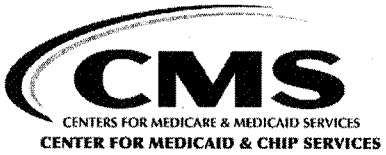
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850



State Demonstrations Group

JUL 12 2016

Stephanie McGree Azar
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, AL 36103-5624

Dear Ms. Azar:

The Centers for Medicare & Medicaid Services (CMS) is approving Attachment B, the Integrated Provider System (IPS) Protocols, to Alabama's Medicaid Transformation (Project Number 11-W-00299/4) demonstration Special Terms and Conditions (STCs). The demonstration was approved on February 9, 2016, under the authority of section 1115(a) of the Social Security Act (the Act). This approval does not alter any of the requirements specified in the STCs of the demonstration. A copy of the STCs which includes Attachment B, the Integrated Provider System (IPS) Protocols, are enclosed.

If you have any questions or concerns regarding this approval letter, please do not hesitate to contact your project officer for Ms. Erica Dimes. She is available to answer any questions concerning your section 1115 demonstration. Ms. Dimes' contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-5913
Facsimile: (410) 786-5882
E-mail: Erica.Dimes@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Dimes and to Ms. Jackie Glaze, Associate Regional Administrator in our Atlanta Regional Office. Ms. Glaze's contact information is as follows:

Centers for Medicare & Medicaid Services
Atlanta Federal Center
61 Forsyth Street, SW
Suite 4T20
Atlanta, GA 30303-8909
Telephone: (404) 562-7417
Email: Jackie.Glaze@cms.hhs.gov

We look forward to continuing to work with your staff on the administration of this demonstration.

Sincerely,

[redacted]

Kim Howell
Director
Division of State Demonstrations and Waivers

Enclosures

cc: Jackie Glaze, Associate Regional Administrator, Atlanta CMS Regional Office

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: **11-W-00299/4**

TITLE: **Alabama Medicaid Transformation**

AWARDEE: **Alabama Medicaid Agency**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration, April 1, 2016 through March 31, 2021, be regarded as expenditures under the state's title XIX plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Alabama (state) to operate its section 1115 Medicaid demonstration. These expenditure authorities promote the objectives of title XIX in the following ways:

1. Increase access to stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income individuals in the state;
2. Improve health outcomes for Medicaid and other low-income populations in the state; and
3. Increase efficiency and quality of care through initiatives to transform service delivery networks.

1. **Expenditures for Designated State Health Programs (DSHP).** Expenditures for the approved DSHP specified in and subject to the conditions in section XII and Attachment B of the STCs, not to exceed the amounts specified in the STC 73. This expenditure authority will not be renewed or extended after March 31, 2021.

2. **Expenditures for Transition Pool Payments to Providers.** Expenditures are limited to the amounts specified in STC 78 for incentive payments to providers, including Regional Care Organizations (RCOs). These Payments will provide additional support for providers and during DY1-DY3 as the state transitions to a risk-based capitated managed care delivery system. RCOs and providers must meet the requirements stated in section XIII to receive transition pool payments.

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER LIST

NUMBER: **11-W-00299/4**

TITLE: **Alabama Medicaid Transformation**

AWARDEE: **Alabama Medicaid Agency**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in the accompanying expenditures authorities, shall apply to the demonstration project effective from April 1, 2016 through March 31, 2021. In addition, these waivers may only be implemented consistent with the approve Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs for the Alabama Medicaid section 1115 demonstration.

Title XIX Waiver Authority

Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable Alabama to limit beneficiary choice of providers for beneficiaries enrolled in a Regional Care Organization (RCO) under the demonstration after October 1, 2016 to those providers that are within the RCO network. This does not authorize restricting freedom of choice of family planning providers.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W00299/4**

TITLE: **Alabama Medicaid Transformation**

AWARDEE: **Alabama Medicaid Agency**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the new five-year Alabama Medicaid Transformation section 1115(a) Medicaid demonstration (hereinafter referred to as "demonstration"). To facilitate this demonstration, the Centers for Medicare & Medicaid Services (CMS) has, approved waivers of certain requirements under section 1902(a) of the Social Security Act (the Act), and expenditure authority providing federal matching of certain demonstration costs not otherwise matchable. These waivers and expenditure authorities are separately enumerated. These STCs set forth in detail the operation of the demonstration, including the nature, character and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The demonstration will be statewide and is approved through March 31, 2021. Mandatory enrollment into Regional Care Organizations (RCOs) on a geographic basis will begin on October 1, 2016 for affected populations.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility
V. Benefits
VI. Delivery System
VII. General Reporting Requirements
VIII. General Financial Requirements
IX. Budget Neutrality Determination
X. Evaluation
XI. Health Information Technology
XII. Designated State Health Programs (DSHP)
XIII. Transition Pool Expenditures
XIV. T-MSIS Requirements
XV. Schedule of Deliverables

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

A: Reimbursement and Claiming Protocol for Alabama Designated State Health Programs (DSHP)
Attachment B: Integrated Provider System Program Protocol [RESERVED]

II. PROGRAM DESCRIPTION AND OBJECTIVES

Alabama will use this demonstration to transition from its current fee-for-service (FFS) delivery system to statewide managed care through risk-bearing, provider-based regional care organizations (RCOs). Additionally, under the demonstration, the state will make payments to providers and RCOs that will assist in the transition to new payment methodologies which the state anticipates will create incentives for the efficient use of resources. The RCOs will operate in five distinct regions of the state and affected populations will be assigned to an RCO based on geographic location. All RCOs will complete financial solvency and network adequacy requirements to become fully risk-bearing in demonstration year 1. The goals of the demonstration are to use the RCO delivery system to further the objectives of title XIX by:

- 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.

Authority for supplemental payments to RCOs and providers extends through the end of demonstration year 3. The purpose of the payments is to support the transition to capitated risk-based RCOs and improved care delivery through integrated provider systems. In addition, under the demonstration, expenditure authority will provide federal matching funding for specified state healthcare programs and activities to assist the state in the transition to a reformed Medicaid health care delivery system.

III. GENERAL PROGRAM REQUIREMENTS

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

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

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. The state must accept the changes in writing within 30 calendar days of receipt.

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

a. To the extent that a change in federal law, regulation or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such a change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

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

5. State Plan Amendments. The state will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state Plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

6. Changes Subject to the Amendment Process. Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, and budget neutrality must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. 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;

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;

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

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

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

8. Extension of the Demonstration. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of STC 9.

a. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR section 431.412 and the public notice and tribal consultation requirements outlined in STC 17.

b. Upon application from the state, CMS reserves the right to temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.

9. Compliance with Transparency Requirements 42 C.F.R section 431.412: As part of any demonstration extension requests the state must provide documentation of compliance with transparency requirements 42 C.F.R sections 431, 412, and the public notice and tribal consultation requirements outlined in STC 17 as well as include the following supporting documentation:

a. Demonstration Summary and Objectives. The state must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met.
b. Quality. The state must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and state quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.
c. Compliance with the Budget Neutrality Cap. The state must provide financial data (as set forth in the current STCs) demonstrating that the state has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.
d. Interim Evaluation Report. The state must provide an evaluation report reflecting the hypotheses being tested and any results available.

10. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft plan to CMS. To be assured of approval, if the phase-out of the demonstration will be accompanied by the termination of

coverage, the state must submit the notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with 42 CFR section 431.408. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into the revised plan. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than 14 days after CMS approval of the plan.

b. **Transition and Phase-out Plan Requirements**. The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.

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

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

e. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling beneficiaries.

11. Post Award Forum. Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report associated with the quarter in which the forum was held. The state must also include the summary in its annual report.

12. CMS Right to Terminate or Suspend. CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS must promptly notify the

state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

13. **Finding of Non-Compliance.** The state does not relinquish its rights to administratively and/or judicially challenge CMS' finding that the state materially failed to comply.

14. **Expiring Demonstration Authority.** For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

    a. **Expiration Requirements.** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

    b. **Expiration Procedures.** The state must comply with all notice requirements found in 42 CFR sections 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

    c. **Federal Public Notice.** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

    d. **Federal Financial Participation (FFP).** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of dis-enrolling participants.

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

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

17. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR section 431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration are proposed by the state.

    a. In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR section 431.408(b)(2)).

    b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR section 431.408(b)(3)).

    c. The state must also comply with the Public Notice Procedures set forth in 42 CFR section 447.205 for changes in statewide methods and standards for setting payment rates.

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

IV. ELIGIBILITY

19. **Eligibility Groups Affected By the Demonstration.** This demonstration affects most populations who are eligible under the state plan, unless otherwise excluded as described in STC 20 and those subject to opt-out or opt-in provisions in STC 23 and STC 24. Individuals affected by the demonstration are known as RCO beneficiaries, as they will receive coverage and care coordination through the provider based, risk-bearing RCO. All affected groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs. All Medicaid eligibility standards and methodologies for these eligibility groups remain applicable.

Table 1. Populations Affected By the Demonstration

Eligibility Group/Population	Social Security Act and CFR Citations	Income Level
Parents/caretaker relatives Low-income families	1902(a)(10)(A)(i)(I) and 1931 section 435.110	13 percent of the FPL
Consolidated group for pregnant women 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)	42 CFR section 435.116	141 percent of the FPL
Consolidated group for children <19 Low-income families Qualified children <19 Poverty-level related infants (mandatory/optional) Poverty-level related children 1 – 5 Poverty-level children 6 – 18 Children who would be eligible for AFDC if not institutionalized	42 CFR section 435.118	141 percent of the FPL
Deemed newborns	1902(e)(4) section 435.117	Automatically eligible
Former foster care children up to age 26	1902(a)(10)(A)(i)(IX)	No income test
Transitional Medical Assistance	408(a)(11)(A), 1902(a)(52), 1902(e)(1)(B), 1925, and 1931(c)(2)	No income test
Medicaid extension due to spousal support collections	408(a)(11)(B), 1931(c)(1) Section 35.115(f) – (h)	No income test

Aged, blind or disabled individuals SSI recipients	1902(a)(10)(A)(i)(II) Section 435.120	Automatically eligible if receiving SSI Benefit
Disabled widows and widowers ineligible for SSI due to increase in OASDI (DWB)	1634(b) Section 435.137	SSI standards
Disabled adult children (DAC)	1634(c)	SSI standards
Blind or disabled individuals eligible in 1973	Section 435.133	SSI standards
Individuals ineligible for SSI due to Medicaid prohibited requirements	Section 435.122	SSI standards
Individuals eligible for SSI but for OASDI/COLA increases since 1977	Section 503 of P.L. 94-566 Section 435.135	SSI standards
Individuals who would be eligible for SSI/SSP but for OASDI COLAs in 1972 (closed to new enrollment)	Public Law 92-36 Section 435.134	SSI standards
Early widows/widowers	1634(d) Section 435.138	SSI standards
Individuals eligible as essential spouses in 1973	Section 435.131	SSI standards
Eligibility Groups of Individuals Who May Opt out of RCO Enrollment		
Women who have been screened for breast and cervical cancer under the CDC and Prevention Breast and Cervical Cancer Early Detection Program	1902(a)(10)(A)(ii)(XVIII)	No income test
Child for whom there is in effect a State non-IV E or federal IV-E adoption subsidy agreement	1902(a)(10)(A)(i)(I) 1902(a)(10)(A)(ii)(VIII)	No income test, except xc. non-IV-E must have been Medicaid eligible when adopted

20. Unaffected Populations. The following populations will not be affected by the demonstration and will continue to receive Medicaid benefits through the service delivery system under the approved state plan:

a. Children in foster care
b. Children in the custody of the Department of Youth Services
c. Inmates and people living in Institutions for Mental Diseases (IMDs)
d. Individuals dually eligible for Medicare and Medicaid
e. Aged, blind or disabled individuals receiving only optional state supplements
f. Individuals participating in the Program of All-Inclusive Care for the Elderly (PACE)
g. Individuals receiving long-term skilled nursing care in long-term care facilities
h. Individuals utilizing home- and community-based waiver services
i. Individuals utilizing hospice services
j. Individuals receiving Refugee Medical Assistance
k. Individuals participating in the Plan First Program who only receive family planning services
l. Individuals with other commercial managed care insurance or participating in the Health Insurance Premium Payment (HIPP) program
m. 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)

V. BENEFITS.

21. Individuals affected by this demonstration will receive benefits described in the Alabama State Plan through the RCOs, except for the following services that are excluded in this demonstration and will continue to be provided as indicated in the approved state plan:

a. Children's specialty clinic services
b. Dental services
c. Hearing services
d. Home- and community-based services
e. Home health services
f. Hospice services
g. Intermediate care facility for individuals with intellectual disabilities services
h. Medicaid emergency psychiatric demonstration services
i. Mental illness rehabilitative services if provided by Department of Human Resources (DHR); Department of Youth Services (DYS); or Alabama Department of Rehabilitative Services (ADRS), including Children's Rehabilitation Service (CRS) and Alabama's Early Intervention System (EI).
j. Non-emergency transportation (NET) services that are covered by the Department of Mental Health for clients receiving allowable mental health services at Community Mental Health Clinics
k. Nursing facility and nursing facility ventilator services
l. Organ transplants with the exception of corneal
m. Prescription drugs (NDC codes billed utilizing NCPDP standard transactions)
n. Preventive health education
o. Public health case management services
p. Public health clinic services
q. Public health family planning clinic services
r. School-based services
s. State laboratory services
t. Substance use rehabilitative services
u. Targeted case management services

VI. DELIVERY SYSTEM

The demonstration delivery system is managed care though RCOs. In 2013 and 2014, the state went through a process to grant probationary status to RCOs in each region of the state. Probationary status is given to organizations that meet the initial requirements of having an approved Governing Board of Directors and a Citizen's Advisory Committee. By October 1, 2016, all RCOs will become capitated, risk-bearing managed care plans contingent upon CMS approval of the risk contract and state's completion of appropriate readiness review.

22. Health System Transition. By October 1, 2016, the state will enroll affected individuals in RCOs that provide capitated, risk-based managed care.

a. Transition of State Plan Populations to RCOs
   i) Beneficiaries eligible for RCO enrollment will receive notice no less than 30 days prior to October 1, 2016 that informs them that they are required to enroll in an RCO serving their geographic region by October 1, 2016. If more than one RCO exists in their geographic region, beneficiaries must be able to choose a plan.
   ii) Beneficiaries who receive at least 30 days' notice, but do not choose a plan by October 1, 2016, will be auto-assigned to an RCO. Individuals listed in STC 23 below may opt out of mandatory enrollment into RCOs at any time and receive Medicaid services as otherwise authorized under the approved state plan. Individuals listed in STC 24 must not be auto-assigned, but must be able to choose to opt into RCO enrollment.
   iii) If only one RCO exists in a geographic region, beneficiaries who reside in an urban area will receive at least 30-day notice that they will be passively enrolled into the RCO, unless they opt

out to remain in FFS. Beneficiaries in urban areas in which there is only one RCO must be able to opt back into FFS at any time. Beneficiaries in rural areas in which there is only one RCO must be permitted to choose from at least two physicians or case managers and obtain services from any other provider under the circumstances described on 42 CFR 438.52(b)(2).

23. Individuals Who May Opt Out of Mandatory RCO Enrollment. The state must follow all standard MCO enrollment and disenrollment rules under 42 CFR Part 438. All beneficiaries in the demonstration residing in an urban area must have a choice of at least two RCOs or have the ability to opt-into FFS at any time. The following individuals may opt-out of mandatory enrollment into RCOs at any time and receive Medicaid services through the FFS delivery system:

a. Women who have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program; and
b. Children for whom there is in effect a federal or state adoption subsidy agreement

24. Individuals who may opt-in to RCO enrollment -American Indians/Alaska Natives. Individuals identified as American Indian or Alaska Native (AI/AN) will continue to access Medicaid services as they do now through the fee for service system unless an individual AI/AN chooses to opt into the demonstration and access coverage pursuant to all the terms and conditions of this demonstration.

a. **Access to I/T/Us.** An eligible AI/AN individual, whether enrolled in this demonstration or not, will be able to access covered benefits through any Indian Health Service (IHS), Tribal or urban Indian organization (collectively, I/T/U) facilities funded through the IHS.
b. **Payments to I/T/Us.** Payments to an I/T/U or a health care provider through referral under purchased/referred care services provided to an eligible AI/AN shall not be reduced by the amount of any enrollment fee, premium, or similar charge, or in amount of any deduction, copayment, cost sharing or similar charges. I/T/U facilities are entitled to payment notwithstanding network restrictions pursuant to section 2016 of the Indian Health Care improvement Act (IHCIA).
c. **Notices to AI/ANs.** As part of the application process, applicants will have an opportunity to verify AI/AN status using appropriate verification documents.

