

**STATE OF ALABAMA**  
**SECTION 1115 DEMONSTRATION APPLICATION**  
**Draft: February 28, 2014**

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**Section I - Program Description**

*This section should contain information describing the goals and objectives of the Demonstration, as well as the hypotheses that the Demonstration will test. In accordance with 42 CFR 431.412(a)(i), (v) and (vii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:*

- 1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act). (This summary will also be posted on Medicaid.gov after the application is submitted.);*
- 2) Include the rationale for the Demonstration;*
- 3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them;*
- 4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate;*
- 5) Include the proposed timeframe for the Demonstration(if additional space is needed, please supplement your answer with a Word attachment); and*
- 6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.*

**A. Summary of Proposed Demonstration**

The State of Alabama Medicaid Agency (AMA) is seeking approval of a Section 1115 Demonstration Project to implement a new care delivery model that will improve upon and ensure the long-term sustainability of Alabama's Medicaid program. This new care delivery model will build upon the current Maternity Care Program; Patient 1<sup>st</sup>, our primary care case management program (PCCM); and the Patient Care Networks (PCNs) of Alabama, Health Home Program, as described later in this proposal. It will enable the State to meet its overall goals that are designed to be consistent with the CMS "triple aim" objectives to improve patient experience, improve health and reduce costs:

- Address fragmentation in the State's delivery system
- Improve beneficiary outcomes
- Support quality care and protect and further improve access to health care providers in Alabama
- Increase transparency and fairness in the Medicaid reimbursement system

Under the Demonstration, AMA proposes to test the effectiveness of the below strategies on improving care coordination, access to care and health outcomes for the Demonstration Populations, while transitioning the State's Medicaid system from utilization-driven

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reimbursement to one that focuses on value over volume. The key programmatic features of Alabama's Demonstration areas are as follows and Section VII includes a complete list of associated waiver requests:

- A delivery system through which risk bearing, provider-based regional care organizations (RCOs) will be paid on a capitated basis to provide the following to the Demonstration Populations:
  - The full scope of Medicaid benefits, including primary, acute, behavioral, maternal, pharmacy and post-acute services
  - Care coordination, including improved coordination of physical and behavioral health services
  - A medical home that provides a primary medical provider (PMP) to provide and arrange for beneficiaries' health care needs and a health home, building upon the current Health Homes program, for individuals with chronic conditions
- Transition from a volume-based, fee-for-service reimbursement system to a capitated payment system that incentivizes the delivery of quality health outcomes
- Transition of the current hospital payment system to one providing incentive payments to RCOs, hospitals and other providers to improve and reform the health care delivery system in the State

When statewide, this Demonstration will serve approximately 654,000 Medicaid beneficiaries (the Demonstration Populations), including approximately 113,000 aged, blind and disabled individuals, some of whom will be mandatorily enrolled and others will have the option to enroll or continue to receive services through the fee-for-service delivery system. See **Figures 3 and 4** on page 19 for list of eligibility groups within the Demonstration Populations.

**B. The Problem: Less Than Optimal Health Outcomes, Increased Costs and System Fragmentation**

The Alabama Medicaid program serves 999,561 enrollees<sup>1</sup> - who account for 20 percent of the State's population, 47 percent of children statewide and 53 percent of births. The total annual budget is \$5.9 billion of which \$1.845 billion is the State's share.

In recent years, Alabama has undertaken initial efforts to address fragmentation in the Medicaid delivery system and begun a transformation to a managed care delivery system focused on quality care, efficiency, and sustainability. Initial programs towards this goal

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<sup>1</sup> As of October 2013.

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include the current Maternity Care Program; Patient 1st, our primary care case management program (PCCM); and the Patient Care Networks (PCNs) of Alabama, Health Home Program. (See **Attachment 1** for an overview of the current program descriptions). Although these programs have been a successful step towards improving health outcomes, current Medicaid costs and enrollment continue to increase while the State struggles to improve health outcomes and encourage appropriate utilization. For example:

- Eighteen percent of Alabama residents were living at or below the Federal Poverty Level (FPL) between 2008 and 2012, compared to the national average of 15 percent of the population.<sup>2</sup>
- Medicaid program enrollment increased over 20 percent during the economic downturn of 2008 to 2012.
- Alabama has the second highest rate of obesity and the seventh highest rate of heart disease nationally.
- The rate of diabetes in Alabama is 50 percent higher than the national average.
- Alabama's utilization rates for hospital admissions, inpatient days and emergency department visits are 13 percent to 17 percent higher than the national average.

The State has found that it faces three primary challenges that it seeks to address through a comprehensive reform of its Medicaid program.

1. *Delivery System Infrastructure:* The care delivery system in Alabama is fragmented, with minimal infrastructure or incentives to coordinate care across providers to drive improved health outcomes. Service fragmentation is particularly acute for some of the State's most vulnerable populations, such as individuals with co-occurring medical and behavioral health disorders. These vulnerable populations often face difficulty navigating the care delivery system to obtain needed services.

Historically, Alabama has had minimal infrastructure or incentives to coordinate care across providers to drive improved health outcomes. The current Patient 1<sup>st</sup> program functions primarily as a gatekeeper to specialty services and is not sufficiently robust to comprehensively manage the State's most vulnerable populations, including individuals with mental illness and substance use disorders. While the current Health Home program has improved coordination for beneficiaries with chronic conditions, it is currently in 21 out of 67 counties. Expanding upon the medical home services currently provided through the Patient 1<sup>st</sup> program and providing Health Home services to beneficiaries with

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<sup>2</sup> Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits. Last Revised: Monday, 06-Jan-2014 17:25:46 EST.

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chronic conditions statewide will improve coordination of care and drive improved health outcomes.

2. *Costs:* Health costs continue to rise at an unsustainable rate in Alabama, with the Medicaid program increasing to one-third of General Fund spending. Costs are concentrated in a disproportionately small portion of the population; primarily the aged, blind, and disabled who make up 31 percent of the Medicaid population but account for 66 percent of program spending. This population is estimated to account for 17 percent of the Demonstration Populations.

Approximately one-third of the State's General Fund spending is devoted to the Medicaid program and is expected to continue to increase. However, the State cannot absorb increases to Medicaid expenditures that are already overburdening the State. For example, Alabama's Medicaid expenditures for behavioral health services exceed \$400 million annually, and are surpassed only by spending for hospital care, nursing homes, and pharmacy services, demonstrating considerable opportunity to more effectively coordinate care for beneficiaries.

There is, however, significant opportunity to control costs through more effective coordination of care for beneficiaries, particularly for beneficiaries receiving services from multiple provider types, such as individuals who are aged, blind, and disabled.<sup>3</sup> The anticipated growth of this population in the current system threatens the State's ability to maintain even a modest benefit package and eligibility criteria for Medicaid beneficiaries and highlights the necessity for Medicaid reform in Alabama.

3. *Payment Methodologies:* State reimbursement methodologies are primarily focused on utilization and volume, rather than value and quality.

AMA has concluded that short-term solutions, such as tweaks to benefit packages or eligibility criteria, will not solve these issues or improve health outcomes or quality of services. Rather, a transformation of the State's Medicaid delivery system is necessary to achieve the State's goals to effectively manage and coordinate care and reduce costs – goals which are in line with the CMS "triple aim" objectives.

### C. Development of a Reform Plan

In October 2012, Governor Robert J. Bentley convened a multi-stakeholder Medicaid Advisory Commission charged with providing recommendations to improve the Alabama Medicaid program that would curb the growth trajectory of the Medicaid program and improve the quality and type of care provided to Medicaid beneficiaries. The Commission brought together a large and diverse group of representatives to review and develop its

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<sup>3</sup>[http://medicaid.alabama.gov/documents/2.0\\_Newsroom/2.5\\_Presentations/2.5\\_FY14\\_Budget\\_Slides\\_Williamson\\_2-20-13.pdf](http://medicaid.alabama.gov/documents/2.0_Newsroom/2.5_Presentations/2.5_FY14_Budget_Slides_Williamson_2-20-13.pdf)

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recommendations. Entities or organizations included: executive officers of state agencies, cabinet-level leaders, State Senators and Representatives, insurance companies, consumer advocates, medical providers, and professional organizations. These professional organizations represented the hospitals, physicians, pharmacy, nurses, primary and rural health clinics, hospice, and nursing homes.

The Commission submitted its recommendations to Governor Bentley on January 30, 2013. The Commission's recommendations focused on the AMA transitioning from utilization-driven reimbursement system to one that incorporates value-based purchasing and provides beneficiaries with a medical or health home, building on AMA's recent successes with Health Homes. See **Attachment 2** for a full list of the Commission's recommendations. The recommendations of the Commission, which align with AMA's overall goals for the Medicaid program (described in Section I.A) became the building blocks for a comprehensive Medicaid reform plan described in this 1115 Demonstration Proposal.

The Commission recommended these reforms as necessary to ensure the long-term sustainability of the Medicaid program, to protect and to further improve access to health care providers in Alabama, and to improve the health of Medicaid beneficiaries.

*1. Regional Care Organizations (RCOs)*

The cornerstone of this reform plan is the development and implementation of RCOs in five regions across the State that will manage and coordinate care for the Demonstration Populations. These RCOs are provider-based, community-led organizations that will, through an at-risk capitated payment model, manage State Plan benefits for the Demonstration Population with the exception of the following benefits:

- Long-term supports and services, hospice, institutional and home- and-community-based, excluded by statute.
- Dental services are also excluded by statute until the completion of a special study to be reported to the Legislature and Governor on October 1, 2015.
- Targeted Case Management, Children's Specialty Clinic Services, rehabilitative substance abuse services, hearing aid services for children, which are provided by other state agencies are excluded for the first two years.

AMA will support the RCOs by providing certain administrative functions and oversight (e.g., timeliness of provider payment).

The plan to transform Medicaid delivery in Alabama by creating RCOs was incorporated into Senate Bill 340, approved by the Alabama Legislature on May 7, 2013, and signed into law by Governor Bentley later that month.

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During June 2013, the Agency met with professional organizations representing hospitals and physicians, and worked with an actuarial consultant to propose regions for the planned RCOs. A proposed Administrative Code rule identifying the RCO regions was submitted to the Alabama Legislative Reference Service on June 20, 2013. Additional written or oral comments were received through August 2, 2013. The new rule, No. 560-X-37.07 was finalized September 17, 2013, and states, “The Alabama Medicaid Agency is responsible for the development and oversight of a Regional Care Organization (RCO) program as part of an overall managed care system within the state. This program will promote accountability for a patient population, coordinate items and services under Medicaid, and encourage investment in the infrastructure of care processes for higher quality and more efficient services provided to Medicaid beneficiaries.”

RCOs will provide integrated, whole-person care, and improve access to health care and health outcomes for the Demonstration Populations. To do so, AMA has identified the following key programmatic design elements:

- **Provider-based community-led organizations.** RCOs will be business entities that are incorporated under Alabama law.

The State will approve a Governing Board of Directors for each RCO that includes risk<sup>4</sup> and non-risk bearing participants (e.g., medical professionals and community representatives). The Governing Board will be responsible for establishment and oversight of the RCO’s health delivery system. Each RCO will also have a Citizen’s Advisory Committee, which will include Medicaid beneficiaries and will advise the RCO on providing more efficient, improved quality care.

To facilitate the development of RCOs, entities and individual providers who are considering developing or participating in an RCO may submit an application to AMA to become a Collaborator.<sup>5</sup> Gaining State recognition as a Collaborator will help to protect these entities and individuals from federal anti-trust laws while they engage in collective negotiations and bargaining, with the goal of developing and operating an RCO. See Section IV.5.e for additional information about how AMA will contract with RCOs.

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<sup>4</sup> A participant bears risk by contributing cash, capital, or other assets to the regional care organization. A participant also bears risk by contracting with the RCO to treat Medicaid beneficiaries at a capitated rate per beneficiary or to treat Medicaid beneficiaries even if the RCO does not reimburse the participant.

<sup>5</sup> A Collaborator is a private health carrier, third party purchaser, provider, health care center, health care facility, state and local government entity, or other public payer, corporation, individual, or consumer who collectively cooperates, negotiates or contracts with another collaborator or RCO in the health care system. In accordance with Sections 22-6-150, et seq. of the Alabama Code, every person or entity who is operating or may operate as a Collaborator in the health care system shall possess a certificate (Certificate to Collaborate) issued by the Medicaid Agency qualifying such person or entity to collaborate as set forth in Section 22-6-163 of the Alabama Code.

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- **Serve most Medicaid beneficiaries.** All beneficiaries, with the exception of Program of All-Inclusive Care for the Elderly (PACE) participants, children in foster care, dually eligible beneficiaries, and individuals residing in long term care facilities or utilizing home- and community-based waiver or hospice services, would be enrolled in and managed by an RCO. AMA may expand the Demonstration Populations enrolled in RCOs through later amendment to the Demonstration Project.
  
- **Mandatory enrollment.** The Demonstration Populations will be assigned to an RCO based on geographic location and other criteria such as historical care patterns and siblings. Most of the Demonstration Populations will be mandatorily enrolled in the RCO model to enable AMA to maximize its ability to better coordinate care for the highest number of beneficiaries. Mandatorily enrolled populations will have a choice of providers within the RCO network. The following individuals will have the choice to opt out of the program to be served through the fee-for-service delivery system: Native Americans; individuals whom public agencies are assuming full or partial financial responsibility; adopted children; aged, blind, or disabled individuals receiving only optional State supplements; and women who have been screened for breast and cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program.
  
- **Build upon successes of current Medicaid programs.** The RCO model will incorporate important structural elements from the Maternity Care, Patient 1<sup>st</sup> and PCN Programs that will allow the RCO to build upon and enhance care management for the Demonstration Populations:
  - ***Maternity Care Program:*** RCOs will provide maternity care services. RCOs will be expected to provide at least the same level of services provided under the current Maternity Care Program, which provides care coordination; Medicaid application assistance; mental health screening; smoking cessation education and access to Medicaid covered contraceptives. RCOs may choose to contract with current Maternity Care entities or build services themselves. Until an RCO is operational in a region, eligible beneficiaries in the Demonstration Populations will continue to receive services through the current Maternity Care Program.
  
  - ***Patient 1<sup>st</sup> Program:*** RCOs will assign each beneficiary in the Demonstration Populations to a medical home, which will provide at a minimum the same level of care coordination services currently delivered through Patient 1<sup>st</sup>. RCOs will develop a provider network in which they will contract directly with providers, including specialists and PMPs. RCOs will determine how to reimburse network PMPs for care coordination services (e.g., use existing per member per month case management fee, an enhanced case management fee, or another arrangement). Until an RCO is operational in a region, the

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Demonstration Populations will continue to receive services through the current Patient 1<sup>st</sup> Program.

- ***PCN (Health Home) Program:*** RCOs will provide at a minimum the same level of services to the Demonstration Populations as is currently provided through the PCN Program which was developed to more effectively address the broad spectrum of behavioral health and physical health needs of Medicaid beneficiaries with chronic conditions including mental illnesses and substance use disorders. RCOs will provide the following services currently provided by Health Homes through the PCN Program, including case management services; coordination of primary, acute, behavioral and post-acute services; and assignment of beneficiaries to PMPs who provide coordination and direct patient care.

Initial outcomes of the PCN Program show reductions in emergency department utilization and total cost. The PCN program has demonstrated increases in medical compliance, efficiency in the delivery system, and cost savings to Alabama Medicaid. Examples include dietician services to reduce obesity, “Summer Camps” focused on healthy lifestyles for children to reduce diabetes and obesity, emergency psychiatric care to prevent re-hospital admissions to behavioral health and substance abuse facilities, and utilizing pharmacists as part of a transitional care team to assist patients in receiving the most effective and cost saving medications as they are discharged from inpatient care.

AMA wants to continue to achieve improved outcomes through expansion of this program statewide and plans to release a RFP to procure additional Health Homes in 2014, concurrently with RCO planning and development. Only organizations that have achieved probationary RCO status will be eligible to submit a proposal to respond to this RFP, as described in Section IV.5.e. Once expanded statewide, AMA estimates 231,200 beneficiaries will be eligible for Health Homes.

RCOs may choose to contract with current PCN Health Homes operating in the same region or provide services themselves. Until an RCO is operational in a region, eligible individuals in the Demonstration Populations will continue to receive services through the PCN Program.

- **Managed physical and behavioral health services.** RCOs will manage primary, acute, behavioral, maternal, pharmacy and post-acute services that are currently provided under the Medicaid program. RCOs will be required to design care coordination programs to ensure the Demonstration Populations has access to adequate physical health care and behavioral health care in addition to connecting them with social services. They will also be tasked with coordinating maternity care to provide prenatal and delivery services.

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- **Partnership with the Alabama Department of Mental Health (ADMH).** To further improve care coordination, access to care and improve health outcomes, AMA will continue to build on its already strong partnership with ADMH, which serves as the single State agency for planning, administration, and certification of services for individuals who have mental illnesses, substance use disorders, and developmental disabilities. Together, ADMH and Medicaid will ensure that each RCO establishes and maintains an adequate network of behavioral health providers to appropriately address the needs of beneficiaries in the Demonstration Populations who have mental illnesses and substance abuse disorders. Mental health and substance abuse providers currently certified by ADMH and functioning as approved Medicaid providers are expected to be critical participants in the RCO provider networks.

Specifically, AMA and ADMH will work together to develop standards for RCOs that incorporate:

- Protocols for clinical care, quality assurance, and utilization review specific to mental illness and substance abuse.
  - Incentives for the provision of evidence-based, recovery and resilience oriented behavioral health care services.
  - Payment mechanisms and services that support and incentivize the transition of individuals from institutional-based care to community-based behavioral health care settings.
- **Connectivity of electronic health records.** RCOs will leverage the health information collected through electronic health records. The Alabama HIE (One Health Record) is currently under development. To ensure better integration of the Medicaid providers into the larger health care marketplace, Medicaid providers will share and access clinical information on patients. Providers affiliated with RCOs will be expected to use the standardized continuity of care record (CCD), which will be a component of the providers' electronic health record. Ultimately, real-time access to data will support providers in predicting, planning for, and intervening when necessary in a beneficiary's care management plan. In the interim, the State has approved other web-based tools to facilitate the efficient exchange of medical information between health care providers.
  - **Statewide integrated back-office functionality.** AMA anticipates providing centralized support for many of the RCO back-office functions. These functions could include, at a minimum, administrative activities such as claims processing, data analytics, third party collections, prior authorization, and other utilization management activities.

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- **At-risk model incorporating value-based purchasing strategies.** AMA will pay capitation payments to RCOs that will be at financial risk for the cost of services for the Demonstration Populations. AMA also anticipates reforming its payment methodologies to implement value-based purchasing strategies. For example, such an approach would transition hospitals from per diem payments to DRG types of payments, which would drive improvements in utilization and avoid incentives for hospitals to keep Medicaid beneficiaries in the hospital when another setting would be more appropriate. RCOs will be expected to comply with certain payment methodologies required by AMA, such as a DRG type of payment, in contracting with providers. An additional value-based purchasing strategy will be implemented through the RCO Quality Assurance Committee<sup>6</sup>, by developing penalties and rewards for performance based on selected quality measures determined by the Quality Assurance Committee.

AMA plans to establish regionally-based RCOs that will cover five geographical regions statewide as shown in **Attachment 12**. With only 12 urban counties out of 67 total, Alabama is considered to be a primarily rural State. Within the five regions, the urban versus rural counties are shown in **Attachment 13** and are as follows:

- Region A: Three urban counties and seven rural counties
- Region B: Four urban counties and twelve rural counties
- Region C: One urban county and twelve rural counties
- Region D: Three urban counties and eighteen rural counties
- Region E: One urban county and six rural counties

AMA estimates that the Demonstration Populations eligible for RCOs will vary by region, from approximately 62,000 eligible beneficiaries in Region C to approximately 220,000 eligible beneficiaries in Region B.

