



ROBERT BENTLEY  
Governor

# Alabama Medicaid Agency

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STEPHANIE MCGEE AZAR  
Commissioner

December 21, 2016

Vikki Wachino, Acting Director  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard, Mail Stop S2-01-16  
Baltimore, MD 21244-1850

Dear Ms. Wachino:

This letter is official written notice that the Alabama Medicaid Agency requests approval of the amended Special Terms and Conditions of Alabama's Medicaid Transition (Project Number 11-W-00289/4) demonstration to account for a revised Regional Care Organization (RCO) program implementation date. The date change does not propose a material change to the demonstration, instead it allows time for the appropriation of additional State funding for the Medicaid program and the subsequent completion of readiness activities. It will also help the State and providers to further prepare to meet the demonstration goals of:

- Addressing fragmentation in the state's delivery system;
- Improved prevention and management of chronic disease;
- Improved access to and care coordination of health services;
- Improved birth outcomes; and
- Healthcare delivery system financial efficiency.

Since the Agency has been actively discussing the proposed amendment with CMS since the summer of 2016, we respectfully request timely approval of the amendment package which includes the following attachments:

1. **Revised STCs:** The STCs that were approved by CMS on February 9, 2016 have been revised to delay the RCO program implementation date from October 1, 2016 to October 1, 2017. To align with the revised RCO program implementation date, the Agency requests to change the demonstration time period from April 1, 2016 through March 31, 2021 to April 1, 2017 through March 31, 2022. The attached STCs have been revised to reflect updated dates and milestones that were conditioned on an October 1, 2016 RCO program implementation date, including dates related to Transition Pool and Designated State Health Program funding, as well as other minor changes. The STCs also include the redlined Integrated Provider System Protocols which were updated to reflect a revised appeals process and the Integrated Provider System Application Process Rule which was updated to simplify the operations of the rule.

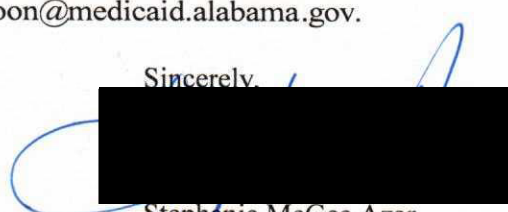



2. **Explanation of the Public Process:** The Agency undertook a public process to notify stakeholders of changes included in the proposed waiver amendment. The Agency has and will continue to offer provider, beneficiary and stakeholder education regarding the revised RCO program implementation date and other associated dates. These dates have been published and discussed in news articles and periodicals. The Agency also conducted a public forum in August 2016, and held other stakeholder meetings in which the Agency notified stakeholders about the RCO program delay. The Agency notified the Poarch Band Indian Health Department and Tribal Government of the amendment and announced the revised RCO program implementation date on November 28, 2016. The letter to the Poarch Band Indian Health Department and Tribal Government and a press release of the delayed implementation date are attached for reference.
3. **Data Analysis Worksheet:** The attached data analysis worksheet identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement.
4. **Updated Budget Neutrality:** The attached updated budget neutrality calculations include the following:
  - a. Historical FFS Data – Unchanged from original submission.
  - b. Without Waiver Projection – Shifts demonstration years back one year.
  - c. With Waiver Projection – Shifts demonstration years back one year and updates projections to use latest RCO expenditure estimates.
  - d. Budget Neutrality Projection – Shifts demonstration years back one year and compares with waiver to without waiver scenarios. Additionally incorporates DSHP CNOM and Transition Pool dollars.
5. **Revised Demonstration Evaluation:** The proposed amendment will not impact the evaluation design. The revised evaluation plan attached includes date adjustments to adjust for the October 1, 2017 RCO program implementation date.

The Agency intends this letter and the supporting attachments to meet the waiver amendment requirements specified in the Special Terms and Conditions.

The Agency looks forward to continuing to work closely with your team to implement the RCO program. If you have any questions, please feel free to contact Dr. Robert Moon at (334) 242-5619 or [Robert.Moon@medicaid.alabama.gov](mailto:Robert.Moon@medicaid.alabama.gov).

Sincerely,

  
  
Stephanie McGee Azar  
Commissioner

cc: Jackie Glaze, Associate Regional Administrator, CMS Region IV  
Erica Dimes, Project Officer

**Amendment Process.** Requests to amend the demonstration must be submitted to CMS 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 herein. Amendment requests must include, but are not limited to, the following:

- a. An explanation of the public process used by the state, consistent with the requirements of STC 9, prior to submission of the requested amendment;

**The state conducted a post award forum on 9/21/16 and discussed the delay. The state also posted on their website on 12/01/2016.**

**Public Notice on 12/01/16: [http://medicaid.alabama.gov/alert\\_detail.aspx?ID=11950](http://medicaid.alabama.gov/alert_detail.aspx?ID=11950)**

- b. A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

**Alabama has attached budget neutrality worksheets and a document explaining the worksheets.**

- c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

**Worksheet updated**

- d. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation and data supporting the evaluation hypotheses as detailed in the evaluation design in STC 62; and

**Evaluation document attached and includes hypotheses and design information.**

- e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

**Evaluation document attached and includes hypotheses and design information.**

**Alabama Medicaid Agency 1115 Waiver Amendment – DATA ANALYSIS WORKSHEET**

The attached workbook ('DRAFT AL 1115 Budget Neutrality Amendment\_2016.12.14.xlsx') updates the budget neutrality projections as a part of the Alabama waiver amendment notification letter. This document is meant to explain what has been updated as compared to what was included within the original waiver submission. Discussed below are the four tabs included in the workbook as they relate to the amendment request.

**|HISTORIC MEDICAID POPS|** - Shows five years of historical fee-for-service (FFS) data for each population in the form of total dollars, member months, and per member per month (PMPM) expenditures. This tab is unchanged from the original waiver submission.

**|WOW|** - Shows projected without waiver membership, PMPM, and total dollars. The base year and demonstration years are all shifted back one year to be consistent with the timing within the amendment request. Results for demonstration year 1 (DY1) through DY4 are the same as the original waiver submission results for DY2 through DY5 as those years directly overlap. This version has a DY5 of April 2021 through March 2022. The impact of shifting the demonstration years back one year is an increase to the without waiver projection of \$835 million over the 5-year demonstration as compared to the original waiver submission. The PMPM costs have been updated under Special Terms and Condition (STC) 56 in the amendment request to reflect these changes.

**|WW|** - Shows projected with waiver membership, PMPM, and total dollars. Similar to the without waiver scenario, the base year and demonstration years are all shifted back one year to be consistent with the timing within the amendment request. In addition to the shift of demonstration years, the RCO expenditure estimates have been updated using projected capitation rate expenditures developed in April 2016. The impact of the combination of these two components is an increase to the with waiver projection of \$1,061 million over the 5-year demonstration as compared to the original waiver submission.

**|BUDGET NEUTRALITY|** - Shows a summary of the without waiver and with waiver scenarios and compares to derive the budget neutrality projection. All changes described above are included in this summary. Additionally, the Designated State Health Programs (DSHP) costs not otherwise matchable (CNOM) and transition pool expenditures are added to the with waiver scenario. The DSHP CNOM and transition pool dollars are unchanged from the original waiver submission. After the changes discussed, the amended 5-year demonstration budget neutrality amount is projected to be \$587 million.

## BUDGET NEUTRALITY SUMMARY - AS OF DECEMBER 23, 2016 AMENDMENT

## Without-Waiver Total Expenditures

		DEMONSTRATION YEARS						TOTAL
		Apr '17 - Mar '18	Apr '18 - Mar '19	Apr '19 - Mar '20	Apr '20 - Mar '21	Apr '21 - Mar '22		
Medicaid Pop 1	ABD	\$ 1,360,046,383	\$ 1,415,088,871	\$ 1,472,369,603	\$ 1,531,973,772	\$ 1,593,986,791	\$ 7,373,465,419	
Medicaid Pop 2	BCCTP	\$ 35,154,674	\$ 38,023,265	\$ 41,125,974	\$ 44,481,837	\$ 48,111,618	\$ 206,897,368	
Medicaid Pop 3	MLIF	\$ 422,484,166	\$ 445,502,973	\$ 469,770,927	\$ 495,359,707	\$ 522,343,899	\$ 2,355,461,672	
Medicaid Pop 4	SOBRA Child	\$ 1,164,425,238	\$ 1,221,513,802	\$ 1,281,510,721	\$ 1,344,602,921	\$ 1,410,926,127	\$ 6,422,978,808	
Medicaid Pop 5	Transitional	\$ 2,906,889	\$ 2,936,900	\$ 2,967,221	\$ 2,997,854	\$ 3,028,803	\$ 14,837,667	
Medicaid Pop 6	SOBRA Maternity	\$ 452,195,448	\$ 473,155,333	\$ 495,112,718	\$ 518,117,966	\$ 542,222,394	\$ 2,480,803,859	

## With-Waiver Total Expenditures\*

		DEMONSTRATION YEARS						TOTAL
		Apr '17 - Mar '18	Apr '18 - Mar '19	Apr '19 - Mar '20	Apr '20 - Mar '21	Apr '21 - Mar '22		
Medicaid Pop 1	ABD	\$ 1,240,295,046	\$ 1,296,869,045	\$ 1,346,554,205	\$ 1,398,269,243	\$ 1,452,100,307	\$ 6,734,087,846	
Medicaid Pop 2	BCCTP	\$ 20,614,630	\$ 23,133,755	\$ 24,877,160	\$ 26,752,710	\$ 28,770,467	\$ 124,148,723	
Medicaid Pop 3	MLIF	\$ 414,969,979	\$ 436,298,891	\$ 451,070,284	\$ 466,347,695	\$ 482,148,632	\$ 2,250,835,480	
Medicaid Pop 4	SOBRA Child	\$ 1,195,012,046	\$ 1,286,804,214	\$ 1,356,440,602	\$ 1,430,078,931	\$ 1,507,959,185	\$ 6,776,294,977	
Medicaid Pop 5	Transitional	\$ 3,060,320	\$ 3,252,418	\$ 3,390,205	\$ 3,534,086	\$ 3,684,337	\$ 16,921,366	
Medicaid Pop 6	SOBRA Maternity	\$ 318,408,321	\$ 334,730,966	\$ 345,570,066	\$ 356,780,068	\$ 368,374,535	\$ 1,723,863,957	
	DSHP CNOM	\$ 89,217,000	\$ 89,217,000	\$ 67,400,000	\$ 47,000,000	\$ 20,000,000	\$ 312,834,000	
	Transition Pool	\$ 187,500,000	\$ 93,750,000	\$ 46,875,000	\$ -	\$ -	\$ 328,125,000	
WW SUBTOTAL		\$ 3,469,077,343	\$ 3,564,056,289	\$ 3,642,177,523	\$ 3,728,762,732	\$ 3,863,037,463	\$ 18,267,111,349	

TOTAL	\$ (31,864,544)	\$ 32,164,854	\$ 120,679,641	\$ 208,771,324	\$ 257,582,169	\$ 587,333,444
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\* With-Waiver expenditure amounts do not include any additional computable amounts available outside of transition pool.