25. RCO Governance. The RCOs are required to meet the following criteria:

a. Governance and Organizational Relationships.

i) Governance. RCOs are provider-based community led organizations and will be business entities that are incorporated under Alabama law. The state must approve a Governing Board of Directors for each RCO that includes risk and non-risk bearing participants. The Governing Board will be responsible for establishment and oversight of the RCO's health delivery system. Each RCO will also have a Citizen's Advisory Committee, which will include Medicaid beneficiaries and will advise the RCO on providing more efficient, improved quality care.

ii) Partnerships. The RCOs must establish agreements with the Alabama Department of Mental Health (ADMH) to ensure that each RCO establishes and maintains an adequate network of ADMH certified behavioral health providers to appropriately address the needs of beneficiaries in the demonstration populations who have mental illnesses and substance abuse disorders. The RCO provider network must include ADMH-certified mental health and substance abuse providers.

b. Health Information Technology (HIT). As described in further detail in STC 70, the RCOs are directed to use HIT to link services and core providers across the continuum of care to the greatest extent possible. The RCOs are expected to achieve minimum standards in foundational areas of HIT and to develop their own goals for the transformational areas of HIT use.

26. State plan Delivery System. Services will be available in accordance with the provisions of the approved state plan, from any willing and qualified provider, for individuals who are excluded in STC 20 or who opt out of RCO enrollment under STC 23 or 24. Moreover, services will be available in this manner to all individuals who are not enrolled in an RCO.

27. Compliance with Managed Care Requirements. By October 1, 2016, the health care services under the demonstration will be provided through a managed care delivery system. RCOs must meet all requirements of 42 CFR Part 438 section and section 1903(m) of the Act unless otherwise made not applicable. The managed care organizations will also be responsible for the following:

a. Coordination of health care systems, including pre-established provider networks and payment arrangements;
b. Administrative and clinical systems for utilization review, quality improvement, and patient and provider services. See STC 21 for a full description of benefits under the demonstration.

28. Managed Care Readiness. Assignment into an RCO will only begin when each RCO has been determined by the state and CMS to meet certain readiness and network requirements.

29. Network Adequacy and Access Requirements. The state must ensure that every RCO complies with network adequacy and access requirements sufficient to provide access to covered services to the demonstration population. Before implementation each RCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, specialty, and acute services for the anticipated number of enrollees in the service area. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:

a. The number and types of preventive, primary, specialty, and acute providers available to provide covered services to the demonstration population;
b. The number of providers accepting the new demonstration population; and
c. The geographic location of providers, as shown through GeoAccess or similar software.

30. RCO Contracts. No FFP is available for activities covered under RCO contracts and/or modifications to existing contracts that are subject to 42 CFR Part 438 requirements prior to CMS approval of such contracts and/or contract amendments. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 days to review and approve changes to RCO contracts. If changes to contracts are needed based on CMS approval of initial or amended STCs, the state must submit amended contracts within 60 days of approval of the demonstration documents. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

31. Required Notice for Change in RCO Network. The state must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior) a potential change in the number of RCOs available for choice within an area, or any other changes impacting proposed network adequacy. If at any point, there is only one RCO operating in an urban area, beneficiaries in the urban area must be allowed to opt into the state plan service delivery system. If at any point, there is only one RCO operating in a rural

area, beneficiaries in a rural area must be permitted to choose from at least two physicians or case managers and obtain services from any other provider under the circumstances described on 42 CFR 438.52(b)(2). If at any point after implementation, the state determines via monitoring or other means, that an RCO does not meet network adequacy, the beneficiaries in that RCO will be allowed to receive services through the state plan service delivery system. The state must provide network updates through its regular meetings with CMS and submit regular documentation as requested.

32. Effect of Changes in State or Federal Insurance Laws. The following process shall occur in the event of a change in state or federal insurance laws followed under the demonstration:

a. The state shall notify CMS of any change to an applicable state statute or regulation. If the revised statute or regulation provides less beneficiary protection than the relevant requirement in 42 CFR Part 438, then 42 CFR Part 438 will apply.

b. In the event a change to an applicable federal law or regulation is to take place, or if a new federal law or regulation is to be promulgated that would otherwise impact the RCO delivery system, then the process described in STC 3 applies.

33. Sustainability Plan. Within 90 days of approval, the state must submit a sustainability plan on how it will ensure that no more DSHP funding will be needed to support RCOs after the five-year demonstration period.

34. Transition of Managed Care Authority. The state must transition the managed care authority to a section 1932(a) of the Act state plan amendment (SPA) or 1915(b) waiver by the end of the demonstration (March 31, 2021). The state must submit a draft 1932(a) SPA or 1915(b) waiver application by the end of Demonstration Year (DY) 4 (March 31, 2020).

35. Level of Investment. Annually, CMS will analyze the federal and state investment in Alabama Transformation. The state must provide information (as part of the reporting requirements in section VIII) on total new federal funds claimed as DSHP, as well as federal funds claimed using state funds repurposed as a result of DSHP. Any dollars available from federal match for DSHP, not used for the transition pool, must be spent on capitation payments to RCOs or Medicaid Agency administrative costs. Elements in the analysis will include:

a. New federal funds drawn as match against DSHP programs.
b. Level of funds from the federal match of DSHP that were spent on capitation payments to RCOs and the transition pool.
c. Level of funds from the federal match of DSHP that were spent on Medicaid agency administrative costs (the limit for administrative costs is 10 percent of the DSHP that is not being matched for the Transition Pool).
d. The state must provide an annual assurance that federal match for DSHP is only being used to support the overall delivery system reform under the demonstration, including the transition pool, and is not being used in ways that are not consistent with overall delivery system reform goals.

VII. GENERAL REPORTING REQUIREMENTS

36. General Financial Requirements. The state must comply with all general financial requirements under title XIX outlined in section IX of these STCs.

37. Monthly Monitoring Calls. CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

38. Quarterly Progress Reports. The state will provide quarterly reports to CMS. Quarterly reports are due to CMS 60 days after the end of each quarter.

a. Confirmation that RCOs have met state statutory requirements such as governance and organizational relationships.
b. The state must provide updates on use of Health Information Technology (HIT) and achievement of HIT standards.
c. The state must provide updates on RCO partnerships with other state agencies.
d. The state must provide updates on RCO compliance with managed care rules under 42 CFR Part 438 (network adequacy, readiness, and financial solvency), as well as activities required under the managed care contracts. If there is an issue with network adequacy or access, CMS reserves the right to place the state on a corrective action plan (CAP), including allowing beneficiaries to receive services via FFS until such time the CAP is determined fulfilled.
e. The reports must provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.
f. The state must report on the RCO program enrollment figures for the quarter within the quarterly reports. The state will include enrollment numbers for those individuals who are eligible for RCO coverage, number of RCOs participating, how many individuals opted out of RCO enrollment, how many opted in.
g. Reports on speed of enrollment of RCO eligible individuals, including the average number of days between an eligibility determination and RCO plan enrollment.
h. The state must regularly report how many RCOs are meeting the DSHP quality metrics per STC 76.
i. State must describe any interventions taken for RCOs which are failing to meet performance standards per STC 75.
j. The state must report projected number of beneficiaries served by each RCO for this component of the formula for RCO Pool payments.
k. The state must provide updates on how many applications for Integrated Provider System Transition Pool funding it has received.
l. Level of funds expended on DSHP per STC 74.
m. The state must regularly report how many and what types of providers are meeting the eligibility requirements to participate in the transition pool and how many work plans have met the payment criteria at each payment milestone interval per section XIII of the STCs.
n. The state must provide progress updates on evaluation of the demonstration including baseline data that will be used as a basis for comparison for performance for providers and RCOs.

39. Compliance with Federal Systems Innovation. As Medicaid and CHIP Business Information and Solutions (MACBIS) or other federal systems continue to evolve and incorporate 1115 demonstration reporting and analytics, the state shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.

40. Demonstration Annual Report. The annual report must, at a minimum, include the requirements outlined below. The state will submit the draft annual report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the DY to CMS.

a. All items included in the quarterly report pursuant to STC 38 must be summarized to reflect the operation/activities throughout the DY;
b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration); and
d. RCO performance on the DSHP targets.

41. Final Report. Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

VIII. GENERAL FINANCIAL REQUIREMENTS

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

42. Quarterly Financial Reports. The state will provide quarterly title XIX expenditure reports using Form CMS-64, to separately report total title XIX expenditures for services provided through this demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in Section IX of the STCs.

43. Reporting Expenditures under the Demonstration. The following describes reporting of expenditures subject to the budget neutrality agreement:

a. Tracking Expenditures. In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and state Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the state Medicaid Manual. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary Line 10B, in lieu of Lines 9 or l0C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 44.

b. Cost Settlements. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter

on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

c. Pharmacy Rebates. Pharmacy rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form 64.9 or 64.9P Waiver.

d. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (Section IX of these STCs). The state must complete separate waiver forms for the following:

i) Aged, Blind, and Disabled (ABD)
ii) Breast and Cervical Cancer Treatment Program (BCCTP)
iii) Low Income Families (LIF)
iv) SOBRA Child (This group corresponds to the children listed in the consolidated group for children under age 19 in STC #19.)
v) Transitional Medical Assistance (TMA)
vi) SOBRA Delivery (This group corresponds to the consolidated group for pregnant women listed in STC #19.)
vii) Designated State Health Programs (DSHP)
viii) Transition Pool Expenditures (Pool)

e. Demonstration Years. Demonstration Years will be defined as follows:

Demonstration Year 1 (DY 1)	April 1, 2016 - March 31, 2017
Demonstration Year 2 (DY 2)	April 1, 2017 - March 31, 2018
Demonstration Year 3 (DY 3)	April 1, 2018 - March 31, 2019
Demonstration Year 4 (DY4)	April 1, 2019 - March 31, 2020
Demonstration Year 5 (DY 5)	April 1, 2020 - March 31, 2021

44. Expenditures Subject to the Budget Neutrality Limit. For purposes of this section, the term "expenditures subject to the budget neutrality limit" must include:

a. All demonstration medical assistance expenditures (including those authorized through the Medicaid state plan and through the section 1115 waiver and expenditures authorities).

b. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

45. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name "ADM."

46. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

47. Reporting Member Months. The following describes the reporting of members months for the demonstration populations:

a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 38, the actual number of eligible member months for the demonstration populations defined in STC 19. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

b. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

c. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

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

49. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in section IX:

1. Administrative costs, including those associated with the administration of the demonstration.

2. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance

with the approved state plan.

3. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

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

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

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

c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

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

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

b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. Specifically, the state must obtain approval from CMS of the following: its cost reporting template, the methodology by which it will make payment prior to settlement and timeline for settlement by the state. The state also must describe its process for reviewing cost report data prior to claiming incurred cost to CMS. The state's review process will help to assure that only costs allowed under title XIX (or under section 1115 authority) are certified.

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

d. The state must have permissible sources for the non-federal share of payments, which may include CPEs or permissible IGTs from units of government. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w) of the Act, impermissible intergovernmental transfers from providers, or federal funds received from other federal programs

(unless expressly authorized by federal statute to be used for matching purposes). Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

e. Demonstration providers must receive and retain 100 percent of the paid amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the demonstration providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

52. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

IX. BUDGET NEUTRALITY DETERMINATION

53. Risk. The state will be at risk for the per capita cost (as determined by the method described below for the demonstration populations as defined in STC 19, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

54. Expenditures Excluded From the Budget Neutrality Limit. Regular FFP will continue for costs not subject to the budget neutrality limit including:

a. Allowable administrative expenditures;
b. Disproportionate Share Hospital (DSH) payments; and
c. Pharmacy rebates (see STC 43)

55. Overall Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 58 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the composite federal share, which is defined in STC 57 below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following eligibility groups.

56. Budget Neutrality. The table below shows the without-waiver costs of the demonstration for the purpose of the calculation of the budget neutrality limit. The state's budget neutrality is based on managed care savings from the RCO capitation payments. Risk-bearing RCOs will be incentivized to reduce costs and promote efficiency in care management. The following table reflects the without-

waiver trend rates and per-member per-month (PMPM) expenditures each year of the demonstration. In the event that one or more RCOs' contracts are terminated at any time during the demonstration, the state must submit a corrective action plan to make a PMPM adjustment pursuant to STC 59. The state is required to transition the managed care delivery system to a 1915(b) waiver or section 1932(a) SPA by the end of DY 5, March 31, 2021.

EG	TREND	DY 1- PMPM	DY2- PMPM	DY 3- PMPM	DY4-- PMPM	DY5- PMPM
Aged, Blind, and Disabled (ABD)	4.0%	$965.60	$1,004.22	$1,044.39	$1,086.17	$1,129.62
Breast and Cervical Cancer Treatment Program (BCCTP)	4.0%	$2,780.59	$2,891.81	$3,007.48	$3,127.78	$3,252,89
Low Income Families (LIF)	3.9%	$287.63	$298.85	$310.51	$322.62	$335.20
SOBRA Child	2.82%	$199.60	$205.23	$211.02	$216.97	$223.09
Transitional Medical Assistance (TMA)	0.03%	$218.06	$218.13	$218.20	$218.27	$218.34
SOBRA Delivery	4.30%	$1,281.64	$1,336.75	$1,394.23	$1,454.18	$1,516.71

57. Composite Federal Share Ratios. The composite federal share is the ratio calculated by dividing the sum total of Federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. The composite federal share ratios for this demonstration are based on the expenditures reported under the eligibility groups listed in STC 19. Should the demonstration be terminated prior to the end of the extension approval period, the composite federal share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of composite federal share may be developed and used through the same process or through an alternative mutually agreed upon method.

58. Lifetime Demonstration Budget Neutrality Limit. The lifetime (overall) budget neutrality limit for the demonstration is the sum of the annual budget neutrality limits calculated in STC 55. The federal share of the overall budget neutrality limit (calculated as the product of the overall budget neutrality limit times the composite federal share) represents the maximum amount of FFP that the state may

receive for the demonstration expenditures during the demonstration period reported in accordance with STC 57.

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

60. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	2 percent
DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 5	Cumulative budget neutrality limit plus:	0 percent

61. Exceeding Budget Neutrality. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

X. EVALUATION

62. Submission of Draft Evaluation Design.
The state must submit its final evaluation design for CMS approval, within 120 days of the approval date of the demonstration. At a minimum, the final design must include a discussion of the goals, objectives and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, RCOs, market areas and public expenditures. The design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented.

The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results.

The design must describe the state's process to contract with an independent evaluator, ensuring no conflict of interest.

The design, including the budget and adequacy of approach, to assure the evaluation meets the requirements of STC 64, is subject to CMS approval. The budget and approach must be adequate to support the scale and rigor reflected within STC 64.

63. Cooperation with Federal Evaluators. Should HHS undertake an evaluation of the demonstration or any component of the demonstration, the state shall cooperate fully with CMS or the evaluator selected by HHS. In addition, the state shall submit the required data to HHS or its contractor in a timely manner and at no cost to CMS or the contractor, unless the state incurs a cost in which case CMS will participate in accordance with regular administrative matching rules.

64. Evaluation Design Components. The Evaluation Design shall include the following core components to be approved by CMS:

a. A discussion of the following demonstration hypotheses that will be tested:
   i. Integration of physical and behavioral health services will improve quality of covered Medicaid services in comparison to the current FFS delivery system;
   ii. Statewide care coordination through RCOs will result in improved health outcomes in comparison to the current FFS delivery system;
   iii. 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; and
   iv. RCOs will be more effective in coordinating care in comparison to the current FFS delivery system.

65. Final Evaluation Design and Implementation. CMS shall provide comments on the draft design within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS's

comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports.