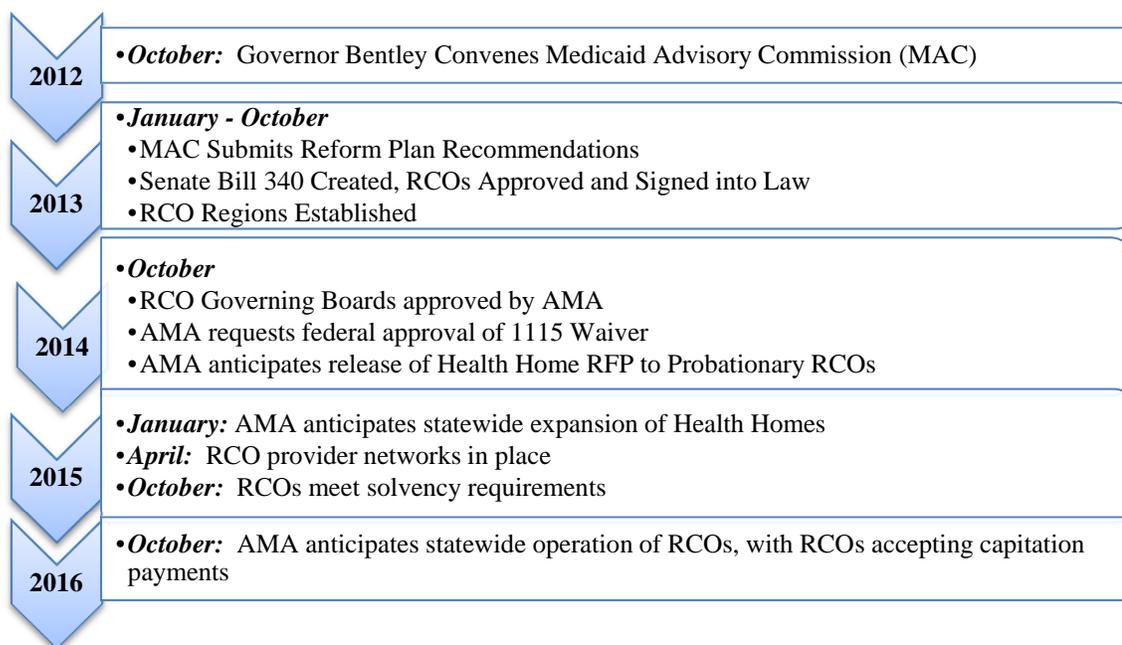
AMA will use a phased approach to implementation based on when an RCO in each region is approved by the State to begin operations. Alabama anticipates some fully certified RCOs to be established as early as October 1, 2015, but no later than October 1, 2016 the entire state should be covered by RCOs. To permit sufficient planning time to meet the target implementation date of October 1, 2015, AMA is seeking federal approval by October 1, 2014. **Figure 1** below outlines the proposed timeline for implementing the RCO model.

**Figure 1. RCO Model Proposed Implementation Timeline**

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<sup>6</sup> Per Alabama Legislative Act 2013-261, the Medicaid Commissioner will appoint the RCO QA Committee consisting of 60 percent physicians participating in the RCOs.

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2. *Funding Pools*

AMA proposes to create funding pools under the Demonstration that support the development, transition and maintenance of a coordinated care delivery system through RCOs, and to provide a mechanism for investments in delivery system reform. The funding pools will have three distinct components for which federal financial participation is requested: (1) funding for designated state health programs (DSHP), (2) transition payments to hospitals and other eligible providers to cover costs associated with transitioning to the RCO model, and (3) a delivery system reform incentive payment (DSRIP) program for eligible hospitals and other providers that will better align provider payment with the value of care.

AMA requests the flexibility to shift funding across the transition payment and DSRIP pools and from DSHP to the transition payment and DSRIP pools to address funding needs and evolving priorities. This flexibility is especially crucial in the first year of the demonstration when AMA plans to support data collection and to help build required infrastructure for the program.

a. Designated State Health Programs and Investment in State Infrastructure

AMA has identified a number of State-funded health care programs for which it will seek federal matching payments under the Demonstration. These include programs funded entirely by the State that provide safety-net health care services for low-income/uninsured individuals such as adult day care, outpatient substance abuse treatment and outpatient care for the mentally ill who are not eligible for Medicaid as it is currently structured. Securing federal support for these State-funded programs

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will free state funds for RCO development, health information exchange (HIE) connectivity for providers, and development of the analytics infrastructure that the State believes is necessary for the RCO model to successfully move forward under proposed timelines.

With DSHP funding, the State will also be able to redirect state funding to make AMA an active purchaser and partner in delivery system transformation. This will require the development of new skills and internal capacity. For instance, AMA must hire staff, or re-train existing staff, to build expertise in contracting for and managing complex, capitation-based contracts. In addition, AMA will need to further develop its own information technology infrastructure to ensure providers and AMA have timely access to the necessary data to best manage Medicaid beneficiaries. At a minimum, this would include an MMIS upgrade for the processing of inpatient hospital claims utilizing a DRG type methodology. To maximize the potential for success, these transformations will need to occur early in the reform process.

The DSHP and the approximate amount of annual funding for each are set forth in **Figure 2** below.

**Figure 2. Designated State Health Program Funding**

State Program	Program Services	Annual Funding
Department of Mental Health	Outpatient substance abuse programs	\$8,620,000.00
Department of Mental Health	Outpatient services for the mentally ill, such as childless men ineligible in Alabama for Medicaid	\$44,500,000.00
Department of Rehabilitation Services	Treatment of hemophilia patients not eligible for Medicaid	\$107,000.00
Alabama Department of Senior Services	SenioRx, a prescription drug assistance program that helps people get free prescription drugs from pharmaceutical companies	\$1,742,877.00
Department of Human Resources	Adult day care services for approximately 350 clients in seven counties	\$1,600,000.00
Department of Education	School Nurse Program for non-Medicaid children	\$15,100,000.00
University of South Alabama	Community health center services and training	\$850,000.00
Mobile County	Inpatient uninsured	\$2,000,000.00

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State Program	Program Services	Annual Funding
Jefferson County	Indigent Care Fund Program	\$44,000,000.00
TOTAL		\$118,519,877.00

Note: Until this Demonstration is officially filed with CMS, the State is continuing to explore opportunities that exist with other State entities to identify State-funded programs that serve the State's low-income/uninsured populations and improves overall health outcomes for State for inclusion in DSHP.

b. Funding Pool Payments

AMA is seeking authority to make payments to hospitals and other providers to support development of infrastructure needs as well as to help reform Alabama's health care system. Alabama believes that making transitional payments along with implementation of a DSRIP program will enhance the State's ability to collaborate with hospitals and other providers in improving the provision of health care and increasing capacity while moving towards a transparent system that pays for value not volume. These pools will provide hospitals and other providers the opportunity to receive funding to build infrastructure to be more active participants in initiatives to improve Alabama's health care system.

Through these payment pools, AMA can provide support to hospitals and other providers in a manner that increases payment accountability as the State transitions to a managed care delivery system. The pool payments will help to fund delivery system reforms that Alabama will implement to achieve long-term improvements in care delivery. This proposed funding under the Demonstration is intended to impact substantially all hospitals in the State.

Pool payments would be new program costs that would not exist in the absence of the waiver. Funding for the State portion of these new costs will come from newly available State dollars acquired from the DSHP costs not otherwise matchable described above as well as other state funds. Although the pools create increased costs, the offsetting savings associated with the medical costs of the Medicaid program will create budget neutrality over the course of the demonstration period. A description of the Budget Neutrality methodology is included in this document in **Attachment 3**, and the Budget Neutrality Spreadsheet is included as **Attachment 8**.

*Transition Payments*

With implementation of the RCO model, there will be extensive changes to Alabama Medicaid's service delivery, which will lead to transition costs for hospitals and other

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providers, over the life of the Demonstration. Hospitals will incur costs in transitioning to the DRG type payment methodology and in changing their overall delivery model. Providers will incur costs developing the interfaces necessary to participate in the statewide Health Information Exchange that will allow them to share critical medical information about Medicaid beneficiaries, including those in the Demonstration Populations. The Transition Payments will help offset the additional costs incurred by hospitals and other providers and smooth the adjustment to the new delivery system for Medicaid for the Demonstration Populations.

Transition Payments will decrease in amount over the life of the Demonstration, with an increasingly larger percentage of the funds being allocated to the DSRIP program described below. These Transition Payments will be largest in Year 1 and will decrease over the 5 years of the Demonstration. See Section VI, Budget Neutrality, for additional information about the allocation of funds across these pools over the five-year waiver period. This approach will help with the transition of hospitals from current volume-based payments to a more cost-effective reimbursement system that focuses on rewarding coordinated management, and cost-effective treatment of services with the RCO and with other RCO providers.

*Delivery System Reform Incentive Payments*

As part of the Demonstration, the AMA is seeking authority to implement a DSRIP pool to make incentive payments to encourage provider reform to match the RCO delivery system and improve the quality of care in Alabama. The proposed investment in this core part of the State's health care infrastructure is critical to increasing the efficiency and effectiveness of care provided to the State's most vulnerable populations and in preparing for full implementation of the RCO model. As greater demands are placed on the health care system, particularly by those patients with multiple chronic conditions who will be managed in a more comprehensive manner through this Demonstration, it is critical that hospitals and other providers expand their capacity and improve efficiencies.

The goals of the DSRIP pool are to incentivize activities that support hospitals' and providers' collaborative efforts to improve access to care and the health of the patients and families they serve. Incentive payments will be made to hospitals and other providers to encourage initiatives that fall into the following categories:

- 1) Infrastructure development: to support transformation to a new delivery system through investments in people, places, processes and technology
- 2) Innovation: to pilot, test and replicate innovative care models
- 3) Quality improvement: to require hospitals and other providers to report on pre-determined measures focused on care coordination and improved health outcomes

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- 4) Health Information Exchange utilization: to report on how use has increased care coordination and improved health outcomes

The DSRIP funds will be implemented in Year 2 and are expected to increase over the 5 years of the Demonstration. Similar to other states operating DSRIP programs, in the early years, Alabama will place more resources and emphasis on Category 1 and 2 projects, and in later years emphasis will shift towards Categories 3 and 4 improvement measures. Over the five-year plan, measures will evolve from process measures to improvement measures that are more outcome-oriented.

Examples of potential projects include:

- Expansion of chronic disease management approaches
- Emergency room improvements and reductions in utilization that reduce unnecessary utilization
- Investment in health information technology designed to increase care coordination such as efforts to achieve increased connectivity of electronic health records (EHRs); participation in the Healthcare Information Exchange; implementing the technology components of EHRs (such as computerized physician order entry and electronic prescribing) and efforts focused on system interoperability; and incentives for behavioral health providers who have not qualified for meaningful use incentives.
- Reducing readmission rates through improved care transitions, implementing evidence-based practices that improve discharge processes, post hospital coordination and patient experience
- Preventing admissions for ambulatory sensitive conditions to support the development of tools and processes to monitor, report and improve care delivery and coordination between hospitals and outpatient clinics, including the use of registries and clinical decision support systems that could be implemented and shared between inpatient and outpatient settings
- Ensuring equitable health care and outcomes by developing systems to stratify patient outcomes and quality measures by accurate patient demographic data such as race, ethnicity, gender, primary language and literacy level

Under the DSRIP program, participating hospitals and other providers must implement new, or significantly enhance existing, health care initiatives. AMA will develop DSRIP Planning Protocols which will serve as the guiding document for the DSRIP program including how the State will determine incentive payouts. Each participating hospital or provider must develop a DSRIP Proposal, consistent with the DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will

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accelerate meaningful improvement. AMA will collaborate with hospitals, other providers and CMS to finalize proposals that include mutually acceptable initiatives and outline timeframes for meeting those milestones.

DSRIP Proposals will describe the initiatives each hospital or provider proposes to undertake. AMA will provide details to hospitals and other providers about the information that must be included in a Proposal, but anticipates information such as the following will be required:

- The DSRIP Category under which the Proposal falls
- Specific measurable goals for the initiative, and where applicable, specific goals for improving the health outcomes of patients and the populations the hospital or provider serves
- Data analytics that support the selection of these goals, including baseline data
- Detailed summary of how the hospital or provider will conduct the project that is designed to achieve the identified goals including project milestones

Hospitals and other providers may qualify to receive incentive payments for fully meeting milestones specified in their DSRIP Plans, which represent measurable, incremental steps to complete specific activities, or demonstration of their impact on health system performance or quality of care. The State and CMS must certify the provider's achievement of the required milestones to receive the incentive payments.

See Section VI, Budget Neutrality, for additional information about the allocation of DSRIP funds over the five-year waiver period.

**D. Hypotheses and Evaluation Design**

AMA will test the following research hypotheses through the Alabama Section 1115 Demonstration:

- 1) Integrating services and eliminating the current silos between physical health services and behavioral health services will improve quality in covered Medicaid services.
- 2) Providing statewide care coordination services to Medicaid beneficiaries through an RCO model will result in improved health outcomes when compared with the health outcomes recorded under the current FFS delivery system.
- 3) Providing statewide care coordination services to Medicaid beneficiaries through an RCO model will improve appropriate utilization of hospital and emergency department services when compared to utilization under the current FFS delivery system.

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- 4) Holding RCOs to outcome and performance measures, and tying measures to meaningful financial incentives, will improve results on outcome and performance measures when compared to the current FFS delivery system.
- 5) Contracting with locally-led RCOs will do the following:
  - a. Better engage providers in solving cross-cutting health system issues such as how to coordinate and work with PMPs to establish standards of care
  - b. Assist providers in effectively managing more costly and complex beneficiaries
  - c. Better utilize claims and other data to identify beneficiaries most likely to benefit from intervention and to provide feedback to providers regarding care patterns and interventions

AMA will submit to CMS an evaluation design for the Demonstration no later than 120 days after CMS' approval of the Demonstration. AMA's evaluation design will:

- 1) Test the hypotheses described above
- 2) Describe specific outcome measures that will be used in evaluating the impact of each Demonstration-related program during the period of approval
- 3) Detail the data sources and sampling methodologies for assessing these outcomes
- 4) Describe how the effects of all Demonstration-related programs will be isolated from other initiatives occurring in the State
- 5) Discuss AMA's plan for reporting to CMS on the identified outcome measures and the content of those reports

AMA will submit the final evaluation design to CMS no later than 60 days after receiving comments on the draft evaluation design from CMS. AMA will submit progress reports in quarterly and annual Demonstration reports, and submit a draft final evaluation report within 120 days of the expiration of the Demonstration.

## **Section II-Demonstration Eligibility**

*This section should include information on the populations that will participate in the Demonstration, including income level. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:*

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- 1) *Include a chart identifying any populations whose eligibility will be affected by the Demonstration.*

Provider-based, community-led RCOs will manage and coordinate care for the Demonstration Populations. **Figures 3 and 4** below provide a listing of the mandatory and optional groups included in the Demonstration Populations.

The Demonstration will exclude PACE participants, children in foster care, dually eligible beneficiaries, and individuals residing in long term care facilities or utilizing home- and community-based waiver services. AMA is not requesting to expand to new populations through this Demonstration.

**Figure 3: Eligibility Chart for Mandatory State Plan Groups**

Eligibility Group Name	Social Security Act and C.F.R Citations	Income Level
Children age 6-18	1902(a)(10)(A)(i)(VII) and 1902(l)(1)(D) of the Act	100% FPL
Children age 1-5	1902(a)(10)(A)(i)(VI) and 1902(l)(1)(C) of the Act	133% FPL
Pregnant women and infants under 1 year of age	1902(a)(10)(A)(i)(IV) and 1902(l)(1)(A) and (B) of the Act	133% FPL
Child born to a woman eligible and receiving Medicaid as categorically needy on the date of the child's birth	1902(e)(4) of the Act	No income limits apply as they are deemed eligible.
Qualified Pregnant Women and Children	Sec. 1902(a)(10)(A)(i)(III) of the Act	AFDC standards as of 1996
Individuals other than qualified pregnant women and children who are members of a family that would be receiving AFDC under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC	Sec. 1902(a)(10)(A)(i)(V) and 1905(m) of the Act, Sec. 1902(e)(5) of the Act, Sec. 1902(e)(6) of the Act	AFDC standards as of 1996
Individuals ineligible for AFDC because of eligibility requirements prohibited under Medicaid	42 C .F.R. 435.113	AFDC standards as of 1996
Individuals who would be eligible for AFDC except for the increase in benefits who were entitled to OASDI in August 1972, and receiving cash assistance in 1972	42 CFR 435.114	AFDC standards as of 1996
Qualified Family Members	Sec.407(b), 1902(a)(10)(A)(i) and 1905(m)(1) of the Act, Sec1902(a)(52) and 1925 of the Act	AFDC standards as of 1996

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Eligibility Group Name	Social Security Act and C.F.R Citations	Income Level
Recipients of AFDC	42 CFR 435.110	AFDC standards as of 1996
Deemed Recipients of AFDC	42 CFR 435.115 and 1902 (a)(10)(A)(i)(I), Sec. 402(a)(22)(A) of the Act, 406(h), Sec.1931, Sec. 1902(a)(10)(A)(i)(I), Sec 1925 of the Act, Sec.1902(a) of the Act	AFDC standards as of 1996
Individuals receiving SSI	42 CFR 435.120	Federal Benefit Rate
Transitional Medical Assistance	408(a)(11)(A), 1902(a)(52), 1902(e)(1)(B), 1925, and 1931(c)(2)	185% FPL
Medicaid extension due to spousal support collections	408(a)(11)(A), 1902(a)(52), 1902(e)(1)(B), 1925, and 1931(c)(2) §435.115(f) – (h)	Eligible without a Medicaid income test
Disabled widows and widowers ineligible for SSI due to increase in OASDI (DWB)	1634(b) §435.137	SSI standards
Disabled adult children (DAC)	1634(c)	SSI standards
Early widows/widowers	1634(d) §435.138	SSI standards
Individuals ineligible for SSI due to Medicaid prohibited requirements	§435.122	SSI standards
Individuals eligible for SSI but for OASDI/COLA increases since 1977	Section 503 of P.L. 94-566 §435.135	SSI standards
Individuals who would be eligible for SSI/SSP but for OASDI COLAs in 1972 (closed to new enrollment)	Public Law 92-36 §435.134	SSI standards
Institutionalized individuals continuously eligible since 1973, excluding individuals in long term care facilities. (closed to new enrollment)	§435.132	SSI standards
Blind or disabled individuals eligible in 1973	§435.133	SSI standards
Individuals eligible as essential spouses in 1973	§435.131	SSI standards
Children receiving adoption assistance under title IV-E	1902(a)(10)(A)(i)(I) §435.115(e) and §435.145	Eligible without a Medicaid income test

**Figure 4: Eligibility Chart for Optional State Plan Groups**

Eligibility Group Name	Social Security Act and C.F.R Citations	Income Level
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Eligibility Group Name	Social Security Act and C.F.R Citations	Income Level
Women who have been screened for breast and cervical cancer under the CDC and Prevention Breast and Cervical Cancer Early Detection Program	1902(a)(10)(A)(ii)(XVIII) of the Act	Eligible without a Medicaid income test.
Optional Targeted Low Income Children	1902(a)(10)(A)(ii)(XIV) of the Act	100% FPL
Individuals not described in 1902(a)(10)(A)(i) of the Act who meet the income and resource requirements of the AFDC State Plan, under age 19	Sec. 1902(a)(10)(A)(ii)(I) and Sec. 1905(a)(i) of the Act	AFDC standards as of 1996
Reasonable classifications of individuals for whom public agencies are assuming full or partial financial responsibility and who are under age 21 , in private institutions	42 CFR 435.222	AFDC standards as of 1996
Child for whom there is in effect a State adoption agreement other than under Title IV-E of the Act) with special needs	1902(a)(10)(A)(ii)(VIII) of the Act	Eligible without a Medicaid income test
Aged, blind, or disabled individuals receiving only optional State supplements	1902(a)(10)(A)(ii)(IV) and (XI) §435.232 or §435.234	Income levels established by DHR
Native Americans	1903(m) and 1905(t)(3) of the Act.	Eligible without a Medicaid income test.

- 2) *Describe the Standards and Methodologies to Determine Eligibility for Any Population Whose Eligibility is Changed Under the Demonstration Project (if standards and methodologies differ from State Plan).*

There is no change from the State Plan methodology.