## 5 YEARS OF HISTORIC DATA - AS OF DECEMBER 23, 2016 AMENDMENT

## SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:

	2009	2010	2011	2012	2013	5-YEARS
<b>Medicaid Pop 1</b>	ABD					
<b>TOTAL EXPENDITURES</b>	\$ 996,435,492	\$ 1,155,112,091	\$ 1,065,121,800	\$ 1,154,453,513	\$ 1,196,291,624	
<b>Eligible Member Months</b>	1,383,677	1,411,890	1,432,298	1,395,726	1,407,332	
<b>PMPM COST</b>	\$ 720.14	\$ 818.13	\$ 743.65	\$ 827.13	\$ 850.04	
<b>TREND RATES</b>	<b>ANNUAL CHANGE</b>					<b>5-YEAR AVERAGE</b>
TOTAL EXPENDITURE		15.92%	-7.79%	8.39%	3.62%	4.68%
ELIGIBLE MEMBER MONTHS		2.04%	1.45%	-2.55%	0.83%	0.42%
PMPM COST		13.61%	-9.10%	11.23%	2.77%	4.23%

<b>Medicaid Pop 2</b>	BCCTP					
<b>TOTAL EXPENDITURES</b>	\$ 7,826,938	\$ 11,418,546	\$ 10,647,575	\$ 30,723,165	\$ 27,231,879	
<b>Eligible Member Months</b>	4,010	5,463	7,233	10,223	11,125	
<b>PMPM COST</b>	\$ 1,951.85	\$ 2,090.16	\$ 1,472.08	\$ 3,005.30	\$ 2,447.81	
<b>TREND RATES</b>	<b>ANNUAL CHANGE</b>					<b>5-YEAR AVERAGE</b>
TOTAL EXPENDITURE		45.89%	-6.75%	188.55%	-11.36%	36.58%
ELIGIBLE MEMBER MONTHS		36.23%	32.40%	41.34%	8.82%	29.06%
PMPM COST		7.09%	-29.57%	104.15%	-18.55%	5.82%

<b>Medicaid Pop 3</b>	MLIF					
<b>TOTAL EXPENDITURES</b>	\$ 156,251,939	\$ 184,492,882	\$ 190,155,518	\$ 260,818,658	\$ 247,399,479	
<b>Eligible Member Months</b>	716,782	808,025	903,720	1,011,946	974,029	
<b>PMPM COST</b>	\$ 217.99	\$ 228.33	\$ 210.41	\$ 257.74	\$ 254.00	
<b>TREND RATES</b>	<b>ANNUAL CHANGE</b>					<b>5-YEAR AVERAGE</b>
TOTAL EXPENDITURE		18.07%	3.07%	37.16%	-5.15%	12.17%
ELIGIBLE MEMBER MONTHS		12.73%	11.84%	11.98%	-3.75%	7.97%
PMPM COST		4.74%	-7.84%	22.49%	-1.45%	3.90%

<b>Medicaid Pop 4</b>	SOBRA Child					
<b>TOTAL EXPENDITURES</b>	\$ 613,434,993	\$ 710,785,178	\$ 725,768,648	\$ 823,455,525	\$ 911,026,117	
<b>Eligible Member Months</b>	3,759,792	4,184,002	4,603,924	4,953,892	4,995,939	
<b>PMPM COST</b>	\$ 163.16	\$ 169.88	\$ 157.64	\$ 166.22	\$ 182.35	
<b>TREND RATES</b>	<b>ANNUAL CHANGE</b>					<b>5-YEAR AVERAGE</b>
TOTAL EXPENDITURE		15.87%	2.11%	13.46%	10.63%	10.39%
ELIGIBLE MEMBER MONTHS		11.28%	10.04%	7.60%	0.85%	7.37%
PMPM COST		4.12%	-7.21%	5.44%	9.70%	2.82%

<b>Medicaid Pop 5</b>	Transitional					
<b>TOTAL EXPENDITURES</b>	\$ 2,645,937	\$ 3,078,473	\$ 3,640,744	\$ 3,666,947	\$ 3,020,176	
<b>Eligible Member Months</b>	12,161	14,659	16,300	16,212	13,864	
<b>PMPM COST</b>	\$ 217.58	\$ 210.01	\$ 223.36	\$ 226.19	\$ 217.84	
<b>TREND RATES</b>	<b>ANNUAL CHANGE</b>					<b>5-YEAR AVERAGE</b>
TOTAL EXPENDITURE		16.35%	18.26%	0.72%	-17.64%	3.36%
ELIGIBLE MEMBER MONTHS		20.54%	11.19%	-0.54%	-14.48%	3.33%
PMPM COST		-3.48%	6.36%	1.27%	-3.69%	0.03%

<b>Medicaid Pop 6</b>	SOBRA Maternity					
<b>TOTAL EXPENDITURES</b>	\$ 271,475,300	\$ 257,350,697	\$ 306,770,284	\$ 335,453,619	\$ 349,259,320	
<b>Eligible Member Months</b>	290,651	286,209	288,824	298,599	312,470	
<b>PMPM COST</b>	\$ 934.03	\$ 899.17	\$ 1,062.14	\$ 1,123.43	\$ 1,117.74	
<b>TREND RATES</b>	<b>ANNUAL CHANGE</b>					<b>5-YEAR AVERAGE</b>
TOTAL EXPENDITURE		-5.20%	19.20%	9.35%	4.12%	6.50%
ELIGIBLE MEMBER MONTHS		-1.53%	0.91%	3.38%	4.65%	1.83%
PMPM COST		-3.73%	18.12%	5.77%	-0.51%	4.59%

## WITHOUT WAIVER PROJECTION - AS OF DECEMBER 23, 2016 AMENDMENT

MEDICAID POPULATIONS										
ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR Apr '16 - Mar '17	TREND RATE 2	DEMONSTRATION YEARS					TOTAL WOW
					Apr '17 - Mar '18	Apr '18 - Mar '19	Apr '19 - Mar '20	Apr '20 - Mar '21	Apr '21 - Mar '22	
<b>Medicaid Pop 1</b>	ABD									
Eligible Member Months		39	1,353,725		1,354,331	1,354,943	1,355,561	1,356,185	1,356,815	
PMPM Cost	4.00%		\$ 965.60	4.00%	\$ 1,004.22	\$ 1,044.39	\$ 1,086.17	\$ 1,129.62	\$ 1,174.80	
Total Expenditure			\$ 1,307,157,166		\$ 1,360,046,383	\$ 1,415,088,871	\$ 1,472,369,603	\$ 1,531,973,772	\$ 1,593,986,791	\$ 7,373,465,419
<b>Medicaid Pop 2</b>	BCCTP									
Eligible Member Months		39	11,689		12,157	12,643	13,149	13,675	14,222	
PMPM Cost	4.00%		\$ 2,780.58	4.00%	\$ 2,891.81	\$ 3,007.48	\$ 3,127.78	\$ 3,252.89	\$ 3,383.01	
Total Expenditure			\$ 32,502,437		\$ 35,154,674	\$ 38,023,265	\$ 41,125,974	\$ 44,481,837	\$ 48,111,618	\$ 206,897,368
<b>Medicaid Pop 3</b>	MLIF									
Eligible Member Months		39	1,392,969		1,413,700	1,434,746	1,456,112	1,477,803	1,499,825	
PMPM Cost	3.90%		\$ 287.63	3.90%	\$ 298.85	\$ 310.51	\$ 322.62	\$ 335.20	\$ 348.27	
Total Expenditure			\$ 400,659,578		\$ 422,484,166	\$ 445,502,973	\$ 469,770,927	\$ 495,359,707	\$ 522,343,899	\$ 2,355,461,672
<b>Medicaid Pop 4</b>	SOBRA Child									
Eligible Member Months		39	5,561,741		5,673,757	5,788,616	5,906,396	6,027,177	6,151,042	
PMPM Cost	2.82%		\$ 199.60	2.82%	\$ 205.23	\$ 211.02	\$ 216.97	\$ 223.09	\$ 229.38	
Total Expenditure			\$ 1,110,123,522		\$ 1,164,425,238	\$ 1,221,513,802	\$ 1,281,510,721	\$ 1,344,602,921	\$ 1,410,926,127	\$ 6,422,978,808
<b>Medicaid Pop 5</b>	Transitional									
Eligible Member Months		39	13,194		13,326	13,460	13,594	13,730	13,868	
PMPM Cost	0.03%		\$ 218.06	0.03%	\$ 218.13	\$ 218.20	\$ 218.27	\$ 218.34	\$ 218.41	
Total Expenditure			\$ 2,877,184		\$ 2,906,889	\$ 2,936,900	\$ 2,967,221	\$ 2,997,854	\$ 3,028,803	\$ 14,837,667
<b>Medicaid Pop 6</b>	SOBRA Maternity									
Eligible Member Months		39	337,214		338,280	339,367	340,476	341,606	342,760	
PMPM Cost	4.30%		\$ 1,281.64	4.30%	\$ 1,336.75	\$ 1,394.23	\$ 1,454.18	\$ 1,516.71	\$ 1,581.93	
Total Expenditure			\$ 432,186,991		\$ 452,195,448	\$ 473,155,333	\$ 495,112,718	\$ 518,117,966	\$ 542,222,394	\$ 2,480,803,859

## NOTES

"Base Year" is the year immediately prior to the planned first year of the demonstration.