66. Interim Evaluation Report. The state must submit an interim evaluation report to CMS as part of any future request to extend the demonstration at least one year prior to the expiration date of the demonstration. The interim evaluation report will discuss evaluation progress and present findings to date including the following:

a. An executive summary;
b. A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;
c. A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;
d. A description of the population included in the evaluation;
e. Final evaluation findings, including a discussion of the findings (interpretation and policy context); and
f. Successes, challenges, and lessons learned.
g. Plans for evaluation activities during the extension period and if changes are requested;
h. Identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions.

67. Final Evaluation Report. The state must submit to CMS a draft of the evaluation final report by 360 days after the end of the demonstration period. The state shall submit the final evaluation report within 60 calendar days after receipt of CMS comments.

68. Public Access. The state shall post the final approved evaluation design on the state Medicaid website within 30 days of approval by CMS.

69. Electronic Submission of Reports. The state shall submit all required plans and reports using the process stipulated by CMS, if applicable.

XI. HEALTH INFORMATION TECHNOLOGY

70. Health Information Technology (HIT). The state will use HIT to link services and core providers across the continuum of care to the greatest extent possible. The state is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

a. The state must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified electronic health record (EHR) technology and the ability to exchange data through the state's health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.

b. The state must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. Federal funding for developing health information exchange (HIE) infrastructure may be available, per state Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers.

XII. Designated State Health Programs (DSHP)

71. DSHP Expenditures. DSHPs are state-funded health care programs serving low-income and uninsured individuals in Alabama that are not otherwise eligible for federal matching funds. Expenditures are claimed in accordance with CMS-approved claiming and documentation protocol specified in Attachment A. The state must comply with the requirements for reporting DSHP expenditures in the protocol in Attachment A in order to draw down DSHP funds for the demonstrations. The state will report all expenditures for DSHP payments to the programs listed above on the forms CMS-64.9 Waiver and/or 64.9P Waiver under the waiver name "DSHP."

72. DSHP. To support the goals of health system transformation, the state may claim FFP for the state programs subject to the annual limits and restrictions described in Table 2 under STC 73 and in Attachment A through March 31, 2021, unless otherwise specified. The state may not request renewal of this authority after March 31, 2021. If CMS determines that the state has not met the operational and quality performance targets described in STC 76 by the end of a demonstration year, CMS will prospectively reduce annual DSHP expenditure authority for the succeeding year by an amount equal to the percent of total DSHP funding for that year as described in Table 4 under STC 76. The state must report data by the end of DY 1 for all of the quality metrics that will be evaluated DY2-DY5 listed in Table 4.

73. Aggregate DSHP Annual Limits – Expenditure authority for DSHP is limited to the total computable amounts in each demonstration year through March 31, 2021 according to Table 2 below.

Table 2. DSHP Annual Limits

Demonstration Year	Time Period	Total Computable Annual Limit
DY 1	04/01/2016-03/31/17	$89,217,000
DY 2	04/01/2017-03/31/2018	$89,217,000
DY 3	04/01/2018-03/31/2019	$67,400,000
DY 4	04/01/2019-03/31/2020	$47,000,000
DY 5	04/01/2020-03/31/2021	$20,000,000

74. Restrictions on DSHP Programs. Approved DSHP for which FFP can be claimed are outlined in in Table 3 below. Attachment A provides a detailed description of each program. The DSHP Total Annual Funding Limit for DY 3 – DY 5 may be claimed from one or more Designated State Health Programs listed in Table 3 up to the approved individual State Program total annual limit outlined for DY 1 and DY 2 in Table 3 below.

Table 3. Annual Funding Limits for Each DSHP

State Program	DY1 Funding Limit	DY 2 Funding Limit	DY 3 – DY 5 Funding Limit
Department of Mental Health—Outpatient Mental Illness	$43,909,000	$43,909,000	The state may claim federal match for any of the Designated State Health Programs in accordance with the Claiming Protocol in Attachment A as long as the total amount does not

Community Programs			exceed the annual limit described in Table 2.
Department of Rehabilitation Services—Treatment of Hemophilia patients not eligible for Medicaid	$ 1,047,000	$1,047,000	
Department of Senior Services—SenioRx Prescription Drug Assistance	$1,803,000	$1,803,000	
Department of Youth Services—Community Diversion Program	$12,289,000	$12,289,000	
Department of Public Health—Disease Prevention and Control Program	$8,915,000	$8,915,000	
Jefferson County Indigent Care Fund Program	$21,254,000	$21,254,000	
Totals	$89,217,000	$89,217,000	$67,400,000

75. Consequences to RCOs for Failing to Fulfill Requirements or Meet Performance Standards.

a. **Statewide quality monitoring and analysis.** The state, working with the RCOs shall monitor statewide RCO performance, trends, and emerging issues within and among RCOs on a monthly basis, and provide reports to CMS on a quarterly basis. The state must report to CMS any RCO issues impacting the RCO's ability to meet the goals of the demonstration, or any negative impacts to enrollee access, quality of care or beneficiary rights in order to meet the requirements in Table 4 in STC 76.

b. **Intervention to improve quality.** Upon identification of performance issues, indications that quality or access goals are being compromised, deficiencies, or issues that affect beneficiary rights or health, the state shall intervene promptly within 30 days of identifying a concern, with CMS' technical assistance, to remediate the identified issue(s) and establish care improvements. Such remediation could include additional analysis of underlying data and gathering supplementary data to identify causes and trends, followed closely by interventions that are targeted to improve outcomes in the problem areas identified.

76. Reduction in DSHP Expenditure for Failure to Meet Targets. The table below describes the quality targets and metrics the RCOs are required to meet for the state to qualify for DSHP funding. The DSHP will be reduced in the prospective demonstration year if the RCOs did not meet the target for the previous year.

Table 4. DSHP Expenditure Reductions for each Demonstration Year

Demonstration Year (DY)	**Quality/Operational Improvement Targets** (measure at the end of DY submitted with annual report)	**Metrics/Reporting Tool**	**Percent Reduction in DSHP Expenditure Authority if State does not meet Quality Improvement Target from the prior DY**
DY 1 April 1, 2016 through March 31, 2017	At least one fully risk-bearing RCO that can accept capitation payments is in each region and state provides data for DSHP quality targets for DY 2-DY 4.	State reports in Annual Report at least one RCO in each region has met readiness requirements, network adequacy, and other requirements with a CMS-approved managed care contract. Data for DSHP quality targets for DY 2 – DY 4 must be submitted with the DY 1 annual report.	N/A
DY 2 April 1, 2017-March 31, 2018	RCOs demonstrate All Patient Refined Diagnostic Related Group (APR-DRG) hospital payment, or similar Alabama Medicaid Agency	State reports in annual report that RCOs have demonstrated that 100% of all hospitals in the RCO networks	10% of $89,217,000 ($8,921,700 is deducted from DSHP limit for

Demonstration Year (DY)	Quality/Operational Improvement Targets (measure at the end of DY submitted with annual report)	Metrics/Reporting Tool	Percent Reduction in DSHP Expenditure Authority if State does not meet Quality Improvement Target from the prior DY
	(AMA) and CMS approved payment methodology, is implemented	are no longer reimbursed on a per diem basis but are reimbursed via an APR-DRG payment or similar AMA and CMS approved payment methodology	DY 2 if DY 1 target is not met)
DY 3 April 1, 2018-March 31, 2019	Increase well-child visits by 7.22 percentage points from the current baseline for children ages 3-6. The state's current baseline is 59.65 percent. Therefore, the data from DY 3 must show that at least 66.87 percent of children ages 3-6 have received one or more well-child visits. Increase well-care visits for adolescents age 12-21 by 4.8 percentage points. The state's current baseline is 40.5 percent. Therefore, the data from DY 3 must show that 45.3 percent of adolescents receive at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner.	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life Adolescent Well-Care Visits	15% of $67,400,000 ($10,110,000 is deducted from DSHP limit for DY 3 if DY 2 target is not met)

Demonstration Year (DY)	**Quality/Operational Improvement Targets** (measure at the end of DY submitted with annual report)	**Metrics/Reporting Tool**	**Percent Reduction in DSHP Expenditure Authority if State does not meet Quality Improvement Target from the prior DY**
DY 4 April 1, 2019- March 31, 2020	Reduce Rate of Ambulatory Care-Sensitive Condition Admissions by 9 percentage points from the current baseline data. For Age 1-12 For Age 13-18; and For Age 19-74 The current baseline is 1,226 per 100,000. Therefore, data from DY 4 must show that the rate is 1,116 per 100,000. Increase percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment by 16 percentage points. The state's current baseline is 64.4 percent. Therefore, the data from DY 4 must show that 80.4 percent of deliveries received a prenatal care visit.	Ambulatory Care-Sensitive Condition Admission Timeliness of Prenatal Visits	20% of $47,000,000 ($9,400,000 is deducted from DSHP limit for DY 4 if DY 3 target is not met)
DY 5 April 1, 2020- March 31, 2021	N/A	N/A	25% of $20,000,000 ($5,000,000 is deducted from DSHP limit for DY 5 if DY 4 target is not met)

XIII. TRANSITION POOL EXPENDITURES

77. Transition Expenditures. In order to support the transition to managed care, the Transition Pool allows federal match for additional payments to RCOs and providers for providing medical services to Medicaid beneficiaries and meeting the reporting, operational, and quality targets described below. The state may claim FFP for the transition pool expenditures in years 1-3 of the demonstration. The Transition Pool contains two components—transition payments to RCOs and transition payments to selected providers. The expenditures shall be subject to the annual limits and restrictions described in this section through DY 3 (March 31, 2019). Expenditures are claimed in accordance with the state reporting requirements in STC 42 subject to CMS approval. The RCOs will receive payment from the state from the Transition Pool for both the RCO and the provider payments. All funds will be distributed each year; there will be no carryover to the next demonstration year.

78. Limits on Allowable Transition Pool Expenditures. The transition pool expenditures are subject to the following annual total computable limits:

Table 5. Aggregate Limit on Pool Expenditures

Demonstration Year	RCO Component: Annual Limit on Expenditures for Transition Pool for RCOs	Integrated Provider System (IPS) Component: Annual Limit on Expenditures for Transition Pool for Selected Providers	Total Annual Limit on Expenditures
DY1 04/01/2016 through 03/31/2017	$50,000,000	$137,500,000	$187,500,000
DY2 04/01/2017 through 03/31/2018	$0	$93,750,000	$93,750,000
DY3 04/01/2018 through 03/31/2019	$0	$46,875,000	$46,875,000
Total	$50,000,000	$278,125,000	$328,125,000

79. RCO Requirements to Receive Payments. To qualify for Transition Pool payments, the RCO must meet the following requirements in DY 1:

a. Execute an RCO contract with AMA that includes the following:
   i) Key staffing and governance;
   ii) Provider services and materials;
   iii) Network adequacy;
   iv) Claims processing and payment;
   v) Solvency and audit;
   vi) Financial;
   vii) Care coordination;
   viii) Quality management;
   ix) Grievances and appeals;

x) Requirements related to enrollees;
xi) Administrative Support;
xii) Technical infrastructure;
xiii) Utilization management;
xiv) Compliance and oversight; and
xv) Demonstrate HIT/data sharing capabilities consistent with the RCO contract;

b. Submit annual budget for RCO startup costs to AMA in the RCO startup cost template; and
c. Submit projected number of beneficiaries served.

80. Methodology for Determining Payment to RCOs: The RCO sub-pool award methodology is based on the projected number of beneficiaries served by each RCO and varies based on the RCO's need for initial start-up support. There are four third party administrators (TPAs) providing back-office services to the 11 RCOs. To account for TPAs partnering with multiple RCOs, the formula distributes the total fixed costs allowed for by the RCO sub-pool across the RCOs being served by these four TPAs, as described in the formula below. Each RCO's award cannot exceed $7.5 million or the RCO-specific estimate submitted to AMA in the RCO Startup Cost Estimate Template – whichever is less. The formula is as follows:

Figure 1. RCO Award Formula

$$\textbf{Formula for RCO Pool Dollar Award to Each RCO} = \left[\frac{\text{Fixed Cost per Common TPA}}{\text{Number of Beneficiaries Served by Common TPA}} + \text{Per Beneficiary Variable Cost Amount} \right] \textbf{X} \text{ Number of RCO Beneficiaries}$$

The formula components in Figure 1 are defined as follows:

a. **Fixed Cost per Common TPA**: A distribution of fixed costs by the number of common TPAs to compensate for TPA shared systems/institutional knowledge and avoid duplication of funding. AMA adjusted the estimated start-up costs provided by the RCOs in the RCO Startup Cost Estimate Template proportionally in each RCO startup cost category based on total RCO pool dollars available. AMA also categorized these costs as fixed and variable costs based on the percentages defined in the table below. Overall, AMA estimates that 54 percent of the RCO startup costs are fixed. The RCOs will submit adjustments to their cost estimates for each of the categories in Figure 3 in 2016.

Figure 2. Fixed Cost per Common TPA Formula

$$\text{Fixed Cost Per Common TPA} = \frac{\text{Total Fixed Cost Dollars Available}}{\text{Number of RCO TPAs Operating in Alabama}}$$

Figure 3. RCO Startup Cost Estimate Fixed and Variable Assumptions

RCO Startup Cost Estimate Category	Fixed Percent	Variable Percent
Administrative Expenses	80%	20%
Enrollee and Provider Support	80%	20%
Financial and Management Information Systems	80%	20%
HIE and IT Systems	80%	20%
Legal and Consulting Services	80%	20%
Medical Management	80%	20%
Policy and Procedure Development	80%	20%
Quality Measures, Reporting, and Data Analytics	80%	20%
Training	0%	100%

b. **Number of Beneficiaries Served by Common TPA**: An allocation of RCO beneficiaries to each of the four TPAs, based on the relationship between the TPA and the RCOs and the Number of RCO Beneficiaries

c. Per Beneficiary Variable Cost Amount: An allocation of variable costs on a per beneficiary basis, based on AMA's categorization of fixed vs. variable costs by RCO startup cost estimate category.

Figure 5. Per Beneficiary Variable Cost Amount Formula

$$\text{Per Beneficiary Variable Cost Amount} = \frac{\text{Total Variable Cost Dollars Available}}{\text{Total Number of Beneficiaries in RCO Program}}$$

d. **Number of RCO Beneficiaries**: An even distribution of the estimated number of Medicaid beneficiaries that will be served October 1, 2016-September 30, 2017 between RCOs in each region (with an even distribution since the first payment will be prior to finalized enrollment numbers)

Figure 6. Number of RCO Beneficiaries Formula

$$\text{Number of RCO Beneficiaries} = \frac{\text{Number of Beneficiaries in Region where RCO Operates}}{\text{Number of RCOs in Region where RCO Operates}}$$

e. **Reallocation Amount**: AMA may award undistributed DY 1 RCO pool dollars at the end of DY1. RCOs that have not reached their maximum RCO pool amount would be eligible for these funds on a per beneficiary basis, as long as they have met the payment milestone for DY 1. The reallocation amount is also subject to a reconciliation process.

Figure 7. Reallocation Amount Formula

$$\text{Reallocation Amount per beneficiary} = \frac{\text{Total RCO Pool Dollars Available} - \text{Total Dollars Distributed in DY}}{\text{Number of beneficiaries within RCOs that have met the DY Payment Milestone and have not Reached Max Award}}$$

Reconciliation Process: AMA may retroactively reconcile RCO pool awards if the actual RCO expenditures are materially less than the RCO pool award. This reconciliation process will occur in DY 1.

Table 6. Schedule of Payments and RCO Milestones

Payment Milestone	Deadline for Demonstrating Achievement	Payment Date
Executed RCO Contract	October 1, 2016	July 1 – November 1, 2016 *(varies based on contract execution)*

81. Structure of the Integrated Provider System (IPS) Component of the Transition Pool Structure. In addition to having authority to make a Transition Pool payment to RCOs for meeting the requisite milestone in DY 1, the state may also make payments to the RCOs for administering payments to qualified providers from DY 1 through DY 3 of the demonstration for achievement of targets. Each qualified provider or group of providers may submit a detailed work plan selecting one or more targets for health care quality improvement, integration and alignment with RCO quality improvement, and cost reduction. The RCOs in each region will be responsible for coordinating provider applications from within their provider network, and putting forward the applications to AMA for scoring and valuation of the provider application. AMA will then make awards to the highest scoring applications within each region. The RCO to which the provider is contracted will then monitor progress of the work plan and report completion to the AMA to qualify for payments at each milestone listed below. The RCO may retain up to 10 percent of the total payment to the provider for administering and monitoring the work plan per the requirements of STC 88. All valuation of provider work plans is subject to audit.

