Alabama Coordinated Health Network (ACHN) Quality Strategy

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Section I: Introduction

The Alabama Medicaid Agency (Agency) began operations on January 1, 1970 and is a state and federally funded program that pays for medical and long-term care services for low-income pregnant women, children, certain people on Medicare, disabled individuals, Plan First (Family Planning) 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 2021, the Alabama Medicaid program provided health care services to nearly 54% percent of children statewide and 26% 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 $7.7 billion in Fiscal Year 2021.

As the Medicaid population continues to grow in the State of Alabama, the Agency has taken the initiative to create a more efficient and effective way to serve its Medicaid eligible individuals. The Agency evaluated its managed care programs, previously acting in a standalone manner, and took the approach of creating and implementing a coordinated care health network in order to better monitor, serve, and treat actively enrolled Medicaid participants, ultimately improving the quality of care. Medicaid recipients that participate in the coordinated health network fall into the following eligibility categories:

- Plan First recipients (women ages 19-55 and men 21 and older);
- Maternity Care recipients;
- Blind/Disabled children and adults;
- Aged and related populations;
- Children under age 19;
- Parents or other caretaker relatives (POCR);
- Foster children;
- Former Foster Care;
- Breast and Cervical Cancer; and
- American Indians (note: may opt-out at any time).

In order to create a more effective managed care program with a defined purpose and improve the quality of care, while using resources efficiently, it is important to understand the previous managed care programs and the history associated with each program.

History of Managed Care in Alabama

The Agency previously operated statewide Maternity Care, Patient 1st, Health Home, and Plan First programs for Alabama's Medicaid Eligible Individuals (EIs). Care coordination services were 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 programs are as follows:

Maternity Care Program

The Alabama Maternity Care program was a statewide program established in 1988 under the 1915(b) Waiver authority designed 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 was 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 subcontracted with healthcare providers for the provision of prenatal, delivery and postpartum care. Two districts were not under the District Plan and maternity services were paid fee-for-service (FFS) to the provider of the services. Primary contractors were paid a capitated payment for each delivery. Some services were outside the capitated payment methodology and were 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 ended September 30, 2019. Care coordination services are currently 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.

The Agency monitored the Maternity Care program through statewide quality measures, medical record reviews and administrative reviews. The Agency 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%

Measure	Benchmark
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 was a Primary Care Case Management (PCCM) Program that served more than 600,000 participants. Since its launch in 2004, Patient 1st had 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 provided patient-centered, quality-focused care by creating a medical home for each Medicaid recipient. Each recipient had a primary medical provider (PMP) who provided or arranged the recipient's health care needs. The Patient 1st program ended September 30, 2019. Care coordination services are currently 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. Medicaid's Health Home Program was a Section 2703 approved Health Home Program that integrated and coordinated care for patients with certain chronic conditions to achieve improved health outcomes. The Health Home program added additional support to Patient 1st PMPs by intensively coordinating care for patients who had or were at risk of having chronic conditions including:

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

Health Homes connected patients with needed resources, teaching self-management skills, providing transitional care, and bridging medical and behavioral health services. The Health Home Program ended September 30, 2019. Care coordination services are currently 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)[1]

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
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

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

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 are still provided by Alabama Department of Public Health (ADPH) or any other Plan First enrolled provider. The care coordination component of Plan First is now provided by the Alabama Coordinated Health Network Program.

Medicaid Transformation in Alabama

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

Alabama Coordinated Health 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 was 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 use is a national crisis, and we have much work to do on this issue in Alabama.

The Agency proposed a system transformation that included 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 (PCCM) entities 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 established the Alabama Coordinated Health Network (ACHN) statewide in 2019 to streamline and increase access to care coordination for Medicaid eligible individuals. Seven Regions were 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, Medicaid in partnership with the ACHN Program can more effectively manage the total cost of care and improve health outcomes. 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 One Health Record®. The ACHNs 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 ACHN 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 (2021) (Heart Disease Deaths per 100,000)	247.5	173.8
Mental Health (2021) (Percent of Adults with Poor Mental Health)	39.6	39.5
Diabetes (2021) (Percent of Adults who Ever Had Diabetes)	17.4	12.6
Cardiovascular Disease (2021) (Percent of Adults with Cardiovascular Disease)	10.0	7.1
Asthma Prevalence (2021) (Percent of Adults with Self-Reported Asthma)	9.8	9.6
Smoking (2021) (Percent of Adults who Smoke)	14.8	12.4
Body Mass Index (BMI) (2021)		
(Percent of Adults who are Obese, BMI >=30)	39.0	32.8
(Percent of Overweight or Obese Children, Ages 10-17)	35.0	34.0
Cancer (2021) (Cancer Deaths per 100,000)	160.2	146.6

Condition (Health Status Measure)	Alabama	National
Maternity		
(Teen Birth Rate per 1,000 ages 15-19) (2021)	22.9	13.9
(Infant Mortality Rate per 1,000) *2020 data	7.0	5.4

Source: Kaiser Family Foundation State Health Status Data (2021)

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, higher rates of avoidable emergency department utilization, preventable admissions and readmissions and poorer health outcomes statewide. The state experiences higher than average inpatient admissions and emergency department visits. However, those numbers have decreased in the state compared to 2017. In addition, the state has fewer office (outpatient) visits compared to the national average. The number of outpatient visits in 2021 were lower in comparison to 2017. 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	119	96
Hospital Emergency Department Visits per 1,000 Population	411	383
Hospital Outpatient Visits per 1,000 Population	1,714	2,367
Percent of Adults Reporting Not Seeing a Doctor in the Past 12 Months Because of Cost	8.6	8.7
Percent of Adults Reporting Not Having a Personal Doctor	12.0	14.0
Percent of Adults Reporting Any Mental Illness in the Past Year (2018-2019)	21.3	19.9
Percent of Individuals Reporting Alcohol Dependence or Abuse in the Past Year (2018-2019) Adults Age 18+	5.7	5.7

Kaiser Measure	Alabama	National
Percent of Individuals Reporting Illicit Drug Dependence or Abuse in the Past Year (2018-2019) Adults Age 18+	3.1	3.0
Opioid Overdose Deaths as a Percent of All Drug Overdose Deaths	70%	75%

Source: Kaiser Family Foundation State Health Status Data (2021)

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 fifth poorest state in the country, nearly 16 percent of Alabama residents live at or below the Federal Poverty Level (FPL) compared to 13.4 percent in the nation.[2] This has led to an increase in Medicaid enrollment from 750,000 in 2008 to over 1.1 million in 2021. 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 $7.7 billion in 2021. This is leading to an unsustainable rate of health care costs in Alabama.

[2] 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 2019 American Community Survey, "America's Richest (and Poorest) States." May 10, 2021. Available at: https://247wallst.com/special-report/2021/05/10/americas-richest-and-poorest-states-11/

Section II: Goals and Objectives for Continuous Quality Improvement

The Agency is contracting with the ACHNs, which are responsible for managing the quality of Medicaid services and related care coordination for defined populations. We will 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.

The ongoing use of care coordination tenets that are central to the ACHN Program will drive quality improvements, while potentially decreasing the rate of expenditure growth for Medicaid in the long term. In addition, an ACHN will work to align all members to a primary care provider (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.

As mentioned earlier, Alabama has room to improve in the areas of maternity outcomes, obesity, and substance use. Therefore, at a minimum, ACHNs must develop Quality Improvement Projects (QIPs) to address the following: prevention of childhood obesity; infant mortality/adverse birth outcomes; and substance use disorders. QIPs will be discussed later.

The table below presents Strategy goals and objectives established by the state to improve health outcomes among the state's Medicaid population through the ACHN Program.

Objective	Objective description	Quality measure	Statewide performance baseline (year)	Statewide performance target for objective (year)
Goal 1: Improve access to quality, cost-effective coordinated care for enrollees				
1.1	Increase percentage of children 0-15 months who had 6+ well child visits in the measurement year	Well child visits in the first 15 months of life (W15-CH)	52.8% (2021)	60.2% (2022)
1.2	Increase percentage of children 12-24 months who had a visit with a PCP in the measurement year	Children and Adolescents' Access to Primary Care Practitioners (CAP-CH1)	86.4% (2021)	95.7% (2022)
1.3	Increase percentage of children 25 months - 6 years who had a visit with a PCP in the measurement year	Children and Adolescents' Access to Primary Care Practitioners (CAP-CH2)	81.7% (2021)	88.3% (2022)
1.4	Increase percentage of children 7-11 years who had a visit with a PCP in the measurement year	Children and Adolescents' Access to Primary Care Practitioners (CAP-CH3)	85.9% (2021)	91.6% (2022)
1.5	Increase percentage of children and adolescents 12-19 years who had a visit with a PCP in the measurement year	Children and Adolescents' Access to Primary Care Practitioners (CAP-CH4)	83.9% (2021)	89.7% (2022)

Goal 2: Improve maternal and infant health of enrollees at risk for adverse birth outcomes				
2.1	Increase percentage of mothers receiving timely prenatal care in the measurement year	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	75.5% (2021)	*79.2% (2024)
2.2	Decrease percentage of live births weighing less than 2,500 grams for infants born to mothers during the measurement year	Live births weighing less than 2,500 grams (LBW-CH)	11.3% (2021)	9.0% (2022)
Goal 3: Improve health of enrollees with childhood obesity				
3.1	Increase percentage of children 3-17 years who had an outpatient visit and BMI percentile documentation during the measurement year	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	95.9% (2021)	**TBD (2024)
Goal 4: Improve behavioral health of enrollees with substance use disorder				
4.1	Increase percentage of enrollees who timely initiate treatment for AOD (within 14 days of diagnosis)	Initiation and Engagement of Treatment for AOD - Initiation (IET-AD)	34.9% (2021)	40.1% (2022)
4.2	Increase percentage of enrollees who initiated treatment for AOD and were timely engaged in ongoing treatment (within 34 days of the initiation visit)	Initiation and Engagement of Treatment for AOD - Continuation (IET-AD)	6.9% (2021)	7.9% (2022)

*State has met the 2022 and 2023 targets for PPC-CH. The new target is 79.2% which is the 5-year benchmark for 2024.
**State has met the 5-yr benchmark for WCC-CH and will continue to progress towards an optimal rate.