- 3) *Specify Any Enrollment Limits for Expansion Population*

There is no expansion population.

- 4) *Projected Number of Eligible Individuals*

*Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.*

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AMA will directly contract with RCOs for the Demonstration Populations, approximately 654,000 beneficiaries, including approximately 113,000 individuals who are aged, blind and disabled.

5) *Post-Eligibility Treatment of Income if Long-Term Services & Supports Provided*

*To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).*

Not Applicable. This Demonstration Proposal does not include long term services and supports or individuals who reside in long term care facilities or who are utilizing home- and community-based waiver services. The RCO will be required to provide coordination for beneficiaries in the Demonstration Populations who are transitioning into long-term care or a home- and community-based waiver and for individuals who are transitioning out of long-term care or a home- and community-based waiver and will be enrolled in the RCO.

6) *Changes in Eligibility Procedures for Populations Under Demonstration*

*Describe any changes in eligibility procedures the State will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).*

AMA is not requesting any changes in program eligibility.

7) *Eligibility Changes State Seeks to Undertake to Transition Medicaid or CHIP Eligibility Standards to Methodologies, Standards, or Other Changes Applicable in 2014*

*If applicable, describe any eligibility changes that the State is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.*

Alabama is not seeking any eligibility changes under the Demonstration.

As of January 2014, Alabama has made the following changes based on the Affordable Care Act (ACA):

- Collapsed the mandatory coverage groups for children, pregnant women, Medicaid for Low Income Families, and Children into coverage groups Pregnant Women, Children, and Parent/Caretakers. Alabama will apply the Modified Adjusted Gross

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Income (MAGI) to calculate the MAGI household and MAGI income, 42 CFR 135.603. In addition, we added coverage for former foster care clients under 26 years of age.

- Taken steps to align income limits for all children, up to the age of 19, at the same income level of 141 percent of the Federal Poverty Level (FPL). The income level for Pregnant Women, due to the conversion standard for Alabama, will also be at 141 percent FPL. The AFDC related groups will be set at 13 percent of the FPL rather than the dollar amount currently used.
- Eliminating disregards that we apply today. A 5 percent FPL general disregard will be applied to determine eligibility for each program.

**Section III-Demonstration Benefits and Cost Sharing Requirements**

*This section should include information on the benefits provided under the Demonstration as well as any cost sharing requirements. Specifically, this section should:*

- 1) *Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State Plan:*

Yes                       No (if no, please skip questions 3 – 7)

- 2) *Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State Plan:*

Yes                       No (if no, please skip questions 8 - 11)

- 3) *If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration:*

Not applicable.

- 4) *If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:*

Not applicable.

- Federal Employees Health Benefit Package
- State Employee Coverage
- Commercial Health Maintenance Organization
- Secretary Approved

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*Under section 1937(a)(2)(B) of the Act, the following populations are exempt from benchmark equivalent benefit packages: mandatory pregnant women, blind or disabled individuals, dual eligibles, terminally ill hospice patients, individuals eligible on basis of institutionalization, medically frail and special medical needs individuals, beneficiaries qualifying for long-term care services, children in foster care or receiving adoption assistance, mandatory section 1931 parents, and women in the breast or cervical cancer program. Also, please note that children must be provided full EPSDT benefits in benchmark coverage.*

Not applicable.

- 5) *In addition to completing the Benefit Specifications and Qualifications form (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf>), complete the following charts if the Demonstration will provide benefits that differ from the Medicaid or CHIP State Plan (refer to the list of Medicaid and CHIP benefits at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Medicaid-and-CHIP-Benefits.pdf> when completing chart):*

Not applicable.

- 6) *Indicate whether Long Term Services and Supports will be provided.*

Yes                       No

- 7) *Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.*

Yes (if yes, please address the questions below)

No (if no, please skip this question)

- a. *Describe whether the State currently operates a premium assistance program and under which authority, and whether the State is modifying its existing program or creating a new program*
  - b. *Include the minimum employer contribution amount*
  - c. *Describe whether the Demonstration will provide wrap-around benefits and cost-sharing*
  - d. *Indicate how the cost-effectiveness test will be met*
- 8) *If different from the State Plan, provide the premium amounts by eligibility group and income level.*

Not applicable.

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- 9) *Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State Plan.*

Not applicable.

*If the State is proposing to impose cost sharing in the nature of deductions, copayments or similar charges beyond what is permitted under the law, the State should also address in its application, in accordance with section 1916(f) of the Act that its waiver request:*

- a. will test a unique and previously untested use of copayments;*
- b. is limited to a period of not more than two years;*
- c. will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients;*
- d. is based on a reasonable hypothesis which the Demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area; and*
- e. is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.*

*Please refer to Information on Cost Sharing requirements for further information on statutory exemptions and limitations applicable to certain populations and services at the following link: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Information-on-Cost-Sharing-Requirements.pdf>*

Not applicable.

- 10) *Indicate if there are any exemptions from the proposed cost sharing.*

Not Applicable.

**Section IV - Delivery System and Payment Rates for Services**

*This section should include information on the means by which benefits will be provided to Demonstration participants. In accordance with 42 CFR 431.412(a)(ii), a description of the proposed healthcare delivery system must be included in a state's application in order to be determined complete. Specifically, this section should:*

- 1) *Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State Plan:*

Yes  
 No

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- 2) *Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.*

RCO Delivery System

The cornerstone of this reform plan is the development and implementation of RCOs in five regions across the State that will manage and coordinate care for the majority of Medicaid beneficiaries. These RCOs are provider-based, community-led organizations that will, through a capitated payment model, manage a broad scope of Medicaid benefits including primary, acute, behavioral, maternal, pharmacy and post-acute services for included populations. Because RCOs are provider-based organizations, AMA would establish criteria and oversight procedures that will be managed within the Medicaid Agency to provide additional oversight (e.g., timeliness of provider payment) and monitoring.

As part of its monitoring and supervision, the Medicaid Agency will, as it deems appropriate, request periodic reports and/or additional information regarding the status, progress being made and/or problems encountered in the collaborative process and/or the status of efforts to create integrated networks intended to provide for the delivery of a coordinated system of health care. AMA will dictate governance requirements which RCOs must follow, and will have the power to approve governing board members and to approve the selection process for RCO advisory committees.

RCOs will provide integrated, whole-person care, and improve access to health care and health outcomes for the Demonstration Populations. To do so, AMA has identified the following key programmatic design elements:

- **Provider-based community led organizations.** RCOs will be business entities that are incorporated under Alabama law.

The State will approve a Governing Board of Directors for each RCO that includes risk<sup>7</sup> and non-risk bearing participants (e.g., medical professionals and community representatives). The Governing Board will be responsible for establishment and oversight of the RCO's health delivery system. Each RCO will also have a Citizen's Advisory Committee, which will include Medicaid beneficiaries and will advise the RCO on providing more efficient, improved quality care.

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<sup>7</sup> A participant bears risk by contributing cash, capital, or other assets to the regional care organization. A participant also bears risk by contracting with the RCO to treat Medicaid beneficiaries at a capitated rate per beneficiary or to treat Medicaid beneficiaries even if the RCO does not reimburse the participant.

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To facilitate the development of RCOs, entities and individual providers who are considering developing or participating in an RCO may submit an application to AMA to become a Collaborator.<sup>8</sup> Gaining State recognition as a Collaborator will help to protect these entities and individuals from federal anti-trust laws while they engage in collective negotiations and bargaining, with the goal of developing and operating an RCO. See Section IV.5.e for additional information about how AMA will contract with RCOs.

- **Serve most Medicaid beneficiaries.** All beneficiaries, with the exception of Program of All-Inclusive Care for the Elderly (PACE) participants, children in foster care, dually eligible beneficiaries, and individuals residing in long term care facilities or utilizing home- and community-based waiver services, would be enrolled in and managed by an RCO. AMA may expand the Demonstration Populations enrolled in RCOs through later amendment to the Demonstration Project.
- **Mandatory enrollment.** The Demonstration Populations will be assigned to an RCO based on geographic location and other criteria such as historical care patterns and siblings. Most of the Demonstration Populations will be mandatorily enrolled in the RCO model to enable AMA to maximize its ability to better coordinate care for the highest number of beneficiaries. Mandatorily enrolled populations will have a choice of providers within the RCO network. The following individuals will have the choice to opt out of the program to be served through the fee-for-service delivery system: Native Americans; individuals whom public agencies are assuming full or partial financial responsibility; adopted children; aged, blind, or disabled individuals receiving only optional State supplements; and women who have been screened for breast and cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program.
- **Build upon successes of current Medicaid programs.** The RCO model will incorporate important structural elements from the Maternity Care, Patient 1<sup>st</sup> and PCN Programs that will allow the RCO to build upon and enhance care management for the Demonstration Populations:
  - ***Maternity Care Program:*** RCOs will provide maternity care services. RCOs will be expected to provide at least the same level of services provided under the current Maternity Care Program, which provides care coordination; Medicaid application assistance; mental health screening; smoking cessation education and access to Medicaid covered contraceptives. RCOs may choose to contract with

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<sup>8</sup> A Collaborator is a private health carrier, third party purchaser, provider, health care center, health care facility, state and local government entity, or other public payer, corporation, individual, or consumer who collectively cooperates, negotiates, or contracts with another collaborator or RCO in the health care system. In accordance with Sections 22-6-150, et seq. of the Alabama Code, every person or entity who is operating or may operate as a Collaborator in the health care system shall possess a certificate (Certificate to Collaborate) issued by the Medicaid Agency qualifying such person or entity to collaborate as set forth in Section 22-6-163 of the Alabama Code.

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current Maternity Care entities or build services themselves. Until an RCO is operational in a region, eligible beneficiaries in the Demonstration Populations will continue to receive services through the current Maternity Care Program.

- ***Patient 1<sup>st</sup> Program:*** RCOs will assign each beneficiary in the Demonstration Populations to a medical home, which will provide at a minimum the same level of care coordination services currently delivered through Patient 1<sup>st</sup>. RCOs will develop a provider network in which they will contract directly with providers, including specialists and PMPs. RCOs will determine how to reimburse network PMPs for care coordination services (e.g., use existing per member per month case management fee, an enhanced case management fee, or another arrangement). Until an RCO is operational in a region, the Demonstration Populations will continue to receive services through the current Patient 1<sup>st</sup> Program.
  
- ***PCN (Health Home) Program:*** RCOs will provide at a minimum the same level of services to the Demonstration Populations as is currently provided through the PCN Program which was developed to more effectively address the broad spectrum of behavioral health and physical health needs of Medicaid beneficiaries with chronic conditions including mental illnesses and substance use disorders. RCOs will provide the following services currently provided by Health Homes through the PCN Program, including case management services; coordination of primary, acute, behavioral and post-acute services; and assignment of beneficiaries to PMPs who provide coordination and direct patient care.

Initial outcomes of the PCN Program show reductions in emergency department utilization and total cost. The PCN program has demonstrated increases in medical compliance, efficiency in the delivery system, and cost savings to Alabama Medicaid. Examples include dietician services to reduce obesity, “Summer Camps” focused on healthy lifestyles for children to reduce diabetes and obesity, emergency psychiatric care to prevent re-hospital admissions to behavioral health and substance abuse facilities, and utilizing pharmacists as part of a transitional care team to assist patients in receiving the most effective and cost saving medications as they are discharged from inpatient care.

AMA wants to continue to achieve improved outcomes through expansion of this program statewide and plans to release a RFP to procure additional Health Homes in 2014, concurrently with RCO planning and development. Only organizations that have achieved probationary RCO status will be eligible to submit a proposal to respond to this RFP, as described in Section IV.5.e. Once expanded statewide, AMA estimates 231,200 beneficiaries will be eligible for Health Homes.

RCOs may choose to contract with current PCN Health Homes operating in the same region or provide services themselves. Until an RCO is operational in a

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region, eligible individuals in the Demonstration Populations will continue to receive services through the PCN Program.

**Managed physical and behavioral health services.** RCOs will manage primary, acute, behavioral, maternal, pharmacy and post-acute services that are currently

- provided under the Medicaid program. RCOs will be required to design care coordination programs to ensure the Demonstration Populations has access to adequate physical health care and behavioral health care in addition to connecting them with social services. They will also be tasked with coordinating maternity care to provide prenatal and delivery services.
- **Partnership with the Alabama Department of Mental Health (ADMH).** To further improve care coordination, access to care and improve health outcomes, AMA will continue to build on its already strong partnership with ADMH, which serves as the single State agency for planning, administration, and certification of services for individuals who have mental illnesses, substance use disorders, and developmental disabilities. Together, ADMH and Medicaid will ensure that each RCO establishes and maintains an adequate network of behavioral health providers to appropriately address the needs of beneficiaries in the Demonstration Populations who have mental illnesses and substance abuse disorders. Mental health and substance abuse providers currently certified by ADMH and functioning as approved Medicaid providers are expected to be critical participants in the RCO provider networks.

Specifically, AMA and ADMH will work together to develop standards for RCOs that incorporate:

- Protocols for clinical care, quality assurance, and utilization review specific to mental illness and substance abuse.
- Incentives for the provision of evidence-based, recovery and resilience oriented behavioral health care services.
- Payment mechanisms and services that support and incentivize the transition of individuals from institutional-based care to community-based behavioral health care settings.
- **Connectivity of electronic health records.** RCOs will leverage the health information collected through electronic health records. The Alabama HIE (One Health Record) is currently under development. To ensure better integration of the Medicaid providers into the larger health care marketplace, Medicaid providers will share and access clinical information on patients. Providers affiliated with RCOs will be expected to use the standardized continuity of care record (CCD), which will be a component of the providers' electronic health record. Ultimately, real-time access to data will support providers in predicting, planning for, and

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intervening when necessary in a beneficiary's care management plan. In the interim, the State has approved other web-based tools to facilitate the efficient exchange of medical information between health care providers.

- **Statewide integrated back-office functionality.** AMA anticipates providing centralized support for many of the RCO back-office functions. These functions could include, at a minimum, administrative activities such as claims processing, data analytics, third party collections, prior authorization, and other utilization management activities.
  
- **At-risk model incorporating value-based purchasing strategies.** AMA will pay capitation payments to RCOs that will be at financial risk for the cost of services for the Demonstration Populations. AMA also anticipates reforming its payment methodologies to implement value-based purchasing strategies. For example, such an approach would transition hospitals from per diem payments to DRG types of payments, which would drive improvements in utilization and avoid incentives for hospitals to keep Medicaid beneficiaries in the hospital when another setting would be more appropriate. RCOs will be expected to comply with certain payment methodologies required by AMA, such as a DRG type of payment, in contracting with providers. An additional value-based purchasing strategy will be implemented through the RCO Quality Assurance Committee<sup>9</sup>, by developing penalties and rewards for performance based on selected quality measures determined by the Quality Assurance Committee.
  
- **Enhancing payments for targeted services to enhance access to care.** AMA would enhance reimbursement for a number of services to encourage capacity development. These may include care coordination fees to providers to cover necessary care coordination services that are not directly reimbursable under the current benefit structure. RCOs would be expected to adopt these enhanced payments to further enable delivery system reform and enhance access to care for Medicaid beneficiaries.

3) *Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:*

- Managed Care
- Managed Care Organization (MCO)
- Prepaid Inpatient Health Plans (PIHP)
- Prepaid Ambulatory Health Plans (PAHP)
- Fee-for-service (including Integrated Care Models)

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<sup>9</sup> Per Alabama Legislative Act 2013-261, the Medicaid Commissioner will appoint the RCO QA Committee consisting of 60 percent physicians participating in the RCOs.

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- Primary Care Case Management (PCCM)  
 Health Homes  
 Other (please describe)

The RCO model AMA will implement through this Demonstration is a provider-based community led risk-based model through which regional RCOs will receive capitation payments. RCOs will establish provider networks and manage most State Plan benefits for the Demonstration Populations. AMA will provide administrative support to RCOs that need such support. AMA is also requesting to transition its current 1915(b) Maternity Care Program to be under the authority of this 1115 Demonstration Proposal, as the RCOs will be responsible for the provision of services under that program. They will also be responsible for the provision of Health Home services under the State Plan.

As the RCO model will be implemented using a phased approach, AMA will continue administering the Maternity Care Program, as well as Patient 1<sup>st</sup> and the PCN Program in regions where RCOs are not operational. These programs will be phased out as RCOs are operational in each region, although RCOs will be required to maintain at least the same level of program services as described in Section I.C. RCOs will have the option to contract with existing Maternity Care Program administrative entities and Health Homes or to provide those services in house.

- 4) *If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State Plan, section 1915(a) option, section 1915(b) or section 1932 option:*

Eligibility Group	Delivery System	Authority
<i>(ex: Transitional Medical Assistance)</i>	<i>(ex: Fee-for-service)</i>	<i>(ex: State Plan)</i>
Children age 6-18	FFS and Health Home (if eligible), transitioning to fully capitated RCO model when available in beneficiary's region.	State Plan transitioning to 1115 Waiver when a fully capitated RCO is available in beneficiary's region.
Children age 1-5		
Pregnant women and infants under 1 year of age		
Child born to a woman eligible and receiving Medicaid as categorically needy on the date of the child's birth		
Qualified Pregnant Women and Children		
Individuals other than qualified pregnant women and children who are members of a family that would be receiving AFDC under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC		
Individuals ineligible for AFDC because of eligibility requirements prohibited under Medicaid		
Individuals who would be eligible for AFDC except for the		

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Eligibility Group	Delivery System	Authority
increase in benefits who were entitled to OASDI in August 1972, and receiving cash assistance in 1972		
Qualified Family Members		
Recipients of AFDC		
Deemed Recipients of AFDC		
Individuals receiving SSI		
Transitional Medical Assistance		
Medicaid extension due to spousal support collections		
Disabled widows and widowers ineligible for SSI due to increase in OASDI (DWB)		
Disabled adult children (DAC)		
Early widows/widowers		
Individuals ineligible for SSI due to Medicaid prohibited requirements		
Individuals eligible for SSI but for OASDI/COLA increases since 1977		
Individuals who would be eligible for SSI/SSP but for OASDI COLAs in 1972 (closed to new enrollment)		
Institutionalized individuals continuously eligible since 1973, excluding individuals in long term care facilities. (closed to new enrollment)		
Blind or disabled individuals eligible in 1973		
Individuals eligible as essential spouses in 1973		
Children receiving adoption assistance under title IV-E		
<b><i>Optional State Plan Groups</i></b>		
Women who have been screened for breast and cervical cancer under the CDC and Prevention Breast and Cervical Cancer Early Detection Program	FFS and Health Home (if eligible), transitioning to fully capitated RCO model when available in beneficiary's region for beneficiaries who choose to enroll in the RCO. For those who opt to not enroll, continued provision of services through the fee-for-service delivery system.	State Plan transitioning to 1115 Waiver when a fully capitated RCO is available in beneficiary's region.
Optional Targeted Low Income Children		
Individuals not described in 1902(a)(10)(A)(i) of the Act who meet the income and resource requirements of the AFDC State Plan, under age 19		
Reasonable classifications of individuals for whom public agencies are assuming full or partial financial responsibility and who are under age 21, in private institutions		
Child for whom there is in effect a State adoption agreement other than under Title IV-E of the Act) with special needs		
Aged, blind, or disabled individuals receiving only optional State supplements		

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Eligibility Group	Delivery System	Authority
Native Americans		

5) *If the Demonstration will utilize a managed care delivery system:*

a) *Indicate whether enrollment is voluntary or mandatory. If mandatory, is the State proposing to exempt and/or exclude populations?*

All beneficiaries in the Demonstration Populations will be required to enroll in an RCO based on geographic location with the exception of the following individuals who may enroll at their option: Native Americans; individuals whom public agencies are assuming full or partial financial responsibility; adopted children; aged, blind, or disabled individuals receiving only optional State supplements; and women who have been screened for breast and cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program.

Excluded individuals who will not be enrolled with an RCO are as follows: PACE participants, children in foster care, dually eligible beneficiaries, and individuals residing in long term care facilities or utilizing home- and community-based waiver services.

b) *Indicate whether managed care will be statewide, or will operate in specific areas of the State.*

AMA plans to establish regionally-based RCOs that will cover five geographical regions statewide as shown in **Attachment 12**. Please see Section I.C for additional information for program implementation.