82. Integrated Provider System Eligibility for Payment. The following types of providers that have pending contracts with at least one RCO are eligible to submit a work plan to the RCO to apply for Transition Pool funding and only providers with an executed contract with the RCO will be eligible to receive payments from the Transition Pool funding. RCOs will be responsible for selecting providers and most relevant specialist practice areas pertaining to the program objectives:

a. Hospitals
b. Federally Qualified Health Centers
c. Community Mental Health Centers
d. Primary Medical Providers
e. Specialists
f. Other Providers (to be approved by AMA)

83. Integrated Provider System Application Requirements. First, providers must submit a detailed work plan to the RCO. If the RCO deems that the goals of the work plan are consistent with those goals for at least one of items a.i.a) through d) below, the RCO will apply to AMA for funding on behalf of the provider or group of providers. The state must post on its website for public comment for 30 days all work plans that are submitted to the AMA. As part of the application for funds, RCOs must submit the following to AMA:

a. The Integrated Provider System work plan with the following components
   i. Detailed steps to improve care in one or more of the following areas:

a) Improved prevention and management of chronic disease;
b) Improved access to and care coordination of health services;
c) Improved birth outcomes; or
d) Healthcare delivery system financial efficiency.

ii. Steps to increase electronic information sharing among RCOs, PMPs, specialists, Community Mental Health Centers/Federally Qualified Health Centers, hospitals, and other providers (to be approved by AMA);

iii. Steps to demonstrate joint admission and emergency department discharge and follow-up care planning between hospitals and PMPs;

iv. Steps to develop discharge and transition of care protocols.

b. Inpatient bed needs assessment and ambulatory needs assessment to shift services from inpatient to ambulatory settings (as appropriate);

c. Three and five-year goal statements for achievement of at least one of the outcomes listed above;

d. Demonstrated collaboration with high-volume Medicaid hospitals and providers in region as shown in the integrated provider system work plan;

e. Estimated number of affected Medicaid beneficiaries;

f. Estimated cost of meeting the goals stated in the work plan with a cost-benefit projection;

g. Description of providers included in the work plan; and

h. Proposal for how funds will be distributed to providers.

84. Reporting work plan status to the Alabama Medicaid Agency. RCOs will be required to report on the status of the Integrated Provider System work plan each quarter to qualify for the payment milestones listed in Table 7 below. Quarterly work plan status reports are due two weeks prior to last day of the quarter. Quarterly work plan status report components will be defined by AMA.

85. Methodology for Determining Payment to Participating Providers. Each RCO Region's combined maximum award will be based on a proportionate share of beneficiaries in the region. If the approved applications do not reach a RCO Region's maximum award amount, AMA may allocate that region's remaining funds to other Regions. The maximum award for a single Integrated Provider System plan cannot exceed $20 million or the work plan's budgeted cost, whichever is lower.

Integrated Provider System Award Formula

Integrated Provider System Award = Budgeted Cost * 0.9

Note: The 0.9 in the formula above is a discount to the budgeted cost of each work plan. The purpose of the discount is to require the RCO and/or providers to contribute to the cost of the work plan.

AMA will use the estimated number of RCO beneficiaries in each Region that are projected to be impacted by a Work Plan to evaluate the provider award on a per beneficiary basis through the following formula:

$$\text{Award Per Beneficiary} = \frac{\text{Integrated Provider System Award}}{\text{Number of RCO Beneficiaries in Region Projected to be Impacted by the Work Plan}}$$

The Award per Beneficiary is also used to determine the Maximum Payment Amount for each payment milestone. Forty percent of the total maximum payment award will be paid to the providers upon approval of the work plan while the remaining 60 percent will be distributed only a quarterly basis per the number of quarters that occur over the course of the work plan (the duration of each work plan within the first three years of the demonstration may vary).

AMA may retroactively reconcile Integrated Provider System awards, if the actual number of beneficiaries impacted is materially less than the projected number of beneficiaries impacted.

Table 7. Payment Milestones to Qualify for Award (Payment schedule is based on each individual work plan).

Payment Milestone	Reporting	Payment Date	Maximum Payment Amount (proportion of total award)
Work plan submission and approval	Work plan with budget	Date of award approval	40 percent **x** Award per Beneficiary **x** # of RCO Beneficiaries in Region Projected to be Impacted by the Work Plan
Work Plan Status Report - 1st Quarter end	Work plan status report; submitted two weeks prior to the end of the quarter	Last day of first quarter	60 percent **x** Award per Beneficiary ÷ # Quarters in IPS work plan **x** # of RCO Beneficiaries in Region Projected to be Impacted by the Work Plan
Work Plan Status Report - 2nd Quarter end *Work Plan Status Reporting continues through end of Work Plan*	Work plan status report; submitted two weeks prior to the end of the second quarter	Last day of second quarter	

Last quarter of work plan implementation	Final work plan status report: plan complete submitted two weeks prior to the end of the quarter of the work plan	Last day of quarter	

86. Quality Metrics for Provider Work Plans: Providers will choose from among the RCO quality metrics listed in the RCO contract for tracking as a part of their work plan. RCOs will report to the AMA and CMS on performance of these metrics at the provider level for each provider receiving funding through the Integrated Provider System program for the duration of the demonstration (even after completion of the work plan). RCO's will continuously monitor and evaluate the implementation of provider work plans and if it is determined that the work plan is not likely to result in improved health outcomes, AMA may withdraw approval and further funding of the work plan.

87. RCO Distribution of Funds: While RCOs are the lead applicant for funds, RCOs may only retain up to 10 percent of the funds awarded to providers under the **Integrated Provider System (IPS) Component of the Transition Pool,** to be used for the following purposes:

a. Assurance that the selection of work plans for AMA review are based on appropriate components identified in STC 81;
b. Needs assessment for the specific RCO region (as applicable);
c. Strategy Development and Design for the Approved Integrated Provider System Application to ensure it meets the demonstration objectives;
d. Stakeholder Engagement for each Approved Integrated Provider System Application
e. Project management;
f. Provider training and education on topics related to the work plan; and
g. Beneficiary education and outreach on work plan components

88. **Integrated Provider System Program Protocol.** Within 120 days of approval of the demonstration the state shall submit for CMS approval a protocol describing:

a. The application rating process AMA will use to ensure rigorous analysis in determining which work plans to fund; the process must include an appeals process.
b. The RCO metrics (in Attachment B), organized into the three groups by the work plan topics described in STC 83a, and a description of how AMA will track progress on the metrics for the duration of the demonstration.
c. A conflict of interest policy for use by the RCOs when selecting work plans to submit to the AMA and AMA's review and scoring of the plans. The conflict of interest policy will be designed to protect the integrity of the selection of work plans; at a minimum the policy will provide that the selection of work plans is fair and impartial.

XIV. T-MSIS REQUIREMENTS

On August 23, 2013, a State Medicaid Director Letter entitled, "Transformed Medicaid Statistical Information System (T-MSIS) Data", was released. It states that all states are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program against which the demonstration will be compared.

Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and managed care encounter data, in accordance with requirements in the State Medicaid Manual (SMM) Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR Part 43 Subpart C, and 45 CFR Part 95.

XV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

The state is held to all reporting requirements outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Deliverables	Date	STC Reference
Demonstration Transition and Phase Out Plan	Submission of notification letter and draft phase-out plan due 6 months before the effective date of demonstration's suspension or termination	STC 10
Post Award Public Forum pursuant to 42 CFR section 431.420	Within 6 months after the implementation date of the demonstration and annually thereafter	STC 11
Quarterly Progress Reports	Submission due no later than 60 days following the end of each quarter	STC 38
Draft Annual Reports	Submission due 90 days after the end of each DY	STC 40
Final Annual Reports	Submission due within 30 days of receipt of comments from CMS each DY	STC 40
Final Report	Draft due. 120 days following the end of the demonstration for CMS comments. The final report is due to CMS no later than 120 days after receipt of CMS' comments.	STC 41
Quarterly Financial Reports	With quarterly reports	STC 42
Evaluation Design	Final evaluation design within 120 days of the approval date.	STC 62
Final Evaluation	Draft final report due to CMS 360 days following the end of the demonstration. The state must submit the final evaluation report	STC 67

	within 60 days after receipt of CMS' comments	
DSHP Claiming Protocol	State must report expenditures within two years following the calendar quarter in which the state disburses expenditures for the DSHP.	STC 71

Attachment A
Reimbursement and Claiming Protocol for Alabama Designated State Health Programs (DSHP)

To support the goals of health system transformation, the state may claim federal financial participation (FFP) for the state programs subject to the restrictions described in these special terms and conditions (expiration date: March 31, 2021).

For each DSHP, this protocol specifies the program name, program description and population served.

DSHP Claiming Assurances
The state must assure the following DSHP claiming criteria will be met for each program approved in the Alabama Medicaid Reform 1115 demonstration:

- In reporting cost, the state and providers must adhere to 45 CFR §75 Uniform Administration Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement. Pursuant to 45 CFR §75.302(a) the state must have proper fiscal control and accounting procedures in place to permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of applicable statutes. Costs must be supported by adequate source documentation.
- The state must not supplant funding obligations from other federal sources.
- The state must not duplicate payment for activities that are already being offered or should be provided by other entities, or paid for through other programs.
- The state must comply with federal audits.
- The state must deduct the amount of persons who are not lawfully present.
- The state must deduct any room and board costs.
- The state must deduct the amount of persons who are incarcerated.

PROGRAM GROUP: Department of Mental Health (DMH)
Funding Sources: State General Funds

Program: Outpatient Services for Mentally Ill Individuals

- **Brief Description:** This program provides the following community-based services to individuals with mental illness and intellectual disabilities:
  - Intake evaluation
  - Physician/medical assessment and treatment
  - Diagnostic testing
  - Crisis intervention
  - Individual, family and group counseling
  - Adult intensive day treatment and mental illness child and adolescent day treatment
  - Rehabilitative day program
  - Mental health consultation
  - Adult, child and adolescent substance abuse intensive outpatient services
  - In-home intervention
  - Partial hospitalization and pre-hospitalization screening
  - Basic living skills
  - Family support
  - Assertive community treatment program

- Methadone treatment

- **Population Served:** All individuals in need of qualifying mental health services.

PROGRAM GROUP: Department of Youth Services
Funding Sources: State General Funds

Program: Community Diversion Program

- **Brief Description:** The program provides after-school and day treatment for the rehabilitation of youth as an alternative to the detention of low-risk youth in state-operated institutional facilities. The program integrates rehabilitative, health, and educational services allowing youth otherwise at risk for incarceration to remain within the community.

- **Population Served:** Low risk offenders referred to the Department of Youth Services by the state's juvenile courts.

- **Community Settings:** None of the youth are incarcerated in community settings. The services may be delivered in a provider office or at the youth's place of residence. Youth are either living at home or living independently where the doors are not locked and the youth retain their freedom to leave the premises. They are not in the physical custody of Alabama Department of Youth Services and are not incarcerated.

PROGRAM GROUP: Alabama Department of Public Health (ADPH)
Funding Sources: State General Funds

Program: Disease Prevention and Control (HIV/AIDS, Sexually Transmitted Diseases (STDs), Tuberculosis

- **Brief Description:** The three largest disease prevention and control programs administered by the ADPH are for HIV/AIDS, Sexually Transmitted Diseases (STDs) and Tuberculosis. The ADPH provides screening, diagnostic, education and treatment to reduce the incidence and improve the quality of life for persons with disease.

  Disease Prevention and Control Services, as well as other clinical services are available statewide through the State's network of County Health Departments operated in all 67 Alabama counties. Although administered through separate divisions, services are coordinated when appropriate. ADPH performs various Care Coordination activities that improve patient compliance with plan of care, assist patients with psychosocial needs, increase immunization rates, and decrease emergency room visits.

- **Population Served:** Low income individuals who utilize services in the state's Department of Public Health funded clinics.

Program: Family Planning Program

- **Brief Description:** The Family Planning Program promotes the well-being of families, responsible behavior, and healthy mothers and babies. The aim is to prevent unintended pregnancies and abortion through education and contraceptive services, allowing for the planning and timing of

pregnancies. There are 89 clinics throughout Alabama offering family planning services. The clinics provide a wide range of confidential and professional family planning services to both women and men ages 14 and older.

- **Population Served:** Individuals who utilize state Department of Public Health Clinics

PROGRAM GROUP: Alabama Department of Senior Services
Funding Sources: State General Funds

Program: SenioRx

- **Brief Description:** The SenioRx program provides assistance to senior citizens (55+) with chronic medical conditions who have no prescription insurance coverage and limited financial means to apply for drug assistance programs provided by pharmaceutical manufacturers.

- **Populations Served:** Senior citizens (55+) with chronic medical conditions who have no prescription insurance coverage and limited financial means.

PROGRAM GROUP: Alabama Department of Rehabilitation Services
Funding Sources: State General Funds

Program: Hemophilia Program

- **Brief Description:** Treatment for hemophilia patients not otherwise eligible for Medicaid. In 1975, the Alabama State Legislature passed a law establishing the Alabama Hemophilia Program. Children and adults diagnosed with hemophilia or related bleeding disorders are eligible for services provided through the program. Specifically, the program pays for medical care, clotting factor products, and an array of support services for those who meet certain eligibility requirements. The program is administered by Alabama's Children's Rehabilitation Services (CRS) and partially funded through state and federal Title V Maternal and Child Health Bureau grants for Region IV South.

- **Population Served:** Individuals who are residents of the State of Alabama, and who have a diagnosed bleeding disorder are eligible for services through the Alabama Hemophilia Program.

PROGRAM GROUP: Cooper Green Mercy Health Services (CGMHS)
Funding Sources: Jefferson County Tax Collection

Program: Jefferson County Indigent Care Fund Program

- **Brief Description:** The Indigent care fund applies to counties with populations of 500,000 or more. Currently, Jefferson County is the only county in Alabama meeting this criterion with some 660,000 residents. CGMHS has been the recipient of the majority of these funds. CGMHS is a multi-specialty ambulatory clinic located in Jefferson County, Alabama. The program funds outpatient primary, specialty and urgent care/emergency care, radiology and lab services, pharmacy, behavioral health and physical, occupational and speech therapy.

- **Population Served:** Individuals must be eighteen (18) years of age, residents of the State of Alabama for one year, residents of Jefferson County for thirty (30) days, and have income at or below 200 percent of the federal poverty level (FPL).

ATTACHMENT B
Integrated Provider System Protocols

Integrated Provider System Protocols Table of Contents

A. Integrated Provider System Program Purpose and Objectives

On February 9, 2016, CMS approved Alabama's 1115 demonstration waiver for the implementation of a Regional Care Organization (RCO) program, which aims to improve the delivery of care and health benefits of its beneficiaries by moving from a fee-for-service delivery system to enrollment in managed care under locally-administered provider-based RCOs. The Integrated Provider System (IPS) program approved through the waiver is one of the primary vehicles for statewide delivery system transformation. Like the RCO program, the IPS program is intended to improve care coordination, efficiency of service delivery and beneficiary outcomes. The IPS Protocols supplement the requirements set forth in the Special Terms and Conditions (STCs) from CMS that approved funding for the IPS program for the first three demonstration years (DYs), which run from April 2016 through March 2019.

As set forth in greater detail in the STCs, the intent of the IPS program is to finance the implementation of IPS projects that support at least one of the following demonstration/RCO program objectives:

- Improved prevention and management of chronic disease;
- Improved access to and care coordination of health services;
- Improved birth outcomes; or
- Healthcare delivery system financial efficiency.

More specifically, IPS projects should be designed to support the improvement goals listed below as the Alabama Medicaid Agency's (AMA) continued receipt of demonstration funding is contingent upon meeting these goals. The improvement goals for DY 1 and DY 2 are:

- DY 1: A fully risk-bearing RCO is able to accept capitation payments in each of the five regions of the State.
- DY 2: RCOs have implemented an All Patient Refined Diagnostic Related Group (APR-DRG) hospital payment or similar approved payment methodology.