Summary

Goal 1: Improve access to quality, cost-effective coordinated care for enrollees

The National Academies of Sciences, Engineering, and Medicine define access to care as "timely use of personal health services to achieve the best possible health outcomes."[3] The ACHN Program was established to streamline and increase access to care coordination for enrollees. One way to achieve this is to facilitate timeliness of key health activities (e.g., Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings, early entry to prenatal care, care for substance use disorder).

Well Child Visit (EPSDT)

The purpose of the EPSDT program is to find children with actual or potential health problems and to screen, diagnose, and treat the problems before they become permanent, lifelong disabilities. The program also offers preventive health services to Medicaid-eligible children under

[3] Institute of Medicine (U.S.) Committee on Monitoring Access to Personal Health Care Services. (1993). Access to health care in America (M. Millman, Ed.). National Academies Press.

21 years of age. The goal for ACHN care coordination services for EPSDT is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services throughout childhood. The ACHN care coordination services are available to any provider, at no cost, who wishes to benefit from effective intervention. These Medicaid eligible recipients will then be targeted for outreach. The Agency aims to provide effective outreach services for Medicaid-eligible recipients. EPSDT outreach efforts are targeted at two groups: (a) new Medicaid recipients and (b) all Medicaid-eligible recipients under 21 years of age who have not had a well child screening in the last 12 months. The recipients are informed annually about EPSDT services through an outreach letter and are encouraged to make an appointment for an EPSDT screening. In addition, well child visits are an essential part of preventive care and needed services that increases overall wellness and reduces the cost of care. The American Academy of Pediatrics and Bright Futures recommend nine well-care visits by the time a child turns 15 months of age. For the measure, *Well-child Visits in the First 15 months of Life*, there was a decrease in the percentage of children who turned 15 months old during the measurement year (MY) who had six or more well child visits with a PCP in MY 2021 (52.8%) compared to MY 2020 (54.6%). For the measure, *Children and Adolescents' Access to Primary Care Practitioners*, the State did not meet annual targets for any of the age categories in MY 2021 and has shown a decline in performance in three of four age categories compared to MY 2020. The Agency will continue to work with the ACHNs to improve these rates in 2022 and beyond by identifying and addressing access issues faced by EIs particularly in rural communities. In addition, the Agency will encourage collaborative partnerships and work with Providers to understand and mitigate barriers faced when providing care to EIs.

Telehealth/Telemedicine

To promote accessibility to services, all physicians with an Alabama license enrolled as a provider with the Alabama Medicaid Agency are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. Providers are expected to comply with the Alabama Telehealth Medical Services law (Code of Alabama, Sections 34-24-701 through 34-24-707) at all times. Services must be administered via an interactive audio or audio and video telecommunications system which permits two-way communication between the distant site provider and the site where the recipient is located (this does not include electronic mail message or facsimile transmission between the provider and recipient). Per Alabama law, the provision of telemedicine medical services is deemed to occur at the patient's originating site within the state. Telemedicine health care providers shall ensure that the telecommunication technology and equipment used is sufficient to allow the health care provider to appropriately evaluate, diagnose, and/or treat the recipient for services billed to Medicaid and is HIPAA compliant. Telemedicine providers who render maternity related services must sign a Delivering Healthcare Professional (DHCP) agreement with an ACHN to receive reimbursement from Medicaid. During the Public Health Emergency (PHE), telemedicine was made accessible to mostly all appropriate medical services for Medicaid recipients. Providers receive ongoing updates on procedures, claims and billing information. The Agency reviews and verifies that all requirements for the extension of telemedicine services are being met and recoups payments made to Providers that do not meet specifications.

Agency's Telemedicine Policy:
https://medicaid.alabama.gov/documents/4.0_Programs/4.1_Covered_Services/4.1_Telemedicine_Policy_Updated_5-26-23.pdf

Goal 2: Improve maternal and infant health of enrollees at risk for adverse birth outcomes

Adverse birth outcomes include preterm births (less than 37 weeks of gestation) and low birth weight (less than 5.5 pounds or 2,500 grams). Studies show that adverse birth outcomes are likely associated with factors such as age, race/ethnicity, socioeconomic status, and type of health insurance (public or private). According to the Alabama Department of Public Health (ADPH), over 1 out of every 10 births in Alabama were babies born with low birth weights. Further, the infant mortality rate in 2020 was 7.0 deaths per 1,000 births ranking Alabama at 45th in the nation. This rate was an improvement from 2019 – (Alabama ranked 47th at 7.7 deaths per 1,000 births). Suggested strategies to improve pregnancy outcomes include breastfeeding which can reduce the risk of health conditions for both infant and mother, and family planning to help reduce unexpected pregnancies particularly in teen mothers.

Maternity Outcomes

Medicaid covers over half of the births in the state. The Agency aims to reduce undesirable maternity outcomes by using the ACHNs to implement appropriate interventions through their infant mortality/adverse birth outcomes QIP. Some examples of interventions include diabetes prevention among pregnant women, bio-monitoring activities, providing blood pressure cuffs to monitor hypertension, promoting smoking cessation, incentive packets to increase prenatal and postpartum care visits, sexual/reproductive health curriculum in high schools and middle schools, and breastfeeding education. In addition, ACHNs provide maternity and family planning care coordination services to enrollees accepting services. For the measure, *Live births less than 2,500 grams*, there was a slight increase in low-birth-weight deliveries in MY 2021 (11.3%) compared to MY 2020 (11.2%). The Agency will continue to work with Providers and the ACHNs to improve these rates in 2022 and beyond. For the measure, *Prenatal and Postpartum Care: Timeliness of Prenatal Care,* the state has surpassed the target goals for MY 2022 (71.0%) and MY 2023 (75.1%) in that 75.5% of delivering mothers received a prenatal care visit in their first trimester in MY 2021. Therefore, the next goal is set to reach the 5-year benchmark (79.2%) in MY 2024. To help improve maternal health, Medicaid evaluates the usage of benefits and maternal health outcomes (e.g., screening for clinical depression, decreasing the prevalence of hypertension and diabetes during pregnancy, and increasing the rate of contraceptive care) all aspects of inclusive postpartum care. Effective October 1, 2022, Medicaid extended postpartum coverage for pregnant recipients to 12 months after end of pregnancy. With this extension (previously 60 days), there are increased opportunities for support to the recipient through the adjustment of caring for a new baby.

Goal 3: Improve health of enrollees with childhood obesity

Childhood obesity is a serious health concern. According to the Centers for Disease Control and Prevention (CDC), childhood obesity now affects 1 in 5 children and adolescents in the United States. Obesity in childhood and adolescence puts those affected at risk for poor health outcomes in their adult life. Children are considered obese when their body mass index (BMI) is at or above the 95th percentile based on sex and age. Children who are defined as overweight, have a BMI between the 85th and 95th percentile.

Childhood Obesity

In 2019-2020, Alabama ranked the 5th highest state for obesity in children ages 10-17 at a rate of 21.8%. The Agency aims to decrease these rates by using the ACHNs to implement appropriate interventions through their prevention of childhood obesity QIP. Some examples of interventions include promoting well-child visits; distributing MyPlate educational materials; food gardens in

schools; activities to promote healthy lifestyle changes, physical activity, and nutrition counseling through a licensed Dietician; food box distribution program that includes healthy recipes for families, cultures, and ethnicities (i.e., African American and Hispanic minority populations). For the measure, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, 95.9% of children 3-17 years of age who had an outpatient visit with a PCP or OB/GYN in MY 2021 also had evidence of BMI percentile documentation. This was an increase from MY 2020 which had a rate of 93.7%. In recent years, there has been an increasing effort encouraging providers to record the BMI of patients. Rates have continued to improve each year. We anticipate large rate increases every year until an optimal rate is reached.

Goal 4: Improve behavioral health of enrollees with substance use disorder

The National Institute of Mental Health describes a substance use disorder (SUD) as a treatable mental disorder that affects a person's brain and behavior that can lead to an inability to control their use of substances such as drugs or alcohol. According to the 2021 National Survey on Drug Use and Health (NSDUH), 40 million Americans, aged 12 or older, had a substance use disorder in the past year. Substance use disorders continue to be an important health issue in the United States. SUD can lead to reduced health outcomes both directly and indirectly related to the disorder itself, including death by overdose. The drug overdose death rate for Alabama in 2021 is 30.1 per 100,000 population (CDC, National Center for Health Statistics).

Substance use disorder

The Agency addresses substance use disorder by using the ACHNs to implement appropriate interventions through their substance use disorder QIP. Some examples of interventions include use of peer support specialists, SUD education and resources, transportation assistance to treatment facilities particularly in rural areas, partnering with area schools to educate students on substance use, and provider education to reduce stigma. By determining the barriers to timely care after a SUD diagnosis, the ACHNs will be able to address the needs of this population more effectively. For the measure*, Initiation and Engagement of Treatment for Alcohol and Other Drugs (Initiation),* 36.7 % of EIs initiated treatment within 14 days of the SUD diagnosis in MY 2020. For the Continuation phase of this measure, 4.7% of EIs who initiated treatment also were engaged in ongoing treatment within 34 days of the initiation visit. There was a significant change in rates for MY 2021 in that only 34.9% initiated treatment timely while 6.9% were engaged in timely ongoing treatment. The Agency will continue to work with Providers, ACHNs and community partners to improve these rates in 2022 and beyond.

