DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

NOV 27 2017

Stephanie Azar
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue, P.O. Box 5624
Montgomery, Alabama 36103-5624

Dear Ms. Azar:

The Centers for Medicare & Medicaid Services (CMS) is pleased to inform you that Alabama's request to extend its section 1115 demonstration, entitled "Alabama's Plan First Section 1115 Family Planning Demonstration" (Project Number: 11-W-00133/4) has been approved. CMS' approval of this demonstration extension is granted under the authority of section 1115(a) of the Social Security Act (the "Act") and is based on the determination that the expenditure authority granted therein is likely to assist with promoting the objectives of title XIX of the Act. This approval is effective as of the date of this letter through September 30, 2022.

The Alabama Plan First demonstration (hereinafter referred to as "Plan First") extends eligibility for family planning services to:

1) Women, ages 19 through 55, with income up to 141 percent of the federal poverty level (FPL) who are not otherwise eligible for Medicaid; and,
2) Men age 21 or older with income up to 141 percent of the FPL who are not otherwise eligible for Medicaid and are seeking vasectomy services and related counseling and case management services.

CMS has made several changes to the Alabama Plan First Special Terms and Conditions (STCs) to reduce the state's administrative burden associated with the section 1115 approval and monitoring processes while also assuring adequate federal oversight and evaluation. These STC updates include streamlining monitoring requirements to an annual reporting cycle and establishing templates for annual monitoring reporting as well as for evaluating demonstration outcomes that will facilitate the state's data development, collection, and reporting capacity.

CMS' approval of this demonstration project is subject to the state's compliance with the enclosed set of STCs and associated expenditure authorities. All Medicaid title XIX requirements as expressed in law, regulation, and policy statement not expressly identified as not applicable in these approval documents shall apply to the Plan First demonstration. The state's authority to deviate from Medicaid requirements is limited to the specific expenditure authorities

and non-applicables described in the enclosed approval documents, and to the purpose(s) indicated.

This award is subject to your written acknowledgement of the award and acceptance of the STCs and associated expenditure authorities within 30 days of the date of this letter.

Your project officer for this demonstration is Mr. Emmett Ruff, who can be contacted to answer any questions concerning the implementation of this demonstration at 410-786-4252 or at Emmett.Ruff@cms.hhs.gov. Official communications regarding program matters and correspondence concerning the demonstration should be submitted to him at the following address:

Mr. Emmett Ruff
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Official communications regarding this demonstration should be sent simultaneously to Mr. Ruff and to Ms. Shantrina Roberts, Acting Associate Regional Administrator (ARA) for the Division of Medicaid and Children's Health in our Atlanta Regional Office. Ms. Roberts' contact information is as follows:

Ms. Shantrina Roberts
Centers for Medicare & Medicaid Services
Atlanta Federal Center, Suite 4T20
61 Forsyth Street, South West
Atlanta, GA 30303-8909

If you have any questions regarding this approval, please contact Ms. Judith Cash, Acting Director, State Demonstrations Group, Center for Medicaid & CHIP Services at (410) 786-9686.

Sincerely,

[redacted]

Brian Neale
Director

cc: Shantrina Roberts, Acting ARA, CMS Atlanta Region
Alice Hogan, State Lead, CMS Atlanta Region

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: **11 -W-00 133/4**

TITLE: **Alabama Plan First Section 1115 Family Planning Demonstration**

AWARDEE: **Alabama Medicaid Agency**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Alabama for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, be regarded as expenditures under the state's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence to income and eligibility system verification requirements under section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities.

The following expenditure authorities and the provisions specified as "not applicable" enable Alabama to operate its demonstration effective through September 30, 2022.

Effective through September 30, 2022, expenditures for extending Medicaid eligibility for family planning services and tobacco cessation services to:

1. Women ages 19 through 55 with income up to 141 percent of the federal poverty level (FPL) who are not otherwise eligible for Medicaid; and,

2. Men age 21 or older with income up to 141 percent of the FPL who are not otherwise eligible for Medicaid.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. Methods of Administration: Transportation **Section 1902(a)(4) insofar as it incorporates 42 CFR §431.53**

To the extent necessary to enable the state to not assure transportation to and from providers for the demonstration population.

2. Amount, Duration, and Scope of Services (Comparability) **Section 1902(a)(10)(B)**

To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services and tobacco cessation services.

3. Retroactive Coverage **Section 1902(a)(34)**

To the extent necessary to enable the state to not provide medical assistance to the demonstration population for any time prior to when an application for the demonstration is made.

4. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) **Section 1902(a)(43)(A)**

To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration populations.

5. Eligibility Procedures and Standards **Section 1902(a)(17)**

To the extent necessary to enable the state to use Express Lane eligibility determinations and redeterminations for the demonstration population.

Centers for Medicare & Medicaid Services
SPECIAL TERMS AND CONDITIONS

NUMBER: **11 -W-00 133/4**

TITLE: **Alabama Plan First Section 1115 Demonstration**

AWARDEE: **Alabama Medicaid Agency**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Alabama family planning section 1115(a) Medicaid demonstration (hereinafter "demonstration"). The parties to this agreement are the Alabama Medicaid Agency and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective through September 30, 2022. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

Effective through September 30, 2022, the Alabama Plan First section 1115(a) Medicaid demonstration expands the provision of family planning services to women, ages 19 through 55, and men ages 21 or older, with income up to 141 percent of the federal poverty level (FPL), that are not otherwise eligible for Medicaid. Men are eligible to receive only vasectomy services and enhanced family planning counseling services (referred to as "care coordination" services) with respect to arrangement for and follow-up to receipt of vasectomy services under the demonstration. Plan First enrollees are also eligible to receive tobacco cessation counseling and products provided by the Alabama Department of Public

Health, through partnership with the Alabama Medicaid Agency.

Historical Context and Objectives

The Plan First demonstration was initially approved on July 1, 2000 and implemented October 1, 2000. The demonstration has been consistently extended since that date. The Alabama Plan First Program was originally implemented to provide family planning services to women once Medicaid eligibility for pregnancy ended and for those women who could not otherwise qualify for Medicaid unless pregnant, with income at or below 141 percent of the Federal Poverty Level (FPL). With the December 2014 extension of the demonstration, the state was approved to provide two new services: 1) removal of migrated or embedded intrauterine devices in an office setting or outpatient surgical facility; and 2) coverage of vasectomies for males 21 years of age or older with income at or below 141 percent of the FPL.

On November 29, 2016, Alabama submitted a request to amend the demonstration to provide an enhanced family planning counseling benefit (referred to as "care coordination") to males enrolled in the demonstration receiving vasectomy services. The purpose of adding these care coordination services is to help Plan First males with establishing Medicaid, locating the appropriate doctor to perform the vasectomy procedure, and assist with making and keeping appointments for initial consultations and follow-up visits. CMS approved this amendment to the demonstration on June 28, 2017.

On June 15, 2017, Alabama submitted a request to extend the demonstration for a five-year period with no program changes. CMS is approving this extension request through September 30, 2022, as agreed upon with the state, to realign Plan First's annual demonstration cycles back to the original date of implementation. These STCs, accompanying the CMS approval letter, permit section 1115 demonstration authority for the Plan First demonstration through September 30, 2022.

CMS and Alabama expects this demonstration program will promote Medicaid program objectives by:

- Increasing the enrollment of women eligible for Plan First, with a focus to reduce race/ethnicity and geographic disparities in enrollment;

- Maintaining a high level of awareness of the Plan First program among enrollees;

- Increasing the proportion of Plan First enrollees who use family planning services in the initial year of enrollment and in subsequent years;

- Increasing the portion of Plan First enrollees who receive tobacco cessation services or nicotine replacement products;

- Maintaining birth rates among Plan First participants that are lower than the estimated birth rates that would have occurred in the absence of the Plan First demonstration; and,

- Increasing enrollment of men eligible for Plan First and undergoing vasectomy services.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid programs that occur during this demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

    a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.

    b) If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **Changes Subject to the Amendment Process.** Changes related to demonstration features such as eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these demonstration elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 6 below.

6. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS in writing for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay

approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure limit;

c) An explanation of the public process used by the state consistent with the requirements of STC 14; and,

d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

7. **Extension of the Demonstration.** States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of Alabama must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) §431.412(c) or a transition and phase-out plan consistent with the requirements of STC 8.

8. **Demonstration Transition and Phase-Out.** The state may suspend or terminate this demonstration, in whole or in part, at any time prior to the date of expiration.

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the effective date and reason(s) for the suspension or termination. At least six months before the effective date of the demonstration's suspension or termination, the state must submit to CMS its proposed transition and phase-out plan, together with intended notifications to demonstration enrollees. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of public comments received, the state's response to the comments received, and how the state incorporated the received comments into the transition and phase-out plan submitted to CMS.

b. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently

enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.

c. Phase-out Plan Approval: The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

d. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, §431.210 and §431.213. In addition, the state must assure all appeal and hearing rights are afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as found in 42 CFR §435.916.

e. Exemption from Public Notice Procedures 42 CFR §431.416(g): CMS may expedite or waive the federal and state public notice requirements in the event it determines that the objectives of titles XIX or XXI would be served or under circumstances described in 42 CFR §431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out: If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.

g. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

9. **CMS Right to Amend, Suspend, or Terminate.** CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the amendment, suspension or termination, together with the effective date.