The following improvement goals for DY 3 and DY 4 can only be achieved by changes in provider care:

- DY 3: Increase well-child visits by 7.22 percentage points from the current baseline of 59.65 percent for children ages 3-6
- DY 3: Increase well-care visits for adolescents age 12-21 by 4.8 percentage points from current baseline of 40.5 percent
- DY 4: Reduce rate of ambulatory care-sensitive condition admissions by 9 percentage points from current baseline of 1,226 per 100,000
- DY 4: Increase percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment by 16.0 percentage points from the current baseline of 64.4 percent

AMA will post information and updates regarding the IPS program to its IPS webpage: http://medicaid.alabama.gov/CONTENT/2.0_Newsroom/2.7.3.9_RCO_IPS.aspx. AMA will also provide targeted communications regarding the IPS program to RCOs through the RCO Portal and to Medicaid providers through provider alerts.

B. Role of RCOs and Providers in IPS Program

RCOs and Medicaid providers will work together throughout the IPS program, from the development of the IPS application through the duration of IPS funding. It is the State's desire that RCOs and participating providers continue to partner to sustain project performance outcomes after IPS funding ends. A participating provider is defined as a contracted provider that will receive payment from an RCO for implementing an IPS project. As described further below, RCOs are the change agents for transformation and will serve as the administrative leads, coordinating entities

and primary points of accountability to AMA for the IPS program. Provider responsibilities include implementing and sustaining the IPS project.

1. **Role of RCOs in IPS Program**

   RCOs are responsible for working with participating providers to develop proposals for IPS work plans/projects that support the goals identified in the STCs. RCOs, as the coordinating entities, will accept and review work plans from providers for proposed IPS work plans/projects and thereafter submit to AMA for consideration IPS work plans/projects on behalf of the providers up to the limits described in Section D. The RCO can choose not to support a provider's IPS work plan if it does not meet AMA's specifications and goals identified in the STCs and/or the provider's IPS work plan is not identified as a priority project to submit to AMA due to the funding limitations described in in Section D. The following table summarizes RCO responsibilities both before and after the IPS project is approved:

Table 1. RCO Responsibilities

Before IPS Project Approval	After IPS Project Approval
• Ensure that IPS applications will support improvements in one or more of the program objective areas identified in the STCs • Ensure IPS applications meet the overall needs of the RCO's region based on needs assessment studies and evaluations • Collaborate with participating providers (and potentially other RCOs) in the development of IPS applications and ensure that each application meets all of AMA-specified requirements • Submit IPS applications to AMA for review and scoring. An RCO must prioritize the IPS applications that it submits to AMA so that the IPS applications' maximum project awards do not sum to more than the total maximum available funding in the RCO's region (see Section D for more information) • Ensure that the RCO's decisions regarding which IPS work plans/projects to forward to AMA are fair and impartial and are made in strict conformance with all conflict of interest requirements (see Section J for more information)	• Work with providers throughout the IPS project to report on the progress of the IPS project and ensure providers are on track to meet milestones and reach measure targets • Distribute IPS payments to participating providers • For selected RCO Quality Measures, calculate and report measure performance at both the individual provider level and in aggregate for all participating providers that are relevant to the measure (e.g., the RCO would not calculate measure performance for hospitals on the timeliness of prenatal visits measure) o For all other selected performance measures (i.e., measures other than RCO Quality Measures), the RCO and providers receiving IPS funding must jointly develop the approach for accurately reporting on the measures at both the individual provider level in aggregate for all participating providers (see Section G for more information) • Provide ongoing budget reporting on IPS project spending, which will be submitted through the quarterly work plan status reports • Host learning collaboratives to share learnings from IPS projects with other relevant RCO network providers, including providers who may not be participating in IPS projects • Serve as the liaison between AMA and participating providers, communicate program policies and requirements and provide feedback to AMA on program elements that may require policy changes

Before IPS Project Approval	After IPS Project Approval
	• Perform beneficiary education and outreach on IPS project components

2. Role of Providers in IPS Program

Providers are primarily responsible for the development and successful implementation and achievement of outcomes for each IPS project. The following table summarizes provider responsibilities both before and after the IPS project is approved:

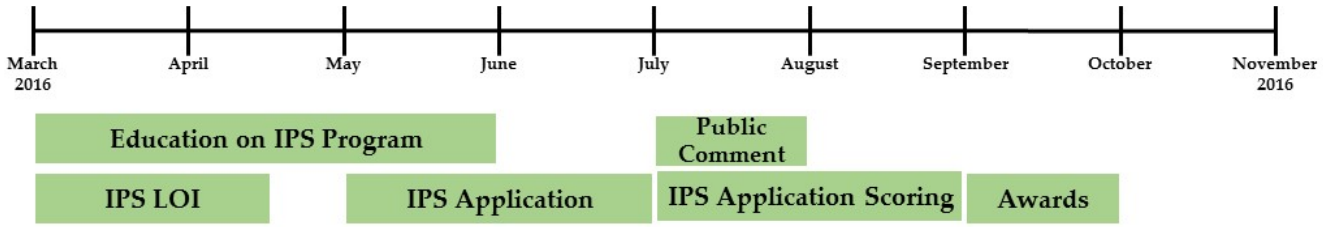
Table 2. Provider Responsibilities

Pre-IPS Project Approval	Post IPS Project Approval
• Propose an IPS work plan to the sponsoring RCO, using the format prescribed by the sponsoring RCO and by the deadline imposed by the sponsoring RCO • Develop and submit an IPS application, including required IPS attestations and other documents, in coordination with the sponsoring RCO; the development of the IPS application is a shared responsibility between the sponsoring RCO and participating providers	• Assure successful implementation and ongoing administration of the IPS project, with administrative support from the sponsoring RCO • For all other selected performance measures (i.e., measures other than RCO Quality Measures), the RCO and providers receiving IPS funding must jointly develop the approach for accurately reporting on the measures at both the individual provider level in aggregate for all participating providers (see Section G for more information) • Develop the mechanisms to assure accurate and timely reporting to the sponsoring RCO through quarterly work plan status reports. This includes but is not limited to: o Progress on selected performance measures o Progress towards achieving project milestones o Barriers o Budget updates • Achieve IPS project milestones and demonstrate progress to continue to receive IPS funding • Share learnings from IPS project interventions, strategies and approaches, identify leading practices and participate in learning collaboratives

C. IPS Program Implementation Milestones in Demonstration Year 1

The following timeline illustrates the major IPS program implementation milestones.

Figure 1. IPS Timeline



The following table provides additional detail regarding IPS program implementation milestones.

Table 3. IPS Timeline and Roles

Timeline Component	Lead	Description
Education on IPS Program	AMA	AMA will host webinars and other meetings with RCOs, providers and stakeholders on topics such as an overview of the IPS program and an overview of how to complete the IPS application. AMA will also respond to stakeholder questions on the IPS program through an email inbox (RCOQuality@alabama.medicaid.gov) and post frequently asked questions. All information about webinars, frequently asked questions and other program information will be available on AMA's IPS webpage.
IPS Letter of Intent (LOI)	RCOs	RCOs must submit an LOI(s) by April 15, 2016, indicating their intention to work with participating providers to develop and submit an IPS application(s).
Provider Submission to RCOs	Providers	Using a format prescribed by the sponsoring RCO and by the deadline imposed by the sponsoring RCO, providers must submit information on their proposed IPS work plan/project to the sponsoring RCO. Providers may contact the RCOs in their region for more information. RCO contact information is available on AMA's IPS webpage.
RCO IPS Application Submission to AMA	RCOs and Providers	Once a sponsoring RCO has received a provider submission, the RCO is responsible for coordinating the provider submissions to develop a complete IPS application, using the IPS application template provided by AMA. Providers are expected to contribute to the development of the complete IPS application.
Public Comment	Interested stakeholders	Interested stakeholders may provide comments on the IPS applications submitted to AMA. AMA will post the IPS applications on its IPS webpage, along with instructions on how to submit comments on the IPS applications.
IPS Application Scoring	AMA, with assistance from independent evaluator	An independent evaluator will perform the initial IPS application scoring, with final review and approval of the scoring by AMA. See Section F for more information on the IPS application scoring process.
Awards	AMA	AMA will distribute IPS initial awards to RCOs based on the approved IPS applications. AMA will distribute subsequent

Timeline Component	Lead	Description
		awards on a quarterly basis based on its review of the quarterly work plan status report submissions.
Work Plan Status Report Submissions	RCOs	RCOs must submit work plan status reports to AMA on a quarterly basis and must work with providers to obtain the information necessary for these status reports. See Section G for more information.
Ongoing Monitoring	AMA/RCOs	AMA and the RCOs will continually monitor the progress and results of the IPS work plans/projects. See Section G for more information on the monitoring process.

D. Maximum IPS Awards by Region

As described in STC 85, each RCO region's combined maximum award will be based on a proportionate share of beneficiaries in the region. The estimated maximum available funding per region is illustrated in Table 4. This allocation by region is subject to change at AMA's discretion. Each RCO must prioritize the applications that it submits to AMA so that the IPS applications' maximum project awards do not sum to more than the total maximum available funding in the RCO's region. For example, an RCO in Region A should not submit IPS applications whose maximum project awards sum to more than $48,943,000.

Table 4. Estimated Available IPS Funding by Region

Region	Estimated Available Funding
A	$ 48,943,000
B	$ 90,045,000
C	$ 24,948,000
D	$ 69,971,000
E	$ 44,218,000
Total	**$ 278,125,000**

E. IPS Application Requirements

As described in Section B above, RCOs will accept and review work plans from providers and thereafter submit IPS applications which the RCO has chosen to sponsor to AMA for consideration on behalf of the providers.

To be eligible to submit an IPS application, RCOs must have met the following criteria:

- A LOI must be submitted by the RCO no later than April 15, 2016, indicating its intention to work with participating providers to develop and submit one or more IPS applications
- A representative of the RCO that will be involved in implementing the IPS project and participating providers must view mandatory IPS-related webinars provided by AMA on 3/10/2016 titled "Overview of IPS Program and Application Process" and on 3/16/2016 titled "Question & Answer Session on IPS Program" (webinar recordings are posted on the AMA IPS webpage)

In addition, IPS applications must meet the following criteria to be reviewed and scored by an independent evaluator and AMA:

- Submitted by close of business July 1, 2016
- Addressed all application elements including submitting a Participating Provider's Letter of Commitment from all of the IPS work plan/project's participating providers (see Exhibit B-2 for the Participating Providers Letter of Commitment)
- Used the IPS application template and instructions provided by AMA (see Exhibit B-1 for the IPS application)

The IPS application includes the following sections:

1. **Cover Letter**

   The Cover Letter section consists of the following elements:

   1.1 Overview (e.g., IPS project name, IPS project duration)
   1.2 Primary RCO contact information
   1.3 Primary participating provider contract information
   1.4 Documents checklist

2. **Executive Overview**

   The Executive Overview section consists of the following elements:

   2.1 A brief executive summary of the IPS project
   2.2 A description of which of the following RCO program objective(s) the IPS project will impact:
   - Improved prevention and management of chronic disease
   - Improved access to and care coordination of health services
   - Improved birth outcomes
   - Healthcare delivery system financial efficiency

   2.3 A description of which of the following Designated State Health Program (DSHP) target measures the IPS project will impact:
   - Increase well-child visits in the third, fourth, fifth and sixth years of life
   - Increase adolescent well-care visits
   - Reduce rate of ambulatory care-sensitive condition admissions
   - Increase percentage of deliveries that receive a prenatal care visit in the first trimester or within 42 days of enrollment

   2.4 An indication of the categories of provider types included in the IPS project
   2.5 If "other providers" are included in the IPS project, a description of those providers
   2.6 A three year goal statement that includes specific goals for the IPS project
   2.7 A five year goal statement what includes specific goals for the IPS project

3. **Beneficiary Impact**

   The Beneficiary Impact section consists of the following elements:

   3.1 The Medicaid target population of the IPS project
   3.2 The specific program interventions and approach, including how beneficiaries will be identified and contacted for participation in the IPS project
   3.3 A description of how the proposed IPS project meets community or health delivery needs; this element must address and consider the findings from the *2015 State of Alabama Community Health*

Assessment[1] developed by the Alabama Department of Public Health and how those needs will be addressed by the IPS project

3.4 A description of how the IPS project will use evidence-based methods and practices to improve outcomes

3.5 The estimated average number of Medicaid beneficiaries for each county affected by the IPS work plan/project. If the IPS project will impact RCO-eligible beneficiaries other than those projected to be enrolled in the sponsoring RCO, those RCO-eligible beneficiaries may be included in the estimated average number of RCO beneficiaries, as long as the IPS project's participating providers attest that they will have a valid contract with the other RCO(s) in the region by the time they receive any IPS funding. Otherwise, the estimated average number of Medicaid beneficiaries should only include beneficiaries projected to be enrolled in the sponsoring RCO.

3.6 The methodology used to calculate the number of estimated RCO beneficiaries in the RCO region affected

3.7 A description of how the estimated number of beneficiaries affected or the number of counties served will change over the five year demonstration period

4. Work Plan

The Work Plan section consists of the following elements:

4.1 The key activities and milestones to be accomplished over the duration of the IPS project and the dates by which each activity and milestone will occur; quarterly IPS payments may be based on the achievement of these milestones

4.2 A description of the degree to which the IPS project can be adopted and applied by other providers and how fast that adoption could occur, as well as the related barriers and accelerators to scaling this IPS project for use by other providers

4.3 A description of how the applicant will identify and disseminate leading practice discoveries and offer shared learning and educational opportunities to other providers to accelerate improvement in care delivery across the region and State

5. Monitoring and Governance

The Monitoring and Governance section consists of the following elements:

5.1 A description of the approach to IPS project governance and oversight

5.2 If applicable to the IPS project, this section should specifically address the development of the following:

- Health information technology (HIT) protocols including how the IPS work plan/project will increase electronic information sharing (including sharing of specific medical and care plan information) for care coordination and treatment planning
- Care coordination protocols that demonstrate coordination between Primary Medical Providers (PMPs), relevant specialists and hospital clinical staff for patients admitted and discharged from hospital inpatient, outpatient and emergency department facilities
- Transition of care protocols to ensure the coordination and continuity of health care for patients as they transfer between different locations or different levels of care, including but not limited to hospitals, sub-acute and post-acute nursing facilities, the patient's home, primary and specialty care offices, and long-term care facilities; protocols should also include

[1] The *2015 State of Alabama Community Health Assessment* is available at the following link: http://www.adph.org/accreditation/assets/CHA2015_Final_RevAugust_R.pdf

development of a comprehensive care plan for patients in transition, which is used to coordinate logistical arrangements, educate the patient and family, and coordinate among health professionals involved in the transition

5.3 A description of how participating providers and beneficiaries will be managed for adherence to the protocols developed as part of the IPS project

6. Provider Collaboration, Participation and Funding Distribution

The Provider Collaboration, Participation and Funding Distribution section consists of the following elements:

6.1 A description of the process by which RCOs conducted outreach and education with participating providers to develop the IPS application and a description of how the collaboration will continue over the duration of the IPS project

6.2 A listing of the participating providers who will participate in the IPS work plan/project. A participating provider is defined as a contracted provider that will receive payment from an RCO for implementing an IPS project. Each provider listed must have an associated Provider Letter of Commitment. The listing must include:

- The names, addresses and National Provider Identification numbers, Medicaid identification numbers, and Tax Identification Numbers of the provider(s) by practice
- The provider and specialty type
- The percentage of the provider's total practice revenue from Medicaid
- The total number of Medicaid beneficiaries currently seen by the provider(s)
- The role of each provider in the IPS project
- The percentage of the total IPS award that will be distributed to each of the provider(s) participating in the IPS project

7. Budget

The Budget section consists of the following elements:

7.1 The total estimated project costs and RCO administrative cost estimates during the IPS project period; the project costs should not include any costs incurred prior to the approval and award of the IPS project

7.2 A description of the roles and responsibilities of the full time equivalents (FTEs) identified in the budget calculation

7.3 A description regarding how the RCO will spend its administrative portion of the IPS award to support the implementation of the IPS project

7.4 Description of how the RCO and/or participating providers will contribute 10 percent, at a minimum, of the total IPS project cost

7.5 If applicable, a detailed listing of capital expenditures included in budget/project cost calculation

8. Return on Investment and Sustainability

The Return on Investment (ROI) and Sustainability section consists of the following elements:

8.1 A simple ROI calculation

8.2 The methodology, assumptions and data sources used in calculating the ROI

8.3 A description of how the IPS project will be sustainable after the IPS work plan/project has been fully implemented. The description should include considerations for how the IPS work plan/project will address the following:

- Cultural assimilation, or the ability to maintain the learnings and approaches from the IPS work plan/project and incorporate them into daily work activities to sustain positive program outcomes beyond the period of IPS funding
- Ongoing performance measurement that supports the objectives of the IPS work plan/project
- Economic continuation, or the ability to staff and finance the level of effort needed to support the continuation of the IPS work plan/project beyond the period of IPS funding
- Organization leadership support, or how the RCO and provider organization(s) involved in the IPS work plan/project will demonstrate a commitment to supporting the benefits of this work plan/project during the IPS funding period and beyond

8.4 A sustainability budget

9. Quality Measures

For all quality measures selected by the RCO and provider IPS applicant to monitor and evaluate the IPS project (i.e., RCO Quality measures, other performance measures), the IPS applicant must develop the measure baseline calculations and identify the measure targets for each demonstration year, as listed in the section elements below. The Quality Measures section consists of the following elements:

9.1 The RCO Quality Measures that will be used to monitor and evaluate the IPS project. The RCO Quality Measures are listed in Exhibit B-3. AMA may evaluate performance on these measures when determining IPS payment over the duration of the IPS project. The IPS applicant must provide:

- The RCO quality measures that will be used to evaluate the IPS work plan/project
- Measure baseline calculations
- How measure baseline was or will be developed
- Measure targets for each demonstration year
- How measures will be monitored over time and how the RCO/IPS management will know that the IPS work plan/project is working
- How the measure performance will be calculated and reported (e.g., by the provider, by the RCO, what data will be used) and how frequently the measure will be reported to AMA

9.2 If applicable, other performance measures that will be used to monitor and evaluate the IPS work plan/project, in addition to the RCO Quality Measures. AMA will evaluate performance on these measures when determining IPS payment over the duration of the IPS work plan/project. The IPS applicant must provide:

- Specifics regarding the measure used, a description of the measure and which of the IPS targeted areas the measure will impact
- Measure baseline calculations
- How measure baseline was or will be developed
- Measure targets for each demonstration year
- How measures will be monitored over time and how the RCO/IPS management will know that the IPS work plan/project is working
- How the measure performance will be calculated and reported (e.g., by the provider, by the RCO, what data will be used) and how frequently the measure will be reported to AMA

9.3 A description of how all quality measures will be communicated to participating providers, beneficiaries and RCO project management.

Table 5 below categorizes measures into four priority levels. Priority levels 1-3 include all 42 RCO Quality Measures and the lowest priority level, level 4, includes all other measures used by the IPS applicant. AMA

will use these priority levels when evaluating IPS applications. Each IPS applicant may propose different measures and measure targets as part of their IPS project, however the measure targets will be subject to AMA approval.

Table 5. Measure Priority Level

Priority Level (1 = Highest Priority)	Measures
Priority Level 1 (Designated State Health Program [DSHP] Funding Accountability Measures)	• Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life • Adolescent Well-Care Visits • Ambulatory Care-Sensitive Condition Admissions • Timeliness of Prenatal Visits
Priority Level 2 (Other RCO Quality Withhold Measures)	• Comprehensive Diabetes Care: HbA1c Testing • Medication Management for People with Asthma • Postpartum Care • Cervical Cancer Screening • Percentage of Live Births Weighing Less Than 2,500 Grams • Antidepressant Medication Management • Follow-Up After Hospitalization (within 30 days) (Behavioral Health-Related Primary Diagnosis)
Priority Level 3 (Other RCO Quality Measures)	An RCO Quality Measure other than those listed in Priority Level 1 and Priority Level 2 above (optional)
Priority Level 4 (Other Measures Proposed by IPS Applications)	To be developed by IPS applicant if additional measures are needed to monitor the performance of the IPS work plan/project (optional)

10. Bonus Points

An IPS application may receive up to 25 bonus points based on the number of low-income uninsured patients impacted by the IPS work plan/project. Low-income is defined as individuals with incomes at or below 138 percent of the Federal poverty level. This section does not need to be completed if the IPS work plan/project does not impact the uninsured population.

11. Existing Grant Information

The IPS applicant must provide a list of any federal grants or funding that the RCO or participating providers currently receive or will receive during the IPS project period which may be duplicative and/or complement the IPS work plan/project.

12. RCO Attestations

12.1 The RCO must certify that the return on investment calculation was calculated using a sound and generally accepted methodology (signed by the RCO's CEO/CFO or an Actuary or Accounting Firm)

12.2 Other attestations

- The RCO must certify that all of the information included in this IPS application is current, true, correct, and complete.
- The RCO must certify that it will fully and timely comply with all applicable terms and conditions set forth in the Transition Pool Terms, a copy of which is attached hereto as Exhibit

B-4. The Transition Pool Terms sets forth the terms and conditions for all expenditures, or proposed expenditures, of IPS funds and is discussed further in Section I.

- The RCO must certify and acknowledge that an award for an IPS work plan/project will cover no more than 90 percent of the IPS work plan/project budget, up to a maximum of $20 million. The RCO and/or participating provider(s) will contribute the remaining funds to implement the IPS work plan/project. The RCO and/or participating provider(s) currently have sufficient funds or resources available to enable them to fund, at a minimum, 10 percent of the IPS work plan/project budget.
- The RCO must certify that it will ensure that the IPS funding it receives will be used to improve quality and beneficiary outcomes by supporting at least one of the demonstration/RCO program objectives.
- The RCO must certify that all decisions related in any way to the IPS application and the IPS work plan/project shall be and have been made in compliance with the conflict of interest requirements contained in Alabama Medicaid Administrative Code Rule 560-X-62-.08 (Conflict of Interest Policy for Directors and Officers of Regional Care Organizations), a copy of which is attached hereto as Exhibit B-5, and in compliance with the RCO's approved conflict of interest policy. Alabama Medicaid Administrative Code Rule 560-x-62.08 provides, in part, for the adoption by each RCO of a conflict of interest policy for directors and officers, including, at a minimum, the requirements set forth in the Rule, and is discussed further in Section J.
- The RCO must certify that members from the RCO, whom will be involved in implementing this IPS work plan/project, have viewed the IPS related webinars provided by AMA on 3/10/2016 titled "Overview of IPS Program and Application Process") and on 3/16/2016 titled "Question & Answer Session on IPS Program," available on AMA's IPS webpage.
- The RCO must certify that the funds the RCO would receive under the IPS project are not duplicative with any federal grants or funding received by participating providers and the RCO.

13. Participating Providers Letters of Commitment

The IPS applicant must provide letters of commitment from participating providers using the template provided by AMA. This template includes the following attestations:

- The participating provider is committed to implementing and supporting the IPS project(s) as described in the IPS application submitted to Alabama Medicaid The participating provider has read and shall comply with all applicable terms of the Alabama Medicaid's Transition Pool Terms, IPS Protocols and other applicable regulations and policies The participating provider understands that the maximum IPS award will cover no more than 90 percent of the approved IPS budget up to a maximum of $20 million. The RCO and/or participating provider(s) will contribute the remaining funds to implement the IPS work plan/project.
- The participating provider will ensure that the IPS funding received will be used to improve quality and beneficiary outcomes by supporting at least one of the demonstration/RCO program objectives
- The participating provider attests that the funds received under this IPS work plan/project are not duplicative to other federal grants or funding received
- The participating provider has viewed the trainings provided by the Alabama Medicaid Agency on 3/10/2016 titled "Overview of IPS Program and Application Process" and on 3/16/2016 titled "Question & Answer Session on IPS Program."

- The participating provider will have a signed and executed contract with the RCO submitting the IPS application and coordinating and monitoring this IPS work plan/project by the time the provider receives IPS funding
- If the IPS project includes Medicaid beneficiaries projected to be enrolled in RCOs other than the sponsoring RCO, the participating provider will have a valid contract(s) with the other RCO(s) in the region by the time the provider receives any IPS funding. The participating provider will also share with the sponsoring RCO all data necessary to calculate performance on quality measures, even if the data are for services the provider provided to Medicaid beneficiaries enrolled in RCOs other than the sponsoring RCO.

14. Letters of Support from Major Stakeholders (optional)

The IPS applicant may provide letters from Alabama provider associations, advocacy groups or other stakeholders indicating support of the IPS work plan/project.

F. IPS Application Scoring

AMA will calculate the final IPS application scores with assistance from an independent evaluator through a contract between AMA and a third party vendor. The independent evaluator will complete the initial review of IPS applications and will ensure that applications include all of the required application elements listed in Section E above. If an application does not include all of the required application components, it will be rejected and the IPS applicant will have no further recourse to appeal the rejection decision.

After the initial review, the independent evaluator will score the application components, using a scoring sheet to be approved by AMA, based on the elements outlined in this Attachment B and the IPS application template, in Exhibit B-1. Each IPS application will be scored out of 200 possible points, with the opportunity to earn up to 25 bonus points. The evaluator will use a panel of two or more reviewers who will each independently review each IPS application. The panel will include individuals with clinical or clinical performance improvement and financial experience. Individual reviewers must declare that they have no conflict of interest before reviewing each application. Individual reviewers will evaluate each IPS application for the following considerations:

1. Validate that all sections of the IPS application were completed
2. Analyze the IPS project rationale/business case and work plan including roles and responsibilities of the RCO and providers
3. Analyze the IPS project's potential to impact RCO program objectives
4. Assess feasibility of three and five year project goals and projections for speed, scope and ability to scale the IPS project for adoption by other similar providers
5. Analyze the proposed IPS and RCO performance measures to assess if they are appropriate to evaluate ongoing progress to meet stated goals
6. Analyze geographic reach and impact on beneficiaries to determine the magnitude of the projects' potential to impact RCO program objectives
7. Analyze IPS project supporting documentation to ascertain the degree to which the project proposes to use evidence-based practices or seeks to develop evidence-based practices
8. Analyze the degree to which the project addresses needs identified in the community or healthy delivery needs assessment
9. Determine the reasonableness of the IPS project budget
10. Determine the reasonableness of the IPS project's ROI estimate, including projections of potential savings and ROI assumptions

11. Determine the reasonableness of the IPS project sustainability plan

Once all independent reviews of an application have been completed, the panel of reviewers together will calibrate scores to arrive at an overall application score. The panel will then rank each IPS application in order of highest score to lowest score overall, by RCO program objective, and by RCO region. The panel will also document areas that may require further clarification before AMA makes a funding decision and recommend changes in IPS project approach or measurement.

Table 6 below summarizes the maximum points associated with each application component. Scoring will be based on the quality of the responses to each application component.

Table 6. Summary of Scored IPS Application Components and Associated Points

Components	Points Possible
Section 1: Cover Letter	NA
Section 2: Executive Overview	Up to 10 Points
Section 3: Beneficiary Impact	Up to 50 Points
Section 4: Work Plan	Up to 15 Points
Section 5: Monitoring and Governance	Up to 15 Points
Section 6: Participating Providers	Up to 15 Points
Section 7: Budget	Up to 20 Points
Section 8: ROI and Sustainability	Up to 50 Points
Section 9: Quality Measures	Up to 25 Points
Section 11: Existing Grants	NA
Section 12: Attestations	NA
Other Materials Submitted (e.g., provider letter of commitment and Letters of Support from Major Stakeholders)	NA
Total	**Up to 200 Points**
Section 10: Bonus Points	Up to 25 Points

After the panel scores each IPS application, the independent evaluator will provide AMA with its scoring materials and recommendations for IPS projects to fund. The independent evaluator will participate in AMA funding allocation decisions considering the available pool of IPS funding, by demonstration year and by RCO region. AMA will make the final IPS award decisions based on the recommendations of the independent evaluator and its determination of which IPS projects are in the best interest of the program. AMA reserves the right to have additional discussions with an IPS applicant that is recommended for funding by the independent evaluator. AMA may adjust the IPS award amount from the amount requested by the IPS application to ensure funding for an appropriate mix of IPS projects in each RCO region and across the State.

In accordance with STC 83, redacted IPS applications will be posted on AMA's IPS webpage for 30 days following the IPS application deadline. As stated in the IPS application, RCOs and participating providers may submit a separate redacted version of the IPS application with redacted information which is claimed to be proprietary or trade secrets in the application. However, the RCOs and participating providers acknowledge and agree that any material submitted to AMA could be required to be released if it is determined under the Alabama Open Records Act to not qualify as confidential information.

AMA will notify IPS applicants in writing regarding awards for each IPS application and will post a listing of all IPS awards on AMA's IPS webpage. In accordance with STC 85, each IPS award will be no greater than 90 percent of the

approved IPS project budgeted cost up to a maximum of $20 million (and may be less than 90 percent of the approved IPS project budgeted cost based on available IPS funding).

G. Performance Measurement and Progress Tracking

AMA will monitor progress on IPS projects through the methods outlined below:

1. As described in STC 84, RCOs must submit quarterly work plan status reports to AMA. The status reports must reflect the implementation status and progress for each IPS project according to approved project milestones, performance measures and related timeframes. RCOs must have a method to gather requisite status report information from participating providers and must provide status reports in a format approved by AMA. AMA will provide further guidance on the work plan status report format through notices to RCOs and through AMA's IPS webpage.
   For all RCO Quality Measures selected to monitor an IPS project through the IPS application process, RCOs must calculate and report measure performance on behalf of participating providers using data from administrative systems, medical records, and electronic records or through other approved processes, in accordance with AMA specifications. RCOs must calculate measure performance both at the individual provider level and in aggregate for all participating providers that are relevant to the measure (e.g., the RCO would not calculate measure performance for hospitals on the timeliness of prenatal visits measure). Because many of the RCO Quality Measures, including the DSHP accountability measures, are annual measures, these measures will only be available to be reported once a year. RCOs must have processes in place to validate that the data they receive from providers for milestone and measure progress reporting is complete and accurate. Exhibit B-3 includes a listing of all of the RCO Quality Measures and indicates which of the four RCO program objectives each of the RCO Quality Measures can be used to evaluate.

   For selected performance measures other than RCO Quality Measures, the RCO and participating providers must jointly develop the approach, subject to AMA approval, for accurately reporting on the measures at both the individual provider level and in aggregate for all participating providers. RCOs must also have mechanisms for ensuring participating providers are progressing towards meeting project milestones and measure targets.

   The approach for reporting and monitoring both RCO Quality Measures and other selected performance measures must be described at a high level in the initial IPS application and must be submitted to AMA for approval along with the first quarter's work plan status report.

   AMA will review status reports to determine whether the IPS projects are progressing and, therefore, eligible to receive future IPS payments. Upon request, the RCO and participating providers must provide documentation to support the information included in the status report. This reporting will continue through the duration of the IPS project. Based on the quarterly status reports submitted, AMA may withdraw further IPS funding if it determines that the IPS project is not meeting its intended objectives and established goals.

   AMA, or its designee, will review the IPS work plan status reports to monitor and track performance related to project milestones and performance measures. This review will include an assessment of progress and challenges identified in each status report, and an evaluation as to whether any modifications to the IPS project approach are necessary to accelerate progress. AMA will post summary information from these reviews on AMA's IPS webpage. AMA staff will work collaboratively with RCOs and participating providers to proactively identify strategies to improve milestone progress and measure performance. These findings will be used to identify opportunities for learning collaboratives, during which RCOs will share learnings from IPS

projects with relevant RCO network providers, including providers who may not be participating in IPS projects.

2. AMA will require RCOs to report on IPS project spending and the distribution of IPS funds to providers throughout the duration of the IPS project through work plan status reports.

3. In accordance with STC 38, AMA will submit quarterly progress reports to CMS. One of the elements of these quarterly progress reports is a summary of how many IPS work plans have met the payment criteria at each payment milestone interval. These quarterly progress reports will also provide updates to CMS on challenges and key achievements related to the IPS program.

4. In accordance with STC 67, AMA will work with an independent evaluator to complete a final evaluation report for the overall demonstration. This evaluation report will include an evaluation of the IPS program and an assessment of the impact of the approved IPS projects on the RCO program objectives and DSHP accountability metrics.