In 2017, Governor Kay Ivey signed Executive Order 708 to establish the Alabama Opioid Overdose and Addiction Council to combat Alabama's opioid crisis. The Council is comprised of over 100 stakeholders and community members. There are seven Council subcommittees with representatives from Alabama Medicaid and the ACHNs as members. Over the last five years, the Council has studied the state's current opioid crisis and identified strategies to reduce the number of deaths and other adverse consequences of the opioid crisis. Alabama is committed to building on the state's efforts to fight opioid addiction by taking actions to reduce inappropriate opioid prescribing and dispensing; increase public awareness about naloxone distribution and access; ensure a pathway to recovery for individuals with substance use disorder; and provide vital resources to all Alabamians living with substance use disorders, including their family members, community providers and healthcare, and law enforcement professionals.

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 and beyond, the ACHN has 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 3 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 below.

    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).

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 CY17-19 data in each Region. The average of the rates over these three (3) 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 CY25, 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 CY29.

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 79 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 participating 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 2,500
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

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, then the PCP/PCP group can quality for a PCP Bonus 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. The 25th or 75th percentile or the median were chosen.

Provider Profiler Narrative

The Alabama Medicaid Agency's Analytics Division is responsible for generating each provider within the state a scorecard that will allow the provider to view and replicate, if desired, his or her quality, cost effectiveness, and/or Patient-Centered Medical Home (PCMH) recognition bonus payment as part of the provider's overall Primary Care Physician (PCP) Bonus Payment.

The PCP Bonus Payment is comprised of three sections as mentioned above. Quality accounts for 50% of the bonus, Cost Effectiveness accounts for 45% of the bonus, and Patient-Centered Medical Home Recognition accounts for the last 5% of the bonus. In addition, this bonus is awarded on a quarterly basis with a $15 million annual limit.

With the transitioning of programs, all participating *and* eligible providers will receive their full PCP Bonus Payment until a specified period in which the bonus will then be calculated based on the provider's performance.

Attribution, the assignment of a recipient to a participating provider/provider group, is the key mechanism in calculating a PCP Bonus Payment and the first step in calculating a payment.

Attribution, briefly defined, takes into account the 24-month claims history of a recipient, and based on a scoring mechanism, assigns a PCP or eligible provider based on a calculated point value. This calculation is completed on a quarterly basis as the PCP Bonus Payment is only distributed on a quarterly basis.
The first PCP Bonus Payment was awarded on November 1, 2019, which fell on the first check write of November. Going forward, these payments were awarded on the second check write of the month in which payment is received (quarterly), starting in January 2020.

PCP Bonus Payment

Quality Bonus Payment – 50%

Quality bonus rates are calculated to reward providers who meet performance criteria in eight quality measures. Based on the age group of the recipients, type of practice, number of recipients, the measures might vary by provider. A provider with only attributed children might not have any adult measures. In that case, the bonus calculations will be based on the eligible measures, and there would be 4 eligible measures for bonus calculation use. A quality measure with 10 or fewer recipients in a denominator will be excluded from the calculations. Bonuses will be determined based on the number of quality measures that meet benchmarks. If a provider group meets at least 50% of quality measures, the provider group will receive a Quality Bonus.

The Agency uses latest attributed recipient list to calculate the PCP Bonus Payment. The quality measure rates for the provider measures are calculated using the latest available quality measure rates. For example: For FY23 bonus rates calculations, the agency uses CY21 quality measures (the latest available data). The rates are compared with the benchmarks to determine whether the measure met or not-met (above or below) the measures. For the bonus calculations, only the providers with the percentage of quality measures met above or equal to 50% are considered.

The following steps take place for the Quality Bonus Payment Calculation:

1) Identify the Attributed Members of the provider practice or group,
2) Determine the Distribution Rate of Attributed Members,
    - Calculation: Members Attributed to Group/Total ACHN Attributed Members X 100.
3) Determine the Quality Score,
    - Calculation: Number of Metrics Met/Total Number of Applicable Metrics (8) X 100.
    - If at least 50% of applicable measures are met, then proceed with calculation, Step 4.
    - If at least 50% of applicable measures are not met, then a Quality Bonus Payment will not be received.
4) Calculate the new Distribution Rate to eliminate those not meeting the quality metrics,
    - Calculation: Number Attributed to Group/Attributed ACHN Members Meeting Minimum Quality Metrics X 100.
5) Calculate the Bonus Distribution Rate,
    - Calculation: Quality Score (% from Step 3) X Distribution Rate for those meeting the Quality Metrics (% from Step 4) = Bonus Distribution Rate %.
6) Calculate the normalized bonus distribution rate in order to distribute funds appropriately to utilize 100% of bonus pool,
    - Calculation: Bonus Distribution Rate (% from Step 5)/Sum of Pre-Normalized Bonus Distribution Rates for Qualifying Groups (Sum of Step 5 for Qualifying Groups).
7) Determine the Bonus Distribution Amount,

- Calculation: Normalized Bonus Distribution Rate (% from Step 6) X Quarterly Pool Amount.

Note: There are 8 defined Provider Quality Measures; 4 Child Quality Measures and 4 Adult Quality Measures. There must be at least 10 attributed recipients in the denominator of each Quality Measure for the Quality Measure to be included in a provider's calculation.

Also, note, the first calculated payment occurred in July 2021. Up until that date (i.e., the first seven quarters of program operation), the provider received a payment based on attribution.

Cost Effectiveness – 45%

The calculation for this portion of the bonus considers the number of members attributed to the provider group as well as the total number of attributed providers in the program. As discussed earlier, this information will be provided to each participating provider/provider group through a scorecard from the Agency's Analytics Division.

The following steps will take place for the Cost-Effectiveness Bonus Payment Calculation:

1) Identify the Attributed Members of the provider practice or group,
2) Determine the Distribution Rate of Attributed Members,
   - Calculation: Members Attributed to Group/Total ACHN Attributed Members X 100.
3) Identify the PCP Group PMPM* (per member per month),
   - Provided via Scorecard.
4) Identify the PCP Group Risk Score,
   - Provided via Scorecard, Calculated with Milliman Adjusted Risk Adjusters (MARA) software.
5) Calculate the Expected PMPM,
   - Calculation: PCP Group Risk Score (Identified Step 4) X Statewide PMPM (Identified on the Scorecard) = $.
6) Calculate the Cost Effectiveness Score,
   - Calculation: PCP Group PMPM (Identified in Step 3) X Expected PMPM (Identified in Step 5).
   - If this calculation is less than 1, then proceed to Step 7.
   - If this calculation is not less than 1, then a cost-effectiveness bonus will not be received.
7) Calculate the new Distribution Rate based to eliminate those that did not meet the cost-effectiveness criteria,
   - Calculation: Group's Attributed Members/Attributed ACHN Members at or below the Median Threshold = %.
8) Lastly, calculate the bonus distribution amount,
   - Calculation: Bonus Distribution Rate (% from Step 7) X Quarterly Pool Amount.

Note: The first calculated payment occurred in January 2021. For the prior five quarters, the provider received a payment based on attribution.
**Starting in April 2022, recipients with $250,000+ in cost were removed from the PMPM calculations. These recipients will still be listed in the attribution list on the Provider Profiler.*

Patient-Centered Medical Home (PCMH) – 5%

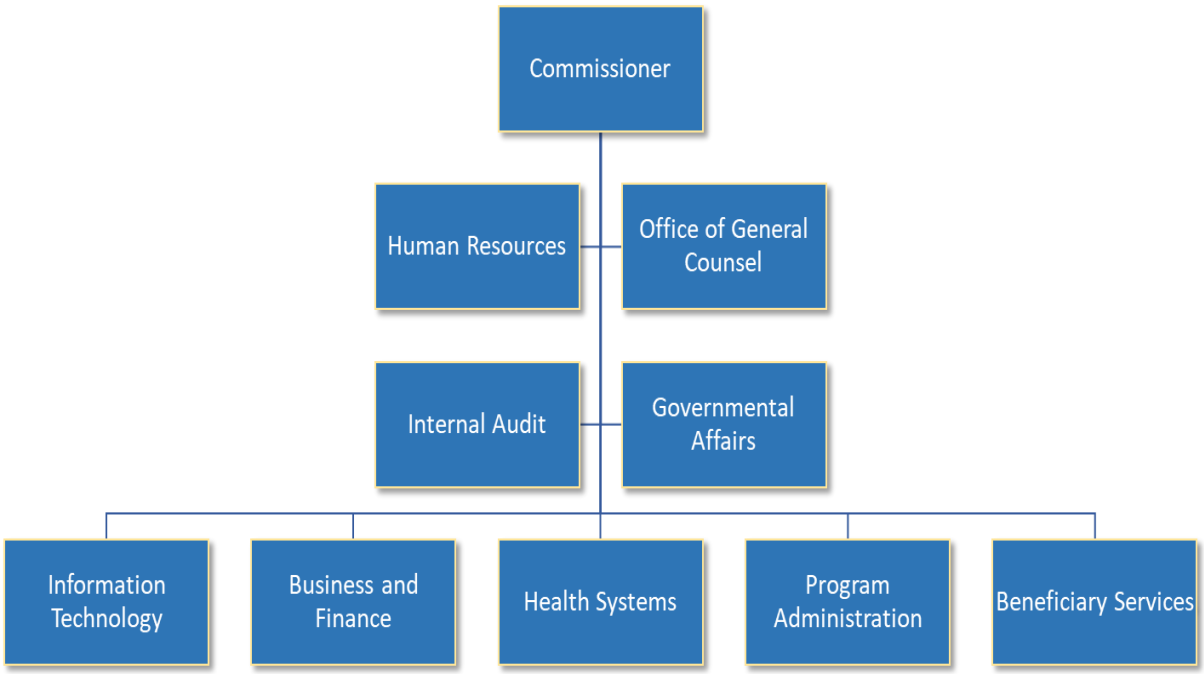
This calculation is based on attributed members and only makes up 5% of the PCP Bonus Payment. The eligible and actively participating provider must establish his or her PCMH status with the Agency in order to receive this bonus payment.