If Alabama is unable to procure an RCO to cover a region, the region will be offered to other RCOs existing in the State. If no other RCO wishes to cover the region, the law contemplates that an alternative care provider will provide services to the beneficiaries in that region.

c) *Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the State).*

AMA will use a phased approach to implementation based on when an RCO in each region is approved by AMA to begin operations. AMA anticipates some RCOs to be established as early as October 1, 2015, but no later than October 1, 2016 the entire state should be covered by RCOs. To permit sufficient planning time to meet the target implementation date of October 1, 2015, AMA is seeking federal approval by October 1, 2014. Please see Section I.C for the proposed timeline for implementing the RCO model.

d) *Describe how the State will assure choice of MCOs, access to care and provider network adequacy.*

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Alabama intends to mandate enrollment into RCOs for most of the Demonstration Populations. To the extent there is more than one RCO in a region, beneficiaries would retain the right to select the RCOs. However, due to the rural nature of the State, it is estimated some regions may only include one RCO to be actuarially sound.

AMA will establish enrollment and disenrollment processes that comply with 42 CFR Part 438. AMA will have mechanisms in place to educate RCO enrollees and potential enrollees about RCO(s) in their region. For example, AMA may provide brochures that provide information about the RCO. Should more than one RCO participate in a region, AMA will assess the appropriate administration of services to assist beneficiaries in selecting an RCO.

AMA will also provide all beneficiaries with information about the program, how to use the RCO, beneficiary rights and responsibilities including but not limited to access to care and appeal rights in adverse decisions. AMA will provide contact information for beneficiaries to assist them with questions about the program, RCO selection (when applicable), PMP selection and enrollment.

Beneficiaries will be encouraged and provided the opportunity to select a PMP. If beneficiaries do not voluntarily choose a PMP, the Agency will automatically assign the beneficiary to a PMP based on existing criteria through the MMIS system, proximity and an auto assignment algorithm. Beneficiaries who are auto-assigned to a PMP will be given an opportunity to change providers within 30 days of their assignment.

AMA will regularly review the assignments to ensure that the assignment process is working correctly. The assignment reason will be compared to the information on file to ensure that the most appropriate assignment algorithm is applied.

To address the needs of the Demonstration Populations, AMA will require that RCOs develop provider networks that include the appropriate provider mix. AMA will require that RCOs submit a formal inventory of providers, by specialty type, that demonstrates compliance with pre-defined network adequacy requirements, as established by AMA. Included in these requirements will be the need for RCOs to maintain an adequate network of providers to meet all health care needs of the Demonstration Populations that includes, but is not limited to, maternity providers, PMPs and mental health providers.

While these network standards are currently in development, the final requirements will be no less stringent than existing distance standards. Providers must also continue to meet standards for timely access to care and services, considering the urgency of the service. AMA is also considering alternative solutions to network development such as requiring the RCOs provide enhanced coverage and payments for targeted services to enhance access.

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AMA will provide oversight of the RCOs to confirm compliance with network requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the Demonstration Populations. AMA will also require RCOs to monitor timely access to care and will require that the RCOs submit regular reports to AMA to demonstrate that they meet network adequacy requirements on an ongoing basis. AMA will monitor RCO networks to ensure that each RCO maintains an adequate network on an ongoing basis, through processes such as review of access to care metrics, beneficiary satisfaction and beneficiary complaints and appeals.

e) *Describe how the managed care providers will be selected/procured.*

AMA will release a request for applications from potential RCOs in calendar year 2014. Any RCO meeting state statutory requirements may apply for and participate in the program.

AMA will review and approve applications for the development of RCOs. There are multiple steps in the process for becoming an RCO:

- **Collaborators.** Any private health carrier, third party purchaser, provider, health care center, health care facility, state and local governmental entity, or other public payers, corporations, individuals and consumer expecting to collectively cooperate, negotiate, or contract with another collaborator or regional care organization in the health care system may operate as a Collaborator if he/she/it possesses a Certificate to Collaborate issued by the Medicaid Agency qualifying them to act as a Collaborator. Certificates to Collaborate may be issued by the Medicaid Agency to persons and entities to allow for collective negotiations, bargaining and cooperation among Collaborators and RCOs.
- **Probationary RCO.** Entities will apply to become a probationary RCO. Probationary RCOs are provider-based organizations that have met an initial set of state-developed requirements such as development of an approved Governing Board of Directors and a Citizen's Advisory Committee. By applying for probationary RCO status, an organization is indicating that it intends to become a fully certified RCO and accept capitation payments for providing Medicaid services to Medicaid beneficiaries.

As discussed in Section I.C, AMA plans to expand the Health Home program statewide and expects to release an RFP to procure additional Health Home providers in 2014. Only probationary RCOs will be eligible to respond to this RFP. AMA encourages probationary RCOs to submit a proposal in response to this RFP so as to further develop care management infrastructure in their path to become fully certified RCOs. However, AMA will not require probationary RCOs to serve as Health Homes prior to becoming fully certified RCOs.

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- **Fully Certified RCO.** Once an organization has achieved probationary RCO status, it will submit regular reports to AMA to demonstrate progress towards being able to provide services pursuant to a risk contract. These reports will address network adequacy and financial solvency, among other requirements. Prior to implementation, an RCO must demonstrate that it meets all criteria for full RCO certification.

It is this process that is creating the need for AMA to use a phased approach for implementation based on when RCOs are approved for operation. In each region, it is expected that AMA will continue operations for Patient 1<sup>st</sup>, PCN, and Maternity Care Programs until an RCO is operational.

- 6) *Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.*

All State Plan benefits will be provided by RCOs for the Demonstration Populations with the exception of the following:

- Long-term supports and services, hospice, both institutional and home- and-community-based, excluded by statute until the completion of a special study to be reported to the Legislature and Governor on October 1, 2015.
- Dental services are also excluded by statute until the completion of a special study to be reported to the Legislature and Governor on October 1, 2015.
- Targeted Case Management, Children's Specialty Clinic Services, rehabilitative substance abuse services, hearing services, which are provided by other state agencies are excluded for the first two years.

- 7) *If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration.*

Yes       No

- 8) *If fee-for-service payment will be made for any services, specify any deviation from State Plan provider payment rates. If the services are not otherwise covered under the State Plan, please specify the rate methodology.*

AMA will not pay fee-for-service rates, but instead will pay the RCOs based on an at-risk capitated payment system.

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- 9) *If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.*

Capitation payments for the RCO will be determined by an actuarial rate setting process in accordance with 42 CFR Part 438. For the initial rate setting process, Medicaid historical FFS data will be used to set rates, and will continue to be used until sufficient RCO encounter data is available. While only FFS data is available, assumptions will be made as to the utilization and unit cost changes associated with the transition to the RCO delivery system.

Rates will be developed at a statewide level based on historical data. The Demonstration Populations will be broken into subpopulations potentially segregated by age, sex, and type of eligibility. Once statewide rates are established, these rates will be adjusted to each regional population's risk and demographics. The final RCO payments will be adjusted for the risk of the population assigned to each RCO. RCO payments will also include appropriate amounts for administration, case management, and risk premium.

- 10) *If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.*

AMA, through the statewide RCO Quality Assurance (QA) Committee's annual adoption of quality measures, will define priority quality initiatives, benchmarks, and metrics. The RCO QA Committee will identify outcome and quality measures for all health services provided by RCOs such as ambulatory care, inpatient care, chemical dependency, mental health treatment, and all other RCO health services. Quality measures will be consistent with existing state and national quality measures. Examples of options for the quality measures include CMS Core Set of Adult and Child Health measures, Health Home for Chronic Disease measures, National Committee for Quality Assurance (NCQA)/ Healthcare Effectiveness Data and Information Set (HEDIS®) measures and Meaningful Use. The selected measures will also support the evaluation requirements of the Demonstration.

AMA anticipates initial quality targets will be focused on metrics to help measure improvements in population health including patient satisfaction, reduction in unnecessary readmissions, equitable health outcomes, effectiveness of care and access to care. AMA will consider aligning quality targets and metrics associated with incentives with existing nationally recognized and validated measures such as the HEDIS®. The RCO QA Committee will adopt outcome and quality measures annually and adjust for the following: global budget of RCOs; changes in membership; costs of implementing outcome and quality measures; and conduct and cost of performing community health assessments.

Additionally, AMA and the Alabama Department of Mental Health (ADMH) will collaborate to develop standards for RCOs that incorporate: protocols for clinical care, quality assurance, and utilization review specific to mental illness and substance abuse; incentives for provision

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of evidence-based, recovery and resilience oriented behavioral health care services; and payment mechanisms/services that support and incentivize transition of individuals from institutional-based care to community-based behavioral health care settings.

AMA proposes withhold of five percent on the capitated payments to each RCO that will be paid pending satisfactory reporting and achievement of outcome and quality metrics and benchmarks as determined by the statewide RCO QA Committee. The RCOs will be eligible for incentive payments out of the withhold for achieving quality outcomes each year of the program. The first year of the program, the RCOs will be eligible for incentive payments for reporting target quality outcomes. In subsequent years, the RCOs will be eligible for incentive payments for achieving benchmarks on approved quality measures. RCOs will be required to report outcomes to determine eligibility for incentive payments.

The outcome and quality measures will be incorporated into RCO contracts for accountability for performance and member satisfaction. AMA will continuously evaluate outcome and quality measures adopted by the RCO QA Committee, will utilize available data systems for reporting adopted outcome and quality measures, will eliminate redundant reporting or reporting of limited value, and will publish aggregate information on quality measures, outcomes, costs, and other information specified in the contract to evaluate the value of RCO health services.

AMA will conduct an independent evaluation of the cost savings, patient outcomes, and quality of care provided by each RCO. This independent RCO evaluation will be used to determine whether to enter into future multi-year contracts or to make changes to the region's care delivery system. AMA will also establish by rule a procedure for termination of an RCO for non-performance of contractual duty or failure to meet or maintain benchmarks, standards, or requirements set forth in the Alabama RCO Law.

To provide increased transparency of the Medicaid program to stakeholders, AMA will publish RCO metrics at aggregate levels, including quality, cost, and outcome data.

## **Section V - Implementation of Demonstration**

*This section should include the anticipated implementation date, as well as the approach that the State will use to implement the Demonstration. Specifically, this section should:*

- 1) *Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone;*

Below is the anticipated implementation schedule. AMA will use a phased approach to implementing the Demonstration in each region based on when RCOs apply and are approved for operations. AMA anticipates the Demonstration will be statewide by October 2016.

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<b>IMPLEMENTATION SCHEDULE</b>	
<b>Dates</b>	<b>Milestones</b>
10/01/2013	RCO regions established
10/01/2014	RCO governing boards approved by Medicaid
04/01/2015	RCO provider networks in place
10/01/2015	RCO must meet solvency requirements
10/01/2016	AMA anticipates statewide operation of RCOs, with RCOs accepting capitation payments

- 2) *Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.*

AMA will establish enrollment and disenrollment processes that comply with 42 CFR Part 438. AMA will have mechanisms in place to educate RCO enrollees and potential enrollees about RCO(s) in their region. For example, AMA may provide brochures that provide information about the RCO. Should more than one RCO participate in a region, AMA will assess the appropriate administration of services to assist beneficiaries in selecting an RCO.

AMA will also provide all beneficiaries with information about the program, how to use the RCO, beneficiary rights and responsibilities including but not limited to access to care and appeal rights in adverse decisions. AMA will provide contact information for beneficiaries to assist them with questions about the program, RCO selection (when applicable), PMP selection and enrollment.

Additionally, AMA will use the following processes to notify beneficiaries prior to and upon enrollment into the RCOs during the transition period and ongoing:

- a) Notification by official Medicaid Recipient Notice to be received by individuals in the Demonstration Populations no later than 10 days prior to the start of the assignment process. This notice is to explain the changes that Medicaid is making regarding implementation of RCOs and what the beneficiary will be expected to do or know to access care.
- b) A second written notice or letter will be sent by Medicaid to advise the beneficiary specifically about assignment to an RCO and PMP within their region. Beneficiaries will have 30 days to request a change to the assignment if desired.
- c) Confirmation/Welcome information/Benefits Guide and related materials will be sent by the assigned RCO to beneficiaries. The information must include benefits covered under the RCO, list of providers included in the RCO network, cost sharing requirements, and contact information should beneficiaries have questions. (AMA will require approval of the confirmation letter and any related materials prior to use.)

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AMA will require that all communications are:

- Written in clear, easy-to-read language in a culturally-appropriate manner
  - Available in all non-English languages spoken by a significant number or percentage, as defined by AMA, of the Demonstration Populations
  - Are worded such that they are understandable to a person who reads at the grade level required by AMA
- 3) *If applicable, describe how the State will contract with managed care organizations to provide Demonstration benefits, including whether the State needs to conduct a procurement action.*

AMA will accept applications from potential RCOs in calendar year 2014. Any RCO meeting the state statutory requirements may participate in the program. See Section IV.5.e for a description of the process to become an RCO.

### **Section VI - Demonstration Financing and Budget Neutrality**

*This section should include a narrative of how the Demonstration will be financed as well as the expenditure data that accompanies this application. The State must include 5 years of historical data, as well as projections on member month enrollment. In accordance with 42 C.F.R 431.412(a)(iii) and (iv), historical and projected expenditures as well as projected enrollment for the proposed Demonstration project must be included in a state's application in order to be determined complete. The additional information requested will be needed before the application can be acted upon.*

*Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf> includes a set of standard financing questions typically raised in new section 1115 Demonstrations; not all will be applicable to every Demonstration application. The Budget Neutrality form and spreadsheet: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf> includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.*

Please see **Attachment 3** for the financing form and **Attachment 8** for the budget neutrality form.

### **Budget Neutrality Background**

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The budget neutrality estimates are created by modeling a with-waiver and without-waiver scenario. The without-wavier scenario shows baseline costs absent of the waiver implementation programs. The with-waiver scenario adds each component of the waiver to the modeling. Savings will be achieved with the implementation of RCOs, statewide Health Homes, and a DRG based hospital payment system. The RCOs, Health Homes, and DRG payment model will shift the current FFS program from rewarding service volume to rewarding service quality. The resulting focus on the appropriate level of and type of service has been demonstrated to reduce the rate of growth of Medicaid expenditures in other states and is the primary driver of savings over the five-year period.

Procedures to track these savings by year will include developing fee-for-service equivalent expenditure estimates by population in the absence of the waiver and comparing that to expenditures by the full risk RCOs (using RCO encounter data and capitation payments as they become available). Additionally, various outcome and quality standards will be in place and tracked as a part of the RCO model as mentioned above within section IV of the application.

As noted above, an RCO model is a significant part of the State's plan to reform the Medicaid program. These RCOs will be provider based and will take on full risk (inclusive of inpatient, outpatient, emergency room, physician and pharmacy services) for their population through a capitation payment. A managed care environment will help to increase quality and reduce cost for the RCO populations.

The with-waiver figures described below represent a preliminary estimate of the capitation rate that will be paid to the RCOs by the State. The rate setting process will include development of rates at a statewide level based, in the early years, on historical fee-for-service data. As encounter data from the RCOs emerges, this will supplement and potentially replace fee-for-service data in the rate development process. The overall RCO population will be broken into subpopulations based on age, sex, and type of eligibility. Once statewide rates are established, these rates will be adjusted to each regional population's risk and demographics. The final RCO payments will be adjusted for the risk of the population assigned to each RCO. RCO payments will also include appropriate amounts for non-medical load: e.g., administration, case management, and risk premium.

RCOs will be responsible for contracting with hospital, physician and pharmacy providers at negotiated rates, with a State-established minimum reimbursement. Supplemental payments currently paid outside of the claims by the State will be incorporated into the capitation payments received by the RCO. The timeframe for moving hospitals to DRG payments is currently being determined. A phase in approach will likely be taken.

The following contains a description of the with-waiver and without-waiver budget neutrality estimates:

**With-Waiver**

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**Overview:**

The with-waiver Trend Rates, PMPM Costs, and Member Months were developed as a preliminary estimate of a reformed Alabama Medicaid system including the addition of a managed Regional Care Organization (RCO) program. The development of these estimates is described below.

**Historical Data:**

The State of Alabama (State) developed the budget neutrality projections using fee-for-service (FFS), encounter, and financial data. The data covers the five year period from 10/1/07 – 9/30/12 (FY08-FY12). Rate cohorts are collected into the following Medicaid Eligibility Groups (MEGs):

<b>MEG</b>	<b>Rate Cohort</b>
ABD	ABD Less Than 1
ABD	ABD 1-5
ABD	ABD 6-14
ABD	ABD 15-18
ABD	ABD 19-44
ABD	ABD 45+
BCCTP	BCCTP
MLIF	MLIF Less Than 1
MLIF	MLIF 1-5
MLIF	MLIF 6-14
MLIF	MLIF 15-18
MLIF	MLIF 19-44
MLIF	MLIF 45+
SOBRA Child	SOBRA Child Less Than 1
SOBRA Child	SOBRA Child 1-5
SOBRA Child	SOBRA Child 6-14
SOBRA Child	SOBRA Child 15+
Transitional	Transitional
Refugees	Refugees
Delivery	Delivery - Normal
Delivery	Delivery - High Risk

The MEGs were determined by grouping rate cohorts into similar risk categories from a cost and actuarial perspective.

The five years of historical data was blended by reviewing the PMPMs and assigning varying credibility to each year, resulting in higher credibility being given to more recent years.

**Program Changes:**

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The State adjusted the data to account for program changes that occurred during the FY08-FY12 data period. All data was normalized to the latest information available. The program changes are further discussed below.

*DME – POP:* Prosthetic, Orthotic, and Pedorthotic Devices were approved with prior authorization (PA) as of 3/1/2008.

*Trofile Assay:* Coverage of Trofile Assay (with PA) began on 12/1/2008.

*Ambulance:* Removed PA requirement except for trips over 100 miles one way as of 2/1/2009.

*Radiology:* Implemented a radiology PA program as of 4/1/2009.

*Hospital Reimbursement:* Inpatient hospital reimbursement changed from a Prepaid Hospital Plan (PHP) to FFS reimbursement as of 9/18/2010. Outpatient hospital reimbursement changed from FFS to PHP.

*Hospital and ASC:* Reimbursement for all surgical procedure groups was decreased by 10% as of 2/15/2010. Hospital and ASC reimbursement was increased by 6% on 10/1/2011.

*Psychologists:* Allowed 30-minute fractional units for 96101-96103; 96118-96120 as of 7/1/2010. Required modifiers (U6, U7, AJ, and HO) for allied mental health professional staff, and reduced reimbursement for these modifiers to 75% of the allowable rate of the psychologist.

*Hospice Election:* As of 7/19/2010, no longer required children under 21 to waive rights, and they can receive hospice services.

*Hospital Outpatient:* As of 10/1/2010, outpatient observation codes 99218-99220 were replaced with G0378.

*Psychology:* As of 1/1/2011, imposed max units of 12 for 90849 and 90853; max units of 26 for 90806, 90812, 90818, 90826, and 90847; max units of 52 for 90804, 90810, 90816, and 90823. The following services are not covered: equine assisted psychotherapy, biofeedback therapy, neurobiofeedback therapy, sleep therapy, dance therapy, music therapy, and art therapy. On 4/1/2011, individual and group therapy to 52 units per year and one unit per week.

*Eye Care:* As of 7/1/2011, Korrekt Optical became the eyeglass vendor. As of 2/22/2012, recipients under 21 were limited to 2 exams, 2 fittings, 2 frames, and 4 lenses each calendar year. As of 6/1/2012, routine eye exams were limited to one every three calendar years and eyeglasses were eliminated for recipients 21 years of age and older. As of 11/1/2012, eyeglass coverage for recipients 21 and older was reinstated at one pair every two years, and routine eye exams were allowed once every two years. As of 3/1/2013, eyeglass coverage for recipients 21 and older was limited to one routine eye exam and one pair of eyeglasses every three years.