"Trend Rate 1" is the trend rate that projects from the last historical year to the base year.

"Months of Aging" equals the number of months of trend factor needed to trend from the last historical year to the Base Year. There are 39 months between the the last historical year and the base year.

"Trend Rate 2" is the trend rate that projects all DYs, starting from the base year.

WITH WAIVER PROJECTION\* - AS OF DECEMBER 23, 2016 AMENDMENT

MEDICAID POPULATIONS													
ELIGIBILITY GROUP	Apr '16 - Mar '17	DEMO TREND RATE	DEMONSTRATION YEARS										TOTAL WW
			Rate Methodology Adjustment	Apr '17 - Mar '18	Rate Methodology Adjustment	Apr '18 - Mar '19	Rate Methodology Adjustment	Apr '19 - Mar '20	Rate Methodology Adjustment	Apr '20 - Mar '21	Rate Methodology Adjustment	Apr '21 - Mar '22	
<b>Medicaid Pop 1</b>	ABD												
Eligible Member Months	1,353,725			1,354,331		1,354,943		1,355,561		1,356,185		1,356,815	
PMPM Cost	\$ 965.60	4.00%	-8.81%	\$ 915.80	0.49%	\$ 957.14	-0.21%	\$ 993.36	-0.20%	\$ 1,031.03	-0.19%	\$ 1,070.23	
Total Expenditure	\$ 1,307,157,166			\$ 1,240,295,046		\$ 1,296,869,045		\$ 1,346,554,205		\$ 1,398,269,243		\$ 1,452,100,307	\$ 6,734,087,846
<b>Medicaid Pop 2</b>	BCCTP												
Eligible Member Months	11,689			12,157		12,643		13,149		13,675		14,222	
PMPM Cost	\$ 2,780.58	4.00%	-41.36%	\$ 1,695.75	3.75%	\$ 1,829.78	-0.58%	\$ 1,892.00	-0.57%	\$ 1,956.39	-0.57%	\$ 2,023.02	
Total Expenditure	\$ 32,502,437			\$ 20,614,630		\$ 23,133,755		\$ 24,877,160		\$ 26,752,710		\$ 28,770,467	\$ 124,148,723
<b>Medicaid Pop 3</b>	MLIF												
Eligible Member Months	1,392,969			1,413,700		1,434,746		1,456,112		1,477,803		1,499,825	
PMPM Cost	\$ 287.63	3.90%	-1.78%	\$ 293.53	-0.29%	\$ 304.09	-1.96%	\$ 309.78	-1.95%	\$ 315.57	-1.95%	\$ 321.47	
Total Expenditure	\$ 400,659,578			\$ 414,969,979		\$ 436,298,891		\$ 451,070,284		\$ 466,347,695		\$ 482,148,632	\$ 2,250,835,480
<b>Medicaid Pop 4</b>	SOBRA Child												
Eligible Member Months	5,561,741			5,673,757		5,788,616		5,906,396		6,027,177		6,151,042	
PMPM Cost	\$ 199.60	2.82%	2.63%	\$ 210.62	2.65%	\$ 222.30	0.48%	\$ 229.66	0.48%	\$ 237.27	0.49%	\$ 245.16	
Total Expenditure	\$ 1,110,123,522			\$ 1,195,012,046		\$ 1,286,804,214		\$ 1,356,440,602		\$ 1,430,078,931		\$ 1,507,959,185	\$ 6,776,294,977
<b>Medicaid Pop 5</b>	Transitional												
Eligible Member Months	13,194			13,326		13,460		13,594		13,730		13,868	
PMPM Cost	\$ 218.06	0.03%	5.28%	\$ 229.64	5.19%	\$ 241.64	3.17%	\$ 249.38	3.18%	\$ 257.39	3.19%	\$ 265.68	
Total Expenditure	\$ 2,877,184			\$ 3,060,320		\$ 3,252,418		\$ 3,390,205		\$ 3,534,086		\$ 3,684,337	\$ 16,921,366
<b>Medicaid Pop 6</b>	SOBRA Maternity												
Eligible Member Months	337,214			338,280		339,367		340,476		341,606		342,760	
PMPM Cost	\$ 1,281.64	4.30%	-29.59%	\$ 941.26	0.47%	\$ 986.34	-1.34%	\$ 1,014.96	-1.34%	\$ 1,044.42	-1.34%	\$ 1,074.73	
Total Expenditure	\$ 432,186,991			\$ 318,408,321		\$ 334,730,966		\$ 345,570,066		\$ 356,780,068		\$ 368,374,535	\$ 1,723,863,957

\* With-Waiver expenditure amounts do not include any additional computable amounts available outside of transition pool.



# A L E R T

December 1, 2016

**TO: All Providers**

**RE: RCO Implementation Changes and Service Delivery Network Timelines**

The Alabama Medicaid Agency is working with Centers for Medicare and Medicaid Services (CMS) to amend the approved 1115 waiver to allow for an October 1, 2017, start date for the Regional Care Organization (RCO) program.

The deadline for probationary RCOs to demonstrate the existence of an adequate service delivery network by submitting to Medicaid signed contracts from their network providers is January 10, 2017. As probationary RCOs work to meet this service delivery network adequacy deadline, providers may be contacted by probationary RCOs with whom they are not currently contracted.

Information about RCOs, implementation or other aspects of this managed care program may be found on the Agency's RCO webpage at [http://www.medicaid.alabama.gov/content/5.0\\_Managed\\_Care/5.1\\_RCOs.aspx](http://www.medicaid.alabama.gov/content/5.0_Managed_Care/5.1_RCOs.aspx).

Provider questions may be emailed to [RCOportal@medicaid.alabama.gov](mailto:RCOportal@medicaid.alabama.gov).

Sign up for email notices from Medicaid at <http://www.medicaid.alabama.gov/Subscribe.aspx>.

# ALABAMA MEDICAID TRANSFORMATION WAIVER EVALUATION

THE UNIVERSITY OF  
**ALABAMA**<sup>®</sup>

*College of*  
**Community Health Sciences**  
Rural Health Research

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# Alabama Medicaid Transformation Evaluation

## 1. BACKGROUND

### **Synopsis of Waiver**

In April 2016, the Alabama Medicaid Agency received approval of their proposed five-year Alabama Medicaid Transformation section 1115(a) Medicaid demonstration from the Centers for Medicare and Medicaid Services (CMS). This waiver establishes mandatory enrollment into Regional Care Organizations (RCOs) on a geographic basis, beginning on October 1, 2017, for the designated Medicaid beneficiary populations and is approved through March 31, 2022.

According to CMS requirements, the Alabama Medicaid Agency must develop and submit a final evaluation design for CMS approval within 120 days of the demonstration waiver approval date. This evaluation will include a discussion of the objectives, hypotheses, and testable research questions with a focus on the demonstration's target populations along with beneficiaries, providers, RCOs, market areas and public expenditures.

The objectives and hypotheses are tested by at least one of the 10 research questions listed in Appendix A. These relationships and data sources are further delineated in Appendix B and the quality incentives and measures are detailed in Appendix C.

### **Key Objectives and Hypotheses of the RCO Demonstration**

#### *Objectives:*

The Alabama Medicaid Transformation aims to achieve the following goals for the Alabama Medicaid Agency by implementing the RCO delivery system to further the objectives of Title XIX by:

1. Addressing fragmentation in the state's delivery system;
2. Improved prevention and management of chronic disease;
3. Improved access to and care coordination of health services;
4. Improved birth outcomes; and
5. Health care delivery system financial efficiency.

#### *Hypotheses:*

The RCO demonstration evaluation will include an assessment of the following core hypotheses in alignment with the purposes of the five goals above:

1. Integration of physical and behavioral health services will improve quality of covered Medicaid services in comparison to the current Fee for Service (FFS) delivery system;
2. Statewide care coordination through RCOs will result in improved health outcomes in comparison to the current FFS delivery system;



3. Care coordination through RCOs will result in appropriate utilization of hospital and emergency department services in comparison to utilization under the current FFS delivery system to reduce avoidable hospitalizations;
4. RCOs will be more effective in coordinating care than the current FFS delivery system.

### **Constructs and definitions:**

*Appropriate utilization of services* – For the purposes of this evaluation, appropriate utilization of services refers to a decrease in hospital stays and emergency department visits with an increase in primary health home utilization.

Health care utilization refers to patients accessing and utilizing inpatient care, ambulatory care, and emergency department care. (Agency for Healthcare Research and Quality, n.d.).

*Care Coordination* – For the purposes of this evaluation, care coordination refers to an increase in coordinated or managed care, particularly for co-morbid and vulnerable RCO beneficiaries.<sup>1</sup>

*Fragmentation* – For the purposes of this evaluation, fragmentation refers to access to preventive, physical, and behavioral health care and health care case management.

It is very difficult for vulnerable populations to navigate Alabama's stressed and disjointed health care infrastructure. Under the FFS system, not all Medicaid beneficiaries have a primary care health home or access to care coordination services. The Alabama Medicaid Transformation demonstration aims to place every RCO beneficiary in a health home.

*Improved Birth Outcomes* – For the purposes of this evaluation, improved birth outcomes refers to increased positive health outcomes for both mothers and infants. This includes such elements as access to prenatal care, rates of premature birth, low birthweight percentages, infant mortality rates, and complications during pregnancy (CDC, n.d.).

*Improved Prevention and Management* – For the purposes of this waiver, improved prevention and management refers to the evidence-based clinical practice of prevention and screening (particularly well-child visits, immunizations, and breast and cervical cancer screening), early diagnosis, and proper management of the most common chronic co-morbidities (including hypertension, diabetes, and asthma).

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<sup>1</sup> The Agency for Healthcare Research and Quality (AHRQ) defines care coordination as “deliberately organizing patient care activities and sharing among all of the participants concerned with a patient's care to achieve safe and more effective care” (AHRQ, n.d.).

It is a priority of the National Quality Strategy to promote the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease (Agency for Health Care Research and Quality, n.d.).

*Financial Efficiency* – For the purpose of this evaluation, financial efficiency refers to the opportunity to control costs through more efficient care coordination. More efficient care coordination may include reducing duplicative or unnecessary services, ensuring that beneficiaries receive care in the most appropriate settings, reducing emergency department visits, reducing inpatient days, increased sharing among health care providers, increased value-based purchasing and incentive strategies, combined behavioral and physical care, and the receipt of preventive and early stage care.