Note: The first calculated payment occurred in October 2020. Prior to that, the provider received a payment based on attribution.

Section III: Alabama Medicaid Agency Infrastructure and Organizational Support

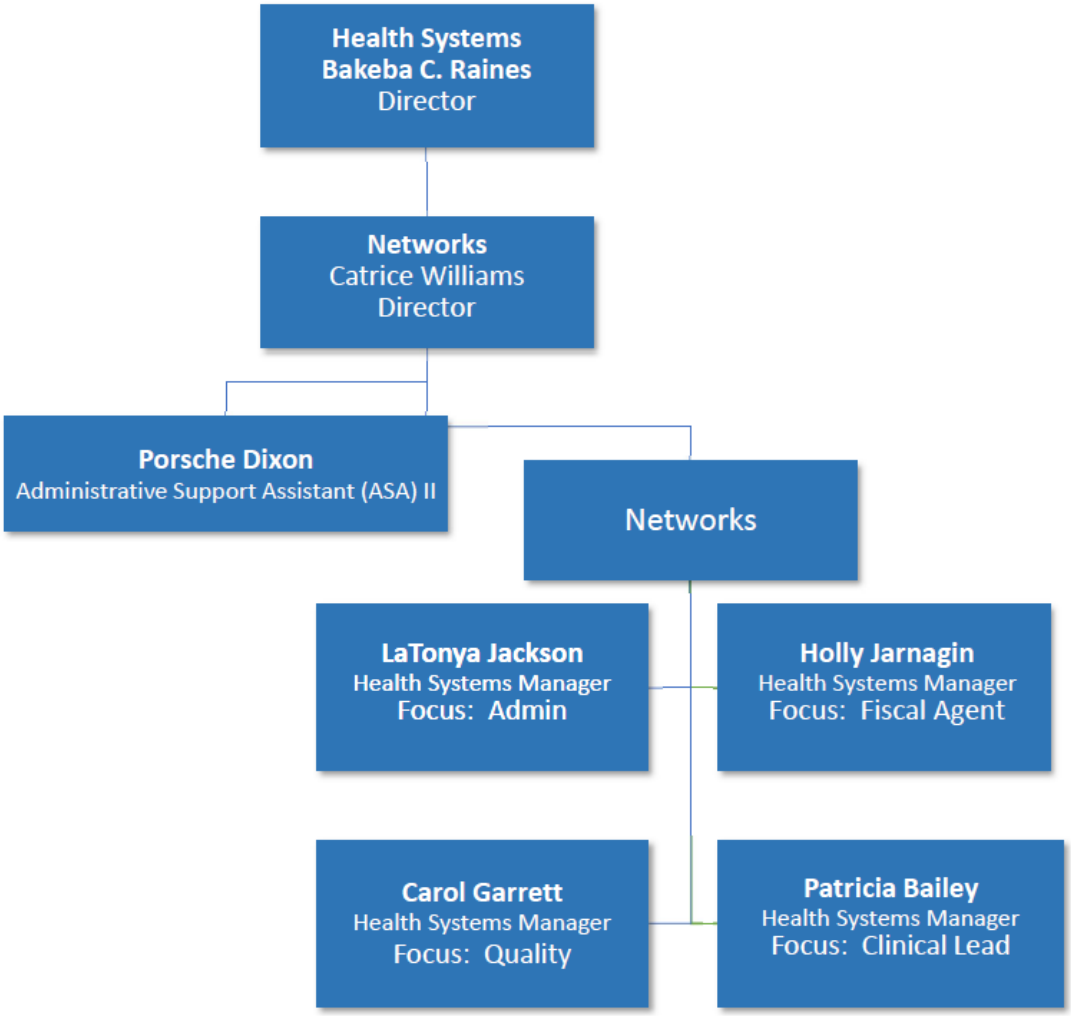
The Agency is responsible for all Medicaid programs and structured to administer, monitor and strategize across various functional areas, overseen by the Medicaid Commissioner. This organizational structure will support the State's and ACHN's quality improvement efforts by assigning dedicated staff to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

Figure 1. Alabama Medicaid Agency Organizational Structure



The Agency 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 Division is primarily responsible for ACHN oversight. See Figure 2 for the Networks Division organizational structure. It reflects modifications that the Agency 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. Networks Division Structure



Networks Division

Previously, the Agency had a specific Quality Division headed by the Deputy Commissioner and Associate Medical Director. The Division is now led by a Health Systems Director. The Agency has renamed its Networks and Quality Assurance Division to Networks Division. By combining the responsibilities of monitoring and reporting of the various programs, waiver-specific quality initiatives and the quality of services provided by Medicaid, the Agency will be able to respond to all inquiries more efficiently by sister state agencies, the Alabama Legislature, and CMS. The 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 Division will oversee contracted quality activities including annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and External Quality Review Organization (EQRO) activities. The ACHN Program is principally a quality program built on a care coordination infrastructure. The Networks Division is tasked with the day-to-day oversight

and monitoring of the ACHNs. Health Systems Manager(s) are assigned region(s) to supervise while also providing technical assistance for a particular subject matter area to all ACHNs. 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 the Agency'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, the Agency 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 12-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 Medicaid. 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 Medicaid 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 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 Health Systems Director, who oversees the policies and structure of the Networks Division, Managed Care Operations Division, and Dental, EPSDT, and Physician Division within the Health Systems Department. The Networks and Managed Care Operations organizational structure is composed of:

One Division Manager: Responsible for oversight of performance of all ACHNs.

Four Health Systems Managers: Oversee the contract compliance and operational effectiveness of ACHN regions; will be responsible for day-to-day relationship management with ACHNs and administrative functions.

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 6 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

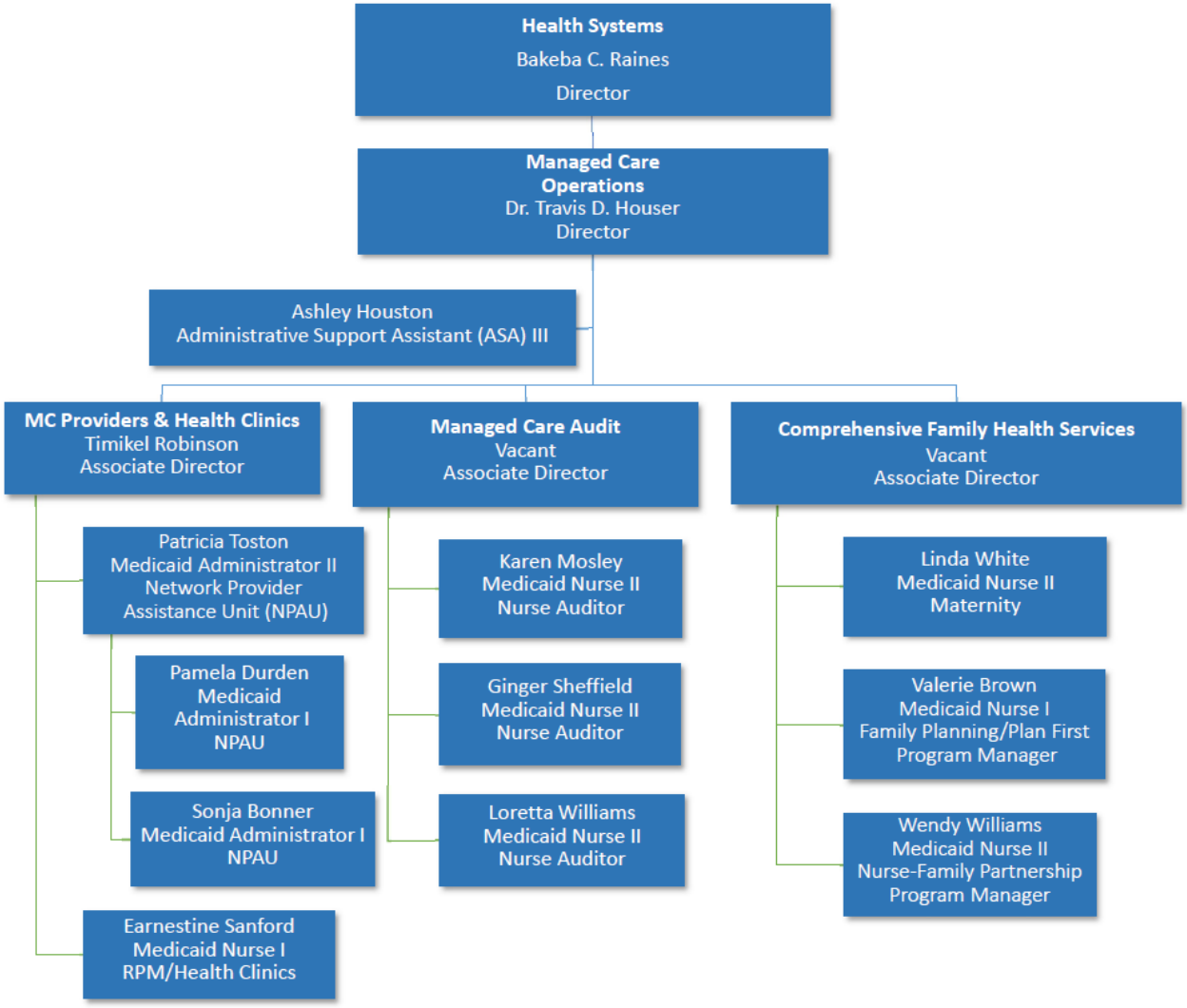
Support Team Area	Primary Responsibilities
Operations	Responsible for evaluating the ACHNs' overall operations and structure by: • Monitoring the ACHNs' provider and enrollee call center statistic reports, appeals reports, and other operational reports as outlined in the ACHN contract • Approving the ACHNs' provider or enrollee outreach materials, staffing and organizational structures, governing board, and provider and ACHN 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 Agency 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, rural health clinics and 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. Further, the State convened an interdisciplinary team that included collaboration with appropriate divisions within the Agency to address Quality Strategy components by providing subject matter expertise. The Networks Division is responsible for creating this Quality Strategy.

