Alabama Medicaid Agency

Plan First Program

Section §1115 Demonstration Waiver

Annual Report

Demonstration Year 17

January 1, 2017 through September 30, 2017

Fiscal Year 2017

October 1, 2016 through September 30, 2017

April 4, 2018

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I. Introduction

The Alabama Medicaid Agency's (Medicaid) Plan First Program began October 1, 2000. It represents a collaborative effort between Medicaid and the Alabama Department of Public Health (ADPH). The Plan First Program increases the availability of family planning services to all women of childbearing age (19-55) with incomes at or below 141% of the federal poverty level (FPL) that would not otherwise qualify for Medicaid or lost Medicaid coverage 60 days postpartum. A standard income disregard of 5% of the federal poverty level is applied if the individual is not eligible for coverage due to excess income. The Plan First Program was predicated on the recognized need for continued family planning once Medicaid maternity eligibility was terminated after the postpartum period, and for those women who would not otherwise qualify for Medicaid unless they were pregnant.

The previous Waiver was approved for effective dates of April 12, 2012, through December 31, 2013. The Centers for Medicare and Medicaid (CMS) granted an extension of the Waiver, effective June 27, 2013, through December 31, 2014. In 2014, Medicaid requested an extension of the Section §1115 Plan First Demonstration Waiver and an approval was granted by CMS, effective December 29, 2014, through December 31, 2017. During this Waiver extension, two new covered services were added, removal of migrated or embedded intrauterine devices in an office setting or outpatient surgical facility and coverage of vasectomies for eligible Plan First males, 21 years of age or older.

In November 2016, Medicaid submitted a Waiver amendment to CMS requesting authority to extend the state's enhanced family planning counseling and case management service (referred to as "care coordination ") to Plan First male enrollees with respect to arrangement for and follow-up to receipt of vasectomy services. CMS approved the amendment on June 28, 2017.

In 2017, Medicaid requested a five-year extension of the Section §1115 Plan First Demonstration Waiver. CMS approved the Waiver extension application on November 27, 2017, effective November 27, 2017 through September 30, 2022.

II. Executive Summary

Plan First is designed to improve the well-being of children and families in Alabama whose income is at or below 141% of the Federal Poverty Level (FPL) by extending Medicaid eligibility for family planning services to eligible childbearing women between the ages of 19-55 and males, ages 21 or older, for vasectomy related services only. Recipients have freedom of choice in deciding to receive or reject family planning services. Acceptance of any family planning service must be voluntary without any form of duress or coercion applied to gain such acceptance. Recipients are required to give written consent prior to receiving family planning services. Plan First recipients are exempt from co-payments on services and prescription drugs/supplies designated as family planning.

Plan First enrollees must meet one of the eligibility criteria described below.

Group 1

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Women 19 through 55 years of age who have Medicaid eligible children (poverty level), who become eligible for family planning without a separate eligibility determination. They must answer "yes" to the Plan First question on the application. Income is verified at initial application and re-verified at recertification of their children. Eligibility is re-determined every 12 months.

Group 2

Poverty level pregnant women 19 through 55 years of age whose pregnancy ends while she is on Medicaid. The Plan First Waiver system automatically determines Plan First eligibility for every female Medicaid member entitled to Plan First after a pregnancy has ended. Women automatically certified for the Plan First Program receive a computer-generated award notice by mail. If the woman does not wish to participate in the program, she can notify the caseworker to be decertified. Women who answered "no" to the Plan First question on the application and women who do not meet the citizenship requirement do not receive automatic eligibility. Income is verified at initial application and re-verified at re-certification of their children. Eligibility is re-determined every 12 months.

Group 3

Other women age 19 through 55 years of age who are not pregnant, postpartum or who are not applying for a child. A Modified Adjusted Gross Income (MAGI) determination will be completed using poverty level eligibility rules and standards. Recipient declaration of income will be accepted unless there is a discrepancy. The agency will process the information through data matches with state and federal agencies. If a discrepancy exists between the recipient's declaration and the income reported through data matches, the recipient will be required to provide documentation and resolve the discrepancy. Eligibility is re-determined every 12 months.