10. **Deferral of Payment for Failure to Provide Deliverables on Time.** CMS will withhold payments to the state in the amount of $1,000,000 per occurrence when deliverables are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS.

a) Thirty days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b) For each deliverable, the state may submit a written request for an extension in which to submit the required deliverable. Should CMS agree to the state's request, a

corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c) The deferral would be issued against the next quarterly expenditure report following the written deferral notification (subject to any extension granted under (b)).

d) When the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in the STCs, the deferral(s) will be released.

e) As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for extension, amendment, or for a new demonstration.

f) If applicable, CMS will consider with the state an alternative set of operational steps for implementing the deferral associated with this demonstration to align the process with any existing deferral process the state is undergoing (e.g., the structure of the state's request for an extension, what quarter the deferral applies to, and how the deferral is released).

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

12. **Withdrawal of Waiver/Expenditure Authority.** CMS reserves the right to amend or withdraw waiver and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the amendment or withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems applicable to the demonstration; compliance with cost sharing requirements to the extent they apply; and reporting on financial and other demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR §431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also

comply with the public notice procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR §431.408(b), State Medicaid Director Letter #01-024, and contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state.

15. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY AND ENROLLMENT

16. **Eligibility for the Demonstration.** Family planning services are provided to eligible individuals for 12 months of continuous eligibility. An individual found to be income-eligible for this demonstration upon initial application or annual redetermination will not require reporting of changes in income or household size for this 12-month period.

    Eligibility for this demonstration is limited to the following individuals who are not otherwise enrolled in Medicaid and have countable income of no more than 141 percent of the FPL (a standard income disregard of five percent of the FPL is applied if the individual is not eligible for coverage due to excess income):

    a) Women ages 19 through 55 losing Medicaid 60 days postpartum;

    b) Women ages 19 through 55 who are not otherwise eligible for Medicaid; and,

    c) Men age 21 or older seeking a vasectomy and associated care coordination services related to arranging for, receipt of, and follow-up to vasectomy services. Individuals in this group are provided 12 months of coverage to allow for the arrangement and completion of a vasectomy procedure. The state may provide additional months of coverage at its discretion for Plan First males who do not complete the vasectomy procedure within the 12-month period or request reapplication for Plan First coverage.

17. **Redeterminations.** The state must ensure that redeterminations of eligibility for Plan First female enrollees are conducted no more than once every 12 months. The state uses an Express Lane Eligibility (ELE) process to automate the renewal of Plan First female enrollees without any participation from the enrollee. If female enrollees cannot be renewed through the ELE process, the state conducts renewals in accordance with regulations at 42 CFR §435.916.

18. **Express Lane Eligibility.** The Medicaid state agency may rely on a finding from an Express Lane Agency when determining whether the individual satisfies one or more components of eligibility derived through the demonstration at the time of initial determination and redetermination. All procedures outlined in the Medicaid Express Lane Eligibility Medicaid

State Plan Amendment must also apply to Express Lane eligibility determinations for the demonstration population.

19. **Demonstration Disenrollment.** If a woman becomes pregnant while enrolled in the demonstration, she may be determined eligible for Medicaid under the State Plan. The state must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid State Plan. In addition, women and men who receive a sterilization procedure and complete all necessary follow-up procedures will subsequently be disenrolled from the demonstration.

V. BENEFITS AND DELIVERY SYSTEMS

20. **Family Planning Benefits.** Individuals eligible under this demonstration will receive family planning services and supplies as described in section 1905(a)(4)(C) of the Act, which are reimbursable at the 90 percent Federal matching rate. The specific family planning services provided under this demonstration are as follows:

    f. FDA-approved methods of contraception; and vasectomy services for men;

    b) Laboratory tests done during an initial family planning visit for contraception, including Pap smears, screening tests for STIs/STDs, blood counts and pregnancy tests. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception;

    g. Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements (subject to the national drug rebate program requirements);

    h. Contraceptive management, patient education, and counseling, including care coordination services that provide enhanced education on appropriate use of the chosen family planning method and further assurance of correct and continued usage to address impediments to successful family planning. These care coordination services will be provided to female enrollees identified by providers as "high risk" or "at risk" for an unintended pregnancy and male enrollees seeking vasectomy services. Care coordination services include:

        i. Assistance with arranging a family planning visit;
        ii. Locating appropriate Medicaid doctor to perform sterilization procedures;
        iii. Assistance with referrals, making appointments, and follow-up to ensure appointments are kept, including subsequent family planning visits;
        iv. Provision of answers to general questions about family planning;
        v. Family planning education utilizing the standardized educational model (PT+3) for providing information in a manner that meets the recipients' level of understanding; and,

vi. Counseling regarding problems with the selected family planning method.

21. **Tobacco Cessation Services.** Individuals eligible under this demonstration are also eligible to receive smoking cessation services and products as authorized in Alabama's approved Medicaid State Plan and provided by the Alabama Department of Public Health, through partnership with the Alabama Medicaid Agency. Smoking cessation services and products are being authorized under this section 1115 demonstration as a separate service provided in addition to family planning services. Tobacco cessation services will be reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate.

22. **Minimum Essential Coverage (MEC).** The Plan First demonstration is limited to the provision of services as described in STCs 20 and 21. Consequently, this demonstration is not recognized as Minimum Essential Coverage (MEC), as indicated by CMS in its February 12, 2016 correspondence to Alabama Commissioner Stephanie Azar regarding our designation of MEC for this section 1115 demonstration.

23. **Primary Care Referrals.** Primary care referrals to other social service and health care providers as medically indicated will be provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The state must facilitate access to primary care services for participants, and must assure CMS that written materials concerning access to primary care services are distributed to demonstration participants. The written materials must explain to the participants how they can access primary care services.

24. **Delivery of Services.** Enrollees in the Plan First demonstration will receive services on a fee-for-service (FFS) basis. Beneficiary freedom of choice of family planning provider shall not be restricted.

VI. GENERAL REPORTING REQUIREMENTS

25. **General Financial Requirements.** The state must comply with all general financial requirements under title XIX and as set forth in section VII.

26. **Reporting Requirements Relating to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section VIII.

27. **Submission of Post-approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

28. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

    f. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
    g. Ensure all 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by

the state; and,

h. Submit deliverables to the appropriate system as directed by CMS.

29. **Annual Monitoring Calls.** CMS and Alabama will participate in annual conference calls following the receipt of the annual progress report, unless CMS determines that more frequent calls are necessary to adequately monitor the demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, benefits, anticipated or proposed changes in payment rates, audits, lawsuits, changes in state sources of funding for financing this demonstration, progress on evaluations, state legislative developments, and any demonstration amendments the state is considering submitting. CMS will update the state on any amendments under review as well as federal policies and issues that may affect any aspect of the demonstration. Alabama and CMS will jointly develop the agenda for the calls.

30. **Annual Monitoring Report.** No later than 90 days following the end of each demonstration year, the state must submit an annual progress report that represents the status of the demonstration's various operational areas and any state analysis of program data collected for the demonstration year. The Annual Monitoring Report will include all elements required by 42 CFR §431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring Report must follow the framework provided by CMS (incorporated in these STCs as "Attachment A"), which is subject to change as monitoring systems are developed and/or evolve, and will be provided in a structured manner that supports federal tracking and analysis. Each Annual Monitoring Report must minimally include the following:

    f. Operational Updates - Per 42 CFR §431.428, the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; descriptions of any public forums held, and a summary of program integrity and related audit activities for the demonstration. The Annual Monitoring Report should also include a summary of all public comments received through the post-award public forum required per 42 CFR §431.420(c) regarding the progress of the demonstration.

    g. Performance Metrics – Per 42 CFR §431.428, the Annual Monitoring Report must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys (if conducted) and grievances and appeals. The required monitoring and performance metrics must be included in writing in the Annual Monitoring Report, and will follow the framework provided by CMS to support federal tracking and analysis.

h. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR §431.428, the Annual Monitoring Report must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Annual Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including a total annual member month count for the demonstration population, total annual expenditures for the demonstration population, and the resulting "per member, per month" calculation. The Annual Monitoring Report must also include the submission of corrected budget neutrality data upon request.

i. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Annual Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

31. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration. The state must confirm its process for ensuring there is no duplication of federal funding in each Annual Monitoring Report as specified in STC 30(a).

32. **Close-out Report.** Within 120 days prior to the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

f. The draft final Close-Out Report must comply with the most current guidance from CMS.
g. The state will present to and participate in a discussion with CMS on the Close-Out Report.
h. The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.
i. The final Close-Out Report is due to CMS no later than 30 days after receipt of CMS' comments.
j. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 10.

VII. GENERAL FINANCIAL REQUIREMENTS

This project is approved for title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

33. **Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports to report total expenditures for services provided under this Medicaid section 1115(a) demonstration following routine CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. CMS must provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined cost limits specified in STC

43.