In order to obtain input from a variety of stakeholders, the Agency publishes the Draft Quality Strategy to the Agency website and provides it to the Poarch Band of Creek Indians for public comment. After being made available for public comment, the draft Quality Strategy is sent to CMS for feedback and comment. At the end of the comment period, the Agency reviews all recommendations and makes necessary revisions. The Agency submits a final version of the Quality Strategy to CMS for review and approval. The final version of the Quality Strategy is published to the Agency website upon final approval from CMS.

The State will continue to update the Quality Strategy as the ACHN Program matures to reflect Agency priorities. Every three years, the Agency will conduct a formal review of the Quality Strategy and make updates that include the recommendations identified by the state's EQRO in its assessment of the Quality Strategy. The state's EQRO assesses the effectiveness of the Quality Strategy at least once every three years and includes the results in the External Quality Review (EQR) technical report that is posted annually on the Agency's website. The Agency will make the updated Quality Strategy available for public comment and submit to CMS for review and comment. Additionally, the Agency will make the Quality Strategy available for public comment when significant changes are made outside of the 3-year review cycle. Significant change defined:

- 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 Program 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

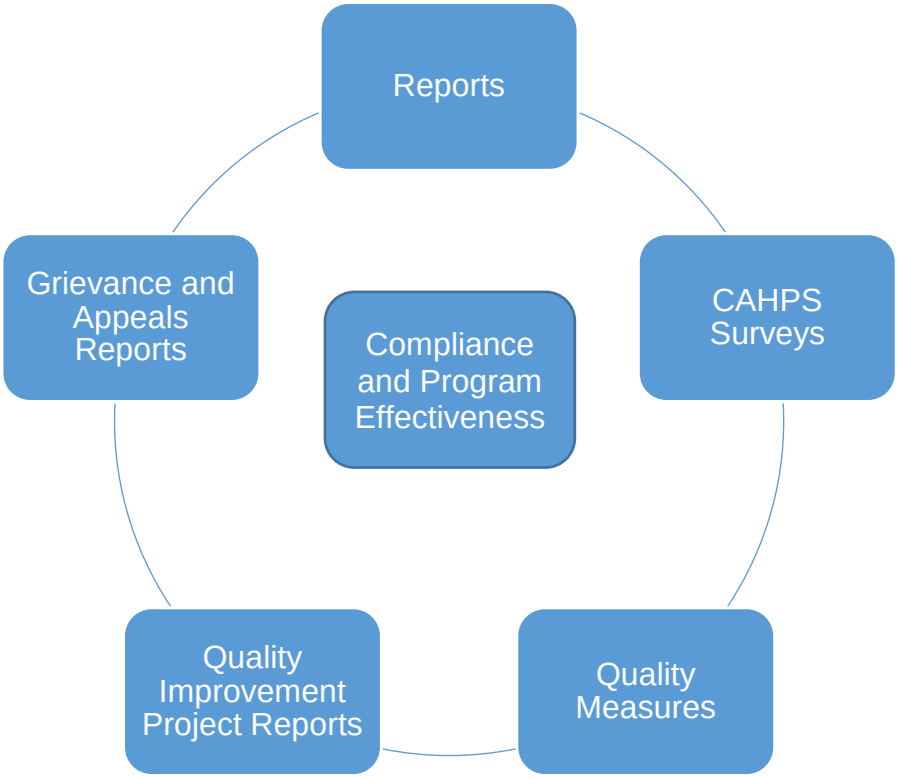
Successful quality improvement will require innovation and collaboration among the Agency, the Networks, Managed Care Operations, and Analytics Divisions, ACHNs (including external committees), providers, enrollees, other state agencies, and advocacy groups. The Agency has informal touch points with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

In addition, the Agency meets with ACHNs on a quarterly basis to discuss operations issues, share performance results, and identify opportunities for improvement based on data and reporting. The Agency may meet with the organizations on a more frequent basis as needed. These meetings promote transparency of ACHN performance, foster shared learning, and create a space to discuss program trends and leading practices. The quarterly meetings 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. The Agency may also invite other stakeholders to participate in these meetings, depending on the topics to be covered. The informal touch points between the Agency and the ACHNs will help inform the agenda topics for these quarterly meetings.

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

The Agency employs 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, the Agency analyzes all available quality reporting to monitor program performance. The Agency evaluates reports not only for compliance with contractual requirements, but also for progress towards achieving the Agency'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 the Agency's program effectiveness measures.

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

To provide stakeholders with information about the programs, the Agency will publicly report summaries at the ACHN-level on quality measures, costs, outcomes and other information. These quality measures and performance outcomes are listed in the state's EQR reports on page 50 in the 2023 EQR technical report and page 59 in the 2022 EQR technical report.

ACHN Readiness Assessment

The Agency conducted 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.
In April 2019, the Agency conducted an ACHN Readiness Assessment Kick-off training outlining Agency expectations regarding quality, materials review/communication compliance, and readiness that included an overview of the readiness assessment tool. This tool is used as a guide for developing a recommendation of demonstrating readiness and is driven by readiness assessment performance in relation to CMS Readiness criteria. Weekly technical readiness calls were held with vendors starting in May 2019 and throughout the process to provide status updates. Desk reviews were completed followed by onsite visits in July 2019 to conduct facility security checks, view HIMS demonstrations, and interview key staff. By September 2019, the Agency made the "Go/No-Go" decision. The Go-Live implementation was October 1, 2019.

ACHN Ongoing Monitoring and Performance

The Agency conducted ongoing monitoring and supervision as required by 42 C.F.R. § 438.66 to address all aspects of the ACHN Program including the ACHN's ability to provide services to EIs and resolve any identified operational deficiencies. Monitoring and supervision include, but is not limited to, conducting clinical documentation review audits, administrative audits, and site visits as determined by the Agency. The ongoing monitoring and supervision ensure care coordination services and program operations are provided according to state and federal regulations and guidelines.

The Agency conducted quarterly onsite reviews before the PHE period. Each PCCM entity received at least two onsite reviews where the provision of care coordination was evaluated, policy and procedures were reviewed, and security was observed. Onsite reports were generated, and areas of deficiencies were noted, if applicable, resulting in corrective action plans. Onsite visits were suspended during the PHE period. However, the Agency continued to conduct review audits which are completed quarterly. The Agency utilizes a Case Management Chart Audit tool to assess the ACHN's care coordination activities for EIs. Monitoring-Medical Review, General, Maternity and Family Planning care coordination services and reports are reviewed to ensure ACHNs are compliant with the requirements described in the ACHN contract, Medicaid's administrative code and policy manuals. The audit questions are categorized as Critical, Non-critical and Mandatory. Because mandatory elements are deemed so significant as to be foundational and utmost priority, case management activities that are not completed as required are eligible for recoupment. The ACHN must score 100% to pass Mandatory and the combined raw score of Critical and Non-critical must be at least 90% to pass the overall audit section.

Review of Regular Reports Submitted by ACHNs

ACHNs are contractually required to submit a variety of reports to the Agency on a regular basis, as illustrated 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. The Agency uses the case management data in its monitoring activities as well as for capitation rate development.

ACHN Reporting Requirements

ACHN Report Title	Frequency
Care Coordination Data	As required
Cash Flow Flash Report	Monthly
Financial	Quarterly and Annually
Fraud and Abuse Activities	As required
Grievances Log	Quarterly
Medical Management Committee Minutes	Quarterly and Annually
Outreach and Education Activities	Quarterly
PCP and DHCP List	Quarterly and Annually
Performance Reports	Quarterly
Pharmacy	Quarterly
Quality Improvement	Quarterly

To help confirm that ACHNs submit reports to the Agency that are meaningful and comparable across ACHNs, the Agency developed a Reporting Manual that has been made available to the ACHNs. This Reporting Manual defines the specifications and formats that ACHNs must use when developing and submitting reports to the Agency. When reviewing the ACHN reports, the Health Systems 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 Systems 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

Beginning January 2017, Medicaid 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 is administered statewide and stratified to compare the experiences between the ACHN regions. UAB surveys ACHN and non-ACHN participants using CAHPS on a quarterly basis with a valid sample of at least 300 complete surveys for each ACHN, the non-ACHN population and 35 highlighted populations groups. The Agency had 3 years of baseline data to compare ACHNs performance to previous recipients' satisfaction of care. In 2021, Alabama Medicaid Analysis presented results from the Alabama Medicaid Member Adult and Child Surveys covering member experiences with access to care and quality of care from October 2019 to February 2021. Adult Survey responses indicated that 82% "Usually and Always" found it easier to get the care, tests, or treatment they needed; 81% "Usually and Always" got needed care as soon as they needed it; and 90% noted that their doctor explained things in a way that was easy to understand. All results were below the benchmarks for the measure (86%; 85%; and 94% respectively). Child Survey responses indicated 72% "Always" got the care needed; 93% "Usually and Always" got an appointment as soon as the child needed it; and 87% "Usually and Always" received the information they needed from customer service at their child's health plan. All results exceeded the benchmarks for the measure (68%; 90%; and 83% respectively). The Agency continues to 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 are required to conduct an onsite visit to ensure the entity is meeting the contractual obligations in addition to efficiently and effectively serving the Medicaid population and improving health outcomes. These visits are performed on a quarterly basis but may occur more frequently in order to avoid any potential issues or address unexpected problems. These visits 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. Onsite visits were suspended during the PHE period with the expectation to resume post PHE.