5. In partnership with AMA, RCOs participating in the IPS program will be responsible for developing learning collaboratives to provide training and education on topics related to IPS projects and facilitate peer-to-peer learning. The learning collaboratives will be especially valuable in sharing leading practices and lessons learned for similar IPS projects across RCO regions. The primary audience for the learning collaboratives is Medicaid providers who are participating in the RCO program. Once learning collaboratives are scheduled, notification of the dates, locations, and relevant audiences will be communicated through AMA's IPS webpage and other targeted communication.

6. In addition, outside of the IPS program, AMA requires through the RCO Contract that RCOs submit annual, quality measure data that has been audited by the AMA-contracted external quality review organization. This requirement extends beyond the duration of the demonstration and will be a mechanism through which AMA tracks progress on the RCO Quality Measures. AMA will closely evaluate performance of these quality measures, with particular attention to the DSHP accountability measures which are a primary focus of the IPS program.

H. Distribution of IPS Payments

The maximum payment amount for an IPS project will be determined in accordance with the formula in STC 85.

AMA will distribute IPS payments for each IPS project on a quarterly basis over the duration indicated in the approved IPS application (not to exceed beyond March 2019). The amount of each IPS payment will be based on completing required elements of the quarterly work plan status reports and the amount of progress made, using a status report format approved by AMA. AMA may consider progress towards achievement of milestones and measure targets in the approved IPS application as part of the IPS payment determination. AMA will provide further guidance on the payment determination process through notices to RCOs and through AMA's IPS webpage.

RCOs will retain their administrative percentage of each IPS payment (up to 10 percent of the total payment) and distribute the remaining amount to providers in accordance with the approved IPS application. Payments from the RCO to providers must occur within 30 calendar days of the RCO's receipt of payment from AMA.

I. Transition Pool Terms

By executing an RCO Contract with AMA, the RCO acknowledges and agrees that the Transition Pool Terms, attached hereto as Exhibit B-4, shall apply and control all expenditures, or proposed expenditures, of IPS funds, including, but not limited to, any suspension, delay, reduction, termination or recoupment of expenditures of IPS funds. As a condition for submitting an application related to an IPS work plan/project, a provider must agree to accept the terms and conditions of the Transition Pool Terms, which shall apply to and control, all expenditures, or proposed expenditures, of IPS funds to the provider. It is the RCO's responsibility to ensure that all providers submitting applications to the RCO for IPS funds bind themselves to the applicable terms of the STCs and the Transition Pool Terms.

J. RCO Conflict of Interest Policy

The RCO's application review process must be fair and impartial, including, but not limited to, strictly following the conflict of interest requirements set forth in Alabama Medicaid Administrative Code Rule 560-X-62-.08 (referenced above and attached as Exhibit B-5), as well as the RCO's own conflict of interest policy that has previously been approved by the AMA.

K. IPS Appeals Processes

Any provider whose application is not selected by the RCO for submission to AMA may make a written request for review of the RCO's decision to the Medicaid Quality Assurance Committee in accordance with the proposed Alabama Medicaid Administrative Code Rule 560-X-62-.27, a copy of which is attached hereto as Exhibit B-6. The Medicaid Quality Assurance Committee may request of both the provider and RCO any information and documents necessary for its review. The RCO's decision shall be entitled to a presumption of correctness, and the Medicaid Quality Assurance Committee shall only reverse the RCO's decision if it finds the application in question satisfies all other requirements and either of the following: (i) that the decision was made on unreasonable grounds or without proper consideration or (ii) any applicable conflict of interest policy was violated during the RCO's decision making process.The Medicaid Quality Assurance Committee shall promptly forward to AMA for consideration any application it determines should have been sent to AMA by the RCO for award consideration. The Medicaid Quality Assurance Committee's decision shall be final and conclusive, and not subject to further review. No member of the Medicaid Quality Assurance Committee who also served as an officer or director of the RCO that reviewed the application that is at issue or is an officer, director, agent, or employee of the provider that submitted the application shall be entitled to vote on or participate in the Medicaid Quality Assurance Committee's review of that application.

In accordance with Section 6 of the proposed Alabama Medicaid Administrative Code Rule, an RCO that has submitted an application that has been rejected by AMA, or the provider or group of providers whose work plan is the subject of such application, may submit a written request for reconsideration to AMA. Such written request shall be submitted to the AMA no later than 5 business days after AMA's decision has been published, and shall state with specificity the issues that the RCO or provider(s) believes warrant a reconsideration by the AMA. AMA shall respond to a reconsideration request within a reasonable time.

3. Exhibit B-1. IPS Application Exhibit B-2. Participating Providers Letter of Commitment

Purpose: This form must be completed by participating providers that wish to participate in the Integrated Provider System (IPS). Participating providers are defined as any qualifying provider (e.g., primary care physicians, hospitals, etc.) that will receive payment from the RCO for implementing the proposed IPS work plan/project. By completing this form, providers are committing to implementing and supporting the proposed IPS work plan/project.

Name of RCO Submitting IPS Application: _____ RCO Region: __

IPS Project Name(s): _____

Attestations:

By signing in the space below, the participating provider attests that the following information is true:

- I am committed to implementing and supporting the IPS project(s) named above as described in the IPS application submitted to Alabama Medicaid.
- I have read and shall comply with all applicable terms of the Alabama Medicaid's Transition Pool Terms, IPS Protocols and other applicable regulations and policies.
- I understand that the maximum IPS award will cover no more than 90 percent of the approved IPS budget up to a maximum of $20 million. The RCO and/or participating provider(s) will contribute the remaining funds to implement the IPS work plan/project.
- I will ensure that any IPS funding that I receive will be used in accordance with the IPS work plan/project approved by Alabama Medicaid and to improve quality and beneficiary outcomes by supporting at least one of the following demonstration/RCO program objectives:
    - Improved prevention and management of chronic disease;
    - Improved access to and care coordination of health services;
    - Improved birth outcomes; or
    - Healthcare delivery system financial efficiency
- The funds I will receive under this IPS work plan/project are not duplicative to other federal grants and other federal funding that I receive.
- I have viewed the trainings provided by the Alabama Medicaid Agency on 3/10/2016 titled "Overview of IPS Program and Application Process" and on 3/16/2016 titled "Question & Answer Session on IPS Program."
- By the time I receive any IPS funding, I will have a valid contract with the RCO submitting this application and coordinating and monitoring this IPS work plan/project.
- If this IPS project includes Medicaid beneficiaries projected to be enrolled in RCOs other than the sponsoring RCO, by the time I receive any IPS funding, I will have a valid contract with the other RCO(s) in the region. I will also share with the sponsoring RCO all data necessary to calculate performance on quality measures, even if the data are for services I provided to Medicaid beneficiaries enrolled in RCOs other than the sponsoring RCO.

_____

Print or Type the Participating Provider's Name

_____ _____

Print or Type the Authorized Representative's Name | Title

_____ _____

Authorized Signature | Date Signed

4. Exhibit B-3. RCO Quality Measures by RCO Program Objective

The table below lists the RCO Quality Measures and indicates which of the four RCO program objectives each of the RCO Quality Measures can be used to evaluate. While all of the RCO Quality Measures are included in this table, as part of the IPS program, AMA will give higher priority to IPS projects that impact the DSHP accountability measures and the RCO quality withhold measures as described in Table 5 above.

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
1	**Access to Care/ Equitable Health Outcomes**	**Adults' Access to Preventive/Ambulatory Services [All Ages]**	This measure is used to assess the percentage of members 20 to 44 years, 45 to 64 years, and 65 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each age stratification and product line (commercial, Medicaid and Medicare) and a total rate.	X	X		
2		**Ambulatory Care, ED Visits**	This Measure summarizes the utilization of Emergency Department Visits for the Medicaid population. Numerator is the number of ED visits, Denominator is the eligible population. Reported as a ED rate	X	X		X
3	**Cardiovascular/ Obesity**	**Adult BMI Assessment**	Percentage of adults 18 years old or older with valid BMI documentation in the past 24 month.	X	X		
4		**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 primary care physician (PCP) or an OB/GYN and who had evidence of: 1) body mass index (BMI) percentile documentation, 2) counseling for nutrition and 3) counseling for physical activity during the measurement year.	X	X		
5	**Care Coordination**	**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.		X		X

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
6		**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.		X		X
7	**Chemical Dependency**	**Assessment and Management of Chronic Pain**	This measure is used to assess the percentage of patient's age 16 years and older diagnosed with chronic pain who are screened for chemical dependency before being prescribed opioid medication.	X	X		
8		**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.		X		
9		**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. - 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.- Engagement of 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.		X		

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
10		**Medical Assistance With Smoking and Tobacco Use Cessation**	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users 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. 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. 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.	X	X	X	
11	**Inpatient Care**	**Ambulatory Care-Sensitive Condition Admission (1)(2)**	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.	X	X		X
12		**Elective Delivery**	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed.			X	X

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
13		**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: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/Denominator) 5. Total Variance	X	X		X
14	**Internal Medicine**	**Cervical Cancer Screening (2)**	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	X	X		
15		**Comprehensive Diabetes Care (2)**	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%) (NQF#0059), HbA1c control (<8.0%) (NQF#0575), HbA1c control (<7.0%) for a selected population, Eye exam (retinal) performed (NQF#0055), Medical attention for nephropathy (NQF#0062), Smoking status and cessation advice or treatment	X	X		X
16		**Medication Management for People with Asthma (2)**	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: 1. Percentage of members who remained on an asthma controller medication for at least 50% of the treatment period. 2. The percentage of members who remained on an asthma controller medication for at least 75% of the treatment period	X	X		X

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
17		**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]	X	X		
18		**ER Utilization Rate for Asthma Patients**	ER Utilization rate for Asthma patients, this is the same metric currently used by PCNAs.	X	X		X
19	**Maternity/Infant Mortality**	**Prenatal and Postpartum Care (1)(2)**	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. 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. 2. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.		X	X	X
20		**Percentage of Live Births Weighing Less Than 1,500 Grams**	The percentage of births with birth weight <1,500 grams			X	
21		**Percentage of Live Births Weighing Less Than 2,500 Grams (2)**	The percentage of births with birth weight <2,500 grams			X	X

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
22		**Frequency of Ongoing Prenatal Care**	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 prenatal visits: •<21 percent of expected visits •21 percent–40 percent of expected visits •41 percent–60 percent of expected visits •61 percent–80 percent of expected visits •=81 percent of expected visits This measure uses the same denominator as the Prenatal and Postpartum Care measure.		X	X	X
23	**Mental Health/ Behavioral Health**	**Antidepressant Medication Management (2)**	The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) 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). b) 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).	X	X		X
24		**Follow-Up After Hospitalization (within 30 days) (Behavioral Health-Related Primary Diagnosis) (2)**	This measure assesses the percentage of discharges for members 6 years of age and 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. Rate: The percentage of members who received follow-up within 30 days of discharge.		X		X

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
25		**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.		X		X
26		**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.		X		
27		**Diabetes Screening for people With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications**	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.	X	X		
28		**Follow-Up Care for Children Prescribed ADHD Medication**	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: 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 with prescribing authority during the 30-day Initiation Phase. 2. Continuation and Maintenance (C&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 (9 months) after the Initiation Phase ended.		X		X

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
29		**Mental Illness: Risk-Adjusted Rate of Readmission Following Discharge for a Mental Illness**	This measure is used to assess the risk-adjusted rate of readmission following discharge for a mental illness for individuals 15 years and 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.		X		X
30		**Screening for Clinical Depression and Follow-up**	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 > 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 depression whose current PHQ-9 score indicates a need for treatment.		X		
31	**Oral Health**	**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 <19, with the denominator to be total population.		X		X
32		**Total Eligibles Who received Preventive Dental Services (ages 1-20)**	The total unduplicated number of children receiving dental preventive services		X		
33	**Patient Safety**	**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.		X		
34		**Patients Who Reported that YES, They were Given Information about what to do During Their Recovery at Home**	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.		X		

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
35	Pediatrics	**Adolescent Well-Care Visits (1)(2)**	At least one comprehensive well-care visit with a primary care practitioner or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year. The primary care practitioner does not have to be assigned to the member.	X	X		
36		**Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (1)(2)**	Percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year	X	X		
37		**Childhood Immunization Status**	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); 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.	X	X		
38		**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).	X	X		-
39		**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.	X	X		-
40		**Immunizations for Adolescents**	The percentage of adolescents 13 years of age who had recommended immunizations by their 13th birthday	X	X		

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
41		**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: •No well-child visits •One well-child visit •Two well-child visits •Three well-child visits •Four well-child visits •Five well-child visits •Six or more well-child visits	X	X	X	
42	**Transition of Care**	**Care Transition – Transition Record Transmitted to Health Care Professional (2)**	Care transitions: percentage of patients, regardless of age, discharged from an 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.	X	X		X

Exhibit B-4. Transition Pool Terms

ALABAMA MEDICAID AGENCY

ALABAMA MEDICAID TRANFORMATION (PROJECT NUMBER 11-W00299/4)

TRANSITION POOL TERMS

1. INTRODUCTION

The Centers for Medicare & Medicaid Services ("CMS") has approved Alabama's request for a five year section 1115 demonstration entitled, "Alabama Medicaid Transformation", Project Number 11-W00299/4 (the "Project"). CMS' approval of the demonstration is conditioned upon compliance with the special terms and conditions for the Alabama Medicaid Transformation, including all attachments thereto (the "STCs"), which detail the operation of the demonstration, including the nature, character, and extent of anticipated federal involvement in the Project. Under the demonstration, the state aims to improve care to and the health of its beneficiaries by moving from a fee-for-service delivery system to enrollment in managed care under locally-administered, provider-based Regional Care Organizations (each an "RCO"). To support the implementation of this new service delivery system, CMS has authorized expenditure authority for a time-limited Transition Pool for the first three years of the demonstration. The Transition Pool allows federal match for additional payments to RCOs and providers in order to improve medical services to Medicaid beneficiaries and reward RCOs and providers who have met the reporting, operational, and quality measures described in the STCs. The Transition Pool contains two components – the transition payments to RCOs (the "Start-up Cost Component") and transition payments to selected providers (the "Integrated Provider System Component" or "IPS Component"). Transition Pool funds are to be used only to support the goals of the transformation under the demonstration.

2. WHEN AN RCO OR PROVIDER IS DEEMED TO ACCEPT THESE TERMS

By executing the Regional Care Organization Contract (the "Risk Contract") with the Alabama Medicaid Agency (the "Agency"), the RCO acknowledged and agreed that these Transition Pool Terms (these "Terms") shall apply to and control all expenditures, or proposed expenditures, of funds from the Transition Pool. The RCOs shall ensure that all providers that submit applications for the award of any Transition Pool funds shall bind themselves to the applicable terms of the STCs and these Terms; provided, however, that by submitting to an RCO an application for an award of any funds from the Transition Pool, a provider shall be deemed to have accepted, and these Terms shall apply to and control, all expenditures, or proposed expenditures, of funds from the Transition Pool. If a provider DOES NOT wish to be subject to these Terms, the provider shall not furnish to an RCO any application for an award or otherwise accept (directly or indirectly) any funds from the Transition Pool.

3. GENERAL REQUIREMENTS FOR TRANSITION POOL EXPENDITURES

The expenditure of Transition Pool funds shall be governed by the STCs, as they may be amended from time to time, including, but not limited to, the requirements, conditions, restrictions, methodologies, and annual limits contained in section XIII of the STCs applicable to the Transition Pool funds (currently STCs 77-88), by these Terms (and any material referenced herein), and any applicable provision of the Risk Contract. All such expenditures are subject to CMS approval and

each RCO and provider receiving Transition Pool funds acknowledge that their receipt and retention of any such Transition Pool expenditures is conditioned upon such approval. RCOs and providers acknowledge reviewing and understanding the STCs and these Terms, and agree to fulfill all requirements and conditions contained therein which are applicable to each. Without limiting the foregoing, the RCOs and providers shall provide to the Agency, within the time and in the manner established by the Agency, all reports and other information required by them in the STCs, or needed by the Agency to fulfill its obligations to CMS, including, but not limited to, the requirements set forth in STCs 38 (Quarterly Progress Reports), 75 (Consequences to RCOs for Failing to Fulfill Requirements or Meet Performance Standards), 80 (Methodology for Determining Payment to RCOs), 84 (Reporting work plan status to Alabama Medicaid Agency), 85 (Methodology for Determining Payment to Participating Providers), and 86 (Quality Metrics for Provider Work Plans). Further, the RCOs and providers shall cooperate with and assist the Agency in fulfilling its monitoring, intervention, and remediation obligations contained in the STCs, and shall cooperate fully with any intervention and/or remediation plan established by the Agency and/or CMS, as referenced in STC 75b. (Intervention to Improve Quality).