34. **Reporting Expenditures Subject to the title XIX Budget Neutrality Agreement.** The following describes the reporting of expenditures subject to the budget neutrality limit:

    a) Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES). All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS and the two digit project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made (e.g., For reporting expenditures with dates of services made in demonstration year 16 (10/1/2015 – 9/30/2016), the state would use "16" as the project number extension).

    b) Use of Waiver Forms. The state must report demonstration expenditures on separate forms CMS-64.9 Waiver and/or 64.9P Waiver each quarter to report title XIX expenditures for demonstration services. The state will use the following waiver names to report expenditures in the MBES/CBES and in the budget neutrality workbooks required to be submitted with the Annual Monitoring Report per STC 30:
        i) Family Planning Services - "Family Planning"
        ii) Tobacco Cessation Services – "Tobacco Cessation"

    c) MBES/CBES Schedule C Reporting Adjustments. The state must submit prior period adjustments subsequent to the routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual to correct medical assistance expenditures reported for demonstration year 13 (10/1/2012 – 9/30/2013) through demonstration year 17 (10/1/2016 – 9/30/2017). The state must complete any corresponding corrective adjustments to administrative costs reported for demonstration year 13 through demonstration year 17. The state shall complete these reporting adjustments within 12 months of the date of CMS' approval of this extension and provide written certification of the accuracy of the adjusted expenditures upon completion.

    d) Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C.

35. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on Form CMS-64.10.

36. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or

termination of the demonstration. During the latter two-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

37. **Reporting Member Months.** The following describes the reporting of member months for the demonstration:

    a) For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the Annual Monitoring Report required per STC 30, the actual number of eligible member months for all demonstration enrollees. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

    b) The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months.

38. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. Subject to the payment deferral process set out in STC 10, CMS shall reconcile expenditures reported on Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

39. **Extent of Federal Financial Participation (FFP) for the Demonstration.** CMS shall provide FFP for family planning and tobacco cessation services at the applicable federal matching rates as described in STCs 20 and 21, subject to the limits and processes described below:

    a) For procedures or services clearly provided or performed for the primary purpose of family planning (i.e., contraceptive initiation, periodic or inter-periodic contraceptive management, and sterilizations), and which are provided in a family planning setting, FFP will be available at the 90 percent federal matching rate. Reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.

       Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate of 90 percent, as described in STC 20, should be entered in

Column (D) on the CMS-64.9 Waiver Form.

b) Pursuant to 42 CFR §433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

c) Tobacco cessation services reimbursed at the FMAP rate must be as described in CMS' June 24, 2011 State Medicaid Director Letter (SDL#11-007) on New Medicaid Tobacco Cessation Services and provided as approved in the Alabama Medicaid State Plan. These expenditures should be entered on "Line 49 – Other Care Services" on the appropriate CMS-64.9 Waiver Form.

d) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if provided by eligible Medicaid providers. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.

40. **Sources of Non-Federal Share.** The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a) CMS shall review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

b) Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

41. **State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a) Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve

a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c) To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

VIII. MONITORING BUDGET NEUTRALITY

The following is the method by which budget neutrality will be monitored for the Alabama Plan First section 1115(a) Medicaid demonstration.

42. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding it may receive on approved demonstration service expenditures incurred during the period of demonstration approval. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the approved demonstration period. Actual expenditures subject to budget neutrality expenditure limit shall be reported by the state using the procedures described in STC 34.

43. **Budget Neutrality Annual Expenditure Limits.** For each demonstration year, an annual budget limit will be calculated for the demonstration. This program's annual demonstration cycle is October 1 through September 30. The state's demonstration years are as follows:

Demonstration Year 1 = October 1, 2000 – September 30, 2001
Demonstration Year 2 = October 1, 2001 – September 30, 2002
Demonstration Year 3 = October 1, 2002 – September 30, 2003
Demonstration Year 4 = October 1, 2003 – September 30, 2004
Demonstration Year 5 = October 1, 2004 – September 30, 2005
Demonstration Year 6 = October 1, 2005 – September 30, 2006

Demonstration Year 7 = October 1, 2006 – September 30, 2007
Demonstration Year 8 = October 1, 2007 – September 30, 2008
Demonstration Year 9 = October 1, 2008 – September 30, 2009
Demonstration Year 10 = October 1, 2009 – September 30, 2010
Demonstration Year 11 = October 1, 2010 – September 30, 2011
Demonstration Year 12 = October 1, 2011 – September 30, 2012
Demonstration Year 13 = October 1, 2012 – September 30, 2013
Demonstration Year 14 = October 1, 2013 – September 30, 2014
Demonstration Year 15 = October 1, 2014 – September 30, 2015
Demonstration Year 16 = October 1, 2015 – September 30, 2016
Demonstration Year 17 = October 1, 2016 – September 30, 2017
Demonstration Year 18 = October 1, 2017 – September 30, 2018
Demonstration Year 19 = October 1, 2018 – September 30, 2019
Demonstration Year 20 = October 1, 2019 – September 30, 2020
Demonstration Year 21 = October 1, 2020 – September 30, 2021
Demonstration Year 22 = October 1, 2021 – September 30, 2022

The budget limit is calculated as the projected per member/per month (PMPM) cost times the actual number of member months for the demonstration multiplied by the Composite Federal Share.

PMPM Cost. The following table provides the approved demonstration cost trend (based on the state's historical rate of growth) and the PMPM (total computable) ceiling for each demonstration year.

	Trend	**DY 18**	**DY 19**	**DY 20**	**DY 21**	**DY 22**
PMPM Ceilings for Family Planning Services	.0%	$26.76	$26.76	$26.76	$26.76	$26.76
PMPM Ceilings for Tobacco Cessation Services	.0%	$0.50	$0.50	$0.50	$0.50	$0.50

a) Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported on the forms listed in STC 32 above, by total computable demonstration expenditures for the same period as reported on the forms. Should the demonstration be terminated prior to the end of the approval period (see STC 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable Composite Federal Share may be used.

b) Structure. The demonstration's budget neutrality model is structured as a "pass-through" or "hypothetical" expenditure population. Therefore, the state may not derive savings from the demonstration.

c) Risk. Alabama shall be at risk for the per capita cost (as determined by the method described in this section) for demonstration enrollees, but not for the number of demonstration enrollees. By providing FFP for eligible enrollees, Alabama shall not be at risk of changing economic conditions that impact enrollment levels. However, by placing Alabama at risk for the per capita costs for enrollees in the demonstration, CMS assures that federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

d) Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures reported by the state on the CMS-64 forms. If at the end of the demonstration period, the costs of the demonstration services exceed the budget limit, the excess federal funds will be returned to CMS. If the costs of the demonstration services do not exceed the budget limit, the state may not derive or utilize any such savings.

44. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

45. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality over the life of this demonstration approval period. As indicated in STC 30 for Annual Monitoring Reports, the state will calculate annual expenditure targets for the completed year and include this calculation in the Annual Monitoring Report submitted to CMS. This amount will be compared with the actual claimed FFP for Medicaid on the CMS-64 waiver forms. Using the schedule below as a guide, if the state exceeds these targets, it will submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative Target Expenditures	Percentage
DY18	DY18 budget limit plus:	2 percent
DY19	DY18 and DY19 combined budget limit amount plus:	1.5 percent
DY20	DY18 through DY20 combined budget limit amount plus:	1.0 percent
DY21	DY18 through DY21 combined budget limit amount plus:	0.5 percent
DY22	DY18 through DY22 combined budget limit amount plus:	0 percent

46. **Exceeding Budget Neutrality.** The state, whenever it determines that the demonstration is not budget neutral or is informed by CMS that the demonstration is not budget neutral, must immediately collaborate with CMS on corrective actions, which includes submitting a corrective action plan to CMS within 21 days of the date the state is informed of the problem. While CMS will pursue corrective actions with the state, CMS will work with the state to set reasonable goals that will ensure that the state is in compliance.

If at the end of the demonstration approval period, the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is

terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

IX. EVALUATION

47. **Draft Evaluation Design.** The Draft Evaluation Design must be developed in accordance with CMS' provided guidance for family planning demonstrations. The state must submit, for CMS comment and approval, a Draft Evaluation Design with implementation timeline, by no later than 120 days after the effective date of these STCs. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state may choose to use the expertise of an independent evaluator in the development of the Draft Evaluation Design.

48. **Evaluation Budget.** A budget for the evaluation shall be provided with the Draft Evaluation Design. It will include the total estimated cost as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

49. **Evaluation Design Approval and Updates.** The state must submit a revised Draft Evaluation Design within 60 days after receipt of CMS' comments. Upon CMS approval of the Evaluation Design, the document will be included as "Attachment B" to these STCs. Per 42 CFR §431.424(c), the state will publish the approved Evaluation Design within 30 days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each Annual Monitoring Report. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval.

50. **Evaluation Questions and Hypotheses.** Consistent with CMS' provided guidance on "Developing the Evaluation Design" and "Preparing the Evaluation Report," the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

51. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR §431.412(c)(2)(vi). When submitting an application

for extension, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

f. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.

g. For any demonstration authority that expires prior to the overall demonstration's expiration date, the interim evaluation report must include an evaluation of the authority as approved by CMS.

h. If the state is seeking to extend the demonstration, a draft Interim Evaluation Report is due when the application for extension is submitted. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses, and how the evaluation design was adapted should be included. If the state is not requesting an extension of the demonstration, a draft Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the CMS approval period, a draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

i. The state must submit the final Interim Evaluation Report 60 days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

j. The final Interim Evaluation Report must comply with CMS' provided guidance in the "Preparing the Evaluation Report" document.