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 2,500
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 first 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

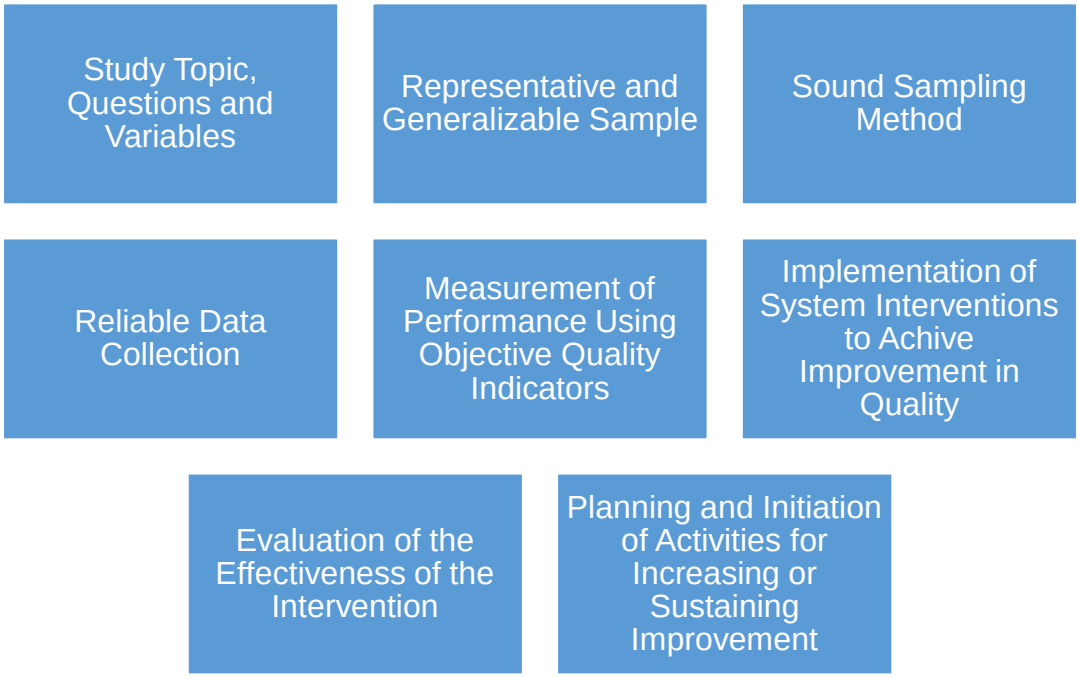
f. Health outcomes of the EIs.

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 the Agency and make available all information regarding the success of the QIP through ongoing reporting and review. The Agency 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. The Agency's 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 Alabama Department of Mental Health. The Agency's annual EQR Technical report includes more information on each of the QIPs implemented by the ACHNs. Table 5 on page 15 lists the QIP topics. QIP summaries, including aim, interventions, and overall performance are reported in Tables 13-19 for each ACHN entity starting on page 31.

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Grievance and Dispute Resolution

ACHNs are required to have a grievance process in place, submit a quarterly grievance log to the Agency, and have a dispute resolution process in place in the event an EI would like to appeal a decision that adversely affects their services. The Agency 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, the Agency 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 the Agency'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 Special Health Care Needs

The Agency 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. The state does not provide long-term services and supports (LTSS) through the ACHN Program.

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. Risk stratification, according to the American Academy of Family Physicians (AAFP), is a technique for systematically categorizing patients based on their health status and other factors. This technique is a process of assigning a health risk status to a patient and using the patient's risk status to direct and improve care. The ACHNs will stratify non-pregnant enrollees into one of three levels (low, medium, or high-risk) or 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. SBIRT services are provided to pregnant women enrolled in the ACHN Program. A set of screening questions are included in the Maternity psychosocial assessment that helps identify pregnant women who are at risk for development of substance use disorders. If screening results indicate an at-risk status, these women receive a brief intervention and are referred to certified Medicaid providers for treatment.

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. A 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.

Sickle Cell Population

Sickle cell disease (SCD) is a group of inherited red blood cell disorders. In SCD, the red blood cells become hard and sticky and look like a C-shaped farm tool called a "sickle" which can block blood flow to areas of the body. This can cause serious health complications such as chronic anemia, harmful infections, severe pain episodes, and stroke. It is estimated that SCD affects approximately 100,000 Americans. Currently there is no cure for SCD, and it requires lifelong management. However, the symptoms and complications can be treated with antibiotics, intravenous fluids, blood transfusions, surgery, pain management, and counseling. According to the Southeast Alabama Sickle Cell Association, "Case managers are in the unique position to minimize barriers to care and foster improved health care outcomes for patients with SCD.

Ensuring evidence-based care and facilitating delivery of equitable care may reduce hospital readmissions, and decrease health care utilization, thus improving health care outcomes for patients with SCD."

In August 2022, members of the Alabama Legislature requested that the Agency create a Sickle Cell report that would replicate a report compiled by the State of Tennessee's Medicaid program, TennCare. In response to this request, Alabama Medicaid's Commissioner, Stephanie Azar, requested data to show the medications, treatment, and services that Alabama Medicaid covers for recipients with a diagnosis of SCD. The FY 2022 data reviewed showed that Alabama Medicaid covered dental, medication costs, outpatient services, professional inpatient services, long term care, emergency department services, labs, and ancillary services for this population. Data also showed:

- Approximately 1,900 Medicaid recipients had a diagnosis of SCD
- Approximately 20% of those diagnosed are receiving care coordination services through the ACHN Program
- Of the 20%, over half are being provided a monitoring medical level of care coordination and the remaining are moderately managed.

Based on this information, it was determined that each ACHN entity will provide intense care coordination, for at least the first six months of care coordination engagement, for all eligible Alabama Medicaid recipients with SCD. The ACHN is responsible for providing intense care coordination activities to 100 percent of the SCD population and must stratify all recipients with SCD as high risk at the initiation of the sickle cell project and upon the recipient's enrollment into the ACHN Program. Care coordination activities include disease education, resource identification, symptom management education as well as crisis prevention education. In addition, a component of this intense care coordination focus is completion of a mandatory Multidisciplinary Care Team meeting within the first six months of engagement and every six months thereafter when applicable. This sickle cell project went into effect January 1, 2023. Data is still being collected.

Initiatives for improved health outcomes

Effective October 1, 2022, Alabama Medicaid began reimbursing for dental services rendered to pregnant adults who are ages 21 and older during pregnancy, and during postpartum in accordance with 42 CFR § 440.210(a)(3), when the services are rendered by Alabama Medicaid enrolled dental providers. Services did not change for individuals under age 21.

Effective October 1, 2022, Postpartum coverage to pregnant Medicaid recipients extended from 60 days to 12 months. After March 31, 2023, when the continuous enrollment requirement ends, pregnant recipients will keep their Medicaid coverage until 12 months after their pregnancy ends. It will then be determined if they are eligible for other Medicaid programs, ALL Kids, or refer them to the Federal Marketplace.

Effective January 1, 2023, Alabama Medicaid increased the annual physician office visit maximum to 32 for Medicaid recipients receiving cancer treatment during the calendar year. This increase is available for each calendar year in which the recipient is receiving cancer treatment and is applicable for all cancers.

Section VII: Transition of Care Policy

The Agency requires ACHNs to have a transitional plan in place 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 State contracts with the ACHN, a PCCM entity, to deliver Medicaid services. In accordance with 42 CFR 438.340(b)(1), Alabama Medicaid defines network adequacy as the ability of a health plan to provide enrollees with timely access to a sufficient number of in-network providers, including primary care and specialty physicians, as well as other health care services included in the benefit contract. The ACHN Contract provides detailed language regarding network adequacy. The ACHNs are required to adhere to availability and timeliness standards defined by the Agency 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.

The state has developed time and distance standards for ACHN participating provider types for enrollee travel to receive services. The following provider types are eligible to participate in the ACHN Program:

- Family Practitioners
- General Practitioners
- Pediatricians
- Internists
- OB/GYN

Alabama Medicaid providers who are interested in participating in the ACHN Program must complete and submit an application and PCP Network Participation Agreement. Out-of-state providers who are interested in participating in the ACHN Program, must be within 30 miles of the Alabama state border. In order to participate as a PCP Group, certain requirements must be met such as complying to all applicable federal and state statutes including but not limited to the Alabama State Plan and Title 42 of the Code of Federal Regulations. The PCP Group must agree to the following timeliness/access standards:

- Establish and maintain hospital admitting privileges or have a formal arrangement with a hospitalist group or another physician or group for the management of inpatient hospital admissions that addresses the needs of all recipients. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a forty-five (45) minute drive time from the Group's practice. If there is no hospital that meets the above geographical criteria, the hospital geographically closest to the PCP Group's practice will be accepted.
- Provide or arrange for primary care coverage, twenty-four (24) hours per day and seven (7) days per week as defined in the PCP Group Agreement, for services, consultation, management or referral, and treatment for emergency medical conditions. Automatic referral to the hospital emergency department for services does not satisfy this requirement. The PCP Group must have at least one telephone line that is answered by the office staff during regular office hours.
- The PCP Group must conform to the following standards for appointment availability:
  - Emergency care – immediately upon presentation or notification
  - Urgent care – within 24 hours of presentation or notification
  - Routine sick care – within 3 days of presentation or notification
  - Routine well care – within 90 days of presentation or notification (15 days if pregnant)
- The PCP Group must conform to the following standards for office wait times:
  - Walk-ins – within two hours or schedule an appointment within the standards of appointment availability
  - Scheduled appointment – within one hour
  - Life-threatening emergency – must be managed immediately

  If these standards cannot be met due to extenuating circumstances, then the recipient should be informed within a reasonable amount of time and given an opportunity to reschedule the appointment.

