DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

FEB - 9 2016

Stephanie Azar
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, AL 36104

Dear Ms. Azar:

The Centers for Medicare & Medicaid Services (CMS) is approving Alabama's request for a new five year Medicaid demonstration under section 1115(a) of the Social Security Act (section 1115 demonstration) entitled, "Alabama Medicaid Transformation" (Project Number 11-W00299/4). The enclosed special terms and conditions (STCs), waiver list and expenditure authorities are effective April 1, 2016 through March 31, 2021. Under the demonstration, the state will reform its delivery system. 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 (RCOs). This demonstration is consistent with our commitment to creating a health care delivery system that delivers better care; a system that spends health care dollars more wisely; and a system that makes our communities healthier. The project also aligns with efforts of the Department of Health and Human Services to support adoption of new payment models that reward the delivery of high quality, efficient care across multiple payers, including Medicare and Medicaid.

RCOs are new organizations, developed and run locally, to help address Alabama's urgent public health needs. RCOs will be responsible for providing care coordination and other interventions aimed at improving health for Alabama Medicaid beneficiaries. RCOs will operate consistent with Medicaid managed care rules and most Medicaid beneficiaries will either choose between at least two RCOs in their region or have the ability to opt into fee-for-service Medicaid if there is one RCO in their region.

RCOs will provide most state plan services—including both physical and behavioral health services—while a limited number of services, such as targeted case management, nursing facility services, and school-based services will continue to be provided on a fee-for-service basis. Certain individuals such as children in foster care, dual eligibles, and individuals receiving long term care supports and services will not be served through the demonstration and will continue to receive care via the fee-for-service system.

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 pool will reward those RCOs and providers who have met operational targets. The targets are designed to support RCO-led quality improvements that will lead to better health outcomes for Medicaid beneficiaries enrolled in RCOs. The demonstration authorizes one time (not subject to renewal) expenditures on certain Designated State Health

Programs (DSHP), which decline over the years of the demonstration and a portion of which is contingent upon realization of annual delivery system goals, such as reduction in ambulatory care-sensitive condition admissions and improved timeliness of prenatal visits. These expenditures are to be used only to support the goals of the transformation under the demonstration, including the transition pool. The state will transition the managed care authority to a section 1932(a) of the Social Security Act (the Act) state plan amendment or section 1915(b) waiver by the end of the five-year demonstration.

The demonstration is approved in accordance with section 1115(a) of the Act. CMS' approval of the demonstration is conditioned upon compliance with the enclosed STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. A copy of the STCs, waivers and expenditure authorities are enclosed.

Your project officer for this demonstration is Ms. Julie Sharp. She is available to answer any questions concerning your section 1115 demonstration. Ms. Sharp's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-2292
Facsimile: (410) 786-5882
E-mail: Juliana.Sharp@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Sharp 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

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, State Demonstrations Group, Center for Medicaid and CHIP Services at (410) 786-9686.

Sincerely,

/s/

Andrew M. Slavitt
Acting Administrator

Enclosures

cc: Jackie Glaze, ARA, Region IV

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.

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 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-W00299/4**

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 expenditure 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 approved 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 18 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 435.916the 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 baseline 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	$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

Illness Community Programs			as the total amount does not 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	N/A

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
		with the DY 1 annual report.	
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 (AMA) and CMS approved payment methodology, is implemented	State reports in annual report that RCOs have demonstrated that 100% of all hospitals in the RCO networks 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	10% of $89,217,000 ($8,921,700 is deducted from DSHP limit for 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	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**
	that 45.3 percent of adolescents receive at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner.		
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	N/A	N/A	25% of $20,000,000

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
April 1, 2020-March 31, 2021			($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)*

82. 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 87. All valuation of provider work plans is subject to audit.

83. Integrated Provider System Eligibility for Payment. The following types of providers that have contracts with at least one RCO are eligible to submit a work plan to the RCO to apply for 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)

84. 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.

85. 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.

86. 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*	Work plan status report; submitted two weeks prior to the end of the second quarter	Last day of second quarter	

through end of Work Plan			
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	

87. 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.

88. 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 82;
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

89. 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 four groups by the work plan topics described in STC 82, 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 120 days following the end of the demonstration. The state must submit the final evaluation report within 60 days after receipt of CMS' comments	STC 65
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 Program Protocol
[RESERVED]