52. **Cooperation with Federal Evaluators.** As required by 42 CFR §431.420(f), the state shall cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR §431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in paragraph 10.

53. **Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with CMS' guidance provided in the "Preparing the Evaluation Report" document. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

f. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 days of receiving comments from CMS on the draft.

g. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

54. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in discussions with CMS on the Evaluation Design, the state's Interim Evaluation Report, and/or the Summative Evaluation Report.

55. **Public Access**. The state shall post the final documents (e.g., Annual Monitoring Reports, Close-out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

56. **Additional Publications and Presentations.** For a period of 24 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Annual Monitoring Report	Within 90 days following the end of each demonstration year	STC 30
Draft Evaluation Design Plan	Within 120 days after the approval of the demonstration extension	STC 47
Final Evaluation Design Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design	STC 49
Summative Evaluation Report	Within 18 months following the end of this demonstration extension period	STC 53

ATTACHMENT A: Family Planning Section 1115 Demonstration
Template for Annual Monitoring Report

Purpose and Scope of Annual Report:

The state must submit annual progress reports in accordance with the Special Terms and Conditions (STC) and 42 CFR 431.420. The intent of these reports is to present the state's analysis of collected data and the status of the various operational areas, reported by month in the demonstration year. The report should also include a discussion of trends and issues over the year, including progress on addressing any issues affecting access, quality, or costs. Each annual report must include:

A. Executive Summary
B. Utilization Monitoring
C. Program Outreach and Education
D. Program Integrity
E. Grievances and Appeals
F. Annual Post Award Public Forum
G. Budget neutrality
H. Demonstration evaluation activities and interim findings.

ANNUAL MONITORING REPORT
FAMILY PLANNING SECTION 1115 DEMONSTRATIONS

State: _____
Demonstration Reporting Period: _____
Demonstration Year: _____
Approved start and end date of the Demonstration _____

A. Executive Summary
- **1.** Synopsis of the information contained in the report
- **2.** Program Updates
  - **a.** Current Trends or Significant Program Changes
    - i. Narrative describing any administrative and operational changes to the demonstration, such as eligibility and enrollment processes, eligibility redetermination processes (including the option to utilize administrative redetermination), systems, health care delivery, benefits, quality of care, anticipated or proposed changes in payment rates, and outreach changes).
    - ii. Narrative on any demonstration changes, such as changes in enrollment, service utilization, and provider participation. Discussion of any action plan if applicable.
    - iii. Narrative on the existence of or results of any audits, investigations, or lawsuits that impact the demonstration.

3. Policy Issues and Challenges
    a. Narrative of any operational challenges or issues the state has experienced.
    b. Narrative of any policy issues the state is considering, including pertinent legislative/budget activity, and potential demonstration amendments.
    c. Discussion of any action plans addressing any policy, administrative or budget issues identified, if applicable.

B. Utilization Monitoring

The state will summarize utilization through a review of claims/encounter data for the demonstration population in the subsequent tables. This includes the following:

Table 1. Utilization Monitoring Measures

Topic	Measure [Reported for each month included in the annual report]
Utilization Monitoring	Unduplicated Number of Enrollees by Quarter
	Unduplicated Number of Beneficiaries with any Claim by Quarter (by key demographic characteristics such as age, gender, and income level)
	Utilization by Primary Method and Age Group
	Total number of beneficiaries tested for any sexually transmitted disease
	Total number of female beneficiaries who obtained a cervical cancer screening
	Total number of female beneficiaries who received a clinical breast exam

Table 2: Unduplicated Number of Enrollees by Quarter

	Number of Female Enrollees by Quarter				
	14 years old and under	15-20 years old	21-44 years old	Over 45 years old	Total Unduplicated Female Enrollment*
Quarter 1					
Quarter 2					
Quarter 3					
Quarter 4					
	Number of Males Who Utilize Services by Age and Quarter				
	14 years old and under	15-20 years old	21-44 years old	Over 45 years old	Total Unduplicated Male Enrollment*
Quarter 1					
Quarter 2					
Quarter 3					
Quarter 4					

*Total column is calculated by summing columns 2-5.

Table 3: Unduplicated Number of Beneficiaries with any Claim by Age Group and Gender per Quarter in the Demonstration Year

	Number of Females Who Utilize Services by Age and Quarter					
	14 years old and under	15-20 years old	21-44 years old	Over 45 years old	Total Female Users *	Percentage of Total Unduplicated Female Enrollment
Quarter 1						
Quarter 2						
Quarter 3						
Quarter 4						
	Number of Males Who Utilize Services by Age and Quarter					
	14 years old and under	15-20 years old	21-44 years old	Over 45 years old	Total Male Users*	Percentage of Total Unduplicated Male Enrollment
Quarter 1						
Quarter 2						
Quarter 3						
Quarter 4						

*Total column is calculated by summing columns 2-5.

Table 4: Utilization by Primary Method and Age Group per Demonstration Year

Primary Method	Total Users					
	14 years old and under	15 – 20 years old	21 – 44 years old	45 years old and older	Total*	Percent of All Devices
Sterilization						
Emergency Contraception						
Intrauterine Device (IUD)						
Hormonal Implant						
1-Month Hormonal Injection						
3-Month Hormonal Injection						
Oral Contraceptive						
Contraceptive Patch						
Vaginal Ring						
Diaphragm						
Sponge						
Female Condom						
Male Condom						

*Total column is calculated by summing columns 2-5.

Table 5: Number Beneficiaries Tested for any STD by Demonstration Year

Test	Female Tests		Male Tests		Total Tests	
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Unduplicated number of beneficiaries who obtained an STD test						

Table 6: Total Number of Female Beneficiaries who obtained a Cervical Cancer Screening

Screening Activity	Number	Percent of Total Enrolled Females
Unduplicated number of female beneficiaries who obtained a cervical cancer screening		

Table 7: Breast Cancer Screening

Screening Activity	Number	Percent of Total Enrolled Females
Unduplicated number of female beneficiaries who received a Breast Cancer Screening		

C. Program Outreach and Education

1. General Outreach and Awareness

- **a.** Provide information on the public outreach and education activities conducted this demonstration year; and,
- **b.** Provide a brief assessment on the effectiveness of these outreach and education activities.

2. Target Outreach Campaign(s) (if applicable)

- **a.** Provide a narrative on the populations targeted for outreach and education campaigns and reasons for targeting; and,
- **b.** Provide a brief assessment on the effectiveness of these targeted outreach and education activities.

D. Program Integrity

Provide a summary of program integrity and related audit activities for the demonstration, including an analysis of point-of-service eligibility procedures.

E. Grievances and Appeals

Provide a narrative of grievances and appeals made by beneficiaries, providers, or the public, by type and highlighting any patterns. Describe actions being taken to address any significant issues evidenced by patterns of appeals.

F. Annual Post Award Public Forum

Provide a summary of the annual post award public forum conducted by the state as required by 42 CFR §431.420(c) that includes a report of any issues raised by the public and how the state is considering such comments in its continued operation of the

demonstration.

G. Budget Neutrality

1. Please complete the budget neutrality workbook.
2. Discuss any variance noted to the estimated budget, including reasons for variance in enrollment and/or in total costs, and/or in per enrollee costs. Describe any plans to mitigate any overages in budget neutrality by the end of the demonstration period.

H. Demonstration Evaluation Activities and Interim Findings

1. Please provide a summary of the progress of evaluation activities, including key milestones accomplished. Include:
   - **a.** Status of progress against timelines outlined in the approved Evaluation Design.
   - **b.** Any challenges encountered and how they are being addressed.
   - **c.** Status of any evaluation staff recruitment or any RFPs or contracts for evaluation contractual services (if applicable).
2. Description of any interim findings or reports, as they become available

ATTACHMENT B: Evaluation Design Plan

Alabama Medicaid Agency

Evaluation Design for the 1115 Plan First Demonstration Waiver

Waiver Period November 27, 2017 through September 30, 2022

Developed by Kari White, PhD MPH
School of Public Health
University of Alabama at Birmingham
Revised May 31, 2018

CMS APROVED EVALUATION DESIGN JULY 11, 2018

Evaluation for Plan First, 2018-2022

Introduction
The Evaluation for Plan First during the 2018-2022 reporting period will consist of two parts. Part I will report on the core objectives of the demonstration program, as stated in the renewal application and described below. This section of the report will highlight program outcomes of care for participants enrolled in Plan First (e.g., enrollment, births), quality of care (e.g., use of effective contraception, screened for cervical cancer), and access to care (e.g., geographic differences in service use, provider participation). Following previous evaluations, Part II of the report will provide an overview of trends for select outcome and utilization indicators by summarizing data from the current reporting period and prior years. Finally, our report will include the costs of operating the program.

We will use 8 sources of data for the evaluation. From the Alabama Medicaid Agency information system, we will obtain (1) monthly enrollment data and (2) claims for the Plan First program. We also will obtain (3) delivery claims on a quarterly basis that can be matched to Plan First participants, and (4) the number of Plan First participants who have been referred to the smoking cessation telephone counseling service (Quit Line). We will use (5) the American Community Survey (ACS) to estimate the age, race and geographic distribution of uninsured women who may be eligible for Plan First. Finally, we will conduct (6) a survey of 800 women enrolled in Plan First about their experiences in the program; (7) a survey of 300 women who are no longer enrolled in Plan First to assess their reasons for not re-enrolling; and (8) a survey of 100 men enrolled in Plan First about their experiences obtaining vasectomy services.