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*Reimbursement cuts:* As of 6/1/2012, reimbursement rates for physicians, dentists, physician lab and x-ray, independent lab and x-ray, DME, and other licensed practitioners were reduced by 10%. These cuts were reversed for physicians, dentists, physician lab and x-ray, independent lab and x-ray, and other licensed practitioners on 10/1/2012. The cuts were reversed for DME providers on 11/1/2012.

*Maternity:* From 5/1/2012 – 12/31/2012, Maternity Contractor rates were reduced by 10%.

*Affordable Care Act Section 1202:* Reimbursement rates for attesting Primary Care Physicians were increased as of 1/1/2013.

*Durable Medical Equipment:* As of 1/1/2013, reimbursement for CPAP machines was changed from ongoing to 4 months capped, humidifiers and CPAP machines were no longer reimbursed separately if billed on the same date of service, and the wheelchair limit was changed from once every 5 years to once every 7 years.

*Reimbursement Cuts:* As of 4/1/2013, dental, independent lab and x-ray, physician lab and x-ray, renal dialysis, and DME reimbursement was cut by 5%.

*Copayment Increase:* Copayments were increase from \$1.00 to a range from \$1.30 to \$3.90 for office visits as of 7/1/2013.

*Teaching Physicians:* As of 8/1/2013, reimbursement for teaching physicians was increased to 150% of the 2011 Medicare rate.

*Physicians:* As of 10/1/2013, physician payment rates were reduced by 7.5%, exclusive of primary care physicians and teaching physicians.

***PMPM Trends and Cost Projections***

In order to perform the trend analysis, the historical data was first normalized for program changes so that all of the data was on the same basis. The data was also normalized for demographic and regional mix. This isolates the pure medical trend from the impact of program changes and regional mix. Trends were developed at the category of service and broad rate cohort level. These trends were developed under a managed care environment and are slightly lower than the trends developed for the without-waiver scenario.

The cost projections for Demonstration Years two forward include a preliminary estimate of the capitation rate that will be paid to the RCOs.

***Member Month Projections***

Member month projections were developed based on analysis of historical member month changes and trends, and adjusted for known changes going forward. The projections are done at the rate cohort level and collected into the MEGs as discussed above. Member month projections are the same for both the with-waiver and the without-waiver scenario.

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***Pools***

As a part of the demonstration, three pools are included in the with-waiver figures:

*DSHP CNOM:* Designated State Health Programs have been identified as programs for which the State will seek federal matching payments under the Demonstration authority.

*Hospital Transition Payments:* The changes to the service delivery system will lead to transitional infrastructure costs for the Medicaid program, specifically for the hospitals. In order to change the delivery model from the current volume-based payment to a system that rewards coordinated management and cost-effective treatment, a transition pool has been suggested. These payments would help offset the additional costs incurred in creating a new delivery system. They would be used for one-time expenditures that would begin in year one of the demonstration and decrease to \$0 by year five.

*DSRIP:* These would include incentive payments to hospitals to engage in delivery system reform initiatives that will improve the quality of care in Alabama.

More detailed information about these pools was discussed above within Section I of the application.

**Without-Waiver**

**Overview:**

The without-waiver figures use blended historical data and projects the data to an FY12 base. The base PMPMs are then projected to the Demonstration period (FY15-FY19). This section describes the methodology used to develop the member month projections, PMPM trends, and cost projections.

***PMPM Trends and Cost Projections***

In order to perform the trend analysis, the historical data was collected and trends were developed at the aggregate MEG level. These trends were developed under an unmanaged fee-for-service environment and are generally higher than the trends that would be expected in a managed care environment.

***Member Month Projections***

Member month projections were developed based on analysis of historical member month changes and trends, and adjusted for known changes going forward. The projections are done at the rate cohort level and collected into the MEGs as discussed above. Member month projections are the same for both the with-waiver and the without-waiver scenario.

**Without-Waiver Summary**

The without-waiver expenditures will be used to determine budget neutrality over the course of the demonstration. Below are historical and projected without-waiver membership and expenditures for the demonstration time periods.

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Historical and Projected Enrollment, in member months

SFY 08 .....	4,170,100	SFY 15 .....	7,386,082
SFY 09 .....	5,896,321	SFY 16 .....	7,431,990
SFY 10 .....	6,446,468	SFY 17 .....	7,478,297
SFY 11 .....	6,989,438	SFY 18 .....	7,525,010
SFY 12 .....	7,250,671	SFY 19 .....	7,572,141

Historical and Projected Expenditures

SFY 08 .....	\$1,434,189,662	SFY 15 .....	\$2,803,135,731
SFY 09 .....	\$1,911,939,472	SFY 16 .....	\$2,935,755,106
SFY 10 .....	\$2,070,539,412	SFY 17 .....	\$3,075,863,079
SFY 11 .....	\$2,375,597,696	SFY 18 .....	\$3,223,987,463
SFY 12 .....	\$2,446,130,256	SFY 19 .....	\$3,380,570,271

The bottom of the budget neutrality form, **Attachment 8**, more detailed demonstration figures are provided.

**Section VII - List of Proposed Waivers and Expenditure Authorities**

*This section should include a preliminary list of waivers and expenditure authorities related to title XIX and XXI authority that the State believes it will need to operate its Demonstration. In accordance with 42 C.F.R 431.412(a)(vi), this section must be included in a state's application in order to be determined complete. Specifically, this section should:*

- 1) *Provide a list of proposed waivers and expenditure authorities; and*
- 2) *Describe why the State is requesting the waiver or expenditure authority, and how it will be used.*

Alabama seeks waivers of provisions of Section 1902 and costs not otherwise matchable under Section 1903 that include, but are not limited to the below.

*Waivers*

- Section 1902(a)(1) (state wideness) to enable the State to use a phased approach to implementation of the RCO model statewide. The State anticipates that RCOs will form and be operational in some regions more quickly than in others.
- Section 1902(a)(17) (comparability) to permit the State to exclude from the Demonstration:
  - 1) Beneficiaries within the same eligibility categories as the Demonstration Populations who are eligible and enrolled in home- and community-based services waivers.

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These beneficiaries will remain in the FFS delivery for all State Plan and HCBS waiver services.

- 2) Beneficiaries in the following eligibility categories: PACE participants, children in foster care, dually eligible beneficiaries, and individuals residing in long term care facilities or utilizing home- and community-based waiver services.
- Section 1902(a)(23)(A) (freedom of choice) to enable the State to mandate enrollment of certain beneficiaries in the Demonstration Populations in risk-based RCOs, as well as to limit them to one RCO in regions where only one RCO operates. Beneficiaries will retain the right to choose between RCOs in regions where more than one RCO participates.

Because of the rural nature of the State, it is estimated some regions may only include one RCO to be actuarially sound. Therefore, AMA is requesting rural exception from choice of RCOs in accordance with 42 CFR 438.52 in all Regions. All beneficiaries enrolled in RCOs will maintain choice of at least two PMPs and will be able to obtain the services of providers outside of an RCO's network in accordance with 42 CFR 438.52(b)(2)(ii).

- Section 1902(a)(13) and (a)(30) (rate setting/payment methodologies) to permit the State to implement a value-based purchasing strategy based on the use of withholds and incentives.

*Costs Not Otherwise Matchable*

- Expenditures to provide federal matching payments to a number of state-only programs. These include programs funded entirely by the State that provide services such as adult day care, outpatient substance abuse treatment and outpatient care for the mentally ill who are not eligible for Medicaid.

Expenditures to pay transition payments and DSRIP to hospitals and other providers as referenced in Section 1, Funding Pool Payments above.

**Section VIII - Public Notice**

**Replacement for Section VIII**

**Section VIII - Public Notice**

*This section should include information on how the State solicited public comment during the development of the application in accordance with the requirements under 42 C.F.R 431.408. (For specific information regarding the provision of state public notice and comment process, see the section 1115 Transparency final rule and corresponding State Health Official Letter:*

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<http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>)

AMA conducted an inclusive process in analyzing Medicaid redesign options and developing the Demonstration design as outlined in the Demonstration Proposal. Governor Bentley convened a multi-stakeholder Medicaid Advisory Commission charged with providing recommendations to improve the Alabama Medicaid program that would curb the growth trajectory of the Medicaid program and improve the quality and type of care provided to Medicaid beneficiaries.

The Commission brought together a large and diverse group of representatives to review and develop its recommendations. Entities or organizations included: executive officers of state agencies, cabinet-level leaders, State Senators and Representatives, insurance companies, consumer advocates, medical providers, and professional organizations. These professional organizations represented the hospitals, physicians, pharmacy, nurses, primary and rural health clinics, hospice, and nursing homes. The recommendations of the Commission, which align with Medicaid's overall goals for the Medicaid program, became the building blocks for a comprehensive Medicaid reform plan described in this 1115 Demonstration Proposal. This reform plan was also passed by the Alabama Legislature and signed into Law by Governor Bentley in May 2014. Additionally, AMA conducted a series of regional public meetings for physicians, hospitals, professional associations, and other interested parties to learn more about Alabama Medicaid's progress in implementing RCOs and to provide participants with an opportunity to ask questions and provide comments.

AMA also conducted a public comment period to receive input about this Demonstration proposal as described in response to the following questions.

*1) Start and end dates of the state's public comment period.*

AMA conducted a public comment period from February 28, 2014 through April 4, 2014.

*2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.*

AMA certifies that it provided public notices about the Demonstration proposal as follows:

- AMA posted the public notice and the draft Demonstration proposal on the AMA website beginning February 28, 2014 at the following link:  
[http://medicaid.alabama.gov/CONTENT/2.0\\_newsroom/2.7.3\\_Regional\\_Care\\_Organizations.aspx](http://medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3_Regional_Care_Organizations.aspx). See Attachment 10 for a copy of the public notice.
- AMA published the abbreviated public notice in Administrative Monthly on February 28, 2014.
- AMA provided the draft Demonstration proposal for public review, upon request, at each county office of the Department of Human Resources and the State Office of the Alabama Medicaid Agency.

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- AMA accepted written comments concerning the 1115 Demonstration proposal submitted via email and postal mail through April 4, 2014.

3) *Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.*

AMA certifies that it will convene two public hearings at least 20 days prior to submitting the Demonstration proposal to CMS. Specifically, AMA is convening the following hearings:

- **March 13<sup>th</sup> at 10:00 am (teleconference capabilities available at this meeting)**  
Alabama Medicaid Agency  
501 Dexter Avenue  
Montgomery, AL 36104
- **March 18<sup>th</sup> at 10:00 am**  
Birmingham Botanical Gardens  
2612 Lane Park Rd.  
Birmingham, AL 35223

**PLACEHOLDER:** Descriptions from the hearings will be added after they occur.

4) *Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)*

AMA certifies that it used its email list system, including providers, RCO collaborators and the general public, to notify the public of the Demonstration proposal.

5) *Comments received by the state during the 30-day public notice period.*

**PLACEHOLDER:** A summary of comments will be added after conducting the Public Notice Process.

6) *Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.*

**PLACEHOLDER:** A summary of responses to submitted comments will be added after conducting the Public Notice Process.

7) *Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.*

A letter was sent by certified mail and through e-mail to the Tribal Chairman of the Poarch Creek Band Indian Tribe on October 22, 2013 notifying the tribe of the 1115 Demonstration Waiver and requesting comments and concerns within 30 days of receipt of letter. No comments or concerns were received by AMA. See Attachment 11 for a copy of the letter.

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**Attachment 1: Overview of Current Maternity Care, Patient 1<sup>st</sup>, and Patient Care Networks (PCNs) of Alabama Programs**

<b>Program</b>	<b>Current Program Overview</b>
Maternity Care Program	<p>The Maternity Care Program was developed in 1988 under 1915(b) waiver authority in an effort to address Alabama’s high infant mortality rate, the high drop-in delivery rate and the lack of delivering physician participation. In the current program, the State contracts with one administrative entity, a Primary Contractor, for each of the 14 districts statewide who has the responsibility for establishing a comprehensive network of subcontractors to provide prenatal, delivery and postpartum care. Medicaid pays for approximately half or 30,000 of all deliveries per year in the State of Alabama utilizing this system.</p> <p>The Maternity Care Program provides care coordination; assistance with more timely eligibility determination through the Application Assistance program; mental health screening; an emphasis on smoking cessation education; access to Medicaid covered contraceptives through local pharmacies and coordination between the Maternity Care Program and the Family Planning Program.</p> <p>The Maternity Care Program promotes improved safety and quality outcomes by supporting the use of best practice guidelines and quality measures that are monitored by AMA’s web based data collection system and medical record documentation.</p>
Patient 1 <sup>st</sup> Program	<p>The Patient 1<sup>st</sup> Program, primary care case management (PCCM) program began under 1915(b) waiver authority on January 1, 1997. The program was later modified and approved (effective September 2013) by CMS under Section 1932 (a)(1)(A) of the Social Security Act as a state plan service. The goal of Patient 1<sup>st</sup> is to create patient centered, quality-focused care. Primary Medical Providers (PMPs) receive a monthly per member, per month case management fees for serving as a medical home and coordinating the care of Medicaid beneficiaries enrolled with their practice. Direct services are reimbursed fee-for-service.</p> <p>The PMP coordinates care for beneficiaries by providing and arranging for each beneficiary’s health care needs. Enrolling beneficiaries into a medical home reduces the need for beneficiaries to seek basic sick care services from a hospital emergency department, reduces duplicative care and optimizes appropriate care delivery.</p>

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<b>Program</b>	<b>Current Program Overview</b>
<p>Patient Care Networks of Alabama (PCNs)</p>	<p>The Patient Care Networks of Alabama (PCNs) began under the 1915(b) Waiver in the fall of 2011. The program was later modified and approved (effective July 2012) by CMS under Section 2703 of the Affordable Care Act as a state plan service. There are currently PCNs in four geographical locations, covering 21 of 67 counties, with the intent to expand statewide in 2014.</p> <p>The PCNs provide health home services to patients with two or more chronic conditions, one chronic with the risk of developing another or one serious mental illness. Diagnoses include asthma, diabetes, heart disease, BMI over 25, transplants with claims data of 5 years, cardiovascular disease, chronic obstructive pulmonary disease, cancer, HIV with claims data of 18 months, and sickle cell anemia.</p> <p>The PCNs provide case management services, coordinate primary, acute, behavioral and post-acute services and assign beneficiaries to a PMP who provides coordination and direct patient care. The PCNs also provide data analytic support, care management services and provider training in evidence-based guidelines.</p> <p>The PCNs and the PMPs receive a monthly case management fee per member per month for Health Home beneficiaries. PMPs are also paid fee-for-service for direct patient care.</p>

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**Attachment 2: Medicaid Advisory Committee Recommendations**

In October 2012, Governor Robert J. Bentley convened a multi-stakeholder Medicaid Advisory Commission charged with providing recommendations to improve the State Medicaid program that would curb the growth trajectory of the Medicaid program and improve the quality and type of care provided to Medicaid beneficiaries. The Commission brought together a large and diverse group of representatives to review and develop its recommendations. Entities or organizations included: executive officers of state agencies, cabinet-level leaders, State Senators and Representatives, insurance companies, consumer advocates, medical providers, and professional organizations. These professional organizations represented the hospitals, physicians, pharmacy, nurses, primary and rural health clinics, hospice, and nursing homes.

The Commission submitted the following recommendations to Governor Bentley on January 30, 2013:

1. Divide Alabama into regions in which a community led network in each region coordinate the health care services of the Medicaid patients in that region. Regional care networks will formally engage consumer input and oversight at all levels of governance and operation.
2. Allow for expanded regional patient care networks to become risk-bearing organizations.
3. Allow regions to choose to contract with a commercial managed care organization to provide care, risk management, or other services in the region.
4. The Legislature where appropriate, and Medicaid where administratively possible, shall authorize regional care networks throughout the state and establish an implementation timeline. Specific benchmarks shall be set that must be met by the networks. Failure to meet the benchmarks shall authorize state intervention.
5. The Alabama Medicaid Agency should seek an 1115 Demonstration waiver from CMS to implement the transformation to managed care.
6. Legislation should be developed to create a Medicaid cap, provided that the legislation ensures adequate flexibility for the Alabama Medicaid Agency to address federal mandates, rules, and regulations; economic uncertainty; catastrophic health events; and provider rates.
7. Because of the essential role of provider assessments in funding the state share of the Medicaid program, the Commission encourages the renewal of the hospital and nursing home provider assessments.
8. Because of the complexity of the CPE, the lack of transparency in its calculation, and the potential future liability created by its use, the Commission recommends the Alabama Medicaid Agency work with CMS to convert some or all CPEs to intergovernmental transfers (IGTs) to provide funding for the hospital program.

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9. Because the current hospital system, by paying per diem and per encounter, encourages utilization rather than coordination of care, the Commission encourages the Alabama Medicaid Agency to explore changing the current hospital payment methodology to a system that pays for outcome, such as DRGs. Any such change should consider the uniqueness of maternal and child health patients who are high users of outpatient services.

In addition:

10. The Commission strongly supports efforts to identify and punish fraud and abuse in the Medicaid program.
11. Because of the significant portion of Medicaid expenditures excluded from consideration when LTC and waiver populations are excluded, the Commission strongly supports the efforts of provider organizations that will in the near future develop programs for coordination of LTC and waivers.

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**Attachment 3 - Demonstration Financing Form**

*Please complete this form to accompany Section VI of the application in order to describe the financing of the Demonstration.*

*The State proposes to finance the non-federal share of expenditures under the Demonstration using the following (please check all that are applicable):*

- State General Funds
  
- Voluntary intergovernmental transfers from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).
  
- Voluntary certified public expenditures from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).
  
- Provider taxes. (Provide description the narrative section – Section VI of the application).
  
- Other (If the State is interested in other funding or financing arrangements, please describe. Some examples could include, but are not limited to, safety net care pools, designated state health programs, Accountable Care Organization-like structures, bundled payments, etc.)  
*This represents Tobacco Taxes and certain other miscellaneous revenues such as prior year deposits and court ordered settlements.*

Currently State funding sources are received by Medicaid and are combined and used to match Federal funds. Under the RCO structure, State funding sources would remain the same with the addition of DSHP funds approved in the waiver. Below is a list of funding sources.

**Federal DSH:** The Federal DSH allocations and payments to hospitals for DSH are outside of the waiver.

**Public Hospital DSH and CPEs:** State match for public hospital DSH is based on Certified Public Expenditures for the uninsured subject to the Federal DSH allocation. Payments to public and private hospitals are not part of the waiver.

**Provider taxes:** The hospital and pharmacy provider taxes will continue to be paid to the state in amounts based on the total revenues of the private hospitals and the total prescriptions written for all pharmacies in the state. The nursing home provider tax will also continue, however, the cost of long term care paid to nursing facilities is not a part of the waiver.

**Public Hospital IGTs:** Effective Oct 1,2013 the public hospitals, including state owned hospitals provide Intergovernmental Transfers to cover the state share of the UPL payments made to those hospitals. It is anticipated that this funding will continue within the RCO structure with the amount of the IGT to be set on a periodic basis (monthly, quarterly or annually) for each hospital

**IGT Agencies:** State Agencies would continue to provide IGTs to fund the State share of expenditures for Medicaid services that they render. Most Agency services are not part of the

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RCOs covered services. For any services that are a part of the RCO, we expect that an IGT amount would be determined on a periodic basis (monthly, quarterly or budget year).

**General fund:** This represents State budget allocations from the State General Fund to Medicaid. RCO funding would represent a portion of the general funds.

**Other:** This represents Tobacco Taxes and certain other miscellaneous revenues such as prior year deposits and court ordered settlements.

**DSHP funds:** As part of the waiver, the State anticipates receiving Federal matching funds for certain Designated State Health Programs that do not currently receive match. The Federal funds received are to be used as State match for specific additional expenditures approved under the waiver.

*Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 percent of the payments for services rendered or coverage provided.*

*Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?*

Yes     No

*If no, provide an explanation of the provider payment arrangement.*

*Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?*

Yes     No

*If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.). Please indicate the period that the following data is from.*

The response to this is included within the response to the previous question. Payments to providers are not required to be returned to the State.

*Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in*

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*the lowering of the amount, duration, scope, or quality of care and services available under the plan.*

*Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.*

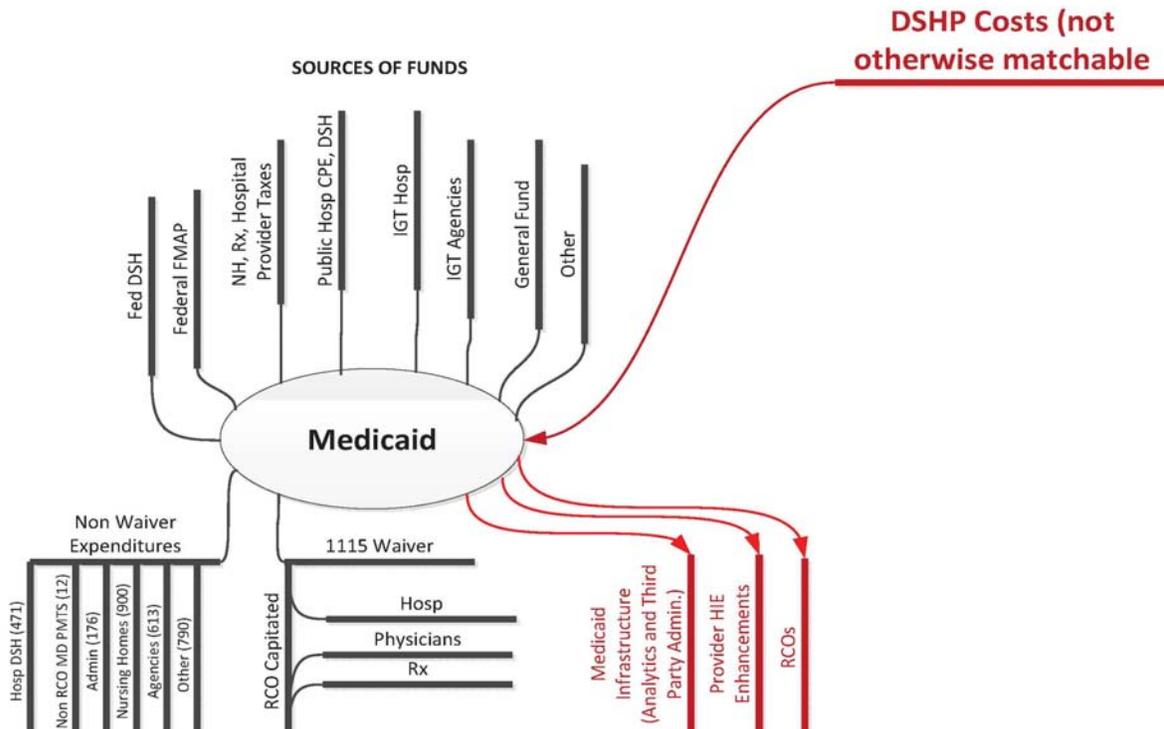
NFS for provider payments are currently from general fund appropriations, agency IGTs as appropriated by the state, provider taxes, local government IGTs, CPEs and other taxes. These sources will be combined to provide the NFS for RCO per member per month payments and other Pool payments.

*Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.*

See above

*Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from:*

See funding chart below.



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*If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.*

Funds from IGTs are received by the Agency prior to disbursement of expenditures

*If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).*

NFS for provider payments are currently from general fund appropriations, agency IGTs as appropriated by the state, provider taxes, local government IGTs, CPEs and other taxes. These sources will be combined to provide the NFS for RCO per member per month payments and other Pool payments.

*For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from:*

Per member per month payments to RCO structure will not be directly funded by CPEs or IGTs.

Section 1902(a) (30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)( 1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type, and indicate the time period that that the data is from.

Currently Private hospitals are paid based on approved demonstrations of the Upper Payment Limit per Medicare based payment principles. Supplemental payments are made based on the difference between the UPL and per diem payments. Effective Oct 1, 2013 state owned and non-state owned public hospitals' UPLs and supplemental payments are made on the same basis. Prior to Oct 1, 2013 state owned and non-state owned public hospitals expenditures were based on approved demonstrations of certified public expenditures and did not receive supplemental payments. Under the RCO structure the RCO would be paid based on actuarially determined per member per month rates.

*Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).*

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See above description

*Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services?*

Yes      No

*If yes, provide an explanation.*

*In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)*

Yes      No      Not Applicable

*If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?*

*If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?*

Yes      No

N/A

*Use of other Federal Funds*

*Are other federal funds, from CMS or another federal agency, being used for the Demonstration program?*

Yes      No

*If yes, provide a list below of grants the State is receiving from CMS or other federal agencies. CMS must ensure these funds are not being used as a source of the non-federal share, unless such use is permitted under federal law. In addition, this will help to identify potential areas of duplicative efforts and highlight that this demonstration is building off of an existing grant or program.*

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Source of Federal Funds	Amount of Federal Funds	Period of Funding
Designated State Health Programs	\$78M	FY15-FY19

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**Attachment 4 - Budget Neutrality Form**

*Section 1115 Medicaid Demonstrations should be budget neutral. This means the Demonstration cannot cost the federal government more than what would have otherwise been spent absent the Demonstration. In this section, the state must provide its explanation of how the Demonstration program will achieve budget neutrality and the data to support its rationale.*

*New Demonstration Request: The following form provides guidance on some of the most commonly used data elements for demonstrating budget neutrality. CMS is available to provide technical assistance to individual states to identify any other elements needed to demonstrate budget neutrality for their specific request. Use the accompanying Excel Workbook to submit supporting data, following the instructions below. All expenditure totals in the Excel Workbook are total computable expenditures (both federal and state shares combined), unless indicated otherwise.*

I. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Recent Historical Actual or Estimated Data

*Provide historic data, actual or estimated, for the last five years pertaining to the Medicaid Populations or sub-Populations (Populations broken out by cost categories) in the Demonstration program.*

*The “Historical Data” tab from the Table Shell contains a structured template for entering these data. There are slots for three Medicaid Populations; more slots should be added as needed. The year headers “HY 1,” “HY 2,” etc., should be replaced with the actual historical years.*

*The Medicaid Populations submitted for budget neutrality purposes should correspond to the Populations reported in Section II. If not identical, a crosswalk must be provided that relates the budget neutrality Populations to the Section II populations. Use the tables below to provide descriptions of the populations defined for budget neutrality, and the cross-walk to Section II.*

*States that are submitting amendments or extension requests and that wish to add new Medicaid populations can use the “Historical Data” tab to provide 5 years of historical data for the new populations.*

Population/Sub-Population Name:	ABD
Brief Description	Aged, Blind, and Disabled as determined by SSI standards.
Relationship to Section II	Individuals receiving SSI, Disabled widows and widowers ineligible for SSI due to increase in OASDI (DWB), Disabled adult children (DAC), Early widows/widowers, Individuals ineligible for SSI due to Medicaid prohibited requirements, Individuals eligible

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	for SSI but for OASDI/COLA increases since 1977, Individuals who would be eligible for SSI/SSP but for OASDI COLAs in 1972 (closed to new enrollment), Institutionalized individuals continuously eligible since 1973, excluding individuals in long term care facilities (closed to new enrollment), Blind or disabled individuals eligible in 1973, Individuals eligible as essential spouses in 1973, Aged, blind, or disabled individuals receiving only optional State supplements
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Population/Sub-Population Name:	BCCTP
Brief Description	Women covered under the Breast and Cervical Cancer Treatment Program.
Relationship to Section II	Women who have been screened for breast and cervical cancer under the CDC and Prevention Breast and Cervical Cancer Early Detection Program

Population/Sub-Population Name:	MLIF
Brief Description	Low income families with children.
Relationship to Section II	Individuals other than qualified pregnant women and children who are members of a family that would be receiving AFDC under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC, Individuals ineligible for AFDC because of eligibility requirements prohibited under Medicaid, Individuals who would be eligible for AFDC except for the increase in benefits who were entitled to OASDI in August 1972, and receiving cash assistance in 1972, Qualified Family Members, Recipients of AFDC, Deemed Recipients of AFDC, Medicaid extension due to spousal support collections

Population/Sub-Population Name:	SOBRA Child
Brief Description	Children under age 6 with family income below 133% of the FPL, and children ages 6 through 18 below 100% of the FPL.
Relationship to Section II	Children age 6-18, Children age 1-5, Child born to a woman eligible and receiving Medicaid as categorically needy on the date of the child's birth, Children receiving adoption assistance under title IV-E, Optional Targeted Low Income Children, Individuals not described in 1902(a)(10)(A)(i) of the Act who meet the income and resource requirements of the AFDC State Plan, under age 19, Reasonable classifications of individuals for whom public agencies are assuming full or partial

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	financial responsibility and who are under age 21 , in private institutions, Child for whom there is in effect a State adoption agreement other than under Title IV-E of the Act) with special needs
--	--

Population/Sub-Population Name:	Transitional
Brief Description	Families who have correctly received MLIF benefits for at least three of the preceding six months and lose eligibility for MLIF due to earned income.
Relationship to Section II	Transitional Medical Assistance

Population/Sub-Population Name:	Refugees
Brief Description	Individuals receiving services through the refugee resettlement program.
Relationship to Section II	Refugee Medical Assistance

Population/Sub-Population Name:	Delivery
Brief Description	Pregnant women with family income below 133% of the FPL.
Relationship to Section II	Pregnant women and infants under 1 year of age, Qualified Pregnant Women and Children

*Explain the sources and methodology used for the actual and/or estimated historical data. If actual data have been provided, explain the source of the data (MMIS data, other state system Medicaid data, other program data, etc.) and the program(s) and source(s) of program funding that the data represent. Indicate if the data represent all Medicaid expenditures for the population. For example, are they inclusive of long-term care expenditures? Were the expenditures reported on the CMS-64? If the data provided are a combination of actual and estimated data, provide the dates pertaining to each type of data. If any of the data are estimated, provide a detailed explanation concerning how the estimated data were developed.*

Historical MMIS fee-for-service (FFS) claims data was utilized as the source of the historical data figures. Additionally, hospital enhancements and CPEs paid outside of the MMIS claims data were included within the historical data. The combination of these two sources builds to the total expenditures for each Medicaid Eligibility Group (MEG).

**B. Bridge Period**

*Based on the ending date of the most recent year of historic data and the proposed Demonstration implementation date, a bridge period will apply to this proposal. Estimates of Demonstration costs must be trended across this bridge period when calculating the projected first year of PMPM costs without the waiver.*

*In the blanks below, enter the last day of the most recent historical year, and the last day of the year immediately preceding the first Demonstration Year. The number of months between these*

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*dates is the length of the bridge period. Depending on the length of the available historical data series and data quality, each demonstration population could have its own unique bridge period.*

*Enter the number of months in the bridge period in the "WOW" tab of the Excel Workbook, in the grayed cell under "MONTHS OF AGING." The spreadsheet is programmed to project Demonstration Year PMPM expenditures and member month totals using historical trend rates and the length of bridge period, and assumes that the same bridge period applies to all calculations. Applicants should feel free to alter these programming features as needed.*

Demonstration Bridge Period: 9/30/2012 to 9/30/14

**C. Without-Waiver Trend Rates, PMPM costs and Member Months with Justification**

*The WOW tab of the Excel Workbook is where the state displays its projections for what the cost of coverage for included Medicaid populations would be in the absence of the demonstration. A block of cells is provided to display the WOW estimates for each Medicaid population specified. Next to "Pop Type," the correct option should be selected to identify each group as a Medicaid population.*

*The workbook is programmed to project without-waiver (WOW) PMPM expenditures and member months using the most recent historical data, historical enrollment and per capita cost trends, and the length of bridge period specified. CMS policy is to use the lower of the state's historical trends and President's Budget trends to determine the WOW baseline.*

*Note that the workbook includes a projected Demonstration Year 0 (DY 00), which is an estimate of the last full year immediately prior to the projected demonstration start date. DY 00 is included to provide a common "jumping off point" for both WOW and with waiver (WW) projections.*

**D. Risk**

*CMS will provide technical assistance to states to establish an appropriate budget neutrality methodology for their demonstration request. Potential methodologies include:*

*PER CAPITA METHOD: The state will be at risk for the per capita (PMPM) cost of individuals served by the Demonstration, to the extent these costs exceed those that would have been incurred absent the Demonstration (based on data shown and to be agreed to above). The state shall be at risk to repay CMS for the federal share of any costs in excess of the "Without Demonstration" cost, based on historical data shown above, which are the sum of the estimated PMPM costs times the number of member months by Population. The state shall not be at risk for the number of member months of participation in the Demonstration, to the extent that they may increase above initial projections.*

*AGGREGATE METHOD: The state will be at risk for both the number of member months used under the Demonstration, as well as the per capita cost for Demonstration participants; to the*

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*extent these exceed the "without waiver" costs and member months that are agreed to based on the data provided above.*

E. Historical Medicaid Populations: With-Waiver PMPM Cost and Member Month Projections

*The "WW" tab of the Excel Workbook is for use by the State to enter its projected WW PMPM cost and member month projections for historical populations. In general, these can be different from the proposed without-waiver baseline. If the State's demonstration is designed to reduce PMPM costs, the number of member months by category and year should be the same here as in the without-waiver projection. (This is the default formulation used in the Excel Workbook.)*

F. Justification for With-Waiver Trend Rates, PMPM Costs and Member Months

*The State must provide below a justification for the proposed with-waiver trend rate and the methodology used by the State to arrive at the proposed trend rate, estimates of PMPM costs, and number of member months.*

**Overview:**

The with-waiver Trend Rates, PMPM Costs, and Member Months were developed as a preliminary estimate of the With-Waiver program including the installment of Regional Care Organization (RCO) programs. The development of these estimates is described below.

**Historical Data:**

The State of Alabama (State) developed the budget neutrality projections using FFS, encounter, and financial data. The data covers the five year period from 10/1/07 – 9/30/12 (FY08-FY12). Rate cohorts are collected into the following MEGs:

<b>MEG</b>	<b>Rate Cohort</b>
ABD	ABD Less Than 1
ABD	ABD 1-5
ABD	ABD 6-14
ABD	ABD 15-18
ABD	ABD 19-44
ABD	ABD 45+
BCCTP	BCCTP
MLIF	MLIF Less Than 1
MLIF	MLIF 1-5
MLIF	MLIF 6-14
MLIF	MLIF 15-18
MLIF	MLIF 19-44
MLIF	MLIF 45+
SOBRA Child	SOBRA Child Less Than 1
SOBRA Child	SOBRA Child 1-5
SOBRA Child	SOBRA Child 6-14

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SOBRA Child	SOBRA Child 15+
Transitional	Transitional
Refugees	Refugees
Delivery	Delivery - Normal
Delivery	Delivery - High Risk

The MEGs were determined by grouping rate cohorts into similar risk categories from a cost and actuarial perspective.

The five years of historical data was blended by reviewing the PMPMs and assigning varying credibility to each year, resulting in higher credibility being given to more recent years.

**Program Changes:**

The State adjusted the data to account for program changes that occurred during the FY08-FY12 data period. All data was normalized to the latest information available. The program changes are further discussed below.

*DME – POP:* Prosthetic, Orthotic, and Pedorthotic Devices were approved with prior authorization (PA) as of 3/1/2008.

*Trofile Assay:* Coverage of Trofile Assay (with PA) began on 12/1/2008.

*Ambulance:* Removed PA requirement except for trips over 100 miles one way as of 2/1/2009.

*Radiology:* Implemented a radiology PA program as of 4/1/2009.

*Hospital Reimbursement:* Inpatient hospital reimbursement changed from a Prepaid Hospital Plan (PHP) to FFS reimbursement as of 9/18/2010. Outpatient hospital reimbursement changed from FFS to PHP.

*Hospital and ASC:* Reimbursement for all surgical procedure groups was decreased by 10% as of 2/15/2010. Hospital and ASC reimbursement was increased by 6% on 10/1/2011.

*Psychologists:* Allowed 30-minute fractional units for 96101-96103; 96118-96120 as of 7/1/2010. Required modifiers (U6, U7, AJ, and HO) for allied mental health professional staff, and reduced reimbursement for these modifiers to 75% of the allowable rate of the psychologist.

*Hospice Election:* As of 7/19/2010, no longer required children under 21 to waive rights, and they can receive hospice services.

*Hospital Outpatient:* As of 10/1/2010, outpatient observation codes 99218-99220 were replaced with G0378.

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*Psychology:* As of 1/1/2011, imposed max units of 12 for 90849 and 90853; max units of 26 for 90806, 90812, 90818, 90826, and 90847; max units of 52 for 90804, 90810, 90816, and 90823. The following services are not covered: equine assisted psychotherapy, biofeedback therapy, neurobiofeedback therapy, sleep therapy, dance therapy, music therapy, and art therapy. On 4/1/2011, individual and group therapy to 52 units per year and one unit per week.

*Eye Care:* As of 7/1/2011, Korrekt Optical became the eyeglass vendor. As of 2/22/2012, recipients under 21 were limited to 2 exams, 2 fittings, 2 frames, and 4 lenses each calendar year. As of 6/1/2012, routine eye exams were limited to one every three calendar years and eyeglasses were eliminated for recipients 21 years of age and older. As of 11/1/2012, eyeglass coverage for recipients 21 and older was reinstated at one pair every two years, and routine eye exams were allowed once every two years. As of 3/1/ 2013, eyeglass coverage for recipients 21 and older were limited to one routine eye exam and one pair of eyeglasses every three years.

*Reimbursement cuts:* As of 6/1/2012, reimbursement rates for physicians, dentists, physician lab and x-ray, independent lab and x-ray, DME, and other licensed practitioners were reduced by 10%. These cuts were reversed for physicians, dentists, physician lab and x-ray, independent lab and x-ray, and other licensed practitioners on 10/1/2012. The cuts were reversed for DME providers on 11/1/2012.

*Maternity:* From 5/1/2012 – 12/31/2012, Maternity Contractor rates were reduced by 10%.

*Affordable Care Act Section 1202:* Reimbursement rates for attesting Primary Care Physicians were increased as of 1/1/2013.

*Durable Medical Equipment:* As of 1/1/2013, reimbursement for CPAP machines was changed from ongoing to 4 months capped, humidifiers and CPAP machines were no longer reimbursed separately if billed on the same date of service, and the wheelchair limit was changed from once every 5 years to once every 7 years.

*Reimbursement Cuts:* As of 4/1/2013, dental, independent lab and x-ray, physician lab and x-ray, renal dialysis, and DME reimbursement was cut by 5%.

*Copayment Increase:* Copayments were increase from \$1.00 to a range from \$1.30 to \$3.90 for office visits as of 7/1/2013.

*Teaching Physicians:* As of 8/1/2013, reimbursement for teaching physicians was increased to 150% of the 2011 Medicare rate.

*Physicians:* As of 10/1/2013, physician payment rates were reduced by 7.5%, exclusive of primary care physicians and teaching physicians.

***PMPM Trends and Cost Projections***

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In order to perform the trend analysis, the historical data was first normalized for program changes so that all of the data was on the same basis. The data was also normalized for demographic and regional mix. This isolates the pure medical trend from the impact of program changes and regional mix. Trends were developed at the category of service and broad rate cohort level. These trends were developed under a managed care environment and are slightly lower than the trends developed for the without-waiver scenario.

The cost projections for Demonstration Years two forward include a preliminary estimate of the capitation rate that will be paid to the RCOs.

***Member Month Projections***

Member month projections were developed based on analysis of historical member month changes and trends, and adjusted for known changes going forward. The projections are done at the rate cohort level and collected into the MEGs as discussed above. Member month projections are the same for both the with-waiver and the without-waiver scenario.

