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Alabama Medicaid Agency

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STEPHANIE MCGEE AZAR
Acting Commissioner

May 17, 2013

Cindy Mann, Director
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: S2-26-12
Baltimore, MD 21244-1850

RE: Alabama 1115 Waiver Concept Paper

Dear Ms. Mann:

The Alabama Medicaid Agency is ready to begin discussions with CMS regarding development of an application for a Section 1115 demonstration project that will 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 project arises out of the recommendations of a multi-stakeholder Medicaid Advisory Commission that was convened by Governor Bentley in October 2012. Per our discussion earlier this year, we understand that you will assign a technical assistance team to support these efforts. Enclosed is a concept paper which provides a high level description of the proposed demonstration.

The point of Agency contact for scheduling conference calls for this project will be Kathleen Hudson at 334-242-5600 or Kathleen.Hudson@medicaid.alabama.gov.

Sincerely,

Handwritten signature of Stephanie M. Azar in blue ink.

Stephanie M. Azar
Acting Commissioner

Handwritten signature of Donald E. Williamson in black ink.

Donald E. Williamson, MD, Chairman
AL Medicaid Agency Transition
Task Force

Encl.

Alabama 1115 Waiver Concept Paper
May 15, 2013

Introduction

The Alabama Medicaid Agency would like to begin discussions with CMS regarding development of an application for a Section 1115 demonstration project that will 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 project arises out of the recommendations of a multi-stakeholder Medicaid Advisory Commission that was convened by Governor Bentley in October 2012. The Commission's recommendations were submitted to the Governor on January 30, 2013 and can be found in Attachment A. More information on the Commission, including the Executive Order and membership roster can be found in Attachments B and C, respectively.

The principal building blocks of a demonstration project, based on the Commission's recommendations that the State transition from utilization-driven reimbursement to value-based purchasing, would include:

- A medical or health home for every Medicaid beneficiary, building on the State's recent successes with the Alabama Patient Care Network (PCN).
- The development of provider-based regional care organizations (RCOs) to manage and coordinate care for the majority of the Medicaid population. Through a capitated payment, RCOs would manage the full scope of Medicaid benefits, including physical, behavioral, and pharmacy services.
- New strategies to more effectively address the behavioral health and physical health needs of Medicaid beneficiaries who have chronic needs, mental illnesses and substance use disorders.

The Commission recommended these steps as necessary to ensure the long-term sustainability of the Medicaid program, to protect and expand access to health care providers in Alabama, and to improve the health of Medicaid beneficiaries. However, it is apparent that implementation will require substantial investment on the part of the State and its providers. Therefore, while remaining budget neutral over the life of the demonstration project, the State would also request that CMS make funds available for certain costs not otherwise matchable, including:

- Investments in Regional Care Organizations to build infrastructure to enable the delivery system transformation.
- Investments to enhance the infrastructure of the State's behavioral health safety-net system to support RCOs in their efforts to provide coordinated care for individuals who have mental illnesses and substance use disorders.
- Provider Payment Transition Pool to support hospitals in the transition from per diem to APR-DRG payment system.
- Quality of Care Pool for incentive payments to RCOs outside of the capitation rate for achieving target quality outcomes.

- Designated State Health Programs (DSHP) that would not otherwise be eligible for Medicaid match.

The availability of federal funds for DSHPs will free up state funds that can be used to make significant investments to the internal infrastructure and capacity within the State Medicaid Agency so that it can be an active purchaser and responsible partner in delivery system transformation. This is a critical component to making the demonstration a success.

The Commission's recommendations were accepted by the Governor and some, such as letting community-led networks coordinate health-care services for Medicaid patients region-by-region, were incorporated in Senate Bill 340, which the Legislature approved May 7, 2013. The state now wants to move quickly. The State is cognizant of CMS's rules and process regarding transparency in the development and submission of demonstration project applications and is committed to following that process and soliciting additional public input on the concepts outlined above in the preparation of the formal application. The purpose of this concept paper is to initiate discussions with CMS to get any early guidance that might shape the discussion at the State level, as well as to ascertain whether there are any roadblocks to proceeding as outlined above.

We provide greater detail on the components of the proposal below.

Current State Program

The Alabama Medicaid program serves 933,907 enrollees¹ with a total annual budget of \$5.9 billion. The program faces three primary challenges that it seeks to address through a comprehensive reform of its Medicaid program:

1. *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. The anticipated rate of growth threatens the State's ability to maintain even a modest benefit package and eligibility criteria.
2. *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. The statewide case management program, Patient First, functions primarily as a gatekeeper to specialty services and is not sufficiently robust to manage the State's most vulnerable populations. Overall, Medicaid capacity is uneven across the State.