PART I: Assessment of reporting-period specific goals

Goal 1. Increase the portion of women eligible for Plan First who enroll, and reduce race/ethnicity and geographic disparities in enrollment.
The program goal is to enroll into Plan First 80% of eligible women between ages 19 and 40 across all racial/ethnic groups and geographic areas.
Hypotheses: We anticipate that the composition of the enrolled population will be demographically similar to the population of eligible participants because of programmatic features designed to reduce barriers to enrollment, such as automatic enrollment following delivery and allowing re-enrollment through Express Lane Eligibility. However, we do not expect the enrolled population to reflect the exact distribution of eligible women because enrollment in the program is voluntary. For example, based on past evaluations of Plan First, we anticipate lower enrollment rates among older women compared to younger women.
Enrollment of income-eligible women is a key metric that documents the impact of the demonstration program on providing coverage. We will report on this outcome using the table templates presented below. Men's enrollment is reported as part of Goal 6, since vasectomy and vasectomy-related care coordination are the only services available to men in Plan First.

Table 1.1. Unduplicated number of female enrollees, by age group and quarter

	19-20*	21-44	45-55	Total enrollment
Quarter 1 (October-December)				
Quarter 2 (January-March)				
Quarter 3 (April-June)				
Quarter 4 (July-September)				

*Women <19 years of age are not eligible for Plan First.

To assess enrollment, we will compare the number of women enrolled in Plan First to estimates of the number of income-eligible women in the American Community Survey, overall and according to age, race/ethnicity and geographic sub-groups. By computing the percentage of potentially eligible women enrolled, we will be able to assess any disparities in enrollment. We will highlight sub-populations where enrollment is less than 80% of the estimated population that is eligible.

Table 1.2. Estimates of low-income women eligible for and enrolled in Plan First, by age, race and public health district.

	ACS Population Estimate	Enrolled in Plan First	% Enrolled
Age, years			
19-24*****			
24-44			
45-54			
Race			
White			
Black			
Hispanic			
Asian/Pacific Islander			
American Indian			
Other race/ethnicity			
Public Health District			
Northern			
Northeastern			
Jefferson			
East Central			
West Central			
Southeastern			
Southwestern			
Mobile			
TOTAL			

*County-level population estimates of low-income women are not available for those 19-20 and 21-24, separately, due to ACS reporting.

We also will examine patterns of re-enrollment in Plan First since this is an important *process indicator* that likely contributes to the overall number of eligible women enrolled in the program. We will use consecutive years of enrollment data to assess re-enrollment patterns. We will compute the overall percentage of women enrolled in the prior demonstration year (e.g., DY17) who re-enrolled in Plan First in the reporting period (e.g.,DY18), and assess differences in re-enrollment across sub-groups using chi-squared tests (Table 1.3). We also will estimate the likelihood of re-enrollment after accounting for differences in characteristics of women in the program using multivariable-adjusted logistic regression

(Table 1.4).

Table 1.3. Percentage of Plan First participants who re-enrolled in the reporting year

	Enrolled in DY17	% Enrolled in DY18		Re-enrolled in DY18	Did not re-enroll
Age, years					
19-24					
24-44					
45-54					
Race					
White					
Black					
Hispanic					
Asian/Pacific Islander					
American Indian					
Other race/ethnicity					
Service use					
Clinical services					
Non-clinical services only					
Did not use services					
Public Health District					
Northern					
Northeastern					
Jefferson					
East Central					
West Central					
Southeastern					
Southwestern					
Mobile					
TOTAL					

Table 1.4. Characteristics associated with re-enrollment in Plan First

	Odds ratio	(95% CI)	Probability compared to chance
Age, years			
19-24			
24-44			
45-54			
Race			
White			
Black			
Hispanic			
Asian/Pacific Islander			
American Indian			
Other race/ethnicity			
Service use			
Clinical services			
Non-clinical services only			
Did not use services			
Public Health District			
Northern			
Northeastern			
Jefferson			
East Central			
West Central			
Southeastern			
Southwestern			
Mobile			

CI: confidence interval

We also will conduct a telephone survey of 300 women who have been terminated from the Plan First program to better understand women's reasons for not re-enrolling in Plan First and identify potential solutions to reduce barriers to re-enrollment. This sample size is feasible given anticipated changes in women's contact information. The survey will be stratified by age because we expect women's eligibility and reasons for not re-enrolling in the program may be different for younger as compared to older women. We will compute percentages and compare differences by age group using chi-squared tests. With a sample size of 300 women and an estimated 30% of women in all age groups reporting that they were unaware that they were no longer enrolled, the margin of error attributable to sampling is estimated to be ±5.2%. Additionally, this sample size will provide 80% statistical power to determine whether there is a 21-percentage-point difference or larger in the number of older women who are eligible but not enrolled versus younger women (e.g., 28% or fewer women aged ≥35 are eligible but not enrolled vs 50% of women under age 35).

Table 1.5. Reasons women did not re-enroll in Plan First and contraceptive use, by age

	Age, years			
	19-24 (n=125)	25-34 (n=125)	35-44 (n=25)	45-54 (n=25)
Aware not enrolled in Plan First				
Yes				
No				
Eligibility for Plan First				

Eligible				
Ineligible, currently pregnant				
Ineligible, had tubal ligation, hysterectomy				
Ineligible, enrolled in MLIF				
Ineligible, income ≥146% FPL				
Reasons not enrolled in Plan First*				
Did not know how to re-enroll				
Problems getting transportation to re-enroll				
Problems providing documents to re-enroll				
No providers she wanted to see in the area				
Does not want family planning services				
Other reason				
Current contraceptive use†				
Sterilization				
IUD or implant				
Injectable				
Oral contraceptives				
Patch, ring				
Condoms, diaphragm, withdrawal				
No method				

*Among women eligible for the program. † Among women who are not pregnant.

Goal 2. Maintain a high level of awareness of the Plan First program among female enrollees.
The program goal is that 90% of surveyed enrollees will have heard of Plan First, and 85% will be aware that they are enrolled in the program.
Hypotheses: Since Plan First is a well-established program, we expect that the majority of women enrolled will have heard of it and will be aware that they are enrolled.
To assess women's awareness of Plan First and their own enrollment in the program, we will conduct a telephone survey of 800 women. We will determine the percentage of women who have heard of Plan First, who are aware they are enrolled in the program, and compare differences in characteristics according to women's awareness of their enrollment status, using chi-squared tests and following the table template below. This sample size will provide 80% statistical power to determine whether there is a 6-percentage-point difference or larger in the number of women using family planning services and contraception who are unaware of their enrollment compared to those who are aware.

Table 2.1. Characteristics of survey respondents, according to awareness of enrollment in Plan First

	Know Enrolled	**Do Not Know Enrolled**
	(%)	(%)
Has heard of Plan First		
Yes		
No		
Last family planning visit		
In last year		
More than year ago		
Never		
Reason for no visit in last year		
I did not think I needed one		
I was too busy to arrange an appointment		
I couldn't afford it		
I did not want to go to the place I went before		

	Know Enrolled	Do Not Know Enrolled
The place I went before could not see me		
Other		
Reasons for not using family planning		
Don't like exam		
No provider you wanted to see		
Hard to reach on the phone		
Couldn't get appointment soon enough		
Waiting time too long at location		
Hours not convenient		
No transportation		
Family member opposes		
No child care		
No money to pay for visit		
Preferred provider does not take Medicaid		
Any birth control method used		
Reasons for not using birth control		
Not having sex		
Want to get pregnant		
Concerned about side effects		
Don't think birth control works		
Religious reasons		
Too much trouble		
Don't think you can get pregnant		
Partner doesn't want you to		
Can't pay for method		
Can't find a place to go		
Ever pregnant		
Age (mean)		
Education		
< high school		
high school		
more than high school		
Race/ethnicity		
White		
Black		
Hispanic		
Asian/Pacific Islander		
American Indian		
Other race/ethnicity		
Marital Status		
Never married		
Married		
Previously married		

Goal 3. Increase the proportion of Plan First enrollees who use family planning services in the initial year of enrollment and in subsequent years.

The program goal is to achieve 70% in the initial year and increase service use to 60% in subsequent years.

Hypotheses: Based on prior evaluations of Plan First, we expect service use to be more common among younger women than among older women, since younger women tend to rely on shorter acting hormonal methods for contraception and are recommended for routine STI and cervical cancer screening, both of which require more regular contact with providers. Because Plan First offers no-cost contraception, we also expect more than half of women using services to have a claim for a moderate or highly effective contraceptive method.

The types of services that women enrolled in Plan First use are *key indicators of the quality of care* provided through the program. We will report on these indicators using the table templates presented below. Men's use vasectomy-specific services is reported as part of Goal 6, since vasectomy and vasectomy-related care coordination are the only services available to men in Plan First.

Table 3.1. Unduplicated number of female beneficiaries with any claim for services, age group and quarter

	19-20*	**21-44**	**45-55**	**Total Users**	**Percent of women enrolled**
Quarter 1 (October-December)					
Quarter 2 (January-March)					
Quarter 3 (April-June)					
Quarter 4 (July-September)					

*Women <19 years of age are not eligible for Plan First.