Approximately one-third of Alabama's General Fund is allocated to increasing Medicaid costs.

## 2. EVALUATION DESIGN

The purpose of this evaluation is to determine the outcomes of the Alabama Medicaid Agency's transformation from Fee-for-Service care to Regional Care Organizations (RCOs) for designated demonstration beneficiaries, providers, RCO entities, market areas, and public expenditures. The design will assess each goal and hypothesis in accordance with the approved CMS waiver and in accordance with the CMS approved evaluation design. As shown in Appendices A and B, each demonstration goal and hypothesis will be assessed using one or more research question evaluation measures. As noted in a recent report by The Kaiser Commission on Medicaid and the Uninsured, a comparison of 1115(a) demonstration waiver measures with state and national values will reveal the significance of the transformation for Alabama Medicaid and will offer insight as to which initiatives are suitable for nationwide adoption (Rudowitz, 2016). The results of this evaluation will be submitted to Alabama Medicaid and CMS. Results will also be submitted for presentation at academic research conferences and for peer-reviewed manuscripts. In the event that the Alabama Medicaid Transformation needs to make changes in order to comply with changes in federal Medicaid and Children's Health Insurance Program (CHIP) law or CMS requests, the evaluation design will also adapt to those changes.

The evaluation will include examinations of RCO beneficiary quality outcome measures alongside measures from representative samples of Alabama Medicaid beneficiaries from as far back as 2010. These comparisons will include administrative data to analyze claims, cost of care, health care utilization, types of services offered and clinical care patterns; Medicaid-covered and statewide birth outcomes; administrative cost; and other data as available.<sup>2</sup> Surveys, focus groups, and key informant interviews will also be conducted with beneficiaries, providers, RCOs and other stakeholders as identified. The evaluation will be modified as CMS requests modifications of the demonstration.

An introduction to the Alabama Medicaid Transformation evaluation study population is detailed in the next section.

### Study Population

As stated in the CMS waiver, this demonstration affects the majority of persons eligible for the Alabama Medicaid plan, unless specifically excluded in STC 20, and those subject to opt-out or opt-in provisions in STC 23 and STC 24. These affected enrollees are referred to as RCO beneficiaries and will begin receiving coverage and care coordination through approved provider-based, risk-bearing RCOs starting on October 1, 2017. Approximately 727,000 people are anticipated to become RCO beneficiaries (Alabama Medicaid, 2016).

Table 1 of the waiver, entitled *Populations Affected by the Demonstration*, clearly defines groups that will become RCO beneficiaries through the Alabama Medicaid Transformation. These include:

- Parents/caretaker relatives of low-income families

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<sup>2</sup> Detailed quality measures for the evaluation are included in Appendix B.

- A consolidated group for pregnant women, including:
  - Low-income families.
  - Qualified pregnant women.
  - Poverty-level related pregnant women (mandatory).
  - Pregnant women financially eligible for AFDC.
  - Pregnant women who would be eligible for AFDC if not institutionalized.
  - Poverty-level related pregnant women (optional).
- A consolidated group for children less than 19 years, including:
  - Low-income families.
  - Qualified children less than 19 years.
  - Poverty-level related children, aged 1-5 years.
  - Poverty-level children, aged 6-18 years.
  - Children who would be eligible for AFDC if not institutionalized.
- Deemed newborns.
- Former foster care children, up to 26 years old
- Transitional Medical Assistance.
- Medicaid extension due to spousal support collections.
- Aged, blind or disabled individuals.
- SSI recipients.
- Disabled widows and widowers ineligible for SSI due to increase in OASDI (DWB).
- Disabled adult children (DAC).
- Blind or disabled individuals, eligible in 1973.
- Individuals ineligible for SSI due to Medicaid prohibited requirements.
- Individuals who would be eligible for SSI but for OASDI/COLA increases since 1977.
- Individuals who would be eligible for SSI/SSP but for OASDI COLAS in 1972 (closed to new enrollment).
- Early widows/widowers.
- Individuals eligible as essential spouses in 1973.

Other groups who may opt out of RCO enrollment may or may not be included in the study population. These include:

- Women who have been screened for breast and cervical cancer under the CDC and Prevention Breast and Cervical Cancer Early Detection Program.
- Children for whom there is in effect a State non-IV-E or federal IV-E adoption subsidy agreement.

American Indian or Alaska Native (AI/AN) individuals will continue in the Fee for Service (FFS) Medicaid system unless they choose to opt in to the waiver demonstration. In the event these individuals opt in, they will become part of the study population.

According the CMS Waiver, certain individuals will not receive care through the RCO demonstration but will continue to receive health services through the Alabama Medicaid service delivery system. Because this group of approximately 333,000 people is very different from the



RCO beneficiary group, it would not be an appropriate comparison sample. Persons in this group include:

- Children in foster care.
- Children in the custody of the Department of Youth Services.
- Inmates and people living in Institutions for Mental Diseases (IMDs).
- Individuals dually eligible for Medicare and Medicaid.
- Aged, blind, or disabled individuals receiving only optional state supplements.
- Individuals participating in the Program of All-Inclusive Care for the Elderly (PACE).
- Individuals receiving long-term, skilled nursing care in long-term care facilities.
- Individuals utilizing home-and-community-based waiver services.
- Individuals utilizing hospice services.
- Individuals receiving Refugee Medical Assistance.
- Individuals participating in the Plan First Program who only receive family planning services.
- Individuals with other commercial managed care insurance or who are participating in the Health Insurance Premium Payment (HIPP) program.
- Individuals with limited or no Medicaid coverage (e.g., some non-citizens only eligible for emergency services or individuals receiving short-term hospital presumptive eligibility).

### **Comparison Group**

The evaluators will conduct cohort comparisons of the RCO beneficiary data by using Population Proportion Sampling to randomly select Alabama Medicaid administrative claims data from 2010-2015. Evaluators will also sample population data from Alabama Medicaid's Health Home Project and the Patient Care Networks of Alabama, precursors to RCO managed care (Spillman, Richardson, & Spencer, 2013).

### **Data Sources and Confidentiality**

The evaluation staff participating in this endeavor thoroughly understand that technology alone cannot protect the highly valuable data outlined below. It is critical that all parties related to these activities follow established and developing protocols to help protect this sensitive information. The following steps will be taken by evaluation staff when handling sensitive information:

- Always understand the sensitivity of the information being used.
- Staff will only use systems authorized by The University of Alabama Office of Information Technology Division of Cyber Security to store, process or transmit sensitive information.
- Only authorized individuals will have access to the system. Authorized individuals will always log in with a unique, non-privileged user ID.
- Only secure, authorized methods that support strong encryption will be used to transfer sensitive information.

The Institute for Rural Health Research (IRHR) will work with Alabama Medicaid, the Alabama Department of Public Health and other resources available at The University of Alabama to compile multiple sources of data to assess the 5 objectives and 4 research hypotheses. IRHR will utilize Alabama Medicaid administrative claims database for: health services cost data, hospitalization data, public health and birth outcomes data, encounter data, and claims data. IRHR will work with key data owners to ensure appropriate data use agreements and any Memorandums of Understandings (MOU) necessary for access to Medicaid claims and encounters data are in place.

One source for this data will be The Statistics Research and Consulting Lab (SRCL) at The University of Alabama. The SRCL is a cooperative research organization that focuses on the application of data analytics in academic, corporate and government environments and has an ongoing partnership with the Alabama Medicaid Agency. The objective of this collaboration is to assist the Agency's Department of Quality Analytics in enhancing research and reporting by aiding with the quantitative aspects of reviews and inquiries. In previous SRCL work, this has been accomplished via assistance with study design, statistical modeling and interpretation of results as well as recommended quality measures for investigations involving Medicaid data. Additionally, the SRCL is responsible for producing patient risk adjustments from Alabama Medicaid claims data.

Additional sources may include the External Quality Review Organization (EQRO), contracted by the Agency to work with each RCO, and any surveys or evaluations undertaken by individual RCO providers. After Alabama Medicaid issues an RFP and establishes contracts for EQROs, EQROs will be charged with validating encounter data and overseeing RCO Performance Improvement Projects. IRHR will incorporate this data into the evaluation reports once it is made available.

Because hybrid or medical record data is currently unavailable at the state level, the original evaluation plan does not include such information. RCOs are intended to address the fragmentation of the health care system that has contributed to this lack of data.

### *Surveys*

Survey recruitment will take place via randomized sampling of each RCO region across the state by consumer, provider, and RCO board groups. Survey recruitment will begin at the end of RCO Enrollment Year 1 (September 30, 2018) and will continue with quarterly rollouts until the end of the waiver. Recruitment will begin with a postcard notification, then mailing of the survey with phone and text reminders.

### Consumer Surveys

Consumer surveys with RCO beneficiaries will be used to assess patient satisfaction and perceived access to and quality of care. These surveys will specifically address the stated objectives (see section 1, pg. 1) and inquire about perceived gaps or fragmentation in the:

- RCO delivery system.

- prevention and management of beneficiaries' chronic disease.
- perceived personal status of health.
- referral to and use of behavioral health services.
- satisfaction with new managed care services provided by the RCO.
- use of hospital and emergency room services.
- continuity with health care providers.

IRHR will work with Alabama Medicaid to deliver survey questions to the beneficiaries that maximize survey and item accessibility while minimizing patient burden. The surveys will be appropriate for a population with lower health literacy, and sampling will be representative of all RCO regions and approved organizations. During initial evaluability discussions with RCO representatives, we will inquire about the need for a Spanish survey in each location. IRHR will also work with Medicaid to utilize any Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data they collect.

### Provider Surveys

Provider surveys will be used to collect data on provider satisfaction regarding the RCO transformation. Questions will attempt to ascertain providers' ability to establish continuity with patients, provide care, refer to services and specialists, integrate behavioral and preventive health services, and follow up with patients post-emergency department visit. Providers will also be asked about their experience working with the RCOs with which they have contracted. The survey sample will be representative of providers across RCO regions and organization contracts.