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 System (HIMS) in order to improve the quality of care provided to Medicaid's population, be cost effective, and reduce health disparities.

HIMS requirements:

- Functional Capabilities

  a) Built-in case management system that includes care coordination documentation, maternity data and the ability to accept Admission/Discharge/Transfer (ADT) feeds.

  b) Ability to provide the Agency a monthly extract of data in the format prescribed by the Agency.

  c) Utilizes specifications from the Agency to document user information and case management.

- Data delivery

ACHN responsibilities:

a) Submits complete and accurate maternity delivery data for each EI who delivers under the ACHN Program.

   i) Ensures data is submitted to Medicaid or Medicaid's designee in the specified format.

   ii) Ensures all delivery data is completed within 90 days of the delivery date.

b) Ensures all PHI data is protected per federal laws, state laws, and Business Associates Agreements.

c) Allows the Agency to maintain access to the system for reviewing case management data and to review security and management components.

Agency responsibilities:

d) Provides to the ACHN HIMS summary level reports for guiding quality improvement, supporting providers, and general population health monitoring.

e) Provides to the ACHN data for EIs in the ACHN regions including:

   - Paid claims data at least monthly or at most after each check write;

   - Pharmacy data daily;

- Eligibility data;
- Provider data; and
- Reference data.

ADT/One Health Record®

One Health Record®, Alabama's State Health Information Exchange (ALOHR), provides interoperability and Information exchange services, including direct secure messaging (DSM) addresses and a clinical viewer through provider portal accounts, to the seven ACHN regions that serves the participating Medicaid recipients. These services will allow the regions to coordinate care management activities for their recipients, access clinical documents through member queries, including HL7 ADT (Admission, Discharge, and Transfer) alert notifications, and read/respond to their direct secure messages.

ADT alert notifications are used to improve health care coordination when an event occurs with a recipient 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. ADTs are now available to track the patients' encounter during the in-patient setting. ADTs will be sent to the corresponding DSM accounts and/or to the ACHN's appropriate HIMS according to the region in which the recipient resides. Members are registered in the Enterprise Master Patient Index (EMPI) and information exchange activity and information are monitored by patient demographics, including but not limited to zip code.

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

Alabama Medicaid Agency, through One Health Record®, maintains compliance with all applicability CMS Rules of Interoperability, in accordance with 21st Century Cures Act, including Patient Access to their clinical and claims information and provider directory services through ALOHR "Myhealth" mobile app.

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 (EQR) 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 has contracted with Island Peer Review Organization (IPRO) to provide external quality review for the seven ACHNs contracted to provide case management activities to Alabama Medicaid recipients.

On an annual basis, the Agency's EQR vendor performs an external quality review and conducts the following activities:

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).

4. Review of Compliance with Medicaid and CHIP Managed Care Regulations.

IPRO conducted the calendar year (CY) 2022 EQR activities for the seven primary care case management entities contracted to furnish Medicaid services in the state. IPRO used the analyses and evaluations of 2021 and 2022 EQR activity findings to assess the performance of ACHN entities in providing quality, timely, and accessible health care services to Medicaid members. The individual entities were evaluated against state and national benchmarks for measures related to the quality, timeliness, and access domains, and results were compared to previous years for trending, when possible. According to IPRO, the EQR activities conducted in CY 2021 and CY 2022 demonstrated that the Agency and the ACHN entities share a commitment to improvement in providing high-quality, timely, and accessible care for eligible individuals. IPRO conducts a comprehensive systems performance review (SPR) once every three years. The most recent review of the ACHN entities covered the state fiscal year (SFY) 2022 review period of October 1, 2021 – September 30, 2022.

To view full EQR report, visit

https://medicaid.alabama.gov/content/5.0_Managed_Care/5.1_ACHN/5.1.5_ACHN_Quality_Measures.aspx.

Section XI: Health Disparities

Pursuant to 42 CFR 438.40(b)(6), the State has taken steps to identify age, race, ethnicity, sex, primary language, and disability status for enrollees at time of enrollment. Except for disability status, all demographic information is collected at time of application by enrollee attestation. Medicaid eligibility for aged, blind, or disabled individuals is determined by the Social Security Administration (SSA). The Agency retrieves an enrollee's final disability date from SSA through the Federal Data Services Hub and the Agency's Bendex, SDX, and SVES data sources. When an individual applies for Medicaid benefits and has not yet received a final disability determination by SSA, the Agency reviews medical records and uses the same criteria as SSA to determine disability status. The responsible division extracts eligibility and enrollment data from the Agency database and sends data files to the ACHNs daily or as deemed appropriate.

The Alabama Medicaid program has engaged in efforts and initiatives aimed at reducing disparities in health care. Prior to inception of the ACHN Program, two such initiatives were the State's Health Home Program (formerly named Patient Care Networks) and the Patient 1st Program. These programs created health homes and medical homes that provided 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 provided care management for high risk, high acuity recipients. Consistent with these programs' approach, the ACHNs promote the delivery of appropriate, evidence-based care and education about disease states and self-management. Both the Health Home and Patient 1st Programs' care coordination service delivery with focus on health disparities have been incorporated into the ACHNs' responsibilities.

Since the inception of the ACHN, resulting from lessons learned, the Agency has expanded on its Population Health approach starting with training videos from reputable sources like CDC and the Health Resources and Services Administration (HRSA) to name a few, directed to ACHN care coordination teams to educate them on topics like, but not limited to, population health, health equity, health literacy, health disparities and social determinants of health. Further, realizing the value in partnerships, the Agency has partnered with Dr. Richard Antonelli, who is co-PI for the HRSA/MCHB National Coordinating Center for Enhancing the Systems of Care of Children with Complex Needs at Boston Children's Hospital. Dr. Antonelli is the developer of the nationally known *Care Coordination Curriculum* from which the Agency has obtained several modules for care coordination training of all ACHN care coordination teams. Social Determinants of Health is one of several modules. Although the modules are framed around the care coordination of children with complex needs, they are still helpful in understanding overarching care coordination principles and practices useful for coordinating the care of Medicaid recipients.

Identifying social determinants of health is important for improving health and reducing disparities in health and health care. By conducting social determinants of health screenings, the ACHN can use the results of the screening to identify barriers to care, address patients' health-related social needs and reduce hospitalizations, emergency visits, and preventable admissions. These screenings also assist in stratifying the enrollee into appropriate risk categories to provide care coordination services as needed. In addition, the Agency's Analytics Division introduced a Social Determinants of Health Data Set in 2022 that details several stratifying categories derived from existing Quality Measure performance data. Some of the categories' data is stratified by, but not limited to, age, gender, rural vs urban, pregnancy status, language, family size, and disability status. Currently, employment type/job, social economic group, and ethnicity are not being captured, but the Agency continues to explore ways to extract this data from other sources. The

existing stratifying data is being stratified using those recipients depicted in quality measures' performance and coupled with data from Psychosocial assessments conducted on participating Medicaid recipients. The data is intended to be used to better recognize social determinants of health and understand areas of the state and populations that can benefit from targeted care coordination efforts statewide.

In 2022, IPRO presented the Disproportionate Index Worksheet to the Agency and ACHNs to help in the identification of disparities (particularly populations that may be over or under-represented). The ACHNs began incorporating the approach into their QIPs to identify and mitigate over/under-utilization by demographic subpopulation. During quarterly calls with IPRO, the ACHNs provide updates on QIP progress and receive feedback on interventions to assess their appropriateness for impacting the target population. In the example below, using the performance indicator, *Live births weighing less than 2500 grams,* the ACHN was able to determine that although there were more than twice as many Caucasian females represented in the member population, the percentage of low-birth-weight deliveries among Black/African American females was twice as high. Based on this information, the ACHN will target interventions to address the racial disparity while identifying any barriers to care. Further, IPRO conducts breakout sessions with the ACHN Quality Managers during quarterly collaborative meetings facilitated by the Agency to further assist the ACHNs with performance improvement.