In addition to reporting the primary method used by women enrolled in the program (Table 3.2), we will report on the overall percentage of women who were provided with a moderately or highly effective contraceptive method. We will define this indicator according to the Health Care Quality Measures for Medicaid Eligible Adults (Measure CCW). Specifically, moderately and highly effective methods will include female sterilization, the contraceptive implant, intrauterine devices or systems (IUD/IUS), injectables, oral contraceptives, hormonal patch, ring and diaphragms.

Table 3.2. Utilization of primary method by age group

	19-20	21-44	45-55	Total	Percentage of all methods
Sterilization					
Emergency contraception					
IUD					
Implant					
Injectable					
Oral contraceptives					
Patch					
Ring					
Diaphragm					
Female condoms*	--	--	--	--	--
Male condoms*	--	--	--	--	--

*Not included in claims for Plan First

We also will use the claims data to compute the percentage of women using specific contraceptive methods and compare differences in use according to the type of provider from whom a participant obtained services and her public health district, using chi-squared tests. This information, along with the overall percentage of women using a long-acting reversible contraceptive method (IUD/IUS or implant), will provide useful ***indicators of women's access*** to the full range of contraceptive methods and potential disparities in access.

Table 3.3. Utilization of primary method, by provider type and public health district

	Sterilization	IUD/IUS or implant	Injectables	Oral contraceptives	Other hormonal method
	N (%)	N (%)	N (%)	N (%)	N (%)
Provider type					
Health Department (Title X)					
Private provider					
Other provider					
Public Health District					
Northern					
Northeastern					
Jefferson					
East Central					
West Central					
Southeastern					
Southwestern					
Mobile					

As an indicator of the quality of contraceptive care, we will determine whether women are using their preferred method of contraception. Following our approach in previous evaluations, we will include questions about the birth control method women are currently using and the method they would like to use in our telephone survey, and compute the percentage of women using their preferred method. We also will ask women why they are not using the method they prefer to identify potential opportunities to meet women's contraceptive preferences in Plan First.

Table 3.4. Current Contraceptive Method Use and Preference

Method Using Now	**% using method**	**% prefer using this method**
Tubal ligation		
Vasectomy		
IUD		
Implanon/Nexplanon		
Injectables		
Oral contraceptives		
Patch		
Condoms		
Natural Family Planning		
Withdrawal		
Other method		

Screening for sexually transmitted infections (STIs), cervical and breast cancer are other quality of care indicators that will be included in our evaluation report. To assess screening for STIs, we will use claims

for chlamydia, gonorrhea, herpes, HIV, syphilis and trichomonas. We will report this indicator for women only since STI screening is not a covered benefit for men enrolled in Plan First. We also will report separately on chlamydia screening for sexually active women 21-24, following the Health Care Quality Measures for Medicaid Eligible Adults (Measure CHL-AD). We will evaluate cervical cancer screening according to the Health Care Quality Measures for Medicaid Eligible Adults recommendation (Measure CCS-AD) by evaluating claims for a Pap test in the demonstration year or 2 prior years for women 21-55 and claims for HPV co-testing in the demonstration year or 4 prior years for women 30-55. Claims for clinical breast exams will be used to assess the number (percentage) of women who received this service.

Table 3.5. Beneficiaries screened for sexually transmitted infections, cervical and breast cancer during the demonstration year

	Number of women tested or screened	Percent of women enrolled
Sexually transmitted infections		
Chlamydia*		
Cervical cancer		
Breast cancer		

*reported for women 21-24 only

We also will assess how participation in Plan First varies according to women's initial and subsequent enrollment. We will calculate the number and percentage of women using clinical and non-clinical services, and compare differences according to women's type and duration of enrollment using chi-squared tests. This will provide evidence of women's demand for services and identify potential sub-groups for focused outreach on program services. This assessment will use data from eligibility determination and Plan First claims.

Table 3.6. Type of Plan First participation, according to women's duration of enrollment

	Newly enrolled		**Re-enrolled**	
	Postpartum	Not postpartum	From DY17	From DY17 & DY16
Used clinical services				
Any service				
Contraceptive services				
Only had non-clinical encounter				
Only had case management				
Did not use services				
Total				

DY: Demonstration Year

Goal 4. Increase the portion of Plan First enrollees who receive smoking cessation services or nicotine replacement products.

The program goal is to have 85% of smokers receiving these services.

Hypothesis: Data from recent surveys of Plan First enrollees indicate that approximately 25% are smokers. We expect that the majority of enrolled smokers will report that their health care provider advised them to quit smoking and about half will report they were provided with information about smoking cessation services.

Smoking cessation coverage has been available in Plan First since 2012. As a key *process indicator* of offering this coverage, we calculate the number and percentage of Plan First participants in the telephone survey who were asked by their Plan First provider about smoking and which smoking cessation options were discussed: use of Nicotine gum, patch, spray, pill or referral to the Alabama Quit Line. We also will assess the number and percentage of women who are interested in using these products and services to quit smoking.

Table 4.1. Smoking among Plan First participants and content of smoking cessation discussions at family planning visits

	N	%
Reported Smoking		
Asked about smoking at FP visit		
Advised to quit by FP provider		
Received NRT		
Referred to Quit Line		
Received either NRT or Quit Line referral		
Paid out of pocket for NRT products		
Interest in using products/services to quit		

Following previous evaluations, we also will continue to assess two main *outcomes*: the number of Plan First participants who were referred to the Alabama Quit Line and the number who had a claim for a smoking cessation product.

Table 4.2. Smoking Cessation based on Claims and Quit Line Data

	N	%
Plan First service users		--
Estimated number of smokers		
Paid claims for covered NRT products		
Quit Line referrals received from care coordinator		

Goal 5. Maintain birth rates among Plan First participants, which are lower than the estimated birth rates that would have occurred in the absence of the Plan First demonstration.

A rate of about 100 births per 1000 enrollees is estimated to be sufficient to achieve budget neutrality for Plan First.

Hypothesis: Based on prior evaluations of Plan First, we hypothesize that the birth rate among program participants will be less than the expected birth rate in the absence of the program. We also anticipate that birth rates will be lower among women who used Plan First services than those who enrolled but did not have a clinical encounter.

We will evaluate this *outcome* of the program for all women enrolled in Plan First and according to their use of services in the program using SOBRA maternity claims matched to Plan First enrollment and claims files. Following our approach for estimating the birth rate in prior evaluations, we will count births that occurred through 9 months after the end of the demonstration year and exclude births from pregnancies that occurred before women enrolled. Therefore, reports of the birth rate and births averted will be available with a one-year lag (i.e., the birth rate reported in DY18 will reflect those that occurred to women enrolled in DY17). We will compare differences in birth rates among categories of service and non-service users using Poisson regression. Data on cost savings from births averted will be reported separately in the budget neutrality section.

Table 5.1 Estimated and actual birth rates to women enrolled in Plan First

	Number Enrollees	**Number of Births**	**Births/1000**
All enrollees (assuming pre-waiver fertility levels)	**--**	**--**	
All Enrollees (actual births)			
Service Users			
Any risk assessment or case management			
No risk assessment or case management			
Any visit to Title X clinic			
No visit to Title X clinic			
Non-service users			

Goal 6. Increase the number of income-eligible men age ≥21 years who are enrolled in the Plan First program and the proportion of male enrollees undergoing vasectomy.

Our goal is that the number of men enrolled in Plan First for vasectomies and vasectomy-related covered services will increase by 10% annually, 85% of male Plan First enrollees will receive care coordination services, and 75% of male enrollees will undergo the procedure within the enrollment year. We will evaluate this goal based on the number of men enrolled and claims for care coordination and vasectomies.

Hypothesis: We anticipate that men's use of vasectomy services will increase over time, and that those who receive care coordination services will be more likely to obtain a vasectomy through Plan First than those who do not receive care coordination.

We will track men's enrollment and use of vasectomy services using the table templates below.

Table 6.1. Unduplicated number of male enrollees by quarter

	19-20*	21-44	45-55	Total enrollment
Quarter 1 (October-December)	--			
Quarter 2 (January-March)	--			
Quarter 3 (April-June)	--			
Quarter 4 (July-September)	--			

*Men <21 years of age are not eligible for Plan First.

Table 6.2. Unduplicated number of men with claims for vasectomy services, by age group and quarter

	19-20*	21-44	45-55	Total Users	Percent of men enrolled
Quarter 1 (October-December)	--				
Quarter 2 (January-March)	--				
Quarter 3 (April-June)	--				
Quarter 4 (July-September)	--				

*Men <21 years of age are not eligible for Plan First.

We also will compare differences in vasectomy use among enrolled men according to their race, receipt of care coordination services and public health district, using chi-squared tests. This will help us identify sub-groups where additional education and outreach may be needed to improve access to care.

Table 6.3. Percentage of men enrolled who obtained a vasectomy through Plan First

	Enrolled N (%)	Obtained vasectomy N (%)
Race		
White		
Black		
Hispanic		
Asian/Pacific Islander		

American Indian		
Other race/ethnicity		
Care Coordination		
Received care coordination		
Did not receive care coordination		
Public Health District		
Northern		
Northeastern		
Jefferson		
East Central		
West Central		
Southeastern		
Southwestern		
Mobile		
TOTAL		

We also will track the number of care coordination hours billed for male Plan First enrollees.