Service fragmentation is particularly acute for some of the state's most vulnerable populations, such as individuals who have mental illnesses and substance use disorders. Alabama's Medicaid expenditures for behavioral health services exceed \$400 million annually, and are surpassed only by spending for hospital care, nursing homes, and

¹ As of October 28, 2012.

pharmacy services, demonstrating considerable opportunity to more effectively coordinate care for these beneficiaries.

The State has taken initial actions to address fragmentation in the delivery system. Alabama's Patient Care Networks (PCNs) provide health homes for patients with two or more chronic conditions (i.e., asthma, diabetes, HIV, etc.); or one chronic condition and at risk for a second; or a serious mental illness. Primary care providers serve as the health home and are paid an enhanced per member per month care coordination fee, supported by the PCNs. The PCNs provide data analytic support, care management services and provider training in evidence-based guidelines. Initial outcomes show significant reductions in emergency department utilization and total cost. Between July 2011 and February 2012, the total per member per month costs for beneficiaries in network areas decreased by almost eight (8) percent, while the rate for the rest of the state decreased by less than one (1) percent. During the same period, emergency department utilization for PCN beneficiaries dropped by fifteen (15) percent, compared to a two (2) percent increase for all other beneficiaries. Based on this preliminary evidence, Alabama believes the PCN program is a good foundation to address the challenges described above.

3. *Payment Methodologies*: State reimbursement methodologies are based on per diem or fee schedule payments, which mean that both providers and the State are focused on utilization and volume, rather than value and quality.

Comprehensive Reform Initiatives

1. Delivery Model Reforms

The State seeks to adopt delivery system reforms based on the development of statewide care management capacity that would be accountable for health outcomes across the continuum of care. This would be a transformation from the current, fragmented, FFS model. The State would directly contract with regional care organizations for the majority of the Medicaid population (approximately 800,000 beneficiaries). The State would continue and/or expand the existing enhanced primary care case management program (the PCN program) while the RCOs are under development.

Regionally-based, community-led RCOs would manage and coordinate care for the majority of the non-dually eligible Medicaid population. Through a capitated payment, RCOs would manage the full scope of Medicaid benefits, including physical, behavioral, pharmacy and long-term care services (post-acute/rehab). RCOs would be largely governed by provider organizations that agree to share in the risk in a particular region of the State. Because they are provider-based organizations, the State would establish criteria and oversight procedures that will be managed within the Medicaid Agency (separate and apart from traditional insurers). The RCOs would be built over time and could be phased in as pilots across the State.

Regions may first opt to develop a PCN program to serve as the foundation for a future RCO. As these PCNs build additional infrastructure to manage their population under a capitated

arrangement, they would transition to become RCOs. Some regions, such as Huntsville, Birmingham and Montgomery, are better equipped to launch an RCO in the first phase of reform. Federally Qualified Health Centers (FQHCs) are expected to play a role in the development of both the RCOs and PCNs as critical primary care providers.

RCOs would initially manage and be at risk for primary, acute and post-acute care services. As they build capacity, they would be expected to integrate and fully manage behavioral health services for the population served. RCOs will be required to design care coordination programs to ensure these beneficiaries have access to adequate physical and behavioral health care in addition to connecting them with social services. Mental health and substance abuse providers currently certified by the Alabama Department of Mental Health (ADMH) and functioning as approved Medicaid providers are expected to be critical participants in RCO and PCN networks.

The Alabama Medicaid Agency will strengthen its 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 who have mental illnesses and substance use disorders. Specifically, the two agencies 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 healthcare services.
- Payment mechanisms and services that support and incentivize the transition of individuals from institutional-based care to community-based behavioral health care settings.

The RCO model would have the following features:

- **Mandatory enrollment in a care management entity.** All affected beneficiaries would be required to enroll in an RCO or PCN based on geographic location. Mandatory enrollment enables the State to maximize its ability to better coordinate care for the highest number of beneficiaries.
- **Medical/health home model for all Medicaid beneficiaries.** Every affected beneficiary would choose (or be assigned to in the case of non-election) a medical or health home. The medical/health home would be responsible for management and coordination of all benefits, including behavioral health. There would be a mix of primary care and complex medical and health home models used, depending upon the beneficiaries' need.
- **Include most Medicaid beneficiaries.** Initially, all beneficiaries, with the exception of dual eligibles, those in long term care facilities or utilizing home and community-based waiver services, and the developmentally disabled, would be enrolled in and managed by

an RCO. Over time, the RCO, or another model, would work with the state and Medicare to coordinate and provide care for duals as well, including those requiring long term care services.