II. Cost Projections for New Populations

*This section is to report cost projections for new title XIX Populations. These could be Populations or sub-Populations that will be added to the state's Medicaid program under the Demonstration, including "Expansion Populations" that are not provided for in the Act but are created under the Demonstration.*

*In the table below, list all of the New Populations and explain their relationship to the eligibility groups listed in Section II.*

Population Name	Brief Description	Cross-Walk to Section II
N/A		

*Justification for New Populations' Trend Rate, PMPM and Member Month Projections*

*The state must provide below a justification for the proposed trend rate, estimates of PMPM costs, and number of member months for new populations, including a description of the data sources and estimation methodology used to produce the estimates. Historical data provided to support projections for new populations can be displayed in the Excel Workbook's Historic Data tab.*

*Some state proposals may include populations that could be made eligible through a State plan amendment, but instead will be offered coverage strictly through the Demonstration. These populations are referred to as "hypotheticals" and CMS is available to provide technical assistance to states considering whether a Demonstration population could be treated as a hypothetical population.*

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N/A

III. Disproportionate Share Hospital Expenditure Offset

*Is the state is proposing to use a reduction in Disproportionate Share Hospital (DSH) Claims to offset Demonstration costs in the calculation of budget neutrality for the Demonstration?*

Yes       No

*If yes, the state must provide data to demonstrate that the combination of Demonstration expenditures and the remaining DSH expenditures will not exceed the lower of the state's historical DSH spending amount or the state's DSH Allotment for each year of the Demonstration. The state may provide Adjusted DSH Claim Amounts if additional DSH claims are pending due to claims lag or other reasons.*

*In the DSH tab of the Excel Workbook, enter the state's DSH allotments and actual DSH spending for the five most recent Federal fiscal years in Panel 1. All figures entered should represent the federal share of DSH allotments and spending.*

*Provide an explanation for any Adjusted DSH Claim Amounts:*

N/A

*In Panel 2 of the Excel Workbook, enter projected DSH allotments for the federal fiscal years that will overlap the proposed Demonstration period, and in the following row, enter projections for what DSH spending would be in the absence of the demonstration. All figures entered should represent the federal share of DSH allotments and spending.*

*The Excel Workbook is set up to allow for the possibility that Demonstration Years will not coincide with federal fiscal years. If this is the case, and the Demonstration is proposed to last for five full years, then the Demonstration will be in existence for parts of six federal fiscal years. FFY 00 is the federal fiscal year during which the Demonstration is proposed to begin, and FFY 05 is the federal fiscal year that contains the Demonstration's proposed end date. CMS encourages states that use DSH diversion in their budget neutrality model to define Demonstration Years so that they align with the Federal fiscal years. (If Demonstration Years do align with Federal fiscal years, it is not necessary to populate the column for FFY 00.)*

*In Panel 3 of the Excel Workbook, the rows are set up to be used as follows. All amounts entered in Panel 3 are Federal share.*

- State DSH Allotment: Formulas in the Excel Workbook automatically enter the same DSH allotment projects as are shown in Panel 2.*
- State DSH Claim Amount: Enter the amounts that the state projects will be spent on DSH payments to hospitals for each federal fiscal year that overlaps with the proposed demonstration period.*

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- *Maximum DSH Allotment Available for Diversion: If the state wishes to propose a dollar limit on the amount of potential DSH spending that is diverted each year, enter those amounts here. If no such limit is proposed, leave blank.*
- *Total DSH Allotment Diverted: The Excel Workbook is structured to populate the cells in this row from amounts entered in Panel 4. CMS's default assumption is that DSH diversion spending will align with the Federal fiscal year DSH allotments based on date of service. The Excel Workbook allocates DSH diversion spending from one or two overlapping Demonstration Years to each Federal fiscal year DSH allotment.*
- *DSH Allotment Available for DSH Diversion Less Amount Diverted: This row provides a check to ensure that diverted DSH spending does not exceed the Maximum DSH Allotment amount specified by the State. If no Maximum DSH Allotment, delete the formulas in this row.*
- *DSH Allotment Projected to be Unused: This row provides a check to ensure that the combination of diverted DSH spending plus DSH payments to hospitals does not exceed the DSH allotment each year.*

*Panel 4 of the Excel Workbook provides space for the state to indicate amounts of DSH diversion spending are planned for each Demonstration Year, and specify how much of that amount is to be assigned to the overlapping Federal fiscal years. DSH diversion spending is entered here as a total computable expenditures. An FMAP rate is needed for each total computable spending amount entered to enable it to be converted into a federal share equivalent that will appear in Panel 3. The amounts shown in the Total Demo Spending From Diverted DSH row automatically appear in the Summary tab in the Without Waiver panel.*

*Explanation of Estimates, Methodology and Data*

N/A

#### IV. Summary of Budget Neutrality

*The Excel Workbook's Summary tab shows an initial assessment of budget neutrality for the Demonstration. Formulas are included that reference cells in the WOW, WW, and DSH tabs so that projected WOW and WW expenditures for each category of expenditure appear in tabular form and can be summarized by Demonstration Year, and for the entire proposed duration of the Demonstration. The Variance shown for the entire duration of the demonstration must be nonnegative.*

*As indicated above, spending estimates for Other WOW Categories and Other WW Categories should be entered directly into the Summary tab where indicated.*

#### V. Additional Information to Demonstrate Budget Neutrality

*Provide any additional information the State believes is necessary for CMS to complete its analysis of the budget neutrality submission.*

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**Attachment 5 - Budget Neutrality Form – Historical Data**

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:

	SFY08	SFY09	SFY10	SFY11	SFY12	5-YEARS
<b>Medicaid Pop 1</b> ABD						
TOTAL EXPENDITURES	\$ 673,577,746	\$ 922,769,091	\$ 1,012,581,522	\$ 1,097,568,342	\$ 1,155,514,433	\$ 4,862,011,134
Eligible Member Months	1,018,220	1,379,794	1,408,911	1,427,905	1,429,287	
PMPM COST	\$ 661.52	\$ 668.77	\$ 718.70	\$ 768.66	\$ 808.46	
<b>TREND RATES</b>						
ANNUAL CHANGE						5-YEAR AVERAGE
TOTAL EXPENDITURE		37.00%	9.73%	8.39%	5.28%	14.45%
ELIGIBLE MEMBER MONTHS		35.51%	2.11%	1.35%	0.10%	8.85%
PMPM COST		1.10%	7.47%	6.95%	5.18%	5.14%

	SFY08	SFY09	SFY10	SFY11	SFY12	5-YEARS
<b>Medicaid Pop 2</b> BCCTP						
TOTAL EXPENDITURES	\$ 5,605,377	\$ 7,813,768	\$ 10,002,975	\$ 10,434,178	\$ 21,080,182	\$ 54,936,480
ELIGIBLE DELIVERIES	2,808	4,026	5,486	7,078	8,493	
PMPM COST	\$ 1,996.22	\$ 1,940.83	\$ 1,823.36	\$ 1,474.17	\$ 2,482.07	
<b>TREND RATES</b>						
ANNUAL CHANGE						5-YEAR AVERAGE
TOTAL EXPENDITURE		39.40%	28.02%	4.31%	102.03%	39.26%
ELIGIBLE MEMBER MONTHS		43.38%	36.26%	29.02%	19.99%	31.88%
PMPM COST		-2.77%	-6.05%	-19.15%	68.37%	5.60%

	SFY08	SFY09	SFY10	SFY11	SFY12	5-YEARS
<b>Medicaid Pop 3</b> MLIF						
TOTAL EXPENDITURES	\$ 89,602,430	\$ 133,907,638	\$ 148,295,188	\$ 176,794,283	\$ 197,858,555	\$ 746,458,094
Eligible Member Months	461,546	667,239	755,330	845,759	898,511	
PMPM COST	\$ 194.14	\$ 200.69	\$ 196.33	\$ 209.04	\$ 220.21	
<b>TREND RATES</b>						
ANNUAL CHANGE						5-YEAR AVERAGE
TOTAL EXPENDITURE		49.45%	10.74%	19.22%	11.91%	21.90%
ELIGIBLE MEMBER MONTHS		44.57%	13.20%	11.97%	6.24%	18.12%
PMPM COST		3.38%	-2.17%	6.47%	5.34%	3.20%

	SFY08	SFY09	SFY10	SFY11	SFY12	5-YEARS
<b>Medicaid Pop 4</b> SOBRA Child						
TOTAL EXPENDITURES	\$ 388,963,874	\$ 566,843,707	\$ 614,101,822	\$ 757,516,512	\$ 747,495,238	\$ 3,074,921,154
Eligible Member Months	2,678,502	3,832,270	4,261,309	4,691,751	4,896,801	
PMPM COST	\$ 145.22	\$ 147.91	\$ 144.11	\$ 161.46	\$ 152.65	
<b>TREND RATES</b>						
ANNUAL CHANGE						5-YEAR AVERAGE
TOTAL EXPENDITURE		45.73%	8.34%	23.35%	-1.32%	17.74%
ELIGIBLE MEMBER MONTHS		43.08%	11.20%	10.10%	4.37%	16.28%
PMPM COST		1.86%	-2.57%	12.04%	-5.45%	1.26%

	SFY08	SFY09	SFY10	SFY11	SFY12	5-YEARS
<b>Medicaid Pop 5</b> Transitional						
TOTAL EXPENDITURES	\$ 1,957,121	\$ 2,627,805	\$ 2,712,154	\$ 3,853,864	\$ 3,646,392	\$ 14,797,337
Eligible Member Months	8,515	12,239	14,666	16,428	16,763	
PMPM COST	\$ 229.84	\$ 214.71	\$ 184.93	\$ 234.59	\$ 217.53	
<b>TREND RATES</b>						
ANNUAL CHANGE						5-YEAR AVERAGE
TOTAL EXPENDITURE		34.27%	3.21%	42.10%	-5.38%	16.83%
ELIGIBLE MEMBER MONTHS		43.73%	19.83%	12.01%	2.04%	18.45%
PMPM COST		-6.59%	-13.87%	26.86%	-7.27%	-1.37%

	SFY08	SFY09	SFY10	SFY11	SFY12	5-YEARS
<b>Medicaid Pop 6</b> Refugees						
TOTAL EXPENDITURES	\$ 66,482	\$ 102,652	\$ 126,545	\$ 100,443	\$ 143,070	\$ 539,192
Eligible Member Months	509	753	766	517	816	
PMPM COST	\$ 130.61	\$ 136.32	\$ 165.20	\$ 194.28	\$ 175.33	
<b>TREND RATES</b>						
ANNUAL CHANGE						5-YEAR AVERAGE
TOTAL EXPENDITURE		54.41%	23.28%	-20.63%	42.44%	21.12%
ELIGIBLE MEMBER MONTHS		47.94%	1.73%	-32.51%	57.83%	12.52%
PMPM COST		4.37%	21.18%	17.60%	-9.75%	7.64%

	SFY08	SFY09	SFY10	SFY11	SFY12	5-YEARS
<b>Medicaid Pop 7</b> Delivery						
TOTAL EXPENDITURES	\$ 274,416,632	\$ 277,874,810	\$ 282,719,205	\$ 329,330,073	\$ 320,392,387	\$ 1,484,733,107
Eligible Deliveries	29,389	29,142	28,726	29,099	29,398	
PMPD COST	\$ 9,337.39	\$ 9,535.20	\$ 9,841.93	\$ 11,317.57	\$ 10,898.44	
<b>TREND RATES</b>						
ANNUAL CHANGE						5-YEAR AVERAGE
TOTAL EXPENDITURE		1.26%	1.74%	16.49%	-2.71%	3.95%
ELIGIBLE Deliveries		-0.84%	-1.43%	1.30%	1.03%	0.01%
PMPD COST		2.12%	3.22%	14.99%	-3.70%	3.94%

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**Attachment 6 - Budget Neutrality Form – WOW**

MEDICAID POPULATIONS											
ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR FY14	TREND RATE 2	DEMONSTRATION YEARS					TOTAL WOW	
					FY15	FY16	FY17	FY18	FY19		
<b>Medicaid Pop 1</b>	ABD	24									
Eligible Member Months			1,458,016		1,472,596	1,487,322	1,502,195	1,517,217	1,532,389		
PMPM Cost	5.14%		\$ 893.70	5.14%	\$ 939.64	\$ 987.94	\$ 1,038.72	\$ 1,092.11	\$ 1,148.24		
Total Expenditure			\$ 1,303,028,603		\$ 1,383,709,941	\$ 1,469,384,683	\$ 1,560,359,992	\$ 1,656,967,805	\$ 1,759,550,484	\$ 7,829,972,905	
<b>Medicaid Pop 2</b>	BCCTP	24									
Eligible Member Months			9,724		10,404	11,133	11,912	12,746	13,638		
PMPM Cost	5.60%		\$ 2,767.84	5.60%	\$ 2,922.84	\$ 3,086.52	\$ 3,259.37	\$ 3,441.89	\$ 3,634.64		
Total Expenditure			\$ 26,913,468		\$ 30,410,076	\$ 34,360,963	\$ 38,825,198	\$ 43,869,307	\$ 49,568,864	\$ 197,034,408	
<b>Medicaid Pop 3</b>	MLUF	24									
Eligible Member Months			907,519		912,056	916,616	921,200	925,806	930,435		
PMPM Cost	3.20%		\$ 234.53	3.20%	\$ 242.03	\$ 249.77	\$ 257.76	\$ 266.01	\$ 274.52		
Total Expenditure			\$ 212,840,331		\$ 220,744,954	\$ 228,943,290	\$ 237,448,391	\$ 246,273,528	\$ 255,422,894	\$ 1,188,833,056	
<b>Medicaid Pop 4</b>	SOBRA Child	24									
Eligible Member Months			4,945,891		4,970,621	4,995,474	5,020,451	5,045,554	5,070,781		
PMPM Cost	1.26%		\$ 156.52	1.26%	\$ 158.49	\$ 160.49	\$ 162.51	\$ 164.56	\$ 166.63		
Total Expenditure			\$ 774,130,927		\$ 787,793,704	\$ 801,723,621	\$ 815,873,551	\$ 830,296,303	\$ 844,944,302	\$ 4,080,631,482	
<b>Medicaid Pop 5</b>	Transitional	24									
Eligible Member Months			18,481		19,405	20,376	21,394	22,464	23,587		
PMPM Cost	-1.37%		\$ 211.61	-1.37%	\$ 208.71	\$ 205.85	\$ 203.03	\$ 200.25	\$ 197.51		
Total Expenditure			\$ 3,910,808		\$ 4,050,073	\$ 4,194,303	\$ 4,343,686	\$ 4,498,421	\$ 4,658,713	\$ 21,745,196	
<b>Medicaid Pop 6</b>	Refugees	24									
Eligible Member Months			934		1,000	1,070	1,144	1,225	1,310		
PMPM Cost	7.64%		\$ 203.14	7.64%	\$ 218.66	\$ 235.37	\$ 253.35	\$ 272.71	\$ 293.55		
Total Expenditure			\$ 189,781		\$ 218,580	\$ 251,754	\$ 289,955	\$ 333,960	\$ 384,644	\$ 1,478,892	
<b>Medicaid Pop 7</b>	Delivery	24									
Eligible Member Months			30,287		30,741	31,202	31,670	32,145	32,627		
PMPM Cost	3.94%		\$ 11,774.16	3.94%	\$ 12,238.06	\$ 12,720.24	\$ 13,221.42	\$ 13,742.34	\$ 14,283.79		
Total Expenditure			\$ 356,598,739		\$ 376,208,402	\$ 396,896,492	\$ 418,722,307	\$ 441,748,139	\$ 466,040,369	\$ 2,099,615,709	

**NOTES**

"Base Year" is the year immediately prior to the planned first year of the demonstration.  
 "Trend Rate 1" is the trend rate that projects from the last historical year to the Base Year.  
 "Months of Aging" equals the number of months of trend factor needed to trend from the last historical year to the Base Year. There are 24 months between the midpoint of SFY12 (last historical year) and SFY14 (Base Year).  
 "Trend Rate 2" is the trend rate that projects all DYS, starting from the Base Year.

**STATE OF ALABAMA**  
**SECTION 1115 DEMONSTRATION APPLICATION**  
**Draft: February 28, 2014**

**Attachment 7 - Budget Neutrality Form – WW**

MEDICAID POPULATIONS		DEMONSTRATION YEARS										TOTAL WW	
ELIGIBILITY GROUP	FY14	DEMO TREND RATE	Rate Methodology Adjustment - FY15		Rate Methodology Adjustment - FY16		Rate Methodology Adjustment - FY17		Rate Methodology Adjustment - FY18		Rate Methodology Adjustment - FY19		
			FY15	FY15	FY16	FY16	FY17	FY17	FY18	FY18	FY19	FY19	
<b>Medicaid Pop 1</b>	ABD												
Eligible Member Months	1,458,016			1,472,596		1,487,322		1,502,195		1,517,217		1,532,389	
PMPM Cost	\$ 893.70	5.14%	-9.67%	\$ 848.75	-4.64%	\$ 851.00	-5.45%	\$ 845.93	-4.39%	\$ 850.41	-3.19%	\$ 865.63	
Total Expenditure	\$ 1,303,028,603		\$ 1,249,871,564	\$ 1,265,707,758	\$ 1,270,757,414	\$ 1,290,254,729	\$ 1,326,487,566	\$ 6,403,079,032					
<b>Medicaid Pop 2</b>	BCCTP												
Eligible Member Months	9,724			10,404		11,133		11,912		12,746		13,638	
PMPM Cost	\$ 2,767.84	5.60%	-19.56%	\$ 2,350.99	-2.94%	\$ 2,409.64	-3.27%	\$ 2,461.27	-4.26%	\$ 2,488.40	-3.84%	\$ 2,526.81	
Total Expenditure	\$ 26,913,468		\$ 24,460,357	\$ 26,825,552	\$ 29,318,340	\$ 31,716,464	\$ 34,460,428	\$ 146,781,141					
<b>Medicaid Pop 3</b>	MUF												
Eligible Member Months	907,519			912,056		916,616		921,200		925,806		930,435	
PMPM Cost	\$ 234.53	3.20%	-4.40%	\$ 231.38	-1.93%	\$ 234.18	-2.33%	\$ 236.04	-1.80%	\$ 239.20	-1.27%	\$ 243.72	
Total Expenditure	\$ 212,840,331		\$ 211,028,377	\$ 214,653,712	\$ 217,435,806	\$ 221,449,391	\$ 226,768,853	\$ 1,091,336,139					
<b>Medicaid Pop 4</b>	SOBRA Child												
Eligible Member Months	4,945,891			4,970,621		4,995,474		5,020,451		5,045,554		5,070,781	
PMPM Cost	\$ 156.52	1.26%	-2.21%	\$ 154.99	-0.82%	\$ 155.66	-1.05%	\$ 155.96	0.14%	\$ 158.15	0.62%	\$ 161.12	
Total Expenditure	\$ 774,130,927		\$ 770,391,207	\$ 777,577,888	\$ 782,986,849	\$ 797,932,319	\$ 817,025,169	\$ 3,945,913,432					
<b>Medicaid Pop 5</b>	Transitional												
Eligible Member Months	18,481			19,405		20,376		21,394		22,464		23,587	
PMPM Cost	\$ 211.61	-1.37%	13.36%	\$ 236.60	2.08%	\$ 238.21	1.57%	\$ 238.63	2.53%	\$ 241.30	3.07%	\$ 245.30	
Total Expenditure	\$ 3,910,808		\$ 4,591,341	\$ 4,853,709	\$ 5,105,297	\$ 5,420,627	\$ 5,786,039	\$ 25,757,013					
<b>Medicaid Pop 6</b>	Refugees												
Eligible Member Months	934			1,000		1,070		1,144		1,225		1,310	
PMPM Cost	\$ 203.14	7.64%	-17.65%	\$ 180.07	-5.79%	\$ 182.60	-4.34%	\$ 188.02	-6.20%	\$ 189.84	-5.91%	\$ 192.28	
Total Expenditure	\$ 189,781		\$ 180,003	\$ 195,310	\$ 215,191	\$ 251,945	\$ 1,074,929						
<b>Medicaid Pop 7</b>	Delivery												
Eligible Deliveries	30,287			30,741		31,202		31,670		32,145		32,627	
PMPM Cost	\$ 11,774.16	3.94%	-6.31%	\$ 11,466.09	-2.20%	\$ 11,656.15	-2.45%	\$ 11,818.20	-3.21%	\$ 11,889.23	-2.45%	\$ 12,054.86	
Total Expenditure	\$ 356,598,739		\$ 352,477,454	\$ 363,694,845	\$ 374,282,219	\$ 382,179,733	\$ 393,316,737	\$ 1,865,950,987					

