	96.3	96.9	75th %ile	0.62
Child Access to Care: 25 Months - 6 Years	Central	88.5	N/A	88.8	89.0	89.3	89.5	89.8	75th %ile	0.26
	East	*91.6*	N/A	*89.8*	*89.8*	*89.8*	*89.8*	*89.8*	75th %ile	-0.36
	Jefferson / Shelby	72.8	N/A	76.2	79.6	83.0	86.4	89.8	75th %ile	3.40
	Northeast	88.8	N/A	89.0	89.2	89.4	89.6	89.8	75th %ile	0.20
	Northwest	86.6	N/A	86.8	87.0	87.2	87.4	89.8	75th %ile	0.64

	Southeast	*91.3*	N/A	*89.8*	*89.8*	*89.8*	*89.8*	*89.8*	75th %ile	-0.30
	Southwest	85.2	N/A	86.1	87.0	88.0	88.9	89.8	75th %ile	0.92
	Statewide Avg	86.1	N/A	86.8	87.6	88.3	89.1	89.8	75th %ile	0.74
Child Access to Care: 7 - 11 Years	Central	89.8	N/A	90.5	91.2	92.0	92.7	93.4	75th %ile	0.72
	East	*94.4*	N/A	*93.4*	*93.4*	*93.4*	*93.4*	*93.4*	75th %ile	-0.20
	Jefferson / Shelby	74.9	N/A	78.6	82.3	86.0	89.7	93.4	75th %ile	3.70
	Northeast	92.4	N/A	92.6	92.8	93.0	93.2	93.4	75th %ile	0.20
	Northwest	89.9	N/A	90.6	91.3	92.0	92.7	93.4	75th %ile	0.70
	Southeast	*94.0*	N/A	*93.4*	*93.4*	*93.4*	*93.4*	*93.4*	75th %ile	-0.12
	Southwest	88.3	N/A	89.3	90.3	91.4	92.4	93.4	75th %ile	1.02
	Statewide Avg	88.9	N/A	89.8	90.7	91.6	92.5	93.4	75th %ile	0.90
Child Access to Care: 12 - 19 Years	Central	86.8	N/A	87.8	88.8	89.9	90.9	91.9	75th %ile	1.02
	East	91.3	N/A	91.4	91.5	91.7	91.8	91.9	75th %ile	0.12
	Jefferson / Shelby	73.0	N/A	76.8	80.6	84.3	88.1	91.9	75th %ile	3.78
	Northeast	88.9	N/A	89.5	90.1	90.7	91.3	91.9	75th %ile	0.60
	Northwest	87.9	N/A	88.7	89.5	90.3	91.1	91.9	75th %ile	0.80
	Southeast	91.5	N/A	91.6	91.7	91.7	91.8	91.9	75th %ile	0.08
	Southwest	87.0	N/A	88.0	89.0	89.9	90.9	91.9	75th %ile	0.98
	Statewide Avg	86.5	N/A	87.6	88.7	89.7	90.8	91.9	75th %ile	1.08
Prenatal and Postpartum Care: Timliness of Prenatal Care	Central	49.5	N/A	55.4	61.4	67.3	73.3	79.2	Median	5.94
	East	68.1	N/A	70.3	72.5	74.8	77.0	79.2	Median	2.22
	Jefferson / Shelby	62.4	N/A	65.8	69.1	72.5	75.8	79.2	Median	3.36
	Northeast	54.1	N/A	59.1	64.1	69.2	74.2	79.2	Median	5.02
	Northwest	62.1	N/A	65.5	68.9	72.4	75.8	79.2	Median	3.42
	Southeast	64.9	N/A	67.8	70.6	73.5	76.3	79.2	Median	2.86
	Southwest	70.9	N/A	72.6	74.2	75.9	77.5	79.2	Median	1.66
	Statewide Avg	58.7	N/A	62.8	66.9	71.0	75.1	79.2	Median	4.10
	Central	N/A	34.4	35.7	37.0	38.4	39.7	41.0	75th %ile	1.32

Initiation and Engagement of Treatment for Alcohol and Other Drug (Initiation)	East	N/A	33.1	34.7	36.3	37.8	39.4	41.0	75th %ile	1.58
	Jefferson / Shelby	N/A	42.8	*41.0*	*41.0*	*41.0*	*41.0*	*41.0*	75th %ile	-0.36
	Northeast	N/A	40.2	40.4	40.5	40.7	40.8	41.0	75th %ile	0.16
	Northwest	N/A	43.8	*41.0*	*41.0*	*41.0*	*41.0*	*41.0*	75th %ile	-0.56
	Southeast	N/A	39.6	39.9	40.2	40.4	40.7	41.0	75th %ile	0.28
	Southwest	N/A	38.4	38.9	39.4	40.0	40.5	41.0	75th %ile	0.52
	Statewide Avg	N/A	38.8	39.2	39.7	40.1	40.6	41.0	75th %ile	0.44
Initiation and Engagement of Treatment for Alcohol and Other Drug (Continuation)	Central	N/A	3.0	4.5	5.9	7.4	8.8	10.3	25th %ile	1.46
	East	N/A	3.8	5.1	6.4	7.7	9.0	10.3	25th %ile	1.30
	Jefferson / Shelby	N/A	3.5	4.9	6.2	7.6	8.9	10.3	25th %ile	1.36
	Northeast	N/A	5.2	6.2	7.2	8.3	9.3	10.3	25th %ile	1.02
	Northwest	N/A	6.0	6.9	7.7	8.6	9.4	10.3	25th %ile	0.86
	Southeast	N/A	5.6	6.5	7.5	8.4	9.4	10.3	25th %ile	0.94
	Southwest	N/A	3.7	5.0	6.3	7.7	9.0	10.3	25th %ile	1.32
	Statewide Avg	N/A	4.4	5.6	6.8	7.9	9.1	10.3	25th %ile	1.18