- Manage all health and behavioral health services.** The RCOs may have the greatest impact on cost and health outcomes when they are responsible for managing the entire benefit package including behavioral health and pharmacy. It is anticipated that some of these services would be phased in over time as the infrastructure becomes sufficiently robust to support these additional services. RCOs would create the service delivery network and protocols for utilization review.
- Connection with the Statewide Health Information Exchange.** RCOs and PCNs would be required to leverage the health information exchange (HIE) infrastructure under development in Alabama, One Health Record™. To ensure better integration of the Medicaid providers into the larger health care marketplace, the HIE would be the primary vehicle through which Medicaid providers share and access clinical information on patients. Providers affiliated with RCOs would be expected to use the standardized continuity of care record (CCD), which is currently under development and will be a component of the providers’ electronic health records. Ultimately, the HIE will provide real-time access to data that 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 physician offices and health care facilities.

**Table 1.1
Summary of Proposed Care Delivery Models at Full Implementation**

	Regional Care Organizations	Patient Care Networks
Summary	Risk-bearing “regional care organizations” that manage a continuum of health care services under a single capitated rate	Health home model that utilizes a care management organization to support primary care providers in managing the full scope of services
Population	All Medicaid beneficiaries, excluding dual eligibles, those in long term care facilities or utilizing home and community-based waiver services, and the developmentally disabled	Same as for RCO
Benefits	Provide and coordinate primary, acute, behavioral, and post-acute care services	Coordinate primary, acute, behavioral, and post-acute services
Financing and Risk	Capitation with care management payments (transition period could include FFS)	FFS with care management payment. Providers participate in shared savings
Geographic	RCOs in all regions with capacity to organize and accept risk	Certain regions may build PCNs as a foundation for the RCO
Infrastructure	RCOs to build or contract for infrastructure, such as claims processing, network development, member services, provider relations, etc. Providers are	PCNs would build or contract for infrastructure. Providers are expected to leverage statewide HIE to share clinical information

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Governance	The State has developed governance requirements, and will have the power to approve governing board members and to approve the selection process for RCO advisory committees.	PCNs must have multi-stakeholder boards
Procurement	Non-competitive bid based on minimum criteria established by the State	Competitive bid

2. Provider Reimbursement Reforms

- Implement value-based purchasing strategies.** The State will reform its payment methodologies to implement value-based purchasing strategies. For example, such an approach would transition hospitals from per diem payments to APR-DRGs, which would drive improvements in utilization. RCOs would be expected to use this methodology in establishing contracts with providers.
- Enhance coverage and payments for targeted services to enhance access.** The State would enhance coverage or modify 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.

Budget Neutrality and Infrastructure Development

By injecting rigorous care management through community-led initiatives and provider payment reforms, Alabama expects to bend the cost curve, resulting in savings to both the state and federal government over a five year period. Alabama is requesting that the federal government share a portion of its savings through the 1115 waiver, recognizing that budget neutrality must be achieved as a condition of approval. This will enable upfront investments that will allow the State to transform its Medicaid payment and delivery system to achieve these savings and better quality outcomes.

1. Savings

State actuaries have completed an initial estimate of savings for the reforms outlined in this paper. Alabama and the federal government could potentially save between \$748 million and \$1,079 million over five years as a result of implementing regional care organizations throughout the State.

2. Costs Not Otherwise Matchable

In order to assure success of the program, the State will seek to redirect some of the savings from the service delivery and payment reforms into the following areas:

A. Designated State Health Programs.

Alabama has identified a number of State-only programs for which it will seek federal matching payments under the demonstration authority. 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. The initial list of identified programs is included in Attachment D. Securing federal support for these programs will free State funds for some of the infrastructure development that the State believes is necessary for the program to move forward.

B. RCO Investments.

RCOs would be eligible for additional investment payments, outside of the base payment structure, to develop and maintain a coordinated care delivery system. RCOs would be eligible to receive reimbursement for certain upfront development and implementation costs, such as:

- i. Joint governance models to support the ability for multiple providers to oversee and have responsibility for the RCO services provided to its members.
- ii. Initial staff required to manage enrollment and rosters, connect patients with providers, process provider reimbursements, undertake quality management and finances, hire care managers and train staff.
- iii. Information technology (e.g., electronic health records, interoperability, referral management systems, patient tracking, metric reporting, and disease registries), including incentives for behavioral health and long-term care providers who have not qualified for meaningful use incentives.
- iv. Care management tools and protocols, including 24-hour nurse hotlines, care planning infrastructure, intervention services, etc.
- v. Incentives for medical and health home models, including costs associated with care managers.