**STATE OF ALABAMA**  
**SECTION 1115 DEMONSTRATION APPLICATION**  
**Draft: February 28, 2014**

**Attachment 8 - Budget Neutrality Form – Summary**

Budget Neutrality Summary

Without-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					TOTAL
		DY 01 - FY15	DY 02 - FY16	DY 03 - FY17	DY 04 - FY18	DY 05 - FY19	
Medicaid Pop 1	ABD	\$ 1,383,709,941	\$ 1,469,384,683	\$ 1,560,359,992	\$ 1,656,967,805	\$ 1,759,550,484	\$ 7,829,972,905
Medicaid Pop 2	BCCTP	\$ 30,410,076	\$ 34,360,963	\$ 38,825,198	\$ 43,869,307	\$ 49,568,864	\$ 197,034,408
Medicaid Pop 3	MLIF	\$ 220,744,954	\$ 228,943,290	\$ 237,448,391	\$ 246,273,528	\$ 255,422,894	\$ 1,188,833,056
Medicaid Pop 4	SOBRA Child	\$ 787,793,704	\$ 801,723,621	\$ 815,873,551	\$ 830,296,303	\$ 844,944,302	\$ 4,080,631,482
Medicaid Pop 5	Transitional	\$ 4,050,073	\$ 4,194,303	\$ 4,343,686	\$ 4,498,421	\$ 4,658,713	\$ 21,745,196
Medicaid Pop 6	Refugees	\$ 218,580	\$ 251,754	\$ 289,955	\$ 333,960	\$ 384,644	\$ 1,478,892
Medicaid Pop 7	Delivery	\$ 376,208,402	\$ 396,896,492	\$ 418,722,307	\$ 441,748,139	\$ 466,040,369	\$ 2,099,615,709
Pool 1	DSHP CNOM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Pool 2	Hospital Transition Pool	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Pool 3	DSRIP Pool	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>WOW SUBTOTAL</b>		\$ 2,803,135,731	\$ 2,935,755,106	\$ 3,075,863,079	\$ 3,223,987,463	\$ 3,380,570,271	\$ 15,419,311,649

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					TOTAL
		DY 01 - FY15	DY 02 - FY16	DY 03 - FY17	DY 04 - FY18	DY 05 - FY19	
Medicaid Pop 1	ABD	\$ 1,249,871,564	\$ 1,265,707,758	\$ 1,270,757,414	\$ 1,290,254,729	\$ 1,326,487,566	\$ 6,403,079,032
Medicaid Pop 2	BCCTP	\$ 24,460,357	\$ 26,825,552	\$ 29,318,340	\$ 31,716,464	\$ 34,460,428	\$ 146,781,141
Medicaid Pop 3	MLIF	\$ 211,028,377	\$ 214,653,712	\$ 217,435,806	\$ 221,449,391	\$ 226,768,853	\$ 1,091,336,139
Medicaid Pop 4	SOBRA Child	\$ 770,391,207	\$ 777,577,888	\$ 782,986,849	\$ 797,932,319	\$ 817,025,169	\$ 3,945,913,432
Medicaid Pop 5	Transitional	\$ 4,591,341	\$ 4,853,709	\$ 5,105,297	\$ 5,420,627	\$ 5,786,039	\$ 25,757,013
Medicaid Pop 6	Refugees	\$ 180,003	\$ 195,310	\$ 215,191	\$ 232,480	\$ 251,945	\$ 1,074,929
Medicaid Pop 7	Delivery	\$ 352,477,454	\$ 363,694,845	\$ 374,282,219	\$ 382,179,733	\$ 393,316,737	\$ 1,865,950,987
Excluded WW Services <sup>1</sup>		\$ 111,919,979	\$ 113,025,326	\$ 114,154,094	\$ 115,306,556	\$ 116,484,341	\$ 570,890,296
Pool 1	DSHP CNOM	\$ 118,519,877	\$ 118,519,877	\$ 118,519,877	\$ 118,519,877	\$ 118,519,877	\$ 592,599,385
Pool 2	Hospital Transition Pool	\$ 117,142,034	\$ 89,957,139	\$ 50,480,596	\$ 14,143,209	\$ -	\$ 271,722,978
Pool 3	DSRIP Pool	\$ 33,736,193	\$ 60,921,088	\$ 100,397,631	\$ 136,735,018	\$ 150,878,227	\$ 482,668,157
<b>WW SUBTOTAL</b>		\$ 2,994,318,386	\$ 3,035,932,204	\$ 3,063,653,314	\$ 3,113,890,402	\$ 3,189,979,182	\$ 15,397,773,487

<b>TOTAL</b>		\$ (191,182,655)	\$ (100,177,098)	\$ 12,209,765	\$ 110,097,061	\$ 190,591,089	\$ 21,538,162
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<sup>1</sup>Excluded Services include: Dental Services, State Lab, Targeted Case Management (FS Child, Adult PSI, and AIDS), Nursing Facility, Hospice, MEPD, FP 1115 Waiver, and Nursing Home Ventilation.



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Acting Commissioner

## PUBLIC NOTICE

### SUBJECT: NOTICE OF INTENT TO SUBMIT SECTION 1115 DEMONSTRATION PROPOSAL

Pursuant to 42 C.F.R. § 431.408, the Alabama Medicaid Agency (Medicaid) notifies the public that it intends to submit a Section 1115 Demonstration proposal to the Centers for Medicare and Medicaid Services (CMS). A copy of the proposed Demonstration proposal is available at:

[http://medicaid.alabama.gov/CONTENT/2.0\\_newsroom/2.7.3\\_Regional\\_Care\\_Organizations.aspx](http://medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3_Regional_Care_Organizations.aspx). It is also available upon request for public review at each county office of the Department of Human Resources and the State Office of the Alabama Medicaid Agency.

Written comments concerning the 1115 Demonstration proposal should be submitted on or before April 4, 2014 to the following e-mail address:

[publiccomment@medicaid.alabama.gov](mailto:publiccomment@medicaid.alabama.gov) or mailed to: Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, Alabama 36103-5624.

### **Demonstration Description, Goals and Objectives**

Medicaid is seeking approval of a Section 1115 Demonstration Project to implement a new care delivery model that will improve upon and ensure the long-term sustainability of Alabama’s Medicaid program. This new care delivery model will build upon the services provided through the current Maternity Care Program; Patient 1<sup>st</sup>, the primary care case management program (PCCM); and the Patient Care Networks (PCNs) of Alabama, Health Home Program.

Medicaid will implement the following strategies to enable the State to improve care coordination, access to care, and health outcomes for the beneficiaries eligible for the Demonstration, while reducing costs and transitioning the State’s Medicaid system from utilization-driven reimbursement to one that focuses on value over volume:

- A delivery system through which risk bearing, provider-based regional care organizations (RCOs) will be paid on a capitated basis to provide the following to the Demonstration Populations:
  - The full scope of Medicaid benefits, including primary, acute, behavioral, maternal, pharmacy and post-acute services.



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- Care coordination, including improved coordination of physical and behavioral health services.
- A medical home that provides a primary medical provider (PMP) to provide and arrange for beneficiaries' health care needs and a health home, building upon the current Health Home program, for individuals with chronic conditions.
- Transition from a volume-based, fee-for-service (FFS) reimbursement system to a capitated payment system that incentivizes the delivery of quality health outcomes.
- Transition of the current hospital payment system to one providing incentive payments to RCOs and to hospitals to improve and reform the health care delivery system in the State.

Medicaid plans to contract with regionally-based RCOs that will cover five geographical regions statewide, and will implement such contracts using a phased approach. Medicaid will use a phased approach to implementing the program statewide by October 2016; and will therefore continue administering the Maternity Care Program, as well as Patient 1<sup>st</sup> and the PCN Programs in regions until RCOs are operational. These programs will be phased out as RCOs are operational in each region, although RCOs will be required to maintain at least the same level of program services as currently provided through these programs.

When statewide, this Demonstration will serve approximately 654,000 Medicaid beneficiaries (the Demonstration Populations), including approximately 113,000 aged, blind and disabled individuals. Depending on an individual's Medicaid eligibility category, he or she will be mandatorily enrolled, or have the option to enroll or continue to receive services through the FFS delivery system.

## **Benefit Coverage**

The Demonstration will not reduce the benefits currently offered to individuals through the Medicaid program.



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## Eligibility Requirements

Provider-based, community-led RCOs will manage and coordinate care for the Demonstration Populations. The Demonstration will exclude PACE participants, children in foster care, dually eligible beneficiaries, and individuals residing in long term care facilities or utilizing home- and community-based waiver services. Medicaid is not requesting to expand to new populations through this Demonstration. The applicable Medicaid eligibility categories for these Demonstration Populations are detailed in the Demonstration proposal available at

[http://medicaid.alabama.gov/CONTENT/2.0\\_newsroom/2.7.3\\_Regional\\_Care\\_Organizations.aspx](http://medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3_Regional_Care_Organizations.aspx).

## Cost Sharing

Medicaid is not proposing any changes to current Medicaid State Plan cost sharing requirements.

## Annual Enrollment and Annual Expenditures

### Historical Enrollment

	Member Months				
	SFY08	SFY09	SFY10	SFY11	SFY12
RCO Membership	4,170,100	5,896,321	6,446,468	6,989,438	7,250,671
Annual Growth		41.4%	9.3%	8.4%	3.7%

### Projected Enrollment

	Member Months				
	SFY15	SFY16	SFY17	SFY18	SFY19
RCO Membership	7,386,082	7,431,990	7,478,297	7,525,010	7,572,141
Annual Growth	0.6%	0.6%	0.6%	0.6%	0.6%



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### Historical Expenditures

	Dollars					TOTAL
	SFY08	SFY09	SFY10	SFY11	SFY12	
RCO Expenditure	\$ 1,434,189,662	\$ 1,911,939,472	\$ 2,070,539,412	\$ 2,375,597,696	\$ 2,446,130,256	\$ 10,238,396,498
Annual Growth		33.3%	8.3%	14.7%	3.0%	

### Current Projected Expenditures and Savings

	Dollars					TOTAL
	SFY15	SFY16	SFY17	SFY18	SFY19	
RCO Without Waiver Costs	\$ 2,803,135,731	\$ 2,935,755,106	\$ 3,075,863,079	\$ 3,223,987,463	\$ 3,380,570,271	\$ 15,419,311,649
Annual Growth	4.6%	4.7%	4.8%	4.8%	4.9%	
RCO With Waiver Costs	\$ 2,994,318,386	\$ 3,035,932,204	\$ 3,063,653,314	\$ 3,113,890,402	\$ 3,189,979,182	\$ 15,397,773,487
Annual Growth	7.0%	1.4%	0.9%	1.6%	2.4%	
TOTAL WAIVER SAVINGS	\$ (191,182,655)	\$ (100,177,098)	\$ 12,209,765	\$ 110,097,061	\$ 190,591,089	\$ 21,538,162

## Hypotheses and Evaluation Parameters

Medicaid proposes to test the following through the Alabama Section 1115 Demonstration:

- Integrating services and eliminating the current silos between physical health services and behavioral health services will improve quality in covered Medicaid services.
- Providing statewide care coordination services to Medicaid beneficiaries through an RCO model will result in improved health outcomes when compared with the health outcomes recorded under the current FFS delivery system.
- Providing statewide care coordination services to Medicaid beneficiaries through an RCO model will improve appropriate utilization of hospital and emergency department services when compared to utilization under the current FFS delivery system.
- Holding RCOs to outcome and performance measures, and tying measures to meaningful financial incentives, will improve results on outcome and performance measures when compared to the current FFS delivery system.
- Contracting with locally-led RCOs will do the following:
  - Better engage providers in solving cross-cutting health system issues such as how to coordinate and work with PMPs to establish standards of care.



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- Assist providers in effectively managing more costly and complex beneficiaries.
- Better utilize claims and other data to identify beneficiaries most likely to benefit from intervention and to provide feedback to providers regarding care patterns and interventions.

Medicaid will submit to CMS an evaluation design for the Demonstration no later than 120 days after CMS' approval of the Demonstration. Medicaid's evaluation design will:

- Test the Demonstration hypotheses.
- Describe specific outcome measures that will be used in evaluating the impact of each Demonstration-related program during the period of approval.
- Detail the data sources and sampling methodologies for assessing these outcomes.
- Describe how the effects of all Demonstration-related programs will be isolated from other initiatives occurring in the State.
- Discuss Medicaid's plan for reporting to CMS on the identified outcome measures and the content of those reports.

Medicaid will submit the final evaluation design to CMS no later than 60 days after receiving comments on the draft evaluation design from CMS. Medicaid will submit progress reports in quarterly and annual Demonstration reports, and submit a draft final evaluation report within 120 days of the expiration of the Demonstration.

## **Waiver Authority Sought**

Medicaid seeks waivers of provisions of Section 1902 and costs not otherwise matchable under Section 1903 that include, but are not limited to the below. Medicaid will work with CMS to finalize the full list of requested waivers and costs not otherwise matchable.

### *Waivers*

- Section 1902(a)(1) (state wideness) to enable the State to use a phased approach to implementation of the RCO model statewide. The State anticipates that RCOs will form and be operational in some regions more quickly than in others.



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- Section 1902(a)(17) (comparability) to permit the State to exclude from the Demonstration:
  - Beneficiaries within the same eligibility categories as the Demonstration Populations who are eligible and enrolled in home- and community-based services waivers. These beneficiaries will remain in the FFS delivery system for all State Plan and home- and community-based waiver services.
  - Beneficiaries in the following eligibility categories: PACE participants, children in foster care, dually eligible beneficiaries, and individuals residing in long term care facilities or utilizing home- and community-based waiver services.
- Section 1902(a)(23)(A) (freedom of choice) to enable the State to mandate enrollment of certain beneficiaries in the Demonstration Populations in risk-based RCOs, as well as to limit them to one RCO in regions where only one RCO operates. Beneficiaries will retain the right to choose between RCOs in regions where more than one RCO participates.

Because of the rural nature of the State, it is estimated some regions may only include one RCO to be actuarially sound. Therefore, Medicaid is requesting rural exception from choice of RCOs in accordance with 42 CFR 438.52 in all Regions. All beneficiaries enrolled in RCOs will maintain choice of at least two PMPs and will be able to obtain the services of providers outside of an RCO's network in accordance with 42 CFR 438.52(b)(2)(ii).

- Section 1902(a)(13) and (a)(30) (rate setting/payment methodologies) to permit the State to implement a value-based purchasing strategy based on the use of withholds and incentives.

## *Costs Not Otherwise Matchable*

- Expenditures to provide federal matching payments to a number of state-only programs. These include programs funded entirely by the State that provide services such as adult day care, outpatient substance abuse treatment and outpatient care for the mentally ill who are not eligible for Medicaid.
- Expenditures to pay transition payments and Delivery System Reform Incentive Payments to RCOs, hospitals and other providers.



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STEPHANIE MCGEE AZAR  
Acting Commissioner

## Comments and Public Input Process

Medicaid conducted an inclusive process in analyzing Medicaid redesign options and developing the Demonstration design as outlined in the Demonstration proposal now posted for comments. Governor Bentley convened a multi-stakeholder Medicaid Advisory Commission charged with providing recommendations to improve the Alabama Medicaid program that would curb the growth trajectory of the Medicaid program and improve the quality and type of care provided to Medicaid beneficiaries.

The Commission brought together a large and diverse group of representatives to review and develop its recommendations. Entities or organizations included: executive officers of state agencies, cabinet-level leaders, State Senators and Representatives, insurance companies, consumer advocates, medical providers, and professional organizations. These professional organizations represented the hospitals, physicians, pharmacy, nurses, primary and rural health clinics, hospice, and nursing homes. The recommendations of the Commission, which align with Medicaid's overall goals for the Medicaid program, became the building blocks for a comprehensive Medicaid reform plan described in this 1115 Demonstration proposal. This reform plan was also passed by the Alabama Legislature and signed into Law by Governor Bentley in May 2014. Additional examples of the public input that Medicaid has conducted in the development of this program include:

- A series of regional public meetings for physicians, hospitals, professional associations, and other interested parties to learn more about Alabama Medicaid's progress in implementing RCOs and to provide participants with an opportunity to ask questions and provide comments.
- A letter by certified mail and through e-mail provided to the Tribal Chairman of the Poarch Creek Band Indian Tribe on October 22, 2013 notifying the tribe of the 1115 Demonstration proposal and requesting comments and concerns within 30 days of receipt of letter. No comments or concerns were received.

As required by federal regulation, Medicaid is now opening a formal 30-day comment period and directs interested parties to [http://medicaid.alabama.gov/CONTENT/2.0\\_newsroom/2.7.3\\_Regional\\_Care\\_Organizations.aspx](http://medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3_Regional_Care_Organizations.aspx).

Comments will be accepted for consideration on or before April 4, 2014. Medicaid will hold two public meetings to solicit comments on the Demonstration proposal:

# Alabama Medicaid Agency



ROBERT BENTLEY  
Governor

501 Dexter Avenue  
P.O. Box 5624  
Montgomery, Alabama 36103-5624  
www.medicaid.alabama.gov  
e-mail: almedicaid@medicaid.alabama.gov

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334-242-5000 1-800-362-1504



STEPHANIE MCGEE AZAR  
Acting Commissioner

**March 13<sup>th</sup> at 10:00 am**  
Alabama Medicaid Agency  
501 Dexter Avenue  
Montgomery, AL 36104

**March 18<sup>th</sup> at 10:00 am**  
Birmingham Botanical Gardens  
2612 Lane Park Rd.  
Birmingham, AL 35223

Medicaid will provide teleconference access for the March 13<sup>th</sup> meeting at the Alabama Medicaid Agency. Please see the Medicaid website at [http://medicaid.alabama.gov/CONTENT/2.0\\_newsroom/2.7.3\\_Regional\\_Care\\_Organizations.aspx](http://medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3_Regional_Care_Organizations.aspx) for dial-in information.

A handwritten signature in cursive script, reading "Stephanie McGee Azar".

Stephanie McGee Azar  
Acting Commissioner



# Alabama Medicaid Agency

501 Dexter Avenue  
P.O. Box 5624  
Montgomery, Alabama 36103-5624  
www.medicaid.alabama.gov  
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ROBERT BENTLEY  
Governor

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STEPHANIE MCGEE AZAR  
Acting Commissioner

October 22, 2013

Mr. Buford L. Rolin  
Tribal Chairman  
Poarch Band Indian Health Department  
5811 Jack Springs Road  
Atmore, Alabama 36502

91 7199 9991 7031 5527 8996

Dear Mr. Rolin:

As directed by the Tribal Consultation section 1902(a)(73) of the Social Security Act and Federal Regulation, this notice to the Tribal Government is hereby given for the anticipated submission of an 1115 Demonstration Waiver for the Alabama Medicaid Agency to implement a new care delivery model to address fragmentation in the State's delivery system, support quality care, and increase transparency and fairness in the Medicaid reimbursement system. The Demonstration Waiver will transition the State's Medicaid system from utilization-driven reimbursement to value based purchasing through the implementation of three main components:

- A medical or health home for every Medicaid beneficiary, building on the State's recent successes with the Patient Care Networks of Alabama, to more effectively address the broad spectrum of behavioral health and physical health needs of Medicaid beneficiaries including those with acute care needs, chronic conditions, mental illnesses and substance abuse disorders;
- The development of provider-based Regional Care Organizations to manage and coordinate care for the majority of the Medicaid population, to move the State from a volume-based fee-for-service reimbursement system; and
- Reform current hospital payment system to provide incentive payments to RCO's and to hospitals to improve and reform the health care delivery system in the state.

The purpose of this notification is to allow you the opportunity to provide comments and/or relay any concerns that you may have in relationship to the tribe. Native Americans will be given the option of opting out of this program. Please provide a written response regarding any such comments/concerns within 30 days from the date this letter via certified mail.

Sincerely,

Carolyn Miller, LCSW, PIP  
Associate Director, Project Development and  
Quality Improvement  
Managed Care Division

# *Regional Care Organization Districts*

*Effective October 1, 2013*