### RCO Boards of Directors Surveys

Members of RCO Boards of Directors and RCO Executive Directors will be surveyed about their experiences in the following areas:

- Implementation of the RCO transformation
- Pursuit of the goals of integrated physical and behavioral health services
- Quality improvement
- Birth outcomes improvement
- Coordination of RCO beneficiary health care
- Reduction of avoidable hospitalizations
- Interaction with providers
- Interaction with community resources

Boards of Directors will also be surveyed on their:

- Methods for monitoring the program and ensure its improvement.
- Levels of success in achieving the demonstration goals.

There are five RCO regions across the state. Each RCO must have a Governing Board of Directors composed of twenty members<sup>3</sup>, producing an estimated minimum sample pool of 100 board members. Potential RCOs have not officially contracted with Medicaid due to a delay in the RCO rollout, but the survey sample size will be estimated as those values become available.

### *Key Informant Interviews*

Key informant interviews will also be conducted with RCO beneficiaries, providers, and RCO Boards of Directors and staff in order to add context, depth, and meaning to the survey analysis. The questions asked in these interviews will also align with the 5 goals and 4 hypotheses of the Alabama Medicaid Transformation Waiver. The informant selection will be representative of the RCO regions. If the evaluation team determines or an RCO recommends that additional measures are necessary to meet the needs of Spanish-speaking beneficiaries, the evaluation team will utilize Spanish language versions of the interview questions and Spanish-speaking facilitators.

Key informant interview recruitment will begin six-months after the RCO rollout date of October 1, 2017, (March 2018) and will continue every six months throughout the end of the waiver. Recruitment will take place through venue convenience sampling. RCO beneficiaries will be recruited for face-to-face interviews through provider clinics in each RCO region. IRHR will hire and train persons to administer the surveys during wait times.

Providers will be recruited by contacting attendees of state medical professional meetings<sup>4</sup> and conferences to ask if they would be willing to schedule an interview during the meeting. RCO Board Members will also be contacted before state meetings to schedule an interview time that is convenient for them. Given the goals of the interviews (providing context, narrative, and depth to what is learned from the surveys) we expect that the interview sample size will be smaller than the survey sample size and will be estimated as numbers become available.

All interviews and surveys will have Institutional Review Board approval by The University of Alabama before recruitment begins.

### *Qualitative Data Analysis Strategy*

All key informant interviews will be audio-recorded and transcribed by a professional transcription company. Transcripts will be uploaded into NVivo 10 software which will be used to code and analyze the data (NVivo, 2012). As a first step, data will be managed and coded utilizing deductive data analysis (Miles, Huberman, & Saldaña, 2013). A codebook of expected themes will be created based on previous studies and the extant literature. Two trained coders will then utilize a multi-step process to code the interview transcripts in NVivo.

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<sup>3</sup> Twelve risk-bearing and eight non risk-bearing (5 of which must be specific medical professionals providing care in the region, and three must be community representatives).

<sup>4</sup> Examples of such meetings include: the Alabama Primary Health Care Association, Alabama Chapter of the National Medical Association, Alabama Academy of Family Physicians, and Alabama Academy of Pediatrics.



The specific steps are as follows:

1. Independently read and code each transcript based on the codebook
2. Compare and discuss the coded transcripts and
  - a. Modify codes as needed by adding additional (unanticipated) codes and removing unused codes.
  - b. Come to a consensus on the meaning and application of codes to data chunks.
  - c. Come to a consensus on the final thematic code list.
3. Re-read and re-code each transcript based on the new consensus thematic code list. An inter-rater reliability of .80 will be sought.
4. Finally, utilize thematic content analysis to identify themes that address the research questions.

A detailed audit trail will be maintained throughout the entire data management, coding and analysis process (Creswell & Miller, 2000). The audit trail will detail every decision that is made in the analytic process (e.g., creation or elimination of codes, application of codes, etc.).

### **Analytic Methods**

The Institute for Rural Health Research (IRHR) will conduct a scientifically rigorous evaluation with a thoroughly documented data strategy and will report the results. In order to maintain scientific rigor and ensure timely completion of the report, IRHR has hired a full-time data analyst with experience managing and reporting results from large state and national datasets. Additionally, IRHR has hired a full-time writer for reports and manuscripts. Analyses will be conducted to produce research suitable for academic conferences and peer reviewed journals. IRHR will use the best available data. When feasible, IRHR will control for the limitations of data, subsequent effects on results, and the generalizability of the findings, reporting all such information. At a minimum, IRHR will follow HEDIS protocols for calculations and data analysis, allowing for further analyses as appropriate for evaluation of the Alabama Medicaid Waiver.

To determine the efficacy of the Alabama Medicaid Transformation waiver demonstration, evaluators will compare recipients of health care services covered by the waiver with similar groups not covered by a similar waiver. Additionally, health care service recipients may be assessed longitudinally or as cross-sections to include pre-post scenarios, thus allowing recipient groups to serve as their own comparisons. The t-test will be used to ascertain pre-post differences for a single group as the manner and availability of services changes and to compare different groups receiving services by different means. Nonparametric analogs to the t-test will be used when available and deemed necessary. In order to gain a more thorough understanding of the effect of the waiver, further analyses will be performed on subgroups of the population, paying particular attention to inordinately vulnerable populations.<sup>5</sup>

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<sup>5</sup> The effects of the waiver may, for instance, be disproportionate with regards to gender, age, personal/household income level, and eligibility group. Any additional subgroups that emerge as the analysis process matures will be incorporated.

Modern statistical software, such as SAS and SPSS, allow for the adaption of t-tests and nonparametric alternatives to a variety of data environments, including common violations of assumptions.<sup>6</sup> This will allow the use of the maximum available sample size for each group, thus ensuring the greatest accuracy of the final results. As other types of data are encountered, categorical data analysis methods may be employed. Chi-squared analysis, relative risk analysis, odds ratios and logit models may be particularly informative. Discriminant analysis may also prove useful in ascertaining groupings under more complex, multi-factor scenarios.

Should univariate methods prove too limiting, higher order analyses including, but not limited to, multiple regression and multinomial logistic regression will be employed. In such cases, model specification will be undertaken in consultation with subject matter experts (SMEs).

## **Limitations**

Despite the tremendous opportunities to evaluate the Alabama Medicaid Transformation, some limitations are beyond the control of the evaluators.

For instance, new Medicaid innovations may be issued from the Centers for Medicare and Medicaid Services (CMS) or proposed and passed by the Alabama State Legislature or Governor's Office.

As an example, the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) may not specifically address Alabama Medicaid's Transformation Waiver Demonstration, but it may affect the clinical behaviors and choices of physicians and actions of care networks in unpredictable ways that affect Alabama's RCO beneficiaries and thereby contaminate the results of an evaluation of RCO impact. This may particularly be true due to changes in mental health treatment rules.

Another example of ongoing state quality care improvement activities is the work of the Alabama Chapter of the American Academy of Pediatrics (AAP) and their creation of the Alabama Child Health Improvement Alliance which has conducted physician QI programs on topics including: developmental screening, obesity, and Human papillomavirus (HPV) prevention (Alabama Chapter-American Academy of Pediatrics, n.d.). Participating AAP physicians are likely also treating pediatric RCO beneficiaries.

Because state-level health policy changes will likely take effect during the Alabama Medicaid Transformation demonstration, the evaluation team will keep a close track of these changes and add additional research questions and analytic methods as needed to assess the potential effect of these changes. When appropriate, the evaluation team will address these effects through qualitative data collection and analysis.

The evaluators will be able to identify RCO beneficiaries enrolled in Patient 1<sup>st</sup>, a primary care case management (PCCM) program that links Alabama Medicaid Beneficiaries with Primary Medical Providers (PMPs). Patient 1<sup>st</sup> will roll into the RCO structure as each RCO beneficiary

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<sup>6</sup> E.g., unequal variances, an occurrence frequently encountered when using administrative data.

will receive a PMP. Evaluators will be able to identify RCO beneficiaries who are currently in Alabama's Health Home program. The Health Home program offers additional supportive care coordination to Patient 1<sup>st</sup> Primary Medical Providers (PMP) for patients who have or are at risk of having certain chronic conditions such as: asthma, cancer, diabetes, HIV, COPD, mental health conditions, substance abuse disorders, transplants, sickle cell, overweight & obesity, heart disease, and Hepatitis C (Alabama Medicaid Agency, n.d.). The Health Home program will be fully incorporated into the RCO case management operations. It is important to identify this population of RCO beneficiaries because they were already receiving case management, and their outcomes may not be representative of all RCO beneficiaries.

Additional limitations could include:

- Home address and telephone numbers for some consumers may be incorrect, making it difficult to administer RCO beneficiary surveys.
- Varying levels of health literacy and low response rates may also affect the administration of RCO beneficiary surveys.
- IRHR evaluators must also consider that health care providers tend to have low survey response rates.
- There is no direct comparison group for the new Alabama RCO beneficiary sample, making empirical and consistent measures difficult to achieve for certain outcomes. Therefore, there will be instances that require personal perception as a measure. Additionally, a comparison of all health care use and quality outcomes data is unfeasible due to the existence of fifty Medicaid programs, each with their own requirements, waivers and plans and limited publicly available data.
- Comparability will be limited because the comparison data is from different sources and different states instead of a controlled environment with the same purpose of origin. Outcome measures will be carefully selected, but this limitation must be considered when interpreting results.
- Although the evaluation team will access and compile the data as soon as possible, there may be circumstances in which data is not available to IRHR in a timely manner. The evaluators will always use the most recent complete data available.

Although Alabama's Medicaid population is not directly generalizable to other states or the nation, the Alabama Medicaid innovation will affect one of the nation's largest population of individuals afflicted by poverty and chronic illness. The information gathered regarding quality of health care, delivery success and lessons learned from this transformation will be of significant value to other states managing the health care of our nations' most vulnerable populations.

### 3. REPORTING

The Institute for Rural Health Research (IRHR) will prepare a draft evaluation within 120 days of CMS waiver acceptance and a final design for Alabama Medicaid to submit within 60 days of receiving CMS' comments. The evaluation reports will be given to Alabama Medicaid to submit with each of their quarterly and annual progress reports. To ensure Alabama Medicaid is equipped to submit a demonstration extension if they so choose, an interim evaluation report will be produced more than one year prior to the waiver's expiration date. The schedule of deliverables will align with the waiver guidelines of the terms and conditions and will adapt as needed due to changes in RCO initiation and beneficiary enrollment.