C. Quality of Care Pool.

RCOs would be eligible for incentive payments, subject to current CMS limits, for achieving target quality outcomes in the first two years of the program. The state would define priority quality initiatives, benchmarks, and metrics that RCOs would be required to report on to determine eligibility for these incentive payments. It is anticipated that initial quality targets would be set around: patient satisfaction, reduction in unnecessary readmissions, equitable health outcomes and access to care. The state will consider and, to every extent possible, align with existing measures, such as the Healthcare Effectiveness Data and Information Set (HEDIS).

D. Provider Transformation Payment Transition Pool.

Through this reform, Alabama hospitals would be paid through an APR-DRG system for the first time. This shift in payment methodologies will require changes not only in how hospitals code and bill for services but also in how they structure and deliver those services. While Alabama's hospitals have shown a deep commitment to these reforms, the State acknowledges there will be

a transition period during which hospitals may need financial assistance to maintain access for Medicaid beneficiaries. The State requests authority to make temporary additional payments. These payments would be calculated as a portion of the differential between the historical and the new payment rates and would be designated for transformation. Thus the hospital delivery system could become a truly integrated care provider.

3. Agency Transformation Milestones.

With DSHP funding, the State will be able to redirect state funding to make the State Medicaid Agency an active purchaser and partner in delivery system transformation. This will require the development of new skills and internal capacity. For instance, the Agency must hire additional staff with deep expertise in contracting for and managing complex, capitation-based contracts. In addition, the Agency will need to further develop its own IT infrastructure, such as One Health Record™, to ensure that providers and the Agency have timely access to the data they need to best manage Medicaid beneficiaries. In order to maximize the role of the Agency, these transformations need to happen early in the reform process. The State is willing to make the availability of future funding contingent on achievement of these transformation milestones.

Potential Impact on Current Enrollees

Alabama is not requesting any changes in program eligibility at this time. Therefore, there is no anticipated impact on total enrollment as a result of this reform proposal. However, beneficiaries in general will experience:

- Increased access to certain services, such as primary care and case management services;
- Changes in the way their services are delivered (e.g., in the community as opposed to in an institutional setting); and
- In some limited instances, changes in their primary care provider (dependent on network negotiations).

As part of the transparency process for development of the 1115 demonstration project application, the State will seek consumer input in the development of this plan, and conduct a robust education campaign to ensure that beneficiaries understand the changes to their health care coverage.

Proposed Provisions to Be Waived

Upon initial analysis, Alabama has identified the following provisions of federal law that it believes will need to be waived.

- **Statewideness.** Although Alabama intends to quickly expand the RCOs Statewide, it is anticipated that certain regions would be able to move more quickly than others and some regions may not have the capacity to develop an RCO in the next five years. Therefore, the State would seek to waive statewideness requirements.
- **Comparability.** The State may seek to offer slightly different benefits for those members enrolled in an RCO compared to those receiving care coordination services under the

existing fee-for-service model. Therefore, the State would need flexibility to vary the benefit package for certain categories of beneficiaries.

- **Freedom of Choice.** Alabama intends to mandate enrollment into RCOs for most populations. To the extent there is more than one RCO in a region, beneficiaries would retain the right to choose between RCOs. Beneficiaries will retain their choice of medical provider and medical/health home within network.

We look forward to discussion with CMS of the concepts outlined above and to further discussion among all stakeholders at the state level.

Attachment D: Designated State Health Programs

The State of Alabama has identified the following State-only funded health programs that may qualify for status as a “Designated State Health Program” for purposes of federal matching payments.

State Agency	Program
Department of Mental Health	Outpatient substance abuse programs
Department of Mental Health	Outpatient services for the mentally ill, such as childless men ineligible in Alabama for Medicaid
Department of Rehabilitation Services	Treatment of 314 hemophilia patients (145 adults, 169 children)
Alabama Department of Senior Services	SenioRx, a prescription drug assistance program that helps people get free prescription drugs from pharmaceutical companies
Department of Human Resources	Adult day care services for approximately 350 clients in seven counties
Department of Education	School Nurse Program (portion provided to low income children)
University of South Alabama	Community mental health center services and training
Mobile County	Uncompensated care