Table 1: Disproportionate Index Worksheet – Demographic Information for Members with a Live Birth under 2,500 Grams in 2022, Northeast region

Subgroup	Column A Number of members	Column B Percentage of members (Column A ÷ Total Members)	Column C Number of members with a live birth weighing under 2500g	Column D Percentage of members with a live birth weighing under 2500g (Column C ÷ Column A)	Column E Comments on findings
TOTAL	1805	100%	133	7.4%	
Gender					
Female	1805	100%	133	7.4%	
Male	NA	NA	NA	NA	
Age in years					
Under 18	27	1.5%	2	7.4%	
18 - 25	851	47.1%	51	6.0%	
26 - 34	792	43.9%	63	8.0%	
35+ (Geriatric)	135	7.5%	17	12.6%	

Race					
American Indian and Alaska Native	4	0.2%	0	0%	
Asian	3	0.2%	0	0%	
Black/African American	471	26.1%	53	11.3%	
Caucasian	1060	58.7%	58	5.5%	
Native Hawaiian and Other Pacific Islander	3	0.2%	1	33.3%	
Some other race	1	0.0006%	1	100%	(1) member
Unknown (missing)	263	14.6%	20	7.6%	
Ethnicity					
Unknown (missing)	1805	100%	133	7.4%	
Trimester at 1st Prenatal Visit					
1st Trimester	948	52.5%	66	7.0%	
2nd Trimester	693	38.4%	51	7.4%	
3rd Trimester	140	7.8%	14	0.1%	
Unknown (missing)	24	1.3%	2	8.3%	
Term at Delivery (In weeks)					
Preterm (<37)	166	8.6%	76	45.8%	
Full term (37+)	1630	90.3%	56	3.4%	
Unknown (missing)	9	0.5%	1	11.1%	

Finally, each ACHN must develop a Citizens' Advisory Committee whereas each Committee consists 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. The Agency is optimistic that the utilization of former and new partnerships, newly implemented data analysis, and focused education and training will prove favorable in identifying and addressing social determinants of health, reducing health disparities, and improving health outcomes for Alabama Medicaid recipients going forward.

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

The Alabama Medicaid program 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 the Agency gathers additional feedback from stakeholders, beneficiaries, providers and state agencies. The ACHNs and the Agency 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. The Agency will continue to take into consideration all recommendations provided by its EQRO and update the Quality Strategy accordingly.

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
Antidepressant Medication Management	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
	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: Timeliness 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
Initiation and Engagement of Treatment for Alcohol and Other Drug (Initiation)	Central	N/A	34.4	35.7	37.0	38.4	39.7	41.0	75th %ile	1.32
	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

Attachment C. Quality Strategy Evaluation

Alabama Medicaid Quality Strategy

In the Agency's continued effort to place an emphasis on quality and care coordination and to improve health outcomes for Alabama Medicaid enrollees, the Quality Strategy serves as a framework for communicating the Agency's approach to ensuring that individuals have timely access to high quality services in a coordinated, cost-effective manner that contributes to the improved health of the population.

The Agency has used lessons learned from the Regional Care Organizations (RCOs), the Maternity Care Program, the Patient 1st Program, the Patient Care Networks of Alabama (PCNA), and the Health Homes Program to design and implement a new approach for improving healthcare outcomes. 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, the Agency, in partnership with the ACHN program, can improve health outcomes, while using healthcare resources efficiently. 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 also to utilize the Agency's current Health Information Exchange (HIE). The ACHN entities are also responsible for creating their own health information management system (HIMS) to track and monitor patient progress.

In moving toward a system of coordinated care, Alabama has placed an emphasis on quality and has identified maternity outcomes, obesity, and substance use as opportunities/priority areas. Through the ACHN Program, the Agency seeks 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.

Further, the Agency has established the following 3 clinical goals: better birth outcomes, reduce childhood obesity, and improve substance abuse initiation and continuation of treatment. As such, each of the ACHN entities are required to carry out a QIP that targets these topics. The Alabama Child Health Improvement Alliance (ACHIA), Alabama Perinatal Quality Collaborative (ALPQC), and the Department of Mental Health are collaborating with the entities in developing, implementing, and monitoring their QIPs.

To ensure consistent communication and engagement in quality improvement, the Agency has established various forums and requires participation of ACHN entities and their active providers in routine meetings. The Internal ACHN Quality Forum provides a setting for ACHN entities and the Agency to pose questions, share ideas and best practices, discuss new

evidence-based research and initiatives, and request training or other support. The external quality-related committees, including the Quality Assurance Committee and the Citizen's Advisory Committee, are charged with supporting quality management activities. The Quarterly Quality Collaborative is an Agency-led effort in which the ACHN entities must participate to discuss utilization and management reports and strategies, innovative health care strategies, quality improvement goals and measures, QIP progress and evaluation, and share program operations and support needs. The Regional Medical Management Committee is the responsibility of the ACHN entities to establish, chaired by their Medical Director, and comprised of all actively participating providers. The purpose of this 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 entity 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. The Consumer Advisory Committee is designed to advise the ACHN entity on ways it can be more efficient in providing quality care to its enrollees. Lastly, the Medical Care Advisory Committee is a state-established committee to advise on policy development and program administration.

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. The Agency offers a Quality Incentive Payment, wherein the ACHN entity may earn an incentive payment of up to 10% of total revenues if the entity meets quality targets set by the Agency. There are 10 quality measures used to assess ACHN entity performance, in addition to 8 PCP quality measures that are similar to/align with these measures. **Table 2 and Table 3** detail these measures.

Table 1: ACHN Quality Measures

Acronym	Description
W15-CH	Well-Child Visits in the First 15 Months of Life
ABA-AD	Adult BMI Check
WCC-CH	Child BMI
CCS-AD	Cervical Cancer Screen
AMR-CH	Asthma Medication Ratio (Child Measure)
AMR-AD	Asthma Medication Ratio (Adult Measure)
AMM-AD	Antidepressant Medication Management
LBW-AD	Live Births less than 2,500 grams
CAP-CH	Child Access to Care [four age strata]
PPC-CH	Prenatal and Postpartum: Timeliness of Prenatal Care
IET-AD	Initiation and Engagement of Treatment for AOD [initiation and continuation phases]

ACHN: Alabama Coordinated Health Network; BMI: body mass index; AOD: alcohol and other drugs.

Table 2: PCP Quality Measures

Acronym	Description
AWC	Adolescent Well-Care Visits
W34	Well-Child Visits for Children (age 3–6)
CIS	Immunization status – Child
IMA	Immunization status – Adolescent
AMM	Antidepressant medication management
CDC	HbA1c test for diabetic patients
FUA	Follow-up after ER visit for alcohol or other drugs
CHL	Chlamydia screening in women

PCP: primary care provider; ER: emergency room.

At the end of each fiscal year, the Agency meets with the ACHN entities to review the quality measures and share best practices. Further, each quarter, AMA meets with each entity to review preliminary data, review measure specifications, plan for data gathering, and share early successes and challenges.

On a monthly and quarterly basis, the Agency analyzes all available quality reporting to monitor program performance, evaluating reports not only for compliance with contractual requirements, but also for progress toward achieving the Agency's program effectiveness goals. Many reporting elements serve as leading indicators for overall program effectiveness. While the Agency's first step is to provide technical assistance and learning collaborative opportunities for the ACHN entities, the Agency will implement sanctions or corrective action plans to remedy any noncompliance, when necessary.

The Agency conducts ongoing monitoring and supervision as required by 42 C.F.R. § 438.66 to determine the ACHN entities' ability to provide services to EIs and resolve any identified operational deficiencies. the Agency may require the entity to develop and implement corrective action plans (CAPs) demonstrating their ability to satisfy the requirements of their contract. ACHN entities are contractually required to submit a variety of reports to the Agency on a regular basis, as illustrated in **Table 4**. 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, and grievances and appeals, among others. In addition, ACHNs are required to submit accurate and complete case management data monthly. the Agency will use the case management data in its monitoring activities as well as for capitation rate development.

Table 3: ACHN Reporting Requirements

ACHN Report Title	Frequency of Reporting
CAC and Governing Board Minutes	Quarterly (alternating)
Care Coordination Data	As required
Cash Flow Flash Report	Monthly
Financial	Quarterly and annually
Fraud and Abuse Activities	As required
Grievances Log	Quarterly
Medical Management Committee Minutes	Quarterly and annually
Outreach and Education Activities	Quarterly
PCP and DHCP List	Quarterly and Annually
Performance Reports	Quarterly
Pharmacy	Quarterly
Quality Improvement	Quarterly

ACHN: Alabama Coordinated Health Network; PCP: primary care provider; DHCP: delivering health care provider.

To help confirm that ACHN entities submit reports to the Agency that are meaningful and comparable across regions, the Agency developed a reporting manual that is made available to the ACHNs. This reporting manual defines the specifications and formats that entities must use when developing and submitting reports to the Agency. When reviewing the ACHN reports, the Agency uses standard operating procedures to collect, analyze, and summarize findings for each report. Health System Managers also compile report findings across ACHN entities to identify areas of opportunity for discussion at ACHN quarterly meetings and learning collaboratives.

As part of the ongoing monitoring phase, each Health Systems Manager is required to conduct a quarterly 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 provide an insight into 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.

IPRO's Assessment of the Alabama Medicaid Quality Strategy

Alabama's Medicaid Quality Strategy aligns with Federal regulations at 42 CFR 438.340(b). Assessment of the ACHN Program and strategies for improvement are clearly stated, and methods for measuring and monitoring ACHN entity progress toward improving health outcomes incorporate EQR activities. The Quality Strategy will evolve as the ACHN Program continues to grow, as more data become available, and as the Agency gathers additional feedback from stakeholders, beneficiaries, providers, and State agencies.

Recommendations to the Agency

IPRO recommends that the Agency:

- Include in the next iteration of the Medicaid quality strategy quantifiable targets for each quality measure being used to evaluate and incentivize ACHN entities and PCPs. Further, include quantifiable targets for the 3 clinical focus areas (i.e., adverse birth outcomes, childhood obesity, and SUD).
- Continue to work with the ACHN entities to identify and address access issues faced by EIs, particularly in rural communities.
- Work with providers to understand and mitigate barriers they face in providing care to EIs.
- Evaluate and promote telehealth capabilities of providers.
- Outline the PCP Bonus Payment methodology, as this is not currently specified in the Quality Incentive Payment Methodology section of the Quality Strategy.
- Define network adequacy standards.