Group 4

Plan First men, ages 21 and older, wishing to have a vasectomy. Men may complete a simplified shortened Plan First application (Form 357). An eligibility determination must be completed using poverty level eligibility rules and standards. Eligibility will only be for a 12-month period; therefore, retro-eligibility and renewals are not allowed. If the individual has completed the sterilization procedure but has not completed authorized follow-up treatments by the end of the 12-month period, a supervisory override will be allowed for the follow-up treatments. If the individual does not receive a vasectomy within the 12-month period of eligibility, then he will have to reapply for Medicaid eligibility.

In February 2013, AMA implemented automated Express-Lane Eligibility (ELE) renewals for Plan First women as well as children. Medicaid's eligibility system automatically completes the renewal process using a monthly data match with the SNAP and TANF programs. Plan First women and Medicaid children due to renew and found to be active on SNAP, TANF or both are automatically renewed and a renewal notice is generated and sent to the renewed household. This expedited renewal process, completed by the system, requires no participation from the case worker or recipient, enhancing the enrollment process.

Medicaid uses the Federal Hub services to verify income (IRS, SSA, Equifax), SSN, citizenship and alienage, (DHS) as well as other sources (SVES, SDX, PARIS, SNAP, TANF, EDB, vital

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statistics,) to verify income and other points of eligibility as listed in the Alabama verification plan.

Alabama also has a Hub waiver through which we use The SAVE web system (Systematic Alien Verification for Entitlements) for the VLP (verify lawful presence) steps 2 and 3 as needed. VLP 1 is completed through the Federal Hub. Alabama uses the hub service for on-line identity verification.

For income, Alabama uses the following reasonable compatibility model:

1. If available databases find no match, self-attestation will be accepted.
2. If individual self-attestation of income and data match are both below the Medicaid/CHIP MAGI eligibility level, individual will be determined eligible for Medicaid/CHIP benefits.
3. If individual self-attestation of income and data match are both above the Medicaid/CHIP MAGI eligibility level, individual will be determined ineligible, and account transferred to FFM for APTC eligibility.
4. If individual self-attestation of income is above Medicaid/CHIP MAGI level, but data match puts applicant below the Medicaid/CHIP MAGI eligibility level, individual will be determined ineligible and account transferred to FFM for APTC eligibility.
5. If individual self-attestation of income is below Alabama Medicaid/CHIP MAGI level, but data match puts applicant above the Medicaid/CHIP MAGI eligibility level, reasonable compatibility level of 10% will be applied. If less than 10% difference, data is considered reasonably compatible and individual will be determined eligible for Medicaid/CHIP benefits. If more than 10% difference and individual can provide a reasonable explanation (either already indicated on the application, or after formal request from the state), the individual will be determined eligible for Medicaid/CHIP benefits. If more than 10% difference and individual cannot provide a reasonable explanation, the individual will be determined ineligible for Medicaid/CHIP.

Individuals may also renew on-line and receive a real-time eligibility renewal without worker intervention with real time eligibility verification through the Federal Hub.

Upon eligibility approval, recipients receive an award letter informing them of their Medicaid coverage. A letter is also generated if the recipient's services are denied, terminated, suspended, or changed. Appeal rights are included in the letter.

The following goals and hypotheses were targeted for DY 17:

- Increase the portion of income eligible women, ages 19–55 enrolled in Plan First and reduce race/ethnicity and geographic disparities among enrollees.

  Goal-Enroll 75 of all eligible clients (based on census estimates of the eligible population) under age 40 across all race/ethnicity and geographic area groups, thereby

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eliminating disparities across these groups. Census data will be used to generate estimates of the eligible population.

- Maintain the high level of awareness of the Plan First Program among program enrollees.

  Goal-90% of surveyed enrollees will have heard of the program and 85% of these will be aware that they are enrolled in the program. Telephone surveys of enrollees will be used to track changes in levels of awareness of the program and enrollment in the program.

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

  Goal- The proportion of Plan First enrollees who use family planning services in the initial year of enrollment will be 70% and service use will increase by 60% in subsequent years.

- Survey data suggest that approximately one third of Plan First enrollees are cigarette smokers, and 85% of these were advised by their family planning providers to quit smoking.

  Goal-25% of Plan First service users (85% of the 30% who are smokers) will receive either a covered Nicotine Reduction Therapy (NRT) prescription, a referral to the Quit Line or both.

- Maintain birth rates among Plan First service users that are lower than the estimated birth rates that would be occurring in the absence of the Plan First Demonstration.

  Goal-Maintain the overall birth rate of about 100 births per 1000 Plan First enrollees.

- Increase the usage of the Plan First Waiver by making sterilizations available to males ages 21 years or older.

  This goal will be evaluated based on the number of sterilizations performed statewide.

The Annual Evaluation Report for DY17 is still under draft. The report will be submitted to CMS at completion. The anticipated completion date is April 30, 2018. This report will contain the progress of the measures and the achievement of the goals.

Program Highlights

In 2017, CMS approved Alabama’s Plan First Program Waiver extension application on November 27, 2017. The five-year approval included the authority to provide smoking cessation services as a separate service in addition to family planning services. Plan First recipients can receive smoking cessation services and products as authorized in Alabama's approved Medicaid State Plan and provided by the ADPH, through partnership with the Medicaid.

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Reporting Schedule

Demonstration Year	Begin Date	End Date	Annual Report Due Date (90 days following end of Annual date)
15	January 1, 2015	December 31, 2015	March 31, 2016
16	January 1, 2016	December 31, 2016	March 31, 2017
17	January 1, 2017	September 30, 2017	March 31, 2018

Significant Program Changes

- In November 2016, Medicaid submitted a Waiver amendment to CMS requesting authority to extend the state's enhanced family planning counseling and case management service (referred to as "care coordination ") to Plan First male enrollees with respect to arrangement for and follow-up to receipt of vasectomy services. CMS approved the amendment on June 28, 2017.

- In 2017, CMS approved the Alabama's Plan First Waiver extension application on November 27, 2017. The five-year approval included the authority to provide smoking cessation services as a separate service in addition to family planning services. Plan First recipients can receive smoking cessation services and products as authorized in Alabama's approved Medicaid State Plan and provided by the ADPH, through partnership with the Medicaid.

III. Enrollment and Renewal

The table below captures enrollment figures for the following populations:

- *Population 1:* Women losing Medicaid pregnancy coverage at 60 days postpartum
- *Population 2:* Women 19-55 with income at or below 141 percent of the FPL
- *Population 3*: Men 21 and over with income at or below 141 percent of the FPL

	Demonstration Year 15 January 1, 2015 through December 31, 2015			
	Population 1	Population 2	Population 3	Total Demonstration Population
# of Total Enrollees	17,228	13,336	249	429,211
# of Participants	*	*	249	117,312♦
# of Member Months	49,722	36,756	1,102	1,079,346

	Demonstration Year 16 (January 1, 2016 through December 31, 2016)			
	Population	Population	Population	Total Demonstration

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	1	2	3	Population
# of Total Enrollees	11,774	9,799	477	385,579
# of Participants	*	*	477	91,661♦
# of Member Months	67,944	58,794	2,862	767,937

*****Currently Alabama Medicaid is unable to track Populations 1 & 2 ongoing as once a recipient "flips" from maternity to Plan First after the 60th postpartum day or is awarded Plan First coverage, they do not stay in that group and become part of the total population the following month. Alabama Medicaid is also unable to track those enrolled with Express-lane Eligibility ongoing as markers identifying those recipients are removed when matching with SNAP and TANF data.*

♦ *Recipients with a billable service during the quarter (active participants).*

	Demonstration Year 17 January 1 , 2017 through September 30, 2017)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# of Total Enrollees	N/A	107,651	1,091	108,742
# of Participants	N/A	40,260	30	40,290
# of Member Months	N/A	709,607	6,154	715,761

* *DY17 is indicated as 'NA' because the Agency does not have complete maternity statistics for this reporting period.*

IV. Quality Assurance

Alabama Medicaid Agency

The Plan First Program has several quality assurance and monitoring components. Medicaid provides general quality oversight for the Plan First Program through direct monitoring and serves as the clearinghouse for other activities. Oversight includes, but is not limited to:

- Random audits of recipient records to ensure provider compliance with program requirements and guidelines
- Review of utilization reports to monitor trends and utilization
- Review of care coordinator activity summary reports
- Review of summary reports from UAB
- Review and monitor complaints and grievances to acceptable resolution
- Ensure appropriate function of claims system edits and audits to prevent duplication of payments

Record Reviews

In September 2017, Medicaid audited ADPH's Care Coordination program to ensure compliance with program guidelines. Findings were identified and a corrective action plan was implemented. Funds in the amount of $135.00 were recouped for services billed inappropriately. Further record reviews are being conducted by Medicaid's Program Integrity Division. Provider education was completed as a component of this review.

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Utilization Monitoring

Medicaid continues to monitor over-utilization and under-utilization of care coordination. To assist with monitoring. Effective May 1, 2017, Medicaid implemented a policy and system change to add Procedure Codes and modifiers to distinguish face to face encounters from other care coordination activities such as letter writing and postcard communications. The electronic data will be pulled annually to determine utilization and record reviews will be conducted. A utilization audit will occur in 2018 using the new implementation of the Procedure Codes and modifiers.

Alabama Department of Public Health

The Alabama Department of Public Health conducts regularly scheduled internal audits of the care coordination records and program operations utilizing a standardized audit tool. Six weeks after new care coordinators complete certification training, the Central Office training staff reviews the care coordinator's documentation and submits written report to their supervisor. The Public Health Program Integrity staff randomly reviews patient records in county health departments for compliance with travel reimbursement, billing of appropriate time for services, and ensuring that all time coded to Plan First has appropriate documentation to justify billing. A total of 2,388 audits were conducted by Medicaid's monitoring agency with a reported compliance rate of 99%.

The University of Alabama at Birmingham (UAB)

The University of Alabama at Birmingham (UAB) conducts ongoing internal evaluations for this Demonstration Waiver. Their responsibility is to evaluate the program. UAB has designed data collection tools that collect, compile and analyze data, providing feedback annually to the Medicaid and the ADPH on program operation and outcomes. With UAB's assistance, a yearly Demonstration progress report that illustrates progress, goal achievement, and other areas for continued improvement. UAB is not involved in direct patient care for the Plan First Program. Reference Attachment A, Annual Evaluation for DY16.

V. Complaints and Grievances

Complaints and grievances are tracked and monitored until resolution by Medicaid and its partnering Agency, the ADPH. During DY17, Medicaid did not receive any complaints or grievances from beneficiaries, providers or the public and no complaints or grievances were reported on the quarterly reports by Medicaid's partnering agency.

VI. Transition Plan

During DY17, Medicaid did not implement a transition plan for the Plan First Program.

VII. Award Public Forums

As a requirement of the Special Terms and Conditions for the Waiver extension request, Medicaid held an

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open comment period to give the public an opportunity to review and provide input on the §1115 Family Planning Demonstration Waiver that was submitted to the CMS. Two (2) Public Forums were held in different locations: Thursday, May 11, 2017 in Birmingham, Alabama and Friday, May 12, 2017 in Montgomery, Alabama. Questions were received and responses were provided. The questions and responses can be provided at the request of CMS.

VIII. Annual Expenditures

Medicaid is required to provide quarterly expenditure reports using the Form CMS-64 to report expenditures for services provided under the demonstration in addition to administrative expenditures. The chart below includes the expenditure data, as reported on the Form CMS-64 for DY15, DY16 and DY17.

	Service Expenditures as reported on the CMS-64		**Administrative Expenditures as reported on the CMS-64**		**Expenditures as requested on the CMS-37**	**Total Expenditures as reported on the CMS-64**
	Total Computable	Federal Share	Total Computable	Federal Share		
DY 15	$34,504,758.94	$31,054,283.05	$180,231.88	$162,208.70	$36,759,039.00	$34,684,990.82
DY 16	$31,415,107.85	$28,273,597.07	$189,651.21	$170,686.09	$34,908,360.00	$31,604,759.06
DY 17	$20,654,531.53	$18,589,078.38	$119,484.89	$107,536.40	$27,977,507.00	$20,774,016.42

	Demonstration Year 15 January 1, 2015- December 31, 2015			
	Population 1	**Population 2**	**Population 3**	**Total Demonstration Population**
# Member Months	3,805	1,188,680	811	1,193,216
PMPM	$89.12	$26.83	$2.03	$27.01
Total Expenditures *(Member months multiplied by PMPM)*	$339,084	$31,893,273	$1,650	$32,234,008

	Demonstration Year 16 January 1, 2016- December 31, 2016			
	Population 1	**Population 2**	**Population 3**	**Total Demonstration Population**
# Member Months	6,725	1,054,549	7,056	1,068,330
PMPM	$40.41	$27.60	$1.21	$27.50
Total Expenditures *(Member months multiplied by PMPM)*	$271,754	$29,103,698	$8,557	$29,384,008

	Demonstration Year 17 January 1, 2017- September 30, 2017			
	Population 1	**Population 2**	**Population 3**	**Total Demonstration**

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				Population
# Member Months	*N/A	709,607	6,154	715,761
PMPM	*N/A	$28.79	$2.48	$28.56
Total Expenditures *(Member months multiplied by PMPM)*	*N/A	$20,426,757	$15,292	$20,442,049

** Population 1 is indicated as 'N/A' because the Agency does not have complete maternity statistics for this reporting period.*

IX. Actual Number of Births to Demonstration Population

This number captures Plan First participants who received one or more covered family planning services and had an actual birth in the demonstration year.

Demonstration Year	# of Births to Demonstration Participants
DY15	9,643
DY16	7,669
DY17	*N/A

** DY17 is indicated as 'N/A' because the Agency does not have complete maternity statistics for this reporting period.*

X. Cost of Medicaid Funded Births

The average total Medicaid expenditures for DY 15 for a Medicaid-funded birth is noted below.

	Average Total Medicaid Expenditures for a Medicaid-Funded birth
DY15	$8,555
DY16	$9,197
DY 17	*N/A

** DY17 is indicated as 'N/A' because the Agency does not have complete maternity statistics for this reporting period.*

XI. Activities for Next Year

The anticipated activities for DY18 includes putting measures in place to increase utilization of Plan First services and tobacco cessation services. The activities will include measures to:

- Increase public awareness about the Plan First Program
- Increase public awareness regarding tobacco cessation services available to Plan First recipients
- Increase collaboration with ADPH to provide more community outreach to public providers, enrollees and potential enrollees
- Increase auditing and monitoring activities
- Develop a Complaints and Grievance form for providers and recipients with easy web access

- Work with UAB to develop a process to survey recipients who chose to discontinue continuous participation in the program to identify possible barriers and address such barriers
- Research and implement ways to decrease disparities in service areas

XII. Contraceptive Methods

Alabama Plan First Demonstration – Contraceptive Methods			
Demonstration Year 15 (October 2015-September 2016)			
	Number of Contraceptive Method dispensed	Number of Unique Contraceptive Users	Data Source
Male Condom	N/A	N/A	N/A
Female Condom	N/A	N/A	N/A
Sponge	N/A	N/A	N/A
Diaphragm	N/A	N/A	N/A
Pill	6,624	2,739	Paid claims
Patch	21	19	Paid claims
Ring	997	640	Paid claims
Injectable	35,795	15,114	Paid claims
Implant	2,092	1,998	Paid claims
IUD	586	581	Paid claims
Emergency Contraception	N/A	N/A	N/A
Sterilization	315	313	Paid claims

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XIII. DY17 Budget Neutrality Monitoring Worksheet

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

Medicaid Pop 1	**2012**	**2013**	**2014**	**2015**	**2016**	**5-YEARS**
TOTAL EXPENDITURES	40,057,737	41,344,489	38,224,716	31,809,996	27,315,612	$ 178,752,550
ELIGIBLE MEMBER MONTHS	1,149,592	1,277,918	1,301,043	1,194,096	1,069,348	
PMPM COST	$ 34.85	$ 32.35	$ 29.38	$ 26.64	$ 25.54	
TREND RATES						**5-YEAR**
			ANNUAL CHANGE			**AVERAGE**
TOTAL EXPENDITURE		3.21%	-7.55%	-16.78%	-14.13%	-9.13%
ELIGIBLE MEMBER MONTHS		11.16%	1.81%	-8.22%	-10.45%	-1.79%
PMPM COST		-7.15%	-9.19%	-9.33%	-4.11%	-7.47%
						89,112

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	**TREND RATE 1**	**MONTHS OF AGING**	**BASE YEAR DY 00**	**TREND RATE 2**	**DEMONSTRATION YEARS (DY) 2017**	**2018**	**2019**	**2020**	**2021**	**TOTAL WOW**
Medicaid Pop 1										
Pop Type:	**Medicaid**									
Eligible Member Months	-1.8%		1,069,348	-1.8%	1,050,567	1,031,762	1,013,293	995,155	977,342	
PMPM Cost	0.0%	0	$ 25.54	0.0%	$ 26.01	$ 26.01	$ 26.01	$ 26.01	$ 26.01	
Total Expenditure					$ 27,327,762	$ 26,836,117	$ 26,355,751	$ 25,883,983	$ 25,420,660	$ 131,824,273

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	**DY 00**	**DEMO TREND RATE**	**DEMONSTRATION YEARS (DY) 2017**	**2018**	**2019**	**2020**	**2021**	**TOTAL WW**
Medicaid Pop 1								
Pop Type:	**Medicaid**							
Eligible Member Months	1,069,348	-1.8%	715,761	702,948.88	690,366.09	678,008.54	665,872.19	
PMPM Cost	$ 25.54	0.0%	$ 28.56	$ 28.56	$ 28.56	$ 28.56	$ 28.56	
Total Expenditure			$ 20,442,049	$ 20,076,220	$ 19,716,856	$ 19,363,924	$ 19,017,310	$ 98,616,358

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

Actual member months and total expenditures have been entered for the January, 2017 - September, 2017 time period for DY 2017.

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Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2017	2018	2019	2020	2021	
Medicaid Populations						
Medicaid Pop 1	$ 27,327,762	$ 26,836,117	$ 26,355,751	$ 25,883,983	$ 25,420,660	$ 131,824,273

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2016	2017	2018	2019	2020	
Medicaid Populations						
Medicaid Pop 1	$ 20,442,049	$ 20,076,220	$ 19,716,856	$ 19,363,924	$ 19,017,310	$ 98,616,358

Note 1:	Used the historic expenditures and member months from 2012-2016
Note 2:	Added 30 eligible males to approximate member months in DY 2017
Note 3:	Added $12,150 to the total projected total expenditures in DY2017 and calulated the PMPM by dividing total expenditure by eligible member months
Note 4:	Changed PMPM trend rate to 0%

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