Table 6.4. Hours of contact for men who received care coordination services.

	DY18	DY19	DY20	DY21	DY22
Number of male clients					
Mean number of encounters (hours of contact)					

Since vasectomy coverage for men is a new component of Plan First, we will evaluate men's experiences with this service, including their perceptions of access to Plan First providers, the quality of care from care coordinators and vasectomy providers, and their overall satisfaction with the program. In DY18, we plan to conduct up to 25 in-depth interviews with men enrolled in Plan First - those with and without a claim for vasectomy – to capture a range of experiences in their processes enrolling for, seeking and obtaining vasectomy services through Plan First. This information will be used to develop a survey, which we plan to field with 100 men in each of the remaining 4 years of the current demonstration. This sample size is feasible, given the number of men enrolled who we expect to be able to contact. With a sample size of 100 men and an estimated 75% of men reporting that it was somewhat or very easy to make an appointment with a vasectomy provider, the margin of error attributable to sampling is estimated to be ±8.5%.

PART II: Continue monitoring trends in Plan First

In this second part of the evaluation plan, we propose to continue monitoring trends in enrollment and service use, awareness of the program among those enrolled, contraceptive service use and provider participation, use of smoking cessation services, and the impact of the Plan First Program on birth rates. Comparisons largely will be descriptive, and we will use Poisson regression to compute the average annual change over time, as appropriate. Below are tables that we propose monitor these trends.

Trends in enrollment and overall service use
Table 1.1. Plan First enrollment

	DY14	DY15	DY16	DY17	DY18	Annual change N (%)
Age						
19-29	102,469	86,147	86,487			

30-39	34,982	32,566	34,524			
≥40	10,609	9,760	10,276			
Race						
Black	76,716	68,247	69,951			
White	65,889	55,390	53,932			
Hispanic	--	--	--			
Asian/Pacific Islander	--	--	--			
American Indian	--	--	--			
Other	5,455	4,836	7,404			
Public Health Area						
1	9,587	8,309	8,583		--	
2	19,530	16,845	17,149		--	
3	9,144	8,161	8,233		--	
4	19,516	16,004	15,980		--	
5	11,898	10,099	10,105		--	
6	11,466	10,251	10,422		--	
7	7,121	6,370	6,539		--	
8	20,959	18,312	19,173		--	
9	11,350	9,864	10,272		--	
10	10,724	9,737	10,050		--	
11	16,765	14,481	14,880		--	
Public Health District						
Northern	--	--	--	--		
Northeastern	--	--	--	--		
Jefferson	--	--	--	--		
East Central	--	--	--	--		
West Central	--	--	--	--		
Southeastern	--	--	--	--		
Southwestern	--	--	--	--		
Mobile	--	--	--	--		

Table 1.2. Plan First service use

	DY14	DY15	DY16	DY17	DY18	Annual change N (%)
Age						
19-29	52,334	43,132	43,834			
30-39	12,856	12,801	13,007			
≥40	3,009	2,796	2,934			
Race						
Black	38,795	34,139	34,328			
White	27,191	21,928	22,314			
Hispanic	--	--	--			
Asian/Pacific Islander	--	--	--			
American Indian	--	--	--			
Other	2,213	1,942	3,133			
Public Health Area						
1	5,079	4,230	4,652		--	

2	7,822	6,320	6,524		--	
3	4,628	3,996	4,139		--	
4	6,266	5,438	5,279		--	
5	5,050	4,182	4,421		--	
6	5,890	5,066	5,372		--	
7	4,515	3,967	3,972		--	
8	9,476	8,059	8,340		--	
9	5,987	5,055	4,999		--	
10	5,703	5,055	5,622		--	
11	7,783	6,641	6,455		--	
Public Health District	--	--	--	--		
Northern	--	--	--	--		
Northeastern	--	--	--	--		
Jefferson	--	--	--	--		
East Central	--	--	--	--		
West Central	--	--	--	--		
Southeastern	--	--	--	--		
Southwestern	--	--	--	--		
Mobile	--	--	--	--		

Table 1.3. Plan First Participation by Women with Recent Medicaid Maternity Care, by Maternity Care Program District

Maternity Care District	**Demonstration Year (DY)**				
	DY14	**DY15**	**DY16**	**DY17**	**DY18**
Total					
Women with SOBRA deliveries in the previous year and this year	49,760	38,575	36,978		
Women with Plan First participation in DY	13,901	10,406	8,345		
% of women with deliveries participating in Plan First	27.9%	27.0%	22.6%		
District 1 (Colbert, Franklin, Lauderdale, Marion)					
Women with SOBRA deliveries in the previous year and this year	2,194	1,627	1,606		
Women with Plan First participation in DY	684	493	431		
% of women with deliveries participating in Plan First	31.2%	30.3%	26.8%		
District 2 (Jackson, Lawrence, Limestone, Madison, Marshall, Morgan)					
Women with SOBRA deliveries in the previous year and this year	7,099	5,500	5,569		
Women with Plan First participation in DY	1,658	1,242	1,043		
% of women with deliveries participating in Plan First	23.4%	22.6%	18.7%		
District 3 (Calhoun, Cherokee, Cleburne, DeKalb, Etowah)					
Women with SOBRA deliveries in the previous year and this year	3,686	2,934	2,817		
Women with Plan First participation in DY	953	764	625		
% of women with deliveries participating	25.8%	26.0%	22.2%		

in Plan First					
District 4 (Bibb, Fayette, Lamar, Pickens, Tuscaloosa)					
Women with SOBRA deliveries in the previous year and this year	2,618	2,089	2,157		
Women with Plan First participation in DY	731	550	515		
% of women with deliveries participating in Plan First	27.9%	26.3%	23.9%		
District 5 (Blount, Chilton, Cullman, Jefferson, St. Clair, Shelby, Walker, Winston)					
Women with SOBRA deliveries in the previous year and this year	10,797	8,353	7,249		
Women with Plan First participation in DY	2,277	1,692	1,105		
% of women with deliveries participating in Plan First	16.4%	20.3%	15.2%		
District 6 (Clay, Coosa, Randolph, Talladega, Tallapoosa)					
Women with SOBRA deliveries in the previous year and this year	1,849	1,509	1,461		
Women with Plan First participation in DY	550	445	425		
% of women with deliveries participating in Plan First	29.7%	29.5%	29.1%		
District 7 (Greene, Hale)					
Women with SOBRA deliveries in the previous year and this year	332	257	226		
Women with Plan First participation in DY	122	93	38		
% of women with deliveries participating in Plan First	36.7%	36.2%	16.8%		
District 8 (Choctaw, Marengo, Sumter)					
Women with SOBRA deliveries in the previous year and this year	469	356	333		
Women with Plan First participation in DY	172	131	108		
% of women with deliveries participating in Plan First	36.7%	36.8%	32.4%		
District 9 (Dallas, Perry, Wilcox)					
Women with SOBRA deliveries in the previous year and this year	838	541	554		
Women with Plan First participation in DY	390	233	239		
% of women with deliveries participating in Plan First	46.5%	43.1%	43.1%		
District 10 (Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, Pike)					
Women with SOBRA deliveries in the previous year and this year	5,062	4,019	3,770		
Women with Plan First participation in DY	1,465	1,120	877		
% of women with deliveries participating in Plan First	28.9%	27.9%	23.3%		
District 11					

(Barbour, Chambers, Lee, Macon, Russell)					
Women with SOBRA deliveries in the previous year and this year	2,783	2,125	2,094		
Women with Plan First participation in DY	817	595	495		
% of women with deliveries participating in Plan First	29.4%	28.0%	23.6%		
District 12 (Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe, Washington)					
Women with SOBRA deliveries in the previous year and this year	3,476	3,598	3,612		
Women with Plan First participation in DY	1,209	644	1,410		
% of women with deliveries participating in Plan First	34.8%	17.9%	39.0%		
District 13 (Coffee, Dale, Geneva, Henry, Houston)					
Women with SOBRA deliveries in the previous year and this year	2,366	2,604	2,667		
Women with Plan First participation in DY	880	494	1,029		
% of women with deliveries participating in Plan First	37.2%	19.0%	38.6%		
District 14 (Mobile)					
Women with SOBRA deliveries in the previous year and this year	5,156	5,424	5,454		
Women with Plan First participation in DY	1,912	929	1,935		
% of women with deliveries participating in Plan First	37.1%	17.1%	35.5%		

Table 1.4. Availability and Visit Volume for Private Providers

PHA	# Private Providers			# Visits to Private Providers			% Total Visits to Private Providers		
	DY16	DY17	DY18	DY16	DY17	DY18	DY16	DY17	DY18
Total	960			29,929			24.9		
1	63			1,216			17.1		
2	178			3,915			40.7		
3	47			901			14.4		
4	83			1,703			22.2		
5	58			812			12.2		
6	75			1,770			22.3		
7	45			1,927			27.6		
8	133			7,353			17.8		
9	99			3,137			39.4		
10	63			720			8.4		
11	116			6,475			63.6		