Schedule of Evaluation Products for the Alabama Medicaid Transformation Waiver	
Product	Date
Alabama Medicaid Transformation Evaluation Design	
Alabama Medicaid submits Evaluation Design to CMS.	Within 120 days of April 7, 2016 (August 4, 2016)
Alabama Medicaid submits Final Evaluation Design including CMS feedback to CMS.	Within 60 days of receipt of CMS feedback (September 29, 2016)
Alabama Medicaid posts the approved Final Evaluation Design on the state Medicaid website.	Within 30 days of CMS approval of final plan
IRHR evaluation team will identify training opportunities over the next year that may enhance our evaluation skills specific to the Medicaid Waiver population or allow for networking with other Medicaid 1115a evaluators.	January 31, 2017
Anticipated start date for Alabama Medicaid Transformation Waiver.	April 1, 2017
Anticipated enrollment date for RCO beneficiaries.	October 1, 2017
Anticipated RCO health care coverage start date.	October 1, 2017
Monthly RCO beneficiary administrative data transfer to IRHR.	November 1, 2017, and ongoing throughout the time of the waiver
Key informant interview recruitment begins.	March 2018 and every six months thereafter for the remainder of the waiver

Begin survey recruitment	October 1, 2018 and quarterly thereafter for the remainder of the waiver.
Alabama Medicaid Transformation Evaluation Reports	
Quarterly: Provide Alabama Medicaid with an evaluation progress report to submit with their Quarterly Progress Report	45 days after the last day of the quarter, starting February 14, 2018
Annually: Provide Alabama Medicaid with an evaluation progress annual report to submit with their Draft Annual Report	70 days following the end of each RCO enrollment year, December 10, 2018
Annually: Provide Alabama Medicaid with a final evaluation progress annual report to submit upon receipt of comments from CMS	20 days following the receipt of comments from CMS for each RCO enrollment year
Interim: Provide Alabama Medicaid with an interim evaluation progress report to submit to CMS at least one year prior to the end of the waiver.	3 years and 6 months after the acceptance of the demonstration waiver, April 1, 2017 and October 1, 2020
At the end of the 5 year demonstration: Provide Alabama Medicaid with a draft final evaluation report to submit to CMS	100 days following the end of demonstration year 5, March 31, 2022, and July 8, 2022
At the end of the 5 year demonstration: Provide Alabama Medicaid with a final evaluation report to submit to CMS	45 days following the receipt of CMS' comments, fall 2022

As delineated in the waiver, the evaluators will fully cooperate with CMS and HHS. Submitted written reports will follow the pattern required of the interim evaluation report, including each of the following:

1. *Executive Summary* – Executive summaries will include a reprise of the Alabama Transformation Waiver goals and hypotheses, a review of the most relevant findings regarding these goals and hypotheses, lessons learned and program adaptations to proposed revisions.
2. *Description of the Demonstration* – This will include an up-to-date review of programmatic goals, interventions implemented and the resulting impact of these interventions measured thus far.
3. *Summary of the Evaluation Design* – This section will include a review of the research hypotheses, study design, measures, data sources and employed analyses.

4. *Population Description* – Each report will include a recent summary of RCO beneficiary demographics, any changes in the comparison groups and a description of RCO regions sampled in that quarter or year.
5. *Discussion of Findings* – Quarterly and annual reports will include a discussion of both the most recent and cumulative findings. These findings will be interpreted for meaning and delivered in the policy context of delivering health services to Alabama Medicaid beneficiaries along with future policy implications for health services delivery in Alabama and nationally. This section will also discuss the documented successes, challenges and lessons learned thus far.
6. *Evaluation Plan for Next Period* – This section will include the next steps and populations of the evaluation over the next quarter and year. If an extension period is requested, evaluation modifications will also be discussed here.
7. *New Research Hypotheses and Evaluation Adaption* – This section will detail any adaptations in study design with the approval of new research hypotheses or if CMS requests demonstration waiver modifications.

#### **4. INDEPENDENT EVALUATORS**

##### **Institute for Rural Health Research**

##### **College of Community Health Sciences, The University of Alabama**

The Institute for Rural Health Research (IRHR) was established in 2001 to raise standards of attainable health status and quality of life for rural citizens. The Institute pursues this mission through the combined strength of scientific knowledge, community involvement and informed public policy. IRHR's research efforts are focused on health issues that impact people who live in rural areas. The goal is to produce research that is useful to communities, policymakers and health care providers as they work to improve the availability, accessibility and quality of health care for rural and underserved citizens. IRHR also serves as a resource for researchers, individuals and organizations working to improve the health of rural communities.

IRHR partners with The University of Alabama colleges and schools and rural communities and has participated in federal and state grants totaling more than \$25 million. IRHR's efforts to reduce health disparities in rural communities are exercised through research, clinical trials, screenings and health education that is participatory and mutually beneficial to communities.

IRHR desktop and laptop computers are configured for key personnel to work with large data sets and to conduct advanced research analysis. Their equipment has adequate processing and graphic capabilities. IRHR has its own server that allows for complex study and GIS mapping as well as use of UA's Center for Business and Economic Research, Alabama State Data Center (a U.S. Census Bureau repository) and the Cartographic and Geographical Information Systems Lab.

The IRHR faculty and staff assigned to this project have skill sets in: epidemiology, health policy analysis, advanced statistical methods, large dataset management, survey development and qualitative research.



## **5. APPENDICES**

### **Appendix A: General Research Questions**

RQ1 - Has the overall well-being of Alabama RCO beneficiaries increased compared to previous years for Fee for Service (FFS) beneficiaries of the same population?

RQ2 - Has the cost per year, per person for Medicaid payments to hospitals decreased for Alabama RCO beneficiaries compared to previous years for FFS beneficiaries of the same population?

RQ3 - Has utilization of preventive care services among Alabama RCO beneficiaries increased compared to previous years for FFS beneficiaries of the same population?

RQ4 - Has access to primary care among Alabama RCO beneficiaries increased compared to previous years for FFS beneficiaries of the same population?

RQ5 - Have rates of potentially preventable hospital and emergency department admissions among Alabama RCO beneficiaries decreased compared to previous years for FFS beneficiaries of the same population?

RQ6 - Has the rate of access to preventive care services among Alabama RCO beneficiaries increased compared to previous years for FFS beneficiaries of the same population?

RQ7 - Has the percent of term singleton live births who did not have significant complications during birth or nursery care increased compared to previous years for FFS beneficiaries of the same population?

RQ8 - Has the percent of term singleton live births whose mothers had significant complications during delivery decreased compared to previous years for FFS beneficiaries of the same population?

RQ9 - Has effectiveness in coordinating care under RCOs increased compared to previous years for FFS beneficiaries of the same population?

RQ10 - Has the combination and/or coordination of behavioral and physical health services improved the quality of covered Medicaid services in comparison to FFS delivery system?

## Appendix B: Evaluation Research Goals, Hypotheses, Research Questions, and Measures

The following is a list of project objectives, with corresponding hypotheses and research questions and measures that will be used to answer the questions. “Data Sources” are those datasets which will be used in addition to the Alabama Medicaid Transformation quality incentives and indicators, which are delineated in Appendix C.

### **Objective 1: Addressing fragmentation in the state’s delivery system**

#### *Research Questions –*

- RQ4 - Has the access to primary care among Alabama RCO beneficiaries increased compared to previous years for Fee for Service (FFS) beneficiaries of the same population?

Measures	
Data Source(s)	<ul style="list-style-type: none"><li>• Administrative Claims Data</li><li>• RCO primary care provider to pediatric and adult RCO beneficiary ratio</li><li>• Distance to Primary Care Provider for pediatric and adult RCO beneficiaries, both rural and urban<ul style="list-style-type: none"><li>○ GIS analysis</li></ul></li><li>• Travel time to Primary Care Provider for pediatric and adult RCO beneficiaries, both rural and urban<ul style="list-style-type: none"><li>○ GIS analysis</li></ul></li><li>• Wait Times for Appointments for Primary Care Providers<ul style="list-style-type: none"><li>○ Stratified random sampling of RCO primary care providers</li><li>○ Patient self-report from survey</li><li>○ Provider self-report from survey</li></ul></li><li>• CAHPS Questionnaire Data</li></ul>
Quality Indicator(s)	<ul style="list-style-type: none"><li>• Access to Care/Equitable Health Outcomes<ul style="list-style-type: none"><li>○ M36, M37</li></ul></li></ul>

## **Objective 2: Improved prevention and management of chronic disease**

### *Hypotheses –*

- Hypothesis 1: Integration of physical and behavioral health services will improve quality of covered Medicaid services in comparison to the current Fee for Service (FFS) delivery system.

### *Research Questions –*

- RQ1 - Has the overall well-being of Alabama RCO beneficiaries increased compared to previous years for FFS beneficiaries of the same population?
- RQ3 - Has utilization of preventive care services among Alabama RCO beneficiaries increased compared to previous years for FFS beneficiaries of the same population?
- RQ6 - Has the rate of access to preventive care services among Alabama RCO beneficiaries increased compared to previous years for FFS beneficiaries of the same population?
- RQ10 - Has the combination and/or coordination of behavioral and physical health services improved the quality of covered Medicaid services in comparison to FFS delivery system?