Any commitment by the Agency of funds from the Transition Pool shall be contingent upon receipt by the Agency of such funds from CMS. Without limiting the foregoing, payment by the Agency of any funds from the Transition Pool is contingent upon the availability of federal and state monies lawfully applicable for such purposes. If the Agency, in its sole discretion, determines at any time that sufficient funds are or will not be lawfully available for the Agency to make payments from the Transition Pool, including, but not limited to, those included in an award of funds from the IPS Component for provider work plan(s), the Agency shall notify the affected RCO(s) to that effect, whereupon the amount of payments from the Transition Pool shall be reduced, in whole or in part, to an amount the Agency determines, in its sole discretion, is available to fund such expenditures.

As a condition precedent to the receipt of each and every disbursement of Transition Pool funds, an RCO and, if applicable, the provider(s) participating in an approved IPS work plan, must be in full compliance with all applicable terms of the STCs, these Terms, and the terms of the Risk Contract, and all providers participating in an approved IPS work plan must have an existing provider contract with the sponsoring RCO. If at any time prior to final payment of an approved IPS work plan the provider contract of any provider participating in an approved IPS work plan is terminated, both the sponsoring RCO and relevant provider(s) shall notify the Agency in writing of such termination within 3 business days of the termination. In addition, both the sponsoring RCO and relevant provider(s) shall submit with such notice a proposal for the continuation, or termination, of the IPS work plan. The Agency, in its sole discretion, shall thereafter decide whether, and under what conditions, such IPS work plan shall be continued or terminated, all subject to CMS's approval.

No Transition Pool funds awarded may be assigned or transferred by the recipient thereof, except in accordance with the express terms of the STCs. No RCO or provider awarded Transition Pool funds may assign, delegate or transfer their responsibilities under an award without the advance written approval of the Agency.

4. SUSPENSION, DELAY, REDUCTION OR TERMINATION OF EXPENDITURES FROM THE TRANSITION POOL

All Transition Pool expenditures, and any commitments made by the Agency regarding Transition Pool expenditures, may be withdrawn, suspended, reduced, delayed, amended or terminated (in whole or in part and in the sole discretion of the Agency) as follows:

a) To the same extent CMS withdraws, suspends, reduces, delays, amends, or terminates the terms of the demonstration or the Agency's expenditure authority thereunder;
b) The Agency discovers the RCO or provider submitted inaccurate or incomplete information with its application for an award of any funds from the Transition Pool; or
c) The Agency determines by audit or other investigation that Transition Pool funds have been misused by the RCO or provider.

In addition, the Agency may withdraw approval and further funding of a work plan in accordance with STC 86 (Quality Metrics for Provider Work Plans).

The Agency may terminate all payments, and terminate, suspend, delay or otherwise amend the terms of any commitments with respect to future payments, made by the Agency regarding Transition Pool expenditures, including, but not limited to, those included in an awarded IPS work plan, should the RCO or, if applicable, the provider(s) receiving funds, directly or indirectly, from the IPS Component, breach any applicable and material provision of the STCs, these Terms, or the terms of the Risk Contract.

Upon early termination of the Risk Contract for any reason under Section 5 of the Risk Contract, the Agency shall immediately and permanently withhold all future payments of Transition Pool funds to the RCO. Should the Risk Contract be terminated pursuant to Subsection 5.1.2 of the Risk Contract at any time during the initial term of the Risk Contract, all Start-Up Component payments previously paid to the RCO shall be promptly refunded to the Agency, in addition to any other amounts owed to the Agency under the Risk Contract. Should the Risk Contract be terminated pursuant to Subsection 5.1.6.3 of the Risk Contract, recoupment or repayment of Start-Up Component shall be made in accordance to the terms of that section, in addition to any other amounts owed to the Agency under the Risk Contract.

Should an RCO receive any funds from the Start-up Cost Component and thereafter not provide any Covered Services as defined in the Risk Contract, the RCO shall refund to the Agency all funds it received from the Start-up Cost Component.

Should the Risk Contract of an RCO that has been awarded an IPS work plan be terminated prior to final payment of the IPS work plan, the Agency, in its sole discretion, shall thereafter decide whether, and under what conditions, such IPS work plan shall be continued or terminated, all subject to CMS's approval.

5. RECOUPMENT BY THE AGENCY OF TRANSITION POOL EXPENDITURES DISTRIBUTED TO RCOs AND PROVIDERS

Expenditures from the Transition Pool are subject to recoupment or recovery if it is determined that such funds were misused and/or information relied upon for payment was in error or misreported to the Agency or if the Agency made an error in determining payment. Further, Transition Pool

payments are subject to recoupment or recovery to the extent CMS: (a) withholds or revokes approval for such payment or (b) recoups, recovers or makes a negative payment adjustment of such amount from the Agency.

6. REQUIREMENT TO MAINTAIN AND PRODUCE RECORDS AND AGENCY AUDIT RIGHTS

RCOs and providers receiving awards shall maintain timely and accurate financial and administrative records related to all Transition Pool funding received. Unless a longer period of time is required by applicable statute or regulations, records shall be maintained for at least 10 years from the date funds are received.

Audits may be performed by the Agency and CMS to validate submissions made to the Agency and performance metrics regarding Transition Pool expenditures. Adjustments may be made to payments from the Transition Pool, and recoupment or recovery of amounts already paid, based on the findings of the audit. The Agency and CMS shall have the right of access to all pertinent books, contracts, documents, papers, and records of the RCOs and providers for the purpose of making audits, financial reviews, examinations, excerpts and transcripts. This right also includes timely and reasonable access to RCO's and provider personnel for the purpose of interview and discussion related to such matters and documents. This right of access is not limited to the demonstration period, but shall last as long as the records are required to be maintained under these Terms.

7. PROCEDURES, REQUIREMENTS, AND CONDITIONS REGARDING TRANSITION POOL EXPENDITURES

In order to obtain funds from the Transition Pool, RCOs and providers must strictly follow the procedures set forth in the STCs, the Integrated Provider System Protocols (STC 88) (the "IPS Protocols"), these Terms, and any applicable regulations and policies promulgated by the Agency. The amount of Transition Pool payments shall be calculated in accordance with the terms of the STCs, and is subject to reallocation and reconciliation as provided in the STCs, including, but not limited to, the terms of STC 80 (Methodology for Determining Payment to RCOs) and 85 (Methodology for Determining Payment to Participating Providers).

IPS work plan applications properly submitted to the Agency will be scored as described in the IPS Protocols. By submitting an application to the Agency, the RCO and applicable providers acknowledge and agree that, due to the limitations, conditions and restrictions contained in the STCs, the Agency will likely be unable to approve all qualified work plans seeking IPS Component funding which are submitted to it, and that approval or denial of IPS work plans will be based upon the scoring method referenced in the IPS Protocols and the Agency's determination, made at its sole discretion, of which plans are in the best interest of the Program, and that the Agency may adjust the IPS award amount from the amount requested by the IPS application to ensure funding for an appropriate mix of IPS work plans in each RCO region and across the State, and to the extent the Agency determines such adjustment is in the best interest of the Program. Other than the reconsideration process referenced in the regulations and the IPS Protocols, the Agency's decision whether to approve or award an IPS work plan shall be final and conclusive. In the event of a

reconsideration, the Agency's decision on reconsideration shall be final and conclusive, and not subject to further review.

RCOs will retain their administrative percentage of each IPS payment (up to 10 percent of the total payment) and distribute the remaining amount to providers in accordance with the approved IPS application. . In the event an RCOs obligation to administer and monitor a work plan per the requirements of STC 86 (Quality Metrics for Provider Work Plans) shall terminate prior to full implementation or completion of such work plan, for any reason whatsoever, and including, but not limited to, the termination of the Risk Contract, then the RCO shall forfeit all rights with respect to any portion of the Management Fee that remains unpaid as of such date. No later than 30 days after an RCO receives payment from the Agency pursuant to an approved IPS work plan, such RCO shall pay to the participating provider(s) its/their share of such payment.

RCOs and providers acknowledge and agree that all expenditures of funds from the IPS Component made to them will be spent in strict conformance with the terms of the awarded IPS work plan.

Each RCO and provider acknowledges and agrees that it has been provided equal notice and opportunity to submit work plans in accordance with the STCs, these Terms and the IPS Protocols. Each RCO and provider agrees that communications with the Agency regarding specific IPS work plans will be conducted via RCOQuality@medicaid.alabama.gov or during open discussions at scheduled meetings. RCOs acknowledge and agree that all information provided to the Agency related in any way to the Transition Pool, including, but not limited to, all information submitted in connection with the IPS Component and IPS work plans, may be released by the Agency to CMS and released publically for comment in accordance with the requirements of the STCs.

8. MISCELLANEOUS PROVISIONS

RCOs and providers shall be bound by all decisions of CMS which relate in any way to the Transition Pool, to the same extent the Agency is bound by such decisions. Further, RCOs and providers shall be bound by any and all amendments to the STCs.

To the extent allowable under the law, should the Agency be entitled to the recoupment of any Transition Pool expenditures made to an RCO, the Agency shall be entitled to withhold such amount from payments under the Risk Contract.

RCOs and providers shall be responsible for complying with all applicable laws, ordinances, codes and regulations of the Federal, State and local governments, including, but not limited to, the Beason-Hammon Alabama Taxpayer and Citizen Protection Act (§ 31-13-1, *et seq*, Code of Alabama 1975) and those described in section 26.2 of the Risk Contract.

To the extent a conflict exists between the terms of the STCs and these Terms, the terms of the STCs shall control. If any provision of these Terms shall contravene any statute or Constitutional provision or amendment, either now in effect or which may, during the demonstration be enacted, then that conflicting provision in these Terms shall be deemed null and void. These Terms shall be automatically amended to reflect changes or amendments to the STCs, and to reflect any changes in relevant federal or state law, regulation or policy during the demonstration period. Without

limiting the foregoing, some or all expenditures from the Transition Pool may be reduced to reflect any similar reduction or amendment made by CMS.

5. Exhibit B-5. Rule No. 560-X-62-.08 Conflict of Interest Policy for Directors and Officers of Regional Care Organizations

(1) A regional care organization (RCO) and an organization with probationary RCO certification shall adopt a conflict of interest policy for directors and officers. The conflict of interest policy shall require all directors and officers to conduct their activities as directors or officers so that they do not advance or protect their own interests, or the interests of others with whom they have a private or professional relationship, in a way that is detrimental to the interests of, or to, the RCO or organization with probationary RCO certification, and the conflict of interest policy shall provide for the removal of any director or officer whose conduct violates such policy, unless a remedial action shall be sufficient to bring the director or officer into compliance with the policy. The conflict of interest policy shall require each director and officer to disclose in a written statement all employments, associations, commitments and financial interests within the preceding two years on the part of the director or officer, or his or her immediate family member, including spouse, dependents, adult children and their spouses, parents, spouse's parents, siblings and their spouses, that could reasonably be perceived, directly or indirectly, as a conflict of interest with the RCO or organization with probationary RCO certification. The statement shall also disclose whether the director or officer or his or her immediate family member as described in the preceding sentence is a current or former employee of, consultant with, or lobbyist for the Medicaid Agency. Each director and officer shall file such disclosure statement with the RCO's or organization's board of directors and the Medicaid Agency on an annual basis.

(2) The conflict of interest policy must also:
(a) Require each director or officer to disclose relevant financial interests;
(b) Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise; and
(c) Address remedial action for directors or officers that fail to comply with the policy.

(3) A RCO and an organization with probationary RCO certification and each of its directors and officers must complete and submit to the Medicaid Agency the Disclosure Statement required by Act 2001-955 prior to the RCO entering into a contract with the Medicaid Agency.

(4) All employees and agents of the Medicaid Agency who have responsibilities relating to contracts with a RCO or an organization with probationary RCO certification must comply with applicable provisions of the state ethics laws including, but not limited to, Sections 36-25-5, -7, -8, -11, -12, and -13 of the Alabama Code.

(5) The Medicaid Agency may require a RCO or an organization with probationary RCO certification and each of its directors and officers to comply with additional conflict of interest requirements and policies the Medicaid Agency determines to be necessary to satisfy State and Federal requirements or necessary to address issues of noncompliance with the requirements of this Conflict of Interest Rule.

6. Exhibit B-6. Rule No. 560-X-62-.27 Integrated Provider System Application Selection Process – NEW RULE

(1) The Integrated Provider System ("IPS") application process shall be conducted in accordance with the special terms and conditions issued by CMS (the "STCs") and the IPS Protocols approved by CMS pursuant to STC 88.

(2) The probationary or fully certified regional care organization's (hereinafter collectively referred to as "organizations") review of applications/work plans (hereinafter "applications") submitted to it by providers or groups of providers must be conducted pursuant to a fair and impartial process, including, but not limited to, the organization strictly following the conflict of interest policy for directors and officers of the organization as set forth in Alabama Medicaid Administrative Code Rule 560-X-62-.08, as well as the organization's own conflict of interest policy that has been approved by the Agency.

(3) No later than July 1 of each demonstration year, each organization shall publish and distribute to all providers and groups of providers that submitted applications to the organization and the Agency a listing of all applications received by the organization, including a summary of each application, and the disposition of each application (i.e., whether it was forwarded to the Agency for review or not).

(4) A decision of the organization not to submit an application to the Agency shall be subject to review by the Medicaid Quality Assurance Committee under the following conditions:

(a) Any provider whose application is not selected for submission to the Agency may, no later than July 8 of each demonstration year, make a written request for review of the decision to the Medicaid Quality Assurance Committee, in accordance with this rule, Alabama Administrative Code Rule 560-X-62-.13(12) and all other applicable rules, policies, protocols, and procedures adopted by the Agency. The applicant shall provide the organization a copy of its written request for review at the same time it submits its request to the Medicaid Quality Assurance Committee.

(b) Upon receipt of the request for review, the Medicaid Quality Assurance Committee may request of the applicant or the organization any information and documents necessary for its review and the applicant and organization, as the case may be, shall have 5 business days to provide the Medicaid Quality Assurance Committee with the requested information and documents. In addition, even if not requested by the Medicaid Quality Assurance Committee, the organization may provide the Medicaid Quality Assurance Committee with information and documents the organization relied upon in support of its decision.

(c) The organization's decision shall be entitled to a presumption of correctness, and the Medicaid Quality Assurance Committee shall only reverse the organization's decision if it finds the application in question satisfies the requirements contained herein and either of the following: (i) that the decision was made on unreasonable grounds or without proper consideration or (ii) any applicable conflict of interest policy was violated during the organization's decision making process and. The Medicaid Quality Assurance Committee shall make its decision on all review requests submitted to it no later than July 27 of each demonstration year, and shall notify the applicant(s), the Agency, and the organization of its decision, and shall promptly forward to the Agency for consideration any application it determines should have been sent to the Agency by the organization for award consideration. The Medicaid Quality Assurance Committee's decision shall be final and conclusive, and not subject to further review.

(d) No member of the Medicaid Quality Assurance Committee who also served on an officer or director of the RCO that reviewed the application that is at issue or is an officer, director, agent, or employee of the provider that submitted the application shall be entitled to vote on or participate in the Medicaid Quality Assurance Committee's review of that application.

(5) Applications properly submitted to the Agency, whether directly by an organization or by the Medicaid Quality Assurance Committee, will be evaluated, scored and considered by the Agency as described in the IPS Protocols. Except for the reconsideration process described in subsection (6) below, the Agency's decision whether to accept and/or award applications shall be final and not subject to further review or appeal.

(6) An organization that has submitted an application that has been rejected by the Agency, or the provider or group of providers whose work plan is the subject of such application, may submit a written request for reconsideration to the Agency. Such written request shall be submitted to the Agency no later than 5 business days after the Agency's decision is announced, and shall state with specificity the issues that the organization or provider(s) believes warrant a reconsideration by the Agency. The Agency shall respond to a reconsideration request within a reasonable time. The Agency's decision on reconsideration shall be final and not subject to further review or appeal.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.
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