Awareness of Plan First
Table 2.1. Awareness of Plan First

	Had heard of Plan First before survey (%)	Aware of enrollment (%)	
		Among all surveyed	Among those who had heard of Plan First
DY1	76.8	56.2	73.1
DY2	82.5	64.2	77.9
DY3-4	81.0	64.9	80.2
DY5	85.3	63.6	74.9
DY6	86.8	70.2	82.5
DY7	92.9	80.8	87.1
DY8	88.9	85.3	85.9
DY9	90.8	79.7	87.8
DY10	88.7	78.3	88.2
DY11	90.1	79.3	88.1
DY12	88.7	77.2	87.0
DY13	89.9	79.9	88.9
DY14	90.1	74.9	83.2
DY15	92.6	78.8	85.0
DY16	91.1	77.6	85.2

Contraceptive service use

Table 3.1. Contraceptive use among women

Use of Contraceptives	DY14	DY15	DY16	DY17	DY18
N	1,070	1,080	1,070		
% used any contraception	84.1	85.6	81.6		
% used effective contraception*	75.8	81.3	74.5		
% Tubal	5.3	5.0	9.7		
% Vasectomy	1.3	2.0	2.5		
% IUD	16.4	20.0	18.1		
% Implanon/Nexplanon	15.1	15.6	15.7		
% Depo	39.1	41.5	36.9		
% BC Pills	58.0	53.5	53.3		
Got BC pills from Health Dept.	58.4	51.7	53.5		
Got BC pills from free sample	18.5	21.8	19.7		
Got BC pills from drug store	22.7	26.1	25.9		
Don't know, not sure	0.4	0.4	0.9		
% Nuva-Ring	8.5	7.6	7.9		
Got ring from Health Dept.	46.7	47.1	34.8		
Got ring from free sample	29.9	31.4	40.6		
Got ring from drug store	20.8	21.4	23.2		
Don't know, not sure	2.6	0.0	1.4		
% Patch	6.8	5.7	5.9		
Got patch from Health Dept.	54.1	35.8	40.4		
Got patch from free sample	24.6	26.4	30.8		
Got patch from drug store	21.3	37.7	26.9		
Don't know, not sure	0.2	0.0	1.9		
% Plan B	9.3	7.8	7.4		
% Condoms	78.6	71.0	70.1		
% Natural FP	7.9	8.0	9.4		
% Withdrawal	50.3	51.0	48.2		

*includes any respondent reporting use of tubal ligation, partner vasectomy, IUD, Nexplanon, Depo-Provera, Birth Control Pills, Nuva Ring and/or Patch.

Table 3.2. Contraceptive use by age

Methods	Age 19-24			Age 25-34			Age ≥35		
	DY16	**DY17**	**DY18**	**DY16**	**DY17**	**DY18**	**DY16**	**DY17**	**DY18**
	N=239			N=629			N=244		
% Used any method	81.6			83.4			76.8		
% Used effective method*	74.7			76.2			69.8		
Tubal ligation	2.1			9.4			18.2		
Vasectomy	0.0			1.2			6.6		
IUD	9.6			20.5			20.4		
Implanon/Nexplanon	18.7			16.7			9.9		
Depo	43.8			36.2			31.5		
BC pills	50.3			54.3			53.6		
Nuva-Ring	8.0			8.1			7.2		
Patch	4.3			6.3			6.6		
Plan B	8.0			8.9			2.8		
Condoms	74.3			69.7			66.8		
Natural FP	9.1			9.2			9.9		
Withdrawal	56.7			47.6			40.9		

*includes any respondent reporting use of tubal ligation, partner vasectomy, IUD, Nexplanon, Depo-Provera, Birth Control Pills, Nuva Ring and/or Patch.

Table 3.3. Services provided according to provider type

Service Type	**Provider Type**	**DY14**	**DY15**	**DY16**	**DY17**	**DY18**
Care Coordination	Health Department	52.5%	53.3%	50.3%		
	Private	11.6%	4.6%	3.5%		
	Both	60.6%	57.1%	52.1%		
	Neither	34.2%	33.4%	20.3%		
	Total with Service	25,654	21,559	13,258		
	% All Clients	37.6%	37.2%	29.6%		
HIV Counseling	Health Department	44.6%	61.7%	61.9%		
	Private	1.7%	2.5%	2.4%		
	Both	37.1%	56.1%	57.2%		
	Neither	6.8%	8.1%	8.5%		
	Total with Service	16,391	20,042	13,464		
	% All Clients	24.0%	34.5%	30.1%		
Tubal Ligations	Health Department	0.2%	0.1%	0.2%		
	Private	1.0%	1.2%	1.0%		
	Both	6.3%	5.8%	4.8%		
	Neither	1.5%	1.7%	1.0%		
	Total with Service	564	515	340		
	% All Clients	0.8%	0.9%	0.8%		
Depo Provera	Health Department	40.6%	42.2%	44.4%		
	Private	37.3%	38.1%	39.1%		
	Both	42.2%	45.0%	47.4%		
	Neither	0%	0%	0%		
	Total with Service	20,257	17,895	12,374		
	% All Clients	29.7%	30.8%	27.6%		
Birth Control Pills	Health Department	28.5%	36.6%	36.5%		
	Private	18.0%	1.4%	8.5%		
	Both	24.8%	29.2%	28.7%		
	Neither	27.7%	6.3%	14.2%		
	Total with Service	17,406	12,036	10,029		
	% All Clients	25.5%	20.7%	22.4%		

Smoking cessation

Table 4.1 Smoking Cessation Based on Enrollee Survey Data

	DY14 N (%)	**DY15** N (%)	**DY16** N (%)	**DY17** N (%)	**DY18** N (%)
Reported Smoking	283 (28.6)	269 (25.8)	265 (26.1)		
Asked about smoking at FP visit	265 (93.6)	248 (92.2)	240 (90.6)		
Advised to quit by FP provider	212 (80.0)	205 (82.7)	197 (82.1)		
Received NRT	111 (41.9)	121 (48.8)	112 (46.7)		
Referred to Quit Line	110 (41.5)	132 (53.2)	133 (55.4)		
Received either NRT or Quit Line referral	149 (56.2)	158 (63.7)	158 (65.8)		
Paid out of pocket for NRT products	--	30 (12.1)	27 (11.2)		

-- Not asked in Enrollee Survey

Table 4.2. Smoking Cessation based on Claims and Quit Line Data

	DY16 N (%)	DY17 N (%)	DY18 N (%)
Number of service users	62,608		
Estimated number of smokers	16,341		
Number receiving NRT (paid claim)	39		
Number receiving Quit Line referral from care coordinator	93		

Estimated and actual birth rates
Table 5.1. Birth Rates per 1000

	Estimated birth rate if fertility rates continued at pre-waiver levels	Actual birth rates all enrollees – pregnancies starting during DY	Actual birth rates service users – pregnancies starting during DY	Actual birth rates non-service users – pregnancies starting during DY
DY1	189.8	60.0	47.8	72.3
DY2	200.7	87.5	54.3	118.9
DY3	204.7	96.6	56.5	131.1
DY4	205.9	92.0	56.2	122.9
DY5	202.6	98.3	58.6	121.7
DY6	224.1	81.8	31.1	105.4
DY7	215.0	57.2	44.0	69.7
DY8	214.8	75.7	65.0	86.6
DY9	127.1	59.1	43.3	78.2
DY10	202.3	69.1	60.8	97.0
DY11	200.1	73.3	58.3	92.6
DY12	180.1	77.3	60.8	97.0
DY13	199.9	84.0	72.5	88.6
DY14	203.1	72.4	58.3	84.9
DY15	196.7	62.7	61.0	63.9

Evaluation Budget
We estimate the total cost of the Evaluation Design for the waiver approval period at $86,841 per year. The staffing, data collection and administrative costs are listed in the accompanying table and described below.

Line Item	Components of budget	Cost of each line item
1	Estimated staff	$37,854
2	Survey administration	$26,000
3	Other administrative cost	$22,984
	Total Amount	$86,841

Staffing

Kari White, PhD MPH, Associate Professor, University of Alabama at Birmingham. Dr. White will have overall responsibility for the evaluation, including the developing the evaluation design and data collection instruments, overseeing evaluation staff and analysis of the claims and survey data, and preparing the annual reports. We estimate her annual effort at $9,193.
Janet Bronstein, PhD, Professor Emeritus, University of Alabama at Birmingham. Dr. Bronstein will provide guidance on the evaluation design and data collection instruments and will assist with data analysis and conceptualizing results for the annual report, based on her experience as the lead evaluator for Plan First between 2000 and 2017. We estimate her annual effort at $988.
Lei Huang, MPH, Statistician, University of Alabama at Birmingham. Ms. Huang will be responsible for data management, data cleaning and analyzing the enrollment, claims and survey data for the annual reports. We estimate her annual effort at $18,674.
Elizabeth Howard, MPH, Program Director, University of Alabama at Birmingham. Ms. Howard will coordinate the administration of the annual surveys with the Survey Research Unit at UAB, prepare protocols for Institutional Review Board submissions, and assist with preparing the annual reports. We estimate her annual effort at $8,999.

Survey Administration

Survey Research Unit, University of Alabama at Birmingham. The Survey Research Unit (SRU) will be responsible for contacting Plan First enrollees for the annual survey, administering the survey and preparing a dataset and codebook of survey responses for Dr. White and Ms. Huang to analyze. We estimate the annual cost for these tasks at $26,000.

Other administrative costs

Indirect costs ($22,987) have been calculated at 36% of UAB's base direct costs ($63,854).