<b>Measures</b>	
Data Source(s)	<ul style="list-style-type: none"><li>• Administrative Claims Data</li><li>• CAHPS Questionnaire Data</li><li>• Patient Self-Report from Survey</li><li>• Provider Self-Report from Survey</li><li>• Key Informant Interviews</li></ul>
Quality Indicator(s)	<ul style="list-style-type: none"><li>• Incentive Measures 1, 2, 3, 7, 8, 9</li><li>• Internal Medicine<ul style="list-style-type: none"><li>○ M1. Comprehensive Diabetes Care</li><li>○ M2. Medication Management for People with Asthma</li><li>○ M3. ER Utilization Rate for Asthma Patients</li><li>○ M4. Breast Cancer Screening</li><li>○ M5. Cervical Cancer Screening</li></ul></li><li>• Pediatrics<ul style="list-style-type: none"><li>○ M6. Childhood Immunization Status</li><li>○ M7. Immunizations for Adolescents</li><li>○ M9. Well-Child Visits in the First 15 Months of Life</li><li>○ M10. Developmental Screening in the First Three Years of Life</li><li>○ M11. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life</li><li>○ M12. Adolescent Well-Care Visits</li></ul></li></ul>

	<ul style="list-style-type: none"> <li>• Oral Health <ul style="list-style-type: none"> <li>○ M16. Total Eligibles Who Received Preventive Dental Services (ages 1-20)</li> </ul> </li> <li>• Chemical Dependency <ul style="list-style-type: none"> <li>○ M22. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</li> <li>○ M23. Identification of Alcohol and Other Drug Services</li> <li>○ M24. Medical Assistance with Smoking and Tobacco Use Cessation</li> <li>○ M25. Assessment and Management of Chronic Pain</li> </ul> </li> <li>• Mental Health/Behavioral Health <ul style="list-style-type: none"> <li>○ M26. Follow-Up Care for Children Prescribed ADHD Medication</li> <li>○ M27. Antidepressant Medication Management</li> <li>○ M30. Screening for Clinical Depression and Follow-Up</li> <li>○ M31. Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment</li> <li>○ M32. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications</li> <li>○ M33. Adherence to Antipsychotic Medications for Individuals with Schizophrenia</li> </ul> </li> <li>• Cardiovascular/Obesity <ul style="list-style-type: none"> <li>○ M34. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</li> <li>○ M35. Adult BMI Assessment</li> </ul> </li> <li>• Patient Safety <ul style="list-style-type: none"> <li>○ M38. Patients who reported that staff “always” explained about medicine before giving it to them</li> <li>○ M39. Patients who reported, “yes”, they were given information about what to do during their recovery at home</li> </ul> </li> </ul>
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### **Objective 3: Improved access to and care coordination of health services**

#### *Hypotheses –*

- Hypothesis 2: Statewide care coordination through RCOs will result in improved health outcomes in comparison to the current FFS delivery system.
- Hypothesis 3: Care coordination through RCOs will result in appropriate utilization of hospital and emergency department services in comparison to utilization under the current FFS delivery system to reduce avoidable hospitalizations.

#### *Research Questions –*

- RQ1 - Has the overall well-being of Alabama RCO beneficiaries increased compared to previous years for Fee for Service (FFS) beneficiaries of the same population?
- RQ5 - Have rates of potentially preventable hospital and emergency department admissions among Alabama RCO beneficiaries decreased compared to previous years for Fee for Service (FFS) beneficiaries of the same population?
- RQ9 - Has effectiveness in coordinating care under RCOs increased compared to previous years for Fee for Service (FFS) beneficiaries of the same population?
- RQ10 - Has the combination and/or coordination of behavioral and physical health services improved the quality of covered Medicaid services in comparison to Fee for Service (FFS) delivery system?

Measures	
Data Source(s)	<ul style="list-style-type: none"><li>• Administrative Claims Data</li><li>• Chronic disease management for people with serious mental illness (specifically diabetes care and blood pressure control)<ul style="list-style-type: none"><li>○ HbA1c testing</li><li>○ HbA1c good control (&lt;8.0%) NQF#2608</li><li>○ HbA1c poor control (&gt;9.0%) NQF#2607</li><li>○ Blood pressure control (&lt;140/90 mm Hg) NQF#2606<ul style="list-style-type: none"><li>▪ This data will come from administrative claims data and RCO interviews.</li></ul></li></ul></li><li>• Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year<ul style="list-style-type: none"><li>○ Specifically for adults aged 18-65 with at least one of the following: Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD), or Asthma NQF#709</li></ul></li><li>• CAHPS Questionnaire Data</li><li>• Patient Self-Report from Survey</li><li>• Provider Self-Report from Survey</li><li>• Key Informant Interviews</li></ul>

Quality Indicator(s)	<ul style="list-style-type: none"> <li>• Incentive Measures 1, 2, 6, 7</li> <li>• Internal Medicine <ul style="list-style-type: none"> <li>○ M1. Comprehensive Diabetes Care</li> <li>○ M2. Medication Management for People with Asthma</li> <li>○ M3. ER Utilization Rates for Asthma Patients</li> </ul> </li> <li>• Inpatient Care <ul style="list-style-type: none"> <li>○ M14. Plan All-Cause Readmission</li> <li>○ M15. Ambulatory Care-Sensitive Condition Admission</li> </ul> </li> <li>• Chemical Dependency <ul style="list-style-type: none"> <li>○ M22. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</li> <li>○ M23. Identification of Alcohol and Other Drug Services</li> </ul> </li> <li>• Mental Health/Behavioral Health <ul style="list-style-type: none"> <li>○ M26. Follow-Up Care for Children Prescribed ADHD Medication</li> <li>○ M27. Antidepressant Medication Management</li> <li>○ M28. Follow-Up After Hospitalization (within 30 days)(behavioral health-related primary diagnosis)</li> </ul> </li> </ul> <p>M32. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications</p>
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#### **Objective 4: Improved birth outcomes**

##### *Hypotheses –*

- Hypothesis 2: Statewide care coordination through RCOs will result in improved health outcomes in comparison to the current FFS delivery system.

##### *Research Questions –*

- RQ7 - Has the percent of term singleton live births who did not have significant complications during birth or nursery care increased compared to previous years for FFS beneficiaries of the same population?
- RQ8 - Has the percent of term singleton live births whose mothers had significant complications during delivery decreased compared to previous years for FFS beneficiaries of the same population?

Measures	
Data Source(s)	<ul style="list-style-type: none"> <li>• Healthy Term Newborn, NQF #0716 <ul style="list-style-type: none"> <li>○ Percent of term singleton livebirths (excluding those with diagnoses originating in the fetal period) who DO NOT</li> </ul> </li> </ul>

	<p>have significant complications during birth or the nursery care.</p> <ul style="list-style-type: none"> <li>• Alabama Department of Public Health Morbidity and Mortality Data</li> <li>• Travel Time to OB/GYN care <ul style="list-style-type: none"> <li>○ GIS analysis</li> </ul> </li> <li>• Travel Time to Delivery Site <ul style="list-style-type: none"> <li>○ GIS analysis</li> </ul> </li> </ul>
Quality Indicator(s)	<ul style="list-style-type: none"> <li>• Incentive Measures 4, 5</li> <li>• Inpatient Care <ul style="list-style-type: none"> <li>○ M13. Elective Delivery</li> </ul> </li> <li>• Maternity/Infant Mortality <ul style="list-style-type: none"> <li>○ M18. Prenatal and Postpartum Care</li> <li>○ M19. Frequency of Ongoing Prenatal Care</li> <li>○ M20. Percentage of Live Births Weighing Less than 2,500 grams</li> <li>○ M21. Percentage of Live Births Weighing Less than 1,500 grams</li> </ul> </li> </ul>

### **Objective 5: Health care delivery and financial efficiency**

#### *Hypotheses –*

- Hypothesis 4: RCOs will be more effective in coordinating care compared to the current Fee for Service (FFS) delivery system.

#### *Research Questions –*

- RQ2 - Has the cost per year per person for Medicaid payments to hospitals decreased for Alabama RCO beneficiaries compared to previous years for FFS beneficiaries of the same population?
- RQ5 - Have rates of potentially preventable hospital and emergency department admissions among Alabama RCO beneficiaries decreased compared to previous years for FFS beneficiaries of the same population?
- RQ9 - Has effectiveness in coordinating care under RCOs increased compared to previous years for FFS beneficiaries of the same population?

Measures	
Data Source(s)	<ul style="list-style-type: none"> <li>• Administrative Claims Data</li> <li>• Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year</li> </ul>

	<ul style="list-style-type: none"> <li>○ Specifically for adults aged 18-65 with at least one of the following: Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD), or Asthma NQF#709</li> <li>• Provider Self-Report from Survey</li> <li>• Key Informant Interviews</li> </ul>
Quality Indicator(s)	<ul style="list-style-type: none"> <li>• Inpatient Care               <ul style="list-style-type: none"> <li>○ M14. Plan All-Cause Readmission</li> <li>○ M15. Ambulatory Care-Sensitive Condition Admission</li> </ul> </li> </ul>



## Appendix C: Incentive and Quality Measures

### FY 2017 RCO Incentive Measures

Measure	Age of Measured Population	Composite Measure (Y/N)
1. <i>Comprehensive Diabetes Care: HbA1c Testing</i>	<ul style="list-style-type: none"> <li>• <i>Adults:</i> 18-75 years of age</li> </ul>	N
2. <i>Medication Management for People with Asthma:</i> The percentage of members who remained on an asthma controller medication for at least 75% of the treatment period.	<ul style="list-style-type: none"> <li>• <i>Children:</i> 5-12 years of age</li> <li>• <i>Adolescents:</i> 13-18 years of age</li> <li>• <i>Adults:</i> 19-64 years of age</li> </ul>	N
3. Cervical Cancer Screening	<ul style="list-style-type: none"> <li>• <i>Adults:</i> 21-64 years of age</li> </ul>	N
4. <i>Prenatal and Postpartum Care:</i> 1) Timeliness of Prenatal Care; 2) Postpartum Care	<ul style="list-style-type: none"> <li>• <i>Newborn/Maternity:</i> Less than 1 year of age</li> </ul>	Y
5. Percentage of Live Births Weighing Less Than 2,500 Grams	<ul style="list-style-type: none"> <li>• <i>Newborn/Maternity:</i> Less than 1 year of age</li> </ul>	N
6. Follow-Up After Hospitalization (within 30 days)(BH-related primary diagnosis)	<ul style="list-style-type: none"> <li>• <i>Children:</i> 6-12 years of age</li> <li>• <i>Adolescents:</i> 13-18 years of age</li> <li>• <i>Adults:</i> 19+ years of age</li> </ul>	N
7. <i>Antidepressant Medication Management:</i> 1) Effective Acute Phase Treatment (12 weeks); 2) Effective	<ul style="list-style-type: none"> <li>• <i>Adults:</i> 18+ years of age</li> </ul>	Y
8. <i>Well-Child Visits:</i> Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	<ul style="list-style-type: none"> <li>• <i>Children:</i> 3-6 years of age</li> </ul>	N
9. <i>Well-Child Visits:</i> Adolescent Well-Care Visits	<ul style="list-style-type: none"> <li>• <i>Adolescents:</i> 12-21 years</li> </ul>	N
10. Ambulatory Care-Sensitive Condition Admission	<ul style="list-style-type: none"> <li>• <i>Children:</i> 1-12 years of age</li> <li>• <i>Adolescents:</i> 13-18 years of age</li> <li>• <i>Adults:</i> 19-74 years of age</li> </ul>	N

**Initial RCO Quality Measures Recommended by**

**RCO Quality Assurance Committee and Approved by Alabama Medicaid Agency**

Topic Category	Measure	Description
Internal Medicine	1. Comprehensive Diabetes Care	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing (NQF#0057), HbA1c poor control ([9.0 percent) (NQF#0059), HbA1c control ([8.0 percent) (NQF#0575), HbA1c control ([7.0 percent) for a selected population, eye exam (retinal) performed (NQF#0055), medical attention for nephropathy (NQF#0062), smoking status and cessation advice or treatment.
	2. Medication Management for People with Asthma	The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:  <ol style="list-style-type: none"><li>1. Percentage of members who remained on an asthma controller medication for at least 50 percent of the treatment period.</li><li>2. The percentage of members who remained on an asthma controller medication for at least 75 percent of the treatment period.</li></ol>
	3. ER Utilization Rate for Asthma Patients	ER Utilization rate for Asthma patients (the same metric currently used by PCNAs)
	4. Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer (AQM is 42-69 with two-year look-back period)
	5. Cervical Cancer	Percentage of women 21-64 years of age received one or more Pap tests to screen for cervical cancer.
Pediatrics	6. Childhood Immunization Status	Percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.
	7. Immunizations for Adolescents	The percentage of adolescents 13 years of age who had recommended immunizations by their 13th birthday.

	8. Children's and Adolescents' Access to Primary Care Practitioners	This measure is used to assess the percentage of members 12 months to 24 months, 25 months to 6 years, 7 years to 11 years, and 12 years to 19 years of age who had a visit with a primary care practitioner (PCP). The organization reports four separate percentages for each age stratification and product line (commercial and Medicaid).
	9. Well-Child Visits in the First 15 Months of Life	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported: <ol style="list-style-type: none"> <li>1. No well-child visits</li> <li>2. One well-child visit</li> <li>3. Two well-child visits</li> <li>4. Three well-child visits</li> <li>5. Four well-child visits</li> <li>6. Five well-child visits</li> <li>7. Six or more well-child visits</li> </ol>
	10. Developmental Screening in the First Three Years of Life	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.
	11. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Percentage of members three-six years of age who received one or more well-child visits with a PCP during the measurement year.
	12. Adolescent Well-Care Visits	At least one comprehensive well-care visit with a PCP or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year. The PCP does not have to be assigned to the member.
	13. Elective Delivery	This measure assesses patients with elective vaginal deliveries or elective cesarean greater than or equal to 37 and less than 39 weeks of gestation completed.
Inpatient Care	14. Plan All-Cause Readmission	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: <ol style="list-style-type: none"> <li>1. Count of Index Hospital Stays (IHS) (denominator)</li> <li>2. Count of 30-Day Readmissions (numerator)</li> <li>3. Average Adjusted Probability of Readmission</li> <li>4. Observed Readmission (numerator/denominator)</li> <li>5. Total Variance</li> </ol>

	15. Ambulatory Care-Sensitive Condition Admission	Ambulatory care sensitive conditions: Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years.
Oral Health	16. Total Eligibles Who Received Dental Services (ages 1-20)	The total unduplicated number of children receiving dental preventive services
	17. Rate of Dental Procedures Performed in Surgical Units	Rate of inpatient claims with dental procedures performed in the hospital. Limit the population to only children younger than 19, with the denominator to be total population
Maternity/ Infant Mortality	18. Prenatal and Postpartum Care	<p>The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:</p> <ol style="list-style-type: none"> <li>1. Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.</li> <li>2. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.</li> </ol>
	19. Frequency of Ongoing Prenatal Care	<p>Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected visits:</p> <ol style="list-style-type: none"> <li>1. Less than 21 percent of expected visits</li> <li>2. 21-40 percent of expected visits</li> <li>3. 41-60 percent of expected visits</li> <li>4. 61-80 percent of expected visits</li> <li>5. Greater than or equal to 81 percent of expected visits.</li> </ol>
	20. Percentage of Live Births Weighing Less Than 2,500 Grams	The percentage of births with birth weight less than 2,500 grams.
	21. Percentage of Live Births Weighing Less Than 1,500 Grams	The percentage of births with birth weight less than 1,500 grams.
Chemical Dependency	22. Initiation of Alcohol and Other Dependence Treatment	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following:

		<ol style="list-style-type: none"> <li>1. Initiation of AOD Treatment: The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.</li> <li>2. Engagement o AOD Treatment: The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.</li> </ol>
	23. Identification of Alcohol and Other Drug Services	The number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year: Any service, inpatient, intensive outpatient or partial hospitalization and outpatient or ED.
	24. Medical Assistance with Smoking and Tobacco Use Cessation	<p>Assesses different facets of providing medical assistance with smoking and tobacco use cessation:</p> <ol style="list-style-type: none"> <li>1. Advising Smokers and Tobacco User to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.</li> <li>2. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.</li> <li>3. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.</li> </ol>
	25. Assessment and Management of Chronic Pain	This measure is used to assess the percentage of patients who are age 16 years and older diagnosed with chronic pain who are screened for chemical dependency before being prescribed opioid medication.
Mental Health/ Behavioral Health	26. Follow-Up Care for Children Prescribed ADHD Medication	<p>The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:</p> <ol style="list-style-type: none"> <li>1. Initiation Phase. The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner</li> </ol>

		<p>with prescribing authority during the 30-day Initiation Phase.</p> <p>2. Continuation and Maintenance (C&amp;M) Phase. The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.</p>
	27. Antidepressant Medication Management	<p>The percentage of members 18 years of age and older who were diagnosed with a new episode of a major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported:</p> <ol style="list-style-type: none"> <li>1. Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).</li> <li>2. Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).</li> </ol>
	28. Follow-Up After Hospitalization (within 30 days) (behavioral health-related primary diagnosis)	<p>This measure assess the percentage of discharges for members 6 years of age or older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.</p> <p><i>Rate:</i> The percentage of members who received follow-up within 30 days of discharge.</p>
	29. Mental Illness: Risk-adjusted rate of readmission following discharge for a mental illness	<p>This measure is used to assess the risk-adjusted rate of readmission following discharge for individuals 15 years or older. A case is counted as a readmission if it is for a selected mental illness diagnosis and if it occurs within 30 days of the index episode of inpatient care. An episode of care refers to all contiguous hospitalizations and same-day surgery visits in general hospitals.</p>
	30. Screening for Clinical Depression	<p>Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented. Follow up: Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score greater than 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing</p>

		depression who current PHQ-9 score indicates a need for treatment.
	31. Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Percentage of patient visits for those patients aged 6 years through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.
	32. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotics	The percentage of individuals 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed any antipsychotic medication and had a diabetes screening during the measurement year.
	33. Adherence to Antipsychotic Medications for Individuals With Schizophrenia	This measure is used to assess the percentage of members 19 to 64 years of age with schizophrenia during the measurement year who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.
Cardiovascular /Obesity	34. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Percentage of children 3-17 years of age who had an outpatient visit with a PCP or an OB/GYN and who had evidence of: <ul style="list-style-type: none"> <li>1. Body mass index (BMI) percentile documentation</li> <li>2. Counseling for nutrition</li> <li>3. Counseling for physical activity during the measurement year</li> </ul>
	35. Adult BMI Assessment	Percentage of adults 18 years old or older with valid BMI documentation in the past 24 months.
Access to Care/ Equitable Health Outcomes	36. Ambulatory Care, ED Visits	This measure summarizes the utilization of Emergency Department (ED) visits for the Medicaid population. Numerator is the number of ED visits; Denominator is the eligible population. Reported as an ED rate.
	37. Adults' Access to Preventive/Ambulatory Services (all ages)	This measure is used to assess the percentage of members 20 to 40 years, 45 to 64 years, and 65 years and older who had an ambulatory or preventative care visit. The organization reports three separate percentages for each age stratification and product line (commercial, Medicaid, and Medicare) and a total rate.
Patient Safety	38. Patients who reported that staff "always" explained about medicine before giving it to them	Patients who reported that staff "Always" explained about medicine before giving it to them. This is a standardized question from HCAHPS.
	39. Patients who reported that staff "always" explained about medicine before giving it to them	Patients who reported that YES, they were given information about what to do during their recovery at home. This is a standardized question from HCAHPS.

Transition of Care	40. Care Transition: Transition record transmitted to health care professional	Care transitions: percentages of patients, regardless of age, discharged from and inpatient facility to home or any other site of care, for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.
Care Coordination	41. HBIPS-6: Post-discharge continuing care plan created	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a post-discharge continuing care plan created.
	42. HBIPS-7: Post-discharge continuing care plan transmitted to next level of care provider upon discharge	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a complete post-discharge continuing care plan, all the components of which are transmitted to the next level of care provider upon discharge.



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STEPHANIE MCGEE AZAR  
Commissioner

November 28, 2016

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Health & Elder Services  
Division Director  
Poarch Band Indian Health Department  
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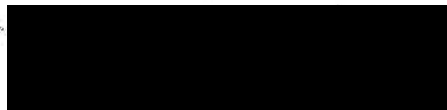
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Dear Ms. Jackson,

As directed by the Tribal Consultation Section 1902(a)(73) of the Social Security Act and Federal Regulation, this notice to the Tribal Government is hereby given to notify the tribe of an amendment to the CMS approved 1115 Waiver Project Number (11-W-00289/5). The amendment will change the implementation date of the RCO to October 1, 2017.

The purpose of this notification is to allow you the opportunity to provide comments and/or relay any concerns that you may have in relationship to the tribe. Native Americans will be given the option of opting in to this program. Please provide a written response regarding any such comments/concerns within 30 days from the date of this letter via certified mail or e-mail to [jerri.jackson@medicaid.alabama.gov](mailto:jerri.jackson@medicaid.alabama.gov).

Jerri R. Jackson



Director  
